HEALTH & DISEASE — GENERAL

1995

JANUARY — MAY.

Drastic strike action looms

By RAY HARTLEY

THE first serious test of the government's resolve to face down public service strikers begins on Tuesday when members of the ultra-left SA Health and Public Service Workers Union (Sahpswu) begin a strike over wages.

The union announced this weekend that its members would occupy government offices and disrupt the delivery of services in the new year in support of a demand for a 15 percent wage increase.

And speaking at the same press briefing in Pretoria, Azanian Peoples' Organisation official Themba Ncalo said his organisation had drawn up secret plans to take senior public servants hostage in support of the striking workers.

Government has repeatedly taken a hard line on a potential strike, saying there was no money to improve wages.

But, said Mr Ncalo, the writing off of Namibia's R700-million debt and the salaries of office bearers was proof there was enough idle government money to meet the union's demands.

The strike announcement came as more substantial right-of-centre and mostly white public servant associations announced they would complete a strike ballot by mid-January with preliminary results showing overwhelming support for industrial action.

Sahpswu's Success Mataitsane said his union would welcome a strike by conservative white public servants as long as they continued to support his union's wage demands.

But, he said, his union did not share the enthusiasm of conservative unions for the constitutional job guarantee for public servants.

"It's quite a tricky situation because we have a problem with directors-generals appointed by the apartheid regime continuing with their jobs".

The strike action would be designed to cause "maximum damage to the regime and minimum damage to us", he said.

Mr Mataitsane said government buildings in all major cities could be occupied on Tuesday, but refused to divulge further details of his union's plan. "In a revolution you don't disclose your tactics," he said.

A union statement described a court interdict preventing a strike at One Military Hospital as "another apartheid tactic to take away our workers' rights".

More money for health

UMTATA. — There would be a marked improvement in the health budget this year compared to the allocation by the former government, President Nelson Mandela said yesterday.

Speaking during a visit to the Bedford orthopaedic hospital here, he said educational institutions and health centres in former homelands were disgraceful when compared to those used by whites. This would have to change fast, he said. — Sapa

Eastern Cape medicine shortages now 'critical'

PORT ELIZABETH — Critical medicine shortages have plunged the Eastern Cape's health system into chaos.

Cape Provincial Administration hospital and health services director Dr Pat Naidoo said medicines were "disappearing" in the Eastern Cape, most notably in the former homelands.

He said some district surgeons were under investigation for fraud. This has been confirmed by Eastern Cape Attorney-General Les Roberts.

It is alleged the surgeons have been submitting inflated claims for services and medicines rendered, totalling millions of rands.

Roberts said he believed there was substance to the allegations of fraud.

Naidoo has blamed medicine shortfalls in the region on a power struggle between the CPA's Cape Town head office and the CPA in the Eastern Cape.

He said the Western Cape CPA last year took control of the Eastern Cape's main medicine supply store in Port Elizabeth, without notifying or consulting anyone.

Naidoo said Western Cape health authorities either did not know about or had chosen to ignore the health crisis in the Eastern Cape.

He said pleas to the Western Cape CPA had been in vain. He had been told the medicine supply stores in the Eastern Cape were assets of the Western Cape CPA.

Naidoo said he was angry that many Eastern Cape hospitals were being forced to buy expensive drugs as a result of shortages of cheaper medicines.

The hospitals' patients were then left with astronomical bills, he said. — Sapa.

New structure for health services

Star 6/1/95

Implementation of a new organisational structure in the Department of Health is to begin this month, the department said in its latest newsletter.

It said the restructuring of health services was well under way.

It involved amalgamating 14 health departments into a national health system based on primary health care.

One of the major challenges was to ensure top departmental posts reflected "the diversity of South Africa's people", the department said.

The new organisational structure has been approved by the Public Service Commission.

The department said top management positions would be new posts requiring new skills. — Sapa.

500 State health jobs due to be axed

(85)

Star 6/11/95

■ BY GLENDA DANIELS

A huge shake-up of the national Health Department is under way, effectively trimming 500 jobs.

The old central health department had a staff of about 7 000, but this will be reduced to about 1 500, with many employees now having to apply for jobs in provincial health departments.

The provinces will absorb 5 000 of the remaining 5 500 employees, Health Ministry Director-General Dr Coen Slabber said yesterday.

He said several press reports had incorrectly claimed that top management officials in the department would have to reapply for their posts. He said that, in fact, most of these old posts would no longer exist.

New positions in central and provincial health departments had been advertised and would continue to be advertised.

■ **Port Elizabeth** — The health crisis in rural former Transkei and elsewhere in the Eastern Cape is deepening and senior officials describe the situation as chaotic, reports **Ecna**.

The region's health delivery system has been plunged into crisis with reports of hospitals and clinics functioning without any water, bodies rotting in morgues at ill-equipped hospitals, severe shortages of doctors and medicines, and poor telecommunications.

The regional government's strategic health manager, Dr Siphiwo Stamper, said the level of care at Transkei hospitals was minimal and the shortage of doctors and medicines critical.

be included. — Sapa.

the SA National Defence Force and the

and Trade and Industry.

Fedsal slams Health Department

THE Federation of SA Labour Unions (Fedsal) has condemned the Health Department's stipulations that senior personnel apply for new posts as part of the department's restructuring.

Health Department director-general Dr Coen Slabber said all but four of the existing positions had been scrapped in the restructuring process, and applications for the 39 new posts were advertised on Wednesday.

Fedsal general secretary Dannhauser van der Merwe said labour relations in the public sector were of grave concern to the federation and would be closely monitored.

Forcing people to reapply for posts many had filled for years was unfair and had been justified by the Ministry as part of restructuring and the creation of new positions.

However, this was often not the case and was being used as a smokescreen to get rid of incumbents.

He said this unfair practice

ERICA JANKOWITZ and KATHRYN STRACHAN

"breaks the morale of many loyal, able and qualified public servants" who were expected to implement government policy. In addition, government had not indicated what the future held for those who were unsuccessful in their applications.

The filling of the 11 000 new public service posts advertised last year would also be monitored as Fedsal did not believe the mistakes of previous governments in employing public servants should be repeated.

Slabber said that in restructuring the national department and devolving most of the staff and functions to the provincial administrations, it was clear that many of the existing functions should no longer be carried out by the national department.

This meant scrapping nearly all existing functions at the national department, and creating new functions and posts.

He said senior officials would be applying for the new posts, but if unsuccessful would still have to be retained by the department at the same salary. Attempts would be made to place them with provincial health authorities. No positions below that of director were affected.

Slabber's post was unaffected as he was taken on on a contract basis by the new Ministry. Three senior posts in the Centre for Occupational Health and the head of the National Institute of Virology were the only other posts remaining unaffected.

Sources said many of the new posts were not significantly different from the old ones, and many saw the restructuring as an attempt to bring in new faces, which had affected morale in the public service.

The target date for new appointments is the end of February.

Deficit in education budget

PIETERSBURG — Northern Transvaal's education department had run up a R239m budget deficit, the region's education minister, Aaron Motswaledi, told teachers, parents and pupils at Lebowakgomo on Wednesday.

There was a deficit of R208m in the former territory of Lebowa and R31m in Venda, he said.

His department was experiencing severe money problems just three months before the 1995/96 budget was to be tabled in the provincial legislature.

"The government will have to come in and bail us out, otherwise we face the next three months with fear," he said.

Another problem facing the department was the province's 1 000 unemployed teachers and the 10 000 who had completed their studies last year.

"This means 11 000 teachers will be looking for work when schools reopen next week. My biggest fear is that even with a pupil-to-teacher ratio of 40-to-one, the province might need only 8 000 teachers."

Motswaledi said the budget was being drafted "in an apartheid way" when the new government came to power.

"We got in and started participating and redirecting the process.

"But it is our experience that it is not easy to get in and undo many years of apartheid in a short time."

He said the province had invited tenders for tents to temporarily relieve a shortage of classrooms. Other tents would be provided by the SA National Defence Force.

Motswaledi appealed to teachers and pupils not to disrupt education with strikes or stay-aways. — Sapa.

Row over MP's death

BLOEMFONTEIN — An initial refusal by hospital authorities to treat Gauteng MP Mandisa Shiceka contributed to her death after a car crash last month, her brother Zweli Shiceka said yesterday.

He said authorities at Bloemfontein's Universitas Hospital insisted she be taken to Bophelong Hospital, historically for blacks.

They agreed only after a long confrontation with him to treat his sister and other injured passengers, he claimed.

The Free State health and welfare department had ordered the hospital to

They were responsible for the deaths of many innocent Malawians," said a al prime minister before the 1994 Reuter-AFP.

New services council heads

WILSON ZWANE

FORMER East Rand Regional Services Council chairman Leon Ferreira and SA National Civic Organisation official Mpho Mofokeng have been appointed chairmen of the new Eastern Services Council.

The council was established by proclamation in Gauteng's extraordinary provincial gazette on New Year's Day and will replace the East Rand RSC.

The new body will have jurisdiction over a much bigger area than the RSC. In addition to areas formerly under the RSC, such as Alberton, Boksburg, Nigel and Greater Germiston, the new body will be responsible for areas such as Bronkhorstpruit, Devon and some parts of Cullinan.

RSCs are responsible for areas not falling under the jurisdiction of the transitional metropolitan councils.

The Eastern Services Council will be responsible for, among other things:

- ☐ The bulk supply of water and electricity;
- ☐ Emergency services;
- ☐ Passenger transport;
- ☐ The upgrading of infrastructure; and
- ☐ Implementing the reconstruction and development programme in rural areas.

Ferreira said while the council came into effect on January 1 in terms of the proclamation, it still had to be formally inaugurated. This would happen soon after he and Mofokeng had received nominations to the council from the CEs of newly established local transitional councils.

He said each TLC would nominate two people — one from the non-statutory componet and another from the statutory component. Non-statutory organisations are those which were not involved in local government in the past.

The North East Rand Transitional Metropolitan Council has also been established, bringing to three the number of such structures in Gauteng. It replaces the town councils of Kempton Park, Tembisa, Midrand, Edenvale and Modderfontein.

The newly established TMC will have three local authorities — Kempton Park/Tembisa, Midrand/Rabie Ridge/Ivory Park and Edenvale/Modderfontein.

Fund 'must be researched'

A NATIONAL health fund should be based on proper research and consultation, the Representative Association of Medical Schemes (Rams) said yesterday.

It was reacting to a statement by Health Minister Nkosazana Zuma that a committee appointed by her had, in principle, agreed to a national health fund. Another committee was investigating its formation.

Rams said planners should take account of the availability of funding, the scope of services the fund would finance, the provision of services and medical supplies, and money management.

Rams chairman Keith Hollis said the fund should be subject to adequate control, independent audit and public reporting.

The fund should provide affordable health care without preventing access to additional paid-for services, and the medical schemes movement should be included. — Sapa.

E Cape doctors fear 'chaos'

HEALTH officials in rural Transkei and the Eastern Cape say the region's health situation has deteriorated to the point of "chaos".

The region's health delivery system has been plunged into severe crisis with reports of hospitals and clinics functioning without any water, bodies rotting in ill-equipped morgues, severe shortages of doctors and medicines and poor communications. The regional government's strategic health manager, Dr Siphiwo Stamper, described the situation at Transkei hospitals and clinics as worse than appalling.

The Transkei was the "sickest patient of apartheid. The situation at Transkei hospitals is pathetic," he said.

Stamper said the level of care at Transkei hospitals was "minimal" and the shortage of doctors and medicines "critical".

A clinic at Nqamakwe, 60km from Butterworth, has been using rain water since New Year's Day when its water pumps broke down.

CPA regional health director Dr Pat Naidoo confirmed that many hospitals, particularly in rural Transkei and Ciskei, were functioning with erratic or no water supplies at all. — *Ecna*.

Eastern Cape drive to recruit health workers

(85) BD 9/11/95

NOMAVENDA MATHIANE

THE Eastern Cape government is undertaking a recruitment drive for health professionals, especially doctors, to upgrade the region's health services.

The move follows findings of the Hospital Services Commission established in September last year which visited 34 hospitals as part of an investigation into the province's health services.

The commission found the area's health delivery system had deteriorated to crisis levels with some hospitals and clinics functioning without water and electricity. There were also reports of bodies rotting in ill-equipped morgues.

It recommended efforts to upgrade hospitals be implemented urgently. Sewerage and drainage systems, kitchen and ablution facilities and medicine and drug supplies were to be dealt with immediately.

Eastern Cape health ministry strategic management team manager Dr Siphiwo Stamper said the problem dated back to the apartheid era and government which did not regard health as a priority.

"The conditions and services are in a poor state. In some areas, the infrastructure has collapsed completely from lack of maintenance. In other areas there is no infrastructure at all," he said.

He said buildings and facilities were not properly maintained because there had been no funds set aside for such expenditure. Other areas had been plagued by a lack of human resources.

Stamper said the situation was worse in rural hospitals.

He said his department was faced with the backlog created by past mismanagement and high expectations of the people.

Hospitals targeted for immediate upgrading were Madwaleni, Tafalofefe, Mount Ayliff, Umtata General, Rietvlei, Bambisa and Canzibe.

The government would lobby central government for more money and approach donor agencies to contribute to solving the province's health problem.

The R1,2bn budget for 1994/95 had to be spread over the former Transkei and Ciskei, the regional health department, Cape Provincial Administration and the Regional Services Council health department.

Stamper said incentives to attract health workers to underprivileged areas were being worked out.

Eskom, govt meet on electricity arrears

BD 9/11/95

WILSON ZWANE

ESKOM, owed more than R1bn in electricity bills, will meet government representatives this week to continue negotiations on how to deal with the debt.

Eskom retail and customer GM Joe Matsau said the meeting would be attended by representatives of central, provincial and new interim local governments.

He said while negotiations on how to deal with the arrears started in 1989 shortly after the utility had taken over electricity supply from black local authorities, the matter would be given "more attention" now that local authorities were amalgamating.

Several white municipalities have expressed concern about inheriting debts of defunct black local authorities.

Meanwhile, Matsau said payment levels were much lower in Vosloorus and Katlehong than in the Benoni area. According to figures, 30% of residents of Vosloorus and Katlehong paid their electricity bills and 50%-60% of residents in Benoni (Daveyton and Wattville) paid their accounts.

He said the utility would now cut off defaulters. The process began last year, but was halted over the Christmas season "to enable people to have lights".

New health

ealth plan

CT 9/1/95

85

Primary care for the unemployed

By CLAIRE BISSEKER

THE government will look this week at ways to implement a national medical insurance scheme to make primary health cover available to the whole population.

Health Minister Dr Nkosazana Zuma will appoint a committee this week to work out the details of a national medical insurance scheme aimed at providing primary health care cover to the unemployed and traditionally uninsured sectors of the population.

The Registrar of Medical Schemes, Mr Danie Kolver, said yesterday: "It may mean that private medical aids are excluded from offering the basic package.

"Alternatively the state may decide to facilitate the delivery of primary cover through a consortium of medical aid schemes or through all the country's medical schemes."

He said the intention was to make medical insurance accessible to those people traditionally uninsured such as township dwellers, squatter and rural communities and the unemployed.

Chief director of health, Mr Coenie Slabber, said national insurance would only cover treatment received by general practitioners and nursing staff at the primary health care level of day hospitals and clinics.

Foreign schemes

Secondary and tertiary health care, such as the services offered by academic hospitals, would not fall under the new system, he said.

Mr Kolver said Canada, Britain, Australia and New Zealand operated on a national scheme which entitled everyone to have access to some basic level of health care funded through national taxation.

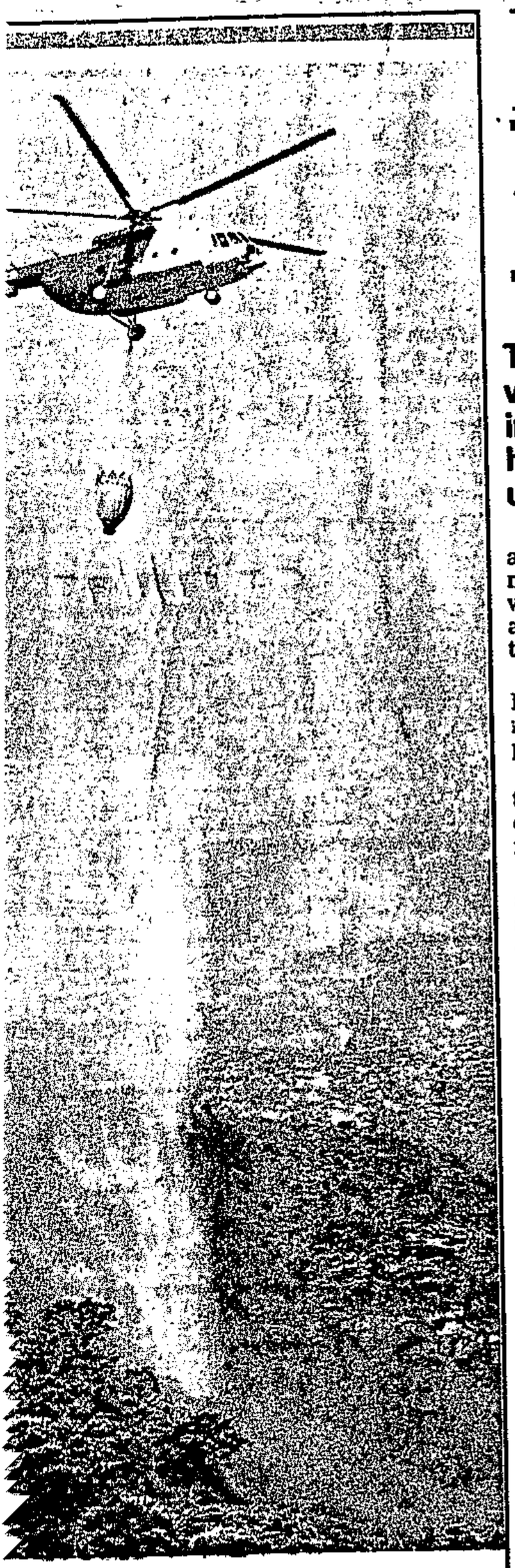
In these countries, private medical aid schemes act as "top-up" insurance only.

Mr Kolver said it was impossible to say, at this stage, what model was favoured for South Africa as there were numerous options available and no firm decisions had been made.

• Mr Deon Harmse, Sanmed chief adviser, recently said the medical aid fund industry could help the government achieve its health care objectives at minimal costs if the existing medical aid fund infrastructure was used to provide for the uninsured.

The costs of the National Health Plan would be 14% of the gross national product.

Mr Harmse said extending the existing medical aid industry by creating a compulsory basic medical aid package for the lower end of the market was far more efficient.



Mil-8 helicopter, contracted by the Cape water over the Constantiaberg along day afternoon to douse a fire which s.

Picture: JACK LESTRADE

National medical insurance 'in by 1996'

(85)

BEATRIX PAYNE

A NATIONAL medical insurance scheme would be introduced sometime during 1996, Health Minister Nkosazana Zuma's special adviser, Dr Olive Shisana, said yesterday.

There were several technical factors that still needed attention and the department needed to consult health service users and providers before the system could be introduced, she said.

Consultations were likely to begin within a few months — once Zuma had studied the recent report of the health financing committee.

Northern Transvaal health and welfare minister Dr Joe Phaahla had said at the weekend that a national medical insurance scheme to replace all existing schemes would probably be introduced before the end of the 1995/1996 financial year.

Shisana said a national scheme would cover only the costs of primary health care such as immunisation, birth control, pre-natal care and education in basic care.

Funding for secondary- and tertiary-level health care — any form of health care requiring the use of a specialist — was likely to be left to private medical aid schemes.

A national insurance system would take much of this burden off the private sector and government would be better able to prevent abuse of the system. BD 11/1/95

National medical insurance would be available to all people, but cross-subsidisation would be used to ensure that the unemployed could qualify for funding, said Shisana.

A system would be introduced to accredit the services of health providers to ensure hospitals provided the same standard of basic care.

The Financial Mail reports today that the Health Department is basing its system on a model designed by Australian doctor and health economist John Deeble.

The magazine said the Deeble plan intended to create a R5,3bn national fund — through a compulsory payroll tax — which would ensure that the employed financed primary health care for the unemployed.

The scheme would bar medical schemes and the insurance sector from funding all general practitioner services.

Medical schemes seek inclusion in health plan

BEATRIX PAYNE

A NATIONAL health insurance fund should not prevent health service users from accessing additional services through the use of supplementary funds, Representative Association of Medical Schemes chairman Keith Hollis said yesterday.

He said Health Minister Nkosazana Zuma needed to consult all interested parties before implementing any system. (85)

"The medical scheme movement should be included as an essential component of the infrastructure to allocate, prioritise, and manage national health funds," he said.

Both private and public sector infrastructure should be used in any system financed by a national health fund to prevent duplication. BD 12/1/95

Hollis urged the Minister to recognise the infrastructure and expertise which existed within the medical schemes movement which was in the process of introducing a nationwide electronic network to connect suppliers and providers.

Reimbursement from a national scheme to service providers should encourage cost-effective use of funds but should not prevent patients from obtaining the care to which they were entitled, he said.

The allocation of limited funds should be prioritised and managed on the basis of reliable information.

"The use of electronically generated information and formalised clinical management systems will greatly assist in this regard," Hollis said.

Medicine shortages cause chaos

PORT ELIZABETH. — Critical medicine shortages have plunged the Eastern Cape's health system into chaos, it was reported yesterday.

Local CPA Hospital and Health Services director Dr Pat Naidoo said medicines were "disappearing" in the Eastern Cape, notably in the former homelands.

He said some district surgeons were under investigation for fraud. This was confirmed by Eastern Cape attorney-general Mr Les Roberts.

Dr Naidoo blamed medicine shortfalls on a power struggle between the CPA's Cape Town head office and the CPA in the Eastern Cape.

He said the Western Cape CPA last year took control of the Eastern Cape's main medicine supply store in Port Elizabeth without notifying anyone.

Salary levy expected to fund national health insurance scheme

(85)
BD 13/11/95

THE Health Ministry released details yesterday of the R6,1bn national health insurance fund to be set up next year.

The health finance committee, appointed by Health Minister Nkosazana Zuma, recommended the fund be financed by a levy of 3% of salaries and wages (1,5% each for employers and employees) and the compulsory contribution (collected through tax) of 2% of annual taxable income from self-employed people.

Ministerial special adviser Olive Shisana said another committee would be set up in two weeks to plan the implementation of the primary health insurance fund — which would be available to contributors and non-contributors.

Estimates based on 1994 figures showed a revenue of R6,1bn could be raised from the new payroll and income taxes, which translated to an average of R152 per person per year.

The committee recommended that the fund pay accredited health centres on a capitation basis. This meant health centres would be paid according to the number of patients registered with the centre — a move which opposed by private doctors.

KATHRYN STRACHAN

The fund would provide universal cover for primary care, including medicines.

The new committee, which would conclude its work by April 23, would be chaired by Shisana and Dr Jonathan Broomberg. Other committee members included Representative Association of Medical Schemes executive director Reg Magennis, Dr Brian Brink of Anglo-American, and Dr H van Heerden of the Health Department.

International members were Australian health economist Dr John Deeble, Prof A Maynard of York University, UK, and Prof WC Hsiao of Harvard University, US.

The committee would prepare a detailed, phased and costed plan for the introduction of the fund.

Shisana said the main deficiency in the health system was in primary care and in the almost complete separation of private doctors from government programmes. About 8 000 private general practitioners served about 20% of the population, leaving about 5 000 to deal with the balance. "Some means must therefore be found to involve the doctors in a national scheme."

Medical schemes would continue to provide cover for hospital and specialist medical services.

The committee recommended that the national health insurance operate through accredited health centres which would be required to provide general medical, nursing and public health services to a defined population. It acknowledged that while the mix of services would vary according to locality, payments to the centres would be based on an assumption that less than 50% of patient contacts would be with a doctor.

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Health crisis

By Glenn McKenzie

HEALTH services in Gauteng could be faced with a shortfall of almost R500 million in the current year and 1995-96, a senior provincial official said yesterday.

Serious budget cuts have forced the country's most populous province to "urgently look at ways of cutting costs", according to Dr Ralph Mgijima, chairman of Gauteng's strategic management team for health.

Mgijima said the province's 1995/96 health budget may be slashed by R200 million to provide funds for more "needy" provinces. And a further R300 million is expected to be cut to pay for debts accumulated by health institutions in 1994.

Mgijima said they hoped to save money by diverting hospital resources towards primary health care projects such as the promotion of disease prevention and rehabilitation and by making the move towards clinics.

To make up for the possible shortfall, Gauteng health officials have applied to the Reconstruction and Development Programme for more than R135 million for the following projects:

- Shifting some health facilities and personnel to clinics;
- Installing computer systems in hospitals.
- Upgrading security systems; and
- Buying devices for physically handicapped people.

In order to cut costs hospitals that are not cost-effective, such as some formerly all-white community hospitals, may be sold or converted to serve the majority.

"We either close these hospitals and take personnel to other areas, or see if we can use them for the larger community."

New health plan

MUSICAL MAESTROS: Cape Town's three top tenors, James Bhemgee, left, Dennis Windell and Fuad Sawyer, get in a bit of enny Pinchers All Stars at the finals of the coon carnival at Green Point stadium tomorrow. **Report on page 5.**

New health care plan

(85) ARG 13/1/95

(From page 1)

Medical aid schemes would continue to provide cover for hospital and specialist medical services and, explained Dr Zuma, state hospitals would still be funded by general taxation.

Ministerial special adviser Olive Shisana said another committee would be set up in two weeks to plan the implementation of the fund.

The estimated cost of the fund was based on 1994 figures, which showed that R6,1 billion could be raised from payroll and income taxes.

It is believed many doctors will be opposed to the fund but Nico Prinsloo, registrar of the South African Medical and Dental Council, said he needed to study the details of the plan more closely before commenting.

(85) 13/1/95 ARG

Each person to pay R152 a year for basic care

The Argus Correspondent

DURBAN. — Basic health care for all South Africans — expected to cost each person an average of R152 a year — will be provided with a R6,1 billion national health insurance fund next year.

Details of a fund for primary health care have been released by the national health department.

The plan will effectively prevent medical aid schemes and health insurance from funding all general practitioner services but will ensure that everyone, whether employed or not, receives basic health care.

A levy of three percent on salaries and wages (1,5 each from employers and employees) and two percent from self-employed people has been recommended by the health finance committee appointed by Health Minister Nkosazana Zuma.

The committee also recommended that the fund pay accredited health centres on a per capita basis.

Dr Zuma said each general practitioner would be expected to register his patients at a centre and would be paid according to those numbers.

She said she envisaged the centres as team practices, including nurses and other health-care workers who would provide preventive health care and health education.

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HEALTH CARE

The socialist option

(85) FM 13/1/95

Health Minister Nkosazana Zuma has instructed her department to proceed with implementing a national health insurance fund for primary health care that will effectively bar medical schemes and the insurance sector from funding all general practitioner (GP) services.

The decision follows the tabling in November of the report of the Health Finance Committee convened last June by special adviser Olive Shisana (*Business* December 16). According to Zuma, the committee, which sat in secret, reached agreement that a national health fund should be introduced and that another committee be appointed to implement it.

Despite the significance of the decision for the health-care industry, Shisana's office has ignored the *FM's* requests for a copy of the committee's report. Health director-general Coen Slabber, however, confirms the department is working from a model designed by Australian doctor and health economist John Deeble.

In a nutshell, the Deeble plan aims to create a R5,3bn national fund — through a compulsory payroll tax — that will ensure the employed finance primary health care for the unemployed. A cornerstone of the new policy is the belief that universal cover for primary care will be possible and affordable only if the State alone funds and provides these services. It is envisaged that State-run centres will supply the bulk of services and private GPs will be contracted to the State on an annual fixed fee per head of R180 each. This is calculated on the assumption that the average person visits a GP three times a year and for each visit will need prescription drugs of only R20. All drugs will be supplied by the State.

The logic for barring the private sector from funding GP services is clear. In a 15-page document, Deeble stresses that a new system is needed to end the present two-tier or "two-class" primary health-care delivery system. He makes it clear, too, that the primary health fund is the first step towards a national health system.

Says Deeble: "Experience everywhere has shown that a parallel private system invariably raises the costs and prices which the public sector must pay. More than 70% of the 40m-50m services provided by private GPs are covered by medical insurance. In any national scheme, the services would have to be spread but there appears to be little chance of attracting GPs to a national programme at affordable prices while their practices are well supported by medical aid."

Speedie ... *standards will decline*

But he does not apply the same logic to hospital and specialist services. "The present system of delivering hospital and specialist medical services is sound in principle, relatively cost-effective and needs no fundamental change."

So, for now, medical aid and private insurance cover are still allowed for specialist and hospital services.

But forcing doctors into State service by barring the private sector from funding their services seems to be a blatant contravention of the principle of economic freedom enshrined in the constitution. Says National Association of Private Hospitals chairman Riel du Toit: "By stressing the need to discourage the development of an ancillary cash market for GP services outside the system, Deeble seems to be admitting the State cannot provide care at the same level the private sector can and wants to prevent people from experiencing quality care."

Hospital group Presmed joint MD Rob Speedie says: "The individual should be free to dispose of his income any way he deems fit." He adds that there is much concern that once the State is the sole provider and funder of services, the user (employer and employee) will have no alternative and standards will plunge.

Hospital care ... *still covered by medical aid?*

Health economist and Wits economics professor Duncan Reekie warns that a payroll tax is dangerous. "The compulsory payroll tax or employer mandate was the main reason for the defeat of US President Bill Clinton's health plan. The White House had to admit it would lead to huge unemployment by pushing up the cost of labour."

Rams chairman Keith Hollis says Rams is willing to participate in the challenge of extending health services. Rams has been criticised by the industry for allowing its executive director, Reg Magennis, to sit on the financing committee when the rest of the public was excluded.

The mechanics of implementing the Deeble proposal are fraught with difficulties. Can people be expected to believe that another State bureaucracy will be able to administer such a big fund after failing dismally with the MVA and AA funds? Says Du Toit: "The proposed system implies sophisticated information systems and databases that would take the State years to establish. The cost, along with the administrative expense, would take much of the money assigned for health services."

The greatest political will cannot guarantee the success of a system if the interests of its funders are ignored. Deeble's plan means a real rise in the cost of GP services for most taxpayers with a guaranteed drop in care. Deeble admits medical schemes pay R1,9bn in GP services. The new tax — 1,5% for employees and employers each and 2% for self-employed, along with user charges that would net R180m — will add R3bn to the tax bill and cut the value of GP services to this sector by R800m.

Patients are not likely to be turned away when they need more than the three visits a year. Queuing and overcrowding could soon become rife, leading to the danger of under-servicing — another shortcoming that will be impossible for a monolithic State structure to monitor, says Speedie. For the employed, employees are likely to make greater use of specialist services that will be covered by medical insurance, ultimately pushing up costs for the private sector. Schemes will suffer as common ailments will not subsidise serious treatments.

Masa head of private practice Herc Hoffman says government probably suspects the private sector will pay cash for GP services rather than use the new State structure.

"It would have been easier and more honest for government to introduce an extra tax instead of trying to establish this elaborate structure and risk destroying a fundamentally sound base."

Deeble's calculations also ignore the

billions of rand the private sector structure passes on to the State through taxes and cross-subsidies. In particular, he appears to have ignored that government buys drugs for as little as a fifth as much as private sector patients pay because they cross-subsidise State prices. *Mirryena Deeb*

Health fund for poor blacks could mean tax increase

W/End Star 14-15/4/95 (85) Sowe

PAISLEY DODDS

A HEALTH care fund that would pay for poor blacks to get treated at local clinics could be financed through a tax increase, government officials said yesterday.

A 3 percent tax increase on salaries and wages and a 2 percent increase tax on the income earned by self-employed people would raise the R6,1 billion needed for the proposed fund, said Harm Pretorius, a Health Ministry official.

Final plans for the fund were expected in April, but criticism has emerged that it would unfairly burden white taxpayers who already pay an average of 35 to 46 percent income tax.

"Most white taxpayers already pay money into (private) health plans," said Mike Ellis, health care spokesman for the Democratic Party.

"But there is a common belief that the white taxpayers will again bear the brunt of the social disparity in this country."

While whites are the minority in South Africa, comprising less than 20 percent of the population, they dominate business and their taxes provide the bulk of tax revenue, particularly at the local level.

Under apartheid, successive white governments provided little money for black health care, particularly in rural areas.

The nation's first all-race election in April ended apartheid and brought the ANC to power.

The ANC promised improved health care to poor blacks, but has acknowledged that the Government lacks the money to address the health issue and a myriad other social problems left over from the apartheid era.

Pretorius said the health care fund was designed to give blacks in rural areas access to full health services.

It would provide money to local health clinics on a per-patient basis, bypassing larger hospitals generally in cities and towns.

"I think that if it's handled carefully it will be looked at as an investment rather than a burden," he said. "Taxes would be higher but the result would be worth it."

"Initially, hospitals will experience a drain in funding, and health care clinics will get a boost," said Dr Pascal Ngakane, superintendent of Johannesburg Hospital.

"But in the long term, I think a health care fund will be mandatory if we are to serve the entire population."

Sapa-AP.

Committee chairman may quit (85)

Split arises over national health plan

BD 17/1/95

THE proposed national health insurance scheme has run into difficulty, with Health Minister Nkosazana Zuma overriding her advisers' recommendations and opting for a controversial plan they had rejected.

The health finance committee, appointed by Zuma to examine options, opposes the Deeble model that she selected.

A further setback arose yesterday with reports that one of the two co-chairmen of the committee charged with implementing the model, Dr Jonathan Broomberg, is considering withdrawing because his committee has been limited to the Deeble model and may not investigate other options.

The Deeble model favoured by the Minister would encompass all primary health care, including all general practitioner services under the scheme. GPs' practices — their services and medicines — would be financed by a straight annual fee, paid by the fund, for each patient serviced.

While the Health Ministry has refused to release the report compiled by the finance committee a copy of the report given to Business Day opposes the option based on the Australian model and punted by Australian health economist Dr Jonathan Deeble.

The report says: "Based on the committee's assessment of the pros and cons of the three options and the financial analysis currently available to the committee, we were of the view that option one (the Deeble model) would not be affordable at present. Moreover, we feel the risks to the public sector of option one are too great and the phased approach offered by options two and three are more sensible. Option two was preferred over option three."

KATHRYN STRACHAN

Option two was that primary health coverage be available to everyone, but with a limited choice of provider. Option three was that primary health care and hospital cover would be available to contributors only and that non-contributors would rely on the state.

The report says option one was likely to lead to an almost entirely contracted private provider system, funded through the national health insurance. "The other options are likely to see the public provider network continue, and hopefully strengthen," the report says.

Zuma's special adviser, Olive Shisana, said the Minister extracted from the report elements that she believed were worth pursuing and which she wanted as a basis for further investigations. She said Zuma would not bother to discuss issues which she did not support because they would raise unnecessary concerns.

Despite what was written in the report there was no unanimity in the finance com-

☐ To Page 2

☐ From Page 1

Health plan (85) BD 17/1/95

mittee, she said.

Zuma would not accept a scheme which excluded people who had been deprived of health care all along, Shisana said. The policy recommended by the finance committee was an option that the Minister felt she could not pursue.

She said the other options either failed to integrate the public and private sectors or they excluded the unemployed.

The finance committee was a special advisory committee set up to assist the Minister in reaching a decision and not a formal committee of inquiry, she said.

While the report says the next step is to examine the financial and logistic feasibility of the options, it is understood that Broomberg is reconsidering his position as co-chairman as the implementation committee is limited to implementing only the one option.

He declined to confirm or deny this, saying discussions were under way.

There is also concern that the data produced by the finance committee is too superficial to form a basis on which to decide the new model.

Sources said members of the finance committee were "incredibly unhappy" about the way in which the Health Ministry was approaching the issue.

Brian Brink of Anglo American, who is a member of the implementation committee, said he was aware of these concerns and would investigate them. National Association of Private Hospitals chairman Hiel du Toit said the lack of transparency in the process was unacceptable.

New health fund imminent

(85) Sowetan 18/11/95

■ FREE SERVICES Healthcare facilities will become available to all South Africans:

By Glenn McKenzie

A NEW national health insurance fund will offer primary health care services to everyone and could replace medical aid schemes, a Ministry official said.

Ministry of Health finance committee spokesman Mr Fezile Makiwane said a new insurance plan would allow all South Africans to register for a "minimum period" with a health care facility of their choice.

The plan promises free health care services, including immunisation, general check-ups and other primary services to all South Africans.

The fund would be paid for with a tax on the incomes of employees and self-employed people. Initially, extra funds from the Finance Ministry would also be needed, Makiwane said.

He added that the plan proposed banning private medical aid schemes from funding primary health care services.

Schemes would still be allowed to participate in "secondary and tertiary level care". Some would be contracted by the government to administer the national insurance plan in various regions and districts.

"Many medical aid schemes are already going bankrupt anyway. They will benefit from this plan," said Makiwane. He added that private general practitioners' fears about the plan were not justified. Average GPs would earn about R200 000 a year, equivalent to rates in Australia.

Meanwhile, opponents of the fund have suggested it would allow clinics and hospitals to load their books with patients, while giving poor services. Makiwane rejected the claim, saying clinics and hospitals would lose patients if they gave poor services.

Health plan spat denied

■ BY GLENDA DANIELS

(85) Star 18/1/95

The proposed national health insurance plan favoured by Minister of Health Nkosazana Zuma fostered equity and efficiency, and not merely financial considerations, National Health Insurance Scheme finance committee co-ordinator Fezile Makiwane said yesterday.

Makiwane denied reports that there was a major split in the committee over the insurance plan, saying it was merely being vigorously debated.

Zuma favoured the Deeble model, which proposed universal cover for everyone. It was one of three being considered by the committee.

The second model favoured cover for those in full employment, and the third option was primary health care and hospital cover for contributors only.

Makiwane said Zuma had criticised the second two options, which seemed to have merely taken financial concerns into account.

He added that the final decision would have to take funding into account, as well as personnel resources, infrastructure, timetables and legislation.

National Health Service at hand

Sowetan 19/1/95

(85)

By Mokgadi Pela

THE restructuring of health services could mean that a National Health Service is around the corner.

The Department of Health says the move will mean fusing 14 fragmented health departments into a single system based on the Primary Health Care model.

"This task involves the dismantling of apartheid structures and the creation of new ones. These new structures should be organised in such a way that they can deliver services to all South Africans," says the department.

"Health priorities as identified in the Reconstruction and Development Programme must also be implemented to meet the demands of those deprived by years of neglect under apartheid rule."

The department says one of the major challenges in the process of restructuring was the need to make the Department of Health representative of all the people it serves.

"Posts at the top echelon need to reflect the diversity of South Africa's people."

According to the department, the following goals have been achieved:

● Dividing functions between national authority and provinces to ensure the success of the NHS.

● A new structure for the department has been submitted to the Public Service Commission for advice before implementation.

● Specific issues having an impact on the implementation of the RDP were addressed. These are the rationalisation of national legislation, the development of a nutrition scheme with emphasis on children under six, the implementation of a maternal and child health programme, the formation of a drug policy that will enable the control of the ever-rising cost of medicine and the creation of National Information System that will facilitate the monitoring of the RDP and support the management of Primary Health Care.

● A comprehensive plan to build 140 clinics within the 1994/95 financial year has been prepared in order to provide health services to mostly rural areas.

● A proposal for the training of senior managers in health was developed.

● Two staff members from the lower ranks of the department were sent to the United States Centre for Disease Control to study management practices with a view to take part in the training of staff in the provinces.

'Doctors support a national health insurance scheme'

(85) BD 20/11/95

KATHRYN STRACHAN

A RECENT survey of doctors has found considerable support for a national health insurance scheme.

The most common reason given by the doctors for a national health insurance scheme was that it would lead to a more equitable form of health care delivery, said Marc Blecher of UCT's health economics unit, who conducted the survey among general practitioners in the Western Cape.

Blecher emphasised that all three options put forward so far by the Health Ministry's finance committee were varying forms of national health insurance.

Their approval depended on details of the various schemes, such as payment mechanisms, workload and income.

Doctors' acceptance was crucial in the light of the fact that powerful lobby groups could affect the workability of the final plan, said Blecher.

In his study, Blecher found the most important consideration for doctors was that they should retain professional autonomy, for example in their choice of medication and investigations.

Nearly all doctors believed additional, private "top-up" insurance should remain available to those who wished to use it.

Meanwhile, the National Progressive Primary Health Care Network said yesterday the question of setting up a national health fund was the single most important issue on which the entire health system rested.

"It is important that we get this right," said network director Judi Fortuin.

She said it was crucial that people should be empowered with the skills toenable them to participate in debates on the proposed new health fund.

The network supported the ANC health plan, released before the elections, and any proposal for a national health insurance scheme would be evaluated against the policy put forward in the ANC blueprint.

PEANUTS By Charles Schulz

HEALTH

A fevered imagination

(85) FM 20/1/95

Higher costs and poorer service for all — and an exodus of doctors

Health-care standards will plunge and costs soar if government accepts a proposed national health insurance system that will bar medical schemes and private insurance from funding any GP services. It will force GPs to work for the State and shift responsibility for all primary care to government.

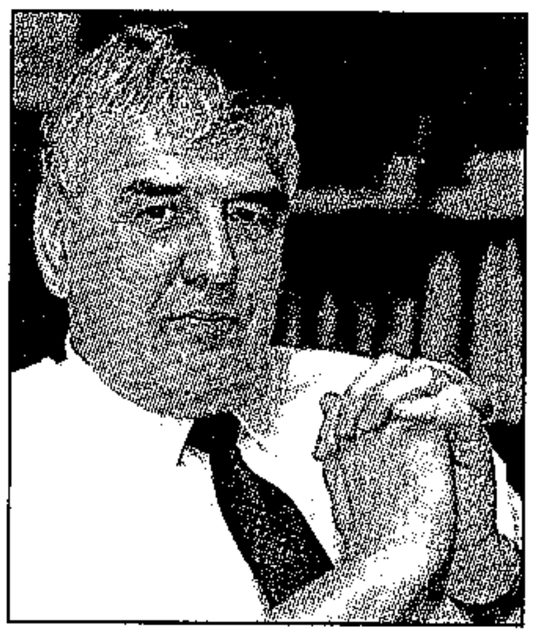
The proposal — by the socialist Australian doctor and health economist John Deeble — has won the approval of Health Minister Nkosazana Zuma. She's now instructed a technical committee to investigate the implementation of the plan.

This decision to change radically the entire health financing structure has been taken without any input from the public or health industry experts. Zuma claims the decision was taken by the Health Finance Committee which was appointed last June by her special adviser, Olive Shisana. The committee — consisting mostly of socialist academics — sat in secret and completed its deliberations last November, but has yet to make public its recommendations.

Zuma

Health director-general Coen Slabber, however, confirms that his department is working from Deeble's model — and Deeble has been appointed to the implementing committee.

Deeble's model aims to raise R5,1bn through a compulsory payroll tax that will subsidise primary care for the poor and unemployed. This is R3,2bn more than the R1,9bn medical aid that members presently pay for GP services. Another R1bn will be added to the fund from the present health budget. User levies will net an estimated further R180m.



Slabber

Deeble believes government will be able to provide universal affordable primary health care if it alone funds and provides these services. So it's envisaged that State-run centres will supply the bulk of services, while private GPs will be contracted to the State on an annual capitation basis (fixed fee per patient, as opposed to fee-for-service) of R180 per patient. This is calculated on the assumption that the average person consults a GP only three times a year and for each visit will need prescription drugs worth only R20. All medicines will be supplied by the State.

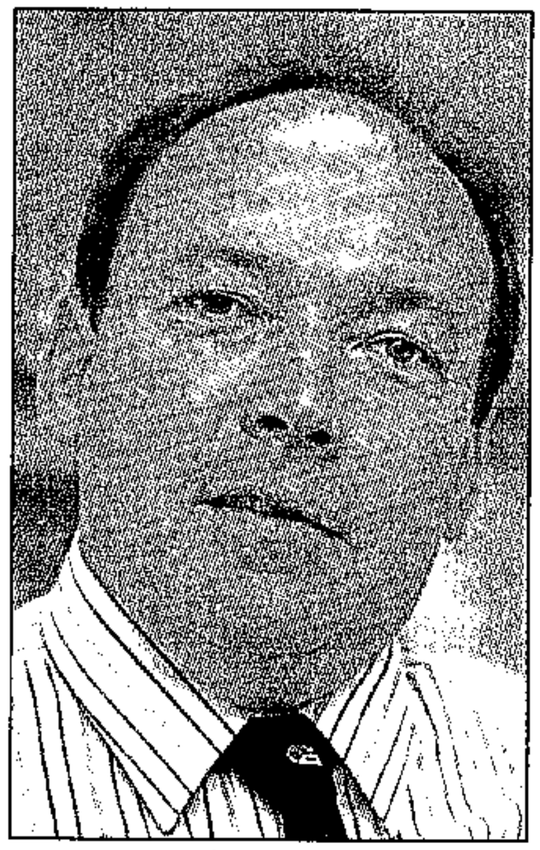
Deeble's logic for barring the private sector from funding GP services is simplistic and contradictory. He stresses that a new system is needed to end the two-tier or "two-class" primary care delivery system.

Says Deeble: "Experience everywhere has shown that a parallel private system invariably raises the price that the public sector must pay. In any national scheme, the services would have to be spread, but there would be little chance of attracting GPs to a national programme at affordable prices while their practices are supported by medical aid."

Deeble doesn't apply the same reasoning to hospital and specialist services — which are still to be covered by medical aid and insurance in his grand plan. Says Deeble: "The present system of delivering hospital and specialist services is sound in principle, relatively cost-effective and needs no fundamental change." But he warns: "There is no reason why public hospitals should not become the sole providers of high cost, high-technology services and no reason why, for insured patients, the insurance funds should not be charged."

The coercion goes further. Says National Association of Private Hospitals chairman Riel du Toit: "By stressing the need to discourage an ancillary cash market for GP services outside the market, Deeble seems to be admitting that the State cannot provide care at the same level the private sector can — and wants to prevent people from experiencing quality care."

Wits economics professor Duncan Reekie points out that a major reason for the defeat of Hillary Clinton's US health plan was her proposed compulsory payroll tax.



Speedie

Deeble claims his model is based on the "successful" UK national health model, but Reekie points out that the features he relies on were abandoned by the UK system in 1991, because they were unworkable. "The reformed UK model exhibits greater market principles," says Reekie.

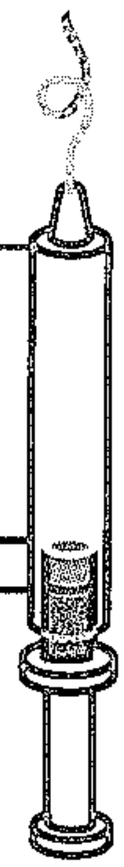
The proposal contradicts the SA government's apparent shift towards privatisation. Says hospital group Presmed joint-MD Rob Speedie: "Why is it now accepted that the private sector can do a better job in the fields of transport, steel production and electricity but not for health care?"

While immediately raising the cost of GP services for the employed by R3,1bn, the new tax — 1,5% each for employees and employers and 2% for the self employed — will immediately cut the value of GP services to this sector by R800m. Deeble also envisages that more than 50% of all care will be administered by a nurse instead of a doctor. This kind of coercion will not please patients, rich or poor.

For the doctors who don't opt to emigrate, the challenge to deliver low-cost care at low capitation rates could prove impossible. Assuming that doctors will still treat patients who exceed their three-visit

PAYING MORE TO GET LESS

FINANCING THE NATIONAL HEALTH INSURANCE FUND



R4,6bn will come from a combined levy of 3% on all salaries and wages

R0,5bn will come from the self-employed as a 2% levy on income

R1bn will come from govt

R6,1bn (estimated total)

annual limit (Deeble admits that three visits is probably inadequate), it's certain that queueing and drug shortages will become the order of the day. Riel du Toit says in practice it's difficult to keep GP visits to less than eight annual visits per patient.

Speedie points out that a remuneration system based on capitation needs to be monitored carefully to ensure that underservicing doesn't take place — a near impossible feat for a monolithic State structure, and an invitation to build more bureaucracy. Du Toit adds that the proposed system implies sophisticated and costly information systems that would take the State years to establish.

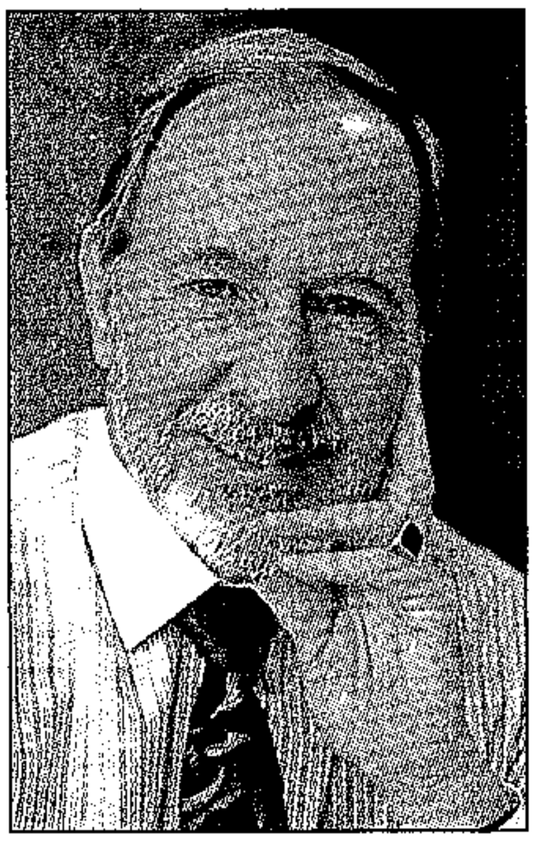
It is also clear that GPs would refer patients for specialist and hospital care more readily, ultimately pushing up the cost spiral for medical schemes.

Medical schemes — serving around 25% of the population — are expected to spend around R12bn this year, compared with the R14bn National Health budget that's available to the other 75% of the population. But the national Budget allocation doesn't have to account for capital expenditures such as fixed and movable property and equipment. State facilities are also able to borrow at substantially lower interest rates. All private sector health services also carry Vat, yielding around R2bn for State coffers.

Then there's the drug bill that makes up 40% of the total health cost. The State has for some 30 years been able to purchase its drugs from the private sector for as little as one tenth the price paid for the same drugs by private sector patients — simply because private patients subsidise the State's bulk purchases. Existing regulations — that Zuma would do better to repeal — also keep the drug prices in the private sector artificially high by barring non-pharmacists from owning retail dispensaries. Hospital group Afrox GM Dick Williamson estimates the total value of the taxes and cross-subsidies passed on to the State at around R5bn.

Implementing Deeble's plan could amount to passing a delayed death sentence for medical schemes. Speedie, the immediate past executive director of the Representative Association of Medical Schemes (Rams), says there's no doubt that the schemes' common risk pool — or the cross-subsidy between serious and less serious ailments — will be eroded as GP care is removed from schemes, along with the tax concession employers presently enjoy for medical aid contributions. Scheme membership could also drop, as members increasingly have to pay cash on the side for good and quick GP care, over and above their tax to the national fund.

Deeble's plan would also undermine medical schemes' ability to offer managed health care options — essential to making private sector health care more affordable and accessible — because it is at the primary care level that health is best managed. In the US, privately managed health-care has cut costs by up to 40%. Says Rams chairman Keith Hollis: "How can schemes be expected to manage care if they are not involved in providing the full spectrum of health care funding?"



Hollis

Certainly, the medical aid system as a funding mechanism, as such, remains sound. Whether schemes can realistically cope with any additional administrative burden, however, is questionable.

Right now, the financial soundness of schemes should be addressed along the lines advocated by the Melamet commission, released last May, but still on Zuma's desk. Melamet recommends greater financial controls and accountability for schemes and greater professional input by people with experience in accounting, law, actuarial science, hospital and business administration. Melamet also called for an end to the regulation that bars employees from chosing to move or stay with a particular medical aid scheme, irrespective of the employers choice.

Ending the tax-concession for employer contributions to medical aid schemes would also make the price of health-care more apparent to employers and encourage bargaining between suppliers and funders.

These are creative options, but Deeble actually admits that private sector alternatives — particularly managed health-care options — haven't been considered.

Certainly, co-operation between the two sectors would help extend health care to the masses. As Du Toit says of hi-tech care: "Once private facilities have covered their basic running costs there's no reason why they can't treat a large number of State

NOT SO BRIGHT

Australian medical economist John Deeble claims his plan for SA is based on the successful UK national health system. It's a claim, however, that needs to be carefully analysed. Health economist and Wits economics professor Duncan Reekie points out that the Deeble document contains mostly elements of the pre-1991 UK model — thrown out because of their inefficiency.

The financing model Deeble recommends for SA talks of "a defined package of primary-care services, to be provided by State-run centres and accredited private GP-run units.

"The accredited centres would be required to provide a specific range of services; to employ qualified staff; and their remuneration would be based on the assumption that less than half of all patient contacts would be with a doctor. Their performance would be monitored and additional charges controlled."

Reekie points out that in 1989, British premier Margaret Thatcher, in an attempt to improve shoddy health delivery in the State-dominant model, set about reorganising the UK national health system to create a "purchaser" and a separate "provider." The GP became the fund holder and NHS hospitals were converted into "trust" hospitals, which sell their services to the doctors. This, claims Reekie, has created competition among hospitals to offer good service. By simulating market principles, Thatcher — acting on the advice of leading US economic adviser Alan Enthoven — also managed to encourage competition between doctors by letting the State's monetary allocation for each patient follow the patient rather than stay with a particular doctor or health centre. Deeble envisages the latter in his model for SA.

Deeble talks about allocating money for services through the provinces to lower level managers or "area health authorities" — a move Reekie says is based on the UK Regional Allocation Working Parties formula. This was abolished in 1991 because it was regarded as highly sophisticated, incomprehensible and unworkable — even for a First World environment.

Deeble's assertion that a parallel private system invariably raises the costs that the public sector must pay is not borne out by the UK experience, says Reekie. He points to research conducted by David Green of the Institute of Economic Affairs in London, showing that medical services were of a higher standard when the private sector was still allowed to exist alongside the public sector between 1911 and 1948. Says Reekie: "Privately employed doctors consistently managed to undercut NHS doctors in price, supply better quality care and show a willingness to work late hours."

Commenting on Deeble, University of St Andrews Head of Health Economics Dr Mo Malek asks: "When will they ever learn? When this was done in the UK, 25% of all GPs emigrated."

patients at a fraction of the real cost." And most private GPs have always treated the poor at very reduced rates — which often include free medicines. Many GPs also discount their services to the State substantially as district surgeons and so on.

Despite Deeble's criticism of the present two-tier system, he needs to be reminded that the State tier has always provided good care to the poor, effectively for free — fees are as little as 50c at State and academic facilities. It is not for nothing that Baragwanath Hospital attracts — and treats — patients from all over Africa.

State-run grand plans won't deliver the goods. Our present system is not perfect, but to break down what does work in favour of a very dubious alternative that has been discredited elsewhere seems like madness. These idealistic social engineers must be stopped before it is too late. *Mirryéna Deeb*

HEALTH — 2

Why the Clintons failed

The US refused to accept enforced medical care by bureaucracy

As President Bill Clinton's overhaul of the US health system lay dying last year, Michael Tannen of the libertarian Cato Institute recalled the joke about the orator at Hyde Park's Speakers' Corner who pledged that when the common man took power he would smoke cigars, wear Armani suits and drink champagne. A common man in the crowd was not impressed. He preferred his pipe, his old tweed jacket and his pint. The speaker, enraged, shot back: "When the common man takes over, he'll bloody well do what he's told."

Oceans of ink have been spilt explaining why Clinton's health reforms, which this time last year were thought to be certain of enactment in some form by the time Congress rose in October, failed so disastrously. Political ineptitude, deep-pocketed special interests, partisan rivalry, putting Hillary Clinton in charge of the effort — all these and more have been cited. In the end, it boiled down to this: the mass of ordinary Americans preferred to stick to what they had, however imperfect, than trust government to do better.

Clinton was inspired by a special Senate election in Pennsylvania in 1991 to make health reform the centrepiece of his election campaign and first term. A liberal Democrat, Harris Woffard, unexpectedly won the seat made vacant by the death of Republican Senator John Heinz.

Woffard had appealed to public fears about rising health costs at a time of severe job insecurity. This led Clinton to believe that there was a huge constituency for sweeping changes, which, properly implemented, would revive the Democratic Party's base much as Franklin Roosevelt's New Deal had done 60 years earlier.

Most Americans obtain health insurance through their employers. Loss of job therefore often means loss of cover. Buying insurance individually, rather than as part of an employee group, tends to be expensive and can be impossible if the purchaser, or a family member, has a serious "pre-existing" condition.

For those without cover but not poor, old or disabled enough to qualify for the federal Medicaid and Medicare safety nets, serious illness can be financially ruinous.

The totally uncovered represent at any given moment about 15% of the population. But this is a highly fluid group. The proportion uncovered for prolonged periods is smaller. A census survey found that only 3,9% had no insurance, public or private, during the 28 months beginning October 1986 — and many of those were younger people less likely to require treatment.

As this suggests, the real problem with the US health system is not the uninsured. The truth is, they tend to be looked after anyway. Contrary to anecdote, uncovered Americans are not left in the streets to die. If they can't pay, the costs are passed along to those who can.

These pass-alongs are only a small portion of what really ails the system: an increase in overall medical costs far outstripping the standard inflation rate. In 1960, health expenditures represented 5,3% of GDP; now they are close to 15%. The reasons for this include an ageing population and advances in medical technology. In theory, better technology should bring higher productivity and lower costs, but the reality has been rather different. This is because the vast majority of patients have not, until lately, had to worry about what their treatment cost. Either their employer, their insurance scheme or government, through Medicaid and Medicare, would foot the bill.

Well before Clinton arrived on the scene, market forces were kicking in to rectify the situation. Employers, their margins eroded by spiralling premiums, have been pressing insurers who have in turn been squeezing providers and drug companies. The process is uneven and there is no doubt that some savings have been taken out of the hides of people who can least afford to pay — the laid-off, self-employed, people with chronic and expensive conditions.

Nonetheless, in the private arena, things are being streamlined. Witness, for example, the exponential growth of health maintenance organisations, giant integrated practices like Kaiser Permanente which charge a flat monthly fee for most services. Only in the government-funded sector, which relies on payroll and other taxes, do costs continue to rise unchecked.

It was ironic when, in September 1993, Clinton unveiled his plan to increase, dramatically, the government's role. The proposal, subsequently contained in a 1 341-page Bill presented to Congress early last year, would have short-circuited market reforms already in train by subjecting the entire system to bureaucratic fiat.

Under the plan, regional purchasing co-operatives, "alliances," would invite bids for insurance schemes covering government-approved treatments. Premiums would have to be at or below a government-set cap. Each alliance would then chose two or more of the bids and require everyone in its area to select one of the plans. It would both collect premiums and channel payments to providers. Individuals would be barred from paying doctors separately for services covered by the schemes.

Larger companies would be required to pay 80% of employees' premiums, or, if they had more than 5 000, could opt out and self-insure as long as their plans met government standards and prices. Small firms might be eligible for subsidies, as would the self-employed. The poor would continue to have bills paid for them.

Bureaucrats would not only decide what treatments patients should receive, and at what cost, they would also dictate how many doctors in each field could be trained — the theory being that the oversupply of specialists is part of the inflation problem, and that, in any event, the whole system needs refocusing towards primary care. Perhaps the crowning touch was a provision to ration specialist training not only in the aggregate, but by race as well.

After the health-care debate ground to a halt in September, the Clintons lamely tried to explain that they had started Left while believing that in the end the result would be a centrist compromise. But centrist compromises were offered and the Clintons rejected them. They also conceded that they had done a bad job of selling their plan and had underestimated the power of special interest lobbies — employers, doctors, insurers and pharmaceutical companies — lined up against them.

What they have yet to understand, even after November's electoral debacle, was that the most powerful lobby of all was the ordinary voter.

The 85% of Americans who are insured may not be happy with the status quo but resent the prospect of having to bloody well do what they're told. *Simon Barber*

HEALTH (85) FM 20/1/95

Hidden agenda

Health Minister Nkosazana Zuma's decision to instruct a committee to implement the Deeble plan (see *Leaders*) — which would radically change health-care in SA — makes a mockery of President Nelson Mandela's promised transparency.

Zuma claims she's acting on the recommendations of her Health Finance Committee (HFC) — appointed last June by special adviser Olive Shisana — which apparently decided that a national health fund for primary-care is necessary.

Zuma adds that the HFC advised her to appoint a new committee to investigate implementing the fund. But certain HFC members are now claiming that the Deeble plan was never formally approved by the HFC and that the committee never met to finalise any specific recommendations. The HFC, itself, sat in secrecy without any input from the public or industry. Shisana's office won't release the report and committee members have been sworn to secrecy.

Members of the new committee are apparently unhappy that they will only be able to investigate implementing Deeble. Shisana is quoted as saying that Zuma extracted elements from the HFC report that she believes are worth pursuing and would not bother to discuss other issues because they would raise unnecessary concerns. Zuma has, allegedly, rejected the recommendations of Shisana's eight other committees on health because they "aren't up to scratch."

The clandestine nature of the proceedings, and the particularly harmful implications for medical schemes of the Deeble report, both raise questions about the role of Reg Magennis, executive director of the Representative Association of Medical Schemes (Rams). Magennis sat on the HFC in his personal capacity — with Rams' approval. Rams chairman Keith Hollis says Rams thought Magennis would introduce alternative views to the committee.

Rams — dominated by large administrators who are legally unaccountable to medical aid members — is clearly hoping to convince Zuma to allow administrators to participate in the costly administration of her grand plan.

Says Hollis: "Schemes should be an essential component of the infrastructure needed to manage a national fund." Hollis says the Rams Council will meet next week to consider approving Magennis's appointment, by Zuma, to the implementing committee for three months.

Despite an uproar from the rest of the medical sector — excluded from both committees — Hollis won't comment on Zuma's decision to implement Deeble because he says he hasn't seen the committee report or the Deeble plan.

Magennis, who has consistently refused to discuss any possible conflict of interests regarding the sector he's paid to represent, also won't comment on the implications for schemes.

Magennis has, since his appointment to Rams at the end of 1993, advocated a compulsory insurance system that would fund basic services for all employed, envisaging that this package would later be extended to the unemployed. He has been criticised for not pushing Zuma to deregulate the sector further, appoint a new council for medical schemes, and adopt the admirable Melamet recommendations. ■

RADICAL HEALTH PLAN

(85) FM 20/1/95

Health Minister Nkosazana Zuma plans to introduce a National Health Insurance Fund that will prevent private medical aids and insurance from funding all GP services.

The move would radically change the entire financing of private health care. Will overcrowding, underservicing and queuing be common as the State takes charge of all GP services?

Zuma will elaborate on the practicalities of her plan at the *FM*'s third annual Corporate Health Care conference on February 7 at Gallagher Estate, Midrand.

Also addressing the conference will be Wits medical researcher Alistair Dry who will detail the rising expectations members have of their medical schemes and, in particular, the administrators. Registrar for Medical Schemes Danie Kolver will elaborate on the findings of the Melamet Commission of Inquiry that recommends greater financial accountability for both schemes and administrators. Steelmed's Ken Morgan will explain the success formula of the once-ailing Metal Industries Medical Aid Fund.

Zuma

For details, contact Odette at Global Conferences: tel (021) 762-8600 or fax (021) 762-8606. *FM* readers qualify for the early bird price of R995, including Vat.

Health alarm

POWER OF THE SPIRIT . . . Mr Robin Moodliar, his body hung with ash-filled brass containers, dances at the festival of Kavady in Cape Town. During the festival, which is to develop spiritual power, prayers are dedicated to Lord Muruga, believed to be the destroyer of all evil.

Picture: BENNY GOOL

Doctors warn of likely exodus

CT 23/1/95 (85)

By CLAIRE BISSEKER

SOUTH AFRICAN doctors expressed alarm yesterday at what they believe to be a lack of government transparency in formulating a radical new national health scheme.

Reacting to leaks of the "secret" scheme, doctors said they believed it could lead to an exodus of general practitioners and send health care costs soaring.

Details of the medical insurance scheme, favoured by Health Minister Dr Nkosazana Zuma, are expected to be released at a press conference today.

A spokesman for Dr Zuma's office said last night that the minister would not comment on the doctors' fears or make any statement about the scheme until the conference today.

According to reports, the proposed health scheme first ran into difficulties when Dr Zuma overrode her advisers' recommendations.

Limited

The health finance committee appointed by Dr Zuma apparently opposed the "Deeble" plan that she favours, which is based on a model by socialist Australian health economist Dr John Deeble.

The committee was reportedly limited to exploring the impact of the Deeble plan and could not explore other options.

Doctors have apparently faxed reports of the committee dissatisfaction and other repors about the scheme to each other.

They claim they have not been consulted in drawing up the scheme. A senior city doctor, expressing concern about "cloak-and-dagger" plans, asked: "What has happened to transparency in the new government."

According to sources, if the Deeble plan is implemented locally, doctors would work for the state at a flat annual rate of R180 per patient.

This assumes patients will make no more than three annual visits to their doctors and require medication not exceeding R20 on each visit.

The national health insurance fund would be financed by a R5,1-billion payroll tax, comprising a 3% levy on all salaries and wages, a 2% levy on the income of the self-employed and R1bn from the state.

The Medical Association of South Africa (Masa) expressed "great concern" over the plan that would force doctors to work for the state at "affordable" rates.

This week Dr Zuma will establish a technical committee to investigate implementing the model despite a report by the finance health committee, which states "it would not be affordable at present" and "the risks to the public sector are too great".

Health director-general Mr Coen Slabber said Dr Zuma favoured the model as it made primary health care affordable to the unemployed and traditionally uninsured sectors of the population.

Masa said it was "imperative" that the technical committee be allowed to look further than one plan or ideology and that "all options should be considered".

It is envisaged that state-run centres staffed by nurses and doctors will supply the bulk of services and the private doctor system will wither because medical aids and private insurers will be prevented from paying.

However, hospital and specialist services may be exempt from the plan and may still be covered by private medical aid and insurance.

If this happened, doctors said, they were likely to refer patients for hospital and specialist treatment more readily, increasing medical aid costs and pushing up the cost of all but the most basic medical treatment.

The chairman of the Cape Independent Practitioners' Association, Dr Steve Jooste, said: "The mechanism they have used is going to self-destruct and the people who will suffer are the very people they are trying most to serve. They should be working through the existing network of primary care doctors, of which the Cape has the most advanced system in the country."

Wits economist Professor Duncan Reekie said: "It's the last thing we want in this country." He said it could lead to a mass exodus of doctors as had happened in Britain after 1948 when 25% of doctors emigrated as state policies gradually supressed salaries.

There was also a "major danger" that it would increase unemployment as a payroll tax made labour more expensive.

Cape Times

Cape Town 2004

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TASK FORCE ...
Dr Nkosazana Zuma

Task force to explore health plan

Staff Reporters

A TASK force is to be appointed by Health Minister Dr Nkosazana Zuma to investigate a national health insurance plan which will grant equal access to primary health care to all.

Dr Zuma said public hospitals were overcrowded partly because people needing primary care sought those services from hospitals.

Medical aid schemes covered only 19% of the population, and the majority of black people could not afford medical aid costs that were escalating faster than inflation.

At a press conference yesterday Dr Zuma warned the system would not be in place before 1996 — and it was not yet known if such a scheme would be affordable.

It became clear at the conference that Dr Zuma had climbed down from her earlier insistence that the technical committee only investigate the socialist "Deeble model".

The model proposed that general practitioners work for the state at a fixed fee of R180 per patient, payrolled by a new tax.

Yesterday the Democratic Party slammed Dr Zuma for the "secret" and "sinister" manner in which the scheme had been investigated.

"The minister must learn that she cannot restructure the health services on her own," DP health spokeman Mr Mike Ellis said.

"From all accounts, the Deeble report, which the minister clearly favours, was not among the recommendations of the first committee."

Responding to claims at the press conference that her stance had caused committee member Dr Jonathan Broomberg to threaten to resign, Dr Broomberg said: "Two weeks ago I had some concerns. The minister has responded to those and the committee is now satisfied with the terms of reference and transparency."

Dr Zuma said the Deeble model was an example of what could be done but the committee was free to examine any option as long as it delivered the promise of equal access to quality primary health care for all, and was affordable.

The committee has to devise a scheme that conforms to four principles:

- **Universal and non-discriminatory access to quality health care.**
- **Affordability and sustainability.**
- **Efficiency and cost control.**
- **Consistency with RDP objectives.**

Dr Zuma said she could not say whether such a scheme was feasible or affordable.

"I don't think we have an option. This government has to offer services to everyone. The committee has to say how it can be done."

As her mandate was mainly primary care, she assumed that secondary and tertiary care offered by private hospitals and specialists would continue to exist without state interference.

FF slates 'socialist' health plan

PRETORIA. — The Freedom Front says it will oppose any health plan aimed at making general practitioners employees of the State.

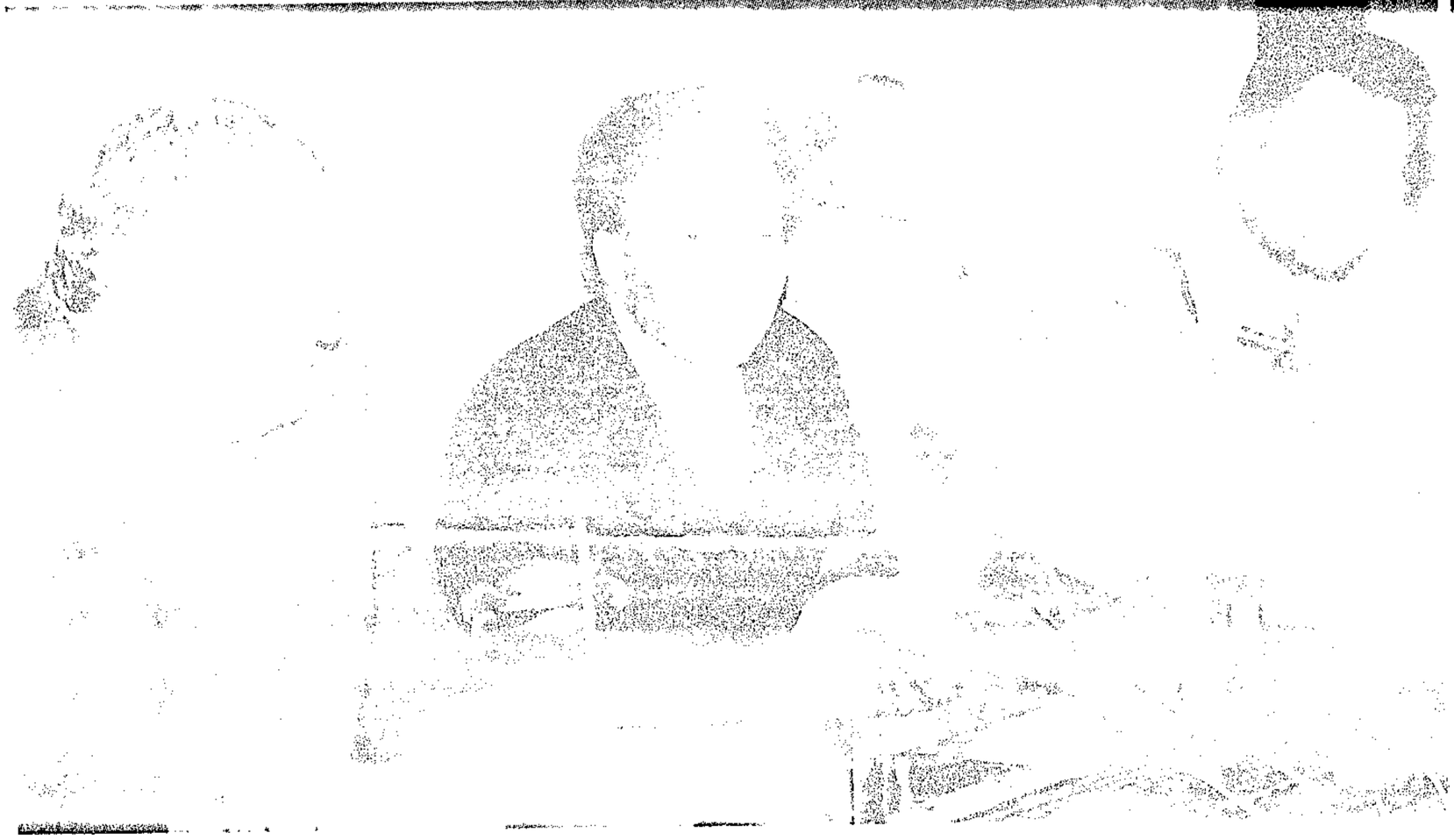
In a statement FF spokesman Senator Carl Werth expressed concern at reports that Health Minister Dr Nkosazana Zuma had told a committee to devise a "socialist" primary health-care system.

The system reportedly entailed doctors and pharmacists being paid by the State instead of by medical aid funds. Employees and employers would be taxed to raise the money for this.

According to the plan the State would pay doctors R180 per patient per year, based on three visits a year. Doctors would have to absorb the costs of additional visits.

Senator Werth said the reported system held the "gravest implications" for the welfare of South Africans. He said the private and public health care sectors should exist in parallel. The FF would table questions on the matter in parliament. — Sapa.

● Nothing definite yet, says Zuma, page 8.



Picture: LEON MÜLLER, The Argus.

HEALTH TALK: National Health Minister Nkosazana Zuma addresses a press conference on a proposed national health insurance plan. With her are, from left, director general of health Coen Slabber, Water Affairs Minister Kader Asmal and Western Cape Health Minister Ebrahim Rasool.

Nothing definite yet, says Zuma

(85)

ARG 24/1/95

□ Health proposals by May

LIBBY PEACOCK
Health Reporter

THERE is still no clarity on a future health insurance plan for primary health care in South Africa — but the bottom-line is that it will have to make primary health care available to everybody.

At a press conference yesterday national Health Minister Nkosazana Zuma avoided giving any details about a proposed plan, saying a technical committee was to be appointed to work out details of a financially viable model.

The committee, which is to work within a certain framework, has to submit the plan by the end of April.

Dr Zuma denied reports that she favoured any specific option — more specifically the controversial "Deeble model", drawn up by Australian health economist John Deeble.

She said the parameters within the committee had to work were "universal access to primary care without discrimination" and a "affordable, sustainable" plan.

"There isn't any option that this committee has to follow."

The parameters came "from the policy of this government, and if they coincide with that proposal (the Deeble model), well and good", she said.

Only 19 percent of South Africans were covered by medical aid. Primary care had to be reorganised to make it "universally" available.

The Deeble model proposes that the national health insurance be funded by a R5,1 billion payroll tax, but Dr Zuma said yesterday although the committee would have to look at a possible payroll levy, nothing had been cast in stone.

General practitioners would somehow have to be part of the human resource, but details still had to be worked out.

The Deeble model has recommended that care should be provided through accredited health centres.

Remuneration would be based on an assumption that not more than one-third to half of patient contracts would be with a doctor.

Asked about doctors emigrating, Dr Zuma said: "I don't think it will happen more than it has been happening..."

She said with health policy changes going on in many countries, doctors may well find that which they are "running away from" in the places where they go.

She hoped doctors would take up the challenge to make South Africa's health service a better one.

The committee's mandate would be mainly for primary care and did not affect hospitals and specialist services.

No decisions have been made regarding the future of medical aid schemes, she said.

Once the committee has worked out the nuts and bolts of the plan, it would be submitted to the goverment and other groups of comment.

It would not be implemented before next year.

Health union (85) workers halt wages strike

ARG 24/1/95

Political Staff

A STRIKE by the SA Health and Public Service Workers Union (Sahpswu) workers has been called off after the government reopened salary negotiations.

The union, which claims a membership of 68 000, had planned to resume the strike yesterday after suspending it earlier this month to give the government time to reconsider.

Sahpswu publicity secretary Themba Ncalo said the strike was suspended to give the new wage negotiations a chance, but said that if the scheduled meetings failed to reach agreement the union would strike on February 11.

Wage talks are scheduled from January 31 to Februrary 10 in Durban. Sahpswu is demanding a minimum R1 500 a month and a 15 percent increase.

Earlier this month Sahpswu went on a four-day strike which led to clashes with police.

Govt undecided on imposing health tax

(85) Star 24/1/95

Nkosazana Zuma

■ BY ESTHER WAUGH
POLITICAL CORRESPONDENT

Cape Town — Health Minister Nkosazana Zuma denied yesterday that the Government had decided to impose a health tax, but stressed that "nothing is cast in concrete at this stage".

She said a three-month investigation into primary healthcare financing would be held by a team of experts chaired jointly by her adviser and a medical economics expert.

The team did not intend following a specific healthcare model, but would ensure that a primary healthcare plan was accessible to all South Africans and was non-discriminatory.

She described as "premature" newspaper reports of a 3 percent payroll tax and a plan to make all general practitioners work for the State at a flat rate per patient.

Other factors to be taken into account were the affordability and efficiency of the plan as well as its consistency with the objectives of the Reconstruction and Development Programme.

The committee would receive written evidence and interest groups would be consulted before an interim report was compiled in three months.

The plan would therefore not be included in this year's Budget — to be presented to Parliament on March 15 — and would possibly be introduced in the next fiscal year. Zuma said the public would be consulted before the report was finalised.

Outlining the necessity for restructuring the health service, Zuma said most South Africans had inadequate access to primary healthcare and only 19 percent of the population belonged to medical aid schemes.

She stressed that no decisions had been taken and it was therefore still unclear what the role of doctors in private practice would be in the proposed plan.

National health insurance shelved

(85) Sowetan 24/11/95

■ MEDICS ASSURED Doctors will be consulted about new a plan:

By Glenn McKenzie

SOUTH AFRICA WILL not have a National Health Insurance plan in 1995 and may never have one at all, Ministry of Health officials say.

Speaking at a Press conference in Cape Town yesterday, Minister of Health Dr Nkosazana Zuma contradicted earlier reports that the Government was backing a plan to offer universal health insurance, paid for by a three percent salary tax.

Instead, Zuma said a new Committee of Enquiry would investigate the issue of health insurance and make recommendations to the ministry.

The minister assured anxious doctors that all relevant stakeholders would be consulted before a plan was released.

The minister insisted that a future health plan must fit a broad framework: services must be universal, equal, affordable, efficient and accessible to everyone.

"There is nothing cast in concrete at this stage.

"There is no decision to overturn," said Zuma.

Between now and April, the Committee of Enquiry will prepare a detailed financial plan to introduce a national health insurance plan "or a publicly supported alternative".

Interesting three months

"It will be an interesting three months" said Professor A Maynard, a committee member from York University in the UK.

Committee co-chair Dr Johnathan Broomberg said the body's mandate was broad and open ended.

Recommendations made by the recently disbanded Health Care Finance Committee could be accepted or ignored.

When asked whether the committee might recommend no health insurance at all, co-chairman Broomberg said:

"The answer to that question is that we don't know the answer to that question."

Zuma refused to speculate whether a national health system would mean higher taxes on wages and salaries.

Meanwhile, Zuma insisted that health reform would be tackled "in the shortest possible time".

The committee would search for ways to improve health care in the short term, she said.

Inquiry rejects 'Deeble Plan'

(85)

CT 25/1/95

By BARRY STREEK, Political Staff

SOUTH AFRICA cannot afford a totally state-funded primary health care system at this stage, a government-appointed inquiry concluded in a report which was kept secret until yesterday.

The Health Care Finance Committee — appointed by Minister of Health Dr Nkosazana Zuma — said this system, known as the Deeble Plan, was also "too risky".

The committee believed the phased approach suggested by two other possible options was "more sensible".

Dr Zuma is reportedly in favour of the plan by Dr John Deeble, a socialist health planner at Australian National University.

She has been accused of keeping the committee's report secret because of its findings.

'Secret' report released

However, when asked this week why the report had not been released, Dr Zuma said it could be published, provided it was made clear that the findings were those of the committee, not the government.

For people who already contributed to medical aid schemes, this three percent contribution would substitute part of their current medical aid payment, because the cover provided by health insurance would substitute part of their current medical scheme cover.

Two alternative options — a National Health Insurance and Social Health Insurance — have been referred to another committee appointed this week by Dr Zuma.

The long-term goal of all three options considered by the Health Care Finance Committee is universal cover for comprehensive health care.

The committee recognised that this was not affordable in the short-term and that a phased introduction was required.

"The source of funds would be the same for all three options, namely a compulsory income-related payroll contribution, of the order of three percent, on all employees," the report said.

Picture: LEON MÜLLER, The Argus.

HEALTH TALK: National Health Minister Nkosazana Zuma addresses a press conference on a proposed national health insurance plan. With her are, from left, director general of health Coen Slabber, Water Affairs Minister Kader Asmal and Western Cape Health Minister Ebrahim Rasool.

Nothing definite yet, says Zuma

(85)

ARG 24/1/95

☐ Health proposals by May

LIBBY PEACOCK
Health Reporter

THERE is still no clarity on a future health insurance plan for primary health care in South Africa — but the bottom-line is that it will have to make primary health care available to everybody.

At a press conference yesterday national Health Minister Nkosazana Zuma avoided giving any details about a proposed plan, saying a technical committee was to be appointed to work out details of a financially viable model.

The committee, which is to work within a certain framework, has to submit the plan by the end of April.

Dr Zuma denied reports that she favoured any specific option — more specifically the controversial "Deeble model", drawn up by Australian health economist John Deeble.

She said the parameters within the committee had to work were "universal access to primary care without discrimination" and a "affordable, sustainable" plan.

"There isn't any option that this committee has to follow."

The parameters came "from the policy of this government, and if they coincide with that proposal (the Deeble model), well and good", she said.

Only 19 percent of South Africans were covered by medical aid. Primary care had to be reorganised to make it "universally" available.

The Deeble model proposes that the national health insurance be funded by a R5,1 billion payroll tax, but Dr Zuma said yesterday although the committee would have to look at a possible payroll levy, nothing had been cast in stone.

General practitioners would somehow have to be part of the human resource, but details still had to be worked out.

The Deeble model has recommended that care should be provided through accredited health centres.

Remuneration would be based on an assumption that not more than one-third to half of patient contracts would be with a doctor.

Asked about doctors emigrating, Dr Zuma said: "I don't think it will happen more than it has been happening..."

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She hoped doctors would take up the challenge to make South Africa's health service a better one.

The committee's mandate would be mainly for primary care and did not affect hospitals and specialist services.

No decisions have been made regarding the future of medical aid schemes, she said.

Once the committee has worked out the nuts and bolts of the plan, it would be submitted to the goverment and other groups of comment.

It would not be implemented before next year.

Zuma extends scope of investigation into new health care system

(85) BD 24/11/95

HEALTH Minister Nkosazana Zuma has extended the scope of the investigation into primary health care to include alternatives to national health insurance.

Zuma said at a news conference in Cape Town yesterday a committee, whose composition would still be finalised, would prepare a detailed and costed plan for a national health insurance system — or a publicly supported alternative.

Her statement followed discussions with investigating committee members who last week expressed concern that the inquiry was limited to investigating only one option, known as the Deeble model. A number of health experts said the model, which would force all general practitioners into working exclusively within a system ordered by government, was unworkable.

Zuma said the new committtee's brief was open-ended, but it would be guided by the policy framework. Policy objectives were non-discriminatory access to primary care; affordability and sustainability of the system; efficiency and cost control; and consistency with the reconstruction and development programme's objectives. "The Deeble option is not the only option.

KATHRYN STRACHAN

There isn't any option this committee has to follow except within those parameters."

She had asked for a preliminary report by the end of April.

Reuter reports Zuma said government had not decided on a health tax. Funding options such as a payroll tax or a national health contribution could be considered, but "they have no stamp from me yet to say this is going to be implemented".

The investigation would not impinge on the better services available to private patients. "There will still be private hospitals and the wealthy will still have exclusive use of these hospitals."

Investigating committee co-chairman Jonathan Broomberg said Zuma had addressed the concerns of committee members and they were now comfortable with the process, its terms of reference and transparency. However, he still had concerns about the time span given.

The inclusion in the investigation of options recommended by a previous finance committee is a significant departure from the Ministry's standpoint last week. Ministerial special adviser and investigating committee co-chairman Olive Shisana said last week the policies recommended by the committee were options Zuma felt she could not pursue because they either failed to integrate the public and private health sectors or excluded the unemployed.

The Ministry is still refusing to release the report of the initial finance committee which was concluded in November. Zuma said there was nothing secret about the report but it could not be released because the investigation was continuing.

● Comment: Page 14

NEWS

Report released only after criticism

Public health stint idea for new doctors

(83)

Star 25/1/95

Cape Town — Newly graduated doctors should be forced to do two years' compulsory service in the public health sector before entering private practice, a special committee has recommended to the Minister of Health.

Its report was supposedly completed last year, but the Minister, Nkosazana Zuma, released the document only yesterday, apparently stung into action by DP health spokesman Mike Ellis' criticism that she was operating in a "secret and sinister" way.

Zuma announced on Monday that she was setting up a second committee to inquire into a national health insurance system to fund and organise primary care for all.

Ellis retorted that the findings of the first committee had not been made public, and that the minister appeared to have ignored its recommendations.

The first committee, appointed to investigate health-care financing, also recommended a national health insurance scheme based on a 3 percent tax on the earnings of every wage-earner, and stricter controls on the activities of medical schemes.

It said the national health scheme should initially provide only primary care delivered to contributors and their dependants by general practitioners, sick funds or public sector services.

Non-contributors would be restricted to public sector services or services contracted with the public sector of the national health scheme.

Doctors who did not contract into the system could be paid directly by patients.

The committee said it believed a national health scheme was "worth pursuing" and proposed that a technical team be appointed to see whether it was financially and logistically feasible.

It suggested a major reallocation of the budgets of academic hospitals to bring equity in teaching and tertiary services in under-resourced provinces.

Health Ministry revises universal care plan

(85) BD 25/4/95

KATHRYN STRACHAN

A SYSTEM of universal primary health care coverage with limited choice of provider was recommended in a report released yesterday by the Health Ministry.

The plan, known as "option two", would initially provide primary care delivered to contributors and their dependents by general practitioners, sick funds or public sector services.

Non-contributors would be restricted to public sector services, services contracted with the public sector or the national health scheme.

Doctors who did not contract into the system would be paid by patients.

Option two was recommended on the basis that the initial proposal — universal primary care coverage for contributors and non-contributors — was not financially feasible.

Health Minister Nkosazana Zuma has set up a technical committee to further investigate the possibility of a national health insurance fund. Another recommendation was that a new funding formula be phased in to correct the "glaring inequalities" in health provision between provinces.

The report said the public sector could be strengthened through measures such as forcing newly graduated doctors to do two years' compulsory service in the public sector, and allowing public facilities to retain a part of their revenue.

Financial monitoring of medical schemes should be strengthened, the report said.

The loophole in tax laws that allows benefit funds to be used as tax-deductible savings funds should be closed, and it could be appropriate to revise tax exemptions for medical scheme contributions.

Sapa reports that the SA Chamber of Business welcomed the investigation into the viability of a national health insurance plan.

W Cape has highest health spending

(85)

CT 25/1/95

Political Staff

GOVERNMENT spending on health in the Western Cape was the highest in South Africa and per head was almost nearly 3½ times higher than the Northern and Eastern Transvaal, the Health Care Finance Committee disclosed yesterday.

The per capita expenditure in the Western Cape, including academic hospitals, was R543, while it was R148 per head in the Northern Transvaal and R143 per head in the Eastern Transvaal.

Without the cost of academic hospitals, public spending in the Western Cape was R303 per capita, more than double that in the Northern and Eastern Transvaal provinces.

The report's release was authorised by Minister of Health Dr Nkosazana Zuma yesterday.

It said that in 1990/1 South Africa spent around 6,2% of GNP on health services, both public and private, although a recent study indicated the total spending on health could be about 8% of GNP.

"This is a very high share for a country of South Africa's income level.

"A small proportion of the population benefits from services which are the equal of those found in much richer countries, while a large proportion of the population has very limited access to any form of service."

The expenditure was also biased towards curative, hospital-based care, the report said.

HEALTH 'Sight-saver facilities are necessary'

Rural eye clinics needed

By Mokgadi Pela

THERE is an urgent need for the establishment of sight-saver clinics in rural areas, the *South African Medical Journal* says in its latest issue.

Such clinics should be staffed by ophthalmic medical assistants working full-time in this capacity.

SAMJ says while ophthalmic medical assistants might not be able to offer cataract surgery, they would, among other things, be able to provide appropriate post-operative care enabling patients with 'only eyes' to be operated on at the saver clinic.

They would also be able to dispense aphakic spectacles to patients whose spectacles have been lost or broken.

The *SAMJ* conclusion follows a joint study by the Department of Ophthalmology at Edendale Hospital and the University of the Orange Free State, which was done in the Ingwavuma district of Northern KwaZulu in 1990.

Mosvold Hospital in the area was chosen as a suitable clinic for assessment. A low vision and blindness prevalence survey was conducted in the health ward in September 1990. A random cluster sampling technique, using 60 clusters of 100 people each, was used.

The ophthalmologists examination comprises measurement of the visual acuity in each eye with and without spectacle correction.

Following this survey, eight other saver clinics were conducted at Mosvold Hospital. A second low vision and blindness prevalence survey was repeated in the health ward in July 1993.

Doctors cautiously approve insurance

CT 27/11/95

Staff Reporter (85)

DOCTORS in the Cape Peninsula are cautiously in favour of national health insurance — but strongly opposed to a set pay system favoured by Health Minister Dr Nkosazana Zuma.

This is the finding of a study undertaken by the University of Cape Town's Department of Community Health which is in press for the SA Medical Journal.

Researchers Dr Mark Blecher, Dr Max Bachmann and Dr Di McIntyre interviewed 126 doctors in private practice in the Peninsula early last year.

Of those sampled, 63,3% approved of national health insurance (NHI) in principle but 61,3% disapproved of the capitation method of reimbursement — where doctors are paid a flat annual rate per patient from the NHI fund irrespective of the number of patient visits.

The controversial "Deeble model", reportedly favoured by Dr Zuma, envisaged that doctors would receive R180 per patient a year.

This assumes that patients visit their doctor an average of three times per year.

More than 70% of doctors were willing to compromise and accept the capitation system if they could continue to receive payment from patients with private insurance or medical aid.

More than 82% said NHI would lead to a more equitable system of health care in SA and more than 88% agreed that NHI would probably make services more accessibile to the general population.

The NHI was seen as a possible alternative to the current medical aid system which was seen as profit-driven and excessively fragmented.

Meiring warns of health cuts

(85) ET 27/11/95

Staff Reporter

CERTAIN health services will have to be rationalised and duplications eradicated, the Western Cape Minister of Finance, Expenditures and Services Commission, Mr Kobus Meiring, said yesterday.

Addressing the Bellville Afrikaanse Sakekamer, he said the province again had the "chronic problem" of over-spending on its health budget.

Drastic measures would have to be taken to "stem the flow of this bottomless pit of expenditures", he said.

NEWS *UN body, overwhelmed by paper and statistics, fails to meet challenge of epidemics*

World health needs a new custodian

Sowetan 27/1/95

WASHINGTON — Last year Health Minister Mrs Nkosazana Zuma declared tuberculosis and Aids to be South Africa's biggest health problems.

The incidence of TB in the Western Cape is among the world's highest. "The WHO expects South Africa to lead in the region and to cooperate in terms of tuberculosis research, control strategies and provision of laboratory equipment and drugs."

This was the view expressed by the World Health Organisation's Dr Peter Eriki, a keynote speaker at the Medical Research Council's Tuberculosis — Beyond 2000 conference held in Pretoria earlier last year.

A reasonable expectation, given South Africa's problems and status in the region, but questions must be asked of the body expecting such a lead.

Fighting disease

The WHO has over the past few years drastically changed its focus from being the leading international organisation fighting disease, especially in the third world, to being a coordinating body concerned primarily with organising conferences and generating reports and directives.

This was not always the case. Twenty-five years ago, the WHO led the international campaign to eradicate smallpox. This was one of the greatest achievements of the 20th century. Unfortunately, the WHO has given up campaigns to eradicate diseases and has now become almost exclusively a bureaucratic body generating thousands of reports and hollow edicts.

The current resurgence of TB is primarily due to its devastating link with HIV, the virus that destroys the human cells that keep the TB bacteria dormant. The problem with TB, like most infectious diseases, is that it does not stop at national borders. Hence the fight must be directed by a regional or multilateral international health organisation.

The importance of such an organisation rests on the enormity of the challenges ahead. The new plagues of the 1990s — TB, Aids and hepatitis — afflict hundreds of millions of people. New virulent strains of malaria, resistant to the usual drug treatments, will have killed an estimated two million people in 1994, while more than six million people will have been crippled by leprosy.

But while the world is experiencing an explosion of such epidemics, the WHO's disease prevention and control programmes have been reduced over the past 10 years to 12,5 percent of its regular budget, down from 16 percent. Even more revealing is that the organisation has recently cut its TB budgets by 6 percent in Africa and 25 percent in Asia, where the largest number of people are infected.

Health Minister Nkosazana Zuma.

A billion TB infections

In Asia for example, the WHO's budget to confront the killer disease TB is so small that it contributes about 3 cents for every 400 people infected in this area. Estimates place the number of South-East Asians infected by TB at over one billion.

The problem is not lack of money, but a failure to set the right priorities. The WHO is well funded, with a budget of almost 1 billion a year — more than any other UN organisation. It could easily find the R350 million to fight TB in its budget. But 500 other programmess compete for resources — such as seat-belt safety advertising campaigns, Oral Hygiene Week celebrations and the distribution of millions of World No-Tobacco Day bumper stickers.

> *"The world desperately needs a serious international health organisation that does more than convene conferences and issue Press releases."*

Not being tackled

The tragedy is that while the WHO carries out low-priority public awareness campaigns, basic health needs in developing countries are not being tackled. With modern vaccines and medicines now available to prevent many killer diseases, the misallocation of resources is often the only obstacle to saving lives.

But the WHO, which is supposed to be the world's leading multilateral health organisation, devotes less than one percent of its regular budget to malaria — a disease it has described as the "most serious health problem in the poorest areas of the world".

WHO officials grumbled at last September's AIDS conference in Tokyo that funding for its global programme on AIDS had been cut from R315 million to only R245 million in 1994. What they didn't mention was that donor nations have severely criticised the WHO for wasting most of the money given to it to fight AIDS.

Even the United Nations is fed up with the WHO's management. It recently stripped the WHO of all responsibility for Aids-related programmes. It is now creating a new Geneva-based UN agency to lead the worldwide fight in combating the Aids epidemic.

The sad fact is, the world desperately needs a serious international health organisation that does more than convene conferences and issue Press releases.

The world's donor nations are prepared to provide ample funding and enthusiastic support for an organisation ready to wage all-out war against preventable diseases like TB, malaria, measles, dysentery, cholera and diphtheria. An organisation that would respond quickly and effectively to the emergency health needs of refugees.

But as long as the WHO fails to oversee major reform in how it allocates its resources, the money it has is unlikely to result in any real improvement in TB or the treatment of other diseases in the organisation's mandate.—*Sapa-Reuter*

THE NATIONAL HEALTH

Socialism is a Eurocentric failure

(85) FM27/1/95

The threat of an extensive nationalised health system may have been set back this week but it has not disappeared. Health Minister Nkosazana Zuma tripped over her own government's commitment to transparency and has reconstituted a committee to come to the conclusions within three months that she herself reached some time ago.

The irony is that while top bankers were being told in Johannesburg that they would not get Gauteng's business if they continue their Eurocentric ways and make profitable loans, Zuma in Pretoria has been busy trying to introduce by stealth the most substantial Eurocentric failure of the century: the notion that the community can afford to absorb all the health costs of its members regardless of the social and economic consequences.

There are two central problems with this notion. The first is that experience has shown that the more nations spend on health care, the more unhealthy their citizens become and the greater the demand for health services.

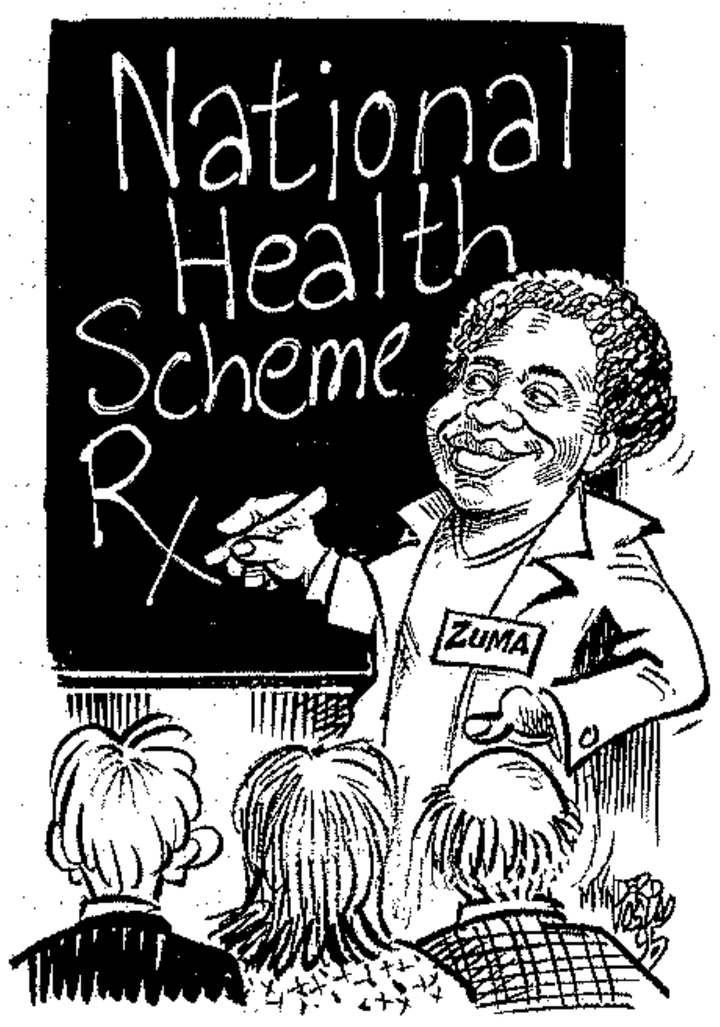
Now that may sound particularly Irish. But it is not. Medical science is now capable of such advanced diagnosis that it pushes patients in advanced countries to the brink of hypochondria. It is also capable of prolonging life for short periods at great cost. There was a time, too, when doctors applied some element of moral judgment to the nature of their treatment. In other words, they took into account the mental, financial and social circumstances of their patients when prescribing treatment.

That enraged socialists like Bernard Shaw, who felt that nationalised health would be prophylactic in this respect, enabling doctors to demand the best and most scientific treatment for all their patients as a basic human right, regardless of cost or any other circumstances.

If the government couldn't pay then the medical aid could. And on that swashbuckling basis they have progressively impoverished the State.

It was also in their interest — and in that of the host of bureaucrats that nationalised medicine spawned — to argue that the provision of health care was not like the provision of other services that could be left to the discerning judgment of the masses. No. Only doctors and medical administrators are capable of recognising medical value.

The same is argued by teachers about the quality of education and journalists of the quality of their newspapers. And they are appallingly wrong: as America's reaction to Hillary Clinton's health "reforms" shows. Ordinary folk know quality when they see it and will put a price to it that is a better reflection of reality than the assumptions of some egghead practitioner.



No nationalised health scheme in the world has been able to provide a widespread, quality health service without introducing some form of constraint on demand to keep it within the bounds of affordable supply. If that constraint is not price, it becomes a queue (for treatment or beds) or some other rationing process. At some times and places in the Soviet Union they withheld the use of anaesthetics, which reduced demand quickly.

The previous Nationalist government understood none of this and, apart from the brief but inadequate reforms of the last Nat Health Minister Rina Venter, it bequeathed an inadequate, inefficient, over-centralised and duplicated health authority to the present government.

It is a system that cannot take the strains of the extension of free health care announced by President Mandela soon after he took office.

That, plus the appalling administrations of the former Ciskei and Transkei, has led to a breakdown in health services in the Eastern Cape.

The tragedy now is that Zuma is about to repeat on a grander scale the mistakes and inadequacies of the Nat health administration unless she is restrained by the Cabinet. She will do so in three months after her ideas are rubber stamped by what is held out to be a representative committee.

Zuma's claims that she has an open mind ring hollow. Elsewhere in this edition we quote from her own correspondence to indicate quite the opposite. In a radio interview she apparently remarked that instead of jumping to conclusions the *FM* should have spoken first to her. Well, we have tried to. Either the faxes were not passed on to her by her staff, or she chose to ignore them.

The *FM* has never been intimidated by Ministers of State. We will happily talk to them at their convenience. There is, of course, nothing in the RDP that says Ministers should talk to us.

Deputy President Thabo Mbeki was the last Minister to attack the *FM* for criticising him without first talking to him. It so happened that the *FM* had on record several faxes to his office requesting an interview. We let it pass.

Perhaps we may be forgiven for the assumption now that this sort of dissembling appears to have become the style of government.

What Zuma announced this week was not enough to restore the faith of any reasonable person in her government's commitment to transparency.

She needs a much more representative committee to undertake the re-investigation and to demonstrate that she has an open mind. ■

HEALTH CARE

Time for a rethink

(85)
FM 27/1/95

Health Minister Nkosazana Zuma has had second thoughts about implementing the Deeble health model which would nationalise most medical services in SA.

Bowing to pressure from the health industry and even her own advisers who accused her of favouring a one-track approach to health-care nationalisation, she has widened the brief of her investigating committee so that it may look at other solutions to SA's health-care crisis.

Zuma said in Cape Town this week that the new Committee of Inquiry into a National Health Insurance System — scheduled to meet for the first time this week — would be free to consider any option provided it fulfilled the policy objectives of universal, non-discriminatory access to health care that was affordable, sustainable, efficient and complied with the aims of the RDP. According to Zuma, it was coincidental that Deeble's plan happened to coincide most closely with government's thinking.

On several occasions Zuma insisted she had never accepted nor planned to implement only one health-care model. But the *FM* has a copy of a letter, from an official source, signed by Zuma, that tells a different story. The letter, confirming the appointment of a committee member to the committee of inquiry states: "I had appointed a committee to investigate different financing options for health care in SA. This committee presented three options out of which I selected one to pursue because it will give all South Africans access to health care. Details for this option need further investigation."

Attached to this letter, apparently as an annexure to the committee's terms of reference, is a document headed "Elements of a National Primary Health Care Insurance System" which contains paragraphs straight out of the Deeble plan.

Chairman of the committee Jonathan Broomberg confirmed he had been unhappy with the committee's initial terms of reference. He said that after discussions with the Minister, the committee was now satisfied with its brief, though details of the brief had not yet been finalised.

The *FM* has learnt that Broomberg and other committee members had threatened to resign because their brief had been limited to implementing the Deeble model.

Zuma's latest concession has been widely welcomed by the industry. Medical Association of SA (Masa) private practice committee chairman Herc Hoffman says: "We are pleased the committee's brief is open and welcome the Minister's commitment to consult interested parties. We hope the private sector will have some say in the design of the final model. You can't change a system without consulting the people intimately involved."

Hospital group Presmed joint MD Rob Speedie says despite the latest developments, a lingering concern remains about the influence the Deeble plan will have on government thinking.

Regrettably, though, Zuma's brief to the committee appears to limit it to implementing a State-dominated and socialised health-care programme. Questioned about whether the private sector — medical schemes and insurance — would be allowed to fund GP services, Zuma said it was likely that these services would be taken out of the private sector to ensure the "universality" of care.

Zuma is determined to introduce a national health plan. She says: "There can be no question of the committee not succeeding. They have to find an affordable solution that works — even if they have to investigate 1 000 options. We are committed to providing universal, affordable primary health care."

Whether her committee will consider private sector options like privatisation and managed health care — increasingly the choice of governments elsewhere — is uncertain. While Zuma has yet to finalise her committee's appointments, many of its members are academics who are known not to favour a market approach to health care.

More alarmingly, none appear to have any meaningful hands-on experience of medical administration and claims patterns. Broomberg, the chairman, is a medical doctor who won a Rhodes scholarship. He received his PhD in health economics from London University. John Mynhard, from York University, is internationally known as a health economist who is largely in favour of State-dominated health care.

John Deeble is openly anti market forces and believes a parallel private system will always tend to push up the cost of public health. Rams executive director Reg Magennis — whose appointment must still be confirmed by Rams — is a CA who has been with Rams for just over a year and doesn't trust market forces for health.

Co-chairman Olive Shisana, who has been Zuma's special adviser for several months, has a doctorate in Social Sciences from John Hopkins University in the US. Described by colleagues as arrogant, she has forbidden members of the Health Finance Committee — the first technical committee charged with investigating a national health system — from speaking to the press.

She has also refused to make public the report of the Health Finance Committee. The reports of eight other committees that she convened have apparently been rejected by Zuma.

Zuma is not understating the situation when she says there are problems with our system. "Our public hospitals are overcrowded, partly because people who require only primary care are seeking services at hospitals. The shortage of primary care services forces people to forgo the services they need," she adds. What Zuma is not admitting is that duplication and fragmentation of services, along with a highly centralised bureaucracy, devours much of the R14bn health budget. ■

FRUIT EXPORTS

A mixed bag

FM 27/1/95

Deciduous fruit farmers in the Cape and citrus farmers in the far north share a common problem — finding sufficient product to meet soaring global demand for SA's fruit exports.

While recurring droughts may ultimately decide matters for citrus growers, Unifruco, the deciduous fruit industry's export arm, predicts the value of its exports is likely to double by 2000 — to R4bn a year.

With increased plantings coming into production, 1995 earnings should reflect

HEALTH CARE POLICY WAR

Thumbs down for the Deeble option

(85) ST 29/1/95

By RAY HARTLEY

THE first shots in the policy war over a health system were fired this week with the release of recommendations on how South Africans can be given equal access to health care.

The report by the Health Care Finance Committee is against a scheme it listed as Option 1, which Health Minister Nkosazana Zuma is said to favour.

Dubbed the Deeble option after its Australian inventor John Deeble, Option 1 has a seductively simple bottom line — in slogan form it would read: "Anybody can go to a doctor or a hospital for free health care."

But, say its detractors, its populist veneer hides a bias against the poor. Given the choice, most people would opt for private treatment, leading to a huge shift in health care to private doctors.

Since doctors would be paid according to the number of patients on their books, the emphasis would shift from quality of treatment to quantity.

And, because healthy people would take up less of their time each year, doctors would prefer to sign them up rather than the time-consuming sick.

Said one critic of this kind of scheme: "There's a story about an American scheme which has its offices on the third floor of a building without a lift to ensure that its patients are by and large healthy."

Should doctors become the major providers of health care, he warned, the prospect of a debilitating doctors' strike aimed at improving government payments would loom large. This would in turn lead to a steady increase in public contributions.

"The Deeble scheme is effective in Australia, but that is a country with six percent unemployment, a population that is 98 percent urban and 100 percent literate. You can't import it to a country with squatter settlements and huge unemployment," he said.

Instead, the committee recommended Option 2, which draws a distinction between earners and non-earners. Under this scheme, earners would be given the choice between private or public sector health care while non-earners would have access only to public sector treatment.

Meanwhile, Mrs Zuma has arranged for another inquiry to take the investigation further.

Warning on cuts to health budget

CT 31/11/95 (85)

Staff Reporter

HEALTH care in the Western Cape would be placed under extreme pressure unless local Minister of Health and Welfare Mr Ebrahim Rasool was able to convince central government to allow less drastic cutbacks to the province.

This was said in a statement on the hospital funding crisis yesterday by Dr T Sutcliffe, deputy director general of health services of the Provincial Administration of the Western Cape.

Moves towards equity in the allocation of funds to the provinces had seen the health budget in the Western Cape cut drastically and should no additional funding be made available, a R362 million deficit could be expected next year, he said.

Mr Rasool will attend a meeting of regional health ministers with national minister Dr Nkosazana Zuma on Friday.

85

Input sought for health plan – Zuma

It is important that all interest groups help devise a model for a national insurance scheme to fund primary health care for all, Health Minister Dr Nkosazana Zuma said in Johannesburg last night.

At the first of a countrywide series of consultative conferences on the scheme, Zuma said she had appointed a committee of inquiry to gather comments from all interest groups.

She denied claims from some quarters that the scheme had already been initiated by her department, and without consultation. Star 1/2/95

"We have only given the committee a policy framework within which to operate, in which role-players, including the public, health providers, employers, pharmacists and medical aid organisations, are to contribute towards a mechanism to achieve a national health system."

Zuma said the committee was made up of representatives from her department and the Department of Finance.

It also included health economics experts, medical scheme administrators and international and national experts on health insurance and financing. — Sapa.

Minister in bid to reduce health cuts

By CHRIS BATEMAN

A LACK of bridging finance would be the "death knell" for health services in the Western Cape and the local Health and Social Services Minister would fly to Pretoria on Friday to make a desperate final appeal to reduce "equity" cuts. 85

This was said yesterday by Dr Tom Sutcliffe, deputy director general of Hospital and Health Services, who added that moves towards equity in health funding between the nine provinces had seen his health budget cut drastically. CT 1/2/95

Without additional funding, a deficit of R362 million could be expected for the 1995/96 financial year — an amount even a comprehensive management plan could not address without "drastic consequences".

While his plan did address the shortfall, its implementation would be a "death knell", Dr Sutcliffe said.

He had therefore drawn up a second financial plan, "implementable and compatible with the survival of the service," but which would need additional funding.

Western Cape Health and Social Services Minister Mr Ebrahim Rasool would put this before central Health Minister Dr Nkosazana Zuma when he and other health MECs met her on Friday.

Dr Sutcliffe said he believed a revision of the Western Cape budget allocation would be decided on by the central cabinet by "early February".

His plans involve the devolution of millions of rands in equipment and staff to outlying rural hospitals from Groote Schuur and Tygerberg Hospitals to bring cost-effective primary health care to those who most need it.

Equipment and staff from Somerset and Victoria hospitals would fill the vacuum in the two academic hospitals, enabling more efficient secondary care.

Move to replace health councils

Cape Town — Draft legislation providing for interim councils to regulate the nursing, chiropractic, homeopathic and allied health professions was introduced by Health Minister Dr Nkosazana Zuma in Parliament yesterday.

The Nursing Amendment Bill provides for the establishment of an interim nursing council to replace the existing four nursing councils and to provide for the same laws for the nursing profession throughout South Africa.

The Chiropractors, Homeopaths and Allied Health Service Professions Amendment Bill seeks to replace the existing governing council with an interim one. — Sapa.

(85) Star 1/2/95

'W Cape can't take a 10% health cut'

(85)
ARG 2/2/95

☐ *Rasool: Extra R201-m fund needed*

LIBBY PEACOCK
Health Reporter

THE accepted international limit by which health budgets can be cut without being hamstrung is 2,5 percent — but the Western Cape has been asked to accept a 10 percent cut.

And while the province is serious about rationalisation of health services, it needs stability and an "orderly process" to do so, provincial Health Minister Ebrahim Rasool said yesterday.

Reacting to serious concern at the effect "equity cuts" may have on the Western Cape's health system, Mr Rasool said: "There is a limit to which one can rationalise and still survive ..."

Having spent R2 billion on health this year, the province has been allocated a R1,8 billion budget for the coming financial year.

But of this sum, R1,6 billion is going to "the old CPA" and R200 million to the Department of National Health in the Western Cape.

Mr Rasool said the R1,8 billion was "equal to what the old CPA got alone in the past".

With a deficit of R362 billion, the province desperately needed an extra R201 million "transformation enabling fund".

He said internationally there was an accepted norm by which health budgets could be cut and not be set back — 2,5 percent.

"So what we've been asked to do is to accept a 10 percent cut ... and we can't do that."

The possibility of a transformation enabling fund had been discussed with Health Minister Nkosazana Zuma and would be put to the cabinet next week.

"We need it to go somewhat further. We need her to say that this transformation in health can't take place in five years, because that takes it beyond the 2,5 percent limit.

"In the absence of any relief there is no way that we can countenance not receiving that R200 million. We must just get it."

Mr Rasool said "part of our motivations would be that the Health Department nationally and in the provinces is carrying the RDP. We haven't seen houses. Education is in difficulty ... so we believe the cabinet must approve this for us because health has delivered."

The Western Cape health system was "far too reliant on the three academic hospitals", but the local health authorities had already launched several projects to take health away from those centres.

A clinic had been launched at Brown's Farm, several hospitals, such as those in George, Worcester and others, were being upgraded.

An academic priorities group was looking at duplication at academic hospitals and had already established that "something like R40 million" could be saved by cutting duplication.

"I believe there will be enough rationality for them (the cabinet) to bail us out."

Mr Rasool refused to elaborate on which services would be affected, cut or done away with, should the money not be available, but said that capital projects — such as building clinics in squatter communities — "may have to go on hold".

"In effect it means there can be no transformation of the health system. In fact, we may have to compromise the quality of health provided by our academic hospitals."

He said the Western Cape was treating patients from all over the country and this should be recognised.

BUSINESS DAY, Thursday, February 2 1995

Gauteng, Western Cape to bear brunt of health cuts

BD 2/2/95 (85)

PROVINCES with good resources, such as Gauteng and the Western Cape, will take the brunt of cuts in state health spending this year.

Health Department director-general Coen Slabber said yesterday that the 1995/96 health budget would remain exactly the same in nominal terms as last year's allocation of R14,2bn. However, Alex van den Heever of Wits University's Centre for Health Policy said in real terms this would mean a cut of R1bn, taking into account a 9% inflation rate.

Slabber said it was necessary to redistribute funds among the provinces to lessen the great disparities which existed. A comparison of state health expenditure in the provinces showed the Western Cape had a R491 per capita allocation, Gauteng R381 and the Northern Transvaal R164.

For every 10 000 people, Gauteng had 127 doctors, 618 nurses and 109 pharmacists. Northern Transvaal had 15 doctors, 293 nurses and 7,8 pharmacists.

Slabber said the State Expenditure Department had been approached for bridging funds for Gauteng and Western Cape to help them absorb the cuts, but no decision had been made. It would be possible to assess the extent of the cuts only once it was known whether these bridging funds were available.

KATHRYN STRACHAN

Slabber said the provinces had reported a total shortfall of R650m in health expenditure this year. However, most of this would be made up. R470m had already been allocated, with R440m coming from the reconstruction and development programme fund for free health services and an additional R30m from the State Expenditure Department.

The Health Department was negotiating for another R200m, and it was optimistic this would be made available by the end of the month. The R200m could be gained from the Commission for Administration through savings gained by the integration of the TBVC states.

A 5% overall cut in the nominal budgets of academic hospitals had already been announced. The cut of R165m would be taken from the four provinces with academic hospitals and redirected to primary health services across the country.

The cuts would vary according to the resources of the various academic hospitals, with hospitals such as Medunsa in Gauteng and King Edward in Durban increasing their budgets.

Wits University medical faculty dean Prof George Hart said an improved primary health service was likely to result in a greater strain on hospitals in the short term because more illness would be picked up.

The answer was to strengthen regional (secondary) hospitals which treated patients at a lesser cost than academic (tertiary) hospitals.

Cuts in academic hospital budgets did not necessarily mean staff numbers would have to be reduced. Hospital staff could serve in peripheral areas on a rotation basis or conduct outreach services while retaining their hospital status.

HEALTH CARE (85)

FM 3/2/95

Users must pay

Australian medical economist Paul Gross this week warned Health Minister Nkosazana Zuma that she risked pressing ahead with the Deeble model, which would effectively nationalise GP services, at her peril. It would, he said, result in political pain for government, public disillusionment and disruption of health services.

Talking at a health-care conference in Sandton, Gross stressed that Deeble's model would fail to generate sufficient funds to pay for the exploding volumes of primary health-care services that would result from a system where consumers were not expected to pay for the attention they received. Says Gross: "Access to care will be impeded with promised free health services and drugs for patients — even if some are charged R10 a visit (the user fee envisaged by Deeble for those who can afford it).

"We know from other nations that if we take a previously uninsured group and give it drug insurance, the volume of drugs consumed per capita can increase 15%-20% and spending per capita up to 30%."

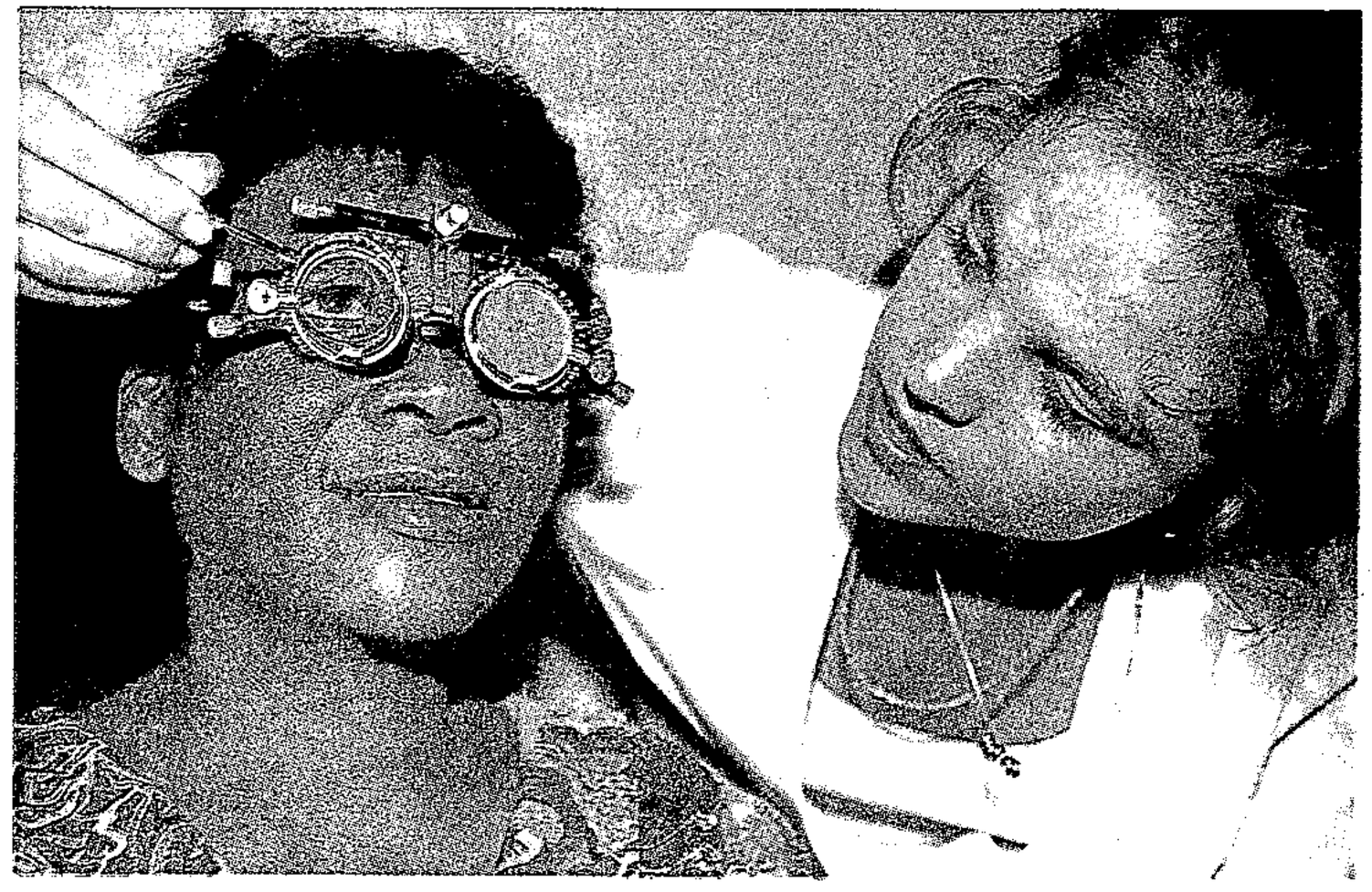
He adds that Deeble's proposed capitation rate for doctors, of R180 per patient per year, is already artificially low and private sector demand is unlikely to decline to three annual visits to the doctor per patient — which is what Deeble assumes.

Gross, who chairs the Institute of Health Economics and Technology Assessment operating in Sydney and France, is particularly concerned that the Deeble plan ignores quality of care (Deeble envisages that more than half of all GP care will be administered by trained nurses).

He says that though primary health-care costs could be partly controlled by initially adhering to the low capitation targets, total health expenditure will not decline because inappropriate hospital care will not be addressed. He warns that short-term focus on costs without assessing outcomes is likely to ignore the potential savings, outside of the primary health budget, that can be achieved through more expensive but effective interventions and medicines. ■

All aboard the health train!

Primary health care has become the catchphrase in South Africa's new health dispensation, but what does the term really mean, and how does it benefit underprivileged, rural communities? Health Reporter LIBBY PEACOCK *checked out one example of active primary care — Transnet's "health train" — during its five-day visit to Riversdal this week.*



TOWARDS BETTER VISION: Optometry student Hilde Saunders selects the correct lenses for patient Elsie Goliath.

BRINGING HEALTH TO THE PEOPLE: Train manager Lillian Cingo chats to Sister Marietjie Bester, responsible for nursing and community work, with the "health train" in the background.

Just the ticket for aches and pains

WE arrive in the southern Cape town of Riversdal in the blistering midday heat. Our unusual destination: the normally quiet railway station.

What we find is not an ordinary sight. The station is alive with activity around Transnet's primary health care train, Phelophepa — meaning "good clean health".

The carriages have been transformed into clinics for oral hygiene, general health care, health education, optometry and other services, while instant waiting rooms with chairs have been set up on the platform.

There are also a medicine clinic, several accommodation units for staff, a storage and laundry van, and kitchen and dining cars.

In April a dental and X-ray clinic will be added.

The train's health personnel treat patients for minor ailments, or diagnose and refer them to specialists where necessary.

Staffed mainly by students, who get valuable experience during the weeks they spend on the train, Phelophepa aims to be a symbol of better health for South Africa's widespread rural communities, which are mostly not within reach of primary and preventive care.

Among the important services delivered on the train are eye tests and, where necessary, glasses are made for patients while they wait.

One such patient is Elsie Goliath, who has cataracts on one eye, while the other is very weak.

The arrival of the train brings her some relief. Her employer brought her for eye tests — and a short while later, she is the proud owner of new glasses. She has also been given a referral to have her cataracts removed surgically.

Train manager Lillian Cingo, a South African who has spent 28 years abroad and has an impressive curriculum vitae — she is, among others, a specialist neurosurgical and neurological nurse, as well as a qualified psychotherapist — arrived from London only weeks ago to take on the job.

One of the train's latest projects is to involve communities along the way by educating people in primary health care, she says.

In this way, something willbe left behind when the train leaves for its next stop.

Born in the Transkei, Ms Cingo has always been "very interested in how rural people live".

Her main worry is that while the train brings health care closer to such communities, distances in South Africa are so vast that people sometimes cannot even get to the train.

"I would like the real grassroots people to visit the train," she says.

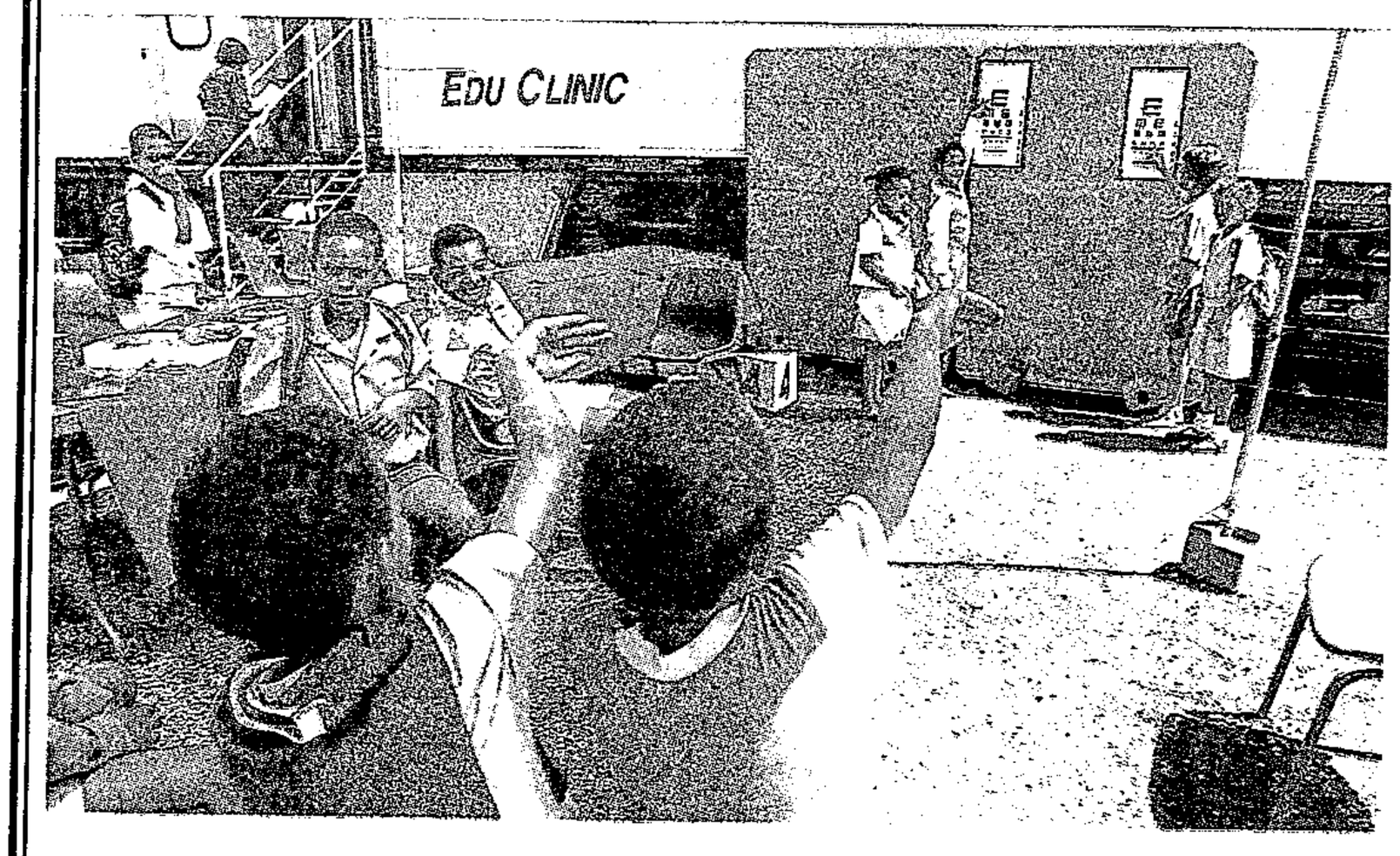
While the train focuses on primary health — because it is always on the move, staff cannot do regular check-ups or offer ongoing treatment — it is envisaged that small ear, nose and throat operations may be added to the services offered in future.

Fees are R5 for consultation, R10 for an eye test and R30 for a pair of glasses.

Sister Marietjie Bester, who is responsible for nursing and community work, says that last year the train was visited by about 900 people a week.

The most common complaints are ear and other infections, sexually transmitted diseases and chronic skin conditions, but illnesses seem to vary from region to region.

In the eye clinic, the most common problem encountered by staff is cataracts.



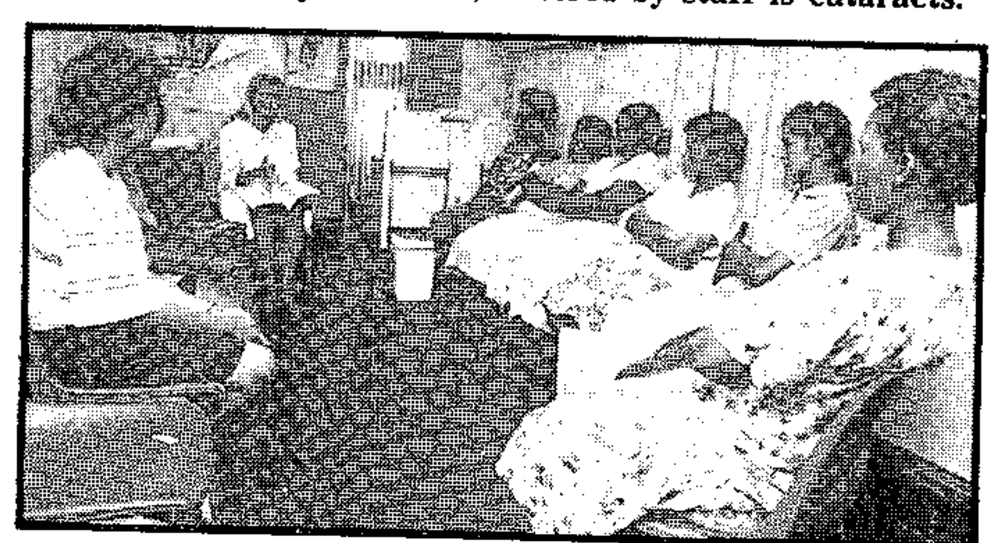
EYE TESTS CAN BE FUN: A group of Riversdal school children "test" each other's eyes.

Pictures: ANDREW INGRAM, The Argus.

DENTAL EDUCATION: Oral hygienist Rainy Makino shows a group of children the finer points of caring for their teeth.

(85) ARG 3/2/95

NEW GLASSES: Elsie Goliath tries on her new glasses, with optometry supervisor Terence Giles looking on.



BUDDING HEALTH WORKERS: Student nurse Marietjie Stenekamp tutors a group of Riversdal women training to become community primary health workers.

'Nightmare for health services'

(85)

ET 3/2/95

Staff Reporter

PROVINCIAL health authorities are burdened by a "massive bureaucratic nightmare" in trying to manage essential health resources in the Western Cape.

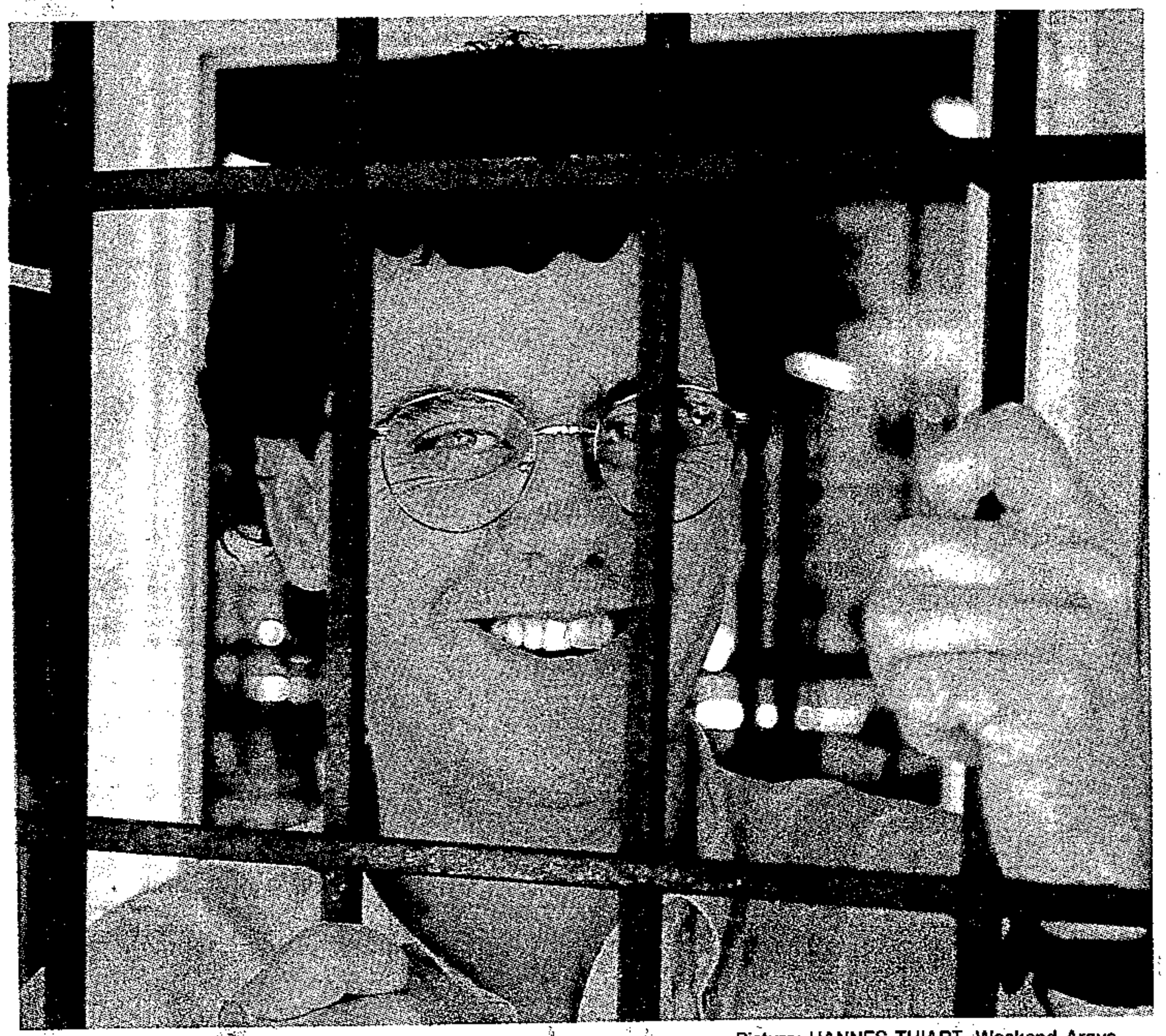
This was said by the head of provincial health services, Dr Tom Sutcliffe, commenting on a crisis at Groote Schuur Hospital, where red tape held up the employment of two anaesthetists and caused five operations to be cancelled on Wednesday.

Since May 1994, when the Public Service Commission announced a nationwide moratorium on all civil service posts, all provincial job applications have had to be individually motivated and authorised by the relevant director-general, minister or premier, and sometimes by all three. With dozens of applications to process at any time, authorisation can take longer than three months to obtain.

A three-month delay in clearing nursing posts at Tygerberg Hospital last year resulted in the present shortage of 100 nurses at the hospital, said acting superintendent Dr Japie du Toit. The entire graduating class of the adjacent Sarleh Dollie Nursing College was snapped up by the private sector and local government during the delay.

Red Cross Children's Hospital superintendent Dr Rod Marshall said: "It's a huge problem that has affected all hospitals greatly."

The Public Service Commission responded that strict control over personnel numbers during rationalisation of the public administration was necessary to ensure the process was co-ordinated effectively and possible redundancy limited.



Picture: HANNES THIART, Weekend Argus.

□ **TRYING:** Optometrist Chris Faul is attempting to break through the bars and restrictions of the eye-care industry.

Chris and Jan run the gauntlet of 'eye spies'

ARG 4/2/95 (85)

GLYNNIS UNDERHILL
Weekend Argus Reporter

PROVIDING eye care at a reduced price has proved a risky and "ugly" business for two Cape Town optometrists.

Chris Faul said this week that he and his partner, optometrist Jan le Roux, have had to face court interdicts, life threats, collusion and prosecution because some people object to their existence.

"There were people who even went as far as to make fictitious appointments in our schedule to fill our appointment book and maliciously undermine our business.

"However, we are determined to pursue our mission of providing affordable eye care without compromising the clinical standards," he said.

Resistance on the part of some optometrists had also created problems for the company, he claimed.

"When we first opened optometrists threatened wholesalers that they would withdraw their support if they supplied us," said Dr Faul.

Now the SA Medical and Dental Council has instructed the company, Spectacle Warehouse, to remove its name because it is against regulations to operate under a name other than the optometrist's.

Dr Faul claims that "hundreds of optometrists" are breaking the same rule but do not face any charges.

"Why should we change our company name? We are trying to attain a corporate identity."

Chris Ecksteen, chairman of the Western Province branch of the South African Optometric Association, said he had held "long discussions" with Dr Faul.

Dr Faul was a member of the association and members were expected to observe the rules.

It was "inviting trouble" to break the rules, he said.

The claims by Dr Faul were straining the relationship between the members of the association, he said.

Dr Faul is undeterred by the controversy surrounding his business.

He said he and his partner opened their business two years ago when eye care was becoming "unaffordable".

The business aims to remove excessive cost in eye consultations and products and to provide a one-stop facility.

The company, which has four branches, offers a range of eye-care, glasses, contact lenses and accessories purchased directly from manufacturers.

"Our policy is very simple. We enable the customer to take charge of the process which will determine the price."

Dr Faul claimed that his products cost between 30 percent to 50 percent less than the normal price.

"We believe in a free market with price advertising which allows us to provide the consumer with affordable eye care," he said.

brain drain

doctors

(88) Star 4/2/98

outrages

on plan

Health

Threats by GPs to pack their bags in what could herald a new brain drain

THERE are fears among medics that Health Minister Nkosazana Zuma will implement the proposed National Health Insurance System.

MAX GEBHARDT

SEVERAL medical doctors contacted by WeekendStar this week have threatened to leave South Africa if Minister of Health Nkosazana Zuma goes ahead with her proposed National Health Insurance System (NHIS) plan.

General practitioners have accused Zuma of forging ahead with her plans without consultation, and fear their livelihood will be destroyed.

According to documents in the possession of WeekendStar, the committee of inquiry into an NHIS has elaborated three principal models, with the help of international consultants.

The second option, which according to the document is favoured by the committee, has a number of doctors threatening to pack their bags in what could herald a new brain drain.

The proposal put forward by Australian doctor John Deeble will result in private GPs becoming State employees.

Instead of charging patients a fee for each consultation, the GPs will, under the proposed system, receive from the State a fixed rate of R180 a year per patient they treat.

The plan is based on the idea that the average patient will visit his or her GP three times a year. The GPs approached by WeekendStar say this is "laughable".

The State will fund these payments, according to the document, by charging employees a compulsory 3 percent payroll contribution.

They hope, through this 3 percent levy, which will be shared by the employees and employers (1,5 percent each), to generate between R4,65 billion and R5,25 billion based on the estimated salary and wage bill for 1994 of R155-R175 billion.

What this means is that primary health care will fall into the hands of the Government and not the private sector.

A GP in Brakpan, who consults up to 10 000 patients a year, said the plan "borders on insanity".

"I have a busy practice. This plan will cut my turnover by 10 times, but I'm still going to have the same overheads," he said.

"I guarantee I will leave if this plan is put into action," he said. He was already looking into opportunities in Mozambique.

Dr Bernard Mandell of the Medical Association of South Africa said the restriction on freedom of choice inherent in the Deeble plan would have serious implications for doctors and their patients.

Doctors at a township hospital on the East Rand believe there is nothing wrong with the present system and are critical of the proposed plan. The doctors, who are mostly from eastern Europe, believe it is just a rehash of the failed systems they left behind.

"The actual problem is not with the medical system but rather with population growth," according to one doctor.

"We have one of the best systems in Africa, so why change it?" was the general consensus in the doctors' tearoom at the township hospital.

During an emotional debate on the NHIS at Johannesburg Hospital on Thursday, Zuma said the committee had not yet come up with proposals and she was sure it would not be called the Deeble plan.

"I'm sure they will not come up with a plan that will mean every doctor will leave the country, I'm sure of that," Zuma said.

But one GP said after the debate that nobody was coming clean on the issue.

He said he believed the proposed consultations and debates that Zuma will hold around the country with interested parties were a farce and that the NHIS would be forced on doctors from behind closed doors.

According to Zuma, the shortage of primary health care forces many people to forego the services they need altogether.

"In order to rectify these problems in the shortest time, substantial health care reform is necessary," she said.

But some experts believe her health reforms could wreck primary health care in South Africa.

HARASSED GP: Some doctors see thousands of patients in a year and believe that the new proposals 'border on insanity'. PHOTOGRAPH: MYKEL NICOLAOU

Boost for W Cape health services

(85)

ARG 7/2/95

☐ *But shortfall still nearly R200 m*

LIBBY PEACOCK
Health Reporter

CENTRAL government has made available a much-needed extra R170 million to the Western Cape's health services.

But while these funds will help the province in off-setting the projected R362 m deficit this year, it will still leave the Western Cape with a R192 m shortfall.

Last week, local health minister Ebrahim Rasool said the province was serious about rationalisation, but that it needed stability and "an orderly process" to achieve this.

The province had been allocated a R1,8 billion budget for the coming financial year, but an extra R201 m "transformation enabling fund" was "desperately needed".

Yesterday's concession followed a week of intensive negotiation between Mr Rasool, national health minister Nkosazana Zuma and health ministers from other provinces, but he is still millions of rands short of the sum asked for.

Reacting to the additional funding, Mr Rasool said although it did not "let us off the hook completely", it was "a most welcome contribution, which makes future financial plans far more manageable ... and will lessen the implications that wiping out a total projected deficit of R362 m would have had."

The R170 m should not be seen as "a hand-out" but as an indication that central government endorsed plans to transform health services in the Western Cape.

It was recently reported that thousands of beds at Cape Town's tertiary hospitals had been earmarked for downgrading to secondary health care.

Mr Rasool said yesterday it was still necessary to scale down expenditure in the province's academic hospitals, "and probably in some metropolitan hospitals as well".

"We are also left with the need to provide funding for upgrading under-provided areas in the Western Cape, in support of minister Zuma's appeal for equity in health service provision," he said.

Mr Rasool also announced a new, "far-reaching" plan to contain expenditure on academic complexes.

He would not release details of this plan — which he described as "both refreshing and rational" — until it has been discussed with the universities concerned and others.

He said he was mindful of the implications for staff and services posed by the scaling down of expenditure, but would avoid the need for retrenchment and service closure where possible.

He said he aimed to maintain 'all that is good in our services'.

Rasool scoops health budget breather

CT 7/2/95 (98) (95)

By CHRIS BATEMAN

THE Western Cape's top health officials breathed a collective sigh of relief yesterday as a R170 million budget allocation saved the region from radical staff and hospital cuts – even though it was R31m short of what they had requested.

Local health minister Mr Ebrahim Rasool said the bridging finance would enable "creativity rather than panic" and bought his department time to convince senior hospital officials their contingency plans were workable.

He ruled out the closure of any of three academic hospitals and the laying off of health service workers. However drastic re-allocation of equipment and staff was on the cards as the province carried out the primary health care plan of "bringing health to the people".

Mr Rasool said this plan had "sold" his budget plea to national health minister, Dr Nkosazana Zuma at the weekend because it showed her the Western Cape was serious about the RDP and transforming health services.

"We managed to break the national mindset that we want to build a super health system here with our three 'Rolls Royce' academic hospitals," he said.

"While she is in this mood I intend asking for another R20m from her functions committee next week," Mr Rasool added.

His deputy chief director of health, Dr Tom Sutcliffe, said he was "considerably relieved" at the allocation.

Declining to reveal change plans for the academic hospitals until premier Hernus Kriel and his director-general had been briefed, Dr Sutcliffe said however that there would be a "major moving of equipment and resources".

Both men said the allocation did not "let us off the hook completely".

There was still a total projected deficit of R192m for the 1995/96 year to be managed. Expenditure on academic hospitals and some metropolitan secondary hospitals would have to be "downscaled".

A major emphasis would be on upgrading neglected rural health services, Mr Rasool said.

Fivaz orders probe into 'racist' tapes

CT 7/2/95

PRETORIA. – Police Commissioner George Fivaz yesterday ordered a top-level investigation into the use of racist and abusive language on police radio communications after he listened to a tape recorded during recent disturbances at Orlando Police Station.

The recording of police radio calls was made during a clash late in January between Popcru members and the internal stability division.

Commissioner Fivaz confirmed the tapes would be made public after the investigation had been completed.

According to weekend reports, black and white policemen called each other "kaffirs" and "dogs" on radio.

Mr Fivaz said an extract to which he had listened contained repulsive language and a racist remark that he found unacceptable in the new police service.

Meanwhile, Western Cape Minister of Police Mr Patrick McKenzie has sent a memorandum to police warning them that they could face harsh departmental action or criminal charges for racist remarks. – Sapa, Staff Reporter

'Do or die' for DP in local poll

By BARRY STREEK
Political Staff

THE Democratic Party has effectively decided it could not continue if it does not significantly increase its support base in the October municipal elections.

Party leader Mr Tony Leon said in Johannesburg yesterday that the local government elections were "do or die for the DP".

"Politics is about having a base and a coherent constituency. I am determined to lead this party to renewed growth and revitalisation.

"But it will not happen unless each and every member and supporter and sympathiser of this party realises that in the municipal elections our future existence is on the line," Mr Leon said.

BUSINESS BRIEF

Social insurance a common way of financing health care

(85) MARC BLECHER

BD 7/2/95

NATIONAL health insurance is one of the most common forms of financing health care worldwide.

More than 100 countries have social insurance schemes including much of Europe (eg Germany, France), Canada, Australia and a considerable number of middle income and developing countries, including most of South America (Brazil, Argentina) and many Asian countries.

Recently, many eastern European countries set up such schemes. International proponents of the system include the ILO and the World Bank.

National health insurance has improved the care of population groups previously not insured — especially workers and their families — by increasing the proportion of citizens with access to skilled health practitioners and modern medical care.

Patients who could otherwise afford only occasional "out of pocket" payments for care receive skilled treatment. Social insurance also provides a way of meeting the demands of organised labour.

There are several potential risks which must be considered and addressed.

While national insurance has been a sustainable and effective way to increase financial resources, the potential for expanding health services through increased government finance is often limited.

Poorly managed insurance systems may lead to considerable cost escalation.

In Korea, expenditure on health care as a percentage of GDP has doubled in a decade. Demand-side measures such as raising user charges (in Korea cost sharing reaches up to 65% of the fee), may limit the objective of the scheme.

Solutions have included supply side interventions such as altering reimbursement mechanisms, capping certain categories of expenditure, using managed care principles or encouraging competition between schemes.

Systems in developing countries (eg Brazil, Mexico) have often not been particularly successful in improving the health status of the rural poor.

This is because health facilities and expensive technologies are far more plentiful in urban areas and absorb much expenditure. Services may be so poor in rural areas that contributors may actually subsidise richer urban areas.

Another problem is that social insurance systems tend to be doctor-centred, and environmental, nutritional and social problems are frequently medicalised with inadequate emphasis being placed on public health and prevention.

National health service schemes, such as the British system, are often more effective in this regard.

In many countries social insurance systems began by covering only those in formal employment, with coverage progressively expanding over time. This approach is often financially more feasible than starting out with universal coverage, but does have certain disadvantages.

Entrenchment of a tiered health service may be socially divisive. The health service becomes fragmented into private, social insurance and public sectors, and coordinated national or regional planning may be difficult. The social insurance system may drain valuable staff away from the public sector.

If governments subsidise limited coverage schemes even greater inequality between employed and unemployed persons may result.

In designing national health insurance, many choices have to be made. These include whether coverage should be universal or not, and whether benefits should include primary health care only or all levels of care.

☐ **Blecher is a doctor in UCT's community health department.**

Health care for the poor 'neglected'

CT 8/2/95 (85)

MIDRAND. — Private sector criticism of the proposed National Health Insurance Scheme stemmed from apartheid history, Health Minister Dr Nkosozana Zuma said yesterday.

"The response from the private sector comes from our history where people who have professional health care don't see why we should change it," she told reporters after addressing a conference on corporate health care here.

The scheme, proposed for discussion by a committee appointed by Dr Zuma, provides for a compulsory payroll tax through which the employed will cross-subsidise care for the unemployed.

"We have inherited a system where there has been deliberate neglect of the majority of our people in health care," Dr Zuma said. "We have people who on one end of the spectrum have the best health care, and they happen to be rich and white: On the other end of the spectrum, there are people who have no access even to basic health care, and they happen to be black and poor."

Only six percent of black South Africans were covered by medical aid, she said, and although private health care would be sustained, the government's responsibility extended to developing care for the poor, squatters and rural communities.

A technical committee she had appointed to investigate the health insurance scheme would present its report within three months, she said.

"We have to make efficient and affordable primary health care, on a non-discriminatory basis, a reality," Dr Zuma said. — Reuter

Hospital linen request slated

JOHANNESBURG. – A statement by Baragwanath Hospital in Soweto that patients should bring their own linen and bed-clothes to hospital was described yesterday as "scandalous" by DP health spokesman Mr Jack Bloom.

He accused the Gauteng health department of failing to effectively deal with a crisis in state hospitals arising from managerial deficiencies and budget constraints.

"Hospitals such as Baragwanath desperately need more autonomy and freedom from inappropriate bureaucratic controls," Mr Bloom said.

"It is simply unacceptable that standards of care could deteriorate so badly that sick patients are further traumatised by lack of basic linen and bed-clothes." – Sapa

EU launches R87m health plan in SA

JOHN DLUDLU

THE European Union would sign an R87m agreement with Health Minister Nkosazana Zuma and Finance Minister Chris Liebenberg today enabling it to launch its national health programme for SA, EU ambassador Erwan Fouéré said yesterday.

In addition, he said three SA banks would be selected shortly to assist the EU in the implementation of its European Community Investment Partners programme, which would promote joint ventures between SA and European companies.

(85) BD 8/2/95

About R1,2bn worth of finance was in the pipeline for SA over the next two years through the European Investment Bank.

The loans would be used for strengthening regional co-operation, infrastructural development, small business development and tourism.

Fouéré said the EU would help SA and the southern African region achieve economic stability and become more competitive on international markets.

He told the Austrian Business Circle in Sandton yesterday the EU was keen to contribute to the reconstruction and development programme.

The EU had already extended several trade and investment facilities to foster stronger ties with SA, including the revised generalised system of preferences.

Europeans aid SA Aids plight

PRETORIA. — Health Minister Dr Nkosazana Zuma yesterday signed two aid agreements with the European Union aimed at improving South Africa's health system.

In terms of the first, the EU will assist the Department of Health in setting up a strategic planning team, Dr Zuma said at the signing ceremony at the Union Buildings here.

The second treaty provides for aid to develop district health systems.

Dr Zuma said a third agreement, in terms of which the EU would help South Africa to fight Aids, would be signed in about two weeks.

"This will give us some of the resources we need to put our Aids plan into action," she added.

EU ambassador to South Africa Mr Erwan Fouere said the signing of the agreements marked the first direct co-operation between the EU and the new government.

He added that the EU had so far approved about R100 million for the health sector in the country.

Nearly half of this money was for the fight against Aids. — Sapa

EU ambassador to SA Erwan Fouéré, Health Minister Nkosazana Zuma and Finance Minister Chris Liebenberg at the signing of documents in Pretoria yesterday making funds available for health services. Picture: ROBERT BOTHA

EU's R100m for health first direct aid to govt

(85) BD 9/2/95

NOMAVENDA MATHIANE

THE European Union had for the first time given direct financial aid to the new government in the form of R100m for the health sector, EU ambassador to SA Erwan Fouéré said yesterday.

Speaking at the signing ceremony in Pretoria, when the funds were handed over, he said until now all the EU's assistance to SA had been through partnerships with non-governmental organisations.

He said the R100m had been taken from the 1994 special programme budget for SA. Most of the funding would go to the Health Department and the nine provincial health departments.

Health Minister Nkosazana Zuma said the money would be used in three programmes, the first of which was to set up a team to assist with strategic planning and implementation.

The second programme would deal with developing district health systems around the country.

"It is where the vast majority of people come into contact with health services, and it is the area in which we would like to see dramatic improvements.

"Most of the aid under this agreement will be channelled to the provinces to assist them to develop health districts," Zuma said.

The third programme would focus on ways of containing the AIDS epidemic.

The search for a 'magic bullet' to heal all ills

(85)

WM 10-16/2/95

Dr Jonathan Broomberg, co-chairman of the ministerial inquiry looking into health care reform, pleads for greater public understanding and input into this crucial debate

THE public debate about the minister of health's investigation into reforms of health care financing has been intense, acrimonious and, until this point, largely destructive.

While there may be arguments about the respective roles of the government and the press in the handling of the debate, there can be none about the urgency of the issue. The minister has rightly recognised that this is the moment to dispense with the old pattern of tinkering at the margins of the system, and to attempt bolder reforms.

This presents an exciting opportunity for public participation in the policy-making process, an opportunity which has been constrained by gross oversimplification.

What is urgently needed is a clearer public understanding of the range of possible approaches to reform presently under consideration.

The two basic forms of public funding for health care are general taxation funding and national health insurance (NHI). An NHI system consists of a compulsory payroll tax which is earmarked for health care, as distinct from the allocation of general tax revenues to the health sector, which is the current method of funding the public health care system in South Africa.

The NHI payroll tax is usually paid by all in formal employment and their employers, and is linked to the provision of a defined package of health care benefits.

NHI systems have several advantages over general tax funding, among them the stability of funding they guarantee and the relative public acceptability of dedicated health care taxes. Variants of NHI are thus widely used throughout the developed and developing worlds, including Holland, France, Germany, Canada, Australia and Israel — and, more importantly from our point of view, in numerous middle-income countries in Latin America and Asia.In addition to its general appeal, an NHI system has attracted the attention of South African policy makers because it offers, at least in theory, answers to some thorny and peculiarly South African health care problems.

In particular, it offers a potentially powerful mechanism for the redistribution of some of what are now exclusively private-sector resources. In a context in which 61 percent of total health care spending, 60 percent of doctors and more than 90 percent of dentists are reserved for the exclusive use of about 23 percent of the population, the appeal of some form of redistribution is clear.

In addition, through the creation of a single purchaser of services and tighter controls and regulation, an NHI system has the potential to address effectively several of the critical efficiency and cost problems affecting both the private and public health sectors.

No wonder, then, that NHI has been perceived as the policy equivalent of a "magic bullet".

There are, however, a range of critical factors, once again peculiar to our own situation, which may constrain the ability of an NHI system to live up to its potential. In almost every country in which NHI has been introduced, the initial stages have required a distinction between contributors and non-contributors to the system, with contributors gaining access to the insured benefit package and non-contributors continuing to rely on the pre-existing public health care system.

This system is often termed social health insurance (SHI) to distinguish it from NHI, in which the whole population has access to the benefit package. The pattern of initially introducing an SHI, with the explicit intention of moving rapidly towards NHI, has occurred particularly in countries with highly unequal income distributions and significant unemployment levels, in which the relatively small pool of contributors could not at the outset generate sufficient funds to cover the extension of benefits to the whole population.

> This is the moment to dispense with the old pattern of tinkering at the margins of the system

As the economies of these countries grew, cover was systematically extended to larger proportions of the population, with universal cover taking some decades to achieve in several Latin-American countries, and approximately a decade in some Asian countries.

In the South African context, a SHI system would mean that all in formal employment would be obliged to contribute, and would in return obtain access to the insured benefit package. This would make the current medical aid system more affordable and accessible to a much larger proportion of the population.

At the same time, it would bring several benefits to the public sector, on which the unemployed and other non-contributors would continue to rely for the time being. The SHI would remove from the public sector the burden of caring for all those who could afford to pay for their own care. The public sector could also attract substantial revenues from the SHI by treating contributors and charging the SHI for this.

Finally, additional redistributive funding mechanisms that increased support for the public sector could be introduced alongside the SHI.

As attractive as this approach may seem, it has a fundamental and, from a political perspective, apparently fatal flaw. Given our history, and the potential imperatives of both the government of national unity and the ANC, the minister of health has made it clear that the introduction of a reform which explicitly discriminates between the employed and the unemployed is unacceptable. She has thus given an explicit brief to the committee of inquiry that any system it recommends must guarantee universal access to whatever package of care is provided by the system.

It is obvious that South Africa could not at this stage afford to provide a full package of health care benefits, and this has led to the search for a smaller, more basic package of benefits that could be extended to all South Africans. This explains the exclusive focus on primary health care (PHC) in the committee's brief.

A system that was able to fund and deliver a comprehensive range of PHC services to all would clearly be a major step forward. It would enhance the life chances and quality of life of those who have until now relied exclusively on the poorly organised and underfunded public-sector PHC system. Provided it was appropriately structured, it would ensure that those who currently enjoy the benefits of private-sector PHC would not have to accept significant compromises in the levels or quality of care they receive.

It would also address the efficiency and cost problems blighting both the private and public sectors. Over and above these very significant technical advantages, the political appeal of a reform of this kind is obvious.

Once again, however, the apparent attractiveness of this approach disguises several obstacles and problems. The first concerns economic and administrative feasibility. It is not at all clear that the contributions of those in employment will be sufficient to cover the costs of providing a comprehensive PHC package to all, particularly if the system is to incorporate a component of general practitioner (GP) services.

Even if the system turns out to be affordable, there may be an insufficient supply of personnel, facilities and drugs, particularly in rural areas. The administrative burden of the system will also be substantial, particularly in the context of large migrant and homeless populations.

A second set of concerns relates to the health care system itself. The design of a system of funding and providing PHC in isolation from the rest of the health care system, in particular the hospitals, contradicts widely accepted health planning wisdom, and creates serious risks of lack of co-ordination and uncontrolled referrals to the hospitals.

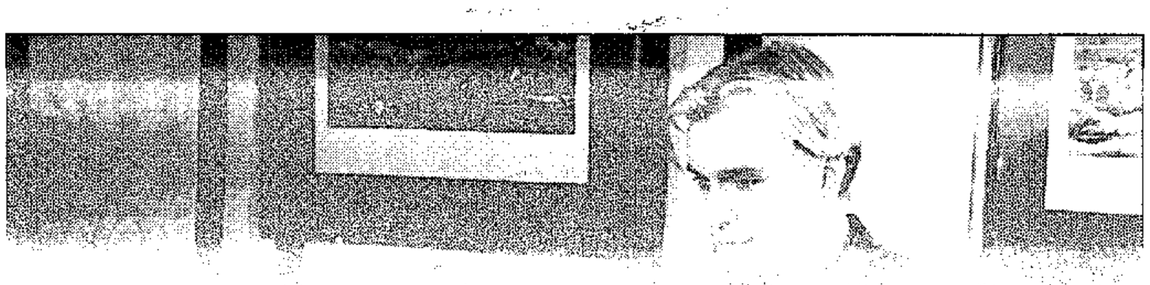
The Department of Health is in the process of designing a vital reform to the public sector based on a district health system model, and it is unclear how an NHI-funded PHC system might be integrated within the district model. There is also a risk that the incorporation of GPs might lead to an unacceptable reorientation of PHC towards the curative model of care which GPs currently practice, and away from a more desirable, comprehensive model of care.

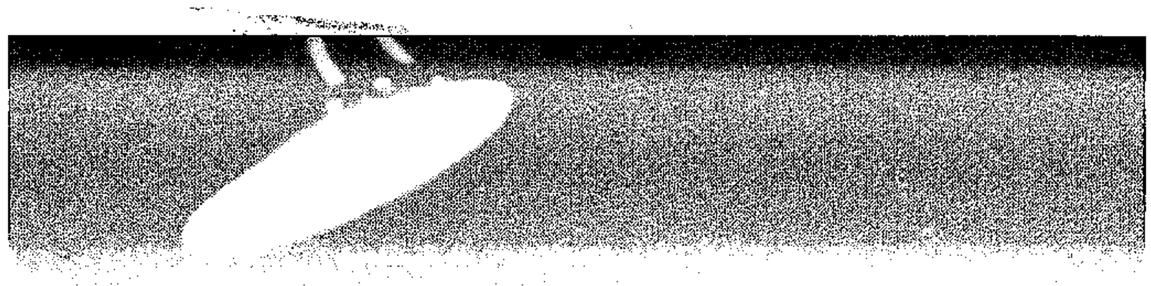
There are also critical questions of political feasibility. There are many potential sources of resistance to a reform of this kind, including employers and employees, private-sector providers and producers. The balance of forces for and against such a reform remains unclear at this stage, and will obviously depend on the nature of the proposals which emerge.The committee of inquiry is faced with a complex task. It has been set broad but firm principles within which to operate, and most solutions it has to investigate have both advantages and problems.

It is vital for the public to understand, however, that the committee is free to investigate any model or system that meets the basic policy objectives, and that much additional data is required before any judgments can be made on the uncertainties and potential problems.

The model that may ultimately emerge may be some permutation of an NHI system but, given the range of difficulties noted above, it is also possible that a model that has nothing to do with NHI may emerge. The committee of inquiry is firmly committed to a process of wide consultation, and to a transparent method of functioning and decision-making. Whatever result emerges will depend in significant measure on informed inputs from all sections of the public. It is vital that this crucial debate be shifted away from crude histrionics, and towards more level-headed and informed public discussions that will facilitate meaningful public input into the committee's deliberations.

4/ARTS & BOOKS





Tricksy stuff: Shirley Johnston, James Baker-Duly and Cait Pocock in the Civic's Arcadia

Ensuring theatre's survival: Tom Stoppard has put the brains back into drama

Cerebrating the magic of theatre

As Arcadia set out to tease audiences in Johannesburg, **Guy Willoughby** spoke to Tom Stoppard between West End rehearsals of his latest play

THERE can be few more incendiary British playwrights living than Tom Stoppard — an evening in the theatre with one of his plays is a bit like a mental Guy Fawkes night. Stoppard doesn't so much celebrate the potential of drama as cerebrate it; by bringing lashings of intelligence and sheer good fun to the stage, he reminds us forcibly that theatre can, well, *do anything*.

One of the things the playwright doesn't like doing, it seems, is passing comment on his own plays — "I talk about them only at gunpoint". However, he kindly allowed himself to be drawn about one or two of them last week, in between the West End rehearsals of his latest play, *Indian Ink*.

Most of our conversation turned on *Arcadia*, his last British and American stage success, currently in production at Johannesburg's Civic Theatre. Naturally, local audiences should prepare themselves for the unexpected.

"*Arcadia* takes place simultaneously in two periods of time," says the playwright cheerily. "First, we have a group of characters at the beginning of the 19th century. Then, a few in the present day. The action alternates between these periods, but always in the same house — in fact, in the same room."

Tricksy stuff, for once again Stoppard is experimenting with the olden dramatic verities. No unities of place and time for Stoppard; in *Indian Ink*, he tells me, the audience must digest two settings as well as time zones. "It's set in India in 1930, and concerns a woman poet; it also takes place in England at the present day."

I ask Stoppard, deadpan, what role he foresees for the long-suffering audience in these plays. He thinks a moment. "Well, of course, the plays are written for audiences. They are the people I tell the story to ... Actually, the audience is the reason I work in the theatre."

Not that that's any reason to mollycoddle playgoers, of course; we return to *Arcadia*. "Two characters are investigating what happened in this house nearly 200 years ago. Lord Byron had something to do with it." He adds wryly: "It gets complicated, I admit."

Complication, of course, is something that the mercurial Stoppard thrives on, especially if there's a bit of literary history, or speculation, thrown in. Playgoers will remember the ingenious *Rosenkrantz and Guildenstern are Dead*, in which Hamlet plays second fiddle to the bit players in Shakespeare's tragedy; or *Travesties*, which manages to make fun of Oscar Wilde, James Joyce and the Dadaist Tristan Tzara all in the same breath.

"*Arcadia* is a kind of literary detective work," Stoppard agrees. "One of the characters is an English academic, who is trying to find evidence of Lord Byron's involvement in a long-buried scandal. No, I've got nothing against English academics, I can assure you."

Is Stoppard in conscious dialogue with Byron, as he is with Shakespeare and Wilde in earlier plays? "No, Byron doesn't really feature himself. He is merely an offstage character." But then, so was Hamlet in *Rosenkrantz and Guildenstern*.

Stoppard has enjoyed playing about with the murder-mystery genre before; mad detectives inhabit *The Real Inspector Hound* and the brilliant *Jumpers*. "In *Arcadia*, the mystery that engrosses the two modern-day characters has already been solved by the audience — they know the answer beforehand."

Like *Hapgood*, Stoppard's curious piece of quantum-theory detective work, *Arcadia* bristles with the strange world of chance that inhabits contemporary science. Does he believe the theatre should engage with novel ideas and theories? His plays seem full of exactly that. Stoppard disclaims such portentous notions: "I don't believe big ideas are necessary to the theatre; theatre is recreation, it must entertain. But does the audience have to understand everything they see? If you or I go into an art gallery, we don't understand what the artist is trying to tell us, though we may enjoy the painting."

Stoppard's teasing attitude towards his audience makes me think of Oscar Wilde — one precursor of Stoppardian wit, and a figure burlesqued in *Travesties*. "I enjoy his prose as well as his plays; it's a pity we only tend to see three of his dramas. He's an admirable figure. I don't spend a lot of time thinking about him, however." And contemporary playwrights? "No, I don't spend a lot of time thinking about them either."

> Does the audience have to understand everything they see? If you or I go into an art gallery, we don't understand what the artist is trying to tell us, though we may enjoy the painting

I ask Stoppard in what ways *Arcadia* beats a path away from previous plays. We talk a little about *Travesties*, my personal favourite, in which the writer turns art and politics into sheer music hall. "Well, unlike *Travesties*, *Arcadia* requires — relies on — a clear narrative line. *Travesties* is a collection of highly wrought comments on styles, myths, philosophies, and so on. *Arcadia* is really concerned with the story it's telling."

Stoppard has strong views about the future of the theatre, of course. "We've been told since about 1960 that it's very, very bleak," he says wryly. "I think it's much stronger now than it was. I think it's proved itself, that it's a thing apart." A steely note comes into his voice. "It can't be replaced: it won't give way on its position."

Stoppard's hackles rise at the mention of the atre's dreaded rival, the one-eyed monster of the living room. "Television doesn't interest me, even though ours in Britain is supposed to be the best in the world. It's an uninteresting medium.

"Now in the theatre, everything you see is in medium-wide shot. There's no intermediary, like the camera, telling you what to focus on. You get the immediate rewards and penalties of the moment. By the way, what's your television like in South Africa ...?"

Stoppard is very fond of radio, however, especially radio drama — a medium in which he has excelled throughout his career. "It's a most efficient dramatic form. You go into production, and in three or four days it's done. Very satisfying. Here in Britain, at least, you can get the services of some of the best actors available. Radio is a playwright's medium." Unlike television, we may infer.

Radio drama has proved a testing ground for Stoppard in other areas too. "I've often stolen from my work on radio. *Indian Ink*, my latest, began as a play for the BBC three years ago." Stoppard continues with an outrageous fib: "Not that I have enough ideas to survive as a writer of radio, TV and theatre."

Well, Stoppard has probably done more in the last 25 years to ensure the commercial survival of theatre than any other British playwright; he has kept the magic and brought back the brains to this most protean of performing arts. His final thoughts on theatre take the form of a post-Wildean paradox. "I love the theatre, of course. But I don't know if I like it because of its value — or if it's of value because I like it."

Arcadia runs in the Tesson Theatre at the Johannesburg Civic until March 11

HEALTH (85) FM 10/2/95

Blindingly obvious

With health care heading for a major crisis under government's socialist plan, the efforts of nongovernment groups and the private sector in tackling the medical needs of disadvantaged communities will become crucial. And provided State interference is kept to a minimum, there is no reason why they should not succeed in filling a major gap in primary health-care services.

One of the most ambitious projects currently under way in Transnet's primary health-care train, Phelophepa, launched in 1993. With private sector backing and staffed by qualified professionals and optometry and dental students, the train travels around the country diagnosing health problems and treating patients.

This year the train will make week-long stops at 38 rural communities. Last year it stopped at 34 areas and staff saw 33 000 people, says project leader Lynette Coetzee. The original idea for the train came from Rand Afrikaans University which identified the need for eye care in rural areas. The first train had only three coaches and offered only optometry services.

Last year it grew to 13 coaches and was extended to a fully fledged primary health-care facility. It is hoped that by April a new extension will include additional dental care and a radiological service.

Coetzee says the next goal is a second train for minor ophthalmic surgery. Her longer term aim, possibly by the end of the decade, is to see a health-care train operating in each province. Phelophepa supports rather than duplicates existing health-care services, says Coetzee. But it is also clear that in many areas the train provides services that are unavailable or inaccessible to remote communities.

This year the project includes an outreach programme to extend its service beyond the immediate area of the station platform. It includes, for example, sending nurses, optometrists and oral hygienists into communities to conduct hearing and eye tests and examine teeth.

Efforts are also made to recruit and give basic training to 20 "barefoot nurses" to support local health structures in each community visited by the train.

Optometry is still the main service; last year fifty percent of patients examined needed spectacles. Many of the problems identified are related to inadequate health education, so, in the short time they have at each stop, Phelophepa staff emphasise preventative health care.

Train manager Lillian Cingo says it is not enough to merely treat patients. They must also be empowered to help themselves. She says Phelophepa should be seen as complementary to the RDP in that it helps uplift disadvantaged communities.

The train is financed by Transnet which has invested R4m in the project. Monthly operating costs are about R340 000. Consultations for family planning, health education and family care are free. Medicines up to Schedule 3 cost R5, eye tests are R10 and spectacles, R30. Income last year was R80 000.

Coetzee and Cingo . . . *health on track*

The project is backed by the Pretoria Technikon, the universities of Durban-Westville, RAU, the North, OFS, Unisa, Western Cape, Stellenbosch, Pretoria, Medunsa and PE and the Ann Latsky, S G Lourens and SA Medical Services nursing colleges. Private sector sponsors are pharmaceutical companies Boots, Janssens, Madaus and Roche, the Colgate-Palmolive Foundation, Engen, Maskew Miller Longman, Presmed, SA Sugar Association and Teljoy. The train also has the backing of a wide range of Transnet's business units.

If Health Minister Nkosazana Zuma stops to think, she may find that several trains will obviate the need for dozens of expensive clinics. ■

(85) FM 10/2/95
HEALTH CARE CONFERENCE

Healing the wounds

Health Minister Nkosazana Zuma is still attempting to staunch the flow of controversy surrounding her plans to create a national health insurance system.

Addressing the third *FM* Corporate Health Care Conference at Gallagher Estate this week, Zuma stressed that her department had to take cognisance of the policy formulated before last year's general election as a result of wide consultation

with the public.

She adds that her department's emphasis on primary health care is to address the basic needs of a population that largely still has no access to running water, sanitation or electricity along with an inadequate primary health system.

"How can we expect our specialists to tend to flu when they should be looking at serious illnesses. Our hospitals, though infrastructurally sound, are overburdened by patients who should be receiving primary health care treatment at accessible centres or clinics."

Du Toit . . . *governments are not good at producing services*

On the question of whether the private sector will still have a role in a new dispensation, Zuma says private hospitals and specialist care will probably still be available to those who can afford it. Primary health care, however, possibly needs to be funded by the State to ensure universal access, she says.

SA Medical and Dental Practitioners chief Kgosi Letlape says his organisation — representing the largest number of black practitioners — will support the Minister and her department's efforts to make health care accessible through a single comprehensive national system, though he predicts that there will still be a lot of debate as to how this can best be achieved.

National Association of Private Hospitals chairman Riel du Toit agrees with Zuma's belief that a two-tier system of health-care delivery — for primary health care — should not be allowed.

"The State should be prohibited from continuing to deliver health in the extremely inefficient and ineffective manner it presently does," says Du Toit. He adds that it's accepted throughout the First and Third Worlds that governments are not good at producing goods and services — including health care — because they are bureaucratic and inefficient.

Says Du Toit: "Even in countries where the State does deliver health services, the policy makers are being separated from the policy implementers — service providers. This is true for the UK, Ghana and other countries.

"But in SA, our plans for health care look something like those which used to exist in eastern Europe."

FM editor Nigel Bruce stresses that health policies should not be used to overcome macro economic deficiencies beyond their scope. He says despite the destructive effects of apartheid, the SA health system — however inadequate — should be preserved at whatever political inconvenience because it is the only system in Africa and will take generations to replace if destroyed.

Du Toit is particularly concerned that the search for a national health insurance scheme has become so urgent simply because government realises it is unable to fund its proposed National Health Plan.

No Improvement

The plan, says Du Toit, supposedly geared towards consolidating the inherited apartheid-fragmented public health-care system and unlocking vast sums of money previously absorbed by armies of bureaucrats of the old system, appears to need more money than the old system without improving the level of care.

He adds that "all the different Ministers and departments of health under the old system are now simply being replaced with layers upon layers of civil servants whose task it apparently is to control, co-ordinate and integrate."

Registrar for Medical Schemes Danie Kolver suggests that private medical schemes are still viable, pointing out that more than 60% of all medical aid members belong to in-house or closed schemes that are presently operating on average solvency margins of around 28% — higher than the recommended 25%.

Minister Zuma . . . *primary health care must be funded by State*

He stresses that urgent deregulation and the implementation of the Melamet recommendations will definately ensure greater competition and financial soundness for the health-care sector.

Du Toit adds: "There are many exciting projects and ventures being undertaken by the private sector to make health care more affordable and accessible to all.

"The private sector is very keen to help the Minister give our country a health-care system of which we can all be proud." ■

Zuma's health hard-sell

WM 10-16/2/95 (85)

The health minister is on the campaign trail for her department, giving doctors a chance to harangue her in public. Pat Sidley reports

A GATHERING in a huge auditorium at the Johannesburg Hospital last week probably marked the first time in South African history that health care professionals, many of them doctors, had a chance to harangue the minister of health publicly.

When an attempt was made to cut the meeting short after close to two hours, the minister whispered audibly: "No, let it go on. They don't get the chance to do this very often."

So on it went — with doctors, health-sector trade unionists, health care administrators, breast-feeding advocates and the like bending the ear of Health Minister Nkosazana Zuma.

Nkosazana Zuma: Health campaign trail
PHOTO: HENNER FRANKENFELD

It was no hardship for Zuma, however. She was on the campaign trail, selling the health aspects of a better life for all, fertilising the medical grassroots for the vote likely to come up later this year on a national health system and the funding for it.

The "consultation" process followed a spate of negative press reports the department had collected while it delved, out of the public eye, into national health insurance schemes. Scalded by being called secretive, accused of behaving counter to the ANC's desire for transparency, the department was forced into opening itself to public scrutiny. It promised a process of extensive consultation for its newest committee, which is looking into a national health insurance scheme.

The invitation to the media from the department said the minister would begin her consultations by talking to general practitioners at the Johannesburg Hospital. There may have been some GPs there, but the invited audience consisted largely of "progressive" health care organisations, including representatives of the National Education, Health and Allied Workers' Union (Nehawu), health care specialists in the private and public sector and as many hospital and medical school staff as could find room in the vast auditorium.

Any question could be put to the minister, who fielded them alone, with her special adviser Dr Olive Shisana making notes. However, not every question was fully answered, especially not the ticklish ones.

The questions were prefaced by an appeal from the minister to recognise that the country simply had to bring the majority who had not had health care in the past equitably into the system.

Those in the auditorium, she said, probably had more taps than occupants in their homes. But some entire communities did not have access to taps or clean water.

Zuma wrung applause several times from the audience, but nothing like that attracted by the Johannesburg Hospital doctor who drew attention to the appalling working conditions in the public sector.

A Nehawu representative asked if Zuma would be seduced by the lobby of doctors. With her own medical training rising to the fore, Zuma proclaimed that doctors worked largely for the public good, but she would not, despite this, be seduced by the doctors. When she agreed with another questioner that doctors were not the only health care group which should have a stake in the health of the people, she drew applause.

As for the "Deeble plan" — the national health insurance scheme proposed by Australian Dr Johnathan Deeble — she responded to a question about it with the terse statement that whatever plan was adopted, it would not be called the "Deeble plan".

It was one of the times when Zuma the veteran politician answered, rather than Zuma the doctor. Another was when she was asked about the three-month time frame allotted to the committee looking into a national health insurance system. "If we had to wait until we find the perfect model, we would never start," she replied.

A foreign doctor asked about the limited registration available to doctors from most other countries. This, he said, was unfair given the fact that many of these doctors had practised in areas where South Africans refused to work. The minister replied that this was an area she intended to "revisit", and that it did need attention.

All in all it was a most impressive performance, politically. But then, selling an equitable national health system to South Africans is a bit like selling the RDP to the ANC.

A cure for all ills, PAGE 29

Free vaccinations for hepatitis B offered

(85) ARG 10/2/95

LIBBY PEACOCK
Health Reporter

INFANTS are to benefit from a new state policy to provide free vaccination for children under one against the potentially deadly virus, hepatitis B.

And a Cape Town clinic is taking part in an international investigation into the disease.

Hepatitis B can lead to liver disease and liver cancer and, in adults, is transmitted in the same way as the HIV virus.

Mike Voigt, head of the Medical Research Council/University of Cape Town Liver Clinic at Groote Schuur Hospital, said hepatitis B was very common in South Africa and in certain areas — especially rural — up to 10 percent of the population carried the virus.

Dr Voigt said the benefits of the free immunisation would only start being apparent in about 20 year's time, but "highly effective treatments" were becoming available.

The Liver Centre was conducting a clinical trial into a new treatment as part of an international investigation.

Preliminary results had been "very promising" and it was hoped that people who were already carriers of the virus could be cured.

The centre has called for volunteers between the ages of 17 and 70, who have proven hepatitis B, to take part.

In childhood the greatest spread occurs in children under four, but it is not yet known how babies are infected.

A Department of Health spokesman confirmed yesterday that the hepatitis B vaccine would be added to the list of immunisations available free of charge from April 3.

This followed an investigation by a team of health experts from the World Health Organisation, Unicef and other organisations, as well as local health authorities.

The result of the investigation was a decision to change the timing of immunisations.

Up until now vaccinations (for tuberculosis, polio, tetanus and whooping cough — some of which had to be repeated) were given at birth, three months, four and a half months, and six months.

From April, immunisations would be given at birth, six weeks, 10 weeks and 14 weeks, while the measles vaccination would still be given at nine months, as before.

The Department spokesman said this would lead to more children being immunised.

At R10 for a course of three injections, the vaccine could cost the state about R10 million this year, assuming that a million children would be vaccinated.

The vaccine would also be available at just over R10 at private centres.

● Anyone interested in taking part in the clinical trial should call Dr Voigt at ☎ 406 6394.

Drug firms' health plan

CT 10/2/95

JOHANNESBURG. — Some of SA's biggest drug manufacturers have launched an initiative to help tackle the country's health crisis, an industry source said yesterday.

The source said major players in the pharmaceutical industry met with Health Minister Dr Nkosazana Zuma on Wednesday.

An announcement on the scheme, the SA Health Care Initiative, is likely next week. — Sapa-Reuter

(85)

Health workers slate Zuma's plan

ET 10/2/95

Staff Reporter

HEALTH workers — including those involved in primary health care — do not support cuts to tertiary hospitals in favour of primary care.

This was the message to Democratic Party leader Mr Tony Leon, who visited the Langa Day Hospital and the Red Cross Children's Hospital with DP Western Cape health spokesman Professor Richard van der Ross yesterday.

Doctors and nurses said yesterday they did not agree with plans by Health Minister Dr Nkosazana Zuma to downgrade the three Western Cape teaching hospitals — Red Cross, Groote Schuur and Tygerberg — in order to allocate more funding for primary health care.

At the Langa Day Hospital, where the three doctors there each see up to 65 out-patients daily, the doctors and senior professional nurse Sister Maureen Petu said they referred many patients to the hospitals and downgrading them would mean a loss of specialised services.

Regional clinics superintendent Dr Theo Daams, who accompanied the group, said this was a general feeling in the 36 regional community health centres.

Red Cross chief medical superintendent Dr Rob Marshall stressed that although he supported primary health care, it should not be at the expense of tertiary care, "especially" where children were concerned.

Dr Marshall said that if he was forced to bring about cuts the Red Cross out-patient section, where up to 300 000 children annually receive primary care, would be the first to go.

Mr Leon said the proposals were based on the misconception that tertiary hospitals were "First World disease palaces".

He said "tampering" with academic hospitals "would simply move the problems elsewhere".

(85)
CT 13/2/95

DP warns on health 'equity'

'Cuts may destroy all services'

By ANTHONY JOHNSON
Political Correspondent

THE government's commitment to the equalisation of health spending for provinces could result in the "destruction" of academic hospitals in the Western Cape and all health services in South Africa.

This grim warning was issued yesterday by Democratic Party leader Mr Tony Leon, on the eve of the announcement of the Western Cape's health budget this week, after a DP fact-finding tour of clinics and hospitals.

The caution comes hot on the heels of reports that education budgets of Gauteng and the Western Cape are to be slashed by R700 million as part of a new government policy to reduce spending on well-developed provinces to bring them on a par with poorer areas.

The Western Cape has been informed that its education budget will be chopped by R213 million or 6,5%.

Mr Leon, who spoke to a broad cross-section of health workers during the DP tour of health facilities in the Western Cape, said that regional teaching or tertiary level hospitals were often a national resource.

Such institutions often tended to patients and trained personnel who came from or would work in other provinces.

Mr Leon said there was general agreement among health workers that some form of rationalisation was needed between Tygerberg, Groote Schuur and Red Cross hospitals. However, the emergency ad hoc measures now being followed would be more costly in the long run.

"If inadequate government funding destabilises academic hospitals, this will destroy health services in SA as a whole."

A DP report compiled after a task group visited Langa clinics last week emphasises the intricate system of interdependence between primary health care services and academic hospitals.

"Health workers at the clinic stressed that this balance cannot be tampered with in terms of shifting funding from academic hospitals to the clinics, because academic hospitals will eventually not be able to treat patients referred to them by the clinics," the report notes.

A separate report compiled after visiting Red Cross Children's Hospital states that the government announcement of free health care for children under the age of six had led to a 40% increase in the number of outpatients at the tertiary hospital — nearly all of them for primary health care complaints that clinics should be dealing with.

But there are currently only 36 clinics or community health centres in the Cape metropole. These clinics treated 1 557 774 patients last year.

Twice as many clinics are required to handle the primary health needs of this population.

New medical council

BD 13/12/95

DRAFT legislation aimed at bringing all SA medical councils under the same umbrella was tabled in Parliament on Friday.

The Medical, Dental and Supplementary Health Service Professions Amendment Bill proposed replacing the SA Medical and Dental Council, the Ciskeian Medical Council and the Transkeian Medical Council with a single interim council. (85)

NEWS

Policemen injured in Spar sit-in

300 protesters escape from cell

14/2/95 Star

■ LABOUR REPORTER

More than 300 people arrested after a demonstration at a Spar outlet in the city centre escaped from a temporary holding cell at John Vorster Square police station yesterday.

The workers escaped after the door of the holding cell was left open by a policeman, SA Police Service media liaison officer Colonel Dave Bruce said. Only 14 of the workers were still in custody last night, Bruce said.

The escape followed a chaotic and violent attempted sit-in at a Spar store in Eloff Street. The action, which is part of a campaign by Gauteng Spar workers for a central bargaining forum to cover workers in all stores in the region, began at about 11 am when the workers marched to the store.

The escaped workers, all members of the South African Commercial, Catering and Allied Workers' Union, entered the supermarket at about 2.20 pm and began filling large refuse bags with groceries, Bruce said.

Management called the police who arrested the demonstrators and took them away in vans to John Vorster Square. Bruce said those trampled in the attempts to evade arrest were treated by paramedics.

Soon after being let out of the vans at the John Vorster Square holding cells, the demonstrators escaped.

"At the moment we do not know whether the policeman opened the door as a result of intimidation or sympathy with the protesters, but investigations are continuing," he said.

He said substantial damage was caused at the supermarket and a number of policemen were injured when protesters threw bottles of tomato sauce at them.

A witness said the crowd of demonstrators descended on the store and began toyi-toying and chanting in the store. Soon afterwards the police arrived and "all hell broke loose", he said.

"They shot teargas into the air and sjambokked everyone who was there. It was like the old apartheid days," he said.

Council rethinks vaccination project

Star 14/2/95

■ CITY REPORTER

The transitional metropolitan council (TMC) is to review the former Johannesburg City Council's "One-for-One" project which enabled medical aid members to sponsor HIB vaccinations to children in poorer communities.

The project, initiated by the city council in conjunction with several medical aid schemes, enabled medical aid members to sponsor the vaccination of underprivileged children by having their own children inoculated at council clinics. (85)

The vaccine, Haemophilus Influenza Type B, which prevents illnesses such as meningitis, pneumonia and all other flu symptoms, is not compulsory in South Africa, although the national Health Department has recommended that it be given as part of the routine vaccination.

Dr Natalie Mayet of Johannesburg's administration said the high cost of the vaccine was the main reason it had not been made compulsory. Because clinics did not want to turn poor children away, about R300 000 had to be found from other savings to cover the project's costs.

TMC councillor Sizakele Nkosi, who chairs the health and social services committee, said she would ask the executive committee to consider implementing the project throughout Greater Johannesburg, in a manner that benefited poor people from all areas.

Union sticks to its hostage plan

The SA Health and Public Service Workers' Union is continuing with preparations for its campaign, which includes the taking of white employees as hostages, despite joining a government task team to look into conditions of service yesterday. General secretary Silas Baloyi said in Cape Town yesterday that the union did not trust the Government's commitment to improve salaries. The union's campaign got off to a limp start this week when plans to take white employees hostage at 1 Military Hospital near Pretoria were thwarted by the presence of defence force members. — Labour Reporter

STAR 15/2/95

Public talks on health plan

(85)

Staff Reporter CT 15/2/95

PUBLIC workshops will be held in the Peninsula over the next six weeks to allow communities to discuss proposals for the planned District Health System (DHS).

The DHS would form the "cornerstone" of primary health care in the province, said Mr Michael O'Brien, chairman of the Cape Metropolitan Health Care Forum which has been charged with investigating the DHS.

At present the DHS proposal, in its fourth draft, envisages splitting the Western Cape into 24 districts, 10 of them in the Cape metropole.

"But everything is open to discussion," Mr O'Brien said, adding the workshops were intended to "ensure maximum input" from communities.

Workshops will be held between 9am and 1pm on the following dates:

- Saturday: Southern Peninsula;
- March 4: Guguletu and Mitchells Plain;
- March 11: City Bowl and Milnerton/Atlantis;
- March 18: Bellville/Elsie's River and Delft/Blue Downs, and
- March 25: Khayelitsha.

Anyone wanting details should call 483-3555.

Disease profile changing as migration accelerates

(85) BD 15/2/95

KATHRYN STRACHAN

AS PEOPLE continue to flock to the cities from rural areas in search of better opportunities, a new disease profile is emerging.

"SA is experiencing the epidemiological trap which holds people in a situation with the worst of both worlds," says researcher Dr John Seager, who is head of a Medical Research Council programme investigating the health implications of rapid urbanisation.

Seager says the epidemiological transition from "old" to "new" disease patterns is already apparent in SA. The health effects of urbanisation are dominated by poverty related diseases such as measles and gastro-enteritis, which are major causes of infant mortality and are typical of most developing countries.

But along with the diseases of poverty, diseases of affluence such as ischaemic heart disease and cancer, are also increasing.

Unplanned and uncontrolled urbanisation has a wide range of effects and places great strain on health and social services. In 1985 the total black population in the metropolitan areas was 8,7-million. By 2010 a total black metropolitan population of 23,6-million is projected — an increase of more than 170%.

Urbanisation has led to an increase in diseases associated with poor environmental health conditions such as inadequate housing, water, and sewage and refuse disposal. Diarrhoea-related diseases and acute respiratory infections — also major causes of childhood death in SA — are closely related to basic environmental health conditions.

The main problems associated with squatter conditions which lead to the spread of diseases are overcrowding, inadequate services and, most importantly, lack of water supplies and sewage disposal facilities.

"Generally, there is very little investment in facilities for the urban poor," says Seager.

"Improving physical access to essential environmental health services in urban areas and improving the educational status of women are urgently needed if childhood infections are to be prevented."

A critical feature of urban health in developing countries is the enigma that a very large proportion of morbidity and mortality is the result of preventable diseases, such as measles and gastro-enteritis.

The diseases can be prevented by relatively simple intervention such as vaccination. Measles is exacerbated by overcrowding, and poor sanitation and inadequate water supplies are the main causes of gastro-enteritis.

Although measles vaccination is effective, the coverage is often too low to prevent measles epidemics in overcrowded peri-urban areas. An example of the factors which need to be taken into account when planning urban health services is that children born in rural areas are less likely to have been vaccinated than those born in urban areas. This means new arrivals in the city require special attention if urban vaccination campaigns are to be sustained.

As urbanisation proceeds, urban populations in developing countries also begin to experience more of the diseases of affluence, which are predominantly chronic diseases. The most marked increases are in ischaemic heart disease and lung cancer, associated with changes in lifestyle and diet, and the acquisition of habits such as smoking and drinking Western-style alcohol.

Studies of dietary intake as a risk factor for chronic diseases have shown substantial reduction in carbohydrate intake, and its replacement with fat is directly correlated to urban exposure.

Recently urbanised people are particularly susceptible to the new advertising and social pressures of the urban environment as aggressive marketing of tobacco, alcohol and sugar targets these groups.

Another effect of urbanisation is the health risk associated with industrialisation. The council has been involved in a study of air pollution and health in heavily industrialised areas of the Vaal Triangle.

The study, which investigated respiratory health problems in school children by plotting the pollutants and monitoring individual and neighbourhood levels, found domestic coal burning was a large component of pollution. However, many people are unable to afford electrical appliances and continue to burn coal even when electricity becomes available.

Urbanisation is also associated with profound changes in home life, which affect the social and mental well-being of urban residents, especially new arrivals.

During resettlement, people face losing their cultural identity and a weakening of traditional social support structures, which increase stress and instability at individual, home and community level. There is also increased competition for space and jobs. These factors can lead to alcohol abuse, mental disorder and violence.

In the larger metropolitan areas, the rate of alcohol misuse among black men is approaching 40%.

Stress becomes apparent in the high levels of violence — especially within the home — which is responsible for 30% of trauma cases in the larger metropolitan areas. Domestic injuries can also not be overlooked: they account for 40% of injuries in some areas.

One of the world's leading experts in urbanisation, Prof Trudy Harpham of London's South Bank University, who was in SA last month, says mental illness is the fifth most prominent disease facing women in developing countries. She says it has been shown that mental ill-health among recent rural-urban migrants is attributable mainly to poverty and the difficulty in finding jobs.

The trend of urbanisation is inevitable. The solution to health problems lies in integrating migrants into the urban economy, rather than leaving them on the fringes.

While urbanisation is a complex phenomenon which affects a vast range of health issues, Seager believes that developing countries undergoing radical reform might, for once, have an advantage over the developed world — they are in a position to adopt new and perhaps radically different strategies.

Union targets whites

Sowetan 14/2/95

Sowetan Correspondent

THE South African Health and Public Service Workers Union says its campaign to take white civil servants hostage to press home its wage and salary demands will continue this week despite a poor start yesterday.

SAHPSWU publicity secretary Mr Themba Ncalo said yesterday, after a planned hostage-taking campaign at One Military Hospital at Voortrekkerhoogte near Pretoria had failed, his union would strike at white civil servants "where or when the opportunity arose".

He said the union and several other public sector organisations would meet government officials today to resolve the issue. However, if the union's demands were not met, the campaign would not be stopped.

The union's illegal plan to terrorise whites by taking them hostage was foiled by a heavy police presence at the hospital yesterday.

Police and army personnel were also deployed at strategic points in the city.

Major Erica Bird, spokesperson at One Military Hospital, said army troops and reinforcements from the South African Police Services were on the hospital premises and would continue monitoring the situation.

Police spokesman Captain Dave Harrington said the Internal Stability Unit was on standby to respond to any possible flare ups.

The union said in a later statement that the police presence had turned the hospital into a prison for its members and alleged that police insisted on escorting workers to the toilet.

The union announced last week that it would embark on a campaign, called Operation Moonlight, which would include marches on government offices, the taking of white civil servants as hostages and the formation of a so-called workers' army or armed wing.

The union is demanding a R1 500 minimum wage plus a 15 percent across-the-board increase for all its members.

SAHPSWU claims a membership of 68 000, which includes about 800 policemen.

The campaign follows a walkout by the union from negotiations with the government in Durban recently.

Taking of hostages to go on – union

(1030) (85) SAPA 14/12/95

■ BY JUSTICE MALALA
LABOUR REPORTER

The South African Health and Public Service Workers' Union vowed that its campaign to take white civil servants hostage to press home its wage and salary demands will continue this week despite a foiled start yesterday.

But the police and army yesterday backed up warnings that they will not allow a public servants' union to carry out threats to take white government workers hostage.

Police spokesman Captain Dave Harrington said the Internal Stability Unit was on standby to respond to any possible flare-ups.

The union's publicity secretary Themba Ncalo said yesterday after a planned hostage-taking campaign at 1 Military Hospital in Voortrekkerhoogte, near Pretoria, had failed that the union would strike at white civil servants "where or when the opportunity arose".

The union and several other public sector organisations would be meeting government officials today to resolve the issue but said if the union's demands were not met, the campaign would not be stopped.

The union announced last week that it would embark on a campaign highlighting its grievances, called Operation Moonlight, which would include marches on government offices, the taking of white civil servants as hostages and the formation of a "workers' army".

The principal demands of the union are a R1 500 minimum wage plus a 15 percent across-the-board increase for all its members.

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Health plan for the West Cape

(85) 16/2/95

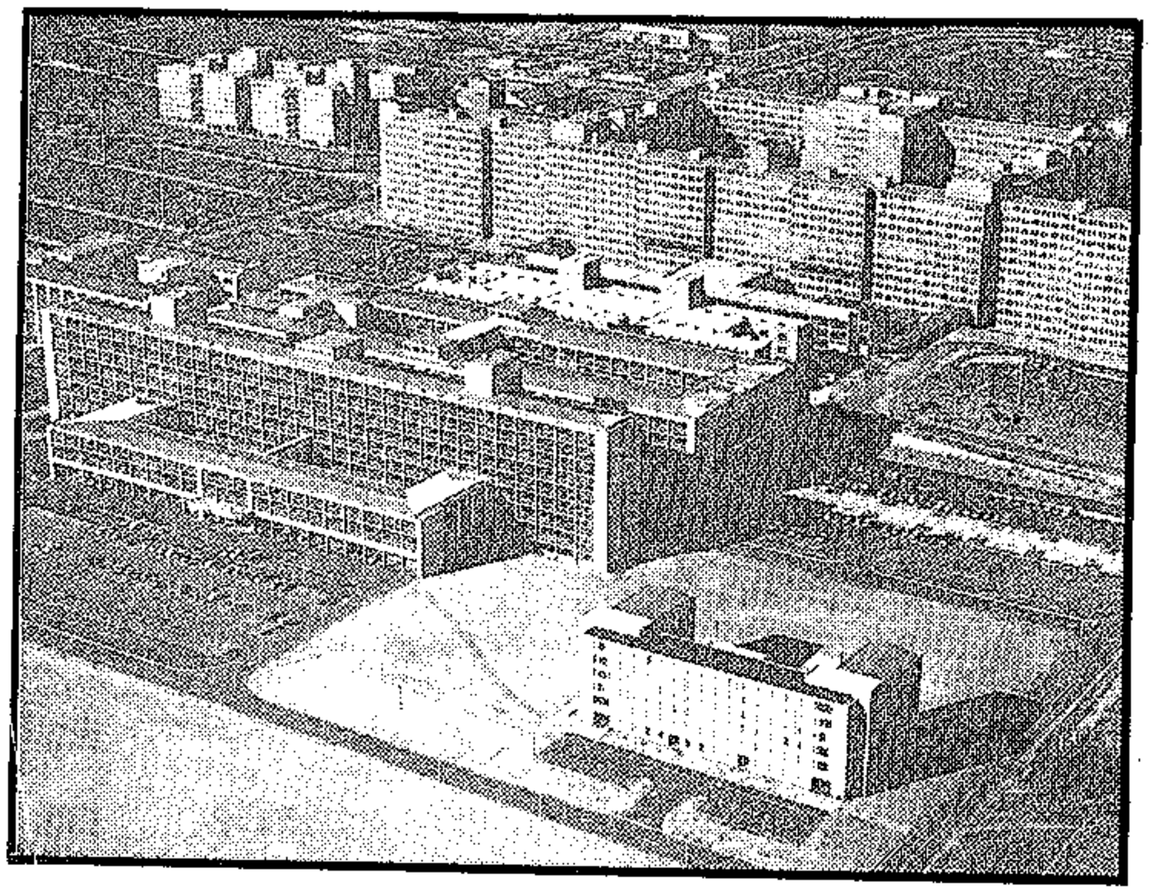
AFTER months of speculation and rumours about hospitals closing and health services breaking down, the local Ministry of Health's Strategic Management Team has presented the Western Cape with a radical new health plan, supported in principle by the provincial cabinet and national Health Minister Nkosazana Zuma. Health Reporter LIBBY PEACOCK reports.

HEALTH services in the Western Cape are being turned upside down.

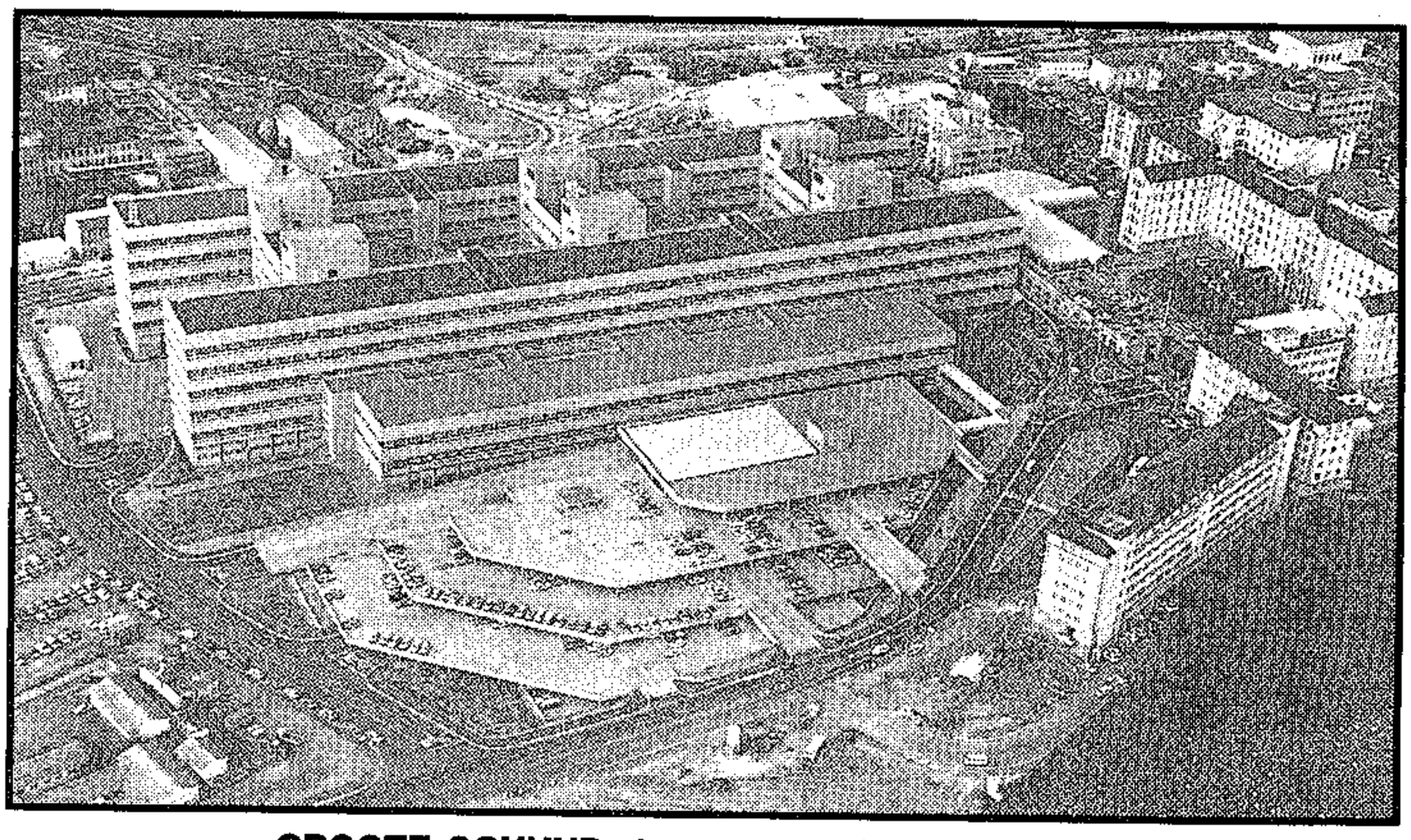
At a lengthy press conference yesterday, Health Minister Ebrahim Rasool revealed a new plan, which, he said, was designed to preserve the "excellence of our service, teaching and research", while at the same time making health care accessible to all.

The plan — which will now be open for public debate — entails Tygerberg Hospital becoming a "general specialist" secondary hospital, Groote Schuur remaining a super-specialist tertiary hospital and Red Cross Children's Hospital its paediatric equivalent.

It is proposed that both Groote Schuur and Red Cross Children's hospitals become referral hospitals only.



TYGERBERG: A general specialist hospital.



GROOTE SCHUUR: A super specialist tertiary hospital.

The plan also recommends that the medical faculties of the universities of Stellenbosch and Cape Town be "uncoupled" from Tygerberg Hospital and Groote Schuur, to be unified — together with the University of the Western Cape's health programmes — under a single co-ordinating mechanism.

There would have to be "a high level" of co-operation among the universities to co-ordinate their use of the teaching facilities.

While finer details are to be worked out by the universities themselves, it is envisaged that Tygerberg Hospital will still be an academic hospital, but for "level 2" (secondary) training.

Mr Rasool said the proposal relied on the relocation of staff and on staff loss through "natural means", such as resignations and retirements, rather than on retrenchments.

The plan follows eight months of planning and consultation and is supported by both Mr Rasool's Strategic Management Team (SMT) and the provincial health administration.

Tom Sutcliffe, head of hospital and health services in the Western Cape, said that before the national government made available an additional R170 million for the province's health services recently, it seemed that any plan fitting the budget would "virtually wipe out health services in the metropole".

But now a vision had been created which would be a framework on which to base future decisions.

While he would not elaborate on how many beds would be cut at the three large hospitals, it is understood that hundreds of beds will be done away with at these hospitals — with the understanding that facilities within communities be expanded and regional hospitals be upgraded.

Dr Sutcliffe said Tygerberg Hospital had been chosen as the principal regional hospital because it was "situated in the community it is going to serve".

Groote Schuur was not ideally situated within the community it was to serve, but was "architecturally newer and probably more appropriate for rendering tertiary service".

He said it was envisaged that the plans be implemented within five to 10 years, but "steps will have to be taken immediately to exclude duplication".

Professor Kay de Villiers, chairperson of the Academic Priorities Group appointed last year to examine various options for academic hospitals, said that while "some degree of sacrifice" was asked from the universities, it was essential that excellent training and research continue.

Far-reaching new W Cape health plan

(85)

ARG 16/2/95

LIBBY PEACOCK, Health Reporter

PLANS to sell off part of Somerset Hospital and close down Conradie Hospital are contained in a comprehensive new health system proposed for the Western Cape.

These proposals are contained in an executive summary of the provincial draft plan for health services here.

The plans include the upgrading of three regional specialist hospitals in Paarl, George and Worcester, a move which will mean the transfer of substantial numbers of staff from tertiary hospitals in Cape Town.

The plan also includes proposals for bold changes to specific metropolitan hospitals.

● See page 23.

These proposals, which have to be commented on before they are implemented, include:

● That the north block of the Somerset Hospital be sold, subject to a number of conditions, and that the proceeds be used to contribute to the building and staffing of a "level 2" general specialist hospital in the Khayelitsha/Delft area;

● That Conradie Hospital, which was to have cost R60 million to repair, be closed and sold, and the spinal unit be moved to Groote Schuur Hospital.

● That Groote Schuur Hospital become the province's main super-specialist facility;

● That Tygerberg Hospital become the Cape Town region's main secondary hospital.

● That Red Cross Children's Hospital be accorded the same status as Groote Schuur.

(To page 5, col 8)

Wide-ranging new W Cape health plan

(85) ARG 16/2/95

(From page 1)

● That the Victoria Hospital site be sold, the hospital moved to the premises of the Princess Alice Orthopaedic Hospital in Retreat and upgraded to a general specialist hospital.

● That the functions of the Princess Alice be moved to Groote Schuur.

● That G F Jooste Hospital in Manenberg open as soon as possible, drawing as much of its required staff as possible from the three academic hospitals.

● That Karl Bremer Hospital, which has recently been upgraded at considerable cost, not be reopened. Its work should be accommodated within the converted Tygerberg Hospital.

The plan, which also envisages the uncoupling of universities from the teaching hospitals, was yesterday supported in principal by the provincial cabinet.

Proposals include the division of the province into four regions and 24 districts and the upgrading of regional hospitals. Each region will have a main regional hospital: Tygerberg in Cape Town, Paarl Hospital for the West Coast region, the Eben Donges in Worcester for the Boland/Overberg region, and the George Hospital for the Karoo and Southern Cape.

Regional offices will be responsible for co-ordinating and monitoring services, TB/communicable disease hospitals and management of the "level two" (general specialist) hospitals.

Picture: BENNY GOOL

Health shake-up

CT 16/2/95 (85)

Plan will cut costs, maintain standards

By CHRIS BATEMAN

A PLAN to reshape the Western Cape's health services, severing traditional university-hospital ties, creating a single teaching platform and transforming Tygerberg into a grand metropolitan hospital, was unveiled yesterday.

Groote Schuur and the Red Cross Children's hospitals will become specialist "referral only" centres for post-graduate training as some 700 costly "academic" beds are converted to secondary health care teaching beds.

Up-graded

Some 48 top specialists at the three academic hospitals and their support teams will be transferred to strengthen and support up-grading of hospitals in George, Worcester and Paarl.

G F Jooste Hospital in Manenberg is being upgraded to a fully equipped emergency hospital.

These were the main tenets of a radical "new vision" outlined by Health and Social Services Minister Mr Ebrahim Rasool and his top medical advisory team yesterday after eight months of planning to cater for severe budget cuts.

Last minute bridging finance of R170 million saved the region from "diabolical" adjustments which would have meant the loss of one of the academic hospitals, deputy health services director Dr Tom Sutcliffe said.

The five-10 year plan is meant to create a cost-effective, more equitable and sustainable health service in a province recognised internationally for the excellence of its clinicians.

The proposals rely on voluntary resignations and retirements and will only turn to staff retrenchments to meet budgetary constraints as a last resort.

Dr Sutcliffe said medical faculties at Stellenbosch University (traditionally coupled to Tygerberg), UCT (linked to Groote Schuur) and UWC would in future fall under a single co-ordinated teaching platform — with equal access to all facilities. Whether this would involve a single new central campus was for the universities to decide, he added.

Tygerberg would remain a base for training medical undergraduates while Groote Schuur and Red Cross would handle all post-graduate training with certain crossover functions.

Professor "Kay" de Villiers, chairman of the Academic Priority Group, said that with each university campus having a distinct culture, philosophy, tradition and pride it would "not be easy".

"It's a shift away from (a dispensation) that people believed was forever — this is a way out and the only way for survival," he said.

Mr Rasool said consultations to determine bed numbers at each of the three academic hospitals would take place within two months. Criteria such as affordability, provincial and metropolitan needs, teaching needs and "super specialist tertiary care" requirements would be considered.

The Western Cape needed to shed R162 million on its academic hospital expenditure.

The universities of Stellenbosch and Cape Town and the Medical Research Council welcomed the re-organisation yesterday.

Stellenbosch University rector and vice-chancellor Professor Andreas van Wyk said the university "welcomes the fact that Mr Rasool's statement makes it clear the two faculties of medicine in the Western Cape will continue to exist independently".

The university said it agreed that maintaining and improving the quality of medical services, training and research would be the deciding factors in any re-organisation attempt.

In its response UCT also welcomed the Province's commitment to develop a plan intended to preserve and enhance the excellence of service, teaching and research in its academic hospitals.

Professor Wieland Gevers, deputy vice-chancellor, said: "The proposed rationalisation of access to training facilities makes sense.

Commitment

"We agree that this will require close consultation and co-ordination between the partners and we are committed to this."

The MRC said the restructuring of Tygerberg to a general specialist hospital would not mean the end of MRC-supported research at the institution since its research portfolio embraced all levels of health.

Medical standards 'won't drop'

(85) CT 17/2/95

STANDARDS of medical practice in South Africa will not drop in the short term because of reduced academic hospital budgets even though changes in the education of local doctors are being made.

This assurance was given yesterday by University of Cape Town medical school deputy dean Dr Rod Colburn amid claims that UCT was lowering its teaching standards through budget and staff cuts as well as the need to teach disadvantaged students.

"I am convinced we will continue to provide excellent doctors — more of them and better. We need only six months extra to introduce disadvantaged but bright students to tertiary education," he said.

Dr Colburn said that after five years of work with such students he was convinced the changed courses offered by UCT would work to continue producing clinicians respected around the world.

A shortage of equipment was also not important: "You need a stethoscope and little else besides sound training and the right approach," he said.

However, there was growing concern about the loss of key medical teaching staff because of pay, conditions or inability — because of lack of funding — to do research.

The salaries of top academics were being lowered compared with overseas.

Medical research could not be dismissed as relevant only in the "first world". — Sapa

Mixed emotions greet new medical plan

(85) ARG 18/2/95

LIBBY PEACOCK
Weekend Argus Health Reporter

CAPE TOWN'S medical fraternity has reacted with mixed emotions to the Western Cape's new health plan.

While some are "cautiously" optimistic, others fear the complete collapse of the system.

The plan recommends that Tygerberg Hospital becomes a general specialist secondary hospital, with Groote Schuur remaining a super-specialist tertiary hospital and Red Cross Children's Hospital its paediatric equivalent.

It is proposed that both Groote Schuur and Red Cross Children's Hospital become referral hospitals only.

The plan also recommends that the medical faculties of the universities be "uncoupled" from Tygerberg and Groote Schuur and that the hospitals co-ordinate their use of the teaching facilities.

Groote Schuur chief medical superintendent Peter Mitchell said the hospital approached the process with "cautious optimism" and recognised the importance of achieving a health system appropriate to the needs of all people.

Patients had to be able to be transferred with ease to the most appropriate level of care, whether primary, secondary or tertiary level. A deficiency at any level would have an impact on the rest.

He said the hospital's first concern was to provide an adequate quantity and quality of treatment for all patients.

"To do this, the hospital must have sufficient staff with the correct skills and the necessary equipment."

For Groote Schuur Hospital to refer patients to more "suitable levels", there would have to be adequate day-hospital facilities and regional hospitals for the communities.

Tygerberg Hospital chief medical superintendent R O Simpson had a curt response to the plan: "We support it. We have to work with it. I've got to live within my budget."

It seemed the "reorientation" of Tygerberg Hospital to a secondary hospital would lead to "an unworkable situation", said one source.

Thousands of patients would suffer, as the number of tertiary beds in the province would be downscaled to about 700 — all based at Groote Schuur.

Alan Puterman, chairman of the Registrar's Association of Cape Town, said the "basic structure" envisaged in the plan was "very good", but there had been representation on the part of specialists, lecturers, nurses, administrative staff or hospital workers when the plan was drawn up.

Rasool's health plan 'disastrous' — doctors

(85) ST 19/2/95

By DIANA STREAK

DOCTORS at Tygerberg Hospital have slammed the proposed rationalisation of academic hospitals in the Western Cape as "impractical", saying it will have "disastrous consequences".

The Specialist Association of Tygerberg Hospital (Sathac) said the scheme proposed by regional Health Minister Ebrahim Rasool would result in the "total disruption of the institutions which are the core of health services in the Western Cape and well beyond its borders".

Under the new system Groote Schuur and Red Cross would become specialist hospitals and Tygerberg a grand metropolitan hospital.

Sathac spokesman James Loock said the artificial separation of the services would result in the irreparable fragmentation of a highly effective training system.

He said there were viable alternatives to the scheme, but the health professionals at the affected institutions had not been allowed to participate.

"Provision of health services will be slashed for an underprivileged community which has no recourse to alternative care," Dr Loock said.

Denise White, chairperson of the Full-time Medical Staff Association at Groote Schuur, said that while supporting the need for health care reform, staff were concerned and uncertain of the implications and consequences of the drastic reorganisation of the two hospitals.

Groote Schuur doctors will meet this week to discuss the proposals.

The association of registrars — RAMFSA — says the scheme will lead to the "total collapse of academic medicine in the Western Cape".

"Undergraduate and postgraduate training of doctors will suffer irreparable harm," Sathac said.

Dr Loock said the fragmentation and logistic impracticability of the plan would cause considerable non-productive expense such as travel and transport costs between the hospitals.

R2,4 bn RDP funds for housing, health

(85)

ARG 20/2/95

GOVERNMENT minister Jay Naidoo today outlined spending plans for the Reconstruction and Development Programme (RDP) in the next year, including R1,4 billion for housing and almost R1 billion for health.

Mr Naidoo, Minister without Portfolio responsible for the RDP, told reporters the RDP budget for fiscal 1995/96 would include R500 million rolled over from the current fiscal year, R2,4 billion to continue existing projects and R2,6 billion for new projects.

He said R700 million of the housing allocation would be for the installation of bulk services and another R700 million would be for housing subsidies administered by the housing department.

"The RDP is having a series of public hearings in which different departments have to present their proposals and we make an allocation in terms of a more transparent process.

"But the indicative allocation for housing and bulk infrastructure is R1,4 billion," he said.

Mr Naidoo said almost R1 billion would be allocated to the department of health as bridging finance to shift the health care priority from urban-based tertiary care to primary health care.

He said the government expected a further R1 billion to become available for the RDP from foreign aid in fiscal 1995/96.

How to fund health care to be debated next week

(85) ARG 21/2/95

The Argus Correspondent

JOHANNESBURG. — Crucial talks on financing health care, including the possible introduction of a national health insurance system, begin in Cape Town next Monday.

The discussions will be held by a technical commission chaired by Olive Shisana, special adviser to the ministry of health, and health economist Jonathan Broomberg.

"We'll be investigating a wide range of health financing options, including options of a non-insurance nature," Dr Broomberg said.

Meanwhile, high levels of public participation and consultation are being encouraged by the Department of National Health as it grapples with the overhaul of the country's ailing health care delivery system as a whole.

Dr Shisana said Health Minister Nkosazana Zuma had already held meetings in Gauteng, KwaZulu-Natal and the Eastern Transvaal, and that more meetings were planned.

"We are actively encouraging all interested parties to contribute to the health debate," she said.

After being appointed last year, Dr Zuma convened special committees to examine key aspects of health care, in particular legislation, financing, academic hospitals, drugs policy, nutrition, human resources and maternal and child care.

The committees completed their tasks last November. Now a consolidating committee has been charged with the task of merging the recommendations into a single coherent policy document.

"This document is currently with the minister, but will be available to everybody, including the Press, within the next two weeks," Dr Shisana said.

A "national health summit" is also being planned for later this year, probably in June.

Dr Shisana said on the issue of national health insurance that the department was particularly interested in people's views on what minimum care should be available to all South Africans, who should provide this care (doctors or nurses), how providers should be paid and how the whole system should be financed.

Dr Shisana said that inputs could be made via ☎ (012) 312 0842 or by fax, (012) 325 2915.

"We are very serious about consulting widely," she emphasised, "and in a way that will enable interest groups and individuals to make a meaningful input into the sort of health care system we eventually create."

Health care financing options to be debated

(85) Star 21/2/95

■ **BY DAVID ROBBINS**
HEALTH WRITER

Crucial talks on the question of health financing, including the possible introduction of a national health insurance system, begin in Cape Town on Monday.

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▶ Health care: commodity or right? – Page 15

***Health Writer David Robbins** examines some of issues in the great debate on the possible introc national health insurance system for South Afr concludes, still a lot of hard talking to be done.*

Health care: commod

An interesting thing about health care is that it need never stop. There's a range of drugs and hi-tech equipment available for most ailments; and increasingly doctors are facing the complex ethical problems associated with turning off or leaving on the machines.

Much less publicised are the equally perplexing problems associated with the other end of the health-care spectrum.

Should basic care be viewed as a commodity, say like hamburgers in the park: those who can afford to, eat several; those who can't, go without? Or is basic health care a right? If so, who should pay? Because in the end there's no such thing as a free hamburger.

Such questions take on painful political overtones in a country like South Africa.

Let's repeat the basic problem: about 20 percent of people (largely but not exclusively urban-based whites) have access via medical aids to health care which ranks among the finest in the world; the other 80 percent are inadequately served, and those in the rural areas are often hardly served at all.

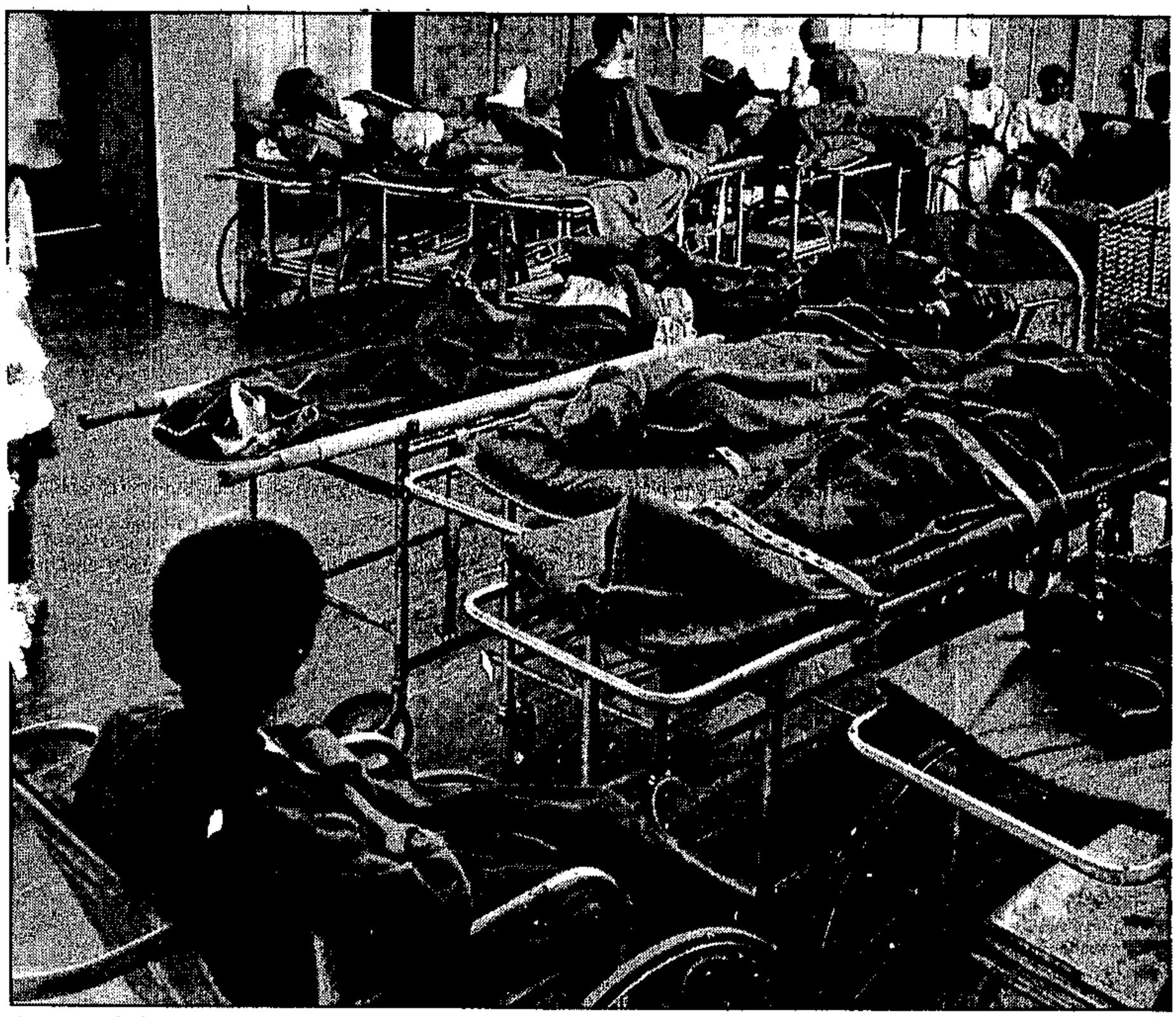
Debates

The solution is to find some way of rectifying these unacceptable discrepancies and of finding sufficient resources (at a time when our health budget is shrinking in real money terms) so that everyone in the park has access to a hamburger.

Clearly, it is the desire to find such a solution that has given rise to the current debates surrounding a national health insurance (NHI) system for South Africa.

But what sort of animal is NHI? In the simplest terms it's a way of raising money or establishing a pool of funds which can be used to help to pay for the basic health-care needs of all South Africans.

Why can't basic health care be financed directly by the Government (using taxes) as in the past? How much will individuals have to pay into NHI? What sort of care will they get for their money? What about those already covered by medical aids? And what about those who are unemployed, and therefore hardly in a position to contribute to



Overcrowded . . . could a national health insurance system improve access to basic health care for all South Africans?

NHI?

One way of finding answers to such questions is to reconstruct the sequence of relevant events as they have unfolded so far.

Charged with the urgent need for reform in many areas of health care, South Africa's new Minister of Health, Dr Nkosazana Zuma, did what sensible ministers all over the world do in similar circumstances. She called in the experts.

These experts came from within the various health administrations, from academia, from the private sector and from outside the country; and they all sat on committees whose task was to make recommendations on the sort of policy options open to the minister as she grappled with the problems of the old system and the expectations of the new electorate.

Various committees examined various ways of improving health's administrative structures and allocation of resources, of integrating the private and public sectors, of adequately staffing health care, and so on. The committee that concerns us most directly here is the one which deliberated on how health should be financed.

As this finance committee looked more closely at the question of NHI for South Africa, certain basic ideas began to emerge. People could contribute to NHI via a payroll tax of 3 percent of which individuals would pay half, companies the other half. The NHI would provide everyone (employed people who paid and those unemployed who did not) with basic health care which would include access to a doctor or nurse and those services and medicines associated with such access.

Obviously enough, a key question to arise concerned the status of contributors and non-contributors. Should they be treated the same? Could NHI in a developing country with high unemployment afford to do so?

One of the options which arose was drawn from the Australian NHI model, based on the work of a Dr John Deeble. In fact, he was one of the experts who sat on the committee. Deeble's idea was that everyone (contibutor and non-contributor) should be able to choose which health-care provider they wanted to use. Such a system, in theory at any rate, would certainly solve the problems of accessibility and equity.

But the committee rejected the idea as being too expensive for a country like South Afri

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Star 21/2/95 (85)

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But the committee rejected the idea as being too expensive for a country like South Africa. And what would happen if everyone chose to see a private doctor rather than go to a state clinic or hospital? The dangers to state health services would be severe if significant numbers of public sector health professionals were tempted into an oversubscribed private sector. There are also well-founded doubts whether the suggested 3 percent payroll tax would be sufficient to render an unrestricted NHI viable and sustainable.

Most importantly, the committee recommended that a special technical commission be established to deal with this detail, and to listen to representations from, and actively seek out the views of, "parties that do not generally have access to such commissions". The commission has already been set up under the co-chairmanship of Dr Olive Shisana, special adviser to the Minister of Health, and health economist Dr Jonathan Broomberg.

As one pieces together these events it becomes increasingly clear that the health ministry appeared to be very keen on the Deeble option. At one point, indeed, the ministry attempted to limit the terms of reference of the technical commission to little more than implementing the Deeble option.

But Broomberg says: "Our terms of reference have been broadened to allow us to investigate a great deal more than Deeble and the few options which have developed in reaction to Deeble."

Objectives

It is worth examining the terms of reference in some detail:

The commission has been charged with inquiring into a system which will fund and organise primary health care for all South Africans. Specific objectives are clearly stated: the system must be "universal and non-discriminatory"; it must be affordable and sustainable and consistent with the objectives of the Reconstruction and Development Programme.

Broomberg says that under these terms of reference, the commission will "investigate a wide range of options, including options of a non-insurance nature". But he says its too early to elaborate on these options.

"Discussions start in Cape Town on February 27 on the full range," Broomberg says. "And there'll be some close scrutiny of economic and health service realities. It's also crucial that the public health sector is not undermined."

The debate has come a long way since the Deeble option hit the headlines last month. It's developing into a tough and complex argument about how people interpret such concepts as "access" and "equity". The tensions between political desirability and hard economic reality are already beginning to emerge. And there's a lot of hard talking to be done.

Leak that grew to become hot news

All of a sudden, in January, South Africa was confronted with the news that the Department of Health was investigating a system of national health insurance (NHI) based on a model presented by an Australian health economist, Dr John Deeble.

But the news, at least to begin with, failed to mention that the Deeble option, as it has become known, was only one of several being considered by a committee set up by the health ministry to consider ways of financing health care in South Africa.

How did Deeble become such hot news?

The answer is that in the absence of a free flow of information, leaks become of paramount importance as the media attempts to keep the public informed.

A document containing the Deeble option was presented to the committee, and at about the same time a copy found its way to the media.

That the committee rejected the Deeble option seemed hardly to matter. The media presented it as the one favoured by the ministry, and tore it to shreds.

Events have moved forward since then, as the story on this page indicates. The new technical commission now working on the issue of NHI is examining a much broader range of options than Deeble and a few reactions to it.

Meanwhile, the Department of Health glowers at the media; and South Africa learns a little more about the need for transparency as it struggles towards a workable model of democracy.

General Meath

Deeble's health plan 'sure to fail'

(85)

Sowetan 22/2/95

■ FOREIGN EXPERT Scheme ignores differing income and disease profiles:

By Dr Robert Rapiti

THE growing negative reaction to Australian John Deeble's health plan from a wide spectrum of health groups, including some members of the Department of Health's own commission, makes it quite obvious that the plan is destined to fail.

What is most mindboggling is: why was the "expertise" of a foreigner from a predominantly first world country, such as Australia, chosen over that from South Africa. Have we already fallen into the syndrome that foreign is better?

Failing to recognise local talent says one thing about the people in the Department of Health: they have been away from this country for too long to perceive its problems fully.

Mr Deeble's plan, no matter how well intentioned, seems to ignore the great disparities in incomes, disease profiles and the enormous gulf between the have's and have-nots of this country.

For example, in the rural areas of this country there is greater need for safe drinking water than for the latest remedy on diarrhoea. Minister of Water and Environmental Affairs Professor Kader Asmal is waging an uphill battle trying to increase his budget in order to supply this essential commodity to these areas. Such paradoxes can have only existed under the tyrannical rule of the past government.

The present Government cannot be expected to right the wrongs of forty years of neglect overnight.

Sadly, most government departments want to correct the wrongs of the past with one stroke of the pen.

This can only be done in truly communist countries where grounds of social disparity are levelled by a bulldozer, regardless of the people that get hurt in the process.

No communist country has given us a satisfactory model to follow. No wonder South Africa has chosen the path of free enterprise, democracy and the right of the individual to choose what's best for him or herself.

The Department of Health has the unenviable task of pleasing its vast constituencies of have-not's with the least amount of trauma to its small number of haves, who will fund the system.

We can neither unscramble the apartheid egg, nor can we start afresh. We have to improve on what we have at a pace that is gradual and acceptable.

Extending health cover to the have-nots is not a new idea. President Clinton pledged to extend health cover to 30 million Americans and even in a rich country, his pledge still remains only that. Furthermore, he has a very slim chance of retaining power in the next election so as to covert his pledge into reality.

His attempts to extend cover to 30 millions Americans was blocked by big business interests.

We need to be careful of the same thing happening in this country. The previous government gave business the right to establish profit-making medical aid societies in this country. America has any number of medical aid societies, yet the cost of health care in that country is the highest in the world and every effort to extend cover to the uncovered is blocked by big business.

South Africa must be careful not to fall into the same trap.

Only the people can be the watchdog of the Government and the way it delivers.

Having followed different health systems in the world, I believe we have some excellent systems in place which can be improved upon to have a major impact on the standard of health care in this country without making too many waves.

A National Health Insurance is the way to go. The present medical aid administrators could become the financial houses that run the system. Their role of controlling the providers of services should be transferred to the representatives of the consumers and the providers themselves.

The removal of guaranteed payment and a scale of benefits has not improved the standard of health care for users of the system. In fact, it has helped to make dictators of some medical aids that are concerned more with profits more than the standard of services.

Rights of mentally ill

Sowetan 22/2/95

While SA prepares for a new democratic constitution, one body is fighting for the protection of the rights of mental patients, *Sowetan* reporter **Glen McKenzie** writes:

OF ALL THE urgent human rights issues the Constitutional Assembly will tackle during the next five years, one stands out from the others.

It is not a visible issue. Some say it is not an issue at all.

It involves people who don't have a voice. Not in the courts and not in the Press.

Not even now, since elections, can these people speak out.

They number more than 20 000 people but you will never see them.

That is because they have been declared insane or mentally ill.

The Citizen's Commission on Human Rights believes, the interim constitution does not adequately protect the rights of mental patients in South Africa.

Whether human rights abuses take place in the country's private and public mental hospitals is not clear.

Some organisations such as the CCHR have always argued that patients have been mistreated, forced to work as labourers and even physically and psychologically abused in mental hospitals.

But there is no way to know, since monitoring organisations and the media are not allowed complete access to these facilities.

Under an amendment to the Mental Health Act of 1976, no person "without the authority in writing of the Director-General" (of the province concerned) may take photographs of any institution or patient in that institution.

The amendment also restricts the media by warning that anyone who publishes any "false information concerning the detention, treatment, behaviour or experience in an institution of any patient ... or concerning the administration of any institution" shall be liable to a fine of R1 000 or one year's imprisonment.

Ironically the onus is on the media institution to prove all allegations, even though the media do not have access to hospital premises or records.

This week CCHR submitted a proposal to the Constitutional Assembly to change the laws which govern mental patients and the institutions they live in.

Under the proposal, mental patients and their next of kin would have the following rights enjoyed by other people:

- To see one's own medical records;
- To receive telephone calls and get visitors;
- Medical treatment for ordinary physical illness;
- To make complaints officially to an independent board without reprisal; and
- To accept or refuse treatment: sterilisation, electric shock treatment, insulin shock, narcosynthesis, lobotomy, aversion therapy and any drugs producing unwanted side effects.

A patient at Millsite Hospital. There have been unproven allegations of abuse at this institution.

Should a mental patient who may or may not be stable have the right to sue a psychiatrist or a hospital?

CCHR Executive Director Paul Sondergaard suggests that increased rights of patients can only benefit them and society.

Increased public attention is also an essential part of maintaining human rights he adds.

Mummified bodies

"In Italy the media can enter institutions at any time. They have uncovered all sorts of things that no one knew was possible including mummified bodies and that sort of thing. Without media access none of it would ever have come to light," says Sondergaard.

No one is suggesting that mummified bodies are hidden under hospitals like Millsite or Sterkfontein, but numerous allegations of abuse have been laid by staff in these hospitals. So far, an independent inquiry has not put these claims to rest.

"They (the Mental Health Act and the Amendment Act) confer unconstitutional powers on psychiatrists to commit patients without any system of referral or objection.

The Amendment Act prevents anyone investigating or exposing psychiatric violations of human rights," says Sondergaard.

Psychiatric hospital administrators often defend restrictions on the media by saying that they are protecting patients cannot protect themselves.

Protection is often necessary. Many patients are not credible sources. Others cannot speak coherently.

But when family members, independent investigators and the media cannot see the truth for themselves, who is anyone to believe?

In an interview late last year, Sterkfontein principle psychiatrist Dr Ewart Smith told *Sowetan* that he didn't believe that the media should have access to the hospital.

"You could seriously jeopardise patients. We cannot have media people coming in here who don't understand what it means to treat a patient. It isn't right," said Smith.

But what is right? For family members of mental patients who have disappeared from mental hospitals without explanation, privacy and protectiveness is often offensive.

When Elizabeth Kinghorn disappeared from Sterkfontein hospital in 1990, her sister Barbara tried to question staff members and see her sister's medical records. Administrators allegedly refused the request.

"No one even told me that they were sorry that my sister had disappeared," said Kinghorn.

Another tragedy is that administrators and staffers in mental hospitals often work under extremely stressful conditions.

They have to deal with difficult and sometimes dangerous personalities on a daily basis.

One Millsite hospital employee, who asked not to be named, has alleged that hospital staff sometimes make mistakes or mistreat patients because of the pressure they are under.

In turn, these staff members cover up their mistakes because they fear repercussions from other patients or administrators.

Sondergaard suggests that these types of problems will never be solved unless hospitals are opened to public scrutiny and possibly reform.

"We cannot have a free society unless we guarantee the rights of mental patients," says Sondergaard.

SA may play part in WHO plan

(85) CT 22/2/95

Own Correspondent

PRETORIA. — South Africa needs a more coherent environmental health policy, World Health Organisation official Dr Wilfried Kreisel said yesterday.

The present system of spreading responsibilities among a number of government departments could be disadvantageous, he said.

Dr Kreisel, WHO's executive director, health and environment, was commenting on the country's overall environmental health situation.

He is a guest of the Department of Health.

However, Dr Kreisel said of all the countries he had visited in Africa, SA had the most potential to uplift itself, especially with regard to the provision of water and sanitation.

"Your RDP is the right umbrella for this task, but miracles must not be expected," Dr Kreisel warned.

A crash course in human resources development aimed particularly at local leaders was a priority, he said.

This would enable them to assist with the empowerment of their communities to improve their lot with assistance of the regional and national governments.

Dr Kreisel had suggested during his meeting with Health Minister Dr Nkosazana Zuma that a WHO Africa environmental health centre be established in South Africa.

This would enable the country to play an important role in WHO's Africa 2000 policy aimed at accelerating provision of water and sanitation throughout Africa, he said.

Protest over health plan

Municipal Reporter

SEVEN HUNDRED Western Cape health workers who belong to the traditionally-conservative SA Association of Municipal Employees (SAAME) are to protest at the Good Hope Centre today.

SAAME national president Mr Hans Deetlefs said yesterday the protest was over the announced takeover by the province of parts of health services that have traditionally fallen under municipalities. CT 24/2/95

He warned that unless the situation in local authority health services was addressed "industrial action will shortly follow, bringing health services to a grinding halt".

HEALTH CARE (85) FM 24/2/95

Witty riposte

An alliance of powerful drug manufacturers — Glaxo, Roche, Logos, Adcock Ingram, SA Druggists — and medicines clearing agent Medikredit has formed the SA Health Care Initiative in what it says is a bid to help government reform health care in the drug industry.

Says Glaxo MD Andrew Witty: "We have a good private sector that can give government most of what it wants while freeing up the tax rand for those who really need it. We want to engage in health-care delivery in an interdisciplinary fashion that moves away from a narrowly defined self-interest base."

But Witty stresses that government and the alliance must concentrate on de-regulating the drug sector if high prices are to be addressed.

"Private sector drug prices are among the highest in the world because of over-regulation rather than any failing of the market system or private sector."

On this score Witty believes that de-regulating the ownership of pharmacies to allow big business, medical schemes and hospitals to own retail outlets is essential to usher in greater price competition.

"Deregulation of the distribution chain in the UK and US brought about huge savings. Of course, this would threaten the independent, small, pharmacist-owned retail pharmacy — presently the only legal retail outlet along with dispensing doctors — but they need to survive because they are competitive, not because they are legally protected."

Witty argues that greater transparency in drug pricing is needed to bring about savings. He would like to see wholesalers and retailers make simple and obvious mark-ups on manufacturers' prices rather than continue to rely on traditional mark-ups (17% at wholesale level and 50% at retail) which are then discounted. The present system tends to disguise actual prices, he says.

Witty believes the new alliance is ideally placed to provide government with information systems that would minimise theft and waste, ensuring maximum use of cheapest available resources.

The alliance is keen to help Health Minister Nkosazana Zuma extend services to the underserved areas. Drug manufacturers, says Witty, are ideally placed to help government develop disease management techniques focused on cost-effective treatments rather than narrowly defined short-term costs.

The private sector could well help to develop disease management protocols for the public sector that could effect huge savings.

For an illness such as TB, an effective protocol could, in fact, cure the illness.

Meanwhile, the National Association of Private Hospitals last week began spearheading discussions to ensure extended health cover for all.

Says chairman Riel du Toit: "The whole sector must be brought together to find solutions. There's already a great deal of agreement that existing delivery systems — private and public sector — must become more effective and efficient through greater competition."

Zuma

Medical schemes, for example, should bear greater financial risk rather than continue to operate, ostensibly, as non-profit organisations, he says. "This would usher in greater responsibility and competition in the industry."

Du Toit adds that the industry is investigating ways of ensuring a package of core health-care services that would be available in the private and public sector without additional costs to health care. ■

A look at health of children

24/12/95 Sowetan

THE rights and health of children are to be addressed by a special national plan of action, consistent with aims of the United Nations' Convention on the Rights of the Child, Health Minister Dr Nkosazana Zuma said yesterday.

In a statement issued during a two-day workshop on the development of the national plan of action for South African children, Zuma said its success depended on acceptance by both Government and non-governmental organisations.

Thousand births

"We urgently need such a programme. The UN Children's and Educational Fund has determined that for our Gross National Product per capita we should have an under-five mortality rate of 34 out of a thousand births.

"Unfortunately our under-five rate is presently 72." — *Sapa.*

Views invited by Rasool

CT 24/2/95

Staff Reporter

CRITICS of wide-ranging proposals to restructure the Western Cape's health services have two months to comment, provincial Health and Social Services Minister Mr Ebrahim Rasool said yesterday. (85)

Speaking at a meeting of the Transitional Provincial Health Advisory Committee, a 62-member body representing all parties in the provincial health community, Mr Rasool said the cut-off date for comment would be April 23.

It was hoped a final analysis of the health plan would be completed a month later.

He said there would be no changes at institutions till the overall plan had been completed.

Private health sector rallies against proposal

(85)

ST 26/2/95

By CAS St LEGER

PRIVATE doctors, hospitals and pharmacists are joining forces in an unprecedented move to work out an alternative to the controversial Deeble health insurance proposal said to be favoured by the government.

Some 40 representatives, including medical aid executives, are meeting this weekend to decide on a united front against national health insurance plans they believe could sound the death knell for private sector health care in this country.

They aim to present Minister of Health Dr Nkosazana Zuma with an alternative to the present system that will ensure quality health care's survival.

Dr Zuma last month appointed a committee to investigate an equitable primary health system. But senior medical sources fear that committee member and Australian doctor John Deeble's proposal for state medical care is being favoured.

The committee begins taking oral representations from tomorrow until March 17 under the co-chairmanship of Dr Olive Shisana, special adviser to the minister, and Dr Jonathan Broomberg, a medical doctor, health economist and financial consultant.

Dr Broomberg dismissed private sector fears as unfounded. He said an "infinite" number of health insurance models were being considered. The final plan was likely to be made up of many submissions, taking the best from each.

But widespread fears persist in the private sector that committee opinion is weighted in favour of the Deeble proposal, which would place primary health care in government rather than private hands.

In terms of the plan, doctors would receive a fee of R180 a patient a year from the state.

The scheme would be funded by levying a three-percent payroll tax shared between employees and employers, generating up to R5,25-billion.

"The country can't afford additional taxes. Improving the efficiency of both the public and private sectors will enable the minister to achieve the quality of primary health cover she is seeking," said Riel du Toit, chairman of the National Association of Private Hospitals, which initiated this weekend's meeting.

"We want to come up with alternatives which will make it work," he said.

The provision of equitable health care without the need for additional funds is the key point in the plan the association will be submitting to the committee.

But Mr du Toit and other private sector providers feel they have not gone far enough. Rather than individual doctors, pharmacists and medical aids each putting forward their separate solutions, they believe points of common interest should be identified and a united representation made.

"For the first time, the private sector is saying that we need to do something together," said Mr du Toit.

This week, the health sector of the Reconstruction and Development Programme council said there was unanimous agreement that transformation of the health system should strengthen the public health sector.

De facto chairman Judi Fortuin, co-ordinator of the National Progressive Primary Health Care Network, said: "There is no way the private sector can continue as it is at the moment. There should be a link between the private and public sectors."

Another point of contention is a proposal that junior doctors perform two years of compulsory rural service. One counter-proposal suggests two years of research into a particular disease or condition instead.

The committee will submit its report to Dr Zuma at the end of April. Then it will be debated publicly before being ratified by Parliament.

Hepatitis protection for babies

(85)

CT 1/3/95

BABIES under a year old will be the target of a Department of Health immunisation campaign against Hepatitis B, Health Minister Dr Nkosazana Zuma announced in Cape Town yesterday.

The vaccine formed part of a new immunisation schedule to be implemented from April 3 and will cost about R12 million a year, she told a press briefing.

The Hepatitis B virus infects about two billion people in the world, resulting in 350 million chronic carriers, and more than a million deaths every year.

Children under a year old are most at risk.

The National Institute for Virology estimates that about two million South Africans are carriers of the virus.

The Medical Research Council welcomed the Minister's announcement. — Sapa

Star 1/3/95

Doctors hail vaccination programme

(95)

■ BY DAVID ROBBINS
HEALTH WRITER

The intention of the Department of National Health to immunise all South African infants against the hepatitis B virus is being widely praised by medical experts.

Director of the National Institute for Virology, Professor Barry Schoub, called it "an excellent move", and Professor Walte Trozesky, president of the Medical Research Council (MRC), said the council was delighted by the move.

Health Minister Dr Nkosazana Zuma this week announced that the hepatitis B vaccine would be introduced into a new immunisation schedule which will, from April 3, also protect babies against diphtheria, tetanus, whooping cough, measles, polio and tuberculosis.

Work done in the former homeland of KaNgwane several years ago by Professor Michael Kew of the MRC's Molecular Hepatology Research Unit at Wits showed that the vaccination was 97% effective.

It is estimated the cost of protecting SA's infants against this disease will be around R12 million a year. Schoub pointed out, however, that the introduction of the vaccine would be "very cost beneficial in terms of reducing later hospitalisation ... and years of productive life lost".

Hepatitis B, which is 10 times more infectious than HIV, has a specific tendency to attack the liver, causing a variety of diseases including cancer.

There are more than 1 million carriers of the virus in South Africa, of which considerable numbers will eventually die of liver cancer.

Infants can contract the infection from their mothers

Eastern Cape, Gauteng, KwaZulu-Natal, Northern Transvaal and Orange Vaal Regions

No such incidents were reported during the period under review in these regions.

†Dr T J KING: Madam Speaker, arising from the hon the Minister's reply, I would like to know what is being done about the teacher's position and whether they are still receiving their salaries. I would also like to know what is being done about further career prospects for them.

The MINISTER OF EDUCATION: Madam Speaker, each case is dealt with according to merit. They are paid, and in some cases arrangements are made to have them placed in other schools.

Educational television service for schools by SABC

*11. Mr T C NTSIZI asked the Minister of Education:

(1) Whether his Department has taken any steps to establish a full-scale educational television service through the South African Broadcasting Corporation to schools throughout the country; if not, why not; if so, what steps;

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

N32E

The MINISTER OF EDUCATION:

(1) This matter has been receiving attention for a period of some length.

Mere broadcasting of programmes serves virtually no purpose; they are not necessarily watched by those for whom they are intended. In fact, many of those people do not have access to the required equipment—for example, individuals and institutions do not even have electricity. It is only now that we are arranging to electrify all the schools.

Networks first have to be developed—in particular, networks of support material and contact points. The White Paper on Education and Training refers to community colleges and certainly once community education structures have been developed, these will provide an ideal support structure for distance education. When this point has been reached, the time will be ripe to negotiate with the SABC and other such bodies.

In the meanwhile, a new directorate for distance education has been created in the Department of Education. Extensive preparatory work has also been done over a long period, both by state structures and by NGOs. All this work makes a most valuable contribution towards policy development.

(2) No.

SA Law Commission: investigation into legal position of natural father

*12. Dr F J VAN HEERDEN asked the Minister of Justice:

(1) Whether the South African Law Commission has completed its investigation into the legal position of the natural father of a child born out of wedlock; if not, when is this commission expected to report; if so,

(2) whether the commission's report has already been published; if not, why not; if so, (a) when and (b) what are the further relevant details?

N33E

The MINISTER OF JUSTICE:

(1) Yes.

(2) No, it is in a process of being printed by the Government Printer and will be published as soon as the printing thereof has been finalised.

Establishment of post of attorney-general

*13. Mr P A MATTHEE asked the Minister of Justice:

Whether any consideration is being given to the establishment of a post of attorney-general to whom existing attorneys-general will be subordinate; if not, what is the position in this regard; if so, what are the relevant details?

N43E

The MINISTER OF JUSTICE:

No concrete proposal of any kind with regard to the office of the attorney-general is presently under consideration. I am, however, of the view that an open and constructive discussion on the structure, position, role and function of the prosecutorial authority should be encouraged for the following reasons:

(1) Over the years under the apartheid system the prosecutorial authority (which includes the attorney-general) was used as an instrument to enforce apartheid and repressive laws and policies. The question is: Has the prosecutorial authority been freed from that legacy?

(2) The new constitutional order has put an end to the system of parliamentary sovereignty and has ushered in the epoch of constitutionalism. It is the constitution, not parliament, which is supreme. Our constitution also contains a chapter on fundamental rights (chapter 3).

In such a dispensation many policy issues are likely to arise before our courts—particularly the constitutonal court. This has already happended. The question is: what is the position of the attorney-general in relation to policy matters? Who makes policy? The democratically elected government of the day or the attorney-general? Who speaks on behalf of government or the state with regard to policy matters? This must be openly discussed and clarified.

(3) The issue of the accountability of the attorney-general must also be clarified.

(4) Within the context of the doctrine of separation of powers between the executive, judiciary and legislature, it is generally accepted that the prosecutorial authority is an arm of the Executive. This relates particularly to matters of general policy. What does this mean in relation to the prosecutorial authority?

(5) Whatever approach is adopted, one thing must be clear:

The prosecutorial authority should, within the framework of general policy laid down by government or parliament, be guaranteed its independence to prosecute fearlessly any person or body against whom it believes there is *prima facie* evidence. It should be able to do so without interference from anybody. In this context the independence of the prosecutorial authority should be ensured.

(6) In terms of the constitution, justice is a national competence. In the context of the above, and possibly other considerations which I have not mentioned the question should be asked: Do we not need a national attorney-general? When asking this question, I do not detract from the integrity of and excellent work done by the various offices of attorneys-general throughout this country under difficult conditions.

Hansard 1/3/95

Committee of Inquiry into National Health Insurance Scheme: members (88)

*14. Dr W A ODENDAAL asked the Minister for Health:

(a) What are the (i) names and (ii) post-school qualifications of the members of the Committee of Inquiry into a National Health Insurance Scheme, (b) at which academic institutions did each of these members receive their post-school education and (c) what contribution is it anticipated will each of these members be able to make to the work of the Committee?

N45E

The MINISTER FOR HEALTH: Madam Speaker, I think this is a ridiculous question for an oral reply, but out of respect for the House I will answer it.

COMMITTEE OF INQUIRY INTO A NATIONAL HEALTH INSURANCE SYSTEM
ATTENDANCE LIST

NAME AND POSTAL ADDRESS	POST-SCHOOL QUALIFICATIONS	ACADEMIC INSTITUTIONS
Dr O Shisana	Doctor of Science in Public Health (Behavioural Science focus on social Epidemiology) Masters in Clinical Psychology	John Hopkins University, Baltimore, USA 1984 Loyola College, Baltimore, USA 1978
Dr J Broomberg	MB BCh BA (Hons) Economics MSc (Economics) Completing PhD (Economics)	Wits University 1984 Oxford University 1988 London School of Economics University of London
Dr B A Brink	MB BCh BSc (Med) DA (SA)	Wits University 1975 Wits University 1971 College of Medicine 1981
Mr A Donaldson	BA BA (Hons in Economics) MA in Economics MPhil in Economics	Wits University UNISA Stellenbosch University
Mr R Mabope	National Diploma Medtech	PE Technikon 1979
Mr R Magennis	BComm BAcc CA (SA) MBL	Wits 1980 Wits 1983 Institute of Chartered Accountants UNISA 1988
Mr F Makiwane	BSL (NCT) BSc (MOS) MSc Health Planning and Financing	UCT 1989 Wits 1989 London 1994
Mr K S Mashalane	BComm (Legal) HLD	University of the North
Precious Matsoso	BPharm	University of the Western Cape
Ms Diane McIntyre	BComm BA (Hons) MA Economics Current: Registered for PhD	University of Cape Town 1982 University of Cape Town 1983 University of Cape Town 1986

[Interjections.] No, I will read until I have finished. The hon member must get the answer.

NAME AND POSTAL ADDRESS	POST-SCHOOL QUALIFICATIONS	ACADEMIC INSTITUTIONS
Dr C Mini	MB ChB Community Health	1986-Sofia MB ChB Community Health Tygerberg
Ismail Nomonat	MSc (Economics) 1992/93 BA (Hons) 1992 MSc 1990 Bsc (Hons) 1978 BSc 1977	London School of Economics and Political Science UNISA Wits Wits
Dr T Sibeko	MB ChB Diploma in Health Economics and Management	University of Zambia UCT
Dr J M van Heerden	MB ChB Health Admin Diploma	1966 University of Pretoria 1987 University of Pretoria
Dr J Deeble	BComm PhD Diploma in Hospital Administration	1956/1970 University of Melbourne 1958 University of NSW Aurteka
Professor W C Hsiao	PhD 1982 MA 1974 MPA 1972 BA 1959	Harvard Harvard Harvard Ohio Wesleyan University
Professor A Maynard	BA (Hons) Economics BPhil Economics	University of York 1967 University of York 1968
Dr M Price	MB BCh Rhodes Scholarship Masters Community Health Diploma in Occupational Health	Wits 1979 Oxford 1983 London School 1986 Wits 1992

The MINISTER FOR HEALTH: Madam Speaker, I think from their qualifications the hon member will be able to work out what they can contribute. [Applause.]

Dr W A ODENDAAL: Madam Speaker, arising out of the reply of the hon the Minister, she told me that I had asked a ridiculous question, and I may point out to her that she did not read out the name of the 19th member of this committee, Dr Thomangia Bomvana with an MB ChB degree from Medunsa, and also a BSc degree from Fort Hare, who is the only person representing the general practitioners on this committee.

†From information leaked from her office, it appeared that the proposed Deeble Plan—which was forced down our throats in such a fast manner—would make it impossible for general practitioners in South Africa to continue with their private practices. I want to know why she withheld this last person's name from this House and why only one person, coming from Soweto, was appointed to this committee to see to the interests of general practitioners in South Africa.

The MINISTER FOR HEALTH: Madam Speaker, first of all, this committee was not set up to represent certain township interests. This committee was set up to look at how we can make health accessible to the majority of the people in this country. However, this committee has to look at affordibility, sustainability and efficiency. So, it had to have a variety of people who have expertise in health financing and in public health, and GPs.

Dr W A ODENDAAL: Only one GP?

The MINISTER FOR HEALTH: Madam Speaker, yes, one GP fine. It is not a committee for GPs. It is a committee to look into the National Health Insurance Scheme, which is a financing scheme. It is not about GP practice.

I wish to say that at the moment this committee is looking at a plan and it is consulting the stakeholders. I am doing the same. When the plan is ready we will publish it. People who are stakeholders are making an input into that plan.

This Government of National Unity does not force anything down people's throats. This Government works on a mandate, and the mandate for inquiring into the National Health Insurance Scheme actually was given to this Government by the voters—by 62% at least of the population of this country—on April 27. Having got that mandate, we are still consulting even those who did not vote, those who are not part of that 62%, because we realise that at the end of the day the plan has to be acceptable to everybody.

We have no intention of forcing this down people's throats. We are engaged in a consulting process.

Dr W A ODENDAAL: Madam Speaker, further arising from the hon the Minister's answer, may I point out to you that she still refuses to answer my question. Why did she omit to give members of the National Assembly the last name of the only general practitioner who sits on this committee?

The MINISTER: Sorry, Madam Speaker, I did not answer the member's question. I have just read the name, and not giving it was an oversight on my part. The name is on my list. The practitioner in question is someone who studied in this country and who works in Soweto. His name is Dr Bomvana. [Interjections.]

Dr W A ODENDAAL: Madam Speaker, further arising from the Minister's answer, I still fail to understand whether she has answered my question or not. I asked her why she omitted the last name. [Interjections.]

The SPEAKER: Order! I heard the Minister saying that it was an oversight. [Interjections.]

Advertisements of posts in Department

*15. Dr W A ODENDAAL asked the Minister for Health:

(1) Whether any posts in the top structure of her Department for which the incumbents will have to reapply for appointment have been or are to be advertised; if not, what is the position in this regard; if so, which posts;

(2) whether it is the intention to advertise posts at a lower level of management as well; if not, what is the position in this regard; if so, (a) when and (b) which posts?

N46E

The MINISTER FOR HEALTH:

(1) Yes, all the newly created posts from Director up to and including Deputy Director-General have already been advertised with the exception of the post of Director: National Institute for Virology, Director: Air Pollution and Chief Director: National Centre for Occupational Health. The advertised posts are either new posts that differ significantly from the previous ones or are vacant at present or will be vacant in the near future;

(2) yes

(a) as soon as the posts are created; and

(b) those posts for which serving officials are not available for absorption or are not suitably qualified.

SAA aircraft: transportation of forbidden goods

*16. Mr A J LEON asked the Minister of Transport:

Whether any local regulations were amended in terms of Government Gazette Notice No R1076 of 30 May 1986 to authorise the placing of goods aboard South African Airways aircraft that were normally forbidden for transport by air under any circumstances; if not, what is the position in this regard; if so, why was it decided to amend such regulations?

N53E

The MINISTER OF TRANSPORT:

No, due to the fact that no regulations existed prior to 1986 for the transportion of dangerous goods on an aircraft. The regulations referred to in the question were drawn up with the International Civil Aviation Organisations (ICAO) Technical Instructions as the basis. The regulations that were promulgated in 1986 *inter alia* made provision for the Commissioner for Civil Aviation to grant approval for the transport of certain categories of dangerous goods on aircraft.

These regulations were thereafter reviewed and eventually culminated in the publication of a new set of regulations that were published in Government Gazette No 15724 dated 6 May 1994.

†Mr J CHIOLÉ: Madam Speaker, arising from the answer by the hon the Minister, I would like to know whether the Government would give consideration even to a request to reopen the inquiry into the Helderberg disaster.

The MINISTER OF TRANSPORT: Madam Speaker, a written question with regard to this issue was put on the Question Paper to be answered at a later stage. I shall answer the question at that time.

Involuntary confinement: representations/ legislation

*17. Mr M J ELLIS asked the Minister for Health:

(1) Whether she or any member of her Department has received any representations regarding the Mental Health Act, 1973 (Act No 18 of 1973), with particular reference to Chapter 3 of the Act, in regard to the practice of involuntary confinement; if so, (a) from whom and (b) what was the purport of these representations;

(2) whether she intends introducing legislation with a view to amending the said Chapter; if not, why not; if so, what are the details of the proposed amendments;

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

N54E

The MINISTER FOR HEALTH:

(1) We could find no such representation.

(2) A total revision of the Mental Health Act, 1973 (Act 18 of 1973) is being considered to bring it in line with the Constitution of the Republic of South Africa, 1993 (Act 200 of 1993).

(3) No.

New series of coins: acceptability/ease of use

*18. Mr K M ANDREW asked the Minister of Finance:

(1) Whether any market research has been done into the acceptability or ease of use of the new series of coins; if so, (a) what research and (b) what were the results of the research; if not, why not;

(2) whether any complaints have been received in regard to the size of the new one cent, two cent and ten cent coins; if so,

(3) whether any steps have been taken or are to be taken towards addressing these complaints; if not, why not, if so, what steps?

N55E

The DEPUTY MINISTER OF FINANCE: Madam Speaker, I answer on behalf of the hon the Minister of Finance. He has successfully charted his way through the Senate and come back a bit earlier than we thought, but I shall nevertheless answer the question.

(1) In 1986 Mr Barend du Plessis, the then Minister of Finance, appointed a committee under the Chairmanship of Mr G P C de Kock of the South African Reserve Bank to investigate the feasibility of changing the banknote series. The brief was later extended to include coins.

Extensive intenational research was undertaken to determine the acceptability of a new series of coins in terms of coin sizes, durability, material and factors such as

Attack on health cuts

(85) CT 2/3/95

Political Staff

THE Western Cape could not continue maintaining health services by excluding the vast number of its citizens, Health and Welfare Minister Mr Ebrahim Rasool told his legislature.

He was answering a question by Dr J du Toit (NP) who wanted to know why funding for the province was "cut back so severely" by his national counterpart, Dr Nkosazana Zuma.

Mr Rasool said the five-year restructuring of provincial health services would result in rural communities having secondary health care for the first time.

sday, March 2 1995

Immunisation to include hepatitis

(85) BD 2/3/95

KATHRYN STRACHAN

THE Health Department has announced that the new immunisation programme for the country will include a vaccine against hepatitis B — a virus ten times more infectious than the HIV virus.

The new vaccination schedule, beginning in April, includes the heptatis vaccine at a cost of about R12m per year. Immunisation will be targeted at those most at risk — the under one year old infants.

The new schedule means that most children will be fully protected against poliomyelitis, hepatitis B, diptheria, tetanus and whooping cough by the age of 14 weeks instead of six months. The two doses of measles vaccine at nine months and 18 months will further ensure maximum protection of children from this disease, the department said.

The Medical Research Council president Prof Walter Prozesky said the council was delighted that after years of campaigning for the vaccine, the government was proving its commitment to child health by including the hepatitis B vaccine in its immunisation programme.

"The introduction of the vaccine will be one of the most valuable contributions to child health in the country and will ultimately benefit the health of adults as well," he said.

Hepatitis B affects about one in ten black Africans. There are about two million carriers of the disease in SA, and about half of these will die of liver cancer or cirrhosis.

The hepatitis B virus tends to infect young children. Many of those infected at an early age become carriers of the virus and although infection is often asymtomatic, they are at greater risk of developing cirrhosis and liver cancer later in life.

The majority of liver cancer cases in black South Africans is caused by the virus. In SA liver cancer is four times more common in young males.

In the Far East the virus is usually transmitted vertically (from mother to child), but in Africa transmission is mainly horizontal, infecting children at a young age in unknown ways. It can also be passed on through contaminated needles or sexual intercourse. Other possible causes of transmission include scarring or circumcision rites which are performed with non-sterilised instruments, and bites of blood-sucking vectors.

Scientists are investigating the relationship between hepatitis B and certain toxins which occur in maize and peanut products.

New health system 'may inspire abuse'

(85) BD 2/3/95

BEATRIX PAYNE

THE current debate on a national health insurance programme including the so-called Deeble plan could "institutionalise mediocrity" and create "perverse incentives" to encourage patients to abuse the system, Momentum Health MD Adrian Gore said this week.

However, it was important that all of SA had access to basic health care, although there could be a danger in undermining the private sector.

He said a national health scheme should let those who could afford it pay for private health care.

"Whoever can afford it should be serviced by the private sector, which would free up the state to provide for the needy," he said.

But where primary health care was offered free to the population, costs could soar, he said.

Experience had shown that medical aids which paid for all medical expenses had been abused by patients who were intent on getting their "pound of flesh".

"There is often no incentive not to claim," he said, adding that government could encounter the same problem if it provided free health care across the board.

The proposal that general practitioners be paid on a capitalisation or fee per patient basis could in time lead to underservicing.

He said the system could encourage doctors to boost income through increasing patients at the expense of providing proper service.

The Deeble report had been "vague" concerning the position of pharmacies and dentists.

If the state were to become the only provider of primary health care services, pharmacies would be at risk and could go out of business.

A major problem facing medical aid schemes was the need to provide health care funding for pensioned members. According to the group's calculations, the medical aid industry would need R35bn to fund the health care needs of all pensioned members. But it only had an asset base of around R1,5bn.

The Deeble plan and other funding proposals had made no reference to funding for pensioners.

Apart from the population covered by medical aid, SA was not an ageing population and pensioners might not be a priority, he said.

Momentum Health planned to meet the health financing subcommittee within the next few weeks to present its views on the provision of a national insurance plan.

Thursday March 2 1995 THE

Concern as top UCT doctor quits his post

(85) ARG 2/3/95

☐ *Colborn backs change, then goes*

LIBBY PEACOCK
Health Reporter

THE deputy dean of the University of Cape Town's medical school — who has been forthright in his public support of moves to change the South African health system — has resigned.

Concerned colleagues at Groote Schuur Hospital who called The Argus have claimed Dr Rod Colborn is leaving the country but Dr Colborn has refused to confirm this or to comment on his resignation.

University of Cape Town spokeswoman Helen Zille confirmed that Dr Colborn had resigned for "personal reasons".

Doctors at the hospital said Dr Colborn had expressed the view that standards would not drop because of reduced academic hospital budgets and that primary health care doctors needed "a stethescope and little else besides sound training and the right approach". They questioned his reasons for leaving.

In an interview yesterday, Dr Colborn repeated his conviction that "the training of our students must be at the appropriate health-care level".

He said at primary health care-level, a stethoscope and the ability to manage reasonably simple procedures such as taking blood pressures and X-rays — coupled with the correct training and "the right approach to the patient as a human" — were the most important factors.

This did obviously not apply to specialist level, but "if doctors are tied to fancy equipment we're going to have problems".

While it was unnecessary to have hi-tech equipment in the teaching of graduate students, such facilities were indeed necessary in order to retain quality teaching staff.

Dr Colborn said the country should have had a system of secondary hospitals in place in communities a long time ago.

It was unnecessary that operations to take appendices and tonsils out should have been done at tertiary hospitals like Groote Schuur.

Dr Colborn said he was "very supportive" of the proposed new health plan for the Western Cape.

Free jabs for babies could wipe out liver cancer in 50 years

(85)

☐ *State launches hepatitis B vaccine scheme*

ARG 2/3/95

LIBBY PEACOCK
Health Reporter

ONE of South Africa's deadliest and most common cancers — liver cancer — may be eradicated in 40 to 50 years as a result of a new state policy to provide free vaccination against the hepatitis B virus for children under a year.

This was said by a liver disease expert at a Press conference called by Minister of Health Nkosazana Zuma to announce a new vaccination schedule..

Dr Zuma said the vaccine would cost the state about R12 million. Because it was so expensive, immunisation was targeted at those most at risk — infants under a year.

There are about 350 million chronic carriers of the hepatitis B virus worldwide and the National Institute for Virology estimates that about two million South Africans are carriers.

Hepatits B can lead to liver disease and liver cancer and in adults is transmitted in the same way as the HIV virus but it is not yet known how babies are infected.

The new vaccination schedule will mean most children are fully protected against polio, hepatitis B, diphtheria, tetanus and whooping cough by 14 weeks old, instead of 24 weeks, as in the previous schedule.

Ralph Kirsch, a liver disease expert at the University of Cape Town's medical school,

Nkosazana Zuma

said about 70 percent of adults in the Western and Eastern Cape had been exposed to the virus. Of these, seven to 10 percent were carriers.

The vaccination of infants would mean that liver cancer, one of the most common cancers in South Africa (and often caused by the virus), would start disappearing in 20 or 30 years.

"We believe in 40 or 50 years' time there will be no cases," Professor Kirsch said.

The Medical Research Council said it welcomed the Department of Health's announcement.

The introduction of the vaccine would be "one of the most valuable contributions to child health in the country" and would ultimately benefit the health of adults as well.

Hepatitis B was 10 times more infectious than the HIV virus, the council said.

● Responding to a question about the future of expensive transplant operations, including liver transplants, Dr Zuma said it was "difficult to know where to draw the line", because the country could not afford transplant operations for everyone who needed them.

But it was important to keep expertise and high-tech medicine on the level that it was.

"We can't say we shouldn't do transplants, but we can't afford them for everybody."

She said this might mean that a specific centre in the province, or even in the country, be identified for a fixed number of transplants for which national funding could be provided.

● Dr Zuma also emphasised that doctors in the private sector could not "carry on as they are, unless they don't believe they are in the new South Africa".

"We cannot see the private and the public sectors operate as if they are in different countries . . ." she said..

There had to be a way for the public sector to buy services from the private sector in a cost-effective way'

But Jonathan Brumberg, co-chair of Dr Zuma's technical committee on national health insurance, said this could not be done through "force", but rather by incentives.

Council firm on health

☐ *Minister to be told of insistence on local control*

ARG 7/3/95 (85)

ANDREA WEISS
Municipal Reporter

THE Cape Town City Council is digging in its heels over who should provide primary health care in the new dispensation.

The row has arisen over plans to transfer all health staff to the province to create a new district health system.

At a meeting of the city council's new health and community services committee, it was decided that Health Minister Nkosazana Zuma should be informed that the council would insist on its rights to provide primary health services.

This right is enshrined in the interim constitution, which lists primary health services under the powers and functions of local government.

The committee has appointed a special sub-committee to help medical officer of health Michael Popkiss deal with the issue.

Dr Zuma will also be told that the city council supports the idea of a district health system which improves comprehensive primary health services, but that it believes that local authorities should provide it.

Provincial Health Minister Ebrahim Rasool will also be asked to give details of how much the province currently offers in the way of primary health care within the city council's boundaries.

A third leg of the resolution is to inform the trade unions on the staff implications of the transfer.

A new document on the implementation of a district health system indicates that political endorsement would be required for the transfer of staff to the province or "from the provinces to some of the new local governments".

The document, which summarises obstacles in the way of forming the new system, was released last month.

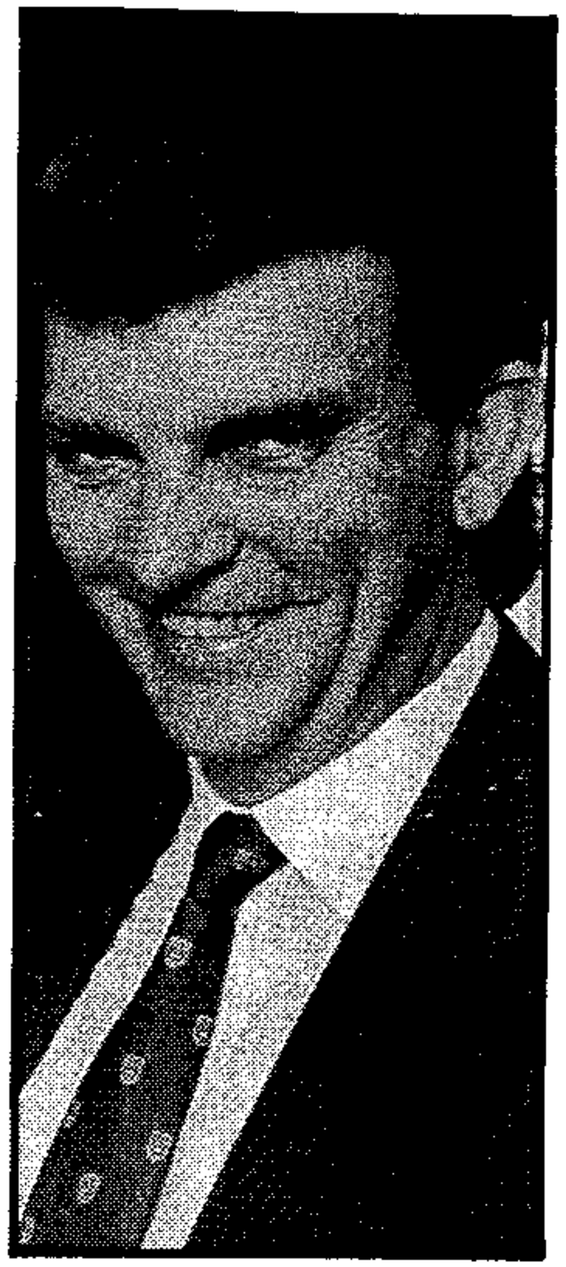
Other political decisions will also be needed.

These include the equalisation of salary scales and conditions of service; what the boundaries of health districts should be; how the new services should be funded; and the setting up of workable structures to implement the system.

Also, the document points out that the wording of the interim constitution should possibly be clarified in the final constitution.

In terms of the World Health Organisation's wording, a district health system comprises a well-defined population, living in a clearly defined administrative and geographical area.

It also consists of a variety of inter-related elements all the way up to tertiary hospital and laboratory level.



Michael Popkiss

Medical objective will be excellence

Health Reporter

(85) ARG 7/3/95

THE Medical Research Council's new board has announced a new philosophy with the emphasis on "an integrated approach to solving the nation's health problems through excellence in scientific research".

Malegapuru Makgoba, chairman of the board, said the "integrated national health research" (INHR) approach could only succeed "if underpinned by strong scientific principles, integrated with all the other determinants of health that our country faces".

Traditional healers help to fight cancer

BY CHRIS BATEMAN
POLITICAL STAFF

TRADITIONAL healers with specialist training are helping to prevent the spread of cancer in Peninsula townships by referring patients to a cancer clinic at Langa's Philani (Get Well) Centre.

This emerged yesterday when Western Cape Health Minister Mr Ebrahim Rasool visited the centre and mobile clinic which has saved more than 100 lives by detecting pre-cancerous conditions.

An unknown number of township residents have also been referred to the clinic by the Philani-trained "nyangas" or traditional healers.

Mrs Priscilla Nelson, the Western Cape manager of the Cancer Association, said that between March 1993 and March 1994, the clinic saw 3 800 women of whom 48% (1 824) had vaginal infections and 3,8% (144) had smears.

"We realised we could not work without the traditional healers otherwise people would just ignore us and go to them. Now we educate the healers about the cancer warning signs and they refer people to us," Mrs Nelson said.

The collaboration, which has attracted the attention of the medical community worldwide, according to Cancer Association regional chairman Dr Carl Albrecht, was motivated by an 80% fatality rate among black women cancer patients at Groote Schuur hospital.

"They came in with breast and cervical cancer so advanced that all we could do was control the pain."

By detecting and cauterising pre-cancerous lesions, the province could save R4 950 to R19 800 per patient, he said.

Mr Philip Kubukeli, president of the Western Cape Traditional Healers and Herbalists Association, said nyangas once believed Western doctors "just cut off the infected part" and black society shunned cancer victims, thinking they were infectious. Now he tells his colleagues "if we don't work with the doctors, we are killing our people".

R5,7m PLAN: Health and Welfare Minister Mr Ebrahim Rasool

R5,7m for better health care

(85)

BY CHRIS BATEMAN
POLITICAL STAFF
CT 8/3/95

MAJOR upgrading of outlying health care facilities in the Western Cape began in earnest with the announcement yesterday by regional health and welfare minister Mr Ebrahim Rasool of a R5,7-million plan involving local townships and Ceres Hospital.

He said R2,8m would be spent on health care clinics in Blue Downs and Delft, and on upgrading Khayelitsha Day Hospital Number Two. Another R900 000 would help turn Guguletu Day Hospital into a 24-hour facility, while at Ceres the local hospital's bed capacity would be increased, more staff posted and a trauma unit added at a cost of R2m.

Mr Rasool said he would soon release details about 15 projects of which the R5,7m spending formed the major part. Speaking at the launch of a joint traditional healer/cancer prevention project in Langa, Mr Rasool also said he may consider passing a regional law setting an age limit for buying cigarettes over the counter.

SA's health will measure success of development

(85) BD 16/3/95

LEN LERER and DEREK YACH

THE debate on the health implications of the reconstruction and development programme (RDP) has focused almost exclusively on components such as free health care for selected groups, nutrition, clinic building and AIDS control.

In addition, the controversy surrounding the proposed national health insurance scheme may lead us to equate health with service provision, rather than to adopt the more holistic approach, as proposed by the World Health Organisation, of the promotion of physical, mental and social wellbeing.

A narrow definition of health prevents us recognising that infrastructural development is a health intervention with the common goals of development and public health — the elimination of poverty-related problems and improvements in quality of life. Investment in infrastructure reduces health-related inequalities more effectively than the provision of health services, so long as such investment targets the poor and is sensitive to community health needs.

The importance of infrastructural development as a health issue was already recognised in the 1940s when the Gluckman commission reported that "unless there are drastic reforms in the sphere of nutrition, housing, health education and recreation, the mere provision of more doctoring will not bring health to the country".

Since the major determinants of health often lie outside the conventional definition of health care, public health sector input is required to assist in fine-tuning housing, water, sanitation and electricity provision.

Housing has been identified as a basic prerequisite for health. Poverty condemns communities to inferior and marginal housing. Appropriate housing promotes physical, emotional and social health, and the requisite infrastructure includes electrification, water and sanitation.

More than 25% of urban and 75% of rural households currently have only limited access to water. A plentiful and secure water supply is a basic requirement for health. Diseases related to inadequate water supply and waste disposal facilities are a major cause of morbidity and mortality. Water and sanitation provision have been indentified by the World Bank as one of the most effective health interventions.

Accelerated national electrification will have substantial health benefits, and will result in a reduction in respiratory disease, burns and childhood paraffin poisoning. A safe and efficient urban transportation system has direct benefits to health through a reduction in injury and violence coupled with easier access to health care.

Rural development, agriculture and public works have substantial health implications. The construction of large dams may be associated with increases in malaria and other vector-borne diseases. Occupational safety in the informal and agricultural sector have become health priorities. Promotion of tourism requires public health input in order to inform visitors of possible hazards and to protect local populations from sexually transmitted diseases.

The RDP approaches infrastructural development as the key to relieving the plight of the poor and underserved. It would be naive to envisage that attempts to alter the profile of poverty within communities will have only beneficial outcomes.

The omnipresent danger of violence, vested interests of factional and criminal elements and apartheid-based degradation of community cohesion make a sensitive and innovative development policy an imperative.

Improved health services should be regarded as infrastructural investments required to respond effectively to demand. While a broad range of non-health interventions may improve health status, it is access to health care that makes these interventions sustainable. A good health system promotes not only equal access to health services, but also equality in health status. Appropriate infrastructural development brings with it a reduction in the need for health services through the control of preventable disease and high-risk behaviour.

Experience from the less developed world is that the ultra-poor and uneducated benefit least from declining mortality and morbidity associated with infrastructrual development due to lack of equity and access.

If one accepts that development can have both positive and negative health effects, then it is important to develop methods of evaluation as an integral component of the RDP.

Essential national health research facilitates linkages between communities, development agencies and researchers. Input into public policy includes the promotion of appropriate and effective infrastructure and advocacy for poor and vulnerable groups.

A range of surveillance and rapid epidemiological methodologies are designed to measure the health impact of development interventions and quality of life outcomes.

With the growth of infrastructrual development (and possibly the RDP) into an autonomous ideology has come a reluctance to admit that the causes of poverty and consequent ill-health lie in the realm of the structural rather than the technical. It is through the broad measurement of health status that we can obtain unbiased information on the success or failure of infrastructural development.

☐ **Lerer is a consultant and Yach a group executive with the Medical Research Council's community health research group.**

SA's alternative medicine moves out of the shadows

By CAS St LEGER

ALTERNATIVE medical practitioners could soon be at a patient's bedside, working hand in hand with medical doctors.

The Medical Association of SA has arranged a workshop this month to thrash out how to incorporate alternate therapists into mainstream medicine.

If the outcome is successful, the SA Homeopathic Association may follow suit. These moves follow the recent scrapping by the SA Medical and Dental Council of a long-disputed ethical rule which prohibited registered medical doctors and dentists from having any dealings with chiropractors, homeopaths or others practising "alternate" medicine.

"The patient has the right to choose his treatment with the advice of the doctor," said Dr Eeddoo Barker, chairman of the medical association's scientific and education committee.

SA Medical and Dental Council assistant registrar Daan Naude said that while the demise of ethical rule 9 (2) still had to be gazetted, this was merely a formality.

Just tell Mama where it hurts!

(85) 8/4/95 ARG

Picture: HANNES THIART, Weekend Argus.

□ **HERB POWER:** Nyanga herbalist Magwanya Maliti, 42, mixes a tonic "care" for Welekazi Mangqasane, 52, of Philippi, who has cancer of the throat. Mrs Mangqasane is holding a herbal tea prescribed for cancer.

ADELE BALETA
Weekend Argus Reporter

PATIENTS from affluent Constantia and as far afield as Stutterheim in the Eastern Cape have trekked to a container in Nyanga in search of a cure or relief from their illness.

They have come to see herbalist Magwanya Maliti, who does not make appointments. When people arrive they take their place in the queue outside the shipping container alongside Cape Flats township residents.

In the business of healing people, Mama Maliti, as she is known, has an arrangement whereby she refers clients to Red Cross Children's Hospital and takes on patients sent to her by the hospital's staff, according to her assistant, Lennox Menqe.

Mama Maliti said: "I have treated many white people for a variety of conditions, including cancer and high blood pressure. They come back. I think more white people would come if I had a better place."

Her consulting room is lined with brightly coloured liquids, azure blue and pink powders in bank packets, boot polish, lucky beads, animal skins and skulls, roots and bark.

Pointing to a potent-looking translucent orange mixture, she warned: "That's for the *tokoloshi* — it's poisonous!"

A patient said the potion is occasionally poured on the floor and that if a dog sniffed or licked it, it would die immediately.

Mama Maliti's "pharmacy" spills on to the pavement, where there are boxes filled with Cape aloes, different types of bark, bulbs and dried grasses — each said to have healing powers.

How does a herbalist know what to prescribe?

"My ancestors tell me in my dreams. They guide me to the right herbs," she said. She took over the business from her father.

Mama Maliti claims to be able to treat a variety of medical complications, including asthma, bronchitis, stomach pains, headaches, high blood pressure, diabetes, elephantitis and cancer. She has not yet found a treatment for Aids, she said.

As a herbalist, she also functions as a therapist helping people with personal problems, stress, insomnia, nightmares and unrequited love.

Herbs collected in the areas formerly known as Transkei and Ciskei are pounded and grounded to make teas, snuff, lotions and ointments.

The juice of the Cape aloe is concentrated into a body wash, which is prescribed for former prisoners on their release. "It's a cleanser which helps them get rid of their bad past," Mama Maliti said.

"I have a patient from Constantia who has cancer in the foot. He was told that he would have to have it amputated. He came to me. I treated him and he still has his foot," she said.

A patient she attended to for cancer many years ago in Stutterheim still makes the long trip to be treated by Mama Maliti.

On the day Weekend Argus visited her "clinic" she was consulting Welekazi Mangqasane, 52, of Philippi, who said she has cancer of the throat.

"I have been coming here for 12 years and I am very happy. Mama Maliti has given me tea to drink three times a day. It makes me feel a lot better," she said, pointing to a bottled labelled "iCancer".

Her assistant, Mr Menqe, gave Weekend Argus a guided tour of the boxes of herbs, explaining their healing powers.

The herbs are mixed differently, according to the ailment.

Dry grass is mixed with other ingredients for good luck. A certain bark mixed with other herbs is used to cleanse blood.

The most sought-after treatment is a mixture called "Magaqani", for general body aches. It costs R20 for a 750ml bottle. "It's cheaper than going to a Western doctor," said Mr Menqe.

There are no set prices for the herbs and Mama Maliti charges what people can afford.

White clients usually offer to pay more.

Can churches contribute again?

Sper 21/4/95

AS South Africa struggles towards equity and accessibility in the provision of health care, the churches are once again being asked to contribute. But can they rebuild what ideology dismantled? Health Writer David Robbins looks at the background to the increasing dialogue between church leaders and the Ministry of Health

It is a truism that the European missionary preceded both the trader and the conquering soldier in many parts of Africa.

While historians may argue on the merits or otherwise of the impact of missions, one factor appears to be above doubt. The missionary contribution to the development of health care networks, especially in the bush, has been considerable.

It still is in most sub-Saharan countries.

For example, Zambia's Chikankata Hospital, an institution with an international reputation for innovative ways of coping with AIDS, is a mission hospital, run and financed by the Salvation Army.

The Christian Hospitals Association of Malawi runs most of that country's mission hospitals and delivers nearly 50% of all hospital services. The same is true of Lesotho, Swaziland and Kenya.

It used to be true of South Africa as well. By the early 1970s, missions were running 107 hospitals and an impressive 602 peripheral clinics which together provided 33 000 hospital beds. Today, these numbers have dwindled to virually nothing. What happened?

Enter the apartheid wizards, and that particularly pernicious box of tricks called separate development. In the eyes of officialdom, there were two problems with mission health services.

The first was that most missions were seen as liberal institutions delivering the sort of influence which was decidedly unwelcome in the old South Africa.

The second was that the health ministries of the newly created homeland governments must have something to administer. So the mission hospitals were expropriated — with disastrous results.

Director-General of National Health, Dr Coen Slabber, explains what happened.

"At first the hospitals were taken over by National Health, and only later passed over to the homeland administrations.

"It is true that some of the missions had financial problems, and also perhaps that a few of them were more interested in the souls than the more temporal health concerns of their patients. Nevertheless, I believe that the state takeover was a serious mistake."

Slabber outlines three areas in particular which ensured the rapid decline of the old mission hospitals:

- Maintenance collapsed under the red tape and bureaucracy imposed by the state.
- The supply of doctors dried up. During the late 1970s and much of the 1980s the vacuum was partially filled by young doctors fulfilling their military obligations, but this source has disappeared.
- As somewhat faceless state institutions, the hospitals lost the involvement (and sense of ownership) of communities, and often of powerful support from further afield. Stellenbosch University, for example, stopped sending its student doctors to South Africa's mission hospitals after the state took them over, preferring other African countries.

It is against this background that the current acute underprovision of rural health services needs to be viewed. Since the mid-1970s, the old mission hospitals have seen an often catastrophic decline, not least because the meagre homeland health budgets, and homeland inefficiencies,have been unable to sustain them.

"I would dearly like to give the hospitals back to the missions and churches under some form of state subsidy scheme," says Slabber, "but I think it's impossible now. They've lost the infrastructure to run them."

Last month, the Minister of Health, Dr Nkosazana Zuma, met South Africa's church leaders to talk about health.

"Our belief," explains Slabber, "is that there are many fields where our interests and those of the churches overlap. The purpose of the meeting was to ask for a partnership with the churches.

"The initiative is indicative of a change in how we see health: not only as the absense of sickness but in terms of a much more holistic well-being. We believe this to be very much the province of the churches as well."

A glance at the agenda reveals the common ground: alcohol and substance abuse, tobacco, stress management, nutrition and diet, healthy environment, AIDS, family planning, abortion.

But what of the underprovision of health services in areas previously served by the country's more than 100 mission hospitals?

"We've asked the churches for help," says Slabber. "And they've agreed to prepare some recommendations on how they might become involved.

"We're looking forward to examining and responding to these at our next meeting with the churches on May 29."

Eskom growth buoyant – good news for all SA

Sowr 13/4/95

■ BY JOHN SPIRA
BUSINESS EDITOR

Eskom's volume flow, probably the most reliable of all economic indicators, is buoyant, suggesting that heightened levels of growth are being achieved by the South African economy.

Allen Morgan, chief executive of the world's fifth-largest electricity utility, says Eskom's volumes for the first quarter of 1995 was 5,1% ahead of the same period last year, thanks to growing demand from industry and commerce.

And demand for electricity from new connections in industry is a massive 60% up on last year.

"It's a performance which should be viewed against the background of a depressed mining sector. The gold mining industry is one of our biggest customers. A decline in offtake by the gold mines has, however, been largely offset by increased demand from ferrometals and coal."

Nor, Morgan stresses, should it be assumed that some of the increase in demand was ascribable to Alusaf, since that company's huge expansion has yet to come on ting rising revenues because of

Allen Morgan, Eskom CE

stream. When fully operational, Alusaf will account for a meaningful proportion of Eskom's volumes.

Further: "What often happens is that we get higher volumes without necessarily get- the nature of the load. This year, however, we've experienced heartening growth in both volumes and revenues."

Accordingly, says Morgan, if he had to project GDP growth, he would certainly be looking at a minimum of 3%.

"Our barometer is that we tend to grow between 1,5 and 2% above GDP, implying that economic growth of 3% is distinctly possible. Indeed, I believe it has the potential to exceed that figure, because we haven't yet felt the impact of any RDP spending."

At the same time, Morgan warns that labour disruptions could upset such a prediction.

"Labour problems, should they continue, will impact negatively not only economic growth but also on confidence. Business won't want to expand production and increase employment if it adds to the burden of labour difficulties."

This fly in the ointment aside, Morgan is optimistic, especially since Eskom is coming off a high 1994 base.

"Last year we estimated growth of 0,3% and landed up with 2,2%. Coming off that high base, we were conservative in our growth estimates for 1995. Right now, it looks very much as though our estimates will again prove to be hugely conservative."

Morgan points out that every new house built under the RDP umbrella is electrified. Eskom's target for 1995 is to electrify 300 000 homes — a figure which includes existing houses not yet electrified.

"We're about 25% behind schedule, but that's not unusual for the beginning of the year, since in the first part of the year we establish infrastructures and only later catch up on connections and build up volumes. We're confident that we'll meet our target."

But isn't RDP spending on mass housing well beind schedule?

"Yes. In some areas the Department of Housing has done well, construction has started. In others, it's behind. Eskom's plans take cognisance of where the department is in its programme and we move in accordance with that. In all, it should be up to 100 000 houses by now. It's well behind, but it should eventually catch up.

Flexible

"In any event, when it does fall behind, Eskom is sufficiently flexible to be able to electrify existing homes and thereby meet our target."

Morgan doesn't see the lack of affordability hampering the mass housing initiative in the long term.

"We've noted a 60% increase in industrial connections. From that perspective we're seeing economic growth and, hopefully, the result will be higher levels of employment. That's going to create affordability."

Our health record looks sick

ST 30/4/95

By CAS St LEGER

SOUTH AFRICA spends more than R30-billion on health care — but its people are far less healthy than in comparable countries.

A study backed by the World Bank has found that the country's spending on health equals 8,5 percent of all the money spent on goods and services (gross domestic product), an average of R740 a person.

But there is a wide gulf between what is spent in the private sector (for less than a quarter of the population) and in the public sector.

The private sector takes up two-thirds of all spending on health while the poor, who rely on public facilities, receive vastly inferior care.

The report estimates that another R1,5-billion to R2,5-billion a year will have to be spent in the public sector before basic care can be provided for everyone.

"There is little doubt that South Africa spends a very high percentage of its GDP on health care — and that the returns are not as good as they could be," said the report on a two-year study conducted by Health Systems Trust with the World Bank's technical support.

The report notes, for example, that more babies die in South Africa before they reach the age of one than in Botswana, with comparative income levels. The infant mortality rate in South Africa is seven times greater among blacks than whites.

Life expectancy in South Africa is 63 years. In Botswana, it is 68. Lifespans are about 10 years shorter for South African blacks than for whites.

Resources were substantial, but there were "gross inequalities" in their distribution — between the public and private sectors, between levels of care, and between geographic areas.

Two years ago the government spent 3,5 times more on people in the Western Cape than in the Eastern Transvaal. The Western Cape has nearly 31 doctors and 24 specialists for every 100 000 people. In the Eastern Transvaal, there are only seven doctors and a specialist for every 200 000. A picture of poverty emerges from the report. Almost 24-million South Africans have incomes of less than R301 a month. Rural areas have 47,2 percent of the population but 68 percent of the poor.

Other findings are:

- Medical schemes spent 15 times more per patient than the government spends on a person using public health facilities in the poorest districts;
- Apart from nurses, there are more health professionals in the private than the public sector;
- Only 17 percent of the population belongs to medical schemes; and
- Hospitals absorb 81 percent of the health budget. Almost half of all public health spending occurred in tertiary hospitals like Addington, Groote Schuur, Frere, Universitas and H F Verwoerd.

The report shows that the cost of private health care is spiralling. A decade ago, medical aid contributions were 7,1 percent of salaries. Ten years later, this figure has shot up to 15,2 percent.

As much as R1-billion is needed to build 1 000 new clinics. Training for district-based primary health care would also incur a large bill.

Neglected provinces need more community hospitals and specialist services for existing hospitals.

The report offers several solutions to the problem of funding. These are:

- Downgrading specialist hospitals, reducing their primary care workload, closing wards or leasing them to the private sector;
- Improving hospital efficiency and primary care management;
- Increasing the number of private patients and the fees they pay in specialist hospitals;
- Increasing government funding, introducing an employees' health care tax, reducing private sector funding, and limiting the money contributed to medical aids for government employees; and
- Increasing support from international donors.

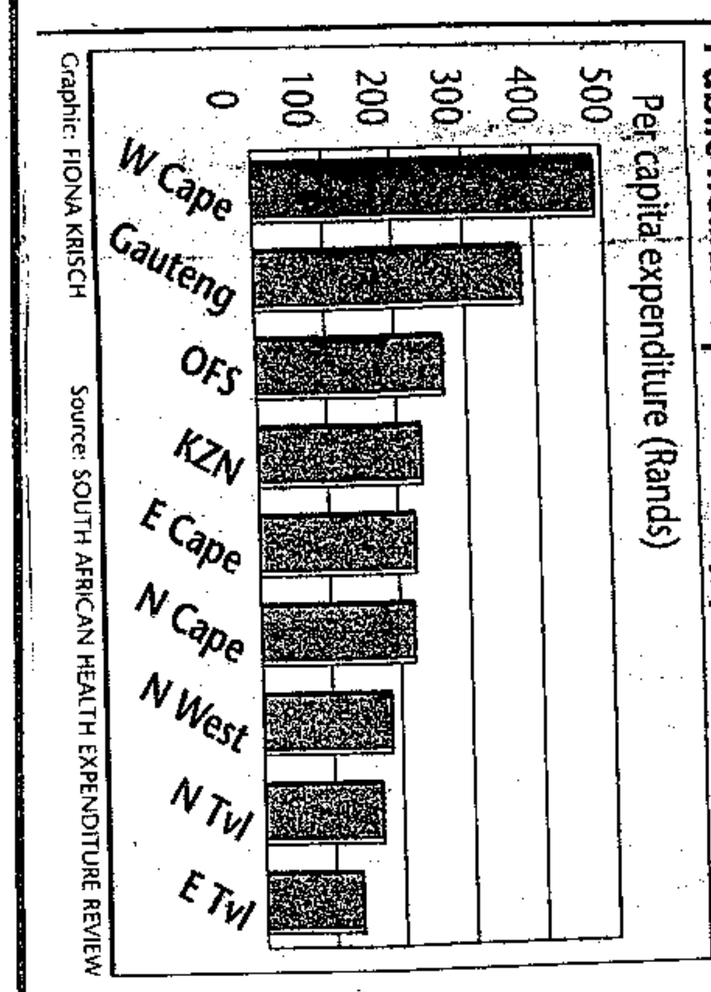
The authors of the report — who include representatives from the ANC, the Department of Health, the European Union, the World Bank and others — say the entire health system without achieving the aim of better health care for all," the report says.

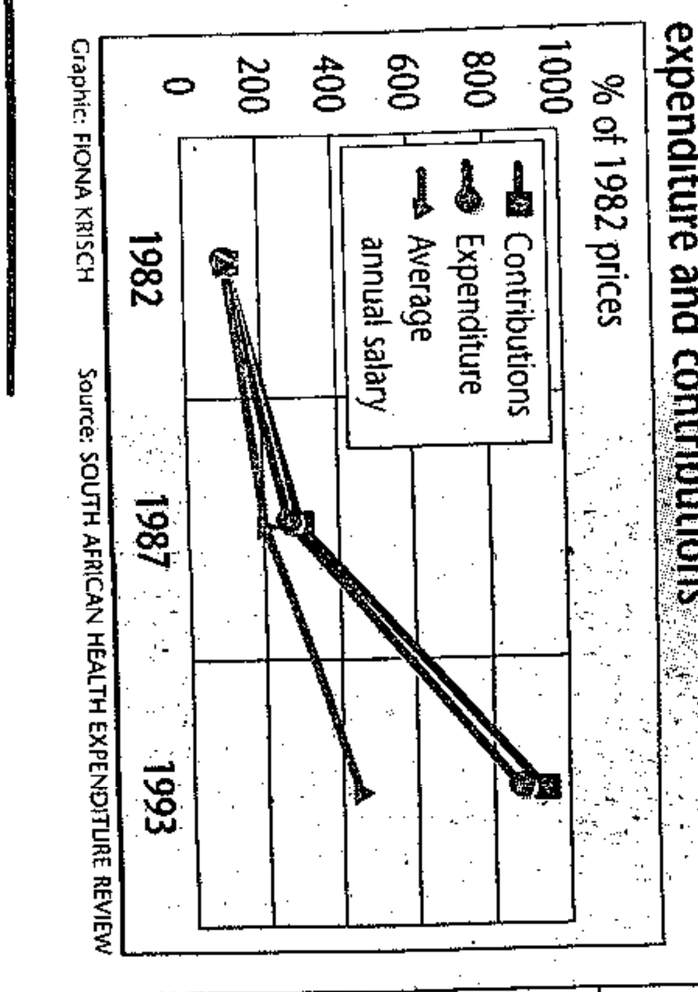
The report cautions that moving resources to neglected areas will be costly and cannot happen overnight.

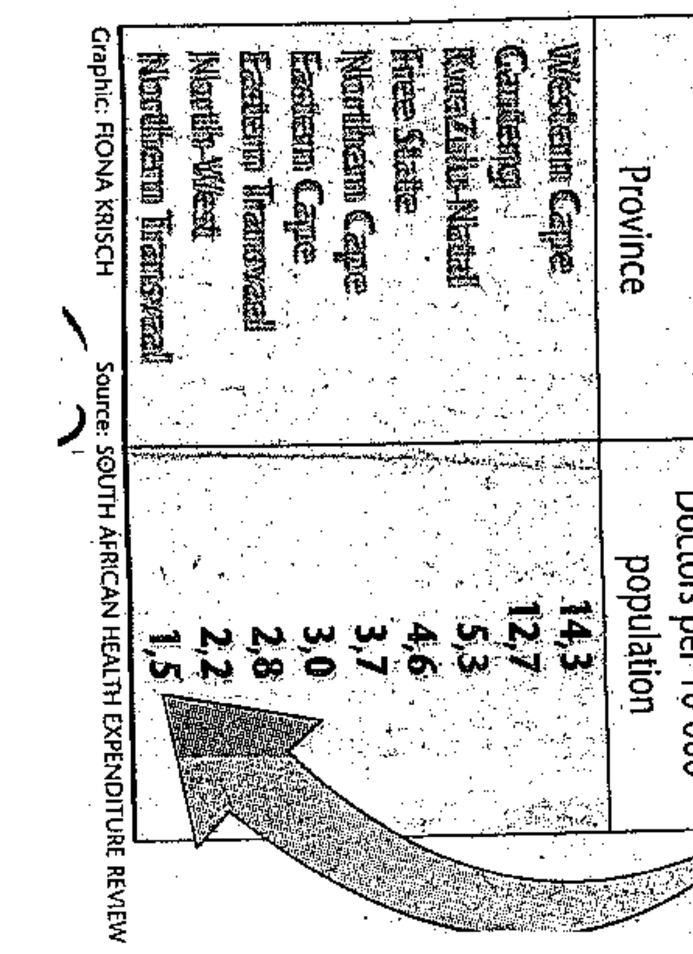
We spend the most ...		but more of our children die ...		more of us are ill ...		and we live shorter lives	
Health spending (% of GDP)		Infant mortality (per 1000)		Incidence of TB (per 100 000)		Life expectancy (years)	
South Africa	**8,5**	Malaysia	15			Chile	72
Hungary	6,0	Hungary	16	Hungary	38	Malaysia	71
Chile	4,7	Chile	17	Venezuela	44	Hungary	70
Venezuela	3,6	Venezuela	34	Chile	67	Venezuela	70
Botswana	3,3	Botswana	36	Malaysia	67	Botswana	68
Malaysia	3,0	**South Africa**	**49**	**South Africa**	**250**	**South Africa**	**63**

Graphic: FIONA KRISCH

Source: SOUTH AFRICAN HEALTH EXPENDITURE REVIEW







Gender discrimination 'must be addressed now'

Susan Russell

BD 30/5/95

MEMBERS of the attorney's profession have criticised government for dragging its heels over the establishment of the gender equality commission provided for in the interim constitution.

An editorial in the June issue of the SA attorney's journal De Rebus said the tardiness in setting up the commission was particularly striking when compared with the progress which had been made in regard to "other building blocks of our new society" which were also provided for in the new constitution.

If affirmative action was necessary to help undo the results of racial discrimination, it said, then it was at least as equally necessary in the case of gender discrimination. "Something more than the bare declaration of equality and prohibition of discrimination contained in section eight of the interim constitution is required," it said.

The editorial said although the drafters of the constitution had made provision for a separate commission on gender equality, there had apparently been little progress made towards setting it up.

"It was only as late as last month that the ad hoc parliamentary committee on the establishment of the commission was due to begin public hearings on the shape it should take.

"Sections 119 and 120 of the constitution envisage an Act of Parliament to govern the commission, but no draft legislation has been published for discussion, although it was reported in the Press that an unpublished draft Bill had been rejected.

"There is a long legacy of gross discrimination which must be overcome if women, who constitute some 54% of the population, are to take their rightful place in the new order," De Rebus said.

Future health in SA 'will depend on outside factors'

(85) BD 30/5/95

Kathryn Strachan

MANY factors influencing the long term health of South Africans were undergoing profound transition, Medical Research Council community health director Derek Yach said.

Progress in improved health for all would depend on macrodevelopment policies outside the health service.

The first of the factors was educational transition which increased people's knowledge and made them more qualified to demand services.

Technological changes in biotechnology, information science and telecommunications would influence the ability to prevent, diagnose and treat disease.

The dissemination of rational explanations and technology had raised expectations of a better quality of life and willingness to accept modern medical treatment.

Political change had led to the recognition of health care as a right, resulting in it being embodied in the Constitution.

Transforming the economy would lay the foundations for household income growth which would accelerate changes in lifestyles that influenced health and would boost medical care demand. "It is this family of transitions that will determine long-term trends in health," Yach said.

Collating these factors it was possible to predict likely demographic trends, the prevalence of disease and disease profiles that together made up the epidemiological transition.

Changes in the age and the spatial distribution from 1991 to 2001 would have a marked effect on demand for health services, he said.

The key issue to emerge was that urbanisation would increase from 47% of the total population in 1980 to 79% by 2000.

The ageing of SA's population would have a direct effect on the need for disease services and hospitals. Ageing would also have a different effect in each province, with the biggest proportion of the elderly living in Gauteng and the smallest in the Northern Transvaal by 2011.

AIDS will also determine demographic trends. A study of the 15 African countries with the highest HIV prevalence showed the overall death rate was 100% higher in 35 to 44-year-olds as a result of AIDS. As SA was about five to eight years behind, the maximum effect of the SA epidemic was likely to be felt between 2010 and 2020.

The distribution of deaths by age in 1990 gave an indication of the future. The cause of death by age profile of Africans and coloureds was likely to approach that of whites and Asians over the next 30 years.

Almost a fifth of deaths among coloureds and Africans occured under the age of five years. It was likely government priorities could rapidly reduce child mortality within the next decade. The electrification programme alone was likely to reduce deaths from acute respiratory infections, pneumonia and paraffin poisoning.

Thus, the policy implications were clear. Continued emphasis on reducing childhood communicable and nutritional diseases should remain the cornerstone of health policy and action at least for the next decade. Greater attention on TB control, HIV and sexually transmitted disease programmes, combined with violence control, would yield gains for adult health, and reduce social class and race inequalities in adult mortality and disease.

Poor sanitation kills

CT 30/5/95

JOHANNESBURG: About 300 000 children die in SA yearly from diseases caused by poor sanitation, Mr L Abrams, adviser to Water Affairs and Forestry minister Prof Kader Asmal, says — Sapa

Star 29/5/95

Focus on ill women and poverty link

(85) (~~55~~)

International Women's Health Day yesterday focused on how poverty contributed towards the ill health of women.

Local health organisations joined the international campaign to highlight how poverty increased maternal mortality and morbidity.

More than 70% of women in Africa are illiterate and live below the poverty line, said the coordinators, The Women's Global Network for Reproductive Rights.

The average maternal mortality rate is around 600 per 100 000, double the average of women in the northern hemisphere.

Women in Africa also face problems such as the HIV/AIDS epidemic, the effects of war, and the increase of domestic violence, which are all aggravated by poverty.

The campaign said women wanted to share family responsibilities, have equal opportunities and equal participation in society, and accessible health services of good quality.

Sacob takes scarce resources into account in health plan

85

BD 3/3/95

KATHRYN STRACHAN

SACOB has released proposals for financing a new health care structure based on the principle the system should fit available funds..

In its submission yesterday to the committee of inquiry into the national health insurance system, Sacob said demand for health care services always exceeded available resources.

It was vital to develop a national policy for both the public and the private sectors on the rationing of scarce resources. The extent to which this rationing of resources was relaxed was dependent on SA's economic growth.

Although a single-tier system with universal cover was the vision to be aimed for, Sacob did not believe it was achievable in the short to medium term, and a two-tier system would remain during the interim period.

Sacob recommended as a first step in creating a future national health system, consideration should be given to the establishment of a social health insurance scheme to cover all those in formal employment. Under this system there should be compulsory membership for all employees and their dependents. Accredited medical schemes and administrators should be used in both sectors.

Sacob believed such an approach would extend cover from about 20% of the population to about 40%-45%, relieving pressure on public sector health care expenditure.

By relieving the public sector of the burden of providing for employed people, their dependents and possibly retired people, it would create capacity within the current health budget for creative restructuring.

The public sector could also boost its income by charging full fees to private patients. Various revenue collection methods for the social health insurance needed to be investigated. These included general taxation, dedicated tax for social health insurance and user fees.

Financial concessions would need to be granted to those industries which already provided services at the workplace.

The way in which the social health insurance services were paid for required investigation. The fee-for-service system was one of the core areas which had resulted in the high medical inflation in the private sector.

However, the capitation system — where doctors were allocated a set payment from medical aids depending on their number of patients — required significant controls and information which did not exist.

Medics reject health tax plan

ST 5/3/95

85

By CAS St LEGER

THE Medical Association of SA and the Chamber of Mines this week criticised suggestions that a further tax be levied on salaries and wages to pay for a national health cover scheme.

The two bodies are among 150 groups making submissions to the ministerial committee investigating the setting up of a countrywide health insurance plan.

The Committee of Inquiry into a National Health Insurance System started receiving oral and written submissions in Pretoria on Monday. It will report to Health Minister Dr Nkosazana Zuma after March 17.

The association and the chamber said government spending on health — about 8,5 percent of gross domestic product — was already too high.

The medical council's federal council chairman, Dr Bernard Mandell, told the committee that health care should continue to be funded through general tax revenues and private health insurance.

Dr Izak Fourie, medical adviser to the Chamber of Mines, told the committee it was "nonsense" to have dedicated taxation for health care.

He said reform could take place under the existing tax system. What's more, any further increase in government spending would divert scarce resources from other critical areas of need.

Dr Zuma is in the middle of a "roadshow" to all the provinces to gauge public and medical opinion on a health cover scheme.

Her spokesman, Vincent Hlongwane, said she had received overwhelming support. "The only concern people expressed was how it was going to be financed," he said.

Major consequences possible for teaching hospitals

(85 STAR 6/3/95

Radical recommendations could transform health care

■ **BY DAVID ROBBINS**
HEALTH WRITER

Radical new recommendations could soon transform health care in South Africa, but some of these could prove to be highly controversial.

If implemented, the recommendations will have major consequences for academic hospitals, the price of medicines, the role of dispensing doctors, the obligations of doctors entering private practice, and the way in which health care is financed and administered.

The purpose of the plan is to guide the country towards a more cost-effective and equitable delivery system.

PURPOSE of plan is to guide the country towards more cost-effective and equitable delivery

But those who could look sceptically at some of the proposals include academic hospitals, pharmaceutical wholesalers, dispensing doctors and young health-care graduates (eg doctors, dentists, therapists, opticians and nurses) wishing to enter private practice.

On assuming responsibility after the election last year, Health Minister Dr Nkosazana Zuma established nine specialist committees to examine various aspects of health care and then to report back with specific recommendations.

The committees looked at drugs policy; information systems; legislation affecting health; finance; human resources; academic hospitals; nutrition; the specific health needs of women and children; and oral health.

They have now made their recommendations, and the Minister is examining a consolidated document which has not yet been released.

Some of the important changes envisaged are:

■ A reduction in size and an increase in geographic responsibilities for tertiary (academic) hospitals.

■ Modifications to the free health policy for nursing mothers and children under six to ensure that patients enter the health-care system at the appropriate level.

■ The possible introduction of obligatory service in underserved areas for health professionals.

■ Stricter control of drugs prices, and special curbs on the mark-up of pharmaceutical wholesalers and the activities of dispensing doctors.

The consolidated document containing these and other recommendations will form the basis of wide-ranging public debate and be placed on the table at a National Health Summit to be held in June.

▶ Looking for that healthy balance – Page 11

Private sector alliance may prove to be a boon for all

■ **BY DAVID ROBBINS**

A powerful new private sector alliance has been established to assist the Ministry of Health as it attempts to provide accessible and equitable health care for all South Africans.

Andrew Witty, chief executive of Glaxo SA, which is one of the members of the new alliance, said: "The private sector must prove its worth.

"The rationale behind the formation of the alliance is that we want to be a part of the process of change."

The alliance — known as the South African Health Care Initiative (SAHCI) — was formed last month, and brings together pharmaceutical giants Glaxo, Roche, Adcock Ingram, Logos, South African Druggists, and the pharmacy benefit management company TPS Mutual Trust.

Initial discussions have already been held between the alliance and Minister of Health Dr Nkosazana Zuma. Further talks are planned for later this month.

"Part of our message has been: don't condemn the private sector because of any characteristics from the past. We have expressed our willingness to work with the Government, and to ensure the private sector becomes an attractive and realistic option to the State," Witty said.

Areas in which SAHCI plans to make a contribution include:

■ An analysis of the role played by the private sector in health provision, especially to employees and their dependents in the private sector. "If all employers were persuaded — or forced — to provide this, it could increase the population covered by health care by at least 10 million and lessen the load placed on the State," Witty said.

■ A contribution to the need for reliable health statistics, by making available to the State the private sector's information technology expertise.

■ Reassessment of the role of the private sector in areas previously neglected by the government and private sector.

■ Special consideration to be given to medicine pricing and to minimising theft and fraud.

"Our intention is to change the private sector to fit with the new realities in SA," said Witty. "And in this regard, our relationship with the Ministry of Health is gathering momentum."

Having a new plan to cope with South Africa's long-standing health crisis is one thing. Implementing it is quite another. But the Ministry of Health committees seem to be developing a workable blueprint, reports Health Writer ***David Robbins***

Looking for that healthy balance

(85) Star 6/3/95

To anyone who has paid a passing interest to this country's continuing health debate, the issues clear enough.

n urban, hospital-based ative system, while offering d care to a few, has proved elessly inadequate to cope the needs of the majority of ith Africans. And those bla- tly discriminatory elements n the old apartheid days, and end up with a situation ch cannot be allowed to con- ue.

fence the need for a new n. At first it was called the C's national health plan; now official government policy. In utshell, 'this policy is about ity of access to health care, h no discrimination based on e or gender or geographical sition. Obviously, equity ans a redistribution of avail- e money and resources — n the centre to the periphery from the haves to the have- s.

The plan, with its emphasis on cost-effective primary health care and its holistic approach to improved health status, is undoubtedly a good one. But what about implementation? How can the huge machinery of state health, and the equally complex private sector, be turned in this new direction?

Already, there have been encouraging signs from the Ministry of Health.

The introduction of free health for mothers and children under six (not covered by medical aid) was clearly an attempt to improve access to an important segment of have-nots, even though the move resulted in undesirable consequences at many hospitals.

The Minister of Health, Dr Nkosazana Zuma, has also persuaded the nation's seven tertiary hospitals to accept a collective 5 percent cut in expenditure, the savings thus effected to be used in the development of more clinics at the periphery.

So far so good. But much more is needed. Enter the nine committees set up by Zuma last year. Their recommendations, when pieced together, begin to resemble a blueprint for the implementation of the original plan.

At the foundation of the blueprint must lie some hard financial realities. For a variety of reasons the health budget is unlikely to increase later this month. A national health insurance scheme could raise extra cash but, even if it does, the emphasis will clearly be focused upon reallocation within the existing budget, cost containment and the need for greater efficiency.

Coupled with the need to spread resources more evenly across the regions, these financial considerations dominate the committees' recommendations.

Take the recommendations relating to tertiary hospital complexes, for example. These complexes "should be significantly reduced in size to mobilise a proportion of funding away from curative and tertiary health care to primary health care".

At the same time, the complexes will be expected to continue as specialist institutions integrated into the health care system as a whole.

To facilitate this, and also to spread expertise more evenly to under-served areas, an important recommendation talks of "catchment areas" and "satellite campuses", with the tertiary facility in Bloemfontein serving the Northern Cape through a satellite campus in Kimberley and Pretoria becoming involved in the Eastern Transvaal.

Some of the recommendations may prove to be controversial. That's to be expected. And in the light of this, it's good news indeed that the Department of National Health is encouraging a high level of public participation before the recommendations are put into practice.

Some of the important recommendations are:

- Tertiary academic complexes to become smaller, but with catchment areas and satellite campuses providing accessible tertiary cover for previously under-served areas (as outlined in the main story).
- A directorate of maternal, child and women's health to be established to co-ordinate relevant action, including free health care for pregnant women and children under six, immunisation, health education, reproductive health services, measures against HIV/AIDS and sexually transmitted diseases, and protection against abuse and violence.
- Public hospitals to retain a percentage of revenues as an incentive to promote quality and efficiency.
- Free health services for pregnant women and children under six to be modified. Services would be free only at clinic level during normal working hours, except in emergencies or unless referred to a hospital from a clinic. The purpose of this recommendation is clearly to alleviate the congestion which has been caused at some hospitals as a result of this policy.
- Equitable allocation of financial resources within five years. Although this will create problems for well-resourced metropolitan areas (like Gauteng and the Western Cape), the recommendations suggest "increased efficiency" as a way of offsetting the inevitable budgetary reductions.
- The maldistribution of health personnel should be corrected by financial and service incentives to health professionals to work in under-served areas, and by the possible introduction of compulsory rural or public sector service for doctors wishing to enter private practice, as well as for senior academic staff. A buy-out charge of R400 000 for doctors and R50 000 for other health professionals has been mooted.
- The nation's 140 000 professional nurses need to be used more effectively, and to this end should be trained in the relevant skills, including diagnostics.
- A participative and democratic style of management to be engendered, and a "culture of caring" encouraged throughout the health services.
- A radical overhaul of the pharmaceutical industry to ensure an adequate supply of effective and affordable drugs to all. Recommendations include "openness" in pricing by the pharmaceutical manufacturers; price controls; the use of generics where possible; wholesalers' mark-up to be removed and replaced with professional fees and reimbursements for costs of acquisition and storage.
- Parallel importation (the import of the same drugs at lower prices than available locally) has specifically not been recommended because of the probable damage which could be inflicted on South Africa's local and multinational pharmaceutical industry.
- South Africa's so-called dispensing doctors to be prohibited from selling medicines where a pharmacy exists within a reasonable distance.

NEWS

Doctors slam committee suggestions

(85) Star 7/3/95

Blow to health plans

■ **BY DAVID ROBBINS**
HEALTH WRITER

Dispensing doctors should be allowed to continue to provide their "invaluable service", and graduating health professionals should not be compelled to do community service before entering private practice.

These are the main reactions to recommendations emanating from the nine Health Ministry committees set up to examine health care.

The national secretary of the Society of Dispensing and Family Doctors has slammed a recommendation that dispensing doctors be prohibited from selling medicines where a pharmacy exists within a reasonable distance.

"To talk about cost-effective health care with one breath and referring patients to pharmacies in the next is a contradiction in terms," Dr Tayob Habib told The Star yesterday.

"When it is realised that most pharmacies operate in town, and that dispensing doctors generally provide medicines within the price of a consultation, there can be little question that the service provided by the profession is invaluable."

Habib conceded that some dispensing doctors bought more drugs than they needed, often allowing the excess to recirculate in the marketplace in an inflationary process known as round-tripping.

"Doctors who practise round-tripping should be brought to book. But it is only a small minority who are tarnishing the good name of the dispensing doctor in this way."

A committee suggestion that graduating doctors be compelled into community service before entering private practice has been rejected by the Medical Association of South Africa.

Federal council chairman Dr Bernard Mandell said community service should be only on a voluntary basis, supported by incentives.

The Junior Doctors' Association of SA supported this stance, adding that senior doctors should be included in any system of voluntary community service "to fulfil a supervisory role".

The committee recommendations will form the basis of public debate culminating in a national health summit this year.

'NO' TO NEW TAX FOR HEALTH INSURANCE

Employed can't pay for national health

(85)

CT 10/3/95

Sacob proposes alternative health scheme limited to the formally employed. **CLAIRE BISSEKER** reports.

SOUTH AFRICA's tax burden is already too high and the South African Chamber of Business (Sacob) will not support the introduction of a new tax to fund a National Health Insurance (NHI) scheme for South Africa.

Sacob's view was presented to the Department of Health's technical committee which has until April to draft an NHI scheme to provide the entire population with a basic level of health care.

Sacob, which represents 40 000 businesses employing about two million people, argued that an NHI scheme should initially be limited to the formally employed.

"Sacob believes that such an approach, which could be implemented quite quickly, would extend cover from about 20% to 40-45% of the population, thus relieving pressure on public health care expenditure."

Such a limited scheme would provide benefits only to contributors and so could justify being funded by a new specific tax, Sacob said.

However, they opposed the creation of an additional tax to fund a comprehensive NHI scheme where the employed would be subsidising non-contributors, namely the unemployed.

Although this was the system in several overseas countries, "the situation in South Africa is quite different due to our massive unemployment problem", they said.

They argued that the creation of an NHI scheme aimed primarily at the unemployed, was in fact just a social welfare scheme and should be funded out of general taxation.

They suggested the central fund could be topped up by tobacco and alcohol taxes and regional and local authorities could also raise funds.

Multi-million rand health network planned

By GARY COLLINS

PLANS to build a comprehensive, multi-million rand network of community health centres throughout the Western Cape to relieve the burden on academic hospitals have been announced by Western Cape Health Minister Ebrahim Rasool.

Speaking in Kleinvlei yesterday, Mr Rasool said the first phase of the project, due to begin early next year, was intended to extend primary health care on the Cape Flats.

"This will relieve the burden on Groote Schuur, Tygerberg and the Red Cross Children's Hospital," he said.

"It is impossible to lessen the burden on academic hospitals without first building services in the districts which will serve as an alternative to these hospitals."

Further community health centres were planned throughout the Western Cape at a later stage, Mr Rasool said.

The new health centres would provide comprehensive primary level health services with a 24-hour casualty section, emergency and obstetrics facilities, and a full-time medical staff.

Mr Rasool said Kleinvlei and Delft would be the first areas to receive community health centres.

"Funding for these projects will come from the Provincial Health Facilities Capital Budget."

The provincial health plan had identified 24 districts in the Western Cape for the construction of community health centres. They would each serve approximately 310 000 people.

Mr Rasool said "plans and proposals" had also been mooted to extend specialist health services to the Cape Flats' areas of Blue Downs, Delft and Khayelitsha.

"Provision is made for such a facility in the draft Provincial Health Plan.

"Funds will have to be made available by scaling down other hospital facilities in the province and staff will have to be drawn from other hospitals."

If approved, a "three to five year time frame" had been set down for establishing this facility, Mr Rasool said.

Clinic to combat dangers of foreign trayel

TRAVELLING to exotic destinations has become a less risky affair with the opening of the SA Institute for Medical Research's travel clinic in Johannesburg.

Clinic head Simmy Waner said the clinic would advise travellers how to protect themselves from the health risks in areas they intended to visit. It also gave them vaccinations and advice on prevention and treatment of illnesses such as diarrhoea. Insect repellants and water purification tablets would also be provided.

BD 15/3/95

KATHRYN STRACHAN

While travellers could get vaccinations from their GPs — except for yellow fever which was available only from district surgeons — local doctors did not have up-to-date knowledge of health risks in other countries, Waner said. The clinic would research health risks in foreign countries and the most up-to-date preventions.

Instead of giving a blanket vaccination to a traveller going to a particular country, the clinic would also be able to research and advise according to the specific area which was being visited.

With foreign tourists flocking to SA, the research would also focus on local health risks, especially the geographical spread of malaria and effective prophylactics.

Waner said local doctors did not take malaria seriously enough, and many were under the misconception that unless a patient was desperately ill with a very high temperature, they could not have malaria.

Health budget to favour poor regions

(85)

BD 15/3/95

CAPE TOWN — Details on the health budget that would include significant cuts for the richer provinces were released by Health Minister Nkosazana Zuma yesterday.

The Western Cape, the Free State and Gauteng would receive significantly less in today's Budget than they had in the past, the Minister told a briefing of the select committee on health, welfare and population development.

The provinces now including the former homelands would receive the largest increases, with the Northern Transavaal, which contained three former homelands, receiving the largest and the Eastern Transvaal the second largest increase.

The remainder would receive increases proportional to their population. The budget was devised to a formula agreed on by the nine provincial health ministers, in which population size was the main criteria.

Those regions with the highest per capita incomes would receive proportionately less than regions with lower per capita incomes, Zuma said.

"We devised a budget for the provinces that was more equitable. The previous budget was not equitable at all."

The Western Cape, the Free State and Gauteng budgets were to be cut to what was considered critical levels, below which they would no longer be able to provide the same quality of services.

Proposed budget cuts were initially given to the ministers for the three provinces who took the proposals back to the provincial health planners.

The planners identified what they thought the critical points were and bridging finance of R503m over and above the budget was made available.

The Western Cape would receive R170m bridging finance, the Free State R32m and Gauteng R300m.

Finance for the presidential programme for children under six and pregnant women would be increased from R440m to R680m.

The provinces would be responsible for the equitable distribution of budgets. The Western Cape had already produced a "reasonable plan" for this. The other provinces had yet to do so.

External funding of R88m had been received from the European Union for AIDS programmes, the development of health districts, and strategic planning within the Health Ministry. — Sapa.

'Drastic steps' to balance books

CT 16/3/95

BY CHRIS BATEMAN

STAFF reductions in the Western Cape's Health and Education departments were among the "drastic steps" that may be necessary to balance the provincial books, local Finance Minister Mr Kobus Meiring warned yesterday.

Reacting to the R7 509,6 million Western Cape allocation — R491m short of what was expected — Mr Meiring said despite recent increases in budgets for education and health, it was clear the province would experience problems in balancing the books of these two portfolios.

He said the government was determined to exercise strong fiscal discipline and to remain within the R153,3 billion total expenditure level — and the Western Cape supported it in this.

Deputy director-general of the Western Cape, Dr Johan Stegman, said he had been expecting R8 billion to ease the local health and education crisis.

"Now we'll have to sit down and analyse all our expenditure patterns, especially with education and health," he said.

WARNING: Mr Kobus Meiring.

Health slice stays stable

■ BY DAVID ROBBINS
HEALTH WRITER

(85)

The R15,4-billion budget allocated to health represents an increase of only 10% in spending, which is roughly the same as last year's slice of the fiscal cake.

One health economist has pointed out that this represents a slight cut in the actual amount available for the operation of existing health services.

Nevertheless, Minister of Health Dr Nkosazana Zuma said she considered it "a better package than last year, with increases being granted for very specific items", listing the school feeding scheme as an important item which had received an earmarked amount.

The minister also welcomed the increased allocation to education.

Star 16/3/95

Health budget redirected

(85)
Sowetan 16/3/95

By Glenn McKenzie

YESTERDAY'S Budget will allow 54 new clinics to be opened in the Northern Transvaal this year. But for Gauteng, the Budget means cutbacks and possible hospital closures.

As expected, the Ministry of Health was given only slightly more than it received last year — R15,4 billion compared to R14 billion in 1994.

Money flow changing

More significantly, the money flow is changing direction. Traditionally underfunded health services in the Northern Transvaal and Eastern Cape will receive more than they have in the past. Gauteng and the Western Cape will receive less.

Northern Transvaal department of health spokesman Mr Tsepho Moshimo said the Budget was good news for people in his province.

The health ministry will receive about R1,44 billion, 23 percent more than in 1994.

The extra money will allow the province to build 10 new clinics in areas such as Sekhukhune and Bochum. Another 44 clinics that currently stand empty can now be staffed and equipped.

"We are one of the lucky provinces. But it was necessary when one looks at what you already have in Johannesburg and Cape Town. Here we have nothing," said Moshimo.

Meanwhile, Gauteng strategic management team for health chairman Dr Ralph Mgijima said the new Budget could mean that funds to some community hospitals in the province will be cut.

"It's a depressing situation. It's going to put serious constraints on our services," said Mgijima.

From yesterday's Budget, Gauteng will receive about R3,1 compared to R2,9 billion in 1994.

After inflation and new expenses are taken into account, this represents a "significant cut" for the province's health services, said Mgijima.

He stressed that traditionally underprivileged hospitals would receive "no cuts or the lowest cuts possible".

Yesterday, National Progressive Primary Health Care Network director Mr Irwin Friedman praised the Government for giving more funding to underprivileged regions.

"The Government has been very responsible in starting to equalise health spending between the provinces," said Friedman.

Health in provincial hands

(85) ARG 16/3/95

Political Correspondent

THE national health budget drops by 27 percent because of the transfer of some powers to provinces.

About 96 percent of the health budget will be spent at provincial level.

Health services spending overall goes up from 10,5 percent to 11 percent of total spending.

The total amount for health is R15,4 billion, including RDP funds carried from last year.

An amount of R400 million from this year's RDP funds has been earmarked for transfer to the health departments of the Western Cape, Free State and Gauteng for the transformation of services from tertiary to primary health care.

Some primary health care programmes will be co-ordinated at national level.

These include combating Aids, an immunisation campaign against hepatitis B, a central budget for tuberculosis control and a national programme against malaria and similar diseases.

(85)

Union 'war' brews

ET 17/3/95

PRETORIA: A "bloody war" could erupt today between members of the South African Health and Public Service Workers' Union and those of the rival National Education, Health and Allied Workers' Union, Sahpswu said last night.

General secretary Mr Silas Baloyi said Nehawu members had earlier "physically removed" three white and three black Sahpswu members from Garankuwa Hospital near Pretoria. – Sapa

No model selected yet for health insurance

(85)

KATHRYN STRACHAN

The committee of inquiry into a national health insurance system was making good progress but no model had been decided on yet, committee co-chairman Jonathan Broomberg said last week. BD 20/3/95

Although certain principles had been set, it was still too early to say what the outcome of the inquiry would be.

While the committee had heard submissions in all provinces from a range of organisations, committee members had also been involved in intensive research into the cost and the feasibility of the different funding mechanisms.

SA population demographics and patterns of disease, including risk profiles, and the purchasing and distribution of medicines were also looked into.

NEWS Strict control measures are needed to stop clinics staff from stea

Crime mars health services

Sowetan 23/3/95 (85)

By Glenn McKenzie

■ PANIC STRICKEN Doctors and nurses fear for their lives at work:

HEALTH clinics in Soweto were struggling to provide services amid a "disturbing wave of crime", a spokesman for the clinics said yesterday.

Reacting to reports of missing and stolen medicine at the township's clinics, Soweto clinics superintendent Dr Samoojee Natha said theft and violent crime threatened services at Soweto's 13 community clinics.

Natha called on health workers and members of the community to "report criminals who are disrupting our services".

On Monday police seized 17 boxes of medicine, syringes and other medical supplies from a house in Zondi, Soweto.

The medicine seized included boxes of needles marked for Zola and Tshiawelo clinics and antibiotic tablets that had been pre-packed at Baragwanath Hospital.

Last week hundreds of patients were turned away from Tshiawelo Clinic amid a mystery medicine shortage. Nurses at the clinic expressed fears that children with streptococcal throat infections were in danger of contracting more serious diseases.

Natha said she was investigating the possibility that drugs were disappearing from Soweto's clinics on a large scale.

"We know we have a problem with drugs. And we are doing something about it. But in the end we need more staff," said Natha.

Better control measures were required to eliminate temptation among staff to steal medicine.

Yesterday, Gauteng MEC for health Mr Amos Masondo told *Sapa* that his department would spend R60 million to educate health workers and increase security measures in the province's health institutions.

Masondo also called on all health workers and community members to report thieves.

"We are working on educating staff and members of the community to report culprits. We are looking for a general commitment from staff so they feel the institutions belong to them and they have the responsibility of looking after the facilities," Masondo said.

Meanwhile, clinics superintendent Natha said violent crime had compounded the stolen drugs problem in recent months.

Doctors and nurses worked in an atmosphere of "panic and uneasiness" after experiencing a series of violent episodes since January.

In the latest incident, construction workers were robbed and a bakkie was stolen at gunpoint at Soweto's Phomolong Clinic.

In another case in February, a thug allegedly tried to shoot a doctor at Koos Beukes Clinic.

Natha appealed to members of the community to help apprehend criminals who threatened Soweto's health services. Said Natha: "Staff are frightened to death. If you can't be safe at your workplace, where can you be safe?"

HEALTH — 2 (85)

Crippling budget

FM 24/3/95

National health services are bound to suffer this year as health expenditure effectively drops from 10,4% to only 9,6% of State expenditure.

Says Alex van den Heever of the Wits Centre for Health Policy Studies: "While this year's R15,4bn budget appears to represent an aggregate 10% increase on last year's expenditure of R14,1bn, included is an amount of R1,245bn representing RDP carry-through costs for new and specific projects — R680m for free health care, R65m for clinic building and R500m for the primary nutrition programme. This means that existing services will in practice have to make do with around R1bn less than is needed to keep services constant — based on an inflation rate of 6,7%." This effectively means that no allocation has been made for population growth or the extension of services.

A disturbing feature is that while the provinces will be allocated 96% of the budget, no provincial plans are detailed.

Unrealistically, allocations to the provinces will be prioritised to wipe out provincial resource disparities within five years starting with a loading of 30% of the calculated adjustment in the first year — a move that experts say could force the closure of an academic complex in the well resourced province of Gauteng and another in the Western Cape.

It's a formula that appears to be based on a UK model which set about reducing average disparities of around 30% to 10% over 12 years.

An additional R400m has been included in the 1995-1996 RDP vote for transfer to the health departments of Gauteng, Western Cape and Free State to "facilitate the substantial transformation required at tertiary and academic hospitals to cope with the move towards strengthening primary health care and shifting the emphasis away from specialised curative hospital-based care."

Apparently KwaZulu-Natal won't be benefiting from this allocation. ■

7

A look at the health policy document

(85)
Sowetan 24/3/95

By Sizakele Kooma

Recently, nursing practitioner partners Dorothy Mamabolo and Busi Boikanyo organised a seminar to unravel the mystery around the national health policy document.

About 500 health professionals from Soweto and surrounding areas converged at the Vista University, Soweto campus, to hear speakers from the Government discuss the role that the private health sector was expected to play in the implementation of the new primary health care service plan.

Dr Olive Shisana, special adviser to Health Minister Dr Nkosazana Zuma, and Gauteng MEC for health Mr Amos Masondo were their guests.

The two Soweto women, who operate their practice from Dobsonville, were prompted to bring together the professionals and the Government representatives by the desperate need for health services in the communities they work in.

Said Mamabolo: "Dr Zuma talks about the improvements the Government will make in the primary health care service at almost every forum she addresses, but we, the people offering the service, are in the dark as to how it is going to be done and where we will feature."

> *'They (the Government) should do away with the fragmentation of health'*

She said since the Government stopped community health care services after the 1976 uprisings, mothers of newborn babies, patients who needed dressings and those who were dependent on drug treatment to stay healthy were not getting home care visits after being discharged from hospital.

This, she said, had resulted in a crisis in health care. People fell ill from diseases that could be avoided if the symptoms were diagnosed early. Most diabetics and hypertension patients relapsed into illness because no follow-ups were done by the clinics to ensure that they took their treatment.

"Home visits are not only relevant for ensuring full recovery of the patient. They alert the nurses to other problems that may be related to, or even causing, the illness.

"They also enable the nurse to detect symptoms of the same diseases, if it is infectious, in the other family members," said Mamabolo.

The two nurses, who started their service two years ago, are the only black nursing practitioners in the region. They service the whole of Soweto and the west. Their day starts at 7am and ends at 5pm. The nurses say no matter how hard they work and how far they stretch themselves, they will never be able to cover all the work that needs to be done.

Said Boikanyo: "The Government needs to move swiftly on implementation of primary health care in the townships.

"They should do away with the fragmentation of health services and have individual clinics offer a comprehensive service. This way clinics will relieve the hospitals of the heavy load of work they now have."

R6-m health centres plan for townships

(85) ST(CM) 26/3/95

TWO new health facilities are to be built in Khayelitsha and Macassar to provide community services, Western Cape Minister for Health and Social Services Ebrahim Rasool announced yesterday.

By DIANA STREAK

A large new community health centre, built at a cost of R6-million, is nearing completion in Khayelitsha and will be handed over to the Provincial Health Department in May. It will begin operating in August.

This will be the second largest community health centre in Khayelitsha, serving the eastern sector of the area, and will be known as the Michael Mapongwana Community Health Centre in memory of a prominent Khayelitsha leader who was killed in 1993.

A community health centre is also planned for Macassar, which at present has inadequate health care facilities.

A sum of R350 000 has been made available from the RDP for the planning of the centre and R3-million will be provided by the Provincial Health Department for building.

"These developments form part of the process of putting into place, throughout the metropolitan area, facilities which will provide a comprehensive range of community-level services which are easily accessible," Mr Rasool said.

Speaking at the launch of the Western Cape Welfare Forum at the University of Stellenbosch, Mr Rasool said the Western Cape would receive R1,7-billion of the national R13,4-billion health budget, of which 82 percent would be spent on social security.

"There is a general concern that the allocation for social service funding should be increased," he said.

But this could only be done once the provincial health departments could prove that fraud had been removed from the system.

He said groups targeted by the RDP would receive priority.

The historically disadvantaged, especially youth, women, children — with emphasis on homeless children — and the disabled would be addressed through a social safety net in a developmental context.

"It is hoped that criteria to underpin the concept of development will be finalised at the Welfare Summit to be held in April," Mr Rasool said.

"Rural communities and informal settlements are indentified in the RDP as priority areas."

An index could be developed as a basis for the distribution of funds so communities could benefit according to their degree of deprivation.

Govt's provincial health plan 'crude'

BD 27/3/95

KATHRYN STRACHAN

GAUTENG's health budget cut was a "complete catastrophe" for services in the province, a health analyst said on Friday.

The only way in which savings could be made was through staff cuts, he said.

Central government allocated Gauteng's health services only R3,17bn.

Wits University Centre for Health Policy researcher Alex van den Heever said this allocation implied a nominal cut of 10% — which in real terms amounted to a cut of about 22%. The budget has been cut to allow increases to more under-resourced provinces.

Van den Heever said the cut was unsustainable. A cut of these proportions was beyond the ability of the public sector to achieve in such a short period.

To keep health services running at the same level, a budget of from R3,7bn to R3,8bn was needed.

Government had allocated R300m to Gauteng health services to help them bridge the transition phase, but a further R290m was needed to keep the service constant. The bridging finance was a one-off allocation, and Gauteng health services faced potential disaster unless a similar allocation was made next year.

There were many constraints on the public sector which needed longer to put in place changes which would lead to savings.

The cuts could only be made in personnel, which took up about 67% of Gauteng's health budget.

Gauteng was expected also to achieve savings by rationalising its academic hospitals, but to make these savings would take about six years.

Van den Heever said awarding Northern Transvaal an increase of 20% was as illogical. This allocation was for running costs only and did not represent a capital allocation for building new facilities.

It was better to first set up new facilities and then increase recurrent expenditure.

The new plan also failed to take into account the fact that both Gauteng and Western Cape treated many patients who flocked from across their borders.

"This is poor financial management, based on a crude and hopelessly inadequate formula," he said.

Gauteng MEC for Health Amos Masondo said that while he recognised the need to share resources equitably between provinces, Gauteng needed to be given the space to make the transition.

DP health spokesman Jack Bloom said: "The central government objective of 'parity' between provinces is nonsensical in view of the substantial numbers of patients from other provinces who utilise specialist hospitals in Gauteng."

GaRankuwa Hospital cost the province R300m a year, yet 90% of its users were not Gauteng residents.

Police union demands 25% wage rise

BD 27/3/95

FAROUK CHOTHIA

THE SA Police Union (Sapu) would demand a minimum salary increase of 25% in urgent talks with Police Commissioner George Fivaz today and for foreign aid to be channelled to the police budget, Sapu KwaZulu/Natal secretary Bill Dennis said yesterday.

The talks were being held against the backdrop of a "go-slow" started by several thousand Sapu members on Friday in KwaZulu/Natal, Gauteng, the Eastern Cape, the Northern Cape and the North-west, Dennis said.

The go-slow meant policemen "would not work an inch of overtime", except in cases of murder, rape and robbery, until their grievances were addressed.

Dennis said Sapu would not agree to a salary increase of 5% or 10%.

Generals had received an increase of about 20% last year while "everybody else" had to settle for between 3%-5%.

Dennis said foreign aid was being used solely to finance the reconstruction and development programme (RDP), but government had to realise that the RDP was "doomed to fail if the country is unstable".

The Police and Prisons' Civil Rights Union would also attend the meeting.

Finance Minister Chris Liebenberg allocated R2,2bn for policing in the Budget.

While this was an increase of R290m from the previous year's allocation, Sapu argued that it had been a decrease of 2,2% in real terms. Sapu also wanted the power to negotiate directly with Safety and Security Minister Sydney Mufamadi.

As health reform planning moves into top gear, the country's academic hospitals come into prominence once more. Health Writer ***David Robbins*** *reports on a study undertaken in Gauteng regarding these important but expensive institutions*

Health cake needs sensitive slicing

(85) Star 27/3/95

Academic hospitals are part of South Africa's legacy as a country with a curative-based hospital-centred health care system. They are hi-tech institutions with levels of expertise which would figure favourably on any world ratings. They are also extremely expensive to run, and for a variety of reasons are often financially inefficient.

Gauteng's eight academic hospitals, for example, consume two-thirds of the annual expenditure on the province's 40 hospitals, while delivering only half the services. The bottom line is that these hospitals use too much of the budget, which results in serious under-provision of health care at the periphery.

Last year, the Gauteng health ministry called for a report on the situation. An academic hospitals task team was set up. Included in the team was Dr Brian Ruff, a specialist rheumatologist working at the Johannesburg and Hillbrow hospitals, who recently presented the team's findings at a conference on health financing which was organised by the Wits-based Centre for Health Policy.

"As our investigations progressed," Ruff says, "it became obvious that academic hospitals would have to be reduced in size and have smaller budgets.

"But this will have to be done with a clear understanding that academic medicine is a major national asset. Squeeze too hard and the asset is dissipated. Equally, though, if the asset is left without controls it becomes wasteful. A very fine middle line will have to be found; and this will require a high degree of managerial expertise."

Gauteng's academic hospitals are divided into three university-based complexes. Medunsa operates at the GaRankuwa hospital north of Pretoria; Pretoria University uses the H F Verwoerd and Kalafong hospitals; and Wits is active in the Johannesburg, Hillbrow, Coronation, J G Strijdom and Baragwanath hospitals.

Ruff's task team spent time establishing some of the detail of the current situation. This involved using previous studies to separate the various levels of hospital care.

Level one care (such as that provided by general practitioners) accounts for 5 807 of the province's hospital beds; level two (in which the medical team is headed by specialist) had 8 917 beds; and level three (in which most of the medical staff are supra-specialists) had 6 014.

Ruff provides a caution here. "It must be remembered that level three beds are not synonymous with academic beds. Academic training should take place across all three levels, with specialist training divided between levels two and three.

"Nevertheless, the fact remains that Gauteng is over-endowed with level-three beds."

Computer models

How was such a conclusion reached? The catchment areas of the three academic complexes operating in Gauteng have tradionally covered Gauteng itself, and also the Northern Transvaal, the Eastern Transvaal, and the North West. When the combined populations of these regions (approximately 20 million) is divided by the World Bank's recommended ratio of level-three beds to population, a figure of 4 000 beds emerges.

What would be the implications of scaling down Gauteng's academic hospitals in this way? To find answers, Ruff's team devised a few computer models. Crucial to these calculations are the existing ratios of specialists, doctors and nurses to hospital beds at the various levels.

Crunching all the ratios and assumptions together provided some revealing insights. The present situation with regard to personnel only is that about R690-million is spent on level three; R580-million on level two and R410-million level one, giving a total of R1 680-million.

To cut level-three beds to the international standard (4 000 beds) and transfer the excess to level two would save R135-million. But it would also reduce the number of specialists at level three from 824 to 548. By introducing more realistic personnel/bed ratios at level two, specialist numbers would also be cut at this level from a theoretical 415 to 273.

"It's important to remember the theoretical nature of the computer models," Ruff says. "In practice, there simply aren't enough specialists at level-two hospitals, and it seems reasonable to expect that with suitable incentives, this shortage could be alleviated by cutting the size of level-three care.

"Ordinary doctor and nursing posts are also lost, but the assumption is that this expertise could be effectively used as peripheral health services are upgraded and extended."

If the number of level-three beds were cut by 2 000, while retaining the same number of beds at the other two levels, the savings would amount to R231-million a year. Staff cuts would be at level three only, where specialist posts would be decreased by 276, doctors' posts by 395, and nursing posts by a substantial 3 302.

"The point of these computer models is simply to show that there are various ways in which money can be saved," says Ruff.

With these theoretical calculations in mind, Ruff's task team presented the Gauteng health ministry with three possible scenarios, which are outlined in the story alongside.

Ruff isn't saying which, if any, scenario his task team favours. It is up to us all to influence the crucial decisions which will soon be made by those searching for formulas to release resources at the centre and channel them successfully to the periphery of our health care service.

Three routes for academic hospitals

First scenario: Three hospitals instead of eight. About 1 000 academic beds (for training and research) should be allocated to each medical school (Wits, Pretoria and Medunsa). It should be noted here that a recommendation has already been made that Medunsa be relocated in the Northern Transvaal.

The advantages of this scenario are obvious: large savings, economies of scale, consolidated expertise which could enable Gauteng's three academic hospitals to compete effectively for private sector money, and a regaining of control of the other major hospitals by the provincial health authorities.

The disadvantages would be that five hospitals would lose their university status, with possibly severe consequences for conditions of service for staff, and quality of care. The loss of quality staff would lead to a drop in the standard of health care delivery in the province, and an exacerbation of the distinction between service delivery to the haves and the have-nots.

Second scenario: Eight hospitals but with fewer academically funded beds.

University links to the existing academic hospitals should be preserved, but with reduced level-three beds.

The advantages include substantial savings, a reduction of staff, and increased efficiency.

The disadvantages would be that quality staff could be lost rather than voluntarily moving to regional hospitals without university links; and there would be no improvement in service delivery in Gauteng's non-academic hospitals.

Third scenario: University involvement in all hospitals.

Academic (training) beds could now be distributed through all three levels of hospitals, but with the same financial restraints and reduction in level-three beds as outlined in scenario two. Heads of departments at medical schools would become involved in the quality of care in their disciplines throughout the hospital system.

The advantages are the creation of a single class of hospitals, all with university links; the same financial savings could be achieved as in scenario two; the effect of academic input on staff morale and service quality would tend to be positive.

The disadvantages are, first, that this scenario is ambitious and would require complex management systems to succeed; and, second, that academic units may be insufficiently concentrated to ensure effective survival.

the Small Claims Court, the system of community courts and the institution of justices of the peace or similar voluntary and community-based judicial officers. [Time expired.]

Senator C H WERTH: Mr President, I support the interpellation of Senator De Ville along with the previous two speakers. We cannot allow the situation to deteriorate to such a level that confrontation results between the magistrates and prosecutors on the one hand and the Ministry and the Government on the other.

We frequently hear about the importance of the third tier of government because it is closest to the people. Similarly, the third tier of the judicial system, after the Appellate and Supreme Courts, is the magistrates' courts. It is here where the great bulk of the populace has its only and very rare experience of the judicial system. It is here where the people see the realities of law and order in practice. It is here where the citizens are introduced to respect for the law.

We cannot afford to have a crisis at this level, and I support Senator De Ville most wholeheartedly in his interpellation.

Senator Dr R RABINOWITZ: Mr President, while the Government is attempting to cope with the multifaceted aspect of crime prosecution, one area which can be addressed immediately, is that affecting the work of magistrates and prosecutors. Besides the overload, which is a problem throughout the country—particularly in rural areas such as those in KwaZulu-Natal, in which the magistrate is a jack of all trades and has to cope with administrative, civil and criminal affairs—there are other problems.

For example, the onus is on the State to provide proof within 48 hours that an alleged criminal should be denied bail. This is difficult without efficient investigating teams. There are also difficulties in finding witnesses who have the courage to come forward and are not afraid of intimidation. It is difficult to find witnesses who will come back many times when cases are remanded and there is inadequate education of prosecuting officers who have to cope with women who lay charges of rape and family violence. This results in criminals remaining on the streets and commercial syndicates not being brought to book.

We have some suggestions. Night courts that will double working time; lay assessors who will be appointed in consultation with the communities and help find witnesses; pro Deo attorneys who will work as in the Small Claims Court; and improved efficiency by means of electronic equipment such as E-mail facilities. [Time expired.]

Senator R J RADUE: Mr President, the NP is aware of the tremendous workload falling on the shoulders of magistrates and prosecutors at the moment. The rate of crime is so high that our magistrates' courts are clogged up with work and cases.

The problem, however, goes much deeper. The question that needs to be addressed is are these magistrates public servants or are they independent? The Magistrates Act passed a few years ago was to give them an independent status. The Magistrates Commission was established to regulate the appointment and conditions of service.

What have they got? The 11 member commission, under the chairmanship of Mr Justice Van Dijkhorst, consists of six members of the Department of Justice, one attorney, one advocate, one academic and only one magistrate. The old conditions of service have been adopted *mutatis mutandis* by regulation and the commission holds its proceedings in camera and gives no reasons for transfers, etc.

The overwhelming majority of magistrates feel they are still public servants despite the good intentions of the Magistrates Act. They are frustrated and they want to run their own affairs. Can the Minister not do something to correct this very unsatisfactory situation?

*Senator J R DE VILLE: Mr President, the FF wants to appeal urgently to the Department of Justice and the hon the Minister to see to it, in the first place, that vacancies are filled and, in the second place, that training programmes for prosecutors are instituted. We dare not dawdle any longer. Obviously—for Senator Moosa's information—it will cost money. Where proper administration of the law is at stake, it is an investment from which the entire community eventually benefits.

†It is clear that the magistracy, not only in Durban but all over the country, are overworked, understaffed, demoralised and underpaid. They are looking for reasons to resign rather than to stay on. In an effort to solve the problems, we must look at possible remedies.

The magistrates say the problem is apparent. They are excluded from the Public Service Labour Relations Act of 1994. The Magistrates Act, as Senator Radue has mentioned, was a hurried, haphazard and ill-conceived attempt by the previous government to remove them from the clutches of the Public Service. The regulations to the same Act negated this attempt and drove them back to the Public Service.

They seem to be excluded from the Labour Relations Act of 1956, as they are employed by the State. They are excluded from all recent legislation pertaining to the State and the Public Service. They have no or very little rights in respect of collective bargaining.

What are the solutions? The magistracy must be divorced from the Department of Justice and Public Service in real terms and at all levels. If their salaries are rectified, the brain drain will stop. If vacancies are filled, this will reduce the pressure on the magistrates and be conducive to good justice. The accommodating of magistrates in the Labour Relations Act will place remedies at their disposal, both collectively and individually. If their employers are identified . . . [Time expired.]

The MINISTER OF JUSTICE: Mr President, it is very important that when we discuss the issue of magistrates, attorneys-general and prosecutors and the administration of justice generally, the discussions and comments should be done in a responsible manner. One must also be able to distinguish fact from fiction.

It is all very well to generate publicity by making all sorts of accusations as Senator De Ville has done. Some of his remarks border on the irresponsible. I will deal with these remarks later in my speech.

In dealing with some of the facts, however, the Magistrates Commission consists of two regional court magistrates, two chief magistrates, and only the Director-General of the Department of Justice is a representative of the Department of Justice on this commission. We need to look at that.

However, I want to say that at this stage the Magistrates Commission only has jurisdiction over magistrates of the old RSA. The magistrates in the old TBVC states and the other six self-governing territories still fall under the Public Service. I support the view that we should bring them all into the Magistrates Commission so that they can have independence and that such independence must be secured.

Secondly, with regard to the problems in Lebowa and Ciskei which were mentioned, it is true that there are problems in these and others areas. These are not problems of our making but are problems which go back into history and I do not want to deal with that in detail. I think that Senator De Ville knows very well where these problems come from and perhaps he should have mentioned it. [Interjections.]

To equate the position and problems of magistrates with that of interpreters is also irresponsible. We have had to deal with the long-standing problems of interpreters, some of which have now been resolved as a result of hard work and co-operation, not only of the department itself, but also of the Magistrates' Association of this country.

In this regard, I want to say to the hon senators that the Department and I have a very close, cordial and co-operative relationship with the Magistrates' Association of South Africa. We meet often and we discuss the problems which face magistrates, including the working conditions and salary problems. It is true that we have problems with regard to salaries and working conditions and that there is a looming crisis in the Department of Justice unless those problems are addressed. The Department, in co-operation with the Magistrates' Association, is currently addressing those problems.

Debate concluded.

QUESTIONS

†Indicates translated version.

For oral reply:

Questions standing over from Tuesday, 28 February 1995:

Changes in health services (85)

*4. Sen Dr R RABINOWITZ asked the Minister for Health:

(1) Whether she included (a) general practitioners and (b) other private sector representatives in her proposed restructuring of a national health delivery system; if

Hansard 28/3/95

not, why not; if so, which practitioners and representatives;

(2) whether any international models were used as a basis for the proposed South African system; if so, which models;

(3) whether the primary health care system favoured by her Department will allow contributors and non-contributors to choose their own doctors; if not, why not; if so,

(4) whether she or her Department has determined whether this would contribute to better cost control and constructive changes in the health services; if so, how?

S13E

The MINISTER OF JUSTICE (*on behalf of the Minister for Health*): Mr President, I apologise for the absence of the Minister for Health. However, there is a short reply to the question which I will read. If there are any follow-up questions they will be conveyed to the Minister for Health.

(1) (a) Yes—Dr Bomvana, and

(b) Yes—Dr J Broomberg—Monitor Company
Mr R Magennis—Representative Association of Medical Schemes
Dr B Brink—Anglo American Corporation;

(2) there is no proposed South African system. A Committee is investigating the viability of different options. They will report by the end of April 1995;

(3) no system is favoured by the Department at this stage. Question falls away;

(4) as no final system has been decided on the question falls away.

*12. Senator B T NGCUKA: Mr President, may I request that this question stand over for later?

The PRESIDENT OF THE SENATE: Order! Does the hon Senator request that the question stand over for later this afternoon?

Senator B T NGCUKA: No. [Interjections.] Can I please be given an opportunity to address the President? Mr President, I have no information in this regard. Therefore, I would request that this matter should stand over for next time. [Interjections.]

The PRESIDENT OF THE SENATE: Order! That is agreed to.

*12. Sen C R REDCLIFFE—Public Works. [Question standing over.]

*13. Sen C R REDCLIFFE—Public Works. [Question standing over.]

New questions.

School textbook supplements: private printing/ basis of tender

*1. Sen Dr R RABINOWITZ asked the Minister of Education:

Whether school textbook supplements for use in the next three years are to be (a) printed by private printing companies and (b) published on the basis of tender; if not, what is the position in this regard; if so, what are the relevant details?

S27E

The DEPUTY MINISTER OF EDUCATION:

No. My instruction as regards the interim syllabus revision exercise was precisely that there should not be textbook implications. Where applicable, master copies of support material, as prepared by the committees which revised the syllabi, are provided to the provinces. The provinces could in turn make use of private printing companies to duplicate the material.

Electricity distribution rights: TMCs/TLCs

*2. Sen Dr R RABINOWITZ asked the Minister for Provincial Affairs and Constitutional Development:

Whether it is the intention to deny municipalities in the newly formed (a) Transitional Metropolitan Councils and (b) Transitional Local Councils electricity distribution rights; if not, to what extent will such municipalities be able to distribute electricity?

S28E

The DEPUTY MINISTER FOR PROVINCIAL AFFAIRS AND CONSTITUTIONAL DEVELOPMENT:

The question to what extent municipalities will be able to distribute electricity is still being investigated and considered by the National Electrification Forum (NELF) whereafter it

will also be cleared with Organised Local Government and the Minister of Mineral and Energy Affairs.

Departmental committee: terms of reference in respect of proposed National Insurance Scheme

*3. Sen C H WERTH asked the Minister for Health (85) Hansard

(1) What are the terms of reference of the departmental committee which is at present requesting inputs in respect of the proposed National Health Insurance Scheme; 28/5/95

(2) whether any of the members of the committee are non-South Africans; if so, (a) why was it necessary to involve these members, (b) what is the field of expertise of each of the said members and (c) from which countries do they come?

S37E

The DEPUTY MINISTER OF EDUCATION (*on behalf of the Minister for Health*):

(1) To prepare a detailed a costed plan for the introduction of national health insurance system, or a publicly supported alternative with the express aim of ensuring access to primary health care services for all South Africans. The work of the committee should be based on the necessary investigation and consultation, and must address at least the following issues:

— the overall economic feasibility of the proposed system of funding;

— the level of funding required and sources of that funding;

— the availability and distribution of the required service providers, facilities and supplies;

— mechanisms and levels of payment to suppliers and providers of products and services;

— administration and management resources, systems and infrastructure;

— interface with other components of the public and private health care systems; and

— mechanisms and timetable for implementation.

To consult with interested parties and the public in developing a plan addressing the policy objectives.

After the preliminary report and the consideration by the Government, the committee may continue to improve and refine the plan based on feedback arising out of consulation.

To recommend what legislation might be required for the introduction of the system proposed by the committee.

(2) Yes.

(a) As none of the South African members of the committee has experience of developing and implementing a National Health Insurance System. The international consultants' diverse experience and inputs in developing and implementing national health insurance systems are appropriate to the terms of reference and the work of the committee.

(b) Health Economics, Health Financing and Health Insurance.

(d) Dr Deeble — Australia
Prof Hsiao — USA
Prof Maynard — United Kingdom

Licence to pharmacies to substitute generic equivalents for medicines

*4. Sen C H WERTH asked the Minister for Health:

Whether it is the intention to license pharmacists to substitute generic equivalents for medicines on doctors' prescriptions; if not, why not; if so, what are the relevant details?

S41E

The DEPUTY MINISTER OF EDUCATION (*on behalf of the Minister for Health*):

One of the recommendations of the Drug Policy Committee is that generic substitution of medicine should be allowed on prescription. We are at present in the process of discussing this recommendation with the role players.

Shortage of classrooms/classrooms completed

*5. Sen W F MNISI asked the Minister of Education:

(1) With reference to his reply to Question No 3 on 18 October 1994, (a) what is the

Outsiders a big drain on health budget

■ BY JO-ANNE COLLINGE

Gauteng spends an estimated R900-million a year on health care for people who live outside the province but seek treatment within its borders, says Gauteng's chief director for health administration Jan Nagtegaal.

This accounts for 29% of the Gauteng health budget but the province receives no reimbursement from the central Government for the services it offers non-residents.

The amount spent on non-residents far exceeds the potential shortfall between the amount budgeted for health in 1995/6 and the amount required to maintain services.

Nagtegaal put this latter amount at R536-million as he presented details to the Gauteng legislature's standing committee on finance yesterday.

Dr Ralph Mgijima, head of the strategic management team for health, argued that Gauteng's problem lay not in the actual volume of outsiders treated but in the fact that the central Government took no account of the "outsider factor."

Gauteng's health allocation was directly in proportion to its permanent population and there was no increase to accommodate non-resident patient load.

(85) Star 29/3/95

Private patients to pay for poor's cancer tests

By CAS St LEGER (85) ST 21/4/95

URBAN women could help stamp out the biggest killer of their rural sisters by subsidising their cancer tests.

A hi-tech test, due to be introduced in July with the backing of the National Cancer Association, could have private patients paying more than double for pap smears and disadvantaged patients being tested for free.

Cervical cancer kills more black South African women than any other cause, and is the fifth major cause of death among white South African women.

If the cancer is detected early through a simple pap smear, it can be treated successfully by laser or electric cauterisation in an outpatients' clinic.

But only two million South African women — largely from urban areas and almost exclusively private patients — have access to the test.

Now Dr Mark Rutenberg of New York, in South Africa under the auspices of the SA Institute of Medical Research, has introduced automated screening of pap smears to local medical experts. Papnet will be available in SA from July.

"It is a quicker, more accurate cancer screening method that would enable us to test at least another one million women every year," said Dr Rutenberg.

He discovered that the greatest need for tests was in those who used public sector health care — but no funds were available for sophisticated equipment.

Private patients will pay about R115 for the new test instead of the present R47. The extra on the bill would pay for a state clinic or hospital patient to undergo the test.

Dr Rutenberg claimed his solution had private sector and medical aid support.

■ RONDEBOSCH

Health care 'first' at UCT

☐ *British endowment for academic chair*

JILYAN PITMAN

THE University of Cape Town is to establish the first chair in primary health care in South Africa after a gift of about R2,2 million from British-based pharmaceutical giant Glaxo.

This is the first time the British company has endowed an academic chair outside Britain — to be called the Glaxo Chair in Primary Health Care at UCT's Faculty of Medicine.

The company's chief executive officer, Andrew Witty, said the endowment was a vote of confidence in UCT's academic standing, in particular, and South Africa in general.

At a function at UCT's Medical School, vice-chancellor Stuart Saunders promised that the university and the medical school would place their full support behind the initiative to bring healthier lives to millions of South Africans, in partnership with Western Cape health authorities.

"We have been trying to create this chair for four years anticipating the RDP ... now Glaxo's vision has secured the chair as a permanent part of the faculty and health service. We are immensely grateful to Glaxo for its commitment to far-sighted developments," said Dr Saunders.

The new professor of primary health care is still to be appointed.

Minister of Health Nkosazana Dlamini-Zuma was expected, but did not attend the function, which was held up for 30 minutes.

Province must employ health workers

(85)

CT 3/4/95

WEALTHIER municipalities are likely to provide better primary health services than poorer municipalities if these services remain in municipal hands.

That is why there is a debate raging over whether or not the provincial authorities should assume responsibility for providing primary health services in the transitional period — and even in the long-term.

Health planners do not want "the perpetuation of the present apartheid-based inequities".

Virtually everyone agrees apartheid is evil and its remnants must be wiped out as quickly as possible.

Socialist

But if one can remove the apartheid aspect of an "inequity" and still not reach a situation of equity, is that so bad?

The answer depends perhaps on whether one is a socialist regarding the provision of public health services at every level of government.

Urban areas are generally wealthier than rural ones. Not all of this inequity can be blamed on apartheid. It is conceivable that even if each vestige of apartheid was removed, one would still have an urban-rural wealth divide.

How should health planners respond to this? At provincial level, authors of the health plan now being discussed have opted for the promotion of equity across the province.

They are surely correct when they say this can most easily be achieved if the primary health staff are employed by province, although equity can also be worked towards, more laboriously, through legislation, regulation and subsidy-allocation formulae.

In the past, over half the money municipalities spent on health came from central government via the province.

In Cape Town municipality, deputy Medical Officer of Health Dr Johan van Rensburg says, this is no longer the case. Over half is now provided by the ratepayers.

Provincial planners say keeping primary health in municipal hands will make province-wide equity in service provision more difficult to attain as municipalities tend to pay health workers more than the province does.

Also, most primary health workers are employed by the province.

Therefore, transferring the other workers to the provincial authorities would be cheaper than transferring all to local authorities.

But need a uniform approach be taken? In some rural areas, local authority boundaries may not mesh well with some post-apartheid health districts, but in the metro planners have ensured a good fit between the six future municipalities and the ten health districts.

Even socialists should not find it too difficult to live with a situation where the province allows primary health to be taken care of by municipalities in some areas, like the metropole.

Provincial authorities could then only pass regulations which would ensure that minimum standards be met.

Health levy

Beyond that, if relatively wealthy ratepayers want to pay more for better services, then so be it.

If metropolitan areas have to pay a proposed province-wide health levy as is likely since we receive health subsidies, we should not be forced to lower our municipal rates to compensate.

We should decide at local level whether or not to pay more to keep our good health services.

Health care must reach more

(85) ARGT 4/4/95

Staff Reporter

A MORE cost-effective and efficient primary health-care system, serving all the communities in the province, was needed to solve the health crisis, delegates to a meeting of the Cape Independent Practitioners Association were told.

The association, representing pharmaceutical companies, hospitals, health services and several paramedical professions, intends finding solutions to the health-care crisis in under-serviced communities in all parts of the Western Cape.

Chairman Steve Jooste stressed the need to extend services to a greater number of people.

Suggestions for a more cost-effective and efficient health system included:

- Using the most appropriate medicine for the condition to reduce costs for patients.
- Agreeing on a single exit price for drugs to eliminate variable cost structures based on factors such as volume.
- Creating a national code of distribution for drugs to achieve efficient administration of the supply of medicines.
- Guidelines for the best awareness in terms of cost and quality of health care.

Need for 'creative' doctors

ARG 4/4/95

JENNY VIALL
Staff Reporter

A REVIEW of the teaching and learning methods at South African medical schools is needed to produce creative doctors who can deal with the health problems facing the country, says Education Minister Sibusiso Bengu.

Speaking at a conference in Sea Point on training doctors to work in Africa in the 21st century, Professor Bengu said there was a "serious need for introspection" into the curriculum and standards of medical education.

Medical schools in Africa should look at local problems needing urgent attention, and medical education should be examined for its relevance.

"There is a need to re-examine who is taught, by whom, for how long and most importantly for what purpose.

"Can we honestly say that we are equipping our students with skills and knowledge appropriate for the South African context?

"Can our products practise in rural areas, squatter areas or hostels? Can we say that our students are equipped with creative skills to deal with emerging unique South African social problems?"

Professor Bengu said medical schools had to be accountable for the doctors they produced and leaders in medical education had to contribute to the shaping of the health care systems of the future.

Curriculum and staff development had to be looked at when transforming medical education.

"Our present curriculum is overloaded and its content does not meet the changing needs of our country.

"Teaching is still done by people primarily interested in clinical care and research."

Rugby player is 'critical'

The Argus Bureau

PORT ELIZABETH. — A young Port Alfred rugby player is in a critical condition after injuring his head during a game at the weekend.

Riaan Klopper, a 20-year-old furniture salesman, was carried off the field at Port Alfred on Saturday during a match between South Eastern Districts and Fish River Sun.

A spokesman for the Port Alfred rugby club, Ronnie Green, said Riaan was seen jumping for the ball when players ran into him, bumping his legs from underneath him.

It is thought he might have fallen on his neck.

Smoking law 'aids tourism'

Municipal Reporter

THE Cape Town City Council's new smoking by-law has been welcomed as a boost for tourism.

The National Council Against Smoking said it was important that South African cities should aspire to international standards set in European, American and Asian cities.

ARG 4/4/95

Also, British Airways and Cathay Pacific had introduced smoke-free flights to South Africa.

"By restricting smoking, Cape Town will provide a more comfortable, safer and healthier indoor environment, not only for tourists but for all," the council said.

Health care must reach more

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- Guidelines for the best awareness in terms of cost and quality of health care.

'EUROPEAN MODELS ARE INAPPROPRIATE'

Call for new pattern in African health care

(85) CT 4/4/95

IMPROVED health care for the people of Africa requires a "redesign" of doctors, a medical conference in the city has been told. **EUNICE RIDER** reports.

DOCTORS had to be "re-designed'" to improve their communication with patients — and health care in Africa, where medical faculties were in a severely depressed state, had to be improved.

So said former Capetonian and president of the World Federation of Medical Education, Prof Henry J Walton, yesterday.

He was addressing the United Nations-sponsored African Regional Conference on Medical Education and Practice being held here, attended by deans of medical schools and ministers of health from 46 African countries.

Prof Walton said the purpose of the conference was to "re-design" the doctor, and thereby to improve health care for the people of Africa.

Leadership

"We desperately need a new pattern for Africa, with its particular problems of Aids and lack of resources, so that the masses can receive the medical care they need," he said.

He said African medical schools had for too long looked to European centres for leadership, and what was appropriate to European countries was not appropriate to Africa.

The conference is an outcome of the World Summit on Medical Education held in Edinburgh last August, supported among others by the World Health Organisation (WHO) and the World Bank.

The conference at the Arthur's Seat Hotel, which ends tomorrow, will discuss topics including communication with the public and patients, seeking a balance between specialists and generalists and educational preparation for health in transition.

For further details please contact the WHO's temporary Cape Town information officers at 434-3344.

Medical schemes could be given much wider role

BD 5/4/95 (85)

THE committee of inquiry into National Health Insurance is to hold a five-day meeting from today to sift through submissions before drawing up its final report, to be delivered to Health Minister Nkosazana Zuma by the end of the month.

Under the spotlight will be proposals to tap additional sources of private sector funding through a payroll tax, a levy on the total pool of private health insurance funds or an increase in excise duties, health finance committee co-chairman Jonathan Broomberg said yesterday.

The committee would look at gaps in current health financing and would first attempt to find ways to plug them through restructuring state expenditure before attempting to source funding from the private sector, he said.

In a report submitted to the committee recently, the medical schemes industry proposed that membership of a medical scheme be compulsory

BEATRIX PAYNE

for people in formal employment and their dependants. It was proposed also that medical schemes become service providers through health management organisations.

Such a move would assist in the accelerated extension of primary health care as it could alleviate the state's burden by roughly 7-million beneficiaries, the report said.

Medical schemes were still debating certain issues concerning the financing of a national health system and final proposals should be announced at the Representative Association of Medical Schemes (Rams) conference later this month.

Rams executive director Reg Maggenis — who also sits on the committee — said any methods to tap private funding should be considered in the context of the overall tax burden.

If the tax benefit of medical aid contributions was removed, for example, users might decide to move away from self-funding and fall back on the state to provide health care.

Industry sources said other issues discussed during workshops with the committee included proposals to deregulate the ownership of pharmacies and to fund state health expenditure through a per capita tax on medical aid schemes.

In return for such a tax, it was suggested that the state offer medical schemes the opportunity to operate their own medicine depots by deregulating ownership of pharmacies. These depots would have access to medicines procured through the state tender system at prices considerably lower than those available through the private sector.

The committee had received submissions and had been meeting industry players over the past few weeks, Broomberg said. Depending on Zuma's response to the report, it was likely to go to Parliament for debate in June.

Nationwide immunisation campaign starts this week

(85)

BD 5/4/95

LINDA ENSOR

LONDON — A major nationwide immunisation programme is to be launched by President Nelson Mandela and Health Minister Nkosazana Zuma on Friday.

Zuma, who was en route to Washington on a fundraising trip, announced the programme at a news briefing at the SA High Commission yesterday, and also announced that SA would host a major conference of Commonwealth health ministers in December.

Zuma will participate this week in fundraising for a US bursary scheme which finances medical students to study in SA. She will return home tomorrow to be present at the launch of the immunisation campaign, which she hoped would succeed in eradicating polio from SA within two years.

Her short stay in the UK did not involve meetings with British government ministers, but Zuma said she hoped to meet them in June when she attended a major conference in the UK.

Zuma felt Britain could play an important role in assisting SA in the health sector. Britain had long experience with a national health insurance scheme and could assist in building up administrative capacity in SA and in training personnel.

"All along I thought that the private sector in SA had this capacity, but when I looked at it I found that it did not. It does not exist in either the public or private sector but Britain has a lot of experience in this field," Zuma said.

She added that one of the major debates taking place in the SA health sector was national health insurance as a funding mechanism to provide universal health care and Britain could play a training role in this. Zuma stressed that SA'ssituation was unique and it would not import the health policies of any country.

It was announced on Monday that SA would host the next triennial meeting of Commonwealth health ministers which will take place in Somerset West from December 4-8. This would be the first Commonwealth ministerial conference to take place in SA.

The theme of the conference would be "Women and Health" and would focus on issues such as the contribution of women to health through their roles in the family and the community.

40% of early deaths 'avoidable'

(85) CTS/4/95

EUNICE RIDER

ABOUT 40% of diseases and premature deaths in Africa could be avoided as they were easily manageable and treatable, according to the World Bank's principal management specialist on human resources and poverty in Africa, Mr Edward Elmendorf.

In his address to delegates at the African Regional Conference on Medical Education in Sea Point yesterday, Mr Elmendorf said better health for Africa was "both imperative and feasible".

He said that although substantial improvements had been made in health over the past generation, Africa still lagged well behind the rest of the world.

Mr Elmendorf said the World Bank had committed $1,5 billion (about R5,4bn) for broadly conceived health projects in Africa over the past 15 years and was expected to commit another $1,4bn (about R5bn) over the next four years, so that projects which were successfully started and later dropped through lack of resources could be completed.

The conference, which ends today and has been attended by deans of medical schools and ministers of health from 46 African countries, is an outcome of the World Summit on Medical Education held in Edinburgh last year.

New health care approach urged

ERICA JANKOWITZ

SA's social welfare system needed serious reform, and in some areas — including health care — a completely new approach was required, delegates to a conference exploring German and SA social policy agreed after two days of deliberations at a venue north of Johannesburg.

Leader of the German delegation and prominent Social Democrat parliamentarian Rudolf Dressler warned that SA should put a welfare system in place immediately.

Although affordability was raised by government detractors opposed to demands for increased benefits and for wider welfare accessibility, speakers said the social costs of not paying adequate amounts were far-greater than the added burden this would place on the fiscus. (85)

In many cases the proportion of GNP allocated to health and welfare systems was in line with or even above countries at a similar level of development, but maladministration, leakages and unfair allocation meant those in greatest need were not the ultimate beneficiaries of these funds.

In social pension provisions, delegates heard that current means testing acted as a "disincentive" to private savings or other private means of supplementing retirement income. Currently, anyone with an income of more than R90 a month did not qualify for a state pension. BDS/4/95

Solidarity in SA, built up during anti-apartheid campaigns and incorporated into the reconstruction and development programme, should be extended to underpin social welfare policy, it was argued.

Hollard

Hollard Insurance Company Limited
(Registration number 52/03004/06)
("Hollard")

Broadacres Investments Limited
(Registration number 05/21193/06)
("Broadacres" or "the company")

A change of control of Broadacres and a subsequent disposal of its business and operating subsidiary company

1. **Introduction**

Further to the cautionary announcement published by Broadacres on 2 February 1995, Mercantile Bank Limited ("Mercantile") is authorised to announce that agreements have been entered into which give effect to:

- a change of control of Broadacres; and
- the disposal by Broadacres of its business and its operating subsidiary, Strykpunt Beleggings Limited ("Strykpunt") to Trans Hex Group Limited ("Trans Hex").

The further effects of these agreements are described in this announcement.

2. **Change of control of Broadacres**

Trans Hex has, with effect from 1 February 1995, acquired a controlling interest of 70,56% ("the controlling interest") in the equity of Broadacres from Shui Lung (Proprietary) Limited ("Shui Lung") for a cash consideration of R7 293 664, which is equivalent to 303,2 cents per share. Subject to the implementation of the transactions referred to in paragraph 3 below and subject to the resolutive conditions referred to in paragraph 6 below, Trans Hex has, with effect from 1 February 1995, disposed of the controlling interest in Broadacres to Hollard for a cash consideration of R7 505 344 which is equivalent to 312,6 cents per Broadacres share.

In view of the acquisition by Hollard of the controlling interest in Broadacres, the Securities Regulation Panel ("the SRP") has ruled that Trans Hex need not make an offer to the minority shareholders of Broadacres ("the minorities") pursuant to its acquisition of the controlling interest.

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(85) CTS/4/95

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The conference, which ends today and has been attended by deans of medical schools and ministers of health from 46 African countries, is an outcome of the World Summit on Medical Education held in Edinburgh last year.

Liz being treated for 'serious' heart condition

LONDON: Elizabeth Taylor is said to be receiving treatment for a heart condition as fears for her health grow.

The 63-year-old actress pulled out of an Aids charity party at the last minute on Thursday night last week, prompting one source close to her to indicate that she must be seriously ill.

Miss Taylor is understood to be at her Bel Air home where she is receiving treatment from a top heart specialist after collapsing with chest pains while dressing.

Reports yesterday said the star was confined to bed and linked to cardiac monitors after her blood pressure suddenly surged. — Own Correspondent

Opel Astras, Kadetts recalled

PORT ELIZABETH: The Delta Motor Corporation is to recall 38 000 Opel Astra and Kadett motor cars manufactured in South Africa since 1993 for a safety check.

Delta spokesman Mr Doug Harrison said the measure was purely a preventative one being carried out at the request of Adam Opel AG in Germany.

The move follows problems experienced in Europe with some of the cars' fuel tank inlet pipes.

Car owners concerned will be notified by mail. — Sapa

Healthcare faces a major shake-up

CT(BR)6/4/95

(85)

By Bruce Cameron

ASSISTANT EDITOR

The healthcare industry, including medical aid schemes, faces a major shake-up as government moves towards implementing some type of national healthcare scheme.

Old Mutual's assistant general manager for employee benefits, Barry Crookes, says in a paper on the issue that it is inevitable that there will be some form of universal primary healthcare.

"The result will be significant changes in the way medical schemes operate and possible increases in employers' labour costs."

Consequences of a national scheme he says are likely to include:

☐ Employers facing a substantial revision of the medical cover they provide for workers with, among other things, the possibility of 3 percent being added to payrolls;

☐ Significant changes in medical aid schemes, which are likely to change to systems more akin to health insurance;

☐ Implications for the pharmaceutical industry, with the possibility of the introduction of a nationally-approved drugs list; and

☐ Healthcare providers, in particular general practitioners, having to provide some form of "subsidised" service on a part-time basis.

Crookes says employers should start quantifying their real expenditure on healthcare now and consider the options available to them.

The government is insistent it will provide primary healthcare for all citizens, particularly those who have been excluded in the past. It is only a question of how it will be done.

At the moment a committee under Jonathan Broomberg is considering various options, including the controversial "Deeble" model, named after Australian doctor and health economist John Deeble, who proposed a compulsory universal primary healthcare system for all, regardless of ability to pay contributions.

The committee has to report before April 23. It has to meet four non-negotiable principles laid down by the health minister, Nkosazana Zuma. These are:

☐ Universal and non-discriminatory access to quality healthcare;

☐ Affordability and sustainability of services;

☐ Efficiency and cost control and

☐ Consistency with RDP projects.

Once the Broomberg report has been debated by the Cabinet it will be released for public debate.

Another Old Mutual senior manager and health cover expert, Heather McLeod, said in an interview that one of the problems for the Broomberg committee was to define primary healthcare, including what the percentages of preventive care were in relation to curative care.

Crookes says that social health insurance models, which seemed the most likely course, required people formally employed to contribute, at a relatively low level, to a fund providing a package of primary health care benefits for which both they, and the unemployed, qualify.

Employers would be expected to provide cover for all other levels of care required by their employees and their dependents.

McLeod says most employers already see between 8 and 11 percent of payroll going on health costs. This could increase by another 3 percent.

Crookes says that because of the likely changes, employers should rethink their approach to providing health benefits, rather than simply expanding their medical schemes.

"To accurately determine the likely impact of a system of national health insurance, employers should begin by identifying their total healthcare expenditure and facilities they provide.

"This will form the basis for evaluating the most appropriate mechanisms for the inclusion of all workers and their dependents in health plan arrangements."

Crookes says many companies do not know the real costs of employee healthcare as, over and above direct payments to medical aid funds, many provide occupational health facilities, the cost of which is often lost in operating expenses.

He expects medical aid schemes to move towards the provision of benefits that are insurable, as opposed to primary healthcare, which is likely to be provided by the state.

world body in Bosnia, through Brit... Army Air Corps ...

Health Minister Zuma will vaccinate babies

KATHRYN STRACHAN

TO MARK World Health Day today and to highlight its theme of a world without polio, Health Minister Nkosazana Zuma will vaccinate babies against polio at a ceremony in Sebokeng on the East Rand.

The World Health Organisation has identified the year 2000 as the date by which polio should be eradicated worldwide. President Nelson Mandela, in his address at the Sebokeng ceremony, will announce steps that government is to take to rid the country of one of the main causes of child paralysis and death.

With an infant mortality rate of 49 for every 1 000 births, SA's record on child health is below that of many of its neighbours. It is estimated that 20 000 to 30 000 babies have been born infected with HIV.

In many areas of SA, up to one third of children under the age of five are undernourished.

Mortality among infants and children is being reduced through an improved national immunisation programme which is expected to reach international goals in the next three years. The use of routine immunisation in SA has led to a dramatic decrease in the occurrence of diseases such as polio, neonatal tetanus (lockjaw) and measles.

A new immunisation schedule has been introduced this week to ensure children are protected earlier in their lives and more effectively. Also, the introduction of hepatitis B immunisation will ensure that in the coming decades thousands will be protected against chronic liver disease and liver cancer.

The immunisation programme plans to increase its immunisation services so that its goals of completely eradicating polio in SA by 1998, eliminating neonatal tetanus by 1997, and controlling measles by the end of the decade are achieved.

The Health Department said it planned — with the use of basic preventative measures — to set up a maternal and child health programme, accelerate the immunisation services and reduce disease and death due to diarrhoeal and acute respiratory complaints.

The promotion of maternal health would take place in the broader context of women's needs and rights.

Strategies for alleviating maternal and child health were closely linked to programmes aimed at reducing poverty, malnutrition and environmental problems, the department said.

Health-oriented sport sponsorship on the way

KATHRYN STRACHAN

PLANS to set up a health foundation which would replace the tobacco industry in sponsoring sports events got under way this week with the visit to SA of Australian campaigner Rhonda Galbally.

Galbally is CEO of the Victorian Health Promotion Foundation, which pioneered the concept.

During her visit Galbally will meet Ali Bacher and other prominent sports organisers, as well as a wide range of non-governmental organisations and health organisations to promote the idea.

The Australian scheme is based on increasing taxes on cigarettes and directing a small percentage of the revenue to health promotion.

The remainder is used for sports and arts sponsorship. The plan promotes health on various levels — the increased cost of cigarettes is a strong disincentive to smoke, while the plan also raises revenue for a range of health promotion projects.

These ranged from tobacco control and end-smoking projects to AIDS, nutrition and exercise programmes, and cancer screening.

Galbally said sports sponsorship had proved a far more seductive and powerful force than direct advertising because of associations with popular sports stars.

A study in Autralia had shown that sports sponsorship had an extremely high influence on brand choice.

Because the foundation's goal was to remove the tobacco industry from sports sponsorship, a replacement was needed.

It had transpired in Australia that the funding available for sports sponsorship was higher than it had been when it was dependent on the tobacco industry. An added benefit was that it was not only the high-profile sports which got sponsorship, and the plan helped to develop sport.

National Council Against Smoking director Yusuf Saloojee said that to raise R100m for health promotion in SA, tobacco tax would have to be raised by 10c.

As tobacco sponsorships for sport amounted to between R8m to R20m a year, a health promotion trust would be ideally placed to provide sponsorships to those sports.

Medical Research Council spokesman Derek Yach said many partnerships were developing in SA to promote the idea. However, Health Minister Nkosazana Zuma believed she had to have the backing of the Arts and Sports Ministries before she took the plan to Cabinet.

Huge immunisation plan for SA

CT 7/4/95

LINDA ENSOR

LONDON: A nationwide polio immunisation programme is to be launched by President Nelson Mandela and Health Minister Dr Nkosazana Zuma in SA today.

The World Health Organisation has set the year 2000 as the target for the global eradication of polio and will focus on the disease today — World Health Day.

Dr Zuma, who was en route to Washington on a fund-raising trip, announced the programme at a press briefing at the SA High Commission earlier this week, and also said SA would host a major conference of Commonwealth health ministers at the end of the year.

She said it is hoped that through the campaign polio will be eradicated from SA in two years.

Dr Zuma also announced that the next triennal meeting of Commonwealth health ministers would take place at Somerset West from December 4 to 8.

It will be the first Commonwealth ministerial conference in SA, and the theme will be Women and Health.

● The Western Cape Department of Health will observe today with its own theme — Children's Health. — Staff Reporter

CAMPAIGNING: Health Minister Dr Nkosazana Zuma. (85)

Union lowers wage demand

CT 7/4/95 (85)

PRETORIA: The South African Health and Public Service Workers' Union yesterday lowered its wage demand to the government to R1 350 a month and said it was "not married" to its insistence on a 15% pay rise.

Spokesman Mr Themba Ncalo told reporters here the original demand of R1 500 a month was "not the union leadership's idea, it came from our members".

SAHPSWU members went on strike in January this year to press for a R1 500 for all public servants.

The action was called off after four days "to give the government an opportunity to respond". The union has since made several threats about its demands not being met and has warned that cabinet ministers would be taken hostage.

"Should our demands for a minimum wage not be met we will definitely go on a national strike from May 1," he said. — Sapa

□ **MEDICS ON CALL:** The container might be narrow — but it has been equipped with lifesaving equipment and Defence Force medics.

Picture: FANIE JASON
Weekend Argus

Soldiering on in the healing hut

(85) ARG 8/4/95

GLYNNIS UNDERHILL
Weekend Argus Reporter

SOLDIERS are not always welcome in the townships — but there is an exception to the rule in Guguletu.

Many lives have been saved by the Defence Force SA Medical Services working in collaboration with residents in a container less than one metre wide alongside the police station.

Stab and gunshot victims are a common sight at the 24-hour satellite clinic at weekends. With major hospitals miles away, patients used to wait for ambulances to take them for medical care before the clinic was opened in last December.

Mountain Qumbela of the Community Policing Forum was working a gruelling shift at the clinic when he spoke to Weekend Argus. His work is voluntary and unpaid, he said.

"Everything is going smoothly. We get most of our patients coming in on Friday, Saturday or Sunday," he said. On a busy night the clinic can expect to treat up to 20 patients.

"Our aim is to train the community itself to treat patients," said Mr Qumbela.

Most of the seriously injured patients are stabilised and sent to Groote Schuur and Conradie Hospitals.

The problem facing the clinic was not the welcome presence of the Defence Force medics — but a "financial one," said Mr Qumbela.

Many of the fulltime helpers, like Mr Qumbela, have to eke out a living selling fruit and other wares.

Medic Corporal Conrad Cloete said the clinic had been the joint project of the Defence Force, police and the community.

"It is working well. People have welcomed us here because they need the clinic."

The clinic might be small but it was functional and everybody was "always busy," said Corporal Cloete.

A second container and a telephone would improve conditions, he added.

Health plan idea dropped

KATHRYN STRACHAN

THE investigation into financing health care in SA has moved completely away from the idea of national health insurance.

Sources said the latest plan was to put more emphasis on the private sector's role in enabling every employee to join a medical aid scheme rather than become dependent on the state.

The controversial "Deeble model" — which the Health Ministry had mooted as its favoured option — has been discarded.

"The Deeble plan is not only dead and buried. It has been cremated and its ashes spread in the wind," said a source. This option, based on proposals by Australian John Deeble, had been impossible to implement and had made way for a more science-based and incremental approach.

Despite promises that the process would be transparent, deliberations within the health financing committee have been largely closed to the media. But industry sources said the issues being debated in the committee included increasing the role of the private sector so that all employees were required to join medical schemes. Regulations would ensure that schemes and service providers kept costs down.

By extending the role of the private sector, the burden on the state would be reduced, and it would be able to spend

☐ To Page 2

Health

☐ From Page 1

more on those who relied on government health care.

Unemployed people would be provided for by the state. An extended district health authority would be central to the new, improved state health structure.

The committee was still looking at ways to redistribute resources within the existing health system and to finance a core package of primary health care services that would be available to all.

It was estimated that another R3,9bn was needed to extend primary health care. The options for financing this included a small tax from the pay packets of employers, employees and the self-employed, or an increase in overall taxation. Another option was to impose an additional levy on medical aid and insurance schemes — effectively a double payment for those who contributed monthly to these.

Elements of the plan, which is expected to be submitted to Health Minister Nkosazana Zuma at the end of the month, are likely to:

☐ Draw private general practitioners into the public service with incentives and a further system of accredited practices which would work privately — but for the state's patients;

☐ Eradicate as far as possible the "risk rating" imposed by medical aids and insurance companies so that those most in need of private sector care, such as the aged and chronically sick, could be covered at the same fees as younger and healthier people; and

☐ Give some incentives back to contributors to these schemes by allowing the schemes to buy medicines at the low state tender prices. Savings could then be passed on to contributors.

Call for action on lead levels in Soweto children

(57) (85) (18) CT 11/4/95

SPECIAL CORRESPONDENT

JOHANNESBURG: A co-ordinated metropolitan approach was needed to reduce high levels of lead in many Soweto children, according to local director of environmental health Dr Yasmin von Schirnding.

Dr Von Schirnding said international lead safety levels had been reduced over the last three decades and it was "not known if there is a safe lead level".

While lead levels in the blood of many Soweto children were high, this was not unusual in many parts of the world. However, while lead levels in one child could have little or no effect, another child with the same levels could be severely affected.

"We need a concerted effort to reduce lead levels," Dr Von Schirnding added. Lead was most prevalent in petrol and in leaded paint used in older homes.

Lead levels were not above safety levels throughout the metropolitan area, but there were "pockets of problems", she said. The metropolitan council was in the process of making a comprehensive assessment of the situation to develop a health policy.

Between high technology and no health care at all there must be a middle path, says ***Ron Schurink***

Skeleton of health to be fleshed out

(85) Star 12/4/95

Planned district health committees, electronic data interchange, a powerful business move into medical practice and high medical technology are to be intermingled in South Africa.

Accepted on all sides is that cures are needed for two vastly different ills:

- Lack of circulation of even primary health care to certain sectors of the population.
- Weakness in the strongest part of the system — delivery of health care to those South Africans who have medical aid.

A number of schemes have gone bankrupt; membership of others is deterringly expensive. Even before several inquiries report their findings, Minister of Health, Dr Nkosazana Zuma's, department is moving.

It is liaising with each provincial government on defined health districts, which may differ radically from administrative and local authority jurisdictions.

The plan for a new "basic skeleton" for health care coincides with wide rationalisation of urban medical practice as:

- Thousands of practices, mainly of general practitioners, group themselves in regional independent practitioners associations across the country. These make viable both electronic interchange, or EDI — to speed communication with medical aids and therefore cash flow — and clinics which are IPA staffed.
- The Malbak group, through subsidiary SA Druggists, in partnership with Murray & Roberts Construction, launches new-concept clinics in many urban areas. These aim at cost-effective accommodation and facilities for doctors and dentists and convenience for patients.

More than 1 000 practices in different IPAs already have their patients' claims forwarded to medical aids through an EDI intermediary the day after a consultation.

It's claimed that in many cases payment is received within 25 days, a vast improvement on the longer-than-90-days which many practices say was common and which made them, willy-nilly, unwilling providers of credit.

Doctors say IPAs also give another dimension to the "peer review" exercised by regional committees of their professional body the Medical Association of South Africa. Data is now available to show which doctors' charges are out of line, and which make the best use of more cost-effective "generic" drugs (normally based on "ethicals" whose patent has expired).

Sixteen clinics have already opened, with little fanfare, in different urban areas. Another 40 are on the drawing boards.

The scenario can be seen as a "middle path" between what has generally been the experience of blacks in public hospitals on the one hand and of whites on the other. Practitioners at Medicross clinics drive their own practices and are not in employment like hospital doctors.

The gamble being taken, in true free-enterprise spirit, is that this "middle path" will be the answer to either medical aids or a new insurance body insistence on cost-effectiveness in health care.

The "over-empowerment" of medical aid members, leading to overspending on health care (pushing it up to 8,5% of GDP), can be illustrated by the story of magnetic resonance imaging, or MRI, in this country.

It is one of modern medicine's foremost diagnostic tools. The R10-million cost of the newest units rules them out for radiology practices in this country, but of older ones, costing between R5- and R7-million there are no fewer than 40 — funded at medical aid tariffs.

One guesstimate is that Gauteng alone has more than the whole of Australia. A simple mirror-slice of what South Africa needs must surely show:

- Expensive high tech only at "tertiary" hospitals and clinics (probably also teaching institutions), to which public- or private-sector specialists patients would be referred.
- Well-equipped "secondary" hospitals or clinics, also served by specialists, to which patients would be referred.
- Practices or district clinics providing health care to general practitioner level.

Undoubtedly, there are people who would like South Africa to have only state health care a la Cuba. Hence the case of the shakes in private sector health care, and thoughts of possibly taking Government to the Constitutional Court — before emigrating.

Media banned (85) from medical talks

CT 12/4/95

PRETORIA: The South African Medical and Dental Council (SAMDC) decided at its general meeting here yesterday to discuss the composition of the Interim National Medical Council in camera.

The council felt the strategy it was formulating to be presented to Health Minister Dr Nkosazana Zuma should not be divulged to the media.

It appeared the SAMDC was unhappy because medical professionals, who contributed 78% of the council's funding in membership fees, would be only marginally represented on the interim council.

The interim council, which will include the medical councils of Transkei and Ciskei, could be implemented in June.

The parliamentary committee on health has proposed that 15 interim council members come from the SAMDC, while nine members be drawn from the community and a further nine represent the various regions. Of the latter 18 members, 14 need not be in the medical profession.

Since the SAMDC's function is the promotion of health, it felt there should be a strong medical presence, at least 20 of its members, on the interim council. — Sapa

Inkatha cracks down on financial irregularities

BD 13/4/95

FAROUK CHOTHIA

DURBAN — In a bid to improve its financial health, the Inkatha Freedom Party was cracking down on financial irregularities and abuse of resources within its ranks, Inkatha secretary-general Ziba Jiyane said yesterday.

The party was also set to embark on a vigorous campaign to raise funds both locally and internationally in the run-up to the local government poll, confident that its strong commitment to free enterprise would work in its favour, Jiyane said.

He acknowledged that Inkatha's current financial situation was not healthy.

The party had cracked down on several "syndicates" that were using party receipt books to raise funds, but were not handing the funds over to proper structures. Some Inkatha members had been expelled as a result of the crackdown, while others had been transferred.

Jiyane said the Inkatha head office had also withdrawn most motor vehicles assigned to regions, before selling them off, in order to curb abuse.

Inkatha's once largely dormant ethics and disciplinary committee was now active under the chairmanship of Correctional Services Minister Sipho Mzimela.

It had recommended the public censure of seven senior Gauteng officials, including Themba Khoza and Koos van der Merwe, as a result of financial irregularities during last April's election campaign.

Jiyane said the committee's report would hopefully be discussed at a national council meeting on April 21. The issue was delaying the inauguration of a provincial executive committee in Gauteng.

The powers of the disciplinary committee had also been strengthened recently. It was now the "final court of appeal" for party members, except those elected at the national conference.

Inkatha had decided that for the local government election campaign, each area would raise its own funds.

Councillors elected to transitional metro and local councils would contribute 5% of their salaries to their area campaign. MPs were already making such a contribution to party coffers.

A central kitty, however, would exist.

Jiyane said with Inkatha having thrown its weight behind the November 1 poll, he was confident the party would succeed in raising funds for the campaign. After switching away from its boycott stance during last April's election, Inkatha raised more than R2m in four days from the business sector.

Foreign donors were also willing to contribute towards Inkatha projects with the Dutch government having donated R500 000 last year and R1m this year.

Project-based funding would also come from the German-based Democracy Development Project and the US-based International Republican Institute and the National Democratic Institute for International Affairs.

Inkatha treasurer-general Arthur Konigkramer said he had taken steps to ensure that the disciplinary committee's proposal that he also be censured be rejected.

He was unaware of the existence of the committee, or that it was conducting investigations until it tabled a report at a national council meeting on Saturday. No evidence was sought from him.

Konigkramer said he "utterly rejected" suggestions that he bore direct or indirect responsibility for alleged financial irregularities in Inkatha's Gauteng region.

SA will print poll papers

BALLOT papers for the November local government elections will be printed in SA, a decision welcomed by local printers who were angered last year by the general election ballot printing contract which was awarded overseas.

The Printing Industries' Federation of SA had been appointed to co-ordinate the printing, federation CE Chris Sykes said yesterday.

Local printers were more than equal to the task and would do the work for much less than foreign companies, he said.

Ballots for the April 27 election last year were printed by a British firm for more than R30m, a job the federation said could have been done for around R7m.

"Clearly we don't want business of that nature to go overseas, especially when it costs the taxpayer more," Sykes said.

The Independent Electoral Commission awarded printing contracts abroad last year based on security concerns following bombings and right-wing threats.

Printers would have just 40 days from the closing of the nominations to print ballots for the potential 23-million voters in an estimated 7 000 wards, Sykes said. — Sapa.

Less cash needed to improve health care

BD 13/4/95 (85)

KATHRYN STRACHAN

THE GAP in funding required to get primary health care services up to a desirable standard is smaller than originally thought — a discovery which has increased the flexibility of options now before the health financing committeee.

Committee co-chairman Jonathan Broomberg said primary health care had been given higher priority in existing budgets, and this had meant the funding gap had lessened.

The options, along with detailed recommendations, would be presentened in a report to Health Minister Nkosazana Zuma later this month.

Broomberg said the idea was to enhance public funding for primary health care using a mechanism that could be supported in both macro-economic and political terms.

A wide range of flexible relationships between private doctors and public primary health care facilities were being explored.

Other areas the committee was focusing on were strengthening the public delivery system through competent district health systems, increasing competency and skills, and finding the optimal mix between public and private health care provided.

The committee had investigated the feasibility of a range of options, and it had also looked at political considerations and the views of business and labour.

Boycott decision in July

HEALTH (85) FM 14/4/95

Free-for-all

Government plans for a National Health Scheme are expected to be unveiled later this month. The likely model is "free" primary health care, putting the onus mainly on employers to provide secondary and tertiary levels of care for employees.

The committee investigating a health model — justifying the campaign slogan "free health for all" — is due to report by April 23. After that, the matter goes to

Cabinet for review.

A shake-up in both medical insurance and medical aid schemes, which will need to concentrate in future on benefits which fall outside the primary care category, seems inevitable.

Barry Crookes, director of Old Mutual Actuaries and Consultants, says campaign slogans may have raised false expectations. It's unlikely a National Health Scheme will provide all benefits — such as scans — in the casual way they are prescribed for medical aid members. He argues many expensive procedures are an aid to diagnosis, but do little more than support primary assessments.

He anticipates a forced contribution from the formally employed to finance primary care for all, including the informally employed and the unemployed. "As a result, medical schemes are expected to move away from financing primary health care, and their future focus is likely to be on more insurable risks. Medical insurance and medical schemes will be able to adopt a more long-term focus."

He argues employers should now identify their total expenditure on employee health. This includes not only medical aid contributions, but occupational health facilities, Aids awareness programmes, TB screening, executive health screening, recreation facilities or employee advisory programmes to deal with substance abuse or emotional problems."

With all the costs identified, including some hidden inside manufacturing costs, a total health plan for all employees can be reached — but excluding primary care which will be available to all — "though it's an illusion to believe there is any such thing as free health care." ■

or completely wasted, he says.

Bloom says the amount of water lost in water distribution systems throughout the country is possibly greater than the combined demand of Johannesburg, Durban and Cape Town.

"Municipalities are major culprits through the lack of adequate measures to account for water, often relying on wholly unrealistic estimates by town treasurers rather than accurate measurement by town engineers using the litre-in-litre-out approach," says Bloom.

World Bank figures indicate a target of 15% unaccounted water for urban centres, rather than the 20%-30% existing in most SA cities.

The problem is prevalent in all socio-economic areas of the country, say water engineers. Some of the biggest losses, however, are in traditionally black areas. A recent survey in greater Soweto indicated that leakage through plumbing fittings within properties amounts to millions of rand a year wasted.

Even worse, there are illegal connections to water pipes in many informal settlements which are permanently free-flowing and without seals.

Investment in effective control measures would be a major step towards alleviating the water crisis and averting water rationing, essentially paying for itself in savings from less wastage of water.

What is needed, Bloom says, is the appointment of a technical body to effectively manage the water distribution industry. "There can be no control without measurement, therefore legislation should require all water authorities to undergo an annual water audit undertaken by independent water auditors.

"Such an audit is a management tool to help reduce water and revenue losses, reduce inefficiencies, plan renovations and evaluate operations and water rates. One estimate is that a national policy of water loss management could save R210m on water leakage alone.

According to Rand Water, annual leakage savings of R50m-R80m could realistically be achieved in Gauteng, deferring the need for further expensive water schemes. ■

HEALTH CARE (85) FM 14/4/95

Principled progress

Private-sector health-care players have put their heads together to seek a national health-care system that can deliver universal, affordable and accessible health care to all.

The effort — supported by doctors, private hospitals, drug manufacturers, pharmacists, medical schemes and other industry players — is contained in a document headed the "Balalaika Principles". It serves as a basis for players' individual submissions to the Broomberg/Shisana Committee of Inquiry into a national health insurance system for primary health care.

Convened in January by Health Minister Nkosazana Zuma, following outcry over her attempted implementation of the "Deeble Plan" that sought to nationalise all GP services, the Broomberg/Shisana committee is due to complete its findings at the end of April. The committee is said to have discarded Deeble and the thinking that any State-dominant national health insurance model can deliver the goods.

Zuma . . . *outcry over Deeble Plan*

To this extent, the Balalaika document is valuable. It acknowledges the present health system needs changing, it stresses that the existing infrastructure must be taken into account. Any change must be "incremental, progressive and continuous, including all stakeholders." Change should also be based on a controlled pilot study.

The document calls for more efficient use of existing public and private resources before any contentious or unaffordable enlargement of total health-care expenditure is considered. Experts estimate that deregulation, competition and greater efficiency in both sectors could result in savings of up to 40%.

The document stresses that both the public and private sector have a definite role to play in providing health care.

It states: "The health of the nation is also dependent on infrastructure under the responsibility of other planning and service departments. There should be inter-sectoral responsibility for the development of a health-care system which takes water, sanitation, disease prevention and trauma prevention (violence and road accidents) into account."

Access to a health-care service that the country can afford is considered a human right. There should be universal access to a core package of health-care services which must include all levels of care and not just primary health care. The core package is to be designed by the community, epidemiologists, providers and professionals rather than politicians alone.

Ambitiously, the document states that the core package should include all diseases whose treatment is required to improve the health status and socio-economic needs of the country. "The package should, therefore, be designed on a functional rather than structural basis."

The system design should allow for alternatives which would allow the right of choice for both patients and providers — a proposal that is likely to foster competition. The public should become involved and share responsibility for all aspects of the system — design, control, utilisation, prevention and self-medication, suggests the document.

On funding, the players are adamant that there should be no special or earmarked taxation for health outside general taxation. The system should however, include a centrally controlled "social solidarity fund" to finance the core package. The fund would ensure equal benefits for all, contributions on the basis of community ratings, redistribution of funds and acceptance that existing funders and purchasers could act as agents for the special fund.

The document, in line with latest international thinking, recommends that a separation between the policy makers, providers and funders is essential for both the public and private sectors if efficiency is to be optimised. It also proposes that the community, purchasers and providers of health care set criteria to rate or accredit providers.

Providers from the public and private sectors should be able to compete in the marketplace — a move that is probably designed to attract doctors back into the public sector. Accreditation criteria should include quality and treatment outcome measurement, as well as recognised professional qualifications.

States the document: "Maximum productivity and efficiency is facilitated by appropriate financial incentives for providers, purchasers and patients. Perverse incentives create inefficiencies and should not be permitted in the system" — a recommendation that favours the managed health-care principles that seek alternatives to traditional fee-for-service payments. It stresses that universal access to health care should be at the appropriate level of care — with the focus being on primary care to ensure best use of resources.

The Balalaika document concludes that "equity" should be defined as equal access to the proposed core. But "equity cannot be consistently applied throughout SA due to urban and rural demographic and socio-economic differences as well as variations between public and private facilities. The cost of providing equity is, therefore, beyond the country's short-term financial ability." ■

NEWS Lindiwe Zulu beats off chall

Chairwoman for local legislature

Sowetan 19/4/95 95

■ GOOD FEELING Zulu says she feels elated at her appointment:

By Pamela Dube
Political Staff

AFRICAN NATIONAL CONGRESS member of the Gauteng Legislature Ms Lindiwe Zulu was yesterday elected presiding chairwoman of the provincial parliament.

Zulu beat the National Party's Mr Jacobus Bosman by 44 votes to 23.

Delivering her maiden speech after her election, Zulu said although she felt elated, she still held sad memories of the past.

She recalled days in exile in Angola "where we lived like animals. In those years, none of us knew we would be here in government today. I will always make it my duty to remember my comrades who died in Angola," she said.

In another development, the Gauteng Legislature passed a motion to apply for membership of the Commonwealth Parliamentary Association.

Sapa reports that in another debate in the legislature, Democratic Party spokesman for health Mr Jack Bloom said foreigners accounted for as many as four-fifths of doctors at some Gauteng hospitals, some of whom were unqualified and a possible danger to patients' lives. Gauteng Health MEC Mr Amos Masondo, in a written reply to a question from Bloom, disclosed yesterday that the province employs 500 foreign doctors in its hospitals.

"Very few such doctors are from the highly sophisticated countries of Europe or the Americas, most coming from the underdeveloped world not renowned for high standards in medicine," Bloom said.

Pakistan and Zaïre accounted for 55 doctors each in South Africa, with 49 from Bulgaria, 47 from Poland and 27 from Zambia and Bangladesh, according to Masondo's figures. Some hospitals, particularly those in predominantly black areas, showed a "disturbing reliance" on foreign doctors, Bloom said. Garankuwa had 140 foreign doctors, Tembisa 59 and Sebokeng 40.

The foreigners usually had only limited registration with the South African Medical and Dental Council and were in most cases employed because local doctors could not be recruited to fill vacant medical posts.

(85) Star 29/4/95

Medical boards seek applicants

The South African Medical and Dental Council (SAMDC) yesterday invited the public to apply to serve on 16 of the 17 professional boards comprising the Interim National Medical and Dental Council of South Africa. The SAMDC said the boards wanted to be more representative. The positions would be unpaid for the duration of each board's term of office. Positions were available on the professional boards of clinical technology, dental therapy, dietetics, dispensing opticians, emergency care personnel, environmental health officers, medical orthotists and prosthetists, medical science, medical technology, occupational therapy, optometry, oral hygiene, physiotherapy, podiatry, radiography, and speech-language therapy and audiology. Those interested should send their applications, motivation and curriculum vitae to the Registrar, Public Representation, Professional Board for ... (name of professional board), Box 205, Pretoria 0001. — Sapa.

Radical health 'plan' ahead

By Glenn McKenzie

BACK in January, the media lit up with stories of a radical new, universal health insurance system for this country.

Almost immediately, Health Minister Dr Nkosasana Zuma tried to diffuse the excitement and controversy. There was no "plan" just yet, she said ... but a new ministerial committee would be submitting a proposal to her at the end of April.

Now, Zuma's special adviser Dr Olive Shisana says the new committee has gone a long way towards creating this proposal.

Shisana expects the Government to train more than 8 000 nurses, create an extra 3 000 examination rooms and make jobs for 1 600 doctors and 400 health managers in the next two years.

In addition, universal health coverage for all South Africans will be ensured, including access to drugs to treat the 37 most common ailments seen by primary health care workers. All this at a cost of only R700 million in "extra funds" in 1996.

Sounds easy

Sound incredible? Shisana makes it sound easy. In a lecture to the National Productivity Institute last week, Shisana said the Government already has most of the money needed to reform South Africa's public health system.

In addition, some money will be retrieved from the current budget by "increasing efficiency and shifting policies" in hospitals and other health facilities.

The estimated R700 million shortfall could be raised by taxing individuals, companies, or even medical aid schemes, says Shosana.

"It would be just a small amount of tax that we hope is affordable," she said.

But the money raising task will get tougher as the century winds to a close. According to Shisana, the better South Africa's health system gets, the more money it will need.

By the year 2000, the Health Ministry is expected to need an extra R2 billion a year in addition to its regular income.

That's because as things stand, many South Africans never visit a doctor or nurse.

Government figures show average South Africans visit health professionals only 1,6 times a year.

But with health reform and more clinics in rural areas, this number could rise to 3,5 visits annually by the year 2000. And so far it is not known where the required funds will come from.

NATIONAL HEALTH

Will Zuma back off?

(85) FM 21/4/95

The Broomberg/Shisana Committee of Inquiry into a national health insurance system is due to report back this month and speculation is rife as to whether any of the discredited socialist principles of the Deeble model will survive.

Health Minister Nkosazana Zuma is said to favour the Australian-authored model but industry consensus is that commonsense will win the day and SA will opt for a more workable system.

Committee co-chairman Jonathan Broomberg says that while the committee is still deliberating there is agreement on several key principles. One appears to be that private medical schemes and insurance will still be able to cover GP services — a possibility ruled out under Deeble.

But the concession apparently comes at a price. Says Broomberg: "We are looking to raise additional revenue to bridge the gap between existing public expenditure and what's needed to provide quality primary care. This could be done either through a small payroll tax or an additional charge on medical aid premiums."

Broomberg won't give a figure but says it is far less than originally anticipated since adjustments to the national health budget have already allocated more funds to primary care. (The Deeble model sought to raise R5bn in new revenue.)

It is a proposal unlikely to be received well either by the industry or an already overtaxed public. In individual submissions to the committee the Medical Association of SA (Masa), National Association of Private Hospitals (NAPH), SA Chamber of Business (Sacob) and other major players stress that there should be no new or additional earmarked health tax.

Masa says: "More efficient use of existing resources in both the private and public sector should be explored since present health care expenditure already consumes more than 8,5% of GDP." The World Health Organisation recommends 6% for a developing nation.

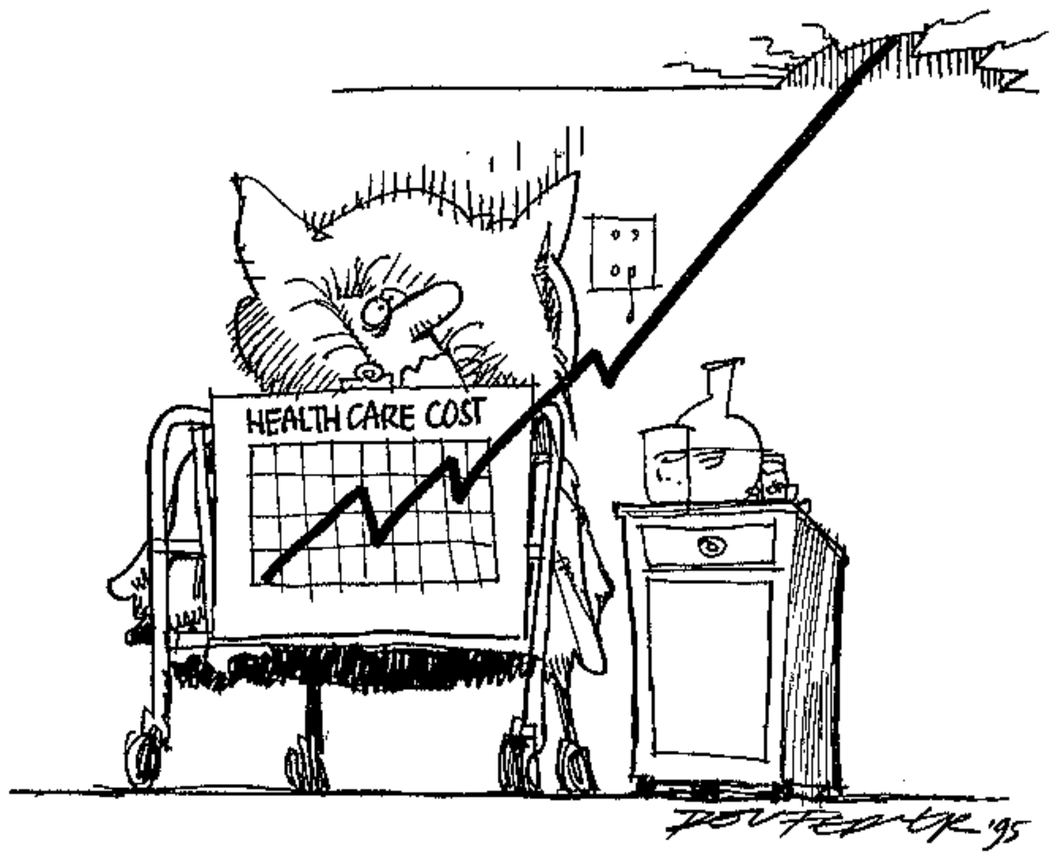
The committee also appears to be considering proposals for compulsory medical aid membership for all employees for a defined package of services.

Broomberg says: "Any mandatory privately funded core package would probably not cover primary health care since government will be offering a very broad and comprehensive, publicly financed primary care system to which everyone will have access."

It's a promise that meets Zuma's requirement that access to primary health cover should be universal, without any discrimination, particularly as to income. But such wide State cover is also unaffordable unless it is premised on the notion that most privately insured patients will make limited use of State facilities.

The Rams submission argues the issue differently: "Affording primary health-care cover to all employed people and dependants through accredited medical schemes would alleviate the State's burden by seven million beneficiaries."

It seems the committee is ready to explore the greater use of private sector providers and facilities. Says Broomberg: "While the public delivery system, through district health authorities, needs to be strengthened, we will try to move to a model where these authorities act only as purchasers of services from a mix of providers — both public and private."



He says the committee is looking at a number of mechanisms to attract doctors and medical personnel into existing State services. "We are also looking to refer patients to the private sector at prenegotiated rates, creating the opportunity for groups of health professionals to deliver composite care to the State through multidisciplinary practices, thus also strengthening co-operation between both sectors."

But if private sector health services are to become more accessible, they need to become more affordable. Broomberg says the committee will make a number of broad proposals to address problems in this sector. Deregulation of retail pharmacy ownership is likely to be among them.

Medical schemes may also find themselves having to return to mandatory community rating as opposed to risk rating — a practice that has gradually been allowed since changes to the Medical Schemes Amendment Act were first made in 1989 and consolidated in 1994.

Community rating seeks to offer cover to groups of people irrespective of their individual claims history.

Schemes argue this leads to abuse and over-use by members and providers. It also unduly punishes those who use their scheme benefits sparingly. ■

AIRPORTS COMPANY

Holding pattern

Government has been advised to wait at least two to three years before privatising State-owned airports. Meanwhile it should consider selling 20% of the Airports Company Limited (ACL) to a "strategic investor" for R200m-R300m to help fund a R1bn capital investment programme needed to upgrade and extend existing airports over the next five years.

The recommendations are the result of a five-month review of airports policy by an investigating team headed by British consultant Allan Munds. The team includes Vienna International Airport president Franz Kotrba and Alistair McDermid, head of airport strategy at BAA, the company that runs Britain's airports.

The results of the investigation were released this week.

The privatisation proposals are a blow to those who believe government should immediately liquidate its investment in the ACL. The Cape Chamber of Commerce and Industry estimated recently that R750m could be raised for RDP projects if the ACL was privatised. This week's report puts the value of the company at R1bn.

Though both the Department of Transport and the ACL have endorsed the review, Transport Minister Mac Maharaj declined to be drawn this week either on privatisation or the sale of a minority stake in the ACL. He pointed out that the investigating team had not proposed privatising the company but merely suggested a strategy for establishing a "reasonable track record" which could place it in a more favourable position over the next few years should government decide to sell it.

Part of that strategy was capital in-

St John extends help in new directions

(85) KATHRYN STRACHAN BD 25/4/95

THE St John Ambulance Foundation has ventured in a new direction, launching a range of health programmes and a community eye clinic.

Regional director Joe Field said the changes in government's health services had left many opportunities for St John to widen its scope.

After discussing its ideas with the community and surveying the most pressing health problems, the organisations began working on its new initiatives.

Its first project, which is aimed at teaching people in the community how to deliver basic services, is being pioneered in the Orange Farm squatter camp, south of Johannesburg.

A community health centre with its own ambulance service has been set up in Orange Farm, and people in the community are being trained to look after minor health problems in the area and to promote health awareness. The training includes basic first aid and home care for the elderly and bedridden, as well as information on issues such as nutrition, hygiene and child care.

Field said St John had made a major transition from being a welfare organisation to being a fund-generating business. It was expected that the Orange Farm health centre would generate income, which would be used to set up similar centres in other areas.

Other St John programmes, which were offered to community organisations and to industry, covered immunisation, TB, nutrition and AIDS. They aimed also at equipping women and the youth with skills. The programmes run for communities were subsidised by the revenue collected from programmes offered to industry, and from the ambulance service.

The latest venture is a community eye clinic opened in Braamfontein, Johannesburg, which is aimed at assisting the underprivileged and those earning less than R1 000 a month with eye tests and spectacles at budget rates. The clinic was set up in partnership with SA Breweries.

SA Breweries backs bid to aid young businessmen

THEO RAWANA

A NATIONAL business initiative for unemployed youth would be launched in Johannesburg next month, SA Breweries announced yesterday.

Kick-Start '95, a joint venture between SAB (Beer Division) and the National Youth Development Forum, would be managed by the Centre for Opportunity Development, SAB said. BD 25/4/95

"The project endeavours to educate and encourage unemployed youth to start small or micro-enterprises. It comprises three phases: mass education, competition, and success enhancement."

The mass education phase consisted of 11 lessons on how to start a small business, to be run in regional newspapers and one national newspaper from May to July.

"During the first phase, 30 community trainers selected by each regional committee will attend a five-day business training course conducted by the Centre for Opportunity Development at venues in the respective regions," SAB said.

Upon successful completion of this course, the community trainers would train 50 young people between the ages of 19 and 30 to develop a business plan, identifying opportunities in their environment and starting up a small business.

The proposals will be submitted for the first round of the competition, by August 7.

"Through a panel of judges, each region will select 50 good business plans whereupon each entrant selected will receive an award of R1 000 as seed capital in order to start the micro-enterprise proposed."

After a period of monitoring by the community trainers, three top performers would be selected from each region to receive start-up capital of between R3 000 and R10 000 in January next year.

"It is foreseen that ongoing support will be provided for the 24 successful young people through ongoing monitoring and assistance from the regional committees."

Zuma calls for healthier lifestyle

(86) BD 25/4/95

KATHRYN STRACHAN

LIFESTYLE diseases were responsible for nearly half the deaths of South Africans, Health Minister Nkosazana Zuma said yesterday in a statement emphasising the need for programmes which addressed unhealthy living.

The major causes of death were cerebrovascular and heart diseases, and tobacco and nutrition-induced cancers.

Estimates showed that between 1-million and 2-million people in SA suffered from diabetes. The hospital costs of these diseases amounted to R202m a year.

Chronic lifestyle diseases, with smoking standing out as the main contributor, cost the country about R5bn a year.

According to the World Health Organisation, lifestyle diseases caused up to 50% of deaths in developing countries, and the trend was starting to have an effect on the disease pattern of SA. As the lifestyles of black South Africans became more Westernised, the burden of chronic lifestyle diseases in SA would soon mirror the pattern of black Americans.

Zuma said programmes were needed to equip people with the knowledge and skills to promote their well-being.

Militants threaten W Cape government

ARG 26/4/95

Staff Reporters

THE militant South African Health and Public Service Union, which shut down Cape Town's ambulance service for eight hours, says it plans to bring the Western Cape government to its knees.

The union says it does not rule out the blockading of highways, the occupation of government buildings or the taking of cabinet ministers hostage to achieve its aims.

The announcement came shortly before police arrested 33 union members at the Pinelands ambulance station on charges of trespassing, after the workers occupied the control centre for more than eight hours yesterday, jamming all incoming calls and radio frequencies.

The union's national publicity secretary Themba Ncalo said the union demanded official recognition by the Cape Town City Council and the removal of the ambulance service's entire top structure, which it accused of being racist.

Last night's arrests followed a breakdown in talks between the union and the city council.

Alan Dolby, deputy city administrator, said talks broke down when the union refused to accept a council proposal.

"The agreement was that council would consider demands for provisional recognition and investigate full recognition.

"They wanted instant agreement, not for council just to consider it."

Mr Dolby said negotiations would continue, but that no more disruption of ambulance services would be tolerated.

Union members did not resist arrest last night and left the control room peacefully, singing and chanting. They were taken to Maitland police station.

Police also took possession of four firearms handed to them by the workers.

The chief officer of the Cape Metropolitan Ambulance Services in the Western Cape, Rod Douglas, said the service covered about four-million people in the Western Cape metropole.

"This is a labour dispute between them and the council. We are in the business of saving lives but cannot do our jobs while calls are blocked.

"This is one of the darkest days in the history of the ambulance services ... The situation has been critical."

Other ambulance staff at the station said they were "sick and tired" of the disruptions caused by their fellow workers.

The South African Health and Public Service Union espouses a socialist line and is not affiliated to a trade union federation. It is strongest in the Gauteng and North-West provinces, and Bloemfontein, and is attempting to increase its membership in the Western Cape.

HANDS UP: One of the 33 South African Health and Public Service Workers Union members arrested for occupying the ambulance control room in Pinelands is searched before being taken to the Maitland police station.

Mr Ncalo returns to Pretoria today to face conspiracy charges after the occupation of a government building amid mass arrests about two months ago.

The union has been linked to the radical Muslim organisation Hamas.

The union claims to have a self-defence unit, trained inside the country, to protect its members from the police. Mr Ncalo said plans were already advanced to form a similar unit in the Western Cape.

Referring to the action by ambulance workers, he said the union did not care that it was disrupting essential services as it had briefed "numerous" community organisations and been given the go-ahead for its proposed action.

● Community leader Hennie van Wyk has hit out at the SA Municipal Workers' Union for failing to accommodate the interests of the demonstrating union.

He said the conflict between ambulance service workers and management had been lingering for at least two years.

Major shake-up in Health Dept

(85)

ANTHONY JOHNSON

CT 27/4/95

MINISTER of Health Dr Nkosazana Zuma yesterday announced the appointment of six new chief directors in the Department of Health.

The appointees, many with foreign academic training, come as part of a major personnel shake-up in the department. Five of the appointees are black and two are women.

They are:

- Dr Glaudine Mtshali as chief director of national programmes. She is presently a director of the Harvard Community Health Plan in Boston.
- Mr Bada Pharasi as chief director of registration, regulation and procurement. He currently works for Wits University.
- Ms Mmathari Matsau as chief director in the operational and technical policy division. At present she works for the Association for the Advancement of Black Accountants of SA.
- Mr Hugo Badenhorst as chief director of departmental support services. He is presently director of administration in the Department of Trade and Industry.
- Dr Mohammed Jeenah as chief director of health information, evaluation and research. At present he works for the Medical Research Council.
- Mr Vuyani Mabope as chief director of health systems. He is currently special adviser to Minister without Portfolio Mr Jay Naidoo.

Knocking health into shape

■ BY DAVID ROBBINS
HEALTH WRITER

When Dr Nkosazana Zuma became South Africa's new health minister in May, she acknowledged immediately: "It's an enormous task, but change is absolutely necessary."

Developments in the past 12 months indicate, however, that the new minister has not forgotten her words.

The system she inherited was riddled with racial and geographical inequities, and to counteract these, Zuma brought with her into the ministry the ANC's national health plan which focused attention on equity and accessibility.

Certain things happened almost immediately. The first was the inaugural announcement by President Mandela that free health care would be available to all pregnant women and children under six years.

At the same time, however, Zuma was speaking to the nation's seven academic hospital complexes. She persuaded them to shave 5% off their collective budget.

Star 27/4/95

Shifting

Soon after taking office she called in the experts. They were drawn from within the various health administrations, from academia, from the private sector and from outside the country.

Many of the recommendations concern the efficient governance of public health facilities, but the most interesting tackle various aspects of the fundamental issue: the shifting of resources from the private to the public sectors.

Recommendations to curtail profiteering in SA's pharmaceutical industry are seen as particularly welcome, as is a recommendation that would optimise the use by both sectors of expensive medical equipment owned by and often under-utilised in the private sector.

More controversial are suggestions to coerce graduate doctors and other health professionals to work for specified periods in underserved areas.

Taken together, the recommendations of Zuma's committees begin to resemble an implementation plan which is currently being debated at provincial level.

Up to R2,5bn a year needed for public health

ET 28/4/95 (86)

THOUGH South Africa spent more than R30 billion on health services in 1992/93, the numbers of hospital beds and health staff relative to population were average or below average for a country with its GDP, a new report on health spending has found.

The report, compiled by the University of Cape Town's health economics unit, also estimated that an additional R1,5 to R2,5bn would have to be spent annually on public sector primary care services to extend basic health services to everyone who needed them.

FUNDS NEEDED: Health director-general Dr Coen Slabber

The document was handed over to Department of Health director-general Dr Coen Slabber on Wednesday.

Ms Di McIntyre, of the unit, said at a press conference the report showed the private sector had to become more supportive of the public sector.

Only 17% of the population had medical aid and only 23% regularly used private sector health services, yet the private sector had a substantial share of total health care resources.

In 1992/93 — most of the statistics in the report were from these years — only 11% of the health budget was used for non-hospital primary health care services.

Public health care resources were also not distributed fairly between provinces, or regions within the provinces.

Dr Slabber said this imbalance had to an extent been adressed in the 1995/96 Budget.

Provinces like the Western Cape had received less than in previous years and provinces like the Northern Transvaal had received substantially more.

Ms McIntyre said that previously the richest magisterial districts had employed 4,5 times more general practitioners, 2,4 times more registered nurses and 6,1 times more health inspectors than the poorest districts.

Average public spending per person in the richest districts was 3,6 times that in the poorest districts.

Additional funding would also be needed to build new primary health care facilities. It would cost up to R1 billion to build 1 000 new clinics.

In areas where there were no public health care facilities but private facilities existed, the government might put out contracts for primary health care services.

World Bank representative Mr Stephan Klasen complimented the country for its collaborative effort in compiling a report which represented the health sector so broadly. — Sapa

NEWS

Blacks, women to the fore

Health gets 6 new heads in shake-up

Star 28/4/95

B5

■ OWN CORRESPONDENT

Cape Town — Minister of Health Dr Nkosazana Zuma has announced the appointment of six new chief directors in the Department of Health. The appointees are part of a major personnel shake-up in the department.

Five of the appointees are black and two are women. Three senior posts are still vacant.

The appointees are:

■ Dr Glaudine Mtshali as chief director of national programmes. She obtained an MBChB and LLB from the University of the Witwatersrand and an MBA from the University of Massachusetts.

■ Bada Pharasi as chief director of registration, regulation and procurement. He obtained an MPharm from the medical academy of Sofia in Bulgaria.

■ Mmathari Matsau as chief director in operational and technical policy. She has a BSc from the University of Lesotho, an MSc in community health from the University of Liverpool and a postgraduate certificate in planning and management from the University of Connecticut.

■ Hugo Badenhorst as chief director of departmental support services. He has a BA (Hons) in public administration from Unisa.

■ Dr Mohammed Jeenah as chief director of health information, evaluation and research. He has obtained a BSc (Hons) and MPhil from the Polytechnic of North London, a PhD from the University of Natal, a BA from Unisa and a PMD from the Graduate School of Business at UCT.

■ Vuyani Mabope as chief director of health systems. He obtained a national diploma in medical technology from the Port Elizabeth Technikon.

The chairman of the portfolio committee on health, Dr M E Tshabalala, has requested that anyone wanting to make representations on the budget vote on health do so in writing by May 20 to the Secretary of Parliament, Box 15, Cape Town 8000.

Health care costs rising higher than inflation

Star 1/5/95 (85)

■ STAFF REPORTER

The cost of private health care is spiralling at a rate far greater than the inflation rate.

According to an extensive report published by the Health Systems Trust and the World Bank, medical scheme contributions equalled 7,1% of average formal sector salaries in 1982. However, 10 years later, they accounted for 15,2% of average earnings, while spending on medicines increased particularly sharply.

The report claimed the increasing amount paid out by medical schemes was due both to rising private sector costs and the fact that beneficiaries were using private sector services to a greater extent. Spiralling costs had placed great pressure on medical schemes, many of which were facing serious financial problems.

The report is the culmination of a two-year study co-ordinated by the Health Systems Trust, with the technical backing of the World Bank and the endorsement of the ANC and the Department of Health. Funding was obtained from the Commission of the European Union and the Overseas Development Administration.

It was found that South Africa spent R30-billion on health services in the 1992/93 financial year — equal to 8,5% of all the money spent on goods and services in the country in that year.

"On average, R740 was spent on health care for each person in South Africa. But a look at a similar level of economic development suggests South Africa does not use its resources for health care optimally."

A comparison between Botswana, Hungary, Malaysia, Venezuela and Chile shows that each country seems to use less money on health care per person, but still appears to have a healthier population.

Botswana, for example, the country closest to home, spent 3,3% of gross domestic product on health expenditure compared with South Africa's 8,5%. SA's infant mortality rate is 49 per 1 000 births, while that of Botswana is 36. And the life expectancy of South Africans is 63 years, compared with Botswana citizens who can expect to be around for 68 years.

The report estimates that an additional R1,5-billion to R2,5-billion a year would be needed to provide access to basic health services for all South Africans. Funding was also needed to build new clinics.

... unified the debate on health reform. In particular, the association has firm views on the possible introduction of national insurance to help finance a more equitable system, reports Health Writer ***David Robbins***

Paying price of national health

Star 3/5/95 (8E)

There's a lot of talk these days about national health insurance in South Africa. In fact, a special commission of inquiry is looking at the whole question of health financing. But what do doctors think? The Medical Association of South Africa (Masa), which represents about 60% of the country's 18 000 to 20 000 practising doctors, has made extensive submissions to the commission.

Masa begins by acknowledging that most of South Africa's health status indicators, such as infant mortality and immunisation levels, are unfavourable. This highlights the need for radical change. Whatever else might be in doubt, the imperative for change is not. Health care reform is as inevitable as it is necessary.

But what sort of change? Much of the reform discussion in recent months has centred on a process which involves changing the current dual system of health care (utilising both the public and private sectors) to a single-tier system of health cover, probably via the vehicle of a national health insurance scheme.

Unworkable

Masa argues, however, that economic realities, especially the high levels of unemployment and the widely differing conditions of employment in the private and public health sectors, would render a universal system unworkable.

A far wiser approach would be to use and enhance the strengths which already exist in South Africa's two-tier system, and to introduce reform measures on an incremental basis.

In a nutshell, Masa agrees that equity of health care is a worthwhile goal, and that some form of national health insurance system should be instituted over a five to 10-year time frame. But this goal should first of all be approached by strengthening both the public and private sectors, and by promoting increased productivity at the interface between these two sectors.

Not surprisingly, an attempt to define what is meant by basic health care is seen as a first priority. To what range of services and treatments should all South Africans have access, regardless of their ability to pay?

This question is crucial to the introduction of a successful national health insurance system, especially in a country where health care spending (at 8,5% of GDP) is already high. What can the country afford within the finite resources available?

Priorities have already been set since the 1994 election, notably the emphasis on child health, safe motherhood and a healthy workforce.

Add the priorities laid down in the RDP, and a core package begins to emerge. It would almost certainly include pregnancy-related care; immunisation against and treatment of the common serious childhood illnesses; the care of specific diseases such as tuberculosis, sexually transmitted diseases, hypertension and diabetes; services to cope with medical emergencies and trauma; as well as special categories of care for the elderly, chronic and mental illness, and rehabilitation.

To assist in the process of defining a core package, Masa suggests that a national advisory committee should be established, consisting of consumers, ethicists, economists and health care professionals. Experience from other countries shows that satisfactory agreement on a core package is often difficult to achieve. For this reason, the process of developing a definition should be highly visible, forming part of the overall political process.

Reforms should also be designed to improve existing health care services, and to prepare the way for the eventual introduction of a universal nation al health insurance system. Since neither the private nor the public health sector can fulfil the health care demands of the total population, Masa recommends that an integrated delivery service be actively promoted.

A glance at some of the disparities in resource allocation between the two sectors underscores the importance of this recommendation. Although expenditure is split more or less evenly, the public sector copes with more than threequarters of the patient load using 79% of South Africa's nurses and 70% of its hospital beds. On the other hand, 59% of South Africa's doctors, 93% of its dentists and 89% of pharmacists are employed in the private sector.

A reform process which seeks to rationalise duplicated services and reduce waste, overcrowding and an often rigid bureaucracy in the public sector has already begun. The emphasis, says Masa, must be concentrated on improving efficiencies and also the referral networks between primary, secondary and tertiary levels of care.

Of particular interest is Masa's suggestion that the provider and purchasing functions in the public sector be separated. This would mean that health authorities at regional and district levels would be able to purchase services from both the private and public sectors, according to need and availability within a particular region. Important savings in capital expenditure could be effected in this way since new public sector facilities would need to be built only where no public or private sector facilities already exist.

Turning its attention to the private sector, Masa notes that cost escalation is rampant. Fee-for-service coupled to third party (medical aid) payment systems have resulted in over-demand and over-supply of services in the past. At the same time, medical aids have staggered into crisis as their membership has aged and as other insurers have enticed away those with good health risks.

A health care system which combines the resources of the private and public sectors could serve as a model for a national health insurance system at a later stage. Masa recommends, for example, that patients be offered a choice between private and public hospitals, with public hospitals encouraged to compete by introducing a system of revenue retention.

Indigent

As one means of ensuring a rapid extension of services, Masa recommends the introduction of a social insurance system to all employed people and their dependents. This would be paid for jointly by employee and employer, and would cover core package health services. An immediate effect would be that about half the total population would be provided with privately funded health care cover, as opposed to the 20% covered by medical aids at the moment.

The reduction in financial pressure on the state would be considerable, and would allow more public funds to be directed towards core package health care for the unemployed and indigent.

Basic care ... mothers and infants wait in Weiler's Farm clinic. Masa acknowledges that health indicators such as infant mortality and immunisation levels are unfavourable, and point to reform. PICTURE: JODI BIEBER

SA medicine is under siege, writes ***Jack Bloom***

Check the malaise in our health system

(85) Star 3/5/95

The furore over the employment of large numbers of foreign doctors of uncertain qualification should not obscure the fact that this is a symptom of a wider problem in our public hospitals.

Most of the 1 797 foreign doctors in South Africa are to be found in the regional hospitals where they can constitute as much as 80% of total doctor staff.

The general breakdown of these hospitals contributes greatly to the current health crisis, failing to serve as a much-needed filter for patients who currently flood the expensive academic hospitals which should ideally be reserved for specialist care only.

Foreign doctors receive limited registration from the SA Medical and Dental Council, which means that they can work only under supervision.

A certain number have escaped the net by obtaining registration in the former Ciskei or in a politically motivated period during which certification of returning exiles was recognised without regular scrutiny.

Conditions are such that locally trained doctors shun the regional hospitals, leaving it to foreign doctors to perform, however inadequately, a vital stop-gap function without which there would be a more complete deterioration.

Whatever the standard of training in their home countries, the fact remains that these doctors have a steep adjustment to make to local systems of operation; language is but one of many barriers.

The better prospects are inevitably retained by the academic hospitals, but the majority often arrive straight at a peripheral hospital where the required supervision is rarely possible.

Since their competency can really only be assessed once they have been in service for a period of time, the tragedy is that they sometimes gain the necessary experience at the cost of patients' lives.

Hospital superintendents are quite forthcoming off the record on some hair-raising experience with foreign doctors, but for obvious reasons there is a conspiracy of silence in public.

The regional hospitals are the stepchildren of South Africa's health system, vastly neglected and particularly badly provided for in a budget that fails to provide for the necessary restructuring that would build up their capacity to more cost-effectively treat patients now seen at the academic hospitals.

Turning the situation around requires a planned programme of investment in the regional hospitals, adding in an academic component with an outreach programme from the academic referral hospital.

This would lift standards and together with an improved pay package could just succeed in attracting back some of our locally trained doctors.

A more rigorous evaluation of foreign doctors should be undertaken, regularising the employment conditions of deserving cases who currently have to renew their working permits on an annual basis and work under the most exploitative conditions.

More importantly, there should be a central recruitment agency which should ensure that all immigrant doctors undergo a one-year training period at a teaching hospital before passing on to any other hospital.

Vulnerable

It is simply criminal to continue the practice of foisting disoriented, untried doctors on the most vulnerable and stressed sector of our health system. For those who do not make the grade, strict supervision is vital and a possible downgrading to a paramedic-type position if they are to be retained at all.

A failure to take the necessary steps now will mean a continuing spiral down in standards, loss of skilled medical personnel and ultimately almost complete dependence on expatriate doctors as has occurred in much of Africa.

■ *Jack Bloom is a Democratic Party member of the Gauteng Provincial Legislature.*

Levy plan for health care

BEATRIX PAYNE

A VAT increase and a levy on medical aid schemes are among health care funding proposals being considered by a national health insurance committee, medical aid industry sources say.

They suggest that in return for a levy on medical aids, medical aid organisations should be allowed to buy drugs through the state tender system or receive rebates on medicines sourced through private distribution networks. BD 4151 95

Sources estimate the state might need to raise between R10bn and R30bn to cover the cost of health care provision.

Medical aid administrator D&E deputy chairman Rod Hallowell, at a conference in Midrand yesterday, said an increase in VAT had been mooted by the medical aid industry as it would be almost impossible to collect contributions from the informal sector, where many economically active people were not members of medical schemes but used health care services.

–A tax on medical aid schemes "would not be a bitter pill to swallow" if they received rebates on medicine costs, which represented 30%-35% of medical aid spending, Hallowell said. If not, the levy would have to be passed on to members.

Industry sources predicted uproar among drug manufacturers if medical aid schemes were allowed access to medicine through the state tender system.

Hallowell said medical aid membership could be made compulsory for employees.

"Employers are likely to have to take more responsibility for the health care of all employees, not just those currently in medical aid schemes. Extending cover to those in formal employment would relieve the state of responsibility for the employed." Medical aid schemes would be expected to provide a basic core package of primary health care. (65)

While one delegate said most medical schemes' processing capacities were already stretched to the limit, Hallowell said a core package of benefits would be simple to administer.

The national health insurance committee is expected to present its report to Parliament next month.

City leads in heart deaths

STAFF REPORTER

CAPETONIANS are more likely than other South Africans to die of heart disease and strokes, while people in Johannesburg and Durban are more likely to die violently, a Medical Research Council (MRC) survey has shown.

According to the report by Dr Debbie Bradshaw, released yesterday, ischemic heart disease (related to the narrowing of cardiac blood vessels) caused nearly 12% of deaths in the Western Cape in 1990. Strokes accounted for 10,5% of deaths and homicide and violence for slightly more than 1,5%.

In kwaZulu/Natal, homicide and other violent deaths accounted for almost 14% of the total, and in Gauteng almost 7,7% of deaths were attributed to homicide or other violent acts.

Preventable

In other areas, such as the North West Province, intestinal infections (18%) and respiratory disease other than TB and lung cancer (12%) were the biggest killers. In the Eastern Cape TB (7,6%) caused the most deaths. The province also showed the highest proportion of perinatal deaths, at eight percent).

Dr Bradshaw said the MRC research, based on an analysis of all reported deaths in 1990, showed South Africans were dying from preventable diseases like tuberculosis as well as respiratory and intestinal illnesses and nutritional deficiencies. The 1990 data did not reflect the impact of AIDS

"Overall the death profile reflects a combination of poverty-related diseases, chronic diseases related to a Western lifestyle, and the simultaneous effects of trauma," Dr Bradshaw said.

The report said death profiles reflected the development status of different provinces. In the Western Cape and Gauteng they were close to those of Brazil and Thailand. The Northern and Eastern Transvaal, Free State and Eastern Cape had death profiles resembling those of several African countries.

The report noted with concern that "ill-defined" deaths averaged 23% of all deaths in SA, pointing to poor access to health services in some areas and inadequacies in the certification of the cause of death.

In the Northern Transvaal some 57% of deaths, more than twice the national average, were ill-defined, and in the Eastern Transvaal the figure was 38%.

It was a national priority to improve the vital statistics system, a process that "will take time", Dr Bradshaw said.

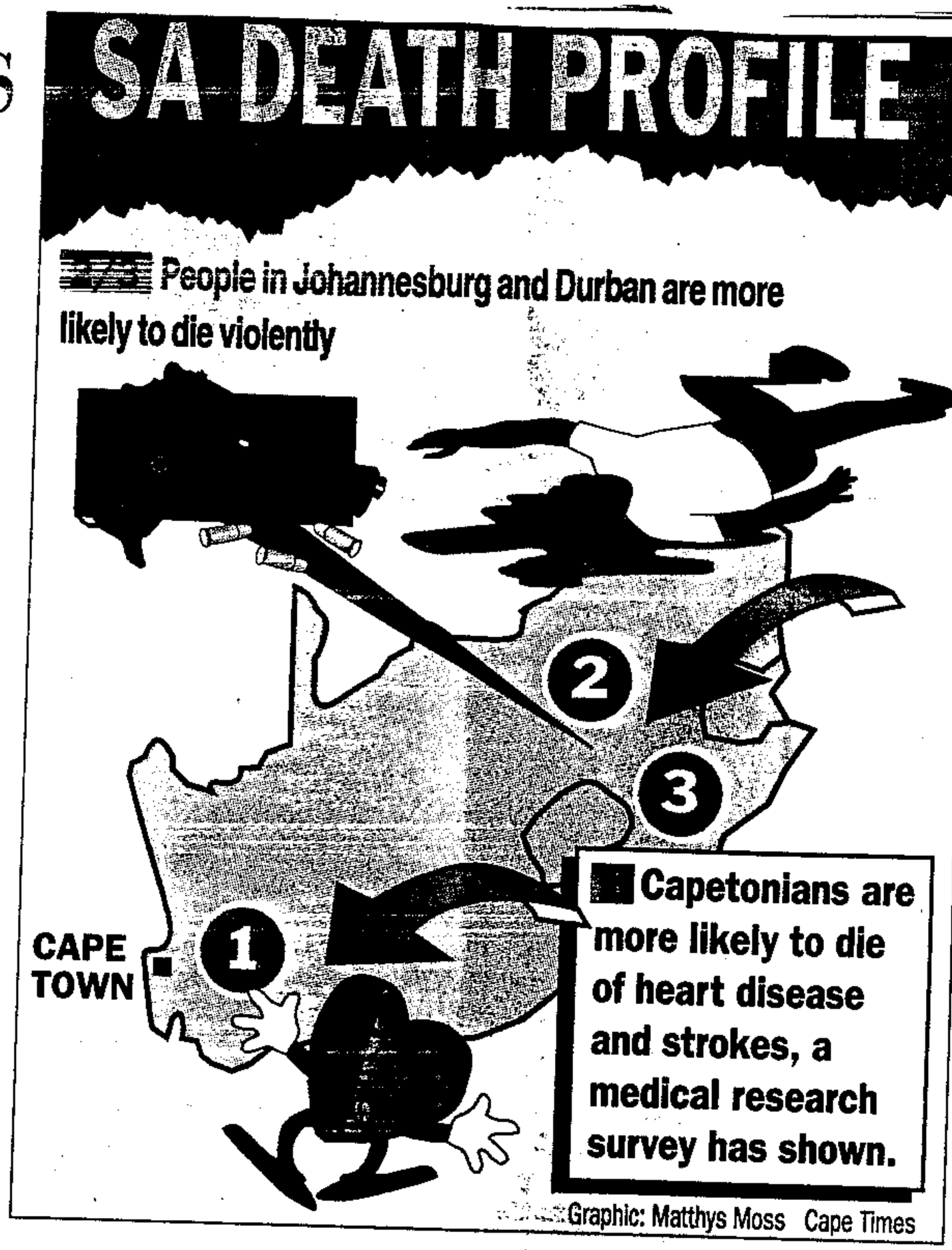
Dr Rodney Ehrlich, of the Department of Community Medicine at the University of Cape Town, said last night the higher proportion of heart disease and strokes in the Western Cape "doesn't mean that we have an unhealthier lifestyle".

He said the province, which was largely urbanised and whose citizens lived Western lifestyles, had fewer infectious diseases and less violence, which could influence the percentage of deaths attributed to heart disease and strokes.

Statistics

He also said white and coloured people — who were "overrepresented" in the Western Cape — showed a higher incidence of heart disease than black people.

Dr Ehrlich also pointed out that the keeping of statistics in the Western Cape was probably more accurate than in other provinces. This would probably have played a role in the quantifying of causes of death.



Reporting of deaths shows 'inadequacies'

Weekend Argus Reporter

MORE than one fifth of all deaths in South Africa are either not reported or are wrongly classified — reflecting poor access to health services and inadequacies in the medical certification of causes of death.

This is according to research by the Medical Research Council.

Debbie Bradshaw of the MRC's Centre for Epidemiological Research in Southern Africa (Cersa) said: "While we believe that the vital statistics system should be improved as a national priority to monitor the health status of South Africans, we know that this will take time.

"We produced this report, based on the latest information, to assist national and provincial health planners in restructuring the health service."

In the Western Cape and Gauteng, death profiles were close to those of Brazil and Thailand, while the Northern and Eastern Transvaal, Free State and Eastern Cape had mortality profiles resembling those of several other African countries.

The 1990 data did not reflect the impact of HIV and Aids.

● The report showed that the Western Cape had an atypical profile of causes of disease with a much higher proportion of chronic diseases than the rest of the country.

(85) ARG 6/5/95

NEWS R50-m for health services ●

Clinics for Free State

(85)

■ CROSSING RIVERS Mandela promises better health care

Sowetan 9/5/95

By Mpikeleni Duma

THE FREE STATE will receive R50 million over the next five years for the building and upgrading of more than 75 clinics, President Nelson Mandela said yesterday.

Opening the clinic and upgrading programme in Thaba Nchu, near Bloemfontein, Mandela said in the next year alone 10 clinics would be built and more than 20 upgraded throughout the province.

The launch was attended by more than 700 people, including Free State premier Mr Patrick Lekota.

Addressed by Minister

It was also addressed by Minister of Health and Social Welfare Dr Nkosazana Zuma and Minister Without Portfolio Mr Jay Naidoo.

Said Mandela: "This clinic upgrading and building programme forms the basis of the Government strategy to transform health services.

"We will move from assisting, which is primarily curative and hospital-based, to one based on primary health care.

"Never again shall our people have to cross rivers and climb mountains to reach distant health services," he added.

He said these projects were designed to set the pace for what the Government envisaged. "A lot still remains to be done. Surely, the Free State still needs more clinics and other health care facilities," said the President.

The communities, he said, needed to help the Government in the implementation of that project.

'Terror' Lekota

Tug of war over health department

☐ *Cape Town city council resists handover*

ARG 11/5/95 (85)

LIBBY PEACOCK
Health Reporter

THE tug of war over Cape Town's city health department — whether it should stay in the hands of the local authority or be transferred to the province — is continuing with no end in sight.

While the city council opposes the transfer, saying the possibility of such a move has already had a hugely demoralising effect on staff, the provincial authorities' view is that there should be one system for the whole province.

The province says the only body with control over the entire Western Cape is the provincial authority.

City medical officer of health Michael Popkiss is outspoken on his opposition to the transfer.

He said that for the past two years the council had been involved in planning the restructuring of the health services and there had been "wide consensus" that health care should be placed at the lowest level of government, which would be more efficient and "more accountable to the people".

But moves at the national level were that the control should be taken away from local authorities and it seemed the final decision would be a political one.

A transfer to the province had major implications for local authority staff, Dr Popkiss said.

Nurses and health inspectors generally earned higher salaries than their provincial counterparts.

This would create problems if they had to be transferred to the province and there was already a great deal of trade union opposition to such a move.

But "if provinicial staff ... come to us, they could come on their existing salaries, but on our scale. It would take a few years before they were phased in".

"The (provincial) planners want a magic wand — they are so naive and inexperienced ..."

While the city council had an "actuarially sound" pension fund, the province's fund was "not financially sound", he claimed.

John Frankish, convenor of the district system sub-committee of Western Cape Health Minister Ebrahim Rasool's strategic management team, said "in principal everybody is in agreement that ideally the district services should be under a single authority — a local authority.

"The problem is still that in non-metropolitan areas there is no single local authority that approximates to the district model.

"The main reason we suggest a provincial responsibility is that at the moment the only authority with control over the whole province is the provincial authority."

Dr Frankish said the salary problem was "secondary".

There was a difference in salaries because of "different mechanisms and forums" which determined salaries.

Reacting to claims that local authority staff earned up to 40 percent more than provincial staff, he said: "The figure of 40 percent is based on one detailed investigation done at the new community health centre in Khayelitsha.

"The position we've taken — and it's a position taken nationally — is that if personnel are transferred, they will be transferred with retention of current salaries and protection of their current benefits."

Negotiations with the unions — which were "obviously concerned about the effects on their members" — would be "more about mechanisms to phase out differences".

Dr Frankish added: "There is recognition among all role-players that one needs to get a decision as soon as possible."

There was a "desire at national level that all of the country should move in the same direction".

He said another "complication" would probably raise its head with the report on national health insurance, which was to be released later this month by the Ministry of Health.

"They're making proposals that private providers will also become integrated into the district health system.

"The question is whether we're not looking at a parastatal body."

CALL FOR GREATER POWER

amaKhosi share 'vision'

CT 15/5/95 (8S)

TRADITIONAL LEADERS met in the city at the weekend at a Constitutional Assembly hearing to give evidence on how they see their role in the new dispensation, reports **SAPA.**

A CONSTITUTIONAL Assembly public hearing aimed at involving traditional authorities in the drafting of South Africa's final constitution ended here on Saturday with amaKkhosi calling for a greater executive and legislative role, especially at local and provincial level.

The critical issue was how to achieve a healthy balance between traditional leaders and elected representatives, Arts, Science, Culture and Technology Deputy Minister Ms Brigitte Mbandla said.

She also warned against creating a situation where the country "degenerated into ethnic tribalism".

One of the major mistakes made during independence was to accept Western political institutions without synthesising African traditional political institutions, the kwaZulu/Natal House of Traditional Leaders said.

Cultures

Congress of Traditional Leaders of South Africa's (Contralesa) Chief S C Mhinga called on "all the people of South Africa to refrain from demonising our cultures".

HEALERS: Two traditional healers at the weekend meeting of South African traditional leaders. ***PICTURE: BENNY GOOL***

Contralesa believes traditional leaders had a role to play in all three levels of government and the country's final constitution had to reflect that South Africa was an integral part of Africa, where traditional leadership was rooted in African soil.

Paying for the national health

ARG 15/5/95

The Medical Association of South Africa has entered the debate on health reform. In particular, the association has firm views on the possible introduction of national insurance to help finance a more equitable system, reports Argus Correspondent DAVID ROBBINS.

THERE'S a lot of talk these days about national health insurance in South Africa. In fact, a special commission of inquiry is looking at the whole question of health financing. But what do doctors think? The Medical Association of South Africa (Masa), which represents about 60 percent of the country's 18 000 to 20 000 practising doctors, has made extensive submissions to the commission.

Masa begins by acknowledging that most of South Africa's health status indicators, such as infant mortality and immunisation levels, are unfavourable. This highlights the need for radical change. Whatever else might be in doubt, the imperative for change is not. Health care reform is as inevitable as it is necessary.

But what sort of change? Much of the reform discussion in recent months has centred on a process which involves changing the current dual system of health care (using both the public and private sectors) to a single-tier system of health cover, probably via the vehicle of a national health insurance scheme.

Masa argues, however, that economic realities, especially the high levels of unemployment and the widely differing conditions of employment in the private and public health sectors, would render a universal system unworkable. A far wiser approach would be to use and enhance the strengths which already exist in South Africa's two-tier system, and to introduce reform measures on an incremental basis.

In a nutshell, Masa agrees that equity of health care is a worthwhile goal, and that some form of national health insurance system should be instituted over a five to 10-year time frame. But this goal should first of all be approached by strengthening both the public and private sectors and by promoting increased productivity at the interface between these two sectors.

Not surprisingly, an attempt to define what is meant by basic health care is seen as a first priority. To what range of services and treatments should all South Africans have access, regardless of their ability to pay?

This question is crucial to the introduction of a successful national health insurance system, especially in a country where health care spending (at 8,5 percent of GDP) is already high. What can the country afford within the finite resources available?

Priorities have already been set since the 1994 election, notably the emphasis on child health, safe motherhood and a healthy workforce. Add the priorities laid down in the RDP, and a core package begins to emerge.

It would almost certainly include pregnancy-related care; immunisation against and treatment of the common serious childhood illnesses; the care of specific diseases such as tuberculosis, sexually transmitted diseases, hypertension and diabetes; services to cope with medical emergencies and trauma; as well as special categories of care for the elderly, chronic and mental illness, and rehabilitation.

To assist in the process of defining a core package, Masa suggests that a national advisory committee should be established, consisting of consumers, ethicists, economists and health care professionals. Experience from other countries shows that satisfactory agreement on a core package is often difficult to achieve. For this reason, the process of developing a definition should be highly visible, forming part of the overall political process.

Reforms should also be designed to improve existing health care services, and to prepare the way for the eventual introduction of a universal national health insurance system. Since neither the private nor the public health sector can fulfil the health care demands of the total population, Masa recommends that an integrated delivery service be actively promoted.

A glance at some of the disparities in resource allocation between the two sectors underscores the importance of this recommendation. Although expenditure is split more or less evenly, the public sector copes with more than three-quarters of the patient load using 79 percent of South Africa's nurses and 70 percent of its hospital beds. On the other hand, no fewer than 59 percent of South Africa's doctors, 93 percent of its dentists and 89 percent of pharmacists are employed in the private sector.

A reform process which seeks to rationalise duplicated services and reduce waste, overcrowding and an often rigid bureaucracy in the public sector has already begun. The emphasis, says Masa, must be concentrated on improving efficiencies and also the referral networks between primary, secondary and tertiary levels of care. Community participation should be encouraged, particularly at the lower levels of health care delivery.

Of particular interest is Masa's suggestion that the provider and purchasing functions in the public sector be separated. This would mean that health authorities at regional and district levels would be able to purchase services from both the private and public sectors, according to need and availability within a particular region. Important savings in capital expenditure could be effected in this way since new public sector facilities would need to be built only where no public or private sector facilities already exist.

Turning its attention to the private sector, Masa notes that cost escalation is rampant. Fee-for-service coupled to third party (medical aid) payment systems have resulted in over-demand and oversupply of services in the past. At the same time, medical aids have staggered into crisis as their membership has aged and as other insurers have enticed away those with good health risks.

A health care system which combines the resources of the private and public sectors could serve as a model for a national health insurance system at a later stage. Masa recommends, for example, that patients be offered a choice between private and public hospitals, with public hospitals encouraged to compete by introducing a system of revenue retention.

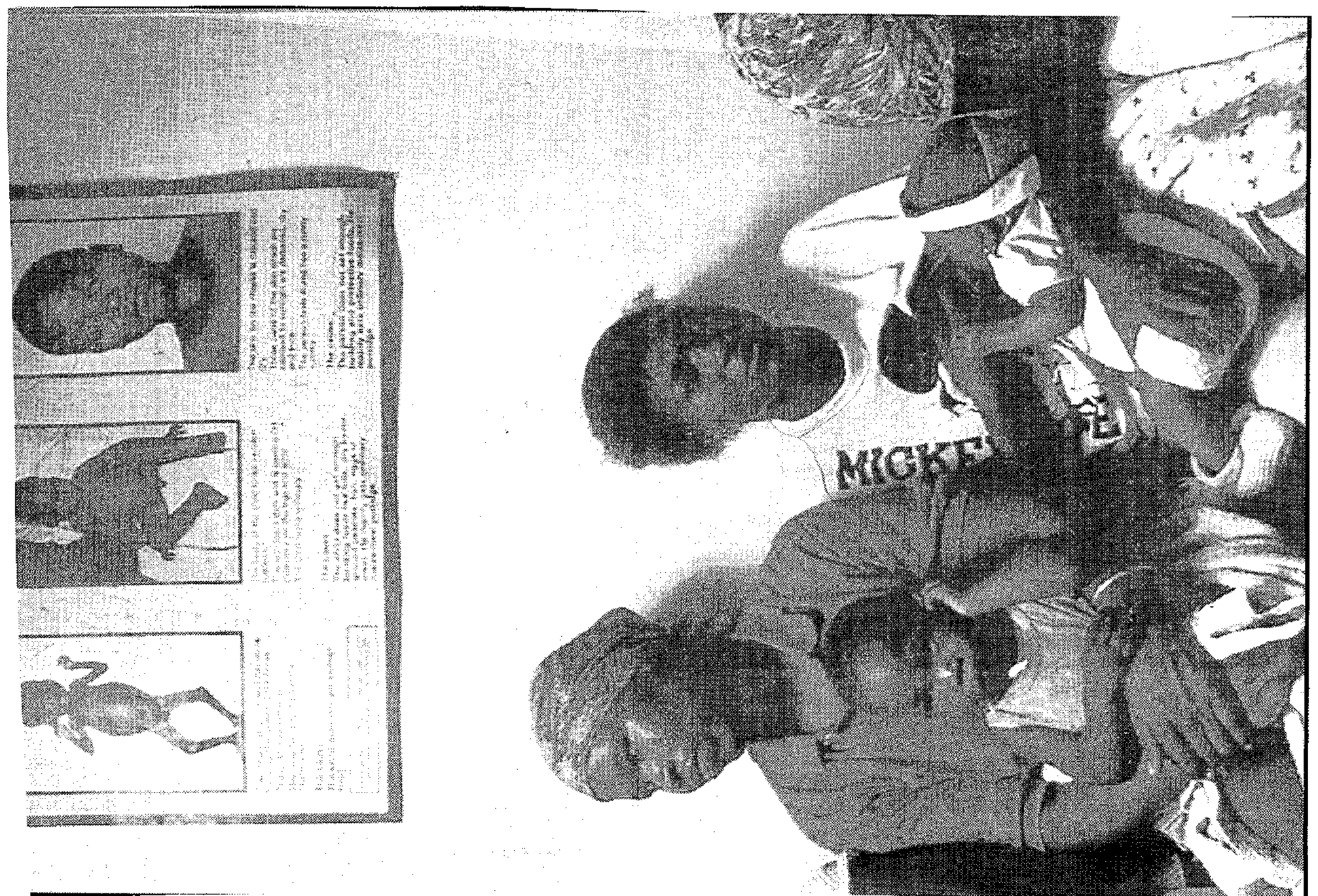
As one means of ensuring a rapid extension of services, Masa recommends the introduction of a social insurance system to all employed people and their dependants. This would be paid for jointly by employee and employer, and would cover core package health services. An immediate effect would be that about half the total population would be provided with privately funded health care cover, as opposed to the 20 percent covered by medical aids at the moment.

The reduction in financial pressure on the state would be considerable, and would allow more public funds to be directed towards core package health care for the unemployed and indigent.

The administration of such a social insurance system could probably be undertaken by the technology being developed by, and already at the command of, existing configurations of medical schemes. But if medical aids take on the job, they should be obliged to accept everyone eligible, regardless of individual health risk.

In these ways, Masa believes that real progress could be made towards the introduction of accessible and equitable health care for all, without imposing additional taxes earmarked for health. Solid foundations would also be laid for the eventual establishment of a national health insurance scheme in South Africa.

Price of health (38)



BASIC CARE ... mothers and infants waiting at a clinic. Masa acknowledges that health indicators such as infant mortality and immunisation level are unfavourable, and point to reform.

SA infant deaths 'can be avoided'

(85) CT 22/5/95

MOST of the deaths of infants and children of poor families in SA could be prevented by simple, low cost extensions to primary health care, a workshop of the National Programme of Action for Children has concluded. This could include the extension of immunisation and provision of access to community health workers and clinics.

Political Staff, Own Correspondent

Monday May 22 1995 **SOWETAN**

NEWS Crowded hospitals

Health crisis looms

(85)

Sowetan 22/5/95

By Glenn McKenzie

IT is a scenario that is becoming increasingly visible in Gauteng: crowded wards, overworked doctors using old equipment and, worst of all, budget cuts.

During a recent tour of Natalspruit Hospital on the East Rand, superintendent Dr Charles Bradfield said his hospital faced a "potential health crisis" under its current budget.

Natalspruit's budget had been cut by five percent, and administrators had been told that going overbudget would not be tolerated. (In the past, the hospital had consistently gone overbudget by between 15 and 20 percent every year.)

Bradfield's response was that the hospital would have to close one-quarter of its services and lay off 400 employees if government guidelines were enforced.

"We're doing the best we can. We have been underfunded for 30 years and now we, because we're not an academic hospital or on the forefront of primary health care, won't see any of the benefits of the Reconstruction and Development Programme," said Bradfield.

Among the services that would be cut are:

- Elective surgery, including operations for cancer and other serious diseases;
- Children's wards, which could be cut or eliminated; and
- Outpatient services for long-term health problems.

To prove Bradfield's point, journalists were shown 30-year-old X-ray equipment that one radiologist called "undependable junk."

Radiologist Dr Margeritte Langton said: "If the radiology is shit, your medical standards slip. If radiographers don't have proper working conditions, standards go down."

In another section of the hospital, up to three babies shared each bed.

"These babies can easily spread diseases to each other," said one nurse.

An hour's drive away, at Baragwanath Hospital in Soweto, shortages and constraints also exist. Babies who could be saved are turned away from the hospital's neonatal intensive care ward.

But Gauteng's new health department boss Dr Ralph Mgijima has assured hospital staff that services there will not suffer as a result of the province's budget cuts.

Impending cuts

Back at Natalspruit, there have been no such assurances. And superintendent Bradfield insists that politicians will have to make all of the impending service cuts at the hospital. He won't.

"I will not make these decisions. I cannot justify turning away patients in dire need," he said.

In the end, the 1.5 million citizens of Katlehong, Tokoza and Vosloorus will suffer, says Bradfield. Patients will be forced to travel to Germiston, Hillbrow or Kempton Park to be treated.

Gauteng Democratic Party health spokesman Mr Jack Bloom attacked the national Health Ministry for forcing Gauteng hospitals to operate under "irresponsible budget constraints."

"It takes two years for capital projects to see the light of day and in the meantime, Gauteng is treating (patients from) all of the other provinces," said Bloom.

Money woes

He believes one solution to the money woes of hospitals like Natalspruit is to make sure only critical cases are treated at Johannesburg Hospital, while regional hospitals like Natalspruit deal with more of the secondary problems.

As things stand, Natalspruit is overburdened with cases that they are not equipped to treat. Long-term patients consume resources and take valuable bed-space because there is no space in academic institutions like Johannesburg Hospital.

Ironically at Johannesburg Hospital, staff are burdened with primary health care and secondary problems that could easily be treated at a smaller facility — like Natalspruit.

"The whole referral system is skewed. Hospitals can't continue to operate the way they have been," said Bloom.

PROFILE *The Eastern Transvaal MEC who gets things*

The lioness of E Tvl

(85) sowetan 23/5/95

■ RISK TAKER

MEC introduces radical changes to health system:

By Glenn McKenzie

SOMETHING NEW AND SOMETHING OLD ... Mashego combines a fresh approach with old-fashioned common sense in her work. Here she is seen at a traditional healers' conference.

AS A CHILD GROWING UP near Kruger National Park, Candith Mashego's biggest fears were lions ... and the police.

Now, at 34 years of age, Mashego is a bit of a lioness herself, and sees no reason to be afraid of men in uniform.

As the Eastern Transvaal's MEC for health, Mashego is cast in the part of a bold risk taker. Unlike some of her more cautious government colleagues, she seems determined to prove herself now, rather than later.

If the changes Mashego has introduced so far to the health system are anything to go by, then the Eastern Transvaal can expect radical things in the future.

So far she has:

- Discovered more than R4 million in "missing money" from the budgets of the former homeland governments;
- Announced that a community hospital in KwaNdebele, which has stood empty for more than three years, will soon open;
- Reformed the way in which health contracts are granted;
- Undertaken to begin building three new clinics within the next month in the impoverished south-eastern region of the province.

"This job is getting easier every day," Mashego told *Sowetan*. "I ask lots of questions, talk to people and real problems become immediately clear. I'm just taking it a step at a time."

Mashego's down-to-earth approach could be a product of her upbringing. She grew up in a village called Chochocho, named after the sound made by human feet crunching through dry underbrush.

At a very early age, Mashego learned to be self-reliant and innovative. She joined the African National Congress, helping exiles sneak back into the country to carry out their missions.

But one of the biggest surprises about this soft-spoken woman is that she is neither a doctor nor a nurse. In fact, until last year, she was a teacher.

Mashego feels that is one of her biggest assets. She takes a neutral stance in squabbles between various health professions. And she tries to view hospitals and clinics as a patient would.

"If I were a health professional, I would feel very confined to one way of looking at things. Instead, I'm an outsider and feel I can be objective," she says.

Objectivity, yes. But that doesn't mean Mashego is afraid to get tough. Recently, she raised the ire of local health officials by demanding they give her itemised budgets, something they never had to do under apartheid.

"I want to know how they are spending money. If they can't tell me that then they won't get any money from me. It is as simple as that," she said.

Mashego also has a straightforward way of dealing with thievery and incompetence. She investigates and then punishes.

She has even gone to the extent of making anonymous visits to clinics and hospitals and conducting her own spur-of-the-moment investigations.

During one such visit — to Temba Hospital near Nelspruit — Mashego walked quietly through the main kitchen, watching staff members stealing large quantities of food. Meanwhile, patients were going without meals. When she turned up to report the offences to a manager who was on duty, she found him drunk: "I immediately realised where the problems at this hospital lay. There are going to be some changes there, you can be sure of that," she said.

Not all of Mashego's discoveries have been negative. While sorting through financial records left by the outgoing homeland government, she found something that would startle even the most experienced auditors — a stash of R4,6 million had been overlooked by KwaNdebele's former health ministry.

"I couldn't believe it. I had to double check. How can they tell everyone that they had no money while in fact they had millions of rands that were just sitting there untouched?" said Mashego with a chuckle.

Special project to help the 'lost generation'

Kathryn Strachan

SA's "lost generation" has been given a second chance to become economically independent through the introduction of a special project which, if successful, will be adopted by government for implementation at schools throughout the country. BD 24/5/95

The matric and skills training project is being run under the auspices of the ORT-Step Institute, the world's biggest educational non-governmental organisation. Its aim is to give students of all ages the skills which are necessary to become part of the employable workforce.

Project co-ordinator Mike Maile said 35 unemployed youths from underprivileged areas had already signed up for the pilot project.

This project, which is being funded by a R600 000 grant from the National Economic Education Trust, the education arm of National Sorghum Breweries, would be restricted to a total of 35 students initially because of cost and space constraints.

"The project came about because, during the course of our community outreach programmes, we were being approached by many people who asked us to help them get education and training," Maile said.

The course is open to students who have a minimum Standard 8. They will attend classes at the ORT college of technology and write the National Certificate Board Examination at the end of the course.

Core subjects will include maths, science, technology, business economics, English and biology. They will be given lessons in life skills, too, and taught problem-solving skills.

Differences in disease profiles of provinces

Kathryn Strachan BD 24/5/95 (85)

THERE are vast differences emerging in the disease profiles of the various provinces — reflecting varying levels of regional development, a new study by the Medical Research Council has found.

While the Western Cape and Gauteng, for example, have cause-of-death profiles similar to countries such as Brazil and Thailand, the Northern and Eastern Transvaal, Free State and Eastern Cape have mortality profiles resembling those of several African countries.

Council spokesman Derek Yach says the regional diversity of mortality profiles highlights the need for a health plan which is nationally coherent yet sensitive to provincial variations.

The study, conducted by council researcher Debbie Bradshaw, shows that people in the Western Cape are more likely than any other South Africans to die of heart disease and strokes, while residents of Gauteng and KwaZulu/Natal are more likely to die as a result of violence.

Ischemic heart disease ranked first in the Western Cape with 11,8% of deaths, while cerebrovascular disease accounted for 10,5% of deaths.

In KwaZulu/Natal murders and other violent deaths accounted for almost 14% of the total, and in Gauteng almost 7,7% of deaths were attributed to violence.

In the Northwest intestinal infections (18%) and respiratory diseases other than TB and lung cancer (12%) were the biggest killers. The Eastern Cape had the highest proportion of TB deaths (7,6%) and perinatal deaths (8%). The Free State had the highest percentage of deaths caused by intestinal infections (21%).

Bradshaw said the research, based on an analysis of all reported deaths in 1990, showed South Africans were dying from preventable diseases such as TB. The data did not reflect the impact of AIDS.

She said the overall mortality profile reflected a combination of poverty-related diseases, chronic diseases related to a Western lifestyle and the effects of trauma. Poverty- and lifestyle-related diseases needed to be fought through an extended primary health care network.

It was a matter of concern that "ill-defined cause of death" accounted for 23% of all deaths in SA. This reflected poor access to health services and the fact that medical certificates stating cause of death had not been issued.

NEWS IN BRIEF

(85) BD 25/5/95

R65m health aid for SA

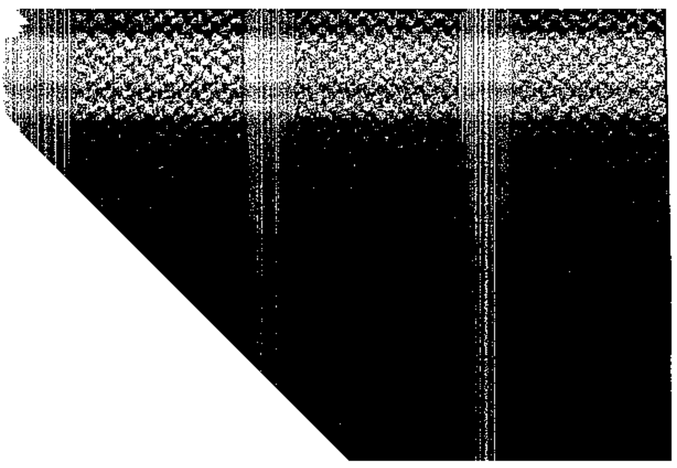
BELGIUM is to donate R65m in health aid to SA, according to an agreement signed by Health Minister Nkosazana Zuma and Belgian ambassador Leo Willems yesterday.

Meanwhile, the US Information Service said US grants amounting to R1,8m a year for self-help projects were signed in Pretoria.

New health plan revealed

WM 26/5-1/6/95(8S)

Access to cheaper drugs is one of the main benefits for patients in the new health care plan about to be announced by the Ministry of Health, writes **Pat Sidley**



AFTER months of haggling, the medical gurus have finally come up with a new primary health care plan for the country.

Although Minister of Health Dr Nkosazana Dlamini Zuma will only

Guardian can disclose that the health package is likely to include:

● Access for both state and private managed care patients to cheaper "essential" drugs.

● An organised referral system with the division of the country into district health authorities, with local clinics to deal with primary health care needs as well as accredited private practioners including GPs, nurses and pharmacists.

● The private sector will remain intact for those wishing — and able — to use it. But there will be increased co-operation between private practioners and the state sector at district health level.

A major casualty of the process is likely to be some of the financial interests of the multi-national pharmaceutical groups, who are gearing up to face the challenges ahead.

The drug industry faces two-pronged action with separate legislation governing the pharmaceutical industry in addition to measures provided in the national health plan intended to drastically reduce drug costs — a major part of escalating health care costs.

Predictably the resistance to the proposed national health plan is coming from these interests as well as from dispensing doctors who have long been used as the marketing arm of the drug companies.

According to industry sources, the committee looking into financing a primary health care plan found that the funding gap between what is available for primary health care and what is needed is much smaller than anticipated.

It's funding proposals include:

● Some form of payroll tax — but set at a low of 0,56 percent of the employee's income and not at the 3 percent envisaged earlier.

● A levy on managed health care schemes such as medical aids, insurance companies or health maintenance organisations. This may include the removal of an implicit state subsidy to the industry in the way it is taxed at present.

Industry sources say the levy is most likely.

Several meetings have taken place between Zuma and colleagues Chris Liebenberg and Alec Erwin in the finance ministry to examine the merits of various options.

One of the major improvements consumers are likely to encounter will be in the form of a primary health care drug package (PHCDP) which will become available to both state patients and those in the private sector using medical aids, insurance or similar managed care plans.

The state is likely to set what are known as "essential drug lists" at several different levels.

These have been worked out as being the most cost effective drugs which treat the most common diseases encountered most effectively.

Research for the committee has shown, for instance, that for most primary health care diseases (colds, sore throats and so on) a drug package need only cost R5,60 calculated at the state tender prices and using largely generic (non-brand name) drugs. According to drug industry sources, this will be even cheaper (R2,20) if it is calculated at the tender prices used internationally for the World Health Organisation. This essential drug list (for the PHCDP) will have around 150 drugs on it to choose from.

Private health care consumers will acquire their drugs, which will be prescribed from this list, through community pharmacies which will charge only a professional fee per prescription (said to be around R8,50) — and not a percentage of the cost of the drug plus a large mark-up.

The latter method of charging for drugs, which is the way they are charged for at present, is widely held accountable as a major reason for the enormous cost of drugs to consumers.

District health authorities, into which the country will be divided, will have a list of around 400 drugs to choose from. Individual clinics will have immediate acces to about 50 different drugs. Tertiary health care institutions — such as the large teaching hospitals — will have a list of between 450 and 550 drugs.

Private health care interests — doctors, specialists, and private hospitals — could continue to prescribe or stock what they want to — but the increased competition in the field will force them to look more carefully at cost containment.

Measures in the new plan aimed at making state doctors happier, and drawing private doctors into the state system are likely to be introduced.

Public sector doctors are likely to find their salaries increased and private doctors will be encouraged to do "sessions" at state facilities with improved remuneration for these.

Some system of referring from nurses at state clinics to private doctors at a fee is likely to be introduced.

Still waiting: The new health care plan will deal with primary health care needs

HEALTH & DISEASE - GENERAL

1995

JUNE - AUGUST

RE-SORTED

HEALTH

At last — a new regulator

After a year's delay, Health Minister Nkosazana Zuma has finally appointed a new Council for Medical Schemes to act as industry regulator.

It's a move welcomed by a sector that's had to face the rigours of deregulation without formal guidance. The council's job is to make policy and advise the Minister. But there's some dismay that Zuma has appointed the council for only a year rather than the traditional three-year term — the council can, by law, hold office for a maximum five years.

Says an industry observer: "There is some concern that the Minister could still be planning a radical revamp of the entire private health sector and anticipates that there will be a new set of rules within months." It's a concern that will probably be answered when the Broomberg/Shisana Committee of Inquiry into a National Health Insurance System finally reports back later this month.

But while a one-year term is unlikely to guarantee continuity in policy formulation as the full council is obliged to meet only twice a year, the calibre of the new team is impressive.

Its expertise appears to span medical schemes administration, labour relations, low- and high-cost medical cover, insurance, actuarial science, accounting, education and philosophy. Says council registrar Danie Kolver: "The Minister has approved a council that combines a wealth of experience with some desperately needed new blood." This is good news as the council's immediate priorities include formulating stricter financial controls and funding guidelines and combating bogus unregistered schemes.

Council chairman is Jack Marais, a former deputy director-general (administration) of the Health Department, hospital group Presmed joint-MD Rob Speedie, the past Representative Association of Medical Schemes (Rams) executive director, has been re-appointed to the council.

Speedie, who spearheaded much of the deregulation of the industry in the latter part of his seven-year term as Rams chief, continues to advocate further deregulation for the entire private health-care industry. In the hospital sector Speedie has in recent months pioneered measures that slash hospital bills by offering schemes pre-negotiated fixed fees.

Medical economist and ANC adviser Alex van den Heever is a council member. A researcher at the Central Health Policy Unit at Wits Medical School, he represented the ANC on the Melamet Commission of Inquiry into medical schemes that released its findings in May.

Chairman of the executive committee is Professor Paul Luthuli, dean of the education faculty at the University of Zululand and head of the department of philosophy, chairman of Bonitas medical fund and vice-chairman of Bonprosan, an association of three medical schemes.

Also on the council is medical consultant Tony Leveton, a founder of medical scheme administrator AMA and of Rams. Other members are Judith Cornell, director of the Industrial Health Research Group at the University of Cape Town; Yekani Tenza, a chartered accountant and director of Medscheme Administrators; Karun Naidoo, a chartered accountant; attorney Keith Kunene; Cape Town GP Norman Levy, a member of the SA Medical and Dental Council who also advises a major medical scheme; Natalmed medical scheme GM Fanie Roodt; Andre Swanepoel of the Financial Services Board; and Anglo American senior medical consultant Brian Brink, a member of the Broomberg/Shisana Committee of Inquiry.

Ironically, one of the council's first tasks is to consider the Melamet report that advised schemes to make greater use of professionals with expertise in law, accountancy, actuarial science, hospital, medical schemes and business administration, and insurance. It's a recommendation that Zuma herself appears to have followed in her choice of council members. It is to be hoped that she will elect to follow more of Melamet's advice. ■

Speedie . . . *spearheaded much of the deregulation*

HOUSING

Home truths

A major push to have 350 000 houses built within five years starts in earnest next Monday when the Housing Ministry's newspaper *Home Truths* is published across the country for the first time.

The intention, says Housing Minister Sankie Mthembi-Nkondo, is to provide detailed information about the various housing subsidies on offer, how people qualify for them and how to raise bank finance to augment them.

She launched the new initiative at the unveiling this week in East London of a R27m housing subsidy scheme by Mercedes-Benz of SA, underwritten by German parent Daimler-Benz.

Six million copies of the tabloid newspaper *Home Truths* have been printed. They will be distributed with established newspapers this weekend, but some will also be available at housing and other government offices and at banks. *Home Truths* is being published in four languages — English, Afrikaans, Zulu and Sesotho — but translations for other language groups will be available at housing offices.

The newspaper publishes updated information on the workings of individual subsidies, subsidies linked to home loans, co-operative and institutional subsidies and consolidation subsidies.

In addition, Nkondo says it will provide information on government's housing support centres designed to "provide advice, finance, training, job opportunities and reasonably priced building materials to the most disadvantaged communities."

The dissemination of *Home Truths* is expected to encourage a deluge of subsidy seekers into the offices of the national and provincial housing boards as well as bank branches around the country.

A Council of South African Bankers spokesman says it is possible that the bureaucratic machinery for processing subsidy applications will be unable to cope initially. But the thinking is that tangible

Cost-effective health care

Beatrix Payne

HEALTH-care strategies which focused on the patient's overall lifestyle, provided cost-effective treatments and monitored the patient's progress could reduce employers' overall medical aid contributions and minimise the risk profile of employees, Glaxo economist Francois Wessels said yesterday.

Such a programme — disease management — was far superior to simple "pharmaco-economics", which calculated the economic effects of a drug but could encourage treatment of only one aspect of the disease.

Disease management was a patient-directed programme which provided disease-specific treatment guidelines in the most cost-effective way. It also focused on maintaining the quality of life and could advise patients on healthier lifestyles.

The programme centred on partnerships between health-care providers and qualified consultants.

Glaxo attempted to provide a consultative service to health-care providers, to guide them through introducing disease management systems.

MAIL & GUARDIAN
June 9 to 14 1995

Olive Shisana, special adviser to the minister of health, in
THE MARK GEVISSER PROFILE

No olive branches from Olive

WM 9-14/6/95 (85)

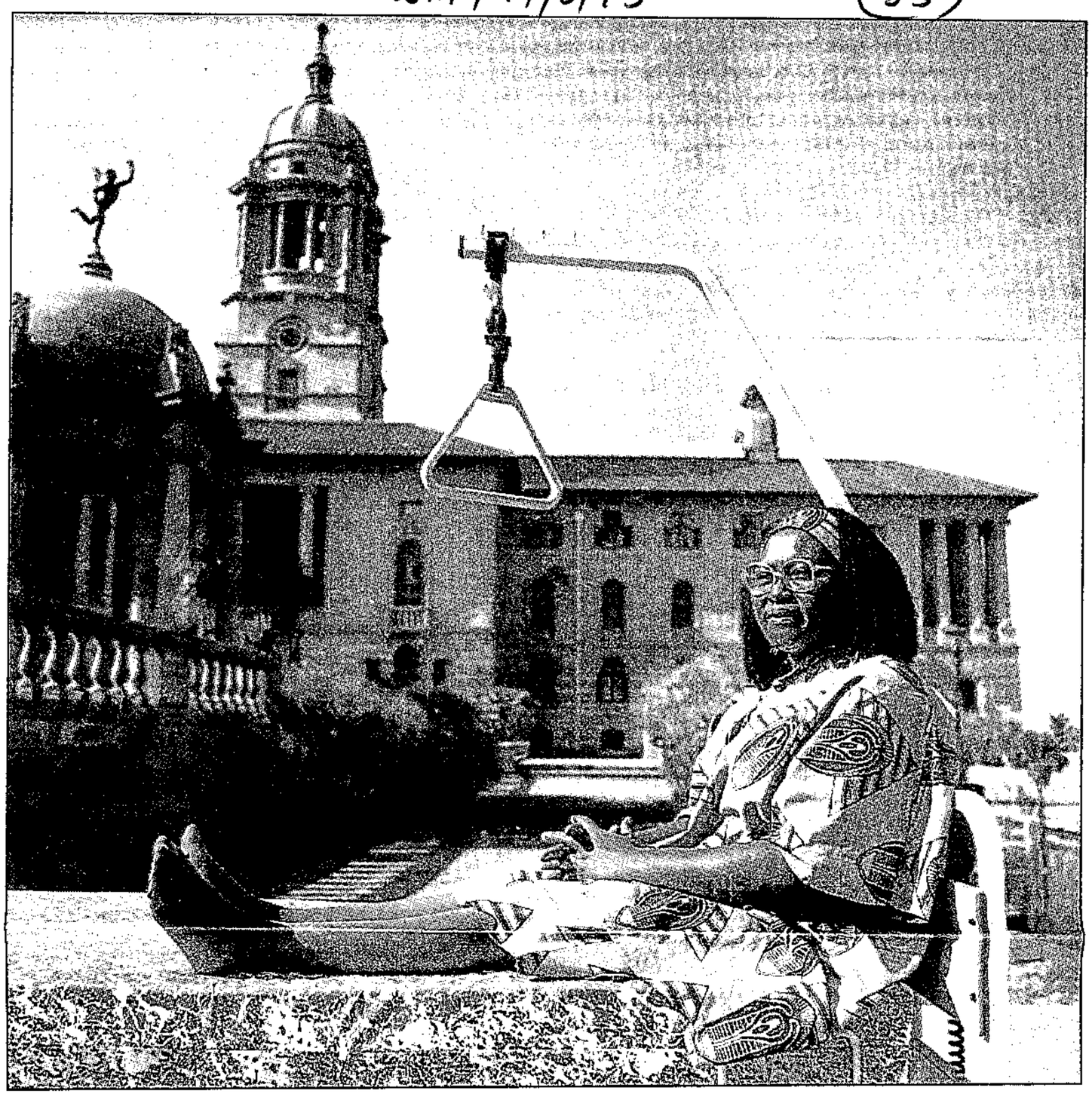
WHEN Olive Shisana was appointed special adviser to the minister of health exactly a year ago, she found herself dreaming the same recurrent nightmare that had dogged her through her first five years of exile: "I am locked up in the borders of South Africa, trying to get out and I can't. The police are after me and I can't escape them. This dream kept coming and coming, and so every white South African who was in government to me was part and parcel of those police out to get me."

And so, when she entered the Civitas building (a Pretoria monument to banality and enclosure carefully designed to make civil servants feel they are being detained without trial) for the first time, "I looked at these people, and in my mind what was coming through was, 'Oh my God! They're gonna get me!' Therefore I must be defensive. I must defend myself otherwise I'm going to be trapped within and I'm never going to come out."

Olive Shisana comes from a family and a part of the world — the far-North — where dreams and visions are taken seriously; where the lines between this world and that of the spirits are not clearly defined. She listens to her dreams. To her immense credit, she is one of the few, in the new black elite, who will articulate the traumas and agonies that accompany sleeping with the former enemy.

And she has been working on it: "It has taken a long time to deal with this, but I've begun to see these people as human beings and colleagues rather than as parts of an evil machine." Not that this admission has made it any easier for those who have borne the brunt of her paranoia (she quotes Kissinger: "Just because I'm paranoid doesn't mean there aren't people after me").

As the woman charged with restructuring the health sector in this country and the leading contender for the position of director general, she is without doubt one of this country's most controversial new technocrats — the quick-witted counterpoint to her phlegmatic minister, but as politically clumsy as Dr Zuma is wily.



Olive Shisana: Has incurred the wrath of almost everybody working in health

PHOTOGRAPH: HENNER FRANKENFELD, BED COURTESY OF ORTHO SURGE

When she first started, notes one of her supporters, "she blundered around in a very self-opinionated way, and she trod on a lot of toes — not only in the department, but in the health policy world. She just didn't trust anyone." That is an understatement — she apparently reduced outgoing director general Coen Slabber — an easy-going gynaecologist from Bloemfontein — to a gibbering wreck, and has incurred the wrath, at one point or another, of almost everyone working in health.

She came in, says one of the leafers of a provincial strategic management team, "shooting from the hip. She wanted to change things, to shake things up, and she had a very poor understanding of the sector. The fact that she was offhand, dismissive and arrogant meant that the people who could have helped her didn't."

Shisana tells the story of how, when she first arrived in the United States in the mid-1970s to study clinical psychology, "I was too scared to open my mouth. I thought, I'm the only black, a rural girl from Africa, what do I have to say?" But a friend — a Jewish woman — took her on, and once pushed her hand up in class, saying, "Sir, Olive has got something to say!"

"She literally forced me into speaking. I'll never forget that experience. I had no self-confidence until then, but once I started talking, I went overboard! Only after a while did I start toning down ..."

Although she disputes it, that seems to me to be the very model of Shisana's first year at Health. Call her Olive Overboard. She has ridden bareback into a whole plain of windmills, the most razor-edged of which was the ill-considered Deeble Plan for national health insurance, which would have guaranteed universal access to health by collapsing the private and public sectors into each other — and bankrupted the system.

'It has taken a long time to deal with this, but I've begun to see these people as human beings and colleagues rather than as parts of an evil machine'

Despite opposition from almost all quarters, she insisted that it be implemented, pre-empting the work of a further committee to be chaired by health economist Dr Jonathan Broomberg.

In the storm that ensued she relented. Now, after having chaired the committee with Broomberg, she has co-authored a plan, to be presented to Parliament next week, that is by all accounts exactly what the doctor ordered. Her comment? "I don't even think Deeble would believe in his plan now, given the process we've gone through and how much more we know and how many people we have consulted."

It is a clear admission of her earlier impetuousness, and a sign of how quick — and willing — she has been to learn. Just like that first year in America, she has begun to tone down. "There has been a definite wind-change," notes her associate. "She now listens to people. She seems comfortable. She delegates. She has begun to smile."

Her detractors and supporters agree that she is both intellectually brilliant (she has a doctorate in public health from Johns Hopkins, perhaps the most prestigious institution of its kind in the world) and belligerent. She claims that she has had to be "tough and firm" to get results: "I came in here," she says, "and I found a department that was unwilling to look at substantive change. I was not put here to reform the system. I was put here to transform it, and I am succeeding."

A more neutral observer, Dr Craig Household, who runs the Free State health system, says: "She has a strong personality, but she gets things done. She has driven the process of change and the result is that health is one of the departments further along the road than any other." Indeed, the funding community has estimated that health is at least nine months ahead of any other department in terms of restructuring, and has thus made Shisana its darling.

She has shaken things up, in terms of staffing, budgetary allocation and interprovincial co-ordination. But there are, once more, many who disagree. Yes, they say, there has been movement. But to what end? They accuse Shisana of academicism; of worrying unduly about policy and restructuring when there is, in fact, a crisis of delivery that needs to be sorted out first.

These people — and they are the ones on the front line, the superintendents of crumbling hospitals and resource-starved provinces — want a manager first. The vision stuff, they say, can wait.

The vision stuff is basic, and powerful: "There is still one thing about the Deeble plan I stick to, and that was its insistence on universal access to health. I will fight for that as long as I live. And, whether or not I am appointed director general, I will stay in government until I see a national health system in place." If this is not hearfelt, then Shisana is an excellent politician.

She claims that her detractors are a small group of people who have been left out of the process. "Let's be frank," she says, "there are people who are uncomfortable about Africans taking on a leadership position. We are challenged as if we are intellectually incapable and we are challenged about our political background." This last point in response to a rumour that Shisana, in contradiction to her CV, was not allied to the ANC in exile, a rumour that is easily disproved.

She is patently wrong when she says that her critics number only a handful and when she implies that they are all not African — critics of Olive Shisana come in all colours, and they are all over the place. But let's be frank, there is a major race issue happening in the upper echelons of the new technocracy; one about which everyone will hold forth at great length off the record, but no-one will tackle publicly.

It goes like this: Africans are bitter that the supposedly-progressive coloured/Indian/white intelligentsia is nabbing most of the senior posts (and indeed, there are very few African directors general), while appropriately qualified, progressive non-Africans fear that they are being left out because they are not black enough. The one side cries "racism!" and the other "Africanism!"; both sides over-exaggerate the issue, but both have a point. And Shisana has become a lightning rod in an ever-intensifying storm.

She responds with indignation. "Wait a minute! Where do I come from? I come from the very people I'm trying to help! It's not academic or theoretical for me! I'm talking about my brother, my sister, my mother, my neighbor; I'm talking about the people I grew up with, in Mamelodi, in Makotopong. Why do I have to prove anything beyond that?"

In a day spent with Olive Shisana one sees both the flickers of embattlement and the ease which comes with a sense of arrival. She talks, with much emotion, about the guilt of bringing her two children, born in the United States, back to the captivity of South Africa (they returned in 1991), and of the house she built with her husband — who lectures at the University of the Western Cape — at Tableview, "with a picture-perfect view of the sea and the mountain".

She had never before been to Cape Town — she and her husband chose it from the pages of a book while in Washington DC as the place they would "return" to. It says something about the single-mindedness with which she is pursuing a sense of emplacement; a sense that was first shattered, perhaps, when she was forcibly removed with her family from their ancestral land at Makotopong, outside Pietersburg.

She was 17 at the time, and her memories of life before removal are pastoral and idyllic — all dew-covered berries, the twittering of birds, and the welcoming hearth for wayward travellers. Even the poverty of having to sleep around a fire under blankets made from mielie meal bags is remembered as being "close to the ancestors".

There is, in Olive Shisana, both a quest for unattainable perfection, and a manifest self-consciousness of her own imperfections. That combination results in the kind of drive that propels a black woman, against all odds and in the face of much opposition, to the very top of the civil service.

students, but the university council is salting away millions for pension payouts, reports **Justin Pearce**

townships for seven bodies

WM 9-14/6/95

The second payment, Tonkin said, was into a fund set up because "staff needed to be protected in case they are chased off campus" — an eventuality which Tonkin described as "the downside of being in a disadvantaged area".

The allegations concerning the funds have provoked fears that the outgoing council is using much-needed university funds to feather the nests of staff who were appointed by the old regime and who are planning to retire under the new.

Vista's history of Broederbond interference is well known. The university was set up by then Minister of Education and Training Dr Andries Treurnicht as a National Party response to attempts by the University of the Witwatersrand to establish a Soweto satellite campus. While Broederbond influence may have waned at executive level, there are still large numbers of academic staff surviving from apartheid days who may well be reconsidering their position when faced with a new regime.

the need to "neutralise the position of some stakeholders who have argued that the council is not legitimate".

This has been interpreted to mean that Bengu has failed in his role as mediator and is taking sides with council. Bengu's representative Lincoln Mali denied this allegation, saying that the use of the word "neutralise" was "unfortunate", and that a word like "satisfy" would have better expressed the minister's intentions.

There is further anger that the post of Vice-Chancellor and Chief Executive Officer was advertised by council in last weekend's newspapers. In terms of the agreement reached by council, the ministry, and the NTF, a permanent incumbent to this position — which is identical to that of rector — should not be appointed until a new council is in place.

The appointment of an acting rector is believed to be imminent, with Dr Julian Sonn widely regarded as the favourite for the position. This will be followed by the selection of a new council, which will oversee the selection of a permanent appointment to the post of rector.

Meanwhile, development of the university is hampered by the lack of leadership: the NTF and LTFs have credibility but little power, while council has power but little credibility.

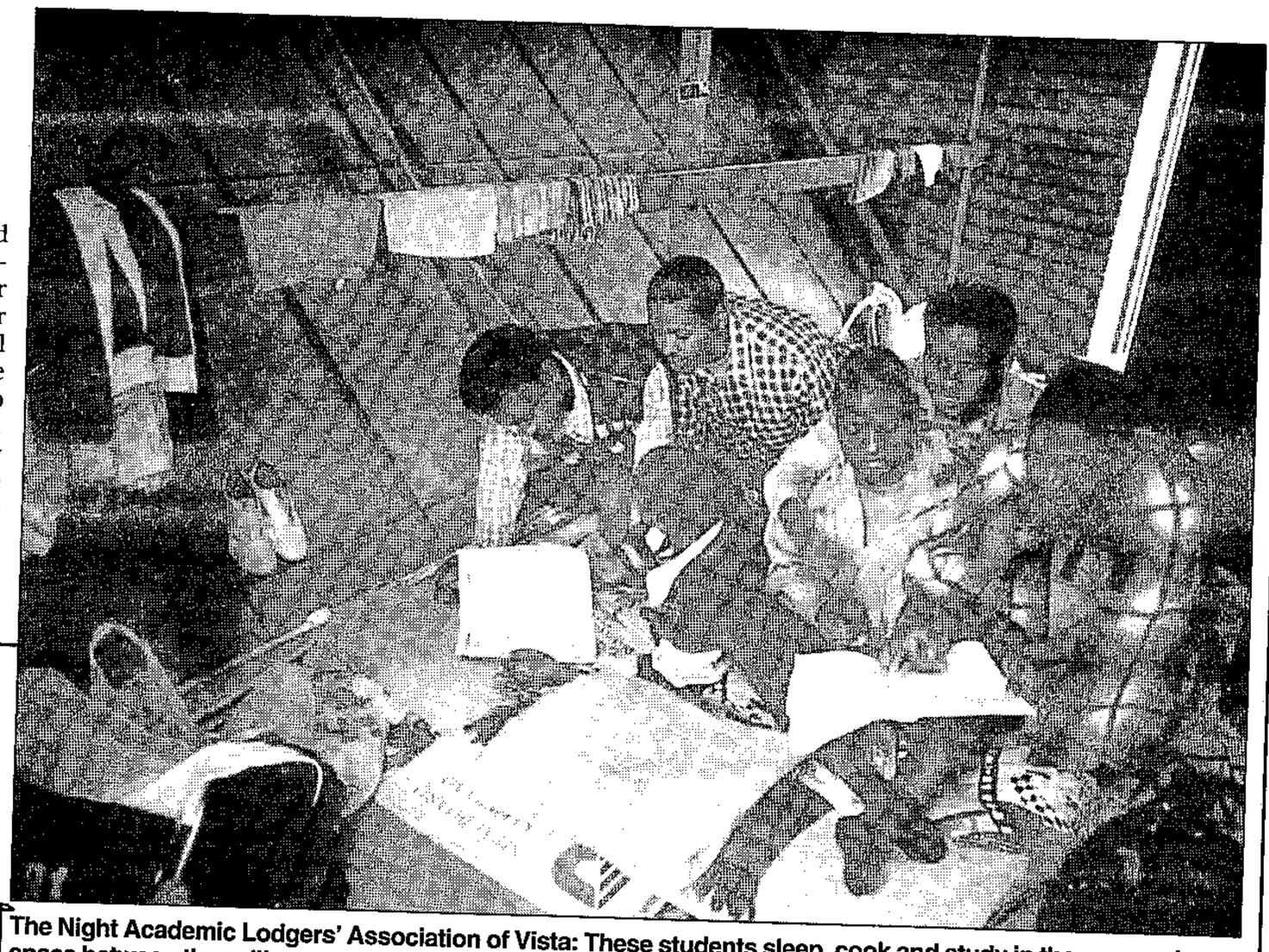
The absurdities of the situation are well illustrated by the case of American lecturer Frank Wilderson, who continues to teach without a salary despite the university's refusal to renew his contract at the beginning of this year.

Wilderson is widely respected as an academic, but his radical political stance has aroused controversy. Until credible leadership is established, Wilderson refuses to bow to the decisions of an undemocratic council and an equally undemocratic English Department.

At the level of the campuses, the power vacuum has been filled by the Interim Management Committees, which are responsible to the LTFs and have a large degree of control over the day-to-day running of the campus — but no control over finances, which are still in the hands of council. Academic planning is hampered by the need for uniformity among the campuses, since all Vista students take the same examinations.

Vista's academic curriculum is still based on a series of slim "study manuals" which encourage rote learning rather than critical analysis and wide reading. Apologists for the system say it is necessitated by the fact of students on seven campuses having to sit the same examinations.

Library stocks remain at the appalling level of two books per student (in contrast to 15 per student at the University of the Western Cape, itself an institution which had to overcome apartheid origins). With no effective leadership to take decisions around funding and academic policy, an institution claiming to be "the RDP university" remains mired in its origins as a series of urban bush-colleges.



The Night Academic Lodgers' Association of Vista: These students sleep, cook and study in the cramped space between the ceiling and roof over Vista lecture halls PHOTOGRAPH: HENNER FRANKENFELD

Vista's unofficial hostels – in the ceilings

WM 9-14/6/95

IT was a perfectly normal lecture until Daniel Zikalala fell through the ceiling. But then, people who know Vista know it as the university where almost anything can happen. And after Zikalala had picked himself up off the floor and walked quietly out of the lecture room, class went on.

The incident has become legendary on the Soweto campus — and since then no-one has been able to ignore the latest acronym among the student body: Nalav, otherwise known as the Night Academic Lodgers' Association of Vista.

There are currently at least 20 students who sleep on Vista's Soweto campus — which, like the other Vista campuses, has no student hostels. The "night academic lodgers" endure cramped and squalid living conditions, but have chosen to study and sleep on campus rather than put up with equally cramped and expensive township accommodation.

The most well-established dormitories are between the ceiling of the lecture rooms and the roof, which explains Zikalala's plunge when he trod on a weak spot in the ceiling.

Next to each lecture room there's a narrow passage which is used to gain access to the roof. With the addition of an electric hotplate, this space serves as a kitchen and lounge for the lodgers. From the passage, a submarine-style ladder goes up to an overhead trap door, which leads to the "bedroom" under the roof. Here the students sleep in shifts, whenever there's space on the mattress on the floor.

First-year student Welile Ndawo, 20, came from Newcastle in KwaZulu/Natal to study at the campus. When he arrived he stayed with relatives in Soweto, but had trouble paying the rent they charged, and found it difficult to study in the cramped house.

Coming to stay on campus was clearly the lesser of two evils.

"We face some problems," he says calmly. "The technical services department where we wash is often locked, or the geysers are switched off. And they are threatening to throw us out."

So far the students have managed to resist eviction, thanks to the state of quiet anarchy on the campus, where no-one is entirely sure who is in charge. But they are still blamed whenever incidents of theft or vandalism occur on campus, they complain.

Enoch Malinge, 21, is one of the most long-established lodgers, having moved in a year ago.

"The conditions at home were unconducive to studying," he says. "It was noisy, and we were 10 people in a four-room house."

The relative quiet of campus means that the number of lodgers increases dramatically during exams. Regular Nalav members boast that they are the top academic achievers on campus. To prove it, they have an "honours board" in one of the passages which they occupy. Here they paste up marked test papers in which their members have achieved distinctions.

The 'silent majority' raises its voice

Pat Sidley

LAST week's march on Parliament by thousands of angry Christians highlights the rapid growth of fundamentalist Christian groups in South Africa, and mirrors the advance of the religious right wing in the United States.

The marchers had come to protest the exclusion of the words "Almighty God" from the Constitution. But their agenda reaches much further than this.

Several of the groups, which marched under the same banner and share the same concerns, have large memberships, including the KwaSizabantu ministers, who see themselves as a counter to the more liberal churches which signed the Rustenberg Declaration several years ago.

One of the organisers of the march, Reverend Peter Hammond, says many of them have grave concerns, aside from the Constitution, such as the exclusion of Ascension Day from the public holidays, the proposed legalisation of abortion and the growth of the pornography industry.

The group set up to represent those interests is called "The Christian Voice" and it raised tens of thousands of rands locally to fund the march, says its representative Reverend Soon Zevenster of the Evangelical Reform Church.

Hammond and Zevenster told the *Mail & Guardian* that the group was set up only a month ago with the express purpose of taking up these causes and the march was only a beginning.

The group hired the buses and trains used to ferry the poorer supporters of its cause from the surrounding townships and squatter camps, according to Zevenster, and printed close to 400 000 pamphlets advertising the march. Money was raised through individual congregations by asking ministers in churches to support the cause.

Hammond's group, the Frontline Fellowship, co-operates with several other groups (with which it shares offices in Cape Town). These include United Christian Action, whose purpose it is, he explained, to carry out the political and social concerns among the "silent majority". The chairman of United Christian Action is Ed Cain, who gained infamy some years ago when he was associated with the Christian League, a front group used by the previous government to counter the influence of the South African Council of Churches.

"He must have been burned in that experience," maintained Hammond, who said Cain authored the organisation's constitution, which explicitly bars the acceptance of any government funding. Cain's daughter Mirian runs another associated group, African Christian Action, whose business it is to fight pornography, abortion, and so on.

The Frontline Fellowship itself, according to Hammond, sends missionaries, bibles, medication and food into countries such as Sudan, Malawi and Mozambique and, to a lesser extent, Rwanda and KwaZulu/Natal. Hammond, with some of his missionaries, spent an uncomfortable week in prison in the hands of Frelimo troops in 1989, when they abducted him from Malawi and accused him of gun-running. He vigorously denies this, stating that he was released after a week.

The Frontline Fellowship, he says, is funded by spontaneous donations from several sources, including local ones, and others in the United States and Europe. He does not, he says, raise funds, having biblical objections to the notion of fundraising. The money flows in spontaneously to do God's work, he explains, while being critical of the Christian Voice's fundraising.

The size of the march, which caught even its organisers off guard, has struck a chord of worry among the leaders of the "mainstream" churches. Many of these leaders noticed with concern that the numbers of marchers must reflect the fact that some of their own members were among them.

At the Press Club in Cape Town this week, Anglican Archbishop Desmond Tutu dealt with some of the complex issues raised.

"There are those Christians who claim that there are unambiguous and categorical directives regarding what the Christian position ought to be on issues such as abortion, homosexuality, divorce, euthanasia, etc.

"Such people are able to claim that 'the Bible says' and then believe that they have dealt once and for all with a complex issue and anyone who disagrees with them is really not Christian."

He argued, too, that the inclusion of the words "Almighty God" in the last Constitution did not prevent abuses of power — a point which Hammond acknowledges. But he points at previously Communist states which guaranteed in constitutions a right to religious freedom — and failed to provide it.

HEALTH

Get the drip ready

FM 9/6/95 (85)

Emergency surgery only, no paediatricians available for night emergencies, doctors working more than 80 hours a week — that will be part of the reality at Baragwanath Hospital (known as Bara) by next month if urgent action is not taken by the Gauteng health authorities. The immediate problem is not budget cuts, though these threaten to be crippling, but bureaucracy.

The difficulty is that the applications for essential medical posts have simply not been processed. This is worse than it may sound. The overwhelming majority of junior doctors at Bara are employed for six months only, starting in January and July each year. As well as offering the high-quality service expected of a major academic hospital (Bara is attached to Wits University), these doctors gain valuable experience before going into other hospitals or private practice. To make matters worse, the more senior registrars also leave in January or July when they reach the end of their fixed four-year appointments.

Masondo

If these people were not replaced at the end of their six-month stint, whole departments would be unable to provide outpatient care, emergency services or 24-hour cover. This is what is about to happen at the beginning of July.

Application forms for posts, together with motivations from senior hospital staff, have been returned three times in the past year to the hospital.

Last year, the 58 applications for appointment on July 1 1994 were still unconfirmed by June 15. Nearly half of those application forms were returned because the criteria for appointment had been changed.

The most recent delay in processing applications was communicated to the hospital on May 17.

The reason given by the provincial authorities in each case: new criteria are being devised for the advertising and filling of posts.

It seems that affirmative action is one of the reasons for the repeated revisions, but there does not appear to be clarity on how it should be put into practice. By the time applications are finally approved, usually at the last minute, many applicants have found work elsewhere.

There are suspicions among senior Bara staff that this debilitating neglect is the result of deliberate sabotage, grand incompetence or both. Either way, the manner in which the province issues imperious directives causes offence. Says Bara Department of Medicine head Professor Ken Huddle: "I don't know who they think they're dealing with. We're not clerks."

Bara administrators have long pleaded for devolution of administrative power so that junior and middle-ranking appointments can be made by the hospital.

When the *FM* contacted the Gauteng MEC for Health, Amos Masondo, he claimed that authority is being decentralised and that, meanwhile, "we attend to problems that are raised with us."

However, when presented with the tale of returned application forms and the imminent shortage of doctors in critical areas, he responded: "That is news to me."

Gauteng health superintendent-general Dr Ralph Mgijima could not be contacted for comment.

These administrative problems are common in State hospitals in Gauteng. Whatever services the budget cuts leave untouched are likely to be killed off by bureaucracy.

Masondo was immediately accessible when his office was contacted for comment and his headquarters staff were courteous, efficient and helpful.

But a strong impression remains that the higher echelons are out of touch with what is happening on the ground.

It will be interesting to see how the voters of Soweto will react in the local elections later this year. ■

COMMUNITY ELECTIONS

More troubles ahead

Voter registration, however unsatisfactory, is complete. Most transitional local authorities have been proclaimed, or are on the verge of being so, and yet it is still uncertain whether some parts of the country will be ready for November's local government elections.

Vic Milne, co-ordinator of the Local Government Elections Task Group's national secretariat, says that while everything is on target to achieve the deadline, problems are looming which could severely strain the whole process.

Topping the list are disagreements between the transitional metropolitan councils of Cape Town, Durban and Johannesburg and their respective provincial governments over substructure boundaries and the number of substructures which should be included in each metro.

"This is of very great concern," says Milne. The disputes centre on how many subcouncils there should be — a detail that should have been decided months ago, because the transitional authorities must make representations to the demarcation boards by the end of this week.

The delay means that other processes — the demarcation boards drawing up recommendations, then ratification by the provinces — have to be condensed to get back on schedule.

He adds that it is difficult to say how far behind the metros are in terms of resolving the problems. The executive committees of the Western Cape and Gauteng have refused to accept key recommendations of their metros, so the issues will have to be resolved by special electoral courts.

"Hopefully it has not reached that stage in KwaZulu-Natal but the bush telegraph suggests that the province's demarcation [illegible] and local government MEC Peter Miller are at loggerheads," says Milne.

From KwaZulu-Natal's viewpoint, last week's proclamation of the Durban metro may seem to be a breakthrough — leaving just one of the province's 56 transitional councils to be established, and that should happen soon. But Miller concurs with Milne — the big battles still lie ahead.

"Far from finally clearing the way for the

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Vic Milne, co-ordinator of the Local Government Elections Task Group's national secretariat, says that while everything is on target to achieve the deadline, problems are looming which could severely strain the whole process.

Topping the list are disagreements between the transitional metropolitan councils of Cape Town, Durban and Johannesburg and their respective provincial governments over substructure boundaries and the number of substructures which should be included in each metro.

"This is of very great concern," says Milne. The disputes centre on how many subcouncils there should be — a detail that should have been decided months ago, because the transitional authorities must make representations to the demarcation boards by the end of this week.

The delay means that other processes — the demarcation boards drawing up recommendations, then ratification by the provinces — have to be condensed to get back on schedule.

He adds that it is difficult to say how far behind the metros are in terms of resolving the problems. The executive committees of the Western Cape and Gauteng have refused to accept key recommendations of their metros, so the issues will have to be resolved by special electoral courts.

"Hopefully it has not reached that stage in KwaZulu-Natal but the bush telegraph suggests that the province's demarcation board and local government MEC Peter Miller are at loggerheads," says Milne.

From KwaZulu-Natal's viewpoint, last week's proclamation of the Durban metro may seem to be a breakthrough — leaving just one of the province's 56 transitional councils to be established, and that should happen soon. But Miller concurs with Milne — the big battles still lie ahead.

"Far from finally clearing the way for the

HEALTH CHIEFS: Newly-appointed members of the Western Cape provincial health team are chief director of social services Virginia Petersen and deputy director-general of health Tom Sutcliffe. With them is Western Cape Minister of Health Ebrahim Rasool.

ARG 12/6/95

85

Top health officials appointed

JENNY VIALL
Health Reporter

THE first senior appointments in the restructuring of the Western Cape health system have been announced by Western Cape Health Minister Ebrahim Rasool.

They are Virginia Petersen who takes the top welfare position as chief director of social services and Tom Sutcliffe who is deputy director-general of health.

Dr Sutcliffe is no stranger to health services in the Western Cape and his appointment is in effect a reappointment. He has played a major role in restructuring the hospital and health services and has worked on the strategic management team to draft proposals for a new health service.

Mrs Petersen, who holds an MA Social Sciences degree in clinical work, has wide experience in social services and social welfare having worked with Shawco, the trade union movement, the disabled and Child Welfare.

She is also a co-ordinator of the strategic management team which has published a draft document on the transformation of the welfare services.

Announcing their appointments, Mr Rasool said this was the first step in reorganising the health and social services departments.

Retiring medical man says country needs strong staff

AFTER more than seven years in the hot seat, Dr Coen Slabber has left the Department of Health. The Star's Health Writer, David Robbins, spoke to him

Dr Coen Slabber

(85) star 12/6/95

"First of all, I'm going to Egypt for a cruise on the Nile," says Dr Coen Slabber, the man who has been at the helm of South Africa's transforming health administration since December 1987.

"I finish up here at the end of June. Then it's off to Egypt for a month. After that, I'm going to Bahrain to visit my son who's with Foreign Affairs there."

It's a well-earned rest for a man who has led the national health administration from the height of the tricameral-constitution days of President P W Botha right through to South Africa's first democratic elections.

Slabber has worked under three health ministers: Dr Willie van Niekerk in the late 1980s, Dr Rina Venter, and now the present incumbent, Dr Nkosazana Zuma. But he is too diplomatic to be drawn into making comparisons.

"Each minister operates in a very specific set of circumstances. Dr van Niekerk formed part of a Cabinet which was ruled with a rod of iron by the then president. Dr Venter opened the hospitals to all races; she had a lot of good ideas, but she struggled to implement them because of the milieu in which she worked.

"Dr Zuma . . . she's tops. She has a very clear vision of what South African health care services should be in the future. And she's got guts."

Slabber (55) was born in Cape Town and went to school in the Karoo. After matriculating in Calvinia, he proceeded to Stellenbosch where he studied medicine and then specialised in gynaecology. A year (1970) of working in New York followed. He then returned to South Africa to open the gynaecology department at the University of the Orange Free State in Bloemfontein.

By 1979, he was Dean of Medicine. Five years later he accepted the position of first head of the white "own affairs" department when the tricameral constitution was implemented.

"I leave with mixed feelings," he admits now. "I think between seven and 10 years in any top job is the maximum. On the other hand, it's a very interesting time in the department. There's a lot happening. So, yes, I do have regrets."

Asked to elaborate, Slabber says immediately: "The department is facing some very difficult decisions. The country is going to need strong people to carry them through."

Slabber warns that, contrary to popular expectations, the introduction of primary health care, with its emphasis on preventive and promotive care, would not solve the current budgetary crisis in health.

"The first fallacy here is that people think primary care (PHC) is cheap. It's not. We'll probably have to spend more simply because good PHC unearths reservoirs of disease in the community which nobody knew existed. The second fallacy is that PHC is an alternative to hospital care."

For this reason, Slabber says, the concept of robbing the hospitals to pay for PHC is bad health planning. Good health planning must be based not only on bridging finance but also on an acknowledgement that health is vulnerable to a whole range of socio-economic factors over which the health department has no direct control.

What message would the outgoing director-general give to his successor?

"I think we have the structures and the policies in place to address the major problems. The time has come, now, for implementation. The key is this: if implementation doesn't quickly make a difference to ordinary people's lives, then we've got a really big problem."

Such urgencies will not be far from Slabber's mind, even as he cruises on the Nile and visits his son in Bahrain, because in August he'll be back, working as a health policy consultant in the Pretoria office of a large multinational management consultancy.

UK health reforms 'should warn SA'

BD 13/6/95 (85)

Kathryn Strachan

A WEEK before the announcement of a plan to finance health care in SA, one of the key architects of the plan said Britain's experience with the implementation of market reform in its national health system should send a warning to SA's government.

University of York economics professor Alan Maynard was one of three international consultants on the committee investigating a national health insurance system for SA.

He said that regardless of its final format, SA's new health dispensation could fail if government did not plan and carry out a strategically sound process of implementation.

The UK national health service was a publicly financed system which provided universal access to health care within fixed budgets and with remarkable cost control.

Four years ago, substantial reforms to the service were implemented, which introduced an internal market in health care, but the success of the reforms was mixed.

Maynard said the UK government adopted its national health service market reforms as a means of mitigating inefficiency in the health services.

He said policymakers outside the UK should recognise that market reforms were not an end in themselves, but a means of improving efficiency while maintaining cost control and equity.

more than 240 written submissions were received for the inquiry into a national health insurance system.

Meanwhile, Representative Association of Medical Schemes executive director Reg Magennis last week told the National Association of Private Hospitals that a new era of co-operation between private and public sectors would go a long way towards solving problems experienced by both sectors.

"The public sector should create opportunities for the private sector to provide innovative solutions to SA's problem of inaccessible and costly health care," Magennis said.

Policymakers also had to recognise the need to distinguish between the rhetoric of the political marketplace where it was essential to claim success and evidence about improved performance in terms of activity, outcome and patient satisfaction.

Next Monday, Health Minister Nkosazana Zuma is also expected to announce the findings of the investigations of another eight committees into various aspects of health care. There has been controversy surrounding these reports as they were completed in December and the six-month delay in their release has resulted in a lack of direction in the areas they cover.

In addition to concern about the confusion caused by the delay, there are also perceptions in the health sector that the eight reports were held back so they could be reshaped by the health ministry.

Zuma said yesterday that

Hospitals ready for health plan

Star 13/6/15 (98) (85)

■ BY JANINE SIMON
MEDICAL CORRESPONDENT

Private sector hospitals have pronounced themselves ready and willing to co-operate with the Government in providing cost-effective health care.

The announcement comes on the eve of the release of the Health Ministry's controversial report into primary health care funding, due to be made public on June 19.

The report is expected to provide a base for dialogue between public and private health sectors, delegate Reg Magennis told the annual meeting of the National Association of Private Hospitals at the weekend.

Magennis, a medical schemes executive, said a new era of co-operation would go a long way towards solving the problems of the private and public sectors.

The public sector should create opportunities for the private sector to provide innovative solutions to South Africa's problems of inaccessible and costly health care, he told delegates.

Association chairman Riel du Toit said the country's private hospital sector was ready to participate with the Government and health funders to provide cost-effective health care.

The association's executive director, Dr Anette van der Merwe, said the private hospital industry believed relationships between players in health care would change dramatically.

"Private hospitals will change from static organisations to large health service networks. We will maintain health, as opposed to treating illness, and market share will be defined less by the number of admissions than by contracted services to a defined population."

UK health economics expert Dr Alan Maynard warned that the new dispensation could fail if the Government did not carry out a strategically sound process of implementation.

Hard choices ahead to get full value for health money

(85) BD 14/6/95

Kathryn Strachan

HARD choices lie ahead if the health sector is to change course and provide all South Africans equal access to health, says a report on SA's health expenditure.

The recently released health expenditure review was conducted over a two-year period with the support of the World Bank, the Commission of the European Union and Britain's Overseas Development Administration.

The review stresses that choices need to be made about which services to cut, which to streamline and where savings can be made.

Ways needed to be found of making optimal use of health resources.

The private sector had to contain costs and make resources available to a broader section of the population. In the public sector, greater investment in training and management was needed at all levels of health care to achieve the savings necessary to fund new projects.

This included better use of health personnel, and better financial management and information.

Great improvements could be achieved at relatively low cost by ensuring access to basic preventative and curative services.

An additional R1,5bn to R2,5bn a year would be needed to provide access to basic health services for all. In addition a further R400m to R1bn was needed to build new clinics.

Strengthening district-based primary care services and integrating public health sector health services would also entail substantial costs in terms of training in clinical care and health services management.

Additional resources to extend health services will have to to come from a combination of savings on existing services and additional funds from other sources, the report says.

Resources could be redirected to primary level by, for example, downgrading some specialist hospitals, or closing wards or hospitals where there was a low bed occupancy.

Money could be saved through greater efficiency, by increasing government and donor funding and by recovering the costs of service delivery by increasing the number of private patients in specialist hospitals, the report said.

An important finding of the review is that SA spends a higher percentage of its GDP on health services than previously thought.

Past estimates set health spending at 6% of GDP — similar to developing countries — while the review found that the country spent R30bn on health, equivalent to 8,5% of its GDP.

This was comparable with spending in developed market economies.

However, the report says SA receives a poor return on its investment in health.

Disparities in the distribution of resources between the public and private sectors, between levels of care, and between geographic regions, meant that many areas were underresourced.

The report argued that a major redistribution of resources was required. This would have to be carefully managed to minimise disruption.

Clinic at Gogela: medication

291. Mr G Q M DOIDGE asked the Minister for Health:

(1) Whether the clinic at Gogela in the Mwaca tribal authority, Mt Ayliff, ran out of medication on 21 April 1995; if so, (a) why and (b) from what date were problems in this regard being experienced;

(2) whether her Department has taken or intends taking any steps with a view to rectifying the situation, if not, why not; if so, what steps?

N601E

The MINISTER FOR HEALTH:

(1) (a) Gogela receives its medicines from the Mt Ayliff Hospital. Medicines for the hospital and its clinics are ordered by the dispensary staff from the Central Medical Stores in Umtata. The store delivers stocks on a six-weekly cycle to each of the hospitals it serves. An order for medicines for Mt Ayliff Hospital was processed by the pharmaceutical depot on 17 April 1995, and delivered there a week later (week 24-26 April). It is therefore quite possible that the clinic stocks were very low on 21 April 1995 as it was immediately after the Easter weekend and before the hospital stocks could be replenished from the depot.

(b) Since the Provincial Department of Health took office, distribution of medicines within the former Transkei, has been identified as an area requiring urgent attention but particularly the accessibility to all the clinics.

(2) After identifying that the medicine distribution system in this entire area needs urgent attention, a quotation was obtained from the relevant contractor for the Department a year ago for the implementation of the COMED Medical Stores Administration System in the Umtata Medical Depot.

Negotiations for the funding of this depot are currently underway and the Eastern Cape Provincial Administration which is responsible for this area is being consulted with a view to rectifying the medicine distribution system within the northern sector of the Eastern Cape.

As an interim measure a team has been appointed to travel throughout the region from hospital to hospital to make contact with the clinics and set up order and stock control systems at each hospital.

Free medical care to children/pregnant women

310. Mr M J ELLIS asked the Minister for Health:

(1) Whether, with reference to her reply to Question No 70 on 9 August 1994, any calculations have been made by (a) each of the nine provinces and/or (b) her Department in respect of the cost of providing free medical care to pregnant women and children under the age of six years; if not, why not; if so, what is the calculated cost in each case;

(2) whether any funds have been made available to provinces to cover the cost of providing such services; if not, why not; if so, (a) which provinces and (b) what amount in each case?

Hansard 15/6/95 N624E

The MINISTER FOR HEALTH:

(1) (a) and (b) Yes. The amounts are as follows:

1994/95: Insufficient base-line data available for accurate comparison, but it was estimated that the amount required would be approximately R485 000 000.

1995/96

Western Cape Province	R146 000 000
Eastern Cape Province	No details available at present
Northern Cape Province	R39 242 432
North West Province	No details available at present
Northern Transvaal Province	30 000 000
Eastern Transvaal Province	No details available at present
Gauteng Province	No details available at present
KwaZulu-Natal Province	R205 071 000
Free State Province	R30 568 000

(2) Yes; (a) all provinces except Northern Cape Province which did not ask for any additional funds; and (b) amounts as follows:

1994/95

Western Cape Province	R 72 233 000
Eastern Cape Province	R 40 676 800
North West Province	R 13 800 000
Northern Transvaal Province	R 18 592 000
Eastern Transvaal Province	R 11 516 198
Gauteng Province	R208 089 000
KwaZulu-Natal Province	R101 893 000
Free State Province	R 18 200 000
TOTAL	R484 999 998

1995/96: R680 000 000 made available to all provinces within the total budget allocation.

Unsafe water supply to Mt Ayliff Hospital

340. Mr G Q M DOIDGE asked the Minister for Health:

(1) Whether the (a) Eastern Cape Provincial Health Authority, (b) Department of Local Government and/or (c) water authority of the Department of Agriculture have taken any action in regard to the unsafe water supply to the Mt Ayliff Hospital; if not, why not; if so, what action;

(2) whether the water supply obtained from the two boreholes at the hospital is (a) safe and (b) adequate; if so, (i) what are the relevant details and (ii) what is the capacity of these boreholes;

(3) whether the borehole equipment was in working order as at 26 April 1995; if so, what are the relevant details?

N602E

The MINISTER FOR HEALTH:

(1) Yes, the Eastern Cape Provincial Health Authority had requested the Department of Public Works to repair the brickwall of the 240 kℓ reservoir in order to increase the water storage capacity at the hospital during emergencies;

(2) (a) yes and (b) no; (i) only one borehole is in use, the other borehole was abandoned when it was discovered to be polluted, the water from the remaining borehole is being treated and the last sampling results indicated that the water is fit for human consumption; (ii) unknown, according to the Eastern Cape Provincial Health Authority the capacity of the borehole is insufficient;

(3) yes, to the knowledge of the Eastern Cape Provincial Health Authority the borehole equipment was in working order.

Tender boards: legislation to regulate granting of preference

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

(1) Whether he is contemplating introducing (a) legislation and/or (b) any other measures to regulate the granting of preference or preferential treatment by tender boards at all levels of government in respect of the procurement of goods and services to (i) local manufacturers and/or tenderers within South Africa or any provinces, (ii) emerging small, medium and micro-enterprises and (iii) tenderers (aa) qualifying as having previously been disadvantaged and/or (bb) involved in programmes aimed at uplifting the previously disadvantaged; if not, why not; if so, (aaa) what are the relevant details in each case and (bbb) when is it anticipated that such legislation and/or measures will be introduced;

(2) whether (a) the private sector and/or (b) any non-governmental organisations have been consulted in this regard; if not, (i) why not and (ii) what action is envisaged to ensure good order in terms of economic unity and protection of the common market in respect of the mobility of goods, services, capital and labour; if so, what are the relevant details in each case?

N710E

The MINISTER OF FINANCE:

(1) (a) No.

(b) No.

(i) A system to regulate the granting of preference for locally or partial locally manufactured products is already in place.

Health bills may cost firms billions

Samantha Sharpe (85) DM 15/6/95

SA COMPANIES could soon face billions of rands in liabilities for unfunded post-retirement medical aid obligations, the SA Institute of Chartered Accountants warned yesterday.

Saica technical director Monica Singer said local companies, which have traditionally provided for pension fund benefits on a pay-as-you-go basis, could find their income statements dented by a call to account for future health care obligations now.

The new accounting practice, compulsory in the US and the UK, was part of a strategy to bring SA's accounting practices in to line with global trends, Singer said.

She said Saica would be putting out an accounting recommendation in the next month calling on companies to make provisions for the often significant unrecognised liability.

It would be impossible to make the recommendation compulsory in the short term — the result could cripple many SA companies — so a phased in approach would probably be adopted.

This would give companies time to put their books in order, Singer said.

She said that in SA few companies had quantified the size of their future health care liabilities.

The accounting recommendation should force companies to quantify these liabilities, she said, with many having to reconsider the benefits they can afford to offer to their employees, especially pensioners.

Anglo American was an exception as it had already quantified its liabilities, Singer said.

Anglo American Corporation financial manager Bob Garnett said the corporation had already revealed unfunded accumulated medical aid benefits net of tax of R213m for the year to March 1994.

The figure did not include the liabilities of its subsidiaries.

The cost to the income statement had been R34m compared with R4m under the pay-as-you-go system, he said. The annual cost to the corporation was likely to continue in excess of R30m.

While the accounting practice was not immediately compulsory in SA, any local company that was a subsidiary of a US company would have to adopt the US standard as would any SA company wanting a listing on the New York Stock Exchange, accounting sources said.

But the alignment of SA's accounting standards with the rest of the world would make it difficult for SA companies to avoid addressing the issue.

Actuarial sources said the new accounting practice would also have a huge effect on companies' balance sheets, with the omission of this potentially significant liability leading to false or misleading financial statements.

Old Mutual Actuaries and Consultants director Heather McLeod said that any company evaluated for sale purposes would have to look at its future obligations if it wanted to reflect fairly what it was worth.

New doctors may be forced into two years' compulsory service

ST 18/6/95 (85) (93)

By CAS St LEGER

THE government is considering forcing medical graduates to do two years' compulsory service in underprivileged communities — but allowing wealthy students who want to emigrate or go into private practice to buy themselves out at a cost of R400 000.

These proposals form part of the draft National Health Act discussion document to be released tomorrow.

The Health Minister, Dr Nkosazana Zuma, will be discussing the national health insurance plan during the health budget debate in Parliament.

The recommendations on medical students were made by a committee appointed by Dr Zuma to investigate regulating the private sector under a new National Health Act.

The committee also proposed that, in addition to the compulsory service, graduating doctors and dentists get six months of supervised experience in general practice before being granted certification by the Medical and Dental Council.

The draft suggests that doctors and dentists wishing to opt out of their obligation to work in underserved communities be allowed to "buy out" of compulsory service at a proposed rate of R400 000 for medical graduates and R50 000 for "other professionals".

The committee also proposed that doctors be prohibited from dispensing medicines in areas where there is a licensed pharmacy.

The draft provisions for the new National Health Act were prepared for the National Health Legislation Review Committee.

One section of the proposed Act — Memorandum Three: The Regulation of the Private Sector — was prepared by another committee chosen by Dr Zuma.

The memorandum was drawn up by Professor Paul Benjamin of the University of Cape Town's Centre for Applied Legal Studies and Stephen Harrison of the Medical Research Council's community health research group.

Among its suggestions are:

- A possible mandatory requirement that the "formal employment sector" contributes financially towards a basic package of health services;
- Cross-subsidisation of health costs between young and old, rich and poor;
- Group risk ratings as opposed to individual ratings for medical scheme members; and
- Continued membership of medical schemes for limited periods after employment.

Forming an addendum to Memorandum Three is a compilation of reports from nine policy committees established last year by Dr Zuma, supplied by Dr Di McIntyre of the

To Page 2 ⇨

Proposals for a new Health Act

ST 18/6/95 (85) (93)

⇨ **From Page 1**

health economics unit at Cape Town University.

It was noted that the Department of Health had not yet indicated which of these recommendations it wished to implement.

One of the recommendations was that registrar training be extended to include a year of public sector experience in a rural health service.

Another suggested bursary holders "be forced to meet either their contractual commitments of service or repayment by means of disciplinary action of the interim Medical and Dental Council". (The interim council will be in place only for two years).

Another recommendation suggested that legislation be amended to "empower health professionals to deliver services in a more effective and efficient manner, including allowing psychologists to prescribe medication from an essential drug list and expanding diagnostic and prescribing activities for registered nurses".

It was also recommended that medical professionals' interests in private hospitals and the pharmaceutical industry be regulated and conditions be laid down under which medical schemes may own pharmacies.

The section on pharmaceutical products includes a proposal to support generic medicines and control and lower the prices of medicines.

Dr Hendrik Hanekom, the secretary-general of the Medical Association of SA, has not been party to the contents of the NHI report and declined to comment.

R9bn bill for health care plan

(85) BD 19/6/95

Tim Cohen

CAPE TOWN — About R9,2bn — over and above extra government funding — will have to be found during the next five years to finance a new public health care system, according to a government study.

The report, commissioned in January by Health Minister Nkosazana Zuma and to be released today, said the cost of the system would rise from R5,52bn next year to R9,22bn in 2000, including a "funding gap" rising from R1,36bn in 1997 to R3,39bn in 2000.

The report was originally intended as an inquiry into a national health insurance system. However, the scope of investigation was extended to cover public and private components of the health care system because the committee felt public health care could not be considered in isolation.

The report is likely to be controversial because of its criticism of SA's private health care system, which the report said represented a "severe maldistribution of resources". It noted that SA spent about R30bn on health care in 1992/93. About 61% of this was accounted for by the private health sector, which provided care for about 23% of the population on a regular basis. It said 59% of doctors and 93% of dentists worked exclusively in the private sector, to which the majority of the population did not have regular access.

The committee recommended that the public health care system guarantee equal access to all permanent residents, with personal consultation and non-personal services provided free.

The system should optimise the public/

Continued on Page 2

Health care

(85) BD 19/6/95

Continued from Page 1

private mix in health care provision and ensure redistribution of resources between the private and public sectors. However, the committee recommended that the system should preserve the individual's choice to use private practitioners.

The projected total cost of the public health care system would be R5,52bn in 1996/97, escalating to R9,22bn in 2000/01. The committee felt real increases in public expenditure of about R300m a year over a five-year period were feasible.

Increased health sector allocations were expected to flow from reductions in Defence expenditure.

Despite this and projections on income from state sales of essential drugs, there would be a huge funding gap, rising from R1,36bn in 1997/98 to R3,39bn in 2000/01. The committee proposed that additional funding be sought to remedy this.

The committee's recommendations will be published for public comment before Zuma considers them.

The committee was chaired by Dr Jonathan Broomberg and Dr Olive Shisana.

Meanwhile, Sapa reports that the Medical Association of SA's secretary-general, Hendrik Hanekom, has declined to comment on a Sunday Times report that government was considering forcing medical graduates to do two years' compulsory service in underprivileged communities.

The report said students wishing to emigrate or go into private practice would be allowed to buy themselves out of the obligation for R400 000. The proposal was part of the document to be released today.

Health funds 'may disappoint'

Beatrix Payne (85) (89)

IT was likely that primary health care funding in SA would fall "far short" of the average salary earner's expectations, Momentum Health MD Adrian Gore said at the weekend.

One funding model being considered by government would make a maximum of R180 a person available annually for primary health care purposes, he said. But studies indicated that the average medical aid scheme member spent R900 annually on primary health care.

Government statements indicated that funding primary health care for the poor was a priority, and others would have to fund their own health care and hospitalisation needs. People were "in for a shock" as the nature of health care changed.

Many medical aid funds, determined to improve their financial position, were reducing benefits and raising contributions. BD 19/6/95

Funds could face a R35bn bill for health care for pensioner members, yet they had an asset base of only R1,5bn and there was increasing resistance to cross-subsidisation. It was therefore vital for salary earners to consider health care in any financial planning, said Gore.

Spiralling costs the target as Zuma unveils plans for health care reform

(85) ARG 19/6/95

Political Staff

HEALTH Minister Nkosazana Zuma is presenting proposals today to fund a National Health Insurance Scheme and provide a solution to the spiralling costs of free state health care.

The NHIS is intended to provide non-discriminatory access to primary health services.

At present only pregnant women and children under the age of six have free full health services.

These services were introduced as an RDP "presidential lead project" and have been funded as a stop-gap measure from the RDP Fund.

The government has been exploring ways to permanently shift the cost of free services from the health budget.

An across-the-board tax on individuals as users of the national health system may be among the proposals.

The committee investigating a NHIS will present its proposals shortly before Dr Zuma tells the national assembly how her department intends spending its R12 billion budget, which does not include the costs of free health care.

Free health care for pregnant women and children under the age of six alone is expected to cost R680 million in the 1995/96 financial year, Dr Zuma told parliament recently.

Last year it cost R484 million.

None of this money came from the health budget but was taken from the RDP Fund, which cannot sustain the high running costs of free health services.

The NHIS proposals are also intended to establish new ground rules for the relationship between government health services and the highly profitable private health sector.

MONDAY
JUNE 19, 1995 ★

Health plan announced today

(85)

CT 19/6/95

POLITICAL STAFF

HEALTH MINISTER Dr Nkosazana Zuma will unveil proposals today for a National Health Insurance Scheme (NHIS) to reduce the cost of providing free health services by the state.

The NHIS is intended to provide universal non-discriminatory access to primary health services.

At present only pregnant women and children under the age of six enjoy free health services.

These free services have been financed by the RDP Fund, which cannot sustain the costs. A users' tax may be proposed.

The committee investigating the NHIS will unveil its proposals shortly before Dr Zuma tells the National Assembly how her department intends spending its R12 billion budget — which does not include the costs of free health care.

Free health care for pregnant women and children under the age of six alone would cost R680 million in the 1995/96 financial year, she told Parliament recently.

Last year it cost R484 million.

The NHIS proposals are also intended to establish new ground rules for the relationship between government health services and the private health sector.

(85)

Free primary health care scheme proposed

Star 19/6/95

■ **BY DAVID ROBBINS**
HEALTH WRITER

An estimated R9-billion of extra funding will be required to finance a proposed national health insurance system (NHIS) for the country over the next five years.

Suggested sources include: general tax revenues; dedicated funding from excise duties, VAT and payroll taxes; and the taxation of medical scheme contributions.

This has emerged from the long-awaited report of the committee of inquiry into an NHIS, released today in Cape Town by Minister of Health Dr Nkosazana Zuma.

The report suggests that newly qualified doctors serve an unspecified stint in the public service. The report is open for public discussion for about the next two months before the Health Ministry takes any decisions.

It is recommended that introduction of the new system begin next year. The envisaged NHIS will cover primary health care (PHC) services only, and will be available free to all citizens and permanent residents.

The report also suggests that health insurance coverage for a hospital benefit package, paid for jointly by employee and employer, be made mandatory for all those employed in the formal sector.

The new NHIS system will be dependent on a major overhaul of basic health care provision, and will seek to combine the resources of the public and private sectors in an attempt to improve access and equity, regardless of race, gender, economic status and geographical position.

The committee of inquiry was appointed by Dr Zuma in January with the objective of achieving such access and equity within the constraints of "affordability and sustainability, efficiency and cost control, and the overall objectives of the RDP".

According to detailed financial modelling which backs up the report, funding for the initial changes next year would be found within the health budget itself, but substantial additional funding would be required thereafter. For the period 1997-2000 this would be R9,21-billion.

The committee was guided by the Government's fiscal policy which is committed to reduction of the deficit, consumption expenditure and the overall tax burden. This, according to the report, led to circumspection in the design of the PHC/NHIS package, but the report stresses that "real increases in funding will be required if genuine improvements are to be realised".

Central to the NHIS proposals is the establishment of district health authorities (DHAs) which will play the key administrative role for the delivery of the NHIS. DHAs will be funded on a capitation basis (an amount per head) and will gradually move from being a funder and provider of care, towards that of public purchaser of services from varying combinations of public and private providers operating on a competitive basis.

Private providers, however, will be accredited only if they band together in comprehensive health care teams.

Even then, accreditation would be gradual, with special emphasis on the extension of more comprehensive services to currently under-served areas.

Other important proposals:

■ Registering the entire population, as broken down into the various areas of DHA jurisdiction, for the purposes of capitation funding.

■ Strengthening the human resource capacity of health care delivery both at managerial and service level, including a renewed emphasis on clinically trained PHC nurses as the

▶ **To Page 2**

Health plan aimed at helping the poor

Sowetan 19/6/95 (85)

Committee recommends that medical graduates must work for two years in underprivileged communities:

Sowetan Correspondent

A PROPOSAL that medical graduates be forced to do two years' compulsory service in underprivileged communities will come under the microscope today in Health Minister Nkosazana Zuma's budget debate in Parliament.

Sunday newspaper reports said the recommendations on medical students, which includes allowing wealthy students who want to emigrate or go into private practice to buy themselves out at a cost of R400 000, were made by a committee appointed by Zuma to investigate regulating the private sector under a new National Health Act.

The draft provisions for the new National Health Act were prepared for the National Health Legislation Review Committee.

Hillbrow Hospital s Professor Harry Seftel said he believed the two-years' service in underserved communities would benefit all.

Although Seftel had not seen the full proposals, he said the suggestion was moral and just.

"Why does one become a doctor? To help people. And what better way to help than to serve in the communities which need you most."

Seftel said that from an economic perspective, medical studies were heavily subsidised with students paying only a fraction of the real cost.

The young doctors would also benefit from the experience of learning all aspects of medicine in a rural setting while the benefit for the underserved communities was enormous, Seftel added.

But some doctors' groups are questioning why the medical profession should be targeted for a "call-up system".

Proposed national health system's funding queried

ARLT 20/6/95 (85)

Political Correspondent

LACK of clarity about funding has been diagnosed as one of the main weaknesses of the proposed national health system.

The system, proposed by a committee appointed by Health Minister Nkosazana Zuma, will cost R5 billion by next year and R9 billion by 2000.

The shortfall in funding next year is expected to be R1,36 billion, rising to R3,39 billion in April 2000.

Options recommended by the committee to make up the shortfall include a payroll tax, general tax, funding from duties on tobacco, alcohol and value added tax; abolishing the tax subsidy for contributions to medical aid schemes and a user charge on voluntary private health insurance.

Dr Zuma told parliament: "We must see health as an investment and not merely as an expenditure item."

Full implementation of the national health system would take five years.

Proposals include access to the national health service for all permanent residents of South Africa, irrespective of whether they have private health insurance or belong to a medical aid scheme.

Services will be free at the point of service.

People who go straight to hospitals for out-patient services without a referral from the primary care facility will be penalised by an extra user charge. This will not apply in emergencies or when public facilities are closed.

In yesterday's national assembly debate on health, Willie Odendaal (NP) said that while his party supported the principle of a basic health service available to all, the committee's proposals were unacceptable.

The system would be open to abuse and lead to a general decline in standards of health care.

Taxpayers would not be able to afford to pay the extra R10 billion a year for the next five years which would be needed to set up the system. These additional taxes would mean people would not be able to keep up payments on their medical aid schemes.

Mr Odendaal said the committee had neglected to make concrete proposals about sources of funding.

Mike Ellis (DP) called for further debate on the taxation measures proposed for fund raising for the scheme.

He was worried by the huge bureaucratic structure being created for health care.

Mixed reaction to health plan

(85) (88)

CT 20/6/95

CLAIRE BISSEKER
STAFF REPORTER

PROPOSALS for a National Health System aimed at providing universal primary health care to all South Africans received a mixed reaction from professional associations and interest groups yesterday.

Cape Independent Practitioners Association (CIPA) chairman Dr Steve Jooste said a national health scheme could not satisfy the population's urgent expectations of free health care unless it incorporated the private sector from the start.

Cape Primary Care chief executive officer Mr Stephan Lukas said that in the long-run GPs should be excited about being allowed to form accredited private multi-disciplinary practices which could compete with Primary Care Centres for government work.

Shrink

The Strategic Health Consultancy's Dr David Green said private practice would shrink gradually but not disappear altogether, while doctors who formed group practices and alliances with other providers to serve underserved communities stood to benefit.

He said doctors in public service could expect better remuneration and improved career paths in primary care.

Health plan gets mostly bouquets

(85) Star 20/6/95

The new proposals for a national health insurance system have been criticised by the National Party, admired by a major medical aid administrator, and drawn mixed reaction from professional associations and other interest groups.

The Representative Association of Medical Aid Schemes (Rams) and the Medical Association of South Africa (Masa) were not prepared to comment at this stage.

Proposals for private sector participation, core benefit medical cover for all employees, and an essential drugs list were among those particularly well received, while fears were expressed about funding mechanisms to cover the estimated R9,2-billion needed over the next five years.

The National Party supported the concept of a basic health care system for all South Africans, but found the Health Department's committee of inquiry proposals unacceptable, NP Health spokesman Willem Odendaal said.

The proposals created a climate for the misuse of the health system and eroded the competitive edge of private initiative, he said.

Freedom Front parliamentary chief whip Joseph Chiole said the committee had sought to politicise the medical board, and to "lower standards to such a degree that the medical profession would be more accessible to everyone more quickly".

Andrew Jackson, MD of SA's largest medical aid administrator, Medscheme, said he had been "particularly impressed with the depth and soundness of the report".

Proposals for an essential drugs list could bring about a meaningful reduction in the medicine bill which comprises 30% to 40% of all medical aid costs, more than double the equivalent in Europe or even Zimbabwe, he said.

Cape Independent Practitioners' Association (CIPA) chairman Dr Steve Jooste said a national health scheme could not satisfy the population's urgent expectations of free health care unless it incorporated the private sector from the start.

General practitioners would see their patient pool shrinking initially as people opted for the "free" health care available at primary care centres, but in the long-run they should be excited about the prospects. — Sapa and Staff Reporters.

Primary health care system approved

Report moots compulsory hospital levy

(85)

BD 20/6/95

Tim Cohen and Kathryn Strachan

CAPE TOWN — Health Minister Nkosazana Zuma said yesterday Cabinet had agreed to establish a universally accessible primary health care system — the first mammoth public sector project to gain the new government's support.

Zuma's statement coincided with the release of a report by a committee which found that the proposed primary health care system would cost SA R5,52bn next year, rising to R9,22bn by 2000.

The committee has proposed that the Health Ministry introduce a mandatory contribution to a basic hospital plan by all in formal employment. .

The proposal was one of many announced yesterday by the committee investigating national health insurance. While no specific mechanism for financing health care was recommended, the committee suggested ways in which resources could be shared more equitably between the public and private health care sectors.

Another proposal was to cut drug prices by means of an essential medicines list. No mark up would be allowed on listed drugs although pharmacists would charge a dispensing fee.

While the gap in funding primary health care services was set at R1,36bn in 1997, it was expected that savings generated by proposals to increase efficiency in hospitals and medicine cost cuts could go a long way to make up this shortfall.

A hospital plan for all in formal employment would apply only to people with no private health cover in an effort to draw them into the health insurance net. Unemployed people not covered by any health plan would have to rely on the state for medical care. It would help stabilise the volatile private health insurance market and generate substantial revenue for the public hospital system.

It was estimated that an average annual fee of R400 a person would yield R1,3bn a year for hospitals.

The report recommended changes to medical aid structures to make the schemes more affordable and to ensure the elderly and the sick were not forced out of schemes by increasing costs.

The committee originally looked into ways of financing universal primary health care coverage but progressed to a more comprehensive approach. It decided against proposing a specific mechanism for funding primary health care and listed five options. These were general tax revenues; dedicated funding from excise duties; VAT; payroll taxes; and taxing medical scheme contributions.

A decision would have to be taken by

Continued on Page 2

Health

(85) BD 20/6/95

Continued from Page 1

Cabinet as it had to be seen as part of the overall fiscal debate.

The committee proposed a national health system for universal primary health care which would allow for extensive co-operation between the public and private sectors and would help the public sector to attract personnel.

The new system would create opportunities for private providers to play a role in the delivery of publicly funded primary health care, acquiring accredited private provider status and entering contracts with public funding authorities.

The report also proposed that doctors be prohibited from dispensing medicines in areas with licensed pharmacies.

Another recommendation was that medical graduates be required to serve stints in underprivileged communities or in the public sector. But the committee said most graduates already served in the public sector for a while after graduating.

During the parliamentary health budget vote yesterday, Zuma said full implementation of a national health system would take five years.

The plan drew guarded support from political parties.

DP MP Mike Ellis warned of the "massive bureaucratic structure" that might result from the plan and said this was to be avoided at all costs. Studies had shown that health care socialisation tended to absorb more money for financing structures than was allocated to the care of patients.

The report was silent on which branch of government the district health authorities responsible for implementing the scheme would be accountable to, he said.

Zuma said some aspects of the report needed to be implemented as a priority. These included the drug list for primary health care services. The state should have the right to import medicines if local manufacturers failed to make them available at reasonable prices.

By April 10 000 nurses with clinical skills would be needed to provide the primary health care envisaged. There were about 1 000 trained primary health care nurses in the country but this was counterbalanced by an oversupply of professional nurses relative to anticipated needs.

'EVERY PERSON LIVING IN SA TO HAVE EQUAL ACCESS'

Health care services for all

(85) CT 20/6/95

A PLAN for free health care, to cost up to R9bn in 1995 prices by the turn of the century, could be funded by increased duties on tobacco and alcohol, among other sources. **ANTHONY JOHNSON** reports.

THE government unveiled an ambitious plan yesterday to revolutionise the health care industry and provide free primary health care to all citizens by the turn of the century.

Details of the National Health System (NHS) — which could cost an extra R1,4 billion or R154 a person in 1997, rising to R3,4bn a year by 2000 — were announced by Health Minister Dr Nkosazana Zuma.

Speaking at a press briefing and later during the debate on her budget vote, the minister said the cabinet had approved the principle of universal free primary health care, but not how to pay for it.

A committee of inquiry Dr Zuma appointed in January had proposed that the new plan would cost R5,5bn in April 1996 (at 1995 prices), escalating to R9,2bn in April 2000.

Committee head Dr John Broomberg said funding options to be considered by the cabinet included a general tax, dedicated payroll taxes, excise duty on tobacco and alcohol, abolishing the tax subsidy for contributions to medical schemes, and the imposition of a user charge on voluntary private health insurance.

He said the committee's brief had been to come up with a plan "that will allow every South African to receive quality primary health care regardless of race, gender, income or place of residence".

The committee's recommendations will be open for public comment until August 18, when the government will begin to formulate final policy and legislation on primary health care.

UNIVERSAL CARE: Minister of Health Dr Nkosazana Zuma has unveiled an ambitious plan.

Dr Zuma said the package of services would include maternal and child health services, family planning services, health education, nutrition, immunisation, screening for common diseases, curative services for acute minor ailments, trauma, endemic diseases, communicable diseases and chronic diseases, primary investigative services in radiology and pathology, basic rehabilitation services, basic optometry services and mental health services.

These services would be available on a non-discriminatory basis. "Every person living permanently in South Africa, whether or nor he or she has private health insurance or a medical scheme, will have the right of access to the NHS on equal terms," she said.

Dr Zuma emphasised that the new dispensation would not only have extra costs, but would also create many benefits.

One step to be undertaken immediately was the drawing up of an essential drug list, listing 90-95% of the medicines used for primary health care.

These drugs would be bought by state tender and made available at cost — pharmacies would be allowed to charge a dispensing fee only. General practitioners would only be allowed to dispense if there was no pharmacy nearby.

"This will ensure the universal availability of safe, efficient and high-quality medicines at affordable prices," she said.

Medical aid schemes would continue under the proposed scheme, but changes had been recommended to the current medical aid structures to make them more affordable and ensure that the elderly and the sick were not forced out by increasing costs.

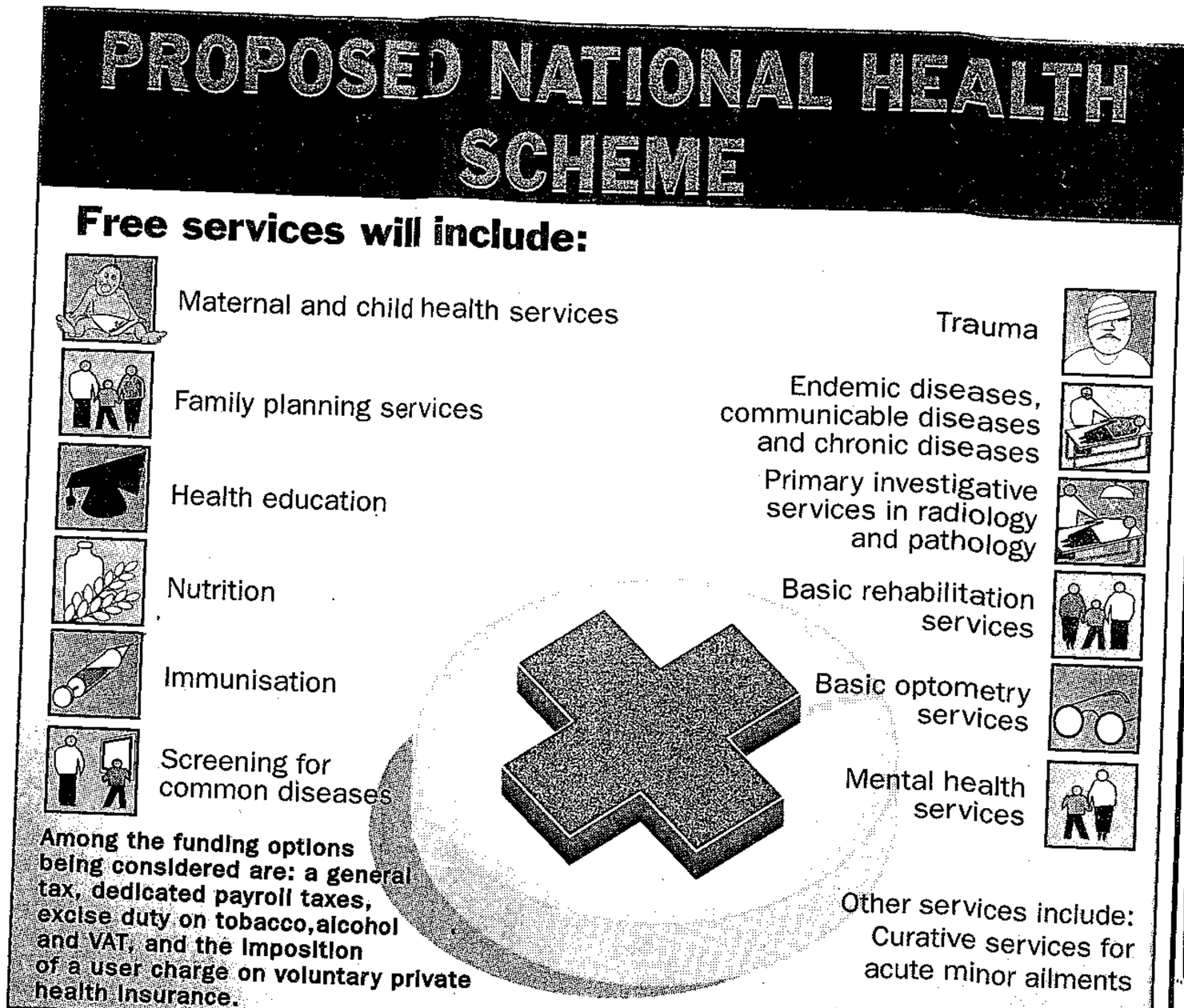
One of the committee's key recommendations was to investigate proposals to make membership of a basic hospital plan compulsory for all employed people.

It also called for 1 846 primary health care doctors next year, up from 984 at present, and for 10 000 primary health care nurses, up from 1 000.

● A massive bureaucratic health care structure had to be avoided at all costs, the DP's Mr Mike Ellis said yesterday.

Studies had shown that health care socialisation tended to absorb more money for structures than was allocated to the care of patients, he said.

● See Page 5



South Africa is almost certainly on course to a national health insurance system. But what sort of system? Health Writer ***David Robbins*** *examines the report released yesterday*

Blueprint for health-care revolution

(85) Star 20/6/95

It hardly needs repeating that at the heart of the move towards a national health insurance system (NHIS) lies the plight of millions of South Africans who simply did not have a fair health deal under apartheid.

When Health Minister Dr Nkosazana Zuma set up a committee of inquiry under the joint chairmanship of her special adviser, Dr Olive Shisana, and health economist Dr Jonathan Broomberg in January, she spelt out the terms of reference very clearly: whatever system the committee proposed, it should have as its central characteristic "universal and non-discriminatory access to quality primary health care (PHC) for all South Africans, regardless of race, gender, income and place of residence".

Of course, the approach to such a system is bedevilled by what actually exists on the ground: an often inefficient and in many areas dilapidated public health system on the one hand, and a super-smooth urban-based private sector with spiralling costs and over-provision on the other. The picture is one of need and plenty starkly juxtaposed.

Over this picture the Broomberg/Shisana committee has superimposed an NHIS which will provide "quality primary health care for all South Africans".

Main characteristics of the system are:

- It will be free at the point of service
- It will be nurse-based
- It will use both public and private sector facilities and expertise
- It will cost in excess of R36 billion over the next five years.

Before we wring our hands in alarm over this amount, we should bear in mind that R27 billion will be spent on primary health care over that period anyway, leaving a shortfall of around R9 billion to drive the proposed NHIS. The committee has several ideas on how to raise this extra finance, but let's see what we'll get for our money.

The services include curative services for acute minor ailments, trauma, endemic diseases, other communicable and some chronic diseases, immunisation and screening for common diseases, family planning, and full maternal and child health services (to be rendered by PHC nurses and midwives with referral to doctors where appropriate).

Essential medicines will be provided at a nominal fee and dispensed by PHC nurses or pharmacists. X-ray and laboratory services will be rendered by the appropriate technicians and basic oral health by dental therapists with referral to dentists where appropriate.

The list goes on: basic optometry services, mental health and social work services, health education, nutritional services, school health, environmental services, essential ambulance services, care of the elderly, epidemiology and information systems, medico-legal services and district hospitals.

What is new in the Broomberg/Shisana committee recommendations is who should administer all these primary health care services. At the moment, it's a fairly inefficient jumble of local authority, provincial and state health bodies. Now, enter the district health authority (DHA).

Although the committee's report does not go into detail, the district health concept, which contains strong community participation elements, divides the population into units of between 100 000 and 500 000 (depending on geographical spread and other considerations), and leaves no corner of the country outside the jurisdiction of one or other DHA.

Equally new is how the DHAs will administer the basic NHIS package. The plan is that they should move away from being providers of services to being purchasers of the best and most effective services available.

The DHA's will have a budget based on a capitation formula, and with it they'll buy whatever is needed, either from the private or the public sectors. Of course, there'll be a fairly tricky transition period before such a system is in place.

The advantages appear to be manifold. To split the funding and provision functions will obviously facilitate greater efficiency. More importantly, the new arrangement will draw in the private sector on a contract basis to improve basic health services for all.

According to research done at the University of Cape Town, nearly 70% of GPs support the general principle of contracting with the DHAs, increasing to over 80% if GPs were allowed simultaneously to maintain their independent status. This seems likely to happen, although at the same time the Broomberg/Shisana committee recommends that private practitioners will be accredited under the NHIS only if they form comprehensive health care teams; and, certainly to begin with, preference will be given to those private teams working in currently underserved areas.

A major area of concern for the committee was the filling of the health personnel gaps in these areas. It is well known that the private sector operates predominantly in urban areas, leaving the countryside, especially the old homelands, seriously under-served. Equally well known is the shortage of medical expertise in the public sector generally.

Many recommendations were made to rectify this situation. These range from improving the total compensation package for public sector medical staff, to offering incentives to those prepared to work in remote areas, to the more controversial introduction of a fixed period of service in the public sector (with a buy-out option) for all new medical and other health professional graduates.

As controversial could be the recommendations surrounding the distribution of medicines. An essential drugs list to cope with the prevention and treatment of more than 90% of the common and important illnesses found in South Africa is being mooted. To keep costs down, however, the committee suggests that curbs be placed on the activities of dispensing doctors, and also that pharmacists be paid for acquisition (with a reasonable profit), storage and dispensing of these drugs, rather than allowing the present system of mark-ups and discounting to prevail.

The resultant reduction in medicine prices should apply to everyone, including those on private medical schemes, says the Broomberg/Shisana committee. The effect would be to roughly halve the value of most prescriptions, thus saving a substantial R1,2 billion on private health expenditure each year.

An important factor in the NHIS recommendations is the acknowledgement that private medical schemes should be allowed to continue to operate, and that the proposed NHIS will be open to all, whether individuals are covered by a medical scheme or not.

The committee nevertheless devotes considerable attention to what it calls the "regulatory reform of the private health sector". The details of these reforms illustrate the concern of the Broomberg/Shisana committee over containing costs in this sector and to achieving a more equitable spread of resources across the entire population.

For example, while medical scheme members will undoubtedly benefit from the implementation of the PHC essential drugs list, they could find themselves paying some form of tax or levy on their medical scheme contributions.

This is one of the suggestions for finding that additional R9-billion needed to instal and operate the NHIS. Other suggestions include an increase in the overall health budget, dedicated funding from VAT and excise duties (notably on tobacco and alcohol) and dedicated payroll taxes.

None of these ideas is new, and the committee recognises "the potential conflict between the Government's fiscal policy objectives and the requirement for additional funding ... But real increases in funding will be required if genuine improvements are to be realised".

So, what about a payroll tax?

The Broomberg/Shisana committee's approach to this is innovative. To understand the approach, one needs to place the proposed NHIS, which covers primary care only, in the context of the country's total health care system. It's a truism that the better the basic care, the more people will need referral to secondary and tertiary levels.

The proposal, therefore, is for the introduction of "mandatory health insurance coverage for a defined hospital benefit package". In other words, a compulsory hospital plan for everyone in formal employment. The package would cover the costs of hospitalisation in the public sector, but the benefits need not be spent in the public sector, and would probably cost in the region of R56 a month for a family of three, to be split equally between employer and employee.

"Conservative estimates suggest," says the report, "that approximately five to six million individuals would be newly covered under this proposal, and that at least R1,32 billion per annum could be generated in hospital user charges."

Apart from vastly improved hospital insurance coverage for millions of South Africans, it would spell definite good news for public hospitals, once they have become more autonomous and better equipped than they presently are to take advantage of cost recovery arrangements. The scheme would also have the effect of stabilising the private health insurance system, by reversing the current trend towards excluding the elderly and chronically unwell from affordable coverage.

Looked at from the point of view of the dreaded payroll tax, the mandatory hospital plan contributions would be equivalent to only about two-thirds of one percent of total taxable earnings.

There can be little doubt that this proposal, coupled with the primary health care NHIS, will have the effect of lifting South Africa from the lower end of the international league tables when it comes to basic health status indicators such as infant mortality, life expectancy and the incidence of preventable diseases.

Proposals aimed at private health sector

Kathryn Strachan (85) BD 21/6/95

ONE OF the most far reaching proposals announced this week by a committee investigating a National Health Insurance was for regulations aimed at containing costs in the private sector.

The private health insurance system was facing a crisis which required urgent response from government. Cost escalations in recent years had begun to undermine the viability of elements of the system, with the risk that the state would be burdened with the care of increasing numbers of people unable to afford the costs of private health care.

These problems had been aggravated by certain recent regulatory reforms.

As well as introducing mandatory health insurance coverage for a defined hospital benefit package for all those in formal employment, the committee proposed all medical schemes should participate in an equalisation fund that received money from schemes and redistributed it to others according to the risk profile of each scheme's members.

Regulatory mechanisms required to reverse the instability, increased costs and reduced coverage which resulted from some regulatory reforms to the private health insurance market included:

- ☐ Schemes may not exclude any individual on the basis of their health risk. There should be open enrolment, guaranteed renewal and transferability of membership between schemes.
- ☐ Schemes are obliged to continue providing health benefits to continuation members (such as pensioners and widows), and for a period to people who lost their jobs.
- ☐ Individuals' contributions may not be related to their health risk.
- ☐ Schemes should be allowed to limit cover for people who start contributing to a scheme only when they are close to retirement.

Doctors welcome health insurance report

(86) BD 21/6/95

Kathryn Strachan

DOCTORS welcomed the new national health insurance report yesterday, saying it recognised the right of the individual to choose health service options and that it encouraged co-operation between the public and private health sectors.

The country's largest medical aid administrator, Medscheme, said the committee had proposed some far-reaching reforms which were "sorely" needed in the public and private health sectors.

Medscheme deputy MD Andrew Jackson said the proposals for an essential drugs list could bring about a meaningful reduction in the medicine bill, which comprised 30% to 40% of all medical aid costs — more than double the equivalent in Europe or even Zimbabwe.

"We are pleased to see that the report promotes the social insurance principles of the RDP while still envisaging a strong role for the private sector in making primary health care accessible to the majority of South Africans," he said.

Jackson said a most significant development in the report was the proposal that all employed people have access to state and provincial hospitals through mandatory contributions to a medical scheme or a national hospital benefit fund, as part of a core benefit package.

"One of the major problems facing government right now is the dual problem of inefficiencies in the state-run sector, and wastage in the private sector.

"We believe the reforms proposed — a good balance of regulation and deregulation — will contribute to better management and synergy between the two sectors."

Medical Association of SA chairman Dr Bernard Mandell said his organisation was impressed by the committee's broad and comprehensive approach to the restructuring of the health care system.

"Their recommendation to build on and strengthen the public health sector, and to create opportunities for private health care providers to play a role in the delivery of publicly funded primary health care coincides to a large extent with Masa's proposals," Mandell said.

Having acknowledged that there were not enough doctors to follow through the proposed plan for extended primary health care, Masa welcomed the ministry's intention to improve working conditions in the public sector; to create incentives to attract doctors to this sector; and to involve them to a greater extent in sessional work and in the provision of referral services.

The Medical Research Council applauded the committee for its broad proposals for the reform of the health care sector. Council president Walter Prozesky said. "This system is the mainstay of care for most South Africans, and the emphasis given to it marks a watershed in coming to grips with SA's priority health needs, in a way compatible with the RDP and existing health care practices."

NP health spokesman Willem Odendaal said, however, that without a dramatic rise in the economic growth rate, the SA economy in general, and the taxpayer in particular, would not be able to afford the additional R10bn, which it was estimated was what the proposed primary health care system would require over the next five years.

He said the proposals for free primary health care shifted the responsibility from the individual to the state. This created a climate for the misuse of the system which, in other countries, had led to the failure of health care systems.

● Comment: Page 14.

Masa welcomes new health moves

(85) ARG 21/6/95

Health Reporter

THE Medical Association of South Africa has reacted positively to the recommendations for a national health insurance scheme, details of which were released this week.

Masa said it welcomed the recognition of the right of individuals to freedom of choice in regard to health service options.

In a statement Bernard Mandell, chairman of the federal council of Masa, said the recommendations encouraged co-operation between the public and private health sectors. The report also envisaged the integration of primary health care services with other levels of health care.

"Health care reform is a complex process and we are impressed by the committtee's broad and comprehensive approach towards the restructuring of the health care system," said Dr Mandell.

On the controversial proposal for two years' compulsory community service for doctors, he said further consideration and debate would be required by stakeholders on this issue.

He said recommendations in the report built on and strengthened the public health sector and created opportunities for private health care providers to play a role in the delivery of public-funded primary health care. These co-incided to a large extent with Masa's proposals.

"Acting on behalf of the doctors of the country we are particularly reassured by the Minister of Health's acknowledgemnt of the role which doctors should play in the provision of primary health care.

"Having acknowleged that there are not enough doctors to follow through the proposed plan for extended primary health care, Masa welcomes the minister's intention to improve working conditions in the public health sector to create incentives to attract doctors to this sector, and to involve them to a greater extent in session work and the provision of referred services."

As far as other aspects of the report are concerned, Masa welcomed the proposed introduction of the principle of cross-subsidisation and the review of legislation governing the private health insurance sector.

The implications of the recommendations will be debated by Masa's Federal Council during the annual meeting in Pretoria next week.

Mostly praise for national health plan

(85) ARG 21/6/95

The Argus Correspondent

JOHANNESBURG. — Proposals for a national health insurance system have drawn praise from professional bodies and medical aid schemes, mixed reaction from other interest groups and criticism from the National Party and other opposition parties.

Proposals for equal access to primary health care, private sector participation, core benefit medical cover for all employees and an essential drugs list were among those particularly well received. But fears were expressed about funding mechanisms to cover the estimated R9,2-billion needed over the next five years.

The NP supported the concept of a basic health care system for all South Africans, but found the proposals created a climate for the misuse of the health system, and eroded the competitive edge of private initiative, NP health spokesman Willem Odendaal said.

Freedom Front parliamentary chief whip Joseph Chiole said the committee had sought to politicise the medical board, and to "lower standards to such a degree that the medical profession would be more accessible to everyone more quickly".

The Medical Association of South Africa said it was impressed by the "broad and comprehensive" approach towards restructuring the health system. It was particularly pleased that the proposals recognised the individual's right to freedom of choice, encouraged co-operation between the public and private sectors and envisaged integration of primary health care services with other levels of health care.

The Representative Association of Medical Aid Schemes generally welcomed the proposals, describing them as a "unique opportunity for the private and public health sectors to interface and extend health care to the entire population."

Andrew Jackson, managing dirtector of South Africa's largest medical aid administrator, Medscheme, said he had been "particularly impressed with the depth and soundness of the report."

ZUMA'S APPROACH 'REASSURING'

Medical profession welcomes health plan

ET 21/6/95

DOCTORS have welcomed Health Minister Dr Nkosazana Zuma's proposed reforms, particularly their focus on co-operation between the private and public sectors.

Health Minister Dr Nkosazana Zuma's plans for a National Health Scheme, released on Monday, have been well-received by the medical community.

The Medical Association of South Africa (MASA) expressed satisfaction that the right to choose between health service options had been recognised, that co-operation between the public and private sectors would be encouraged and that primary health care services would be integrated with other levels of health care.

Dr Bernard Mandell, chairman of the Federal Council of MASA, said: "We are impressed by the committee's broad and comprehensive approach".

"Their recommendations to build on and strengthen the public health sector and to create opportunities for private health care providers to play a role in the delivery of publicly funded primary health care, coincide to a large extent with MASA's proposals."

MASA welcomed Dr Zuma's intention to improve working conditions in the public sector and to create incentives to attract doctors to this sector.

The Representative Association of Medical Schemes (RAMS) also welcomed the "unique" opportunity for the private and public health sectors to work together.

Chairman Mr Keith Hollis said RAMS was pleased individuals would still have freedom of choice.

"Even more welcome is the principle that medical aid members would still have equal access to the public health system."

RAMS was concerned, however, that doctors might be called up for two years compulsory public service and hoped to see the introduction of an incentive to stem the exodus of medical expertise.

The proposed two-tier drug pricing system, where some medicines were provided free at clinics and at cost via private doctors and pharmacists, might be vulnerable to fraud.

The Medical Research Council (MRC) applauded Dr Zuma and her team "for their bold proposals".

MRC president Professor Walter Prozesky said the emphasis given to the public health care system "marked a watershed in coming to grips with South Africa's priority health needs in a way compatible with the RDP and existing health care practices".

The MRC was concerned that Dr Zuma's speech made no mention of the role of health and biomedical research. — Staff Reporter

Medical aid association backs health partnership

(85)

CT 22/6/95

STAFF REPORTER

THE medical schemes association has committed itself to a constructive partnership with the public health sector.

This emerged out of meetings called by the Representative Association of Medical Aid Schemes (Rams) in the city and in Johannesburg yesterday in response to the national health scheme proposed by Health Minister Dr Nkosazana Zuma's committee of inquiry.

Rams said it foresaw "a sound partnership developing by a growing use of public sector hospital services and a consequent flow of funds into the underfunded state hospitals.

"The potential flow of funds from medical schemes was conservatively estimated at over R2 billion and this would make a valuable contribution to upgrading public services," they said.

Challenge

Rams expressed satisfaction that the proposed scheme preserved the free choice of individuals in health care, the use of private health care, and the option of insuring themselves privately.

The association agreed that the private sector should accept the challenge of providing affordable managed health care to the country's existing 6,5 million medical aid subscribers and future members.

RAMS supported the committee's intention to make changes to medical aid scheme structures to protect the aged, chronically ill, and recently retrenched.

In a separate statement, Mr Robin Melville, managing director of D&E Medical Aid Administrators, expressed concern over the proposed regulation of both insurance and medical aid scheme products under a single act.

He said the two products should be differentiated in such a way that nobody was penalised for being members of medical schemes which face far stricter regulations. He praised proposals to enhance the accessibility of medical schemes by replacing individual risk ratings.

Masa gives opinion on health plan

(85)

STAFF REPORTER

ET 22/6/95

SUBMISSIONS on a National Health Scheme put forward by the Medical Association of South Africa (Masa) overlap with many of the proposals announced by Health Minister Dr Nkosazana Zuma this week.

Masa said national health insurance was unaffordable at present and it would be more realistic to build on existing strengths while introducing change gradually.

Dr Zuma's committee of inquiry acknowledged that the primary health care system could not be in place before April 1997 and the entire system would only be fully functional by the turn of the century.

Masa also said mechanisms should be introduced to promote co-operation between the private and public sectors.

In a statement Masa said it was impressed with the committee's approach and noted that many of the committee's recommendations coincided with their own.

'Subscribers will fund health care'

85 ~~2571~~

CLAIRE BISSEKER CT 22/6/95

THE government's proposed National Health Scheme (NHS), which aims to provide free primary health care to all citizens by the turn of the century, will be little-used by the employed medical aid subscriber who will, however, bear the brunt of financing the new scheme.

Health Minister Dr Nkosazana Zuma's committee of inquiry into a NHS has proposed a two-tier system in which the existing private practitioner and private health insurance industry are allowed to function parallel to a public primary health care system where treatment is free.

But the committee estimated that those with medical aid would make limited use of the scheme (0,5 visits a year) compared with the rest of the population at 3,5 visits by the year 2000.

As the NHS will be financed largely through taxation, possibly augmented by user-charges on private medical insurance and the removal of tax concessions on medical aid contributions, the employed and especially the medical aid subscriber will subsidise the unemployed.

Medical schemes back national plan

(85) ~~294~~ Star 22/6/95

■ BY DAVID ROBBINS
HEALTH WRITER

The medical schemes movement has committed itself to a constructive partnership with the State in providing affordable health care to all.

At conventions called by the Representative Association of Medical Schemes (Rams) in Cape Town and Johannesburg yesterday, delegates agreed that the private sector should accept the challenges contained in the national health insurance system (NHIS) report released by the minister of health earlier this week.

Rams chairman Keith Hollis said: "We appreciate the consultative approach adopted by the committee which compiled the report, and we welcome the philosophy of freedom of choice for individuals between private or public care, and a move towards the principle of cradle-to-grave medical scheme cover, regardless of age or existing health problems."

The NHIS proposals, which call for free primary health care for all and encourages much greater co-operation between the private and public sectors in achieving this, would have several positive effects on the current medical scheme situation.

"Because an element of competition has been introduced between the two sectors, quality is bound to increase while the cost of basic medical care will decrease," Hollis said.

He added that his association was particularly supportive of the proposal which would protect the aged, the chronically ill and the recently retrenched. None of these categories, if the NHIS proposals are put into effect, will any longer be excluded from medical scheme membership or full benefits.

Concern was expressed at the Rams conventions over some proposals in the report, most notably the possibility of removing the tax concessions currently enjoyed by contributors to medical schemes.

"The principle of a dedicated health care tax also requires careful investigation in consultation with the business community," Hollis said.

HEALTH

Signs of revival

(85) FM 23/6/95

Some common sense — but with an apparently blind faith that the money can be raised

The findings of the Broomberg/Shisana Committee of Inquiry into National Health Insurance (released this week) are a welcome departure from the discredited socialist ideas of the Deeble report — favoured earlier this year by Health Minister Nkosazana Zuma.

Gone is any talk of nationalising general practitioner (GP) services and barring the private sector from insuring against primary health care costs.

A great deal of realism also pervades the report, with repeated acknowledgements that available resources need to be optimised, fiscal constraints observed and management dramatically improved — even if this means pulling in private-sector managers to do the job.

In a nutshell, the committee's recommendations aim to:

- ❑ Provide universal access to primary health care within five years through the establishment of District Health Authorities;
- ❑ Strengthen the public sector by increasing the number of medical personnel and public facilities;
- ❑ Cut the bill for public and private sector drugs by establishing an Essential Drug List; and
- ❑ Regulate the private sector to ensure greater efficiency, affordability and, presumably, access.

But the committee has ducked major issues and is deliberately vague on others — a tactic National Party adviser and former Health Minister Rina Venter suggests could amount to political expedience. "A committee of experts needs to take a definite stance," she says.

For example, there is no clear definition of what constitutes primary services. The committee says primary care would include district hospital services, environmental health services (supply of clean water and sanitation), preventive care and access to

Broomberg . . . *proposals open to discussion*

essential medicines. These services would cost around R9bn over the next five years, based on the average person needing only two primary visits a year in 1996 and around four visits a year by 2000. If these assumptions are unrealistic — and industry experts think they are — the total cost of services could easily double. This would result in drastic rationing through crude cutbacks or in unacceptable queuing.

The committee's insistence that care should be free for all at the point of access could also send costs spiralling. Wits economics professor Duncan Reekie says: "The committee's proposal that user charges be introduced at a later stage also won't work easily, since international practice has shown that reversing the free care trend is exceptionally difficult."

The committee claims that most of the R9bn estimated cost will be met from health budget allocations, with a shortfall of about R3,39bn. Surprisingly, they haven't decided how to fund that extra third. Co-chairman Dr Jonathan Broomberg says the committee decided that the Cabinet, in conjunction with the Department of Finance, is better equipped to decide whether the appropriate revenue-raising mechanism should be a payroll tax, a dedicated tax, a percentage of private sector medical aid contributions or any other mechanism.

The committee identifies the problem of staffing the public health service with skilled medical personnel as one of the greatest challenges facing the Department of Health. The present shortage of doctors is around 1 000. The report concludes that the only way of ensuring a well-staffed sector in the long term is to improve conditions of service — better working hours and pay. But they realise that immediate short-term changes have to be made, so they propose to upgrade the clinical skills of qualified nurses to enable them to take responsibility for primary care.

For the 1996-1997 year, the committee estimates that about 12 000 nurses will have to receive upgraded training at an estimated cost of around R12 500 each.

Their proposal to introduce unspecified compulsory service for medical graduates, however, is less wise. While graduate doctors already serve a year-long housemanship training during which they work for the State for a nominal fee, to legislate for a further period of service could be unconstitutional and unfair.

Says National Association of Private Hospitals chairman Riel du Toit: "Such a decision could affect the choices people will make about studying medicine. Why should the same principle then not be applied to teachers, engineers and lawyers?"

Medical Association of SA director George Veliotes says many doctors already donate some of their time to the State and would probably not object to assisting further. "A comprehensive human resources strategy based on incentives needs to be adopted. This must take into account selection, training, education and the need to improve facilities and working conditions. In most cases, private doctors avoid working in State facilities simply because of a lack of adequate nursing, equipment and drugs — a situation rendering their efforts futile."

Veliotes welcomes the committee's recommendation to investigate greater use of part-time posts for doctors, as well as the recommendation to use accredited private practitioners in multidisciplinary practices.

Doctors are also concerned with the proposal that recommends the licensing of new

120 HIGH PRESSURE, LOW BODY COUNT

	1996/97			2000/01	
	Requirements	Estimated supply	Gap	Requirements	Total training requirements*
Medical practitioners	1 846	862	984	3 419	2 557
Nurses	7 187	14 479	(8 292)	13 316	(1 163)
Primary nurses	10 766	1 000	9 766	19 946	18 846
Nurses + Primary nurses	17 953	15 479	2 114	33 262	17 783
District managers	363	0	363	385	385

8 292 professional nurses need further clinical training
3 588 new Primary nurses needed

* Total training requirements reflect the total number of personnel who will need to be trained by 2000/01, assuming that the current supply remains constant

practices to encourage doctors to serve under-serviced areas — a practice that is clearly unconstitutional, inconsistent with free market principles and open to administrative abuse and corruption. Broomberg says this is up for discussion.

The committee claims that State drug prices in SA are about 20% higher than the average drug prices procured by government services internationally, despite the present State tender system that enables the State to purchase its drugs from manufacturers for as little as 10% of private sector prices. Their recommendation is to introduce an Essential Drug List — by the end of the year for primary care drugs — that would "consist of medicines critically required for use in the public sector for the prevention and management of 90%-95% of the common and important conditions in the country."

The committee also recommends that the State should be free to make use of direct parallel imports — cheaper but identical drugs manufactured abroad.

It's a recommendation that's likely to incense local drug manufacturers, who argue that these imports pave the way for counterfeit drugs to enter the SA market. They argue, also, that parity in pricing between their international divisions makes measurable savings on a particular drug unlikely.

The committee also rejects arguments that private sector drug prices — around 30% of the private sector health bill — are expensive because manufacturers recoup the large discounts they give to the State through the private sector. Drugs on the Essential Drug List will also be available to the private sector at cost, either at State facilities or through existing retail pharmacies and dispensing doctors.

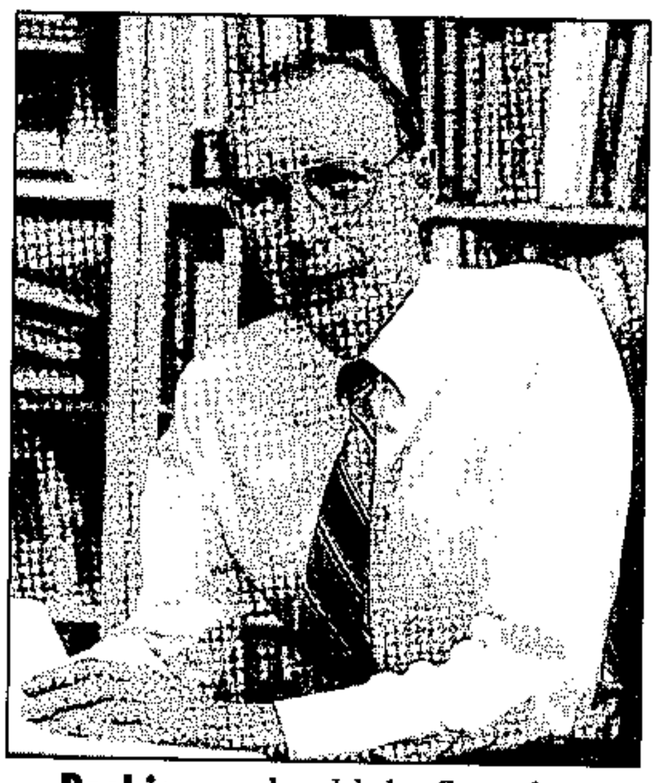
For the public sector, the committee envisages extending this essential list to cover medicines for all levels of care. For the private sector, medicines not on the essential list would be purchased at full private-sector prices.

Reekie says it's acceptable for the State to organise its drug purchases in the most economically efficient manner — through an essential list and parallel imports. But he questions the wisdom of extending the essential drug list to cover private sector purchases. "Why, then, should the State also not buy maize and linen for the private sector?"

He also disputes that private-sector prices do not cross-subsidise State prices. "While the extent of that cross-subsidy could be argued, there is no doubt that the discounts given to the State are, to some extent, made up through private-sector sales. The State thus needs to be careful about not allowing manufacturers to make up their profits in the private sector."

He adds that private-sector drug prices will plunge if Zuma accepts the committee's recommendation to open pharmacy ownership to nonpharmacists — a move that would pave the way for medical schemes and big business to use their bulk-buying power to muscle large discounts from drug manufacturers.

But Reekie warns that essential drug lists in Australia and similar practices in Canada led to the demise of those countries' pharmaceutical manufacturing industries within five to 10 years — an outcome Zuma needs to guard against. "Essential drug lists also tend to send the prices of non-essential drugs soaring, or create a shortage, and encourage the use of older and generic drugs whose efficacy could mean longer recovery periods and even hospitalisation and surgery — sometimes avoidable with the newer drugs."



Reekie . . . *should the State buy maize?*

The greatest shortcomings of the report are seen in the committee's proposed regulation of the private sector.

The report states that the role of the District Health Authority will shift from being that of an integrated funder and provider to a "public purchaser" who would buy services on behalf of public patients from both the public and private sector.

While this thinking mirrors recent international reforms of State health systems and is welcome as a spur to competition between public and private-sector providers, there is a massive conflict of interest in such an arrangement if the district authorities continue to provide actual services.

The report states: "The system will retain a substantial component of direct public sector provision of services. This is particularly the case for district hospital services, environmental health services and other district support services, which the district authorities will continue to fund using normal budgetary mechanisms."

Speedie . . . *potential for conflict and corruption*

Hospital group Presmed's joint MD Rob Speedie stresses that this would allow the provinces and subsidiary public structures to act as policeman, regulator and competitor, particularly if the provinces were to regulate the licensing of private facilities based on criteria like availability and need for beds.

"Such a system increases the potential for conflict and corruption," he says.

The committee proposes mandatory basic hospital cover for employees, presumably to be enforced by employers. The costing on this proposal appears to be unrealistic, since the committee estimates that the minimum coverage for public hospital care might approximate R400 per person a year on average. Speedie says provincial hospitals have, in recent years, charged private-sector patients medical aid rates for their wards and theatres and says that R400 would cover hospital costs for just over one day.

Reekie warns that any mandatory cover for employees should not be linked to the employer or the job, since this would push up the costs of labour and could result in unemployment — the main consideration that led to the defeat in the US of the Clinton proposals for mandatory cover.

The committee seems determined to stop medical schemes practising any form of risk rating for members.

In short, it recommends a return to the pre-1989 community rating, where claims experience had to be ignored.

Warns Pride Group director Neville Koopowitz: "This could mean a return to conditions where, in the absence of competitive forces, medical premiums spiralled. Such a move could also kill product innovation and choice."

Coupled to this, the committee wants to see scheme members free to move between schemes — a move the Melamet Commission endorsed in a bid to foster competition among schemes. But Speedie warns that this could lead to members cherry-picking schemes for specific benefits and undermining any form of cross-subsidisation. "Regulations and penalties are needed to avoid abuse," he cautions. The committee also proposes to end tax deductibility of medical aid contributions.

There is no doubt that the latest plan is more sensible than what has gone before. But drawing up a desirable health system is the easy part; the difficult part will be to put it into practice while maintaining the already threadbare infrastructure — and to find the money.

The Broomberg/Shisana committee implicitly takes the view that the money will somehow be raised. We suspect it cannot, which will make a more conservative approach imperative. ■

The spirit of Deeble lives on

WM 23-29/6/95 (85)

■ From PAGE 11

it is not an emergency — the patient will end up being charged for the visit. The penalty is intended to ensure that hospitals are not inappropriately used, when other, smaller and cheaper facilities will do. A visit to a small clinic costs around R30 while a visit to a hospital like Baragwanath costs R120.

This applies to everybody and follows Health Minister Dr Nkosazana Zuma's injunction to the committee that access to the basic package of primary health care had to be universal.

Those on medical aid or insurance, or those who are simply very wealthy, still have the choice of going to a private practitioner.

But everybody will have access to the cheaper drugs on the essential drugs list — if they can get their doctors to prescribe them. They will be available from pharmacists who would not be allowed to add their usual mark-up. They can recover costs and charge a small dispensing fee.

Medical aid groups who want to keep their costs down will encourage the prescription of those drugs and other generic substitutes where they apply.

To cope with the chronic and serious shortage of staff, the report proposes first addressing salaries for health staff so that competent public health care personnel will stay in the game. Then it proposes to gradually introduce a system of accreditation for private practitioners who could then contract with the district health authority to supply some of the primary health care services.

It hopes also to contract private GPs to do "sessions" at public facilities at attractive rates. The report remarks that this has been an area open to abuse in the past — but newer controls, they hope will curtail abuse.

It makes two controversial proposals — but says they ought to be further explored: medical schools should change their selection processes so that more people from rural areas can train as doctors, as they are more likely to return to those areas than their urban counterparts. And it suggests measures (which several governments have suggested in the past) that students be required to do some form of national service or pay back their fees.

The most ticklish questions — those about how the money will be recouped — have been left for the politicians to sort out

Doctors contracted to the authority will in all likelihood be paid by a system of capitation — which means they would get a sum of money per patient registered — and not be paid for each visit by each patient. This assumes that there would not be as many visits to doctors contracted to the district health authority as there are in the private sector.

But, importantly, evidence before the committee showed that 20 percent of a sample surveyed were refused treatment because they could not pay.

The most ticklish questions — those about how the money will be recouped — have been left for the politicians to sort out.

The committee has made recommendations which will mean that a company's employees will all have to be covered by some form of basic hospital plan. There are to be, according to the report, restrictions reimposed on medical aid. They will not be able to exclude the sickly or the elderly. An equalisation fund will be created to ensure that those carrying a larger risk burden can draw on the fund.

According to the report, the monthly costs of the compulsory hospital plan will be borne by both employees and employers. Members of these plans will be encouraged to use state hospitals when they need hospitalisation — which the schemes will pay for.

Behind much of what the report has recommended is the notion that competition between the private and public sectors — and within both sectors — will help keep costs down. The private hospitals, feeling competition from the public facilities, the theory goes, will have an incentive to cut costs. And the public facilities will have to jack up their service to attract the fee-paying private patients.

Some health care analysts, however, believe that not enough has been specified in the plan to ensure that private health care costs — which contribute the lion's share of the 8,5 percent health portion of the gross domestic product — do not continue to spiral.

These critics believe that public health sector's portion of the 8,5 percent health component of the GDP will go up and with no measures to cut down the spending in the private sector — health could end up taking up 10 percent of the GDP. The only other country in the world with such a high health component of a GDP is the USA.

Next year, some R350-million will be needed to fund the more urgent measures. By 2000, this amount will have become R3-billion at 1995 prices.

Traces of the now-demonised Australian health economist, Dr John Deeble, who contributed in large part to the committee's deliberations, are still to be found in the proposals. The spirit of Deeble lives on in the report's commitment to equal access to health for all.

New health care plan: Deeble's spirit lives on

WM 23-29/6/95 (85)

Pat Sidley dissects the profound — and controversial — changes proposed for South Africa's health services

'A CARING health service" is the Department of Health's slogan describing its work. And it's been a gruelling five months for its committee charged with starting the process.

The Committee of Inquiry into a National Health Insurance System has reported its findings, made several recommendations (and ducked others) after hundreds of hours of oral submissions and thousands of pages of written submissions; it has taxed the best brains in the country — which were carefully selected around gender and race isues — as well as significant talent from three other countries.

The report promises to change profoundly the face of health care in the country — to a service which provides cheap (and sometimes free) basic care for the majority of people who have not had it before.

Anybody who is sick will be treated at a nearby primary health care centre. It may be a clinic, a small practice around a primary health care nurse, or in some cases, a hospital. In many areas, the most important person who will make the initial examination and diagnosis will be a nurse — who will have received a special training.

People getting this service will have to be "permanent residents" — a potentially explosive issue, already causing a problem to the medical aid groups who will be shouldering the bulk of the costs.

Prospective patients will have to be registered in their areas at a district health authority. This will require a larger effort than Home Affairs is making to register voters.

The professional staff at the primary health care facility will also have to be registered and will have some type of accreditation with the authority — which will ensure that they get paid for the work they are doing.

The person who runs the facility may prescribe medicines from a list laid down by the government. This list will specify which drugs can be used, how they should be used and who should prescribe them. The patient will be charged a small fee for the drugs — but if he or she cannot pay, the drugs will be dispensed anyway. The rest of the treatment will be free.

If the patient is particularly ill, or if the complaint falls outside the scope of the medical professional on duty, she will be referred by that person to a larger hospital for treatment. But if the patient goes to the hospital without going first to primary health care centre — providing there is one and

Saturday Star Section 2

Danger of higher health costs seen in government proposals

(85) Star 24/6/95

FINANCE STAFF

The national health care proposals released by Health Minister Nkosazana Zuma this week hold some concerns for the future financing of medical aid schemes, says Neville Koopowitz, director of the Pride Group.

"The fear of a national health system controlled by the State only seems to have been removed as the proposals recognise the continued need for private sector health care provision. However, the proposals recommend some changes to medical schemes which are of concern," says Koopowitz.

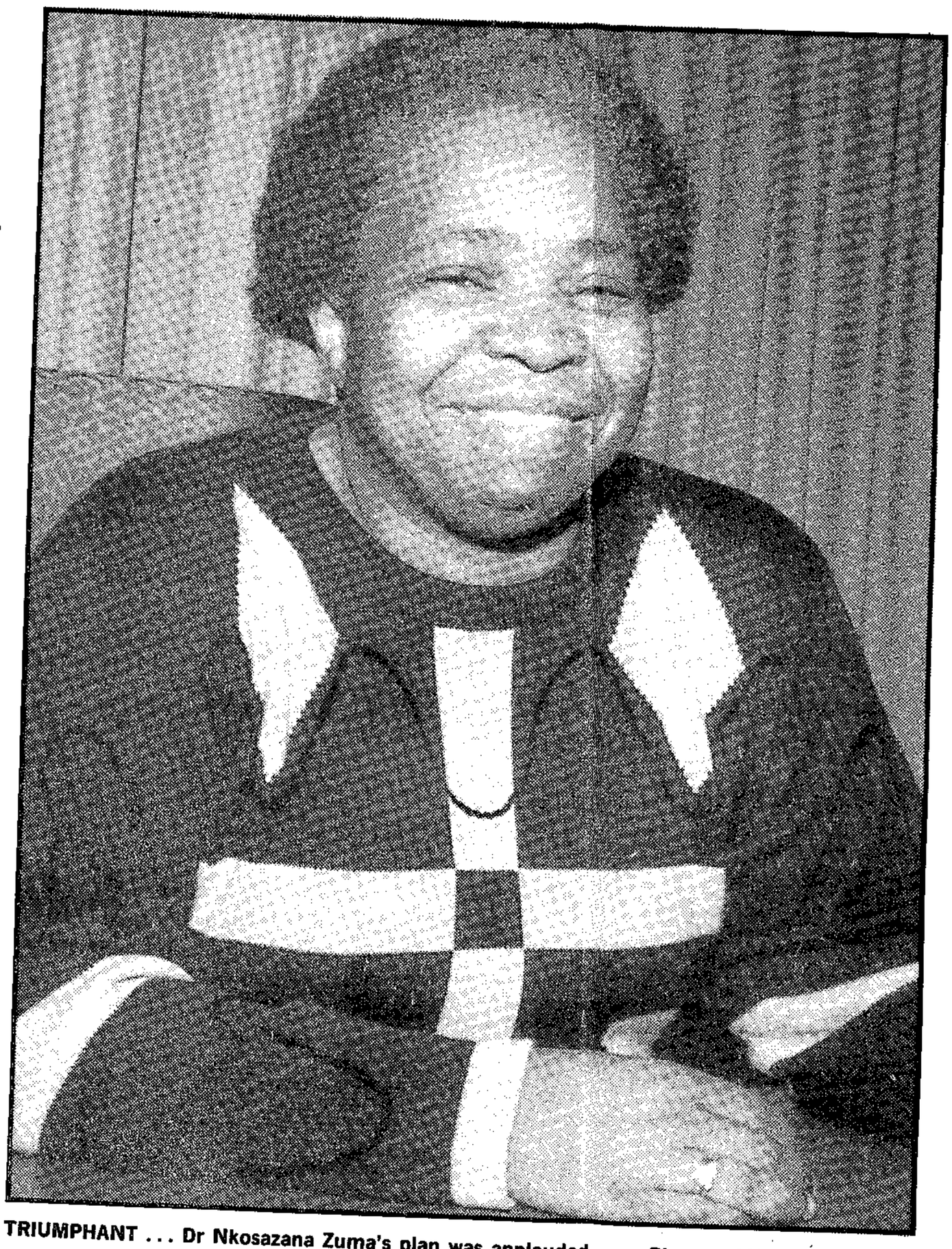
The recommendations are to make schemes more affordable and to ensure that the elderly and the sick are not forced out by price increases.

While morally commendable, says Koopowitz, the only way to do this is to re-introduce absolute cross-subsidisation among fund members. The implications are that funds will no longer be able to load contributions based on a member's health risk, age or claiming pattern.

Koopowitz says that age and risk rating are among the few mechanisms funds can use to contain costs and to stop contribution increases. "In a totally cross-subsidised scenario, members have no incentive to control their costs and this is one of the reasons that has led to the escalation of health costs in recent years," says Koopowitz.

The long road ahead to make it come true

Health Minister Nkosazana Zuma tells EDYTH BULBRING about her plans to have a fully functioning primary health care system in South Africa in five years



TRIUMPHANT ... Dr Nkosazana Zuma's plan was applauded Picture: AMBROSE PETERS

NKOSAZANA Zuma does not plan to do much sleeping in the next five years. "When I am dead there will be lots of time to sleep. Now I have work to do," says the health minister who has given herself until the year 2000 to have a fully functioning national health system in South Africa.

Speaking in her Cape Town office three days after presenting her committee's report on a National Health Insurance Scheme, Dr Zuma, dark rings etched under her eyes, is quick to laugh at just about anything.

One exchange relates to the funding of her scheme. The report says that contributions to the health budget will undoubtedly increase because of cuts in the defence budget.

Dr Zuma laughs at this presumption. Of course the report was not suggesting that the health increases would be funded entirely from cuts to defence, she says. But, well, health has been cited as a priority by the new government. She leaves it at that.

Her ammunition against the might of the army will be her injections, she says, shaking with giggles.

Behind the grey-haired, cherubic face with the gap-toothed smile is a resolve that would, no doubt, prove an adequate match for any Joe Modise or Ronnie Kasrils.

ON THE question of how she hopes to fund a scheme that will provide free primary health care to all who need it, Dr Zuma errs on the side of caution, saying she would prefer to keep her funding preferences to herself lest she either constrain or embarrass the finance minister, who should be her guide.

'I don't want to start a big fight," she says, once again laughing.

Her past year and a bit as the minister of health has been a long, hard stint.

She barely had time to arrange the pictures on her office walls before she was plunged into two presidential projects, to provide free health care for pregnant mothers and children under six and a primary school feeding scheme.

Once these projects got off the ground, albeit patchily in some areas, she moved on to plans for a national health insurance system.

Part of her attitude this week — a combination of lip-smacking satisfaction, shaky laughter and quiet resolve — suggests she is relieved her committee came up with a proposal that has been well received by all quarters.

She had been particularly wounded by criticism in one weekly publication last year when options on a national health system were first mooted.

She says — with a hint of a "they will be eating their words" look about her — that she is waiting to see what the same publication has to say now.

"If I had been susceptible to criticism, I would have given up in January," she says.

DESPITE having presented a proposal that could not be called unreasonable, unrealisable or unaffordable, Dr Zuma continues to tread cautiously, making no rash promises or predictions.

Apart from the five-year deadline, she does not want to be specific about when the system will be up and running in case the infrastructure and personnel are not in place to provide a decent service.

She will also not be tied down on when regulations or legislation will be passed requiring medical students to do public health work for two years before they can enter private practice.

"If I say next year, they will run away overseas to avoid it," she says with some humour.

She plans, however, to finalise an action plan by the end of the year setting out precise targets and timeframes. Legislation — lots of it — on every aspect of the plan will be passed next year.

The last phase of the plan, projected to start in 1997 at the very earliest, will be the steps that will require contributions from the public to a health insurance fund. To expect contributions before a decent service was in place would be unwise, Dr Zuma says.

Her first priority is to start clinical training for nurses. An estimated 10 000 primary health care nurses with clinical skills will be needed by April 1996 to provide the care envisaged in the committee's plan.

Six-month clinical training courses for professional nurses have already begun.

Included in this priority is the need to provide the infrastructure to support a national health system. Not only does this involve setting up more clinics and acquiring more equipment, but it means improving living and working conditions for doctors and nurses she wants to attract to rural areas.

Improvements in service conditions for medical personnel willing to work in short-staffed areas need not all be financially related, Dr Zuma says.

She speaks at some length and with enthusiasm about job satisfaction — the pride of seeing a baby you delivered grow up, the satisfaction of seeing a community respond to medical treatment.

These are some of the incentives that should make nurses and doctors move to understaffed areas, she says.

Lest she be accused of naivety, however, she is also considering incentives such as making rural experience count for specialist study or promotion.

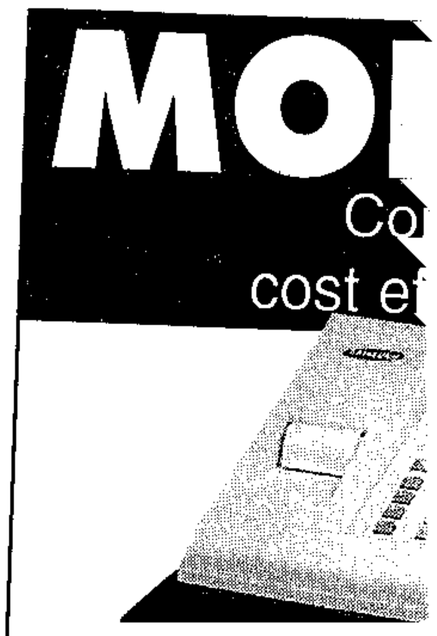
HER second priority is to finalise an essential drugs list for primary health care facilities. She hopes this will be ready by the end of the year.

The third priority is to establish how many doctors in private practice would be prepared to register their services with the public health service. Negotiations on this have already begun and the shortfalls in the personnel will be calculated.

The 1996 population census will give her a clearer indication of what personnel and infrastructure is needed.

Dr Zuma says the report indicates that clinics will be in a position to provide free primary health care by April 1996.

But she is cautious: "Quote the report and not me. I still want to speak to the provinces before I say that," she says.



ST 25/6/95

CAS ST LEGER looks at the report of the Committee of Inquiry into a National Health Insurance Scheme

HOW IT WILL BENEFIT YOU

THE unemployed will receive free treatment from neighbourhood clinics where nurses will perform initial consultations. While a small payment will be levied for medicines issued, those unable to pay will not be turned away.

If necessary, the nurse will refer patients to a doctor or hospital for free treatment. If the patient goes directly to the hospital, bypassing the primary health clinic, a "penalty" will be levied. This charge falls away in cases of emergency or when the clinic is closed.

● Lower-paid workers without medical aid will also be entitled to free primary health care. However, they will be expected to contribute about R56 a month for a "core" state hospital service and will be encouraged to join a medical aid scheme.

● Individuals who already belong to a medical aid scheme, which will in future incorporate the "core" state hospital package, are also entitled to free primary healthcare. However, the long queues at state clinics and hospitals are likely to put them off this option.

If the person in this category opts to visit a state hospital, the medical aid scheme will reimburse that institution. They can continue to visit the GP of their choice and go to private hospitals for treatment, but employers or medical aid schemes are likely to negotiate cheaper options.

These may include the use of a key area of the new plan called group practices, where nurses, doctors, dentists and pharmacists band together and become "accredited" to the health service to provide one-stop medical care.

HOW IT WILL WORK

IF all goes according to plan, the tottering ruins of the old, fragmented public health system with its demoralised staff should be replaced, within the next five years, with a streamlined district health operation where better-paid doctors and nurses at clinics refer patients efficiently upwards to more autonomous academic hospitals.

Hospitals are expected to make considerable savings as patients go to clinics for every-day illnesses instead of hospital outpatients' departments.

It is cheaper for a clinic nurse to treat a sore throat or stitch a wound than a doctor at an academic hospital.

More clinic nurses, more rural doctors and more clinics will be needed to make the plan work. Nurses will be reallocated and retrained in primary health care, while being paid more; doctors will be given incentives to work in rural areas and asked to serve their communities for a fixed period after they graduate.

More than 170 new clinic projects are already in the pipeline.

Dramatic savings are also expected from the introduction of an Essential Drug List, consisting of 137 drugs, ranging from painkillers to antibiotics, used to treat the 118 most common problems.

An average public sector prescription cost for these drugs, using mainly generic medicines, would be R10 — as compared with the average private sector prescription cost of R91 to R158.

Pharmacists would be entitled only to a handling fee and not a mark-up on the drugs on the essential list, so these savings would be available to the private sector, too.

WHAT IT WILL COST

THERE is a substantial gap between available public funds and the projected cost of the new system.

Drafters of the plan expect that the shortfall in the 1997 financial year will be about R1,36-billion. By the end of the decade, it will rise to R3,39-billion. It is not clear how the gap will be funded.

Dr Zuma has suggested that the health budget be bolstered from savings on the defence budget. Other suggestions include: general tax revenues; excise duties; modification of tax benefits on medical aid contributions; and a levy on medical aid contributions.

There seems little doubt that taxes of middle-income individuals are set to increase, particularly from 1997 when the cost of the scheme's "fast-track changes" start to bite.

Lower-paid invididuals not covered by a medical aid scheme will also have to contribute to the running of the plan. They are likely to contribute about R56 a month towards the development of a "core" hospital package, still to be defined.

Workers earning slightly more are expected to contribute perhaps up to about 0,66 percent of their salaries.

Sums have not been worked out for a possible levy on medical aid membership.

Drafters of the plan have left the final decision on funding to the cabinet.

Funds from the Gold Fields Group are making a difference to health care in perhaps the poorest of poor regions in our land, Science Writer ***Anita Allen*** *found*

Vision of a promised land

Star 27/6/95 (85)

In the remote areas of Maputaland, a remarkable party is remembered by mothers who say "My child was born before (or after) the great party". Three of these celebrations took place in the region last week, at each place an ox was slaughtered and young and old walked long distances to join the festivities.

Three days of celebrations marked extensions to the region's community health system, in particular the opening of a new nurses' training centre at Bethesda Hospital in the village of Ubombo, on top of the Ubombo Mountains overlooking the Pongola River flood plains.

The centre will be the main campus for nurses training in the region and has been funded by the Gold Fields Foundation, the social investment arm of the Gold Fields Group.

Its opening means that for the first time nurses from the community can be trained in the communities they serve. Previously nurses had to be drawn from the cities, and attracting qualified staff — and keeping them — has been a real problem.

"Today we walk briskly into the new classrooms and we want to express our gratitude for what Gold Fields has done," Chief Matron Pretty Harrison said at the opening. "We were happy to push on, as long as someone would come along with us."

The mood was expressed by a massed choir of nurses who sang: "When the rich and the poor, get together with the Lord, there'll be singing and shouting. What a glory. Hallelujah."

The centre is affiliated to the Gold Fields Nurses' Training College on the West Rand and nurses will be trained by means of a new distance learning course in primary health care developed by Dr Olga Venter, principal of the college.

Instead of the four hospitals in the Maputaland area doing their own training, each hospital specialises in one component of nurses' training. Within the next few months, they will be connected by a satellite communications link with the Gauteng college.

Model

Venter's nurses training course in primary health care has been accepted by the Minister of Health as a model for the entire country. This week, Venter will be part of a Department of Health team, which will select 40 to 50 nurses throughout the country who will be trained at the West Rand college to run the course. They, in turn, will be responsible for its implementation in other regions of South Africa.

Maputaland may be the poorest of poor regions in South Africa, but thanks to a missionary-type commitment of a small band of dedicated people, and an underlying unity among the inhabitants, its primary health care system is a model for the country.

Each of the four hospitals in the region provide secondary health care for about 100 000 people. Together they form the heart of the primary health care network and are supported by 17 residential clinics scattered through the region which offer all-day services. They are staffed by two nurses accommodated at the site and a doctor who visits once a week.

In addition, 105 health visiting points in even more remote areas are visited once or twice a week by nurses operating from a mobile clinic. Gold Fields has funded the construction of community centres at 14 of these visiting points and two mobile clinics.

Bethesda, like the other four hospitals in the region, was started by missionaries and today children set off to school to the sounds of morning chapel. In remote villages a few kilometres from the Mozambique border where Gold Fields opened two visiting health clinics, the ceremonies began in prayer and even toddlers in arms closed their eyes in thanks under the African sun.

Maputaland is the home of the Tsonga people, who were divided in two by the arbitrary placing of a fence between what is South Africa and Mozambique. Today, the people cross the border at will to visit family, for trade and to make use of medical services.

Ian Cooper, superintendent of Manguzi Hospital, which is closest to the Mozambique border, estimates that the four hospitals serve an additional estimated 450 000 Mozambican people.

With an average annual income per capita of R100, wealth, such as it is, comes from migrant labour working in cities. About 80 percent of all males who are employed work in Gauteng gold mines.

People eke out an existence through subsistence farming, which has been hard hit by severe drought in recent years. Water is available from the Pongola Dam, and there is some underground water, but only three household water schemes have been started in "urban" areas around hospitals at Manguzi, Mseleni and Mosvold.

There are no natural springs and people still fetch and carry water in buckets and walk long distances to and from their homes. The biggest problem at Bethesda Hospital is its uncertain water supply.

The region's people suffer from all the usual tropical diseases — malaria, especially a high incidence of cerebral malaria, and parasites, including hook worm amd bilharzia. Other major problems are TB, an unusually high incidence of a hip joint disease, whose origins are thought to be genetic, and AIDS. About 9,5% of the population are HIV positive and the hospitals are preparing for this to reach 20% by next year.

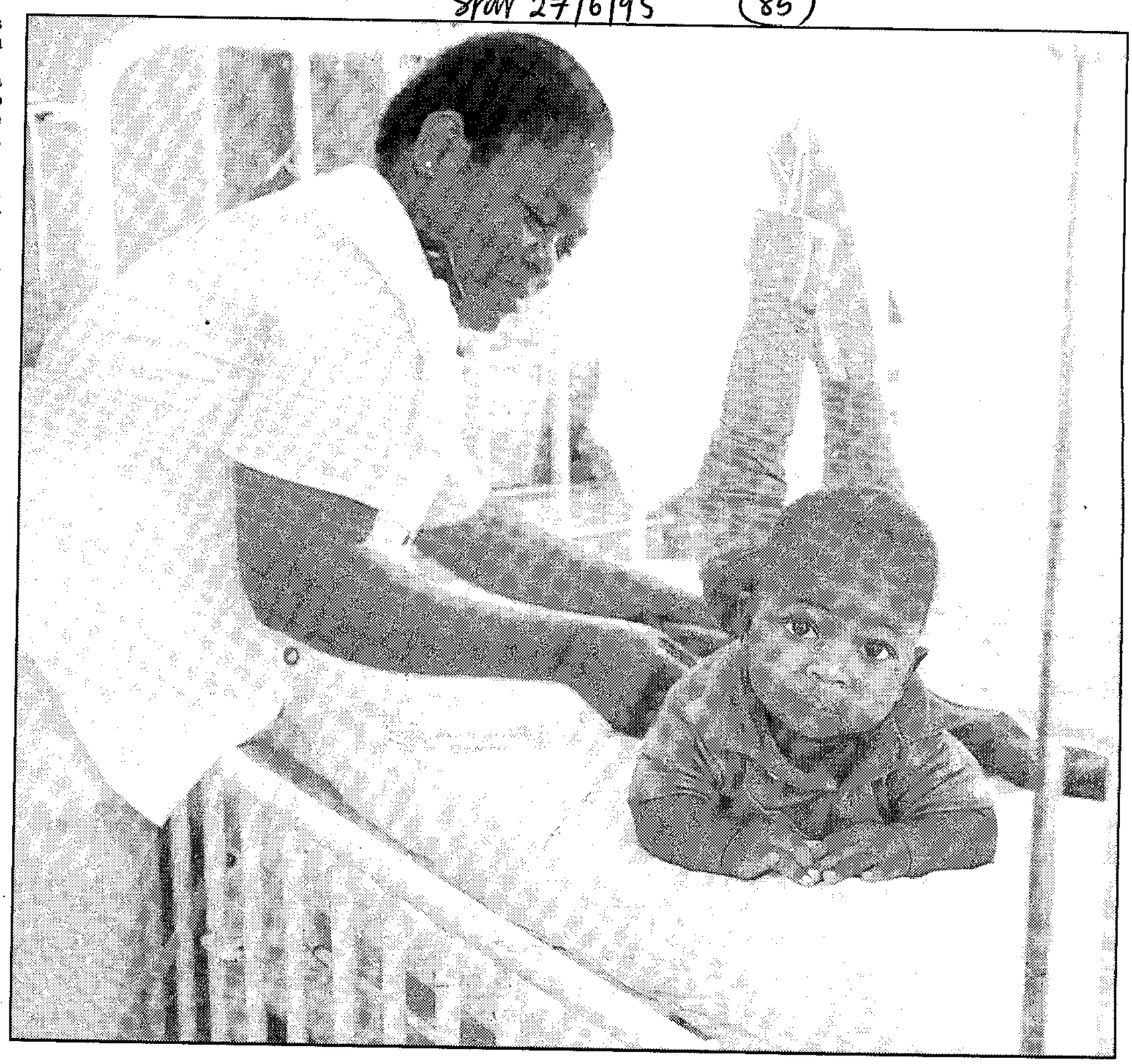
In the vast area, the population is scattered, so that health services have to be extended into the community in order to make it accessible. At the same time, transport is difficult with only one tarred road.

The Gold Fields Foundation works in collaboration with Teba, the recruiting and development arm of the mining industry. Representatives go in to remote areas and talk to community leaders to identify their needs and priorities.

Community committees are formed to handle specific projects. In consultation with the community, the committee decides on all aspects of a project and all funds are paid into a committee account. The one prerequisite of Gold Fields funding is that communities must supply all labour free of charge.

The R4-million investment by the Gold Fields Foundation so far in primary health care facilities have given the people a sense of pride and confidence.

They may be poor, but they are also very rich, as the school children sang: "There are many rivers to cross, there are many mountains to climb, there are many oceans to swim, but Jesus is the power and saviour of my soul. We'll be marching with Jesus to the promised land."



In traction . . . Sister Bhekisiwe takes care of a young patient, who has a hip fracture, at Mosvold Hospital in Maputaland, where community health care is a model for the country. PICTURE: KAREN SANDISON

These all on a critical list

This list of needs varying from small projects to major capital works, for which government funding is unlikely to be forthcoming, has been drawn up by the acting superintendent of Maputuland's Manguzi Hospital, Dr Ian Cooper.

- Three residential clinics at an estimated R1 million each.
- Day clinics, which become community centres and places for skills training, adult literacy classes and all-night study areas for people who have no electricity.
- Vehicles for community health workers, nurses and doctors.
- Primary Health Care competitions.
- Medical staff and student accommodation including prefabricated buildings and caravans.
- Pre-school buildings.
- A playground for the paediatric ward at Manguzi.
- A teacher for the paediatric ward children.

Department for the purpose of his reply, he will make a statement on certain statements made by Mr Mike Leach, former head of intelligence in the Department of Posts and Telecommunications, during a radio interview on SAfm's AM Live programme;

(2) whether he or his Department intends odering an investigation into these statements; if not, why not; if so, what are the relevant details?

N865E

The MINISTER FOR POSTS, TELECOMMUNICATIONS AND BROADCASTING:

(1) Yes. But by way of explanation, let me say that the present department of Posts, Telecommunications and Broadcasting, recast since 1 October 1991, enjoys absolutely no operational powers with respect to either the postal services or Telkom.

The events referred to by Mr Leach regarding the interception of posts and telecommunications apparently occurred under the then legal provisions of section 118A of the Post Office Act, 1958 (Act No 44 of 1958).

With effect from 1 February 1993, this section has been repealed and has been replaced by the Interception and Monitoring Prohibition Act, 1992 (Act No 127 of 1992) which is administered by the Department of Justice. In terms of this legislation, strict provisions are laid down to the effect that any branch of the security services may on application to a Judge of the Supreme Court obtain a warrant empowering them to intercept a postal article or a telecommunications conversation.

At the beginning of my term of office in June 1994 I initiated discussion of this legislation in Cabinet. After lengthy deliberations, the Cabinet satisfied itself that the existing legislation (ie Act No 127 of 1992) conforms to international practice and does not violate the provisions of our interim constitution.

I'm advised by the chief executive of the South African Post Office that all the senior employees in the service of the former Department of Posts and Telecommunications at the time of the alleged interception of postal articles have since left the service of the South African Post Office. The South African Post Office Limited is consequently not in a position to comment on the allegations made by Mr Leach. Enquiries from personnel who are still in service have yielded no results.

(2) Yes. I have requested the chairperson of Telkom SA Limited to institute an internal investigation into the allegations made by Mr Leach. He has reported to me that at present Telkom South Africa Limited is operating a limited number of interceptions on the strength of warrants issued by a Judge of the Supreme Court.

In order to ensure that there are no violations of the spirit and letter of present legislation, the Managing Director of Telkom SA Limited is instituting a number of checks which will entail, among other things, periodic review of the number of warrants in operation and regular reports to him by the technicians charged with these responsibilities.

As with the South African Post Office Limited, the allegations made by Mr Leach apply to the period preceding the commercialisation of telecommunications in this country on 1 October 1991.

Mr L T LANDERS: Mr Speaker, I accept and appreciate the hon the Minister's investigation into the problems pertaining to the present Constitution. However, arising out of his reply, will he give serious consideration to a separate investigation, parliamentary or otherwise, but not internal, to determine the extent to which the old Department of Posts and Telcommunications and possibly Telkom were involved in political destabilisation and the commissioning of crimes?

The MINISTER FOR POSTS, TELECOMMUNICATIONS AND BROADCASTING: Mr Speaker, yes, I shall give serious consideration to the hon member's suggestion, and also to the further inquiry regarding the allegations made by Mr Leach. May I add, just for the information of the House, that there is a limit, of course, to what one can uncover in such investigations unless one obtains the co-operation of the relevant Ministers who were responsible for these departments and line functions in the former government. One hopes that such co-operation will be forthcoming. However, I shall undertake what I can and report

to the House as soon as that information is available.

The DEPUTY SPEAKER: Order! That concludes Question Time. The time allotted for questions has expired. Outstanding replies will be printed in Hansard.

Business interrupted in accordance with Rule 199(3) of the Standing Rules for the National Assembly.

Health services in Vaal region of Gauteng

*13. Dr R A M SALOOJEE asked the Minister for Health:

(1) Whether, with reference to certain particulars furnished to her Department for the purpose of her reply and to reports in a community newspaper in the south of Lenasia concerning a directive issued under the name of a certain person from the provincial hospital services in regard to the quality of health services in the Vaal region of Gauteng, she or her Department intends undertaking an investigation into the statements contained in this directive; if not, why not; if so, what are the relevant details;

(2) whether she or her Department intends taking any steps in this regard, particularly in respect of the level of care and accessibility of patients to hospital care; if not, why not; if so, what steps;

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

N866E

The MINISTER FOR HEALTH:

(1) The Department was informed by the provincial hospital services that a directive was sent to all hospitals regarding the budget and to introduce measures to curtail spending so as to address the problem of overspending.

The hospital superintendent in charge of hospitals in the Vaal region of Gauteng reacted to the abovementioned directive and issued a directive to the hospitals in the Vaal region "That only children under six years and pregnant women to be treated and emergency cases to be admitted. Due to the shortage of funds, all other outpatients not to be treated."

When the problems created by this directive came to the attention of hospital services at Head Office, the directive was withdrawn by Dr R Mgijima: Superintendent General of Health Services.

The Department was also informed that the problem of overspending is a reality and that further steps will have to be taken to address the problem.

(2) The Department is seriously attending to the problems existing at all levels of health care.

Steps to be taken are:

* Capacity building of primary health care.
* Devolution of responsibilities and functions from secondary and tertiary health care to primary health care.
* The development and implementation of an effective and functional referral system.

(3) No.

Area Commissioner for Pietermaritzburg

*14. Mr L T LANDERS asked the Minister for Safety and Security:

(1) Whether a certain brigadier, whose name has been furnished to the South African Police Service for the purpose of his reply, has been promoted (a) to Area Commissioner for Pietermaritzburg and (b) from the rank of brigadier to the rank of major-general; if so, (i) on what grounds and (ii) what criteria are being used by the SAPS in the promotion of police officers;

(2) whether the said person was implicated in the Goldstone Commission Report of March 1994 for having allegedly tampered with investigations into hitsquad activities in KwaZulu-Natal; if so, what are the relevant details?

N867E

ThE MINISTER FOR SAFETY AND SECURITY:

(1) (a) Yes.

(b) Yes.

(i) His application was considered together with all other candidates

Homeopaths welcome bill to form interim council

(85) ARG 29/6/95

Health Reporter

THE Western Cape Homeopathic Association has welcomed the formation of an interim council for homeopathic, chiropractic and allied health professionals to advise Minister of Health Nkosazana Zuma.

"We look forward to the Minister appointing people with the correct professional standing," said Florrie Kerschbaumer, chairman of the association.

The interim council will hold office for two years.

The bill to dissolve the existing council was passed this week. It provides for the establishment of a new, democratically representative interim council comprising, among others, three chiropractors, three homeopaths and six people representative of the community.

SA has the 'drive' to create efficient health care for all

CT(BR)29/6/95

(85)

BY JOHN SPIRA
GAUTENG BUSINESS EDITOR

South Africa has the intellect, drive and experience to expunge inefficiencies from its health care system. Doing so will ensure that money is made available for those who do not have health care and to improve the quality of health care for those who already have such access.

That is the encouraging feedback from Arie van der Zwan, executive director of Southern Life, following the recent release of the government's report on the issue.

Van der Zwan is encouraged by the recommendations that a primary health care nursing force is to be established and that quality drugs be made accessible to all through an essential drug list. He is also pleased with the recommendation that the report is open for further discussion without being indefinitely open-ended.

What about the more controversial aspects of the report, especially the recommendations relating to doctors doing two years' community service and the taxation of medical aid contributions?

About community service van der Zwan says: "Seen in the light that it would not be unreasonable to expect these young doctors to help build their country, it is not an outrageous suggestion. To a great many South Africans, health care has hitherto been a question of running water. Accordingly, asking doctors to do community service is reasonable. Not long ago, they were obliged to spend two years dodging bullets or sitting around wasting taxpayers' money."

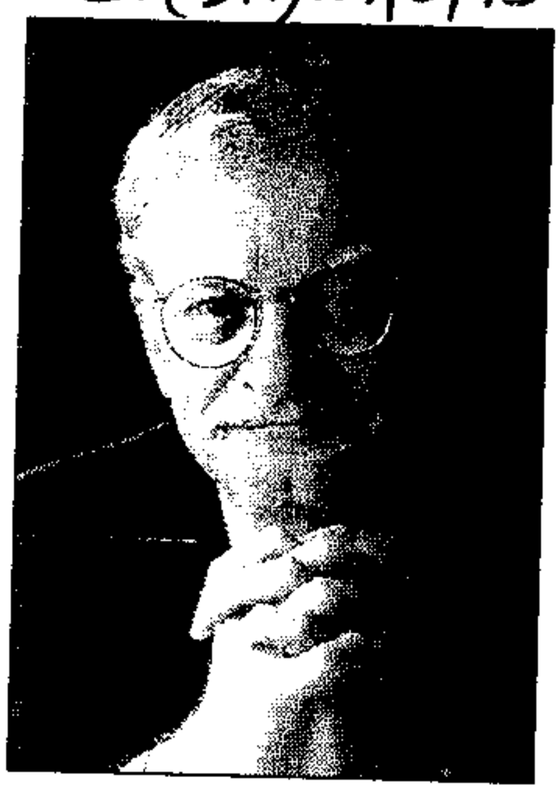
The report contains the proposal that in future the total sum contributed to a medical aid scheme (the employee's contribution plus that of the employer) be taxable in the hands of the employee, the rationale being that in certain instances contributions are being juggled to receive an additional tax break.

Van der Zwan sees the suggestion as encouraging a move towards packaging remuneration — in the process removing fringe benefits — and/or prompting smaller employers to allocate employees a certain sum a month to sort out their own health care.

"I see a danger here, because, in reality, many will simply take the money and not bother about health provision, in which event they'd become a burden on the state.

"We've already seen the response to free medical care for children younger than six years' old. The principle is gratifying as long as they're getting attention. Unfortunately, however, the infrastructure hasn't been there to deal with it. And the same will apply to those who don't make their own provision for health care."

Van der Zwan is unhappy about the vagueness on risk rating



Arie van der Zwan

in the report. "One has to look at prefunding for retirees. It's a universal truth that you spend two-thirds of your total health care outlay in the last five years of your life."

More significantly, how will South Africa fund the system as a whole? One of the proposals is to impose a levy on medical schemes, largely because the money would be easy to collect.

Van der Zwan has a problem with the proposal. "In practice, if the levy is passed on to the consumer, he will either have to pay more for the same benefit or pay the same amount and derive less benefit. This goes against the aim of the report, which stresses quality medical care for all."

Ultimately, what he suggests as crucial to health care is efficient management of the process — the only route to contained costs and better, more accessible, care.

Two examples of the inefficiencies are: First, South Africa's mamagram utilisation rate is 10 percent of the population; in the United States it is almost 50 percent. The reason? The vast majority of mamagrams in South Africa are for women who already have cancer. In America the system requires women to have mamagrams at regular intervals. That is preventative medicine — managed health care.

Second, in the United States the average utilisation of hospitals is 270 bed nights for 1 000 people and the average stay in hospital is five days. In South Africa, the figure is between 600 and 800, with the average stay under three days. Hence, more people are going to hospital in South Africa for treatment that could be undertaken elsewhere — in day clinics or in doctors' rooms.

"As things stand, the time has come when individuals and corporations simply cannot afford health care, the costs of which have risen 23 percent a year over the past five years — way ahead of the country's inflation rate. Those who pay for medical care must demand that they pay no more than the average rate of inflation."

NEWS NATIONAL

Doctors study health plans

(85) Source 29/6/95

THE medical profession's role in the future health dispensation is high on the agenda as doctors from all over the country converge on Pretoria, for the annual federal council meeting of the Medical Association of South Africa.

In a statement in Johannesburg, Masa spokesman Ms Marileen van Wyk said Government proposals for a national health insurance plan, released last week, would be studied in detail with a view to drafting recommendations from the medical profession on its involvement in the development and implementation of the plan.

Masa federal council chairman Dr Bernard Mandell said reaction to the plan was generally positive.

"At this coming meeting we will consider all possible implications for the medical profession and the community in the context of our commitment to broadening access to quality health care for all the people of South Africa," he said.

Subjects for debate

Related debates will address community service, incentives for medical practitioners, labour negotiations, working conditions of doctors, opportunities for cooperation between private and public health sectors, accreditation of medical practitioners and interaction with other health-care sectors.

Private sector help sought by province

(85) Star 30/6/95

"Joint ventures" are the newest examples of health-speak, as Gauteng health authorities look for private sector help in providing Emergency Medical Services (EMS).

Trauma is the second most common cause of death in South Africa, but the province can now only afford the basic and intermediate levels of EMS.

That means first aid and transportation to hospital, or setting up of drips and stabilising patients at the scene before transporting to hospital.

Advanced life support (ALS) is top-of-the-range care, and needs sophisticated monitors and equipment, and top-level critical care assistants qualified to administer drugs and use breathing apparatus.

Some ALS ambulances are intensive care units on wheels capable even of allowing surgery to be performed on site.

There has been talk of co-operation for three years, but sources say it has taken off in the last six months, with tacit ministerial approval backing the province's attempts to smooth over the legacy of arrogance and antagonism, and appeal for help.

"Government is uncertain about what to do, and we believe we can do a better job, for less," says Henk Aartsma, chairman of the Private Ambulance Association, whose 42 members have set up a sophisticated network of EMS vehicles, staff and equipment.

The PAA is less than a month away from submitting to provincial authorities a contract for its members to supply advanced life support and training.

"We have figures which show only two of the local authorities are able to supply emergency services cheaper than private contractors, and we make a profit," he said.

At least one top flight private company is also known to be talking service contracts with local councils, while another has taken proposals regarding advance care to the Minister of Health.

As yet, nothing has been concluded. Gauteng Chief Director of Health Dr Pieter van den Berg says a task group is looking at "all possible" joint ventures with the private sector.

EMS director Dr Phillip van Rensburg says there is "definitely room" for co-operation, with ALS and ALS training, inter-hospital transfers and leasing of vehicle fleets being likely options. A central control has been suggested.

JANINE SIMON

Medical schemes back in traction

(85)
FM 30/6/95

The Broomberg/Shisana committee's report on national health insurance, released last week, acknowledges that the private sector has a role to play in the financing and delivery of health care. But the committee's proposed re-regulation of the private sector could render this concession meaningless.

In chapter eight — headed "Regulatory Reform of the Private Sector" and widely described by the industry as poorly researched, inaccurate and inconsistent — proposals include an end to all risk-rating for medical scheme members, an equalisation fund for schemes and mandatory hospital cover for all employees. These proposals would reverse the deregulatory gains made by the Medical Schemes Amendment Act, which took effect last January.

Says Momentum Health MD Adrian Gore: "The report suggests that schemes face a crisis because of deregulation resulting from the Medical Schemes Amendment Act of 1994. The truth is quite the contrary.

"The crisis facing medical schemes is one of short-term solvency, brought about by the perverse incentives created by the old, highly regulated Medical Schemes Act that guaranteed minimum benefits.

"It is deregulation that has enabled schemes to change benefit structures and avert insolvency."

These sentiments are borne out by the latest results, analysed by the Registrar of Medical Schemes, that already show a 2% improvement on scheme reserves for the short time under consideration. Says Registrar Danie Kolver: "There is no doubt that co-payments, deductibles, managed healthcare principles and limited risk-rating have contributed towards savings."

Representative Association of Medical Schemes (Rams) chairman Keith Hollis has also stressed that the benefits of deregulation will become apparent only after three to five years.

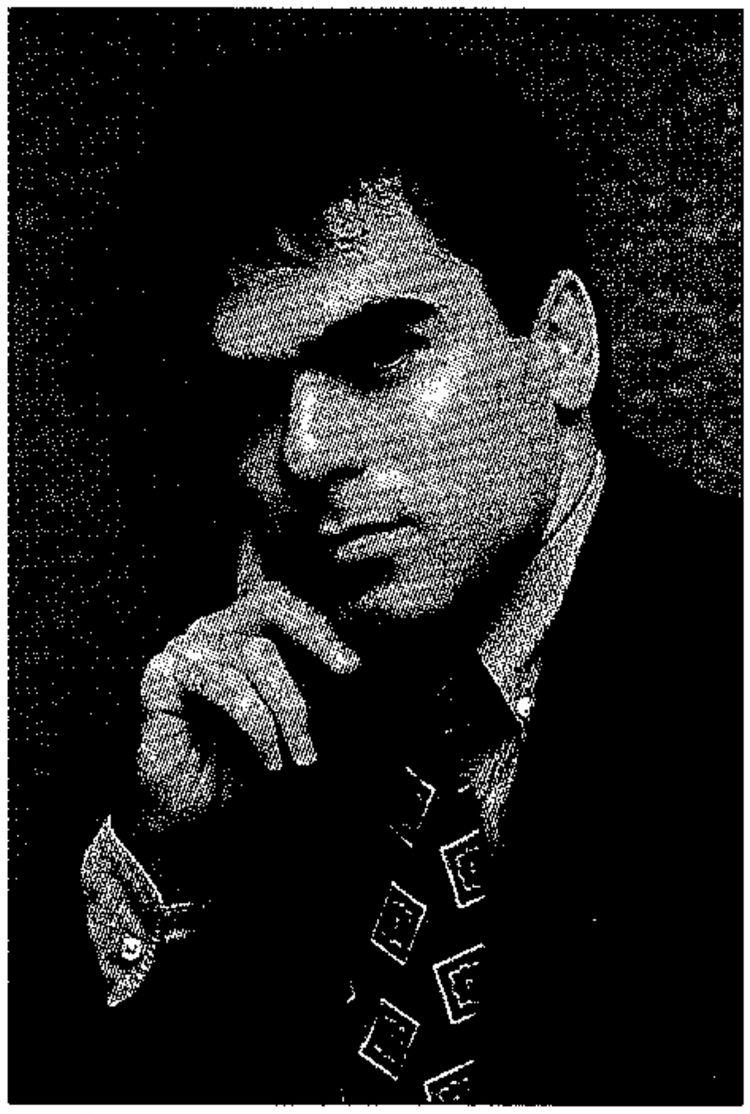
But the committee seems determined to reverse these gains. The report states: "Schemes may not exclude any individual on the basis of his/her health risk. Medical scheme contributions must be based on community or group rating for all members of a given fund. In other words, an individual's contributions may not be related to the individual's health risk (presumably age) or claiming patterns, except where the individual has substantial control over risk — for example, smoking. For noncore benefits, contributions could vary with the number of dependants."

As early as 1989, the industry recognised the need to discourage abuse and fraud that would deplete reserves required to meet genuine claims. This followed a 10-year period characterised by annual average claim increases of around 33%.

Says Gore: "The committee's proposal to bar schemes from loading premiums based on claims experience is simply not workable for voluntary health-care coverage, because this would stifle market innovation. Sick people would seek out the most comprehensive benefit structure.

"No-one would purchase health cover until they became ill — a factor that would erode the cross-subsidisation the committee is trying to ensure."

Yet the report says cover could be limited



Gore . . . *crisis in medical schemes is one of short-term solvency*

for people who start contributing to a scheme only close to retirement, though this should not apply to the core benefits envisaged in the mandatory hospital cover proposed.

Could the committee thus be contemplating compulsory scheme membership for all employees with identical benefit structures?

If the onus of enforcing such a regulation rests with employers, this would load the cost of labour, which could lead to unemployment.

It would also probably mean that schemes would be able to provide cover only for a limited set of benefits as usage soars without disincentives for abuse.

The committee is concerned with the growing number of pensioners unable to afford medical scheme contributions. Says Gore: "What is emerging is a long-term solvency crisis regarding the financing of pensioners that has resulted from the 'pay-as-you-go' system of contributions set on a community rating basis. The market is, however, developing sound actuarially based solutions to avert this crisis.

"Various accounting standards are also being debated to ensure that funds are built up during an employee's active lifetime to ensure that care can be afforded in retirement."

Gore suggests that it would be more appropriate to protect the rights and cover of today's estimated 390 000 pensioner beneficiaries while creating costing and funding mechanisms to ensure that future pensioners are financed properly. This could be achieved though community rating by group, where rates would take into account differences in age and sex.

A related recommendation that is being questioned is the committee's proposal to introduce an "equalisation fund" for schemes that would force them to pay a percentage of contributions into a fund to cover pay-outs to schemes in trouble.

Presmed joint MD Rob Speedie says such a fund could impair the incentive to apply sound management techniques among schemes. "How do you determine why schemes are in trouble? Will this fund reward inefficiencies at the expense of schemes which increasingly effect savings through managed care principles?"

The report proposes open enrolment, guaranteed renewal and transferability of membership among schemes. This is in line with the Melamet report, that suggests such a move would increase consumer choice and heighten competition. Speedie warns this could lead to members "cherry-picking" schemes for specific benefits and undermining any form of cross-subsidisation.

Wits University economics professor Duncan Reekie, welcoming the committee's thinking on this point, suggests members could be restricted to one annual move.

The committee has rejected another report's recommendation for an end to government licensing of private hospitals according to economic criteria that would supposedly put government in a position to assess market needs for new or extended facilities. That report found the existing practice was open to administrative abuse and corruption and said the licensing criteria should be confined to ensuring the maintenance of standards of hygiene and proper care.

The Broomberg/Shisana report also wants to regulate the supply of expensive technology in the private sector — a move previously rejected for the same reasons.

Another recommendation is that the tax deductibility on employer medical aid contributions should remain but that such contributions should be taxed in the hands of employees as a fringe beneft.

The recommendation is not likely to be welcomed by trade unions and could work against the compulsory extension of cover to all in formal employment.

Transnet's health care train due to roll again

(85) BD 30/6/95

Vusi Khoza

TRANSNET's health care train — Phelophepa — is scheduled to tour Gauteng, Eastern Transvaal, Northwest and Northern Province to provide primary health care services to 13 rural communities between July and September.

The train, which made a similar trip last year, will carry additional equipment this time.

Transnet's mobile health care service has been in operation for two years and has been used by thousands of patients.

This year its trained medical personnel have already seen 21 000 patients in 25 communities.

Transnet said that although optometry remained an important component, the range of services the train was offering had broadened.

Dentists were aboard and an X-ray unit had been added to Phelophepa.

The train is the brainchild of Bloemfontein's Transnet engineering section — Transwerk — which revamped an old coach into a high-technology dental and X-ray unit with two consulting rooms.

Pretoria University and Medunsa dental students will be among those offering their services.

Members of the SA Society of Radiographers will work operate the x-ray unit and link chest screening with other health care disciplines.

Pain and sepsis will also be treated on Phelophepa.

Permanent staffers have been employed to run community outreach projects, designed to cover a wider area and to offer support to community nurses and clinics.

Transnet health care manager Lynette Coetzee said primary health care services would be extended to schools.

Local health guidance assistants would be trained to serve communities once the train left.

Health director pledges pay hikes

ST 2/7/95 (85)

By CAS St LEGER

WHEN you wake up tomorrow, spare a thought for Dr Olive Shisana who starts work as the national health department's new director-general.

Her first task — to be accomplished within months — is the transfer of 2 000 health department staff from the old, fragmented system into a unified structure.

Formerly special adviser to the minister of health and fresh from her triumph as co-chairman of the national health insurance plan, Dr Shisana is turning her energies toward putting a "universal" primary health system in place in the next five years.

Her main stumbling block, she says, is finding agreement on a perfect formula for dividing money between provinces. No hospital will be allowed to collapse by the shifting of funding, Dr Shisana pledges.

A priority is to boost morale by implementing more appropriate salaries for doctors and nurses.

The appointment of Dr Shisana, 43, was confirmed by cabinet this week. She takes over from Dr Coen Slabber who will stay on for a while to help Dr Shisana settle in.

Dr Shisana is married to Dr William Shisana of the University of the Western Cape's Department of Industrial Psychology. They have two children, aged 10 and 17.

She has an impressive resumé which includes three degrees — the third being a doctor of science at the Johns Hopkins University school of hygiene and public health in Baltimore in the US.

For relaxation, Dr Shisana spends weekends on a Cape beach with her children and the Sunday papers.

Electricity is a shot in the arm for health

ST 2/7/95

By CAS St LEGER

SCIENTISTS are peeking into fridges in recently electrified homes to monitor new diets and changing lifestyles.

In a three-year project for the reconstruction and development programme, the Medical Reseach Council is examining the long-term health benefits of electrification.

The RDP aims to supply electricity to 2,5 million homes by the end of the century.

The council's community health researchers — Dr Len Lerer, Dr Derek Yach and their team — predict the programme will save R800-million in treating patients with lung disease, burns and paraffin poisoning, which could be avoided if they had electricity.

Six out of every 10 clinics don't have electricity. Electrification would bring refrigeration of vaccines, sterilisation of instruments and health promotion by video.

Due mainly to the use of candles, South Africa's burn fatality rate is four times higher than that of the industrialised world, with 25 babies and 35 of the elderly dying by fire per 100 000 of the population. And at least 16 000 children a year are admitted to hospital for paraffin poisoning.

While street lighting would help cut down crime, the researchers said it was important to consider the role of television violence in interpersonal violence, since electrification was associated with television sales.

They found that in poor households, new refrigerator owners could be at risk of a change to unhealthy, high-fat foods.

Some studies have shown that children living near high-current lines had higher rates of blood and brain cancers.

The research found that half the electrified households surveyed in Gauteng continued to use coal and candles.

Health care in disarray

GP 2/7/95

E Cape has acute shortage of doctors

(85) (2-6)

By STEUART WRIGHT

AS HEALTH CARE in the Eastern Cape slides deeper into chaos, the provincial health department cannot put a figure to the province's chronic shortage of doctors.

The Eastern Cape Health MEC, Dr Trudy Thomas, said earlier that 150 doctors were needed in the province. However, a Cecilia Makiwane hospital spokesman says about 100 doctors are needed at that hospital alone.

The provincial chairman of the Junior Doctors' Association of SA, Dr Shaun Conway, estimates that 400 public service doctors' posts are vacant and about 100 doctors are due to leave the service this month.

The Cecilia Makiwane spokesman puts the shortage down to the lack of academic hospitals in the province and the lack of incentives for doctors from elsewhere to enter public practice in the Eastern Cape.

The spokesman says most people in the impoverished Eastern Cape cannot afford private doctors, placing an extra burden on public hospitals which are poorly equipped to handle the patient load.

While he stresses that no patient has been compromised as a result of the doctor shortage, in some cases it means patients remain in hospital longer than they should as doctors spread themselves thinly among the ill and wounded.

The former Ciskei and Transkei attracted overseas interns with good perks and tax breaks but these have fallen away with the reincorporation of the homelands and the provincial government is not renewing contracts for the expatriates.

The provincial coordinator of psychiatry, Dr Charles Louw, says another 14 psychiatrists are needed in the province.

He says the province's four psychiatrists can barely cope with the medical-legal work which comes with criminals referred by the courts to state psychiatrists for observation.

Both Louw and the Cecilia Makiwane hospital spokesman see only one solution to the problem: better pay and perks to attract doctors.

■ Provincial director of hospital services Dr Pat Naidoo said he was too busy to speak to the press.
– **Ecna**

Chainstore bread pledge

■ BY NIKKI WHITFIELD
CONSUMER REPORTER

Major supermarkets have pledged to keep the price of bread down, despite the announcement by bakeries that they are to up the bread price by 7c a loaf from today.

For the time being, supermarkets will carry the increase, giving consumers — reeling after a week of increases — a bit of relief.

"Labour and packaging costs have gone up, but why do all bakeries have to increase their prices at the same time?," asked Ray Murray, Pick 'n Pay's general manager of perishables.

"Shoprite/Checkers will likewise carry the increase," said Adele Gouws, communications director.

Bakeries have listed wage increases of over 9% as the main reason for the hike.

Star 3/7/95

Micaela probe

■ TAMSEN DE BEER

Child Protection Unit detectives said they would continue investigations into the alleged involvement of a Johannesburg woman in the kidnapping of baby Micaela Hunter from the Marymount Nursing Home last year.

The case against the woman was provisionally withdrawn at the Johannesburg Magistrate's Court on Friday.

She was not named in court,

Works plan ready to go

■ BY JO-ANNE COLLINGE

The Gauteng community-based public works programme is poised to take off on its initial, modest budget allocation of R16-million.

Its major goal will be to reduce unemployment by creating jobs in the construction industry through the repair and expansion of infrastructure and community facilities, says Steve Topham, technical manager for the programme.

At a recent media briefing, Topham stressed the detail of the programme would depend on the pattern of demand voiced by communities themselves.

Generally, projects to "bring dilapidated infrastructure (and buildings) back into use" were regarded as top priority. This was because the returns on such use of funds were relatively quick.

Star 3/7/95

Training — ranging from basic bricklaying to business skills — was an important aspect of the programme.

New hand takes over Health Department helm

(85) Star 3/7/95

■ MEDICAL CORRESPONDENT

Today is the first in office for the formidably qualified Dr Olive Shisana, the new Director-General of the Department of Health.

She takes over from Dr Coen Slabber, the former Dean of the University of the Free State's Faculty of Medicine, who retired as director-general on Friday after more than seven years in the position.

Shisana, until now special adviser to the Minister of Health, and with Dr Jonathan Broomberg architect of the proposed new national health insurance system, had been earmarked for the position for months.

Her appointment was rubberstamped by Minister Dr Nkosazama Zulu on Friday, and she is now perfectly placed to spearhead the implementation of the new proposals.

Shisana has earned a reputation as being "hard-headed" and knowing what she wants, but department staff welcomed her appointment.

"We're very grateful," said one. "She's a lovely choice, the best for the position."

Shisana matriculated in 1970 from the Lemana High School in Louis Trichardt, and obtained her first degree, a BA in Psychology and Social Work, from the University of the North.

She later moved to the United States, where she completed two post-graduate degrees, and obtained a doctorate in science, specialising in social epidemiology, from the School of Hygiene and Public Health, Johns Hopkins University (USA).

She joined the Cape Town-based Medical Research Council as a specialist scientist in community health in July 1991, and was later seconded to develop the MRC's Western Cape School of Public Health — the first in South Africa.

She speaks six languages, has published or co-published more than 30 reports, and received several awards.

IAL

Good health system on the way

(85) sowetan 3/7/95

By Glenn McKenzie

SOUTH Africans will have to wait two to three years before a framework for South Africa's new health system is in place, a senior health official said at the weekend.

In an interview with *Sowetan* on Friday, Department of Health Director-General Dr Olive Shisana said it would take two or three years to build "a good health infrastructure" in South Africa.

Shisana said the Government was "juggling" the task of maintaining existing health services, while transforming apartheid structures to "serve everyone".

She said the new Health Ministry would soon finish its planning stage and prepare to move into an "implementation stage".

"It is a bit like trying to move everyone from one turbulent ship to another in the middle of a storm," said Shisana.

Health services have taken a dive in recent weeks in areas such as Soweto and the East Rand. Clinics and hospitals have been overburdened with patients, and shortages of medicines have been common. In some clinics, hundreds of patients have been turned away without treatment.

Shisana said government leaders were planning "long-term" solutions to medicines shortages and overcrowded health facilities. A National Health System could go to Parliament in January next year.

One proposed solution to drug shortages and overcrowded clinics could be in place before then, said Shisana. A new essential drug list could be instituted by the end of the year, Shisana said. The drug list will ensure that hospitals and clinics are provided with large quantities of commonly used medication. The price of these medicines will also drop. (Pharmacies will only be allowed to charge approximately R10 for most essential drugs).

Shisana said wage increases were also on the cards. Doctors, nurses and pharmacists would be paid more in the future. This should raise the morale of workers and prevent many from leaving the public service.

Research pays off for woman Director-General of Health

Star 5/7/95 (85)

DR Olive Shisana is determined to make health care accessible to all South Africans, reports Janine Simon, Medical Correspondent.

There are flowers on the desk of Dr Olive Shisana, and a smiling queue outside her 20th floor Pretoria office.

"They wanted to frame the first document I signed this morning," grins the newly appointed Director-General of Health, the first women DG in any national department.

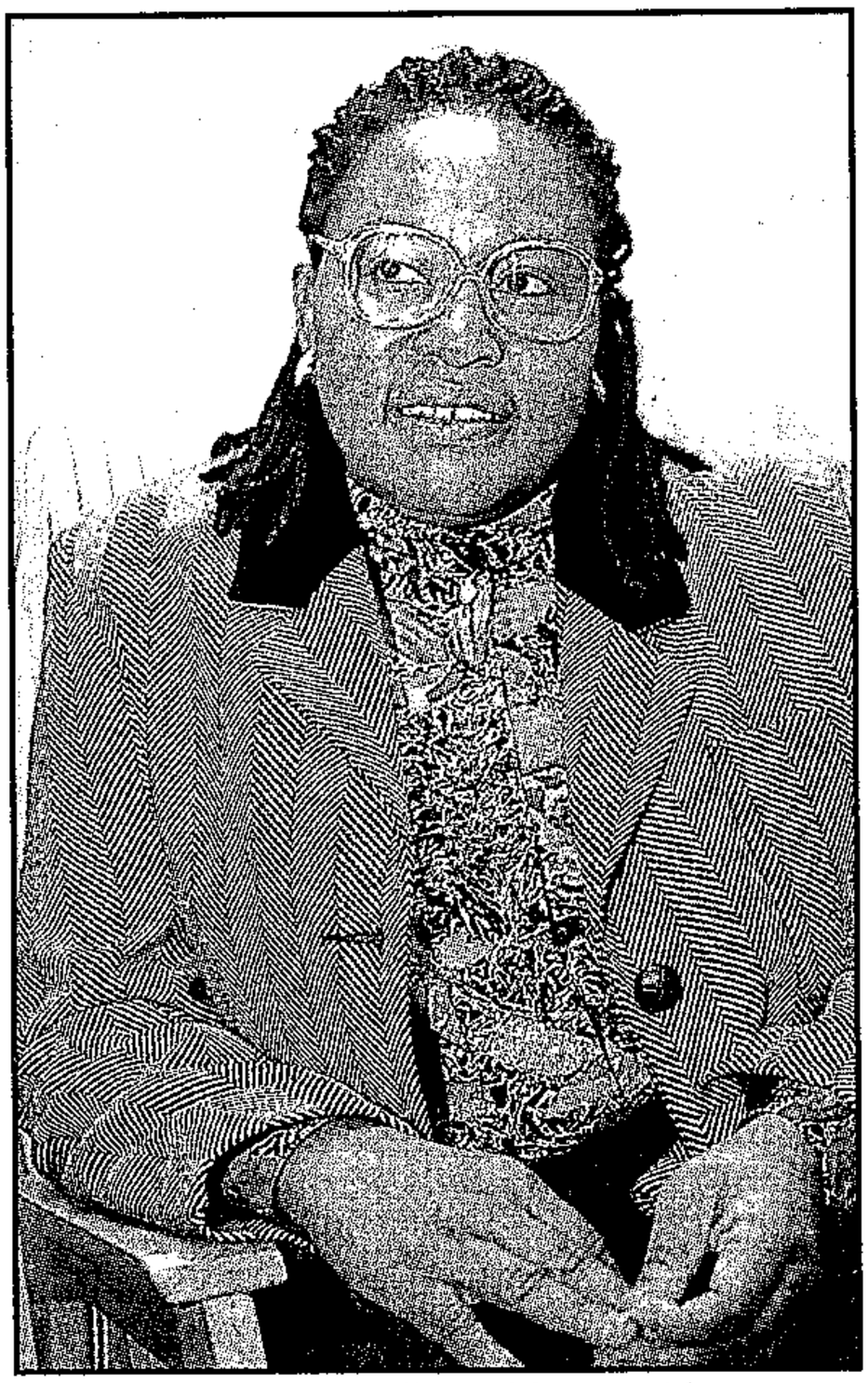
That would not have been the case a year ago, when Shisana marched into the State health services as special advisor to Minister Dr Nkosazana Zulu.

Enter Shisana, a US-trained firebrand fresh from developing South Africa's first School of Public Health and determined to make health care accessible to all South Africans.

There were some uncomfortable clashes, notably over her views on restructuring and plans for national health insurance.

Eventually, exhaustive research won through.

A careful study into a national health insurance system, by a committee which she co-chaired with health economist Dr Jonathan Broomberg, was tabled for public comment last month, and Shisana the researcher took a bow.



Firebrand . . . Dr Olive Shisana, Director-General of Health. PICTURE: MOTLHALEFI MAHLABE

Her first degree was at the University of the North, and it was followed with two post graduate degrees in the United States and, 1984, a Doctorate of Science from the School of Public Health at the renowned Johns Hopkins University.

By the time she left the US in 1991, Shisana headed research at the District of Colombia's Department of Human Services; now, one among her many current projects is to pull together the private sector, NGO's, science councils and community groups to define a research agenda for the country.

"It's crucial," she says. "Research informs and evaluates whether we achieve our objectives."

Caught on her first morning between a call from the Minister and a meeting she is to chair, Shisana seems relaxed but unapologetic about past tensions. She is clearly poised to bring in the new health order, and word from her scurrying support staff is that she's a dynamic, excellent choice for the position.

"The Department has changed, warmed up," Shisana observes. "People are seeing that those appointed are energetic and enthusiastic, and they're engaging the civil service very well."

The public and State medical personnel — hamstrung by slashed budgets, a freeze in posts, and no sign yet of management autonomy — are likely to be less charitable. What will they see after the period for public comment on the new proposals closes on August 18?

"A lot of clinic building and a huge training programme," Shisana says.

"There'll be a lot of negotiating with doctor groups, and private care provider groups; a lot of discussions about setting across-the-board overtime pay rates, and a lot of work in terms of allocation of budgets, both between and within provinces."

Born in the far north, and schooled in Pietersburg and Louis Trichardt, Shisana says she never marked for herself the title of DG.

"I've always worked at playing a role that would make health care accessible to all, but I will be anywhere I can be of help."

In one way the new position will be easier than the last: in 1994 she saw her Cape Town-based family — husband William, an industrial psychology lecturer at the University of the Western Cape, a daughter of 17 and son of 10 — on weekends only.

That's likely to ease now, as the DG is expected to regularly tail the minister to Cape Town.

"I'm one of the new class of professional migrant workers," she says ruefully, "but everyone in the struggle has sacrificed. It's nothing unique to Olive Shisana."

*Medical services in Africa can be dangerously below standard. **Winnie Graham** looks at a high powered South African alternative.*

Jetting in the rescue mission

(85) Star 6/7/95

The telephone call came at 3am. A plane had crashed in Tanzania and the three survivors — badly burnt and battling for life in a remote rural clinic — were in desperate need of medical care.

Could a plane — and medical team — be dispatched as soon as possible to collect them?

Dr Jimmy John, head of International SOS Assistance medical rescue unit in Johannesburg, did not hesitate. There wasn't a moment to be lost.

Two Lear Jets, complete with intensive care equipment and medical teams, immediately prepared for take off in a joint operation between International SOS Assistance and Medical Rescue International.

In the meantime, another problem emerged. Jets can land only on tarmac runways. The road at the village where the survivors were being cared for was gravel.

While the jets were being prepared, SOS called the Flying Doctor service in Nairobi and arranged for the men to be fetched and brought to Nairobi airport where the jets could land. Times were synchronised. The South Africans would meet their patients at Nairobi, transfer them to the jets and bring them to hospital in Johannesburg. It was the fastest possible means of evacuation.

"Rescue operations are carried out with military precision," Dr John said. "The attention to detail is immense. We have to move at speed, but we cannot afford to take short cuts."

The men were transferred to a hospital in South Africa the same day. Three weeks later — having undergone skin grafts — one was allowed home to the United States. The second was discharged. The third man sustained life-threatening lung damage and had to be artifically ventilated for some weeks. He was eventually able to fly home as a routine airline passenger.

Although medical rescues have been undertaken from Johannesburg for the past 20 years, they are becoming increasingly commonplace as more and more South Africans travel north, either on business or leisure. Conversely, more and more people from other African countries fly to South Africa for medical treatment.

Communications in Africa are poor. A patient in Mozambique was not at the airstrip when the plane arrived to fetch him. Dr John and the paramedic team set out to find him at the clinic, walking 14km through bush not fully cleared of landmines to reach their patient who was seriously ill with malaria.

Adventure-lovers, keen to see more of their own continent, are visiting an array of destinations north of the Limpopo but not all know how primitive medical facilities are. With rare exceptions, they are hopelessly inadequate.

Many doctors are poorly trained, medicines unobtainable and operating theatres unusable. In countries where AIDS is endemic, patients cannot be certain that syringes or needles for sutures are sterile. Often it is impossible to buy even a box of asprin.

Travellers going north know they are taking a chance if they don't swallow anti-malaria tablets. They are learning fast that insurance cover in the event of illness or accident in African countries is not enough.

"What is the use of millions of rands worth of medical insurance if there is little you can buy with it?" Dr John asked. "Under these circumstances it is the assistance services that fly you out that save your life.

"A few years ago, when South Africa was able to resume its place in the world, a team of medical experts visited this country to check facilities at our hospitals," Dr John said. "We became a rescue centre because they were satisfied with standards which are the best in Africa."

Among the cases Dr John has dealt with recently include two patients who broke their necks in diving accidents, one who suffered a stroke, one who contracted malaria in Luanda, one with pneumonia from Mozambique, two people injured in car accidents, someone who became ill with a bowel obstruction and a newborn baby with jaundice.

One man died in an east African country. His luggage containing insulin was stolen and assistance could not reach him in time.

Not everyone who is ill in Africa, of course, needs to be evacuated, but could need access to medical care. Organisations such as International SOS Assistance, (there are two or three medical rescue groups which operate throughout Africa), provides emergency medical assistance not only to individuals, but to governments, private companies and NGOs in countries round the world.

By operating a 24-hour service, the intensive care unit (comprising paramedic, ICU nursing sister and doctor) are on standby to help anyone who could be trapped, and ill, in Africa.

"We make a lot of use of the Red Cross jet which is a permanently equipped flying ICU and one of the best of its kind in the world," Dr John said.

Although SOS has carried out many air rescues, often telephone advice on where to find a reputable doctor is all that is needed.

Dr John believes the cost of the cover is "a gift".

"Travellers are assured of care should the need arise — and we hope they won't need it," he said.

To the rescue . . . a patient injured in Africa is cared for by paramedics who flew from Johannesburg to fetch him. As the only country south of the equator offering First World medical care, South Africa is being increasingly used as a rescue base.

All aboard, all aboard, the health-care train is in town

(85) ST 9/7/95

By CAS St LEGER

QUEUES of schoolchildren filed across a railway goods yard and up the steps of a train. Inside they found the latest in medical and dental treatment.

The children had never been to a dentist before, so they were not afraid to visit the surgeries aboard Phelophepa, the health-care train which pulled up at the Breyten station in the Eastern Transvaal this week.

Until the RDP dream of rural clinics thick on the ground is realised, Phelophepa brings hope of health to patients in remote places where doctors and nurses seldom call.

The children lay confidently on the cream leather dental chairs as young oral hygienists and dental students stood in attendance.

Without a murmur or a tear, they endured injections, cleaning, fillings and extractions. One boy was so relaxed he fell asleep in the chair. The children left the surgeries clutching toothbrushes and toothpaste — and instructions on how to use them.

The adult patients, some of whom had queued for up to three days, were a tad more apprehensive.

One woman braved pain-killing shots and braced herself to have several teeth pulled. Instead, she felt a weird buzzing and vibrating in her mouth. She screamed in terror and ran from the surgery on her first encounter with the dentist's drill.

Once she was persuaded to return, she was thrilled when the cavities in her teeth were filled. Dentists, to her, had meant only extractions.

Since the dental coach was added on four weeks ago to make Phelophepa a 15-coach train, the rotating teams of dental students and their supervising lecturers have found few of the patients have ever met a dentist before.

Dr Joeren Kroen from Pretoria University's dental faculty, who supervises Phelophepa's dental clinic, has been shocked to discover the poor state of rural teeth.

"Most of these people have had no access to dental care. Most have dirty teeth and need many fillings or extractions. I put it down to a combination of wrong diet and neglect," he said.

Everywhere the train stops, it draws patients from a radius of 100km. Many walk 15km or more to seek help.

Phelophepa is owned by Transnet, which has invested R4-million in the project, and is backed by a range of sponsors. The monthly running cost is R340 000.

Medical, dental, optometry, nursing and psychology services are provided mainly by top students from South Africa's universities.

Two Rand Afrikaans University optometry students, Kevin Rosen and Leeanne Sallis, said some universities chose only the cream of students, and others drew names from the hat for the privilege, experience and fun of working on the train for a month.

Patients pay R10 for dental treatment, an eye test or an X-ray, R5 for medicine and R30 for a pair of spectacles. The rest, from family planning to health education, is free.

So far this year, more than 21 000 patients have been treated at 25 country railway stations. Last year, at 34 stops, more than 30 000 patients used the clinic.

Blood-pressure readings are taken while the patients wait for their medical examinations. More than half suffer from diet-related high-blood pressure. Another common complaint is a shortage of Vitamin A, which can affect growth and eye sight.

Half of those visiting the eye clinic need spectacles, which can be made on hi-tech equipment in 15 minutes.

The train took to the tracks as an eye train with two clinic coaches in 1993. Since then, it has become a fully fledged mobile primary health-care clinic.

On Friday, the train left Breyten for Marble Hall, where fresh queues of the needy will line up on the station platform tomorrow. Then will come a string of smaller towns — including Graskop, Hoedspruit, Taung, Zeerust — ending up in Bethal at the end of September.

A week or two before each stop, outriders visit each place, alerting local community leaders of the train's arrival, pre-sorting patients and visiting schools to screen children's teeth.

Maputaland is nursing itself to good health

(85) CP 9/7/95

By DAN DHLAMINI

THERE is light at the end of the tunnel for the forgotten communities of Maputaland who had been marginalised by the previous government when it came to health care.

The more than 500 000 people living in abject poverty in the remote north east corner of KwaZulu/Natal have long been plagued by diseases such as Aids, TB, malaria and childhood ailments such as diarrhoea.

Last week the communities had their prayers answered when The Gold Fields Foundation – the social investment division of the Gold Fields Mining Group – opened a training school for nurses at Bethesda hospital, situated on top of the Ubombo mountains.

Maputaland – which is ironically better known by the rich for its ecological beauty than for the poverty of its people – has been divided into four health regions, each centred around one of four rural hospitals.

The hospitals are; Bethesda, Mseleni (next to Lake Sibaya), Manguzi (near Kosi Bay and the Mozambican border) and Mosvold (on top of the Lebombo mountains).

Two health visiting points – complete structures which will later be furnished and provided with the necessary clinic equipment – were also opened in the remote areas of KwaMshudu and Muzi near the Mozambican border, bringing to 14 the number of points funded by the foundation since 1990.

■ Despite their geographical and political isolation, the never-say-die inhabitants of Maputaland – who do not want people to feel sorry for them – have vowed to work hard for their own social upliftment.

HEALTH CARE BOOST . . . Gold Fields Foundation chairman Michael Tagg, Sister Makhosazana Themba, Matron Pretty Harrison and Dr Olga Venter officially open the Bethesda Nurses Training School.

Muzi project co-ordinator Mavis Tembe, a dynamic young woman, told City Press how some nine months ago she and her team of women had worked around the clock to complete the project – while the menfolk had concentrated on their "Lala-palm wine" (intoxicating sap from a cut palm tree).

Tembe thanked the foundation for the medical help and said their prayers had been answered.

The onus was now on the community to maintain and make good use of the facilities donated by the foundation, she said.

Northern region director Sister Dudu Moale, summed up the determined community spirit by saying: "People say we are disadvantaged, we are in remote areas – but we say this is what make us very special people.

"These are the factors that unite and urge us to plan and work together with the support of the foundation."

The principal of Bethesda Training School, Makhosazana Themba, said they had a vibrant nurses training programme.

She said young nurses had been motivated by the success of the Primary Health Care programme which was designed by GF group nursing consultant Dr Olga Venter and now serves as a model for the whole country.

"Our former students always come back to work here – not because there were no vacancies at better hospitals in other towns, but because they have the urge to prove that we can be equal to others if given the opportunity," said Themba.

GFF chairman Michael Tagg said his company had invested over R4 million rand in the past four years to promote primary health care in these villages by building 14 Health Visiting Points and purchasing two mobile clinics.

He said his company would help the communities step by step until they were self sufficient.

Asked why they had concentrated on Maputaland when only 20 percent of their labour force was drawn from there, Tagg said they had tried it in the former Transkei – where 80 percent of their workers lived – but the project had collapsed due to non co-operation from the then authorites.

However, Tagg said they would return to that part of the country to again try to help with the social upliftment of the communities.

Maputaland residents live in scattered homesteads throughout the region.

Roads are in poor condition and many residents can only be reached by making use of strong 4x4 vehicles.

The mining company invited the media on a three-day tour and most nurses and doctors interviewed said their biggest handicap to providing health services was a lack of transport to the remote areas.

Nissan sets precedent with health care model

BD 11/7/95 (492) (85) (294)

Kathryn Strachan

A UNIQUE managed health care plan devised for Nissan workers could become a model for other SA companies.

Nissan SA, together with Numsa, insurance brokers Alexander Forbes and medical aid administrators D&E, devised a plan giving the company's hourly-paid workers at its Rosslyn plants a choice of different levels of health care.

In the past, hourly-paid workers have been largely excluded from joining company medical aid schemes because they do not have the same status as permanent salary earners.

Private medical aid schemes for such workers have failed because of high claims and costs.

Some have been "fly-by-night" operations which have collapsed.

"By developing the plan in partnership with the workers' union we are ensuring the managed health care plan will meet workers' needs and will be accepted by them," said Brian Moor, human resources director of Nissan SA.

The first level of the scheme, fully paid for by the company, is intended to cover basic requirements such as medicines and general practitioners.

Workers can choose to join module two or three, which will cater for hospitalisation, optometry, specialists and dentistry.

These modules will be subsidised by the company, with the level of subsidy still to be finalised.

To reduce costs and ensure claims are held at reasonable levels, while making medical care accessible, a clinic has been opened.

The staff is employed by the managed health care plan. Nissan's workers and their families must use the clinic for treatment or referral to specialists.

Families who live at a distance will utilise their local medical facilities but will be covered.

Star 11/7/95

Zuma appoints health directors

Health Minister Nkosazana Zuma yesterday announced the appointment of nine directors and two chief directors to the Department of Health.

In a statement in Pretoria the ministery said Ingrid van Eeden, Dr Eddie Mhlanga and Danie Vorster have been promoted to director while Nobayeni Dladia, Edgar Jones and Hlengiwe Mkhize were new appointments.

Professor Johan Schlebusch, Dr Neil Cameron and Dr Theo van de Venter maintained their positions as directors. The minister also approved the promotions of Professor Rachel Gumbi and Dr Hans van Heerden to chief directors. — Sapa.

Disease 'a threat to development'

(85)

Vusi Khoza

BD 14/7/95

MEDICAL problems in Africa were a result of government's failure to prioritise spending and not of poverty, World Health Organisation regional virologist and specialist in microbiology Prof Oyewale Tomori said in Midrand yesterday.

Addressing delegates at SA's first international congress on the impact of viral diseases in the developing world, Tomori called for a global approach to the problem of viral diseases in Africa.

Tomori said there could be no development in Africa unless these diseases were properly controlled. The impact of these diseases in all spheres of life could not be ignored.

Canadian insect virologist Richard Hamilton said both plant and animal viral infections affected food production and with malnourishment the major cause of diseases in Africa, the need to combat these viruses was even more pressing.

National Institute for Virology director Prof Barry Schoub warned that emerging diseases were a primary threat to people in Africa. The international community needed to contribute infrastructure to combat this problem.

The most important need identified was that of surveillance, and Schoub urged leaders to direct their attention to the establishment of a databank and public communication and training.

Tomori said there was money in Africa to combat such diseases, but this was spent on less important matters. He said the solution to these problems required an "attitudinal change".

The meeting — attended by representatives of medical, veterinary, insect and environmental agencies — reflected the need for all stakeholders in these fields to work together. Tomori called for developed countries to assist Africa in dealing with these problems.

R500 000 for health care

By Betsy Spratt

Sowetan 14/7/95

THE Department of Health recently allocated R500 000 to the Get-Ahead Foundation's Primary Health Care Programme to administer health care delivery in six of the country's provinces, said Mr Don MacRobert, the foundation's managing director.

Speaking at a Press conference in Johannesburg yesterday, Mr MacRobert said the programme trained community members on the rudiments of health care.

The primary health care programme has been designed to improve the health status of each community by empowering its citizens, said Dr Nthato Motlana, the foundation's chairman.

"The health department's funding has been allocated to Get-Ahead on the understanding that the project's effectiveness must be proven.

"Work already achieved, however, leaves no doubt as to the project's success," Motlana said.

The project trains nompilos (barefoot doctors), elected by the community, in a five to 10-day course on primary health care, said Ms Wendy Richards, the foundation's public relations officer.

More transplant moratoriums considered

Star 15/7/95 (85) (85)

By GRANT ROBBINS

Gauteng health authorities are considering a moratorium on liver and kidney transplants and expensive treatment for cancer and leukaemia as the province moves from expensive specialised health to primary care.

A moratorium on heart transplants has been in effect for several months in Gauteng. Budget cuts had forced the province to examine the rationalisation of other sophisticated operations, health head Dr Ralph Mgijima told Sapa.

He said this was in line with national health policy.

The heart transplant moratorium would remain until health specialists had submitted plans on what tertiary activities could be scaled down, Mgijima said.

The highly sophisticated burns unit at Soweto's Baragwanath Hospital could, for example, become the only hospital in the province to handle critical burn patients. This would cut duplication of high-technology treatment.

Pretoria doctor Fanus Serfontein (32) was threatened with disciplinary action this week after performing a heart and lung transplant at Pretoria's H F Verwoerd Hospital.

Gauteng health authorities said Serfontein broke the province's moratorium by performing two heart transplants in March and June, and last week successfully transplanted a heart and lung into a 22-year-old student.

Mgijima said Serfontein would not be fired from his surgeon's position. Democratic Party health spokesman Jack Bloom said the DP was concerned at the "high-handed" treatment of Serfontein.

In a statement, Bloom called for an urgent review of Gauteng's health services, saying the province could not afford to lose highly qualified surgeons.

The head of the transplant unit at Groote Schuur Hospital in Cape Town, Professor Del Khan, said Serfontein should be praised rather than scolded.

He said Serfontein was an outstanding surgeon who delivered good results.

Serfontein said earlier this week he had nad to go through numerous channels each time he wanted to perform a transplant and virtually had to beg to do his job.

He claimed his operating staff were willng to assist for free in heart transplant operations. — Sapa

Devote time to primary health, doctors urged

PRISCILLA SINGH
Staff Reporter

DOCTORS must devote more time and energy to rural health clinics, instead of looking after their own back pockets, says Get Ahead Foundation chairman Nthato Motlana.

Dr Motlana made the statement at the announcement of a R500 000 grant allocated by the Department of Health for the foundation's primary healthcare programme for the training of community workers across the country.

The first allocation of funds by the National Health Department to a non-government organisation (NGO) sees the provision of funding for the unique programme which focuses on training to provide community-owned, preventive and curative healthcare.

Dr Motlana said he was glad the work of NGOs was being recognised, "especially efforts in promoting healthcare in the rural areas".

"But it will be a tremendous blessing if general practitioners can devote their expertise to primary healthcare programmes.

"One of the problems, I think, is the lack of incentives. Another major concern is the large number of medical students from former homelands who study at universities in Johannesburg and Pretoria and don't return to their rural districts.

"We don't want to force them back, but they need to be encouraged to pump their resources back into the community and get involved in primary healthcare programmes," said Dr Motlana.

Nthato Motlana

He described how the current programme works: "Initially, a health co-ordinator from each area is trained by the foundation. This person is a qualified nurse, who in turn trains community health workers called nompilos (mothers of life).

"The programme trains the nompilos in the eight basic primary healthcare principles. To ensure their acceptability, these Nompilos are selected by members of their community," he said.

Each family pays a monthly subscription fee of R5, regardless of the number of members.

ARCT 15/7/95

Heart surgeon's defiance pays off

(85) ST 16/7/95

By CAS St LEGER

THE surgeon who defied a ban on heart transplants in Gauteng made a midnight phone call to the provincial health minister last week warning that a 22-year-old patient would die unless the minister gave the go-ahead to swop his heart and lungs.

Dr Fanus Serfontein told the minister, Amos Masondo, that he had Bradley Robinson on an operating table and a heart ready for transplant.

He said the Pretoria Technikon student would die if Mr Masondo did not give him permission for the operation to go ahead.

Yesterday a health official, Dr Eric Buch, said Mr Masondo had been forced to give his permission.

This week, the 32-year-old cardio-thoracic surgeon — regarded by colleagues as brilliant and a leader in his field — explained why he had defied the ban and still has four patients on his "most needy" waiting list.

A transplant cost less, he said, than it did to keep a patient in intensive care and on expensive drugs.

Since such operations were banned in January, Dr Serfontein has performed successful heart transplants at the H F Verwoerd hospital in Pretoria on three patients who had days to live without new hearts.

This week, while waiting to see if the ban would be continued, Dr Serfontein whittled his waiting list of needy patients down to four.

"How do you turn away a black woman who needs a new heart and hasn't the funds to travel to Groote Schuur hospital (in Cape Town)?" he asked.

"If politicians have a say in whether we can do heart transplants, where is it going to end?"

He has turned away 35 people needing new hearts this year.

Threats to fire Dr Serfontein for the latest operation fizzled out on Friday morning.

Instead, the Gauteng health department promised him it would decide in a matter of weeks whether his transplant programme could go ahead.

Dr Serfontein reasoned that the eight to 10 heart transplants he needs to do a year are "a drop in the ocean of the primary health care budget". In any case, he claimed, he and his team had performed the three operations free and had arranged private sponsorships to help pay other operation costs.

In private practice, the cost of a heart transplant totals about R100 000.

At Groote Schuur Hospital, where 40 heart transplants are performed every year, it costs between R20 000 and R30 000. The cost of drugs and aftercare the patient will need for the rest of his life adds about another 60 percent on top of this total.

But Dr Serfontein said heart transplants were cheaper and easier to perform than heart bypass operations.

Gauteng's superintendent general of health, Dr Ralph Mgijima, takes a sterner view.

He said that "all expensive treatments" faced budget cuts in favour of primary health care.

The health department was looking for ways to treat larger numbers of patients with the resources it had, he said.

Meanwhile, Dr Serfontein has withdrawn his threat this week to leave South Africa.

"If they decide not to allow us to continue, I'll carry on with our ordinary work," he said. "It would be a pity not to do heart transplants, though."

Heart surgeons said this week they were alarmed at the slide away from First World medicine.

Professor John Barlow, a Wits University cardiology specialist, said: "Even when the concern is with primary care, tertiary care has to continue. Otherwise, where do we end up?

"It is illogical not to do cardiac transplants occasionally."

Professor Ulrich von Oppel, who heads the country's leading unit at Groote Schuur Hospital, where Professor Chris Barnard performed the world's first successful heart transplant in 1967, is fighting budget cuts by raising funds privately in a national drive launched a couple of months ago.

The unit needs another R2-million to R4-million over and above its budget of R4-million, and could do with another R10-million or more to bump up its transplant rate to 100 hearts a year.

In addition to the operations, Groote Schuur cares for up to 150 patients for the rest of their lives after their transplants.

Professor von Oppel said it would take 20 to 30 years to see any improvement in primary health care and, in the meantime, any increase in primary care would result in greater pressures on tertiary care.

"No nation on earth can afford to have free health care for every patient up to transplant level."

A surgeon at Milpark hospital in Johannesburg who conducted the province's first successful private heart transplant in January supports H F Verwoerd hospital's attempts to remain in the heart transplant programme.

He said academic hospitals were already "very shabby".

"The slide has started," he said. "If you are going to stop heart transplants, then you might as well do away with all heart surgery. It is a drop in the ocean of the health care budget. Will they also stop cancer treatment and hip replacements? Where do you draw the line?"

A total of 54 heart transplants were performed on patients at Groote Schuur between December 1993 and May this year. Of these, four patients died within 30 days.

Another 13 transplants were performed at private and other provincial hospitals over the same period. Out of these, seven patients died within 30 days.

Gauteng faces cash dilemma over heart transplants — official

Kathryn Strachan (85)(88) BD 18/7/95

THE Gauteng health department faces a dilemma in using resources to provide essential basic services while maintaining expertise in academic hospitals, says department deputy director-general Eric Buch.

Buch said heart transplants could be introduced into Gauteng academic hospitals, but only in the context of a rational plan for tertiary care.

Following surgeon Fanus Serfontein's defiance of provincial policy, Buch said, a misconception had arisen that a moratorium was being placed on existing transplants. In fact, the province was only at the stage of considering starting transplants, and a moratorium, agreed to by medical schools and hospitals, was placed on the introduction of the procedure while the process was being costed and planned.

Buch said the department met deans of medical schools and heads of surgery in April to discuss the possibility of introducing organ transplants. As all the hospitals had the capacity to do transplants, it was jointly decided that the process would not be started until costs had been analysed and a plan formulated.

The department depended on the expert proposals of the institutions, as they were the only ones with the ability to determine the costs of the operation.

However, three months later only one hospital had submitted a draft proposal, and that was incomplete.

"If it was such a critical issue, why had they not got the plans in, or at least asked us for a meeting?" said Buch.

With a 25% cut in real terms in its expenditure this year, the Gauteng health department had difficult choices to make. "We need to look at deaths during childbirth and at children dying because there is no penicillin nearby," he said. "This will not collapse academic medicine — we just need to use the public's money wisely. We need to maintain the vibrancy and expertise of academic institutions without them bleeding the system to death."

The department was working with institutions to find a way of restructuring. They had discussed ways of making savings without jeopardising quality, for example by making space available for private paying patients.

The department was looking also to get bridging finance from the reconstruction and development programme, and to charge other provinces for services.

A financial analysis, which included areas where savings could be made and areas where extra investment was needed, would be submitted to Cabinet next week.

Meanwhile, Sapa reports heart transplant pioneer Chris Barnard defended the controversial heart-lung transplant at the HF Verwoerd Hospital in Pretoria.

Barnard said transplants were routine operations which could be performed by any competent team.

On the transplant moratorium in Gauteng hospitals and the censuring of Serfontein for performing the heart-lung transplant at HF Verwoerd, Barnard said it was best to do the operation in the same hospital where the donor was "because the organ is in a better condition".

Prof Del Khan, head of Groote Schuur's transplant unit, agreed it was cheaper to perform transplants than to treat patients awaiting transplants for long periods.

NP, DP slam health ruling

Business Day Reporter

GAUTENG's health department came under fire at the weekend for its "ham-handed" handling of the controversial heart-lung transplant performed by Dr Fanus Serfontein at Pretoria's HF Verwoerd Hospital a week ago.

Both the NP and DP criticised the department for placing a moratorium on "first-world" medical procedures in an effort to divert limited finances to primary health care.

Serfontein's "dismissal" following his flouting of the moratorium to save the life of a 22-year-old student was overturned last week, but officials declined to review their decision not to finance expensive procedures.

Fibre optics, PCs and satellites enter SA world of medicine

Hi-tech boon for primary health care

Star 17/7/98(85)

■ BY JANINE SIMON
MEDICAL CORRESPONDENT

Telediagnostics is a new concept in medicine and one which the developers believe can cut costs and revolutionise the standard of primary health care. It was launched in South Africa this month.

Telediagnostics uses fibre optics, PCs and satellites, or dedicated digital lines, to send high quality colour pictures of, for example, x-rays, slides of tissue samples, or skin lesions, from medical staff in one centre to another, hundreds, or even thousands, of kilometres away.

Transmission can take place in real time, or be stored to be sent in batches when communication lines are less jammed — stretching diagnosis time to a matter of days, at most.

The technology is backed by a multi-lingual medical thesaurus, and codes to ease the secretarial process of typing a diagnostic report and comments.

Savings

In practice, it could mean that a patient in a peripheral area will not have to travel to an urban centre to be diagnosed or referred for correct treatment. It also means that rural nurses and general practitioners have direct access to specialist information and continuing education.

Savings on, for example, time, transport, human resources, and incorrect treatment are enormous, says Dr Pierre Dusserre, medical director of French developer Resintel.

The body, which is funded, by among others, Harvard Medical School's Medical Science Partner Fund, says telediagnostics has been internationally proved to be a high-quality, complement to existing methods of diagnosis.

It was routinely used in Switzerland, Canada, the United States, Germany and Norway to connect peripheral areas to medical experts in the bigger centres, according to John Malherbe, director of the South African agent. Resintel was also active in Saudi Arabia, and would be in Syria and Morocco before the end of the year.

Malherbe said that there was no single cost of the system because it was modular, and could be scaled to the user's requirements.

Other advantages included that patient information was anonymous, and that data could be integrated into existing medical files.

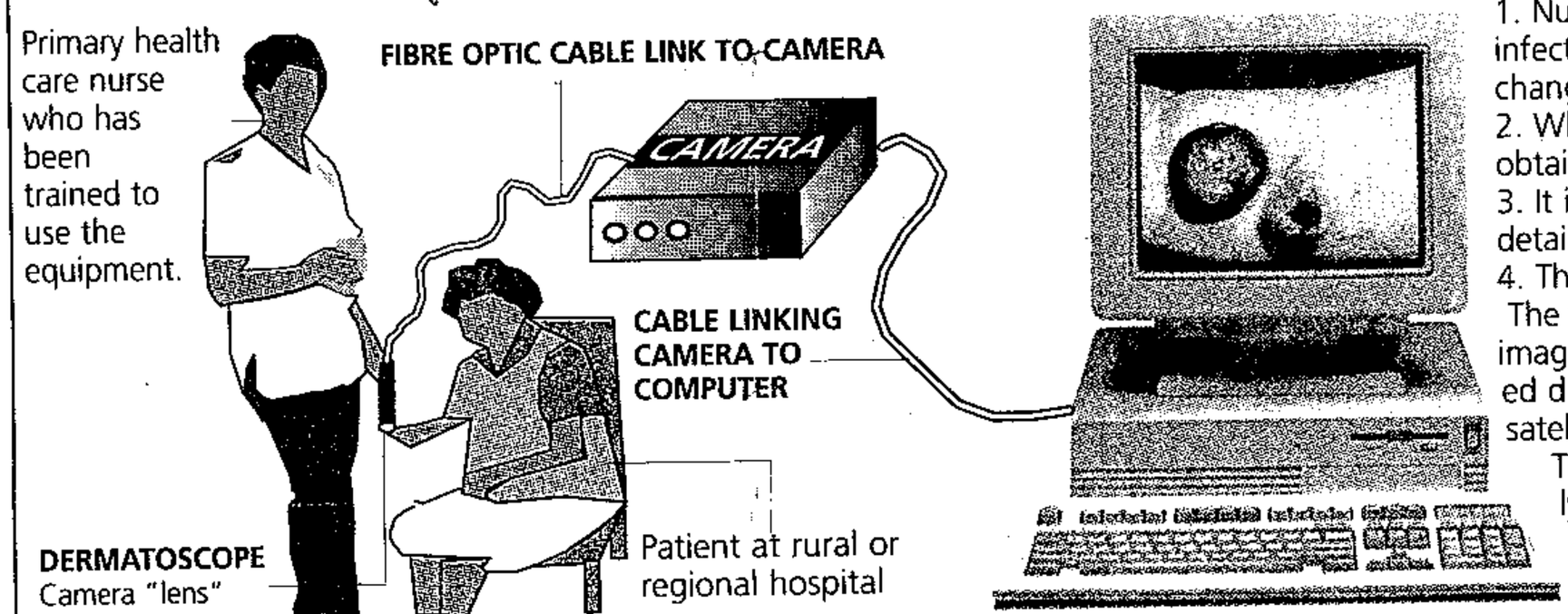
A mobile unit complete with electricity generator and satellite dish for on-line transmission was being developed, and a research agreement had been signed with a major American company to investigate setting up a satellite communication system, he added.

A consultant at Monitor Company, Dr Jonathan Broomberg, said the idea seemed to have great potential, but that cost, logistics, and skill level of users were issues which needed to be addressed in using telediagnostics in SA.

"A pilot project would be a good way to examine these issues", he said.

An example of diagnosis by computer for patients in rural areas

SENDER STATION: COULD BE AT RURAL OR REGIONAL HOSPITAL OR MOBILE UNIT



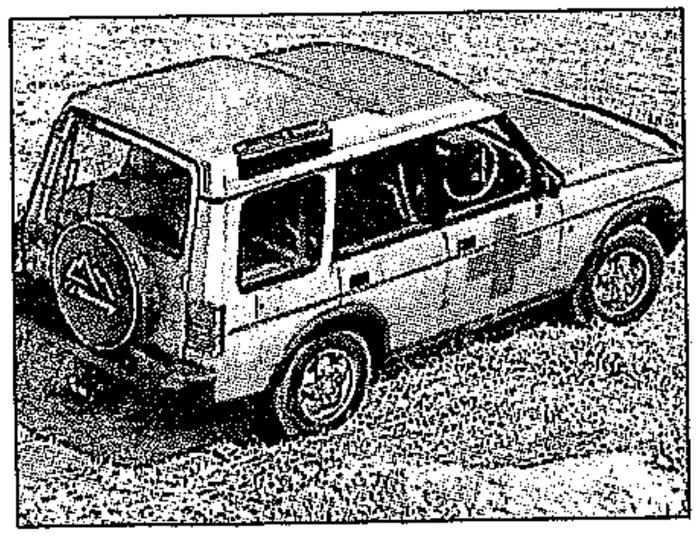
1. Nurse scans dermatoscope over infected area while viewing the changing image on the monitor.
2. When a satisfactory image is obtained it is frozen.
3. It is stored with the patient's details on the computer.
4. The image is compressed

The file containing details and image/s can be sent by a dedicated digital line or, in the future, by satellite.

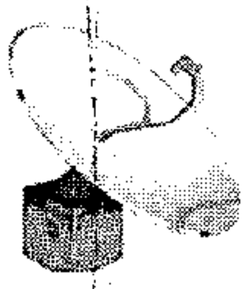
The file can be sent immediatly or overnight when the line is not so busy.

CUSTOM MOBILE UNIT

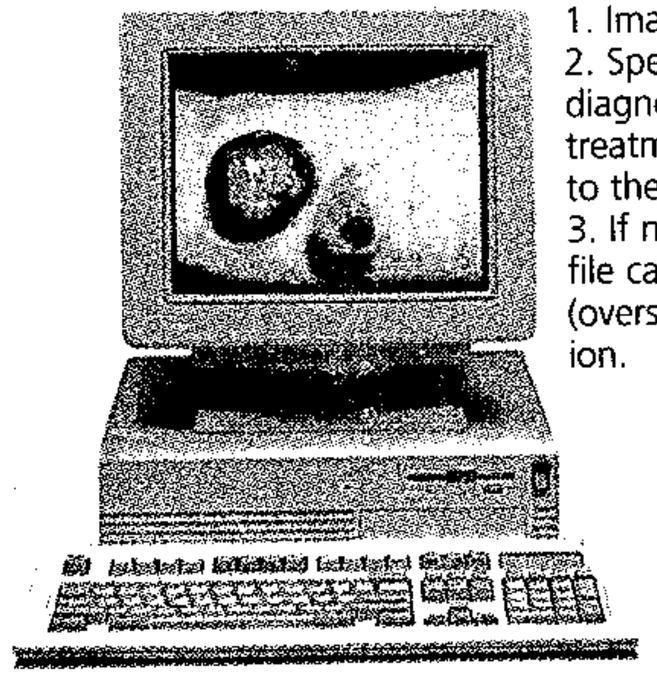
Option for patients at rural hospitals, clinics or communities.
Van equiped with diagnostic unit and generator.
Stores images for downloading overnight from sending station.



An option being researched: satellite dish on van for direct online sending.



MANAGEMENT STATION AT TERTIARY HOSPITAL



1. Image is decompressed.
2. Specialist sitting at the PC diagnoses problem and sends treatment proceedure back to to the sender station.
3. If necessary a copy of the file can be sent to a colleague (overseas) for a second opinion.

ADVANTAGES

- Improves quality of care
- Reduces cost of care
- Saves time
- Saves transport costs for patients /personnel
- Improves access to specialist knowledge
- Decreases incidents of incorrect treatment
- Allows GP's and young doctors access to continuing specialist education.

DISADVANTAGES

- Still has to be intergrated into medical practice
- Still has to be accepted by medical practice
- Skill levels of operators
- Logistics in SA conditions
- Affordability

Plan to increase fluoride content of domestic water

(85) Star 17/7/95

■ BY GLENDA DANIELS

Adjustment of the natural fluoride content of domestic water is on the cards in South Africa, according to specialists.

This is the cheapest way to ensure that a large number of people achieve the greatest protection against tooth decay, says Dr Gonda Perez, recently elected chairman of the Water Fluoridation Committee set up by Health Minister Dr Nkosazana Zuma.

Tooth decay is one of the most common health problems in the country, says Perez, who is also registrar of the department of community dentistry at the University of the Witwatersrand.

The committee hopes that systems to implement the new fluoridation policy will be in place by the end of the year.

Where water fluoridation is not possible, fluoride toothpaste will be made readily available to needy communities.

Besides being the cheapest way to protect against tooth decay, water fluoridation acts as a preventive measure which will reduce the disease burden in the country.

It is expected that within two years of enactment, tooth decay should be reduced by at least 50%, according to Perez.

She points out that the number of lost working days will be reduced and that lower-income groups, including women and children, will especially benefit from the policy.

Fluoride, in recent years, has also been used in the treatment of osteoporosis. This is of particular importance to women as they lose bone mass density as they get older.

▶ **See Trends – Page 9**

Faculty supports moratorium

Varsity sorry over transplant

Star 17/7/95

■ BY PAULA FRAY

UNIVERSITY says it regrets that a surgeon of its medical faculty did a heart transplant in defiance of provincial policy

The University of Pretoria (UP) has apologised for the heart transplant performed at the university's medical faculty at H F Verwoerd hospital and said the surgeon who performed the transplant had also apologised.

In a statement yesterday the university said it fully supported the Gauteng health department's moratorium on organ transplants.

While the UP "understood" transplant surgeon Dr Fanus Serfontein's desire to alleviate the suffering of patients, it regretted that he had not "abided by stated policies on heart transplants".

Serfontein started a furore when he transplanted a heart and lungs to a 22-year-old student last week in defiance of the moratorium.

The UP supports the moratorium on heart transplants as an interim measure, the statement said.

"The UP faculty of medicine will continue to support the Gauteng health department within the context of savings in tertiary care."

Meanwhile, the head of the transplant unit at Groote Schuur hospital in Cape Town, Professor Ulrich von Oppell, said SA did not yet perform enough heart transplants to justify two transplant units.

According to Von Oppell, Groote Schuur performs 36 transplants a year. In international terms, a country with a population of 40-million such as SA should perform about 100 heart transplants a year, he said in an interview with The Star.

"At the moment we are doing about 36 and are restricted by organ donors. Ideally, any transplant unit must do at least 25 transplants a year to maintain expertise and consistent results," he said.

The logical site for a second transplant unit would be Gauteng, but only when the number of transplants being done made this cost-effective, as the highest cost of transplants were in equipment and personnel.

"The most critical aspect of transplantation is that we must have a critical mass of equipment and diverse specialised personnel if we want to have a sustainable programme that gives optimal results. Studies in America have shown that the results of heart transplantation are poor in any unit that does less than nine transplants annually," he said.

"If the Government decides to fund a limited amount of transplants then these must be properly funded. With limited funds it does not make sense to divide these funds into two units."

Transplants, he added, were complex in that they required complex after-care services. International experience had shown that any unit starting up would have a high mortality rate.

Between December 1993 and May this year, 54 heart transplants had been performed at Groote Schuur. Of these, four patients died within 30 days. During the same period, 13 transplants were performed at private hospitals and other provincial hospitals. Seven patients died within 30 days.

"When we assess our transplant unit in terms of international standards, we are understaffed. But we are coping," he said.

Von Oppell has embarked on a private fund-raising drive "to sustain the unit for funding for equipment and personnel from alternative sources".

The unit needs another R2-million to R4-million above its budget of R4-million for ongoing care.

Sharing the primary health task

(85) Sowetan 18/7/95

For 150 000 people Hlatlolanang is bringing new hope in place of despair

By Joe Mdhlela

The Hlatlolanang project tries to encourage communities to protect themselves against disease by getting medical attention at clinics.

IF IT IS TRUE THAT FLOWERS AND BEES are dependent on each other for their existence, this should serve as a lesson that people can also work together to improve their lot.

This message of hope comes from Ms Rose Mazibuko, head of Hlatlolanang Community Primary Health Care project, which is based in Jane Furse, Northern Province.

The term Hlatlolanang is of Sesotho origin, and means "to share the burden". The project is funded from a R2 million donation by the United States-based Kaizer Family Foundation.

The situation is desperate in Jan Furse, a poverty-stricken area with a population of about 150 000 spread across 36 villages in the surrounding areas of Nebo and Sekhukhuneland.

Relief and hope

Through this project, staffed by 34 workers, Mazibuko has been able to bring some relief and hope to the lives of people who have lost hope.

Mazibuko, extending her analogy, states that black rural folk should resist being totally reliant on hand-outs, and should instead try to uplift themselves.

"There is this belief that blacks cannot do anything without the assistance of a white man," she says.

"That is not true. Black people are thinking people and should be challenged to produce food rather than watch the sun rise and set.

"This idea that *'setlhare sa motho ke lekgowa'*, the remedy of a black person is a white person, should be dispelled. We should all appreciate that blacks have brains to do things for themselves."

What is true, conceded Mazibuko, is that blacks have had no access to things that are essential to their own development.

Blurring the picture

This, therefore, tends to blur the picture and creates the impression that they depend for their livelihood on white people.

For example, people interviewed bemoaned the fact that the support they received from Operation Hunger "had dried out".

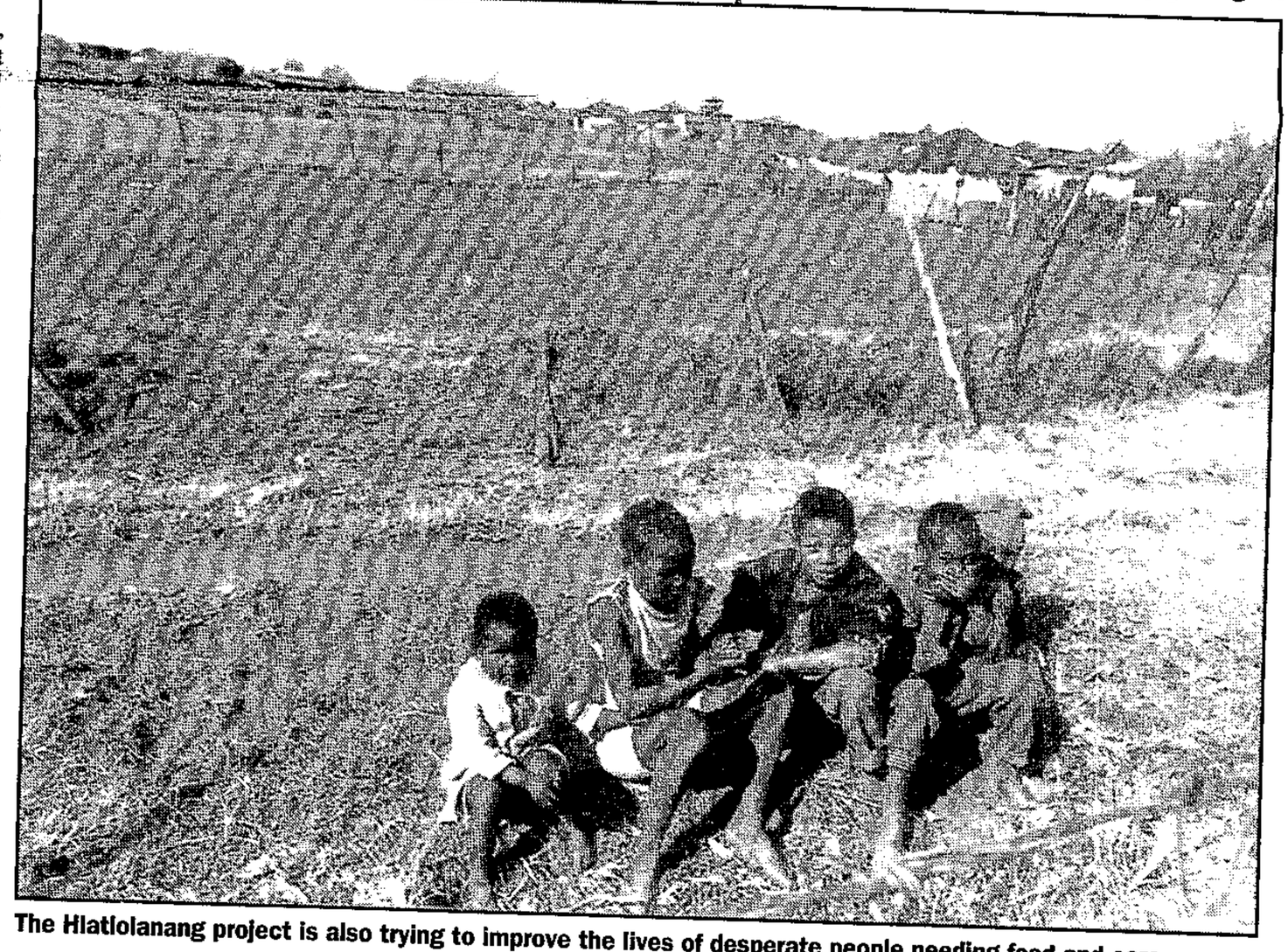
"We cannot do anything without the assistance of a white man," says a desperate elderly woman.

Mazibuko believes the medicine to cure the ills of the poverty-stricken society lies with that society and not "some white people".

"We need to work together, identify problems and then begin to tackle them with a lot of commitment,"she says.

The approach she adopts is to directly involve the communities, so that "you are able to restore dignity and respect to people".

Mazibuko argues that through people's involvement it is possible to increase their capacity to be more self-reliant, and therefore give them a stake in finding solutions to their problems.



The Hlatlolanang project is also trying to improve the lives of desperate people needing food and care.

Vegetable gardens are mushrooming and so are other income-generating projects.

Literacy programmes are becoming widespread too.

Simultaneously, the people of this area are encouraged to love nature and appreciate that it is a good thing to preserve the environment.

Due to deforestation and erosion, top soil valuable for planting seeds has been swept away, making it impossible for the community to live off the land.

The community is encouraged to engage in a tree-planting venture by the project, which has seen over 1 000 trees planted in the area.

At face value, the project gives the impression that its main thrust is health. The truth is that the project addresses all facets of life.

Mazibuko's simple philosophy is that in order to improve the quality of life, it is essential to deal with socio-economic problems as well.

"In so doing your approach becomes integrated and you are able to have a wide perspective on issues," says Mazibuko.

Because of an integrated approach, the projec. has reached out to all the people of Jane Furse, including the older citizens who had given up hope that their problems would ever be solved.

"Because of this interaction, older women of this area feel rejuvenated. They feel good that they too can work and produce goods for themselves, and therefore contribute to the good of the community," Mazibuko says.

Where does she get her inspiration from? She believes in things spiritual, in God.

"I have been influenced by my spiritual orientation and believe that I am supported by God in my work," she says.

Mazibuko is generally happy with the way things are going, even though she is quite mindful there is still a long way to go before an ideal situation is attained.

Steeped in superstition

A major problem in the region, concedes Mazibuko, is to try to introduce aspects of the modern world in an area steeped in tradition and superstition.

"Belief in witches and wizards and the casting of spells is still firmly entrenched.

"Families often hide sick and mentally ill relatives in the belief that they are cursed," she says.

Also, explains Mazibuko, it is considered a bad omen when a child dies at infancy.

"The child is often quietly buried in the yard, with the mother speaking to nobody about her personal tragedy," she says. "We need to build trust and encourage people to share this grief with others."

● For another view on this story, watch NNTV at 7.30 tonight.

Obasanjo jailed for life

LAGOS — Nigeria's former military ruler, General Olusegun Obasanjo, has received a life sentence from a secret tribunal for an alleged coup plot against the country's military government and his deputy has been sentenced to death, according to a weekend news report.

The *Lagos Press* said it received the information from relatives of Obasanjo and his former deputy, Major General Shehu Musa Yar'auda.

Both families have sent emissaries abroad to urge Western leaders to put pressure on the government of General Sani Abacha to free the men, the newspaper said.

"This is not a time for confrontation but a time to beg," it quoted an unnamed relative as saying. The secret military tribunal began on June 6, after the government alleged it had foiled an attempt to overthrow it.

The government announced on Friday that 40 of the 51 military and civilian suspects had been convicted, but it did not release their names, the charges for which they had been convicted, or their sentences. The sentences are believed to range from various prison terms to the death penalty. More than 115 people were executed by firing squad in connection with the last three coup plot trials in Nigeria.

Another Lagos newspaper, *This Day*, said on Sunday Yar'auda was one of 14 who received the death penalty. Chris Anyanwu, editor-in-chief of the weekly *Sunday Magazine*, received a life sentence, the newspaper said. — *Sapa-AP*.

Hostel men want peace

By Russel Molefe

SOWETO hostel dwellers yesterday extended an arm of friendship to local residents, assuring them there would be no attacks to avenge the killing of three Diepkloof Hostel dwellers at the weekend.

The three were killed when a group of Inkatha Freedom Party supporters returning from a "peace feast to cement ties between Soweto residents and hostel dwellers" was ambushed on Saturday.

The killings raised tension and fears that Soweto could slide back to the violence experienced in 1992-93 in which scores of people were killed.

National Hostel Residents' Association spokesman Mr Thulani Mlotswa said the killings called for leaders of all organisations to fight and expose criminals.

"An eye-for-an-eye approach would hamper any progress that South Africa has achieved so far. We won't be drawn into the battlefield by anti-progressive and ill-minded people who don't want to see blacks living together in peace," Mlotswa said.

Jo'burg's election dispute to end soon

JOHANNESBURG'S local government election demarcation dispute could be resolved before the end of the week, Provincial Affairs and Constitutional Development Minister Roelf Meyer said yesterday.

"People from Gauteng who recently consulted with the special electoral court are confident that Johannesburg will meet the November 1 (election) deadline," he told reporters at an international constitutional conference in Pretoria.

Target date

November 1 was still the target date for the local government elections. If demarcation problems in other areas could not be settled, Meyer said the special electoral court would probably be the only solution.

He emphasised that a decision on these issues was not up to central government. The proclamations prescribing local government election procedures were in the hands of provincial MECs.

Meyer and his deputy, Mr Valli Moosa, would meet provincial MECs on July 25 to evaluate the progress made in the election preparations.

"We have to draw up a balance sheet of the pros and cons and produce recommendations on which options will have the least possible negative effect," Meyer said.

State of flux

The recommendations would be submitted to Cabinet for discussion on July 26.

Those arguing for postponement of the election date were not taking all concerns into account, Meyer said.

Local government was in a state of flux with "the buck being passed when it comes to decision-making".

"People are also reluctant to take decisions on local government finance, especially if they know that such decisions will only be temporary," Meyer said. — *Sapa*.

In Angola, MK members and their Cuban comrades got together to commemorate the date," the ambassador said.

Heart experts meet in SA

Kathryn Strachan 85
00 1917 195

HEART experts from across the globe will meet in Johannesburg tomorrow to explore methods of bringing hi-tech First World medicine into a Third World setting.

Pinhas Sareli, head of Baragwanath's cardiology department, said his work was situated on the boundary between the First and Third Worlds, and the conference would explore cost-effective ways to bring the two together.

Arising out of the conference would be a task force which would test the workability and cost factors of the various options for dealing with heart disease in a Third World context.

Following the furore caused by Pretoria surgeon Fanus Serfontein last week when he broke provincial policy and carried out a heart and lung transplant on a 22-year old student, Sareli said there was a place for sophisticated heart surgery, but priorities needed to be made.

Milpark Hospital cardiologist Pro Obel said that even at the Boston Massachusetts General Hospital, heart-lung transplants were never done. Because of the shortage of donors, a patient could either have only a heart or one lung.

"Even at the most advanced hospital in the world priorities have to be made," he said.

"People have to be realistic about the problem."

SA had to balance out its problems with staff shortages in hospitals leading to children dying in queues while waiting for flu treatment on the one hand, and with R100 000 being spent on a single heart transplant on the other.

Doctors support ban on transplants

Sowetan 19/7/95 (85)

By Glenn McKenzie and *Sapa*

MOST doctors in underprivileged communities have thrown their support behind the Government's moratorium on organ transplants, a leading medical organisation said yesterday.

The South African Medical and Dental Practitioners Association, which represents about 1 000 doctors in poor communities, said the surgeon who performed an organ transplant last week was "irresponsible" if he was aware of Gauteng's moratorium on such operations.

Association spokesman Dr Kgosi Letlape said doctors should pursue their Hippocratic oaths (to heal people) by supporting good health care for all South Africans. Expensive operations came at the expense of thousands of poor people, he said.

"We have a shortage of penicillin in some medical centres. Penicillin can save lives and prevent expensive heart valve replacement operations. This should be a priority," said Letlape.

The comments come after Pretoria surgeon Dr Fanus Serfontein performed a heart and lung transplant on a 22-year-old student at the HF Verwoerd Hospital in Pretoria last week. The Gauteng government had earlier declared a moratorium on organ transplants in public hospitals.

"We cannot afford the health ministry to be undermined," said Dr Letlape.

'Establish health care priorities'

(85) CT 19/7/95

STAFF REPORTER

A NATIONAL health advisory committee must be established to decide which core services the health system should focus on, the Medical Association of South Africa said in a statement yesterday.

The proposal followed heated public debate over an unauthorised heart and lung transplant by Pretoria surgeon Dr Frans Serfontein.

The committee should include representatives from the community, health care professionals and other experts. An "explicit" priority list needed to be drawn up, taking into account quality, cost, affordability and fairness of treatment.

The provincial health department said yesterday it was expecting a priority directive from the ministry of health soon.

Move to end transplant dispute

Gauteng's health administration and the University of Pretoria said yesterday they had set up joint working groups in a bid to end a dispute over the ban on heart transplants.

A young surgeon at Pretoria's H F Verwoerd Hospital, Fanus Serfontein, was threatened with dismissal by the Gauteng Health Ministry last week for performing an operation on a 22-year-old student, despite the ban.

Colleagues supported Serfontein and warned of an increasing medical brain-drain from SA if surgeons were penalised for ethical treatment of patients.

The university's Joan Hettema said: "Talks have cleared the air between the parties. Funding of operations, the position of lecturers, the future handling of relatively expensive treatments and a strategic plan for the Pretoria academic health complex are some of the matters that will be dealt with."

The Gauteng administration's moratorium on transplants at provincial hospitals was set in place to allow for extra funds to be directed towards primary health care. — Reuter.

(98)(85) Star 20/7/95

Anti-polio vaccination campaign 'on target'

RESULTS from six provinces indicated that 82 percent of an estimated target of 3 742 244 young children were immunised against polio during the polio campaign last month, the Department of Health said.

In a statement in Pretoria the department said an "overwhelming response" was received from volunteers from a variety of professions to work at vaccination points during the first round of the campaign.

The second round is to take place from July 17 — 21 at clinics, hospitals, schools.

The department yesterday urged parents to take children under the age of five years for the second dose of polio vaccine. — Sapa.

ARG 20/7/95

Australians donate cash for research

Kathryn Strachan

(85) BD 21/7/95

THE Medical Research Council has for the first time received direct governmental funding from a foreign government.

The Australian government is investing R210 000 in a project to be carried out by the MRC in conjunction with the health department aimed at resolving a major health problem in SA — diarrhoeal disease and the resulting dehydration in babies.

Death caused by diarrhoea accounts for 27,7% of all deaths in children under five in SA. It is anticipated that during the summer months there will be up to 1,5-million cases reported. Rural areas experience the highest mortality rates.

The causes of gastroenteritis are connected to the availability of safe water and sanitation. Plans to address this will take time, and in the meantime efforts had to be made to improve the management of cases of dehydration caused by diarrhoeal disease.

The funding would be used to train primary health care workers in using two new devices which have been developed to treat diarrhoea.

One, an Australian innovation, is a balloon system which drips fluid back into children's stomachs through drips connected through their noses. This simple device replaces intravenous drips which depend on the availability of other equipment.

The second device, a "Manzi meter" was developed by the MRC and monitors the hydration levels in children by measuring the electrodes on their skin.

Northwest official denies corruption

Kevin O'Grady BD 21/7/95

NORTHWEST ANC safety and security MEC Satish Roopa yesterday denied allegations of corruption for using state funds to cover personal expenses.

Roopa said a letter to him from the SAPS head of finance in the province, Lt-Col J Wolmarans, confirmed he was innocent.

Roopa said he reserved his legal rights.

Newspapers named Roopa and media, arts and culture MEC Riana de Wet as two of four MECs under investigation as a result of an internal audit ordered by Premier Popo Molefe earlier this year.

The letter by Wolmarans said: "To the best of my knowledge, all the expenditure paid was official and personal expenditure was for own accounts."

Roopa said he had "in many instances" not claimed reimbursement after using his own money for government expenses.

"The manner in which highly confidential documents, still at a preliminary stage, are leaked to the media, suggests agenda setting by possible political opportunists attempting to derail the ruling party's chances in the ... local government elections," he said.

A spokesman for Molefe yesterday denied reports that he had given the MECs until Thursday to respond to the allegations, saying the premier was only in possession of an interim report and would be given the complete report next week. She declined to comment further.

De Wet, who was alleged to have chartered a private aircraft at the province's expense to attend a Joe Cocker concert at Sun City last year, could not be reached for comment yesterday. (Estate)

Groote Schuur 'can handle all the heart transplants'

BD 21/7/95 (85) (88)

PRETORIA — Cape Town's Groote Schuur Hospital could handle SA's heart transplants, and new facilities would be opened only when it reached capacity, Health Minister Nkosazana Zuma said yesterday.

She was reacting to the controversy over a recent heart transplant at Pretoria's HF Verwoerd Hospital.

"Groote Schuur Hospital has the capacity to handle heart transplants for the country and hence should be a supraregional centre.

"We do not condone duplication of super-specialities such as heart transplants in more than one hospital in SA," Zuma said.

She said it was crucial to rationalise heart transplants to promote excellence and remove duplication.

"Any decision to open new facilities for heart transplants will be taken once the existing facilities at Groote Schuur Hospital have reached maximum capacity in the face of a clearly identifiable need."

This decision would be taken by national and provincial health authorities and not by individual hospitals, Zuma said.

Three heart transplant operations had already been performed at HF Verwoerd Hospital this year.

These operations could have been accommodated at Groote Schuur Hospital where valuable expertise and excellent infrastructure had led to high patient survival rates, she said.

SA had no intention of declaring a moratorium on heart transplants, Zuma added. — Sapa.

Magistrates plan protest

PRETORIA — Pretoria magistrates said yesterday they had started "legal steps" to protest against their 5% pay rise.

"Magistrates believe the government has unfairly divided state funds, and that they should have received a raise of at least 20%, like MPs and judges," the magistrates said.

The group said they were also dissatisfied with working conditions, accommodation and transport.

They were "very angry about attempts by government officials" to find out who "ringleaders" were in the group refusing to accept the increase.

Magistrates in Durban had instructed a prominent advocate to take certain steps on their behalf, while their Johannesburg colleagues were making plans, they said. — Sapa.

Zuma calms row over transplants

SAON 21/7/95

■ BY JANINE SIMON
MEDICAL CORRESPONDENT

Health Minister Dr Nkosazana Zuma quelled part of the current heart transplant debate by announcing yesterday that Cape Town's Groote Schuur Hospital would be the only State institution to handle transplants for the country.

Her statement was in reaction to the controversy over recent heart transplants in Pretoria's H F Verwoerd Hospital, the first time a State hospital other than Groote Schuur had performed the procedure.

Zuma stressed that these operations could have been accommodated at Groote Schuur Hospital, where valuable expertise and excellent infrastructure had led to high patient survival rates.

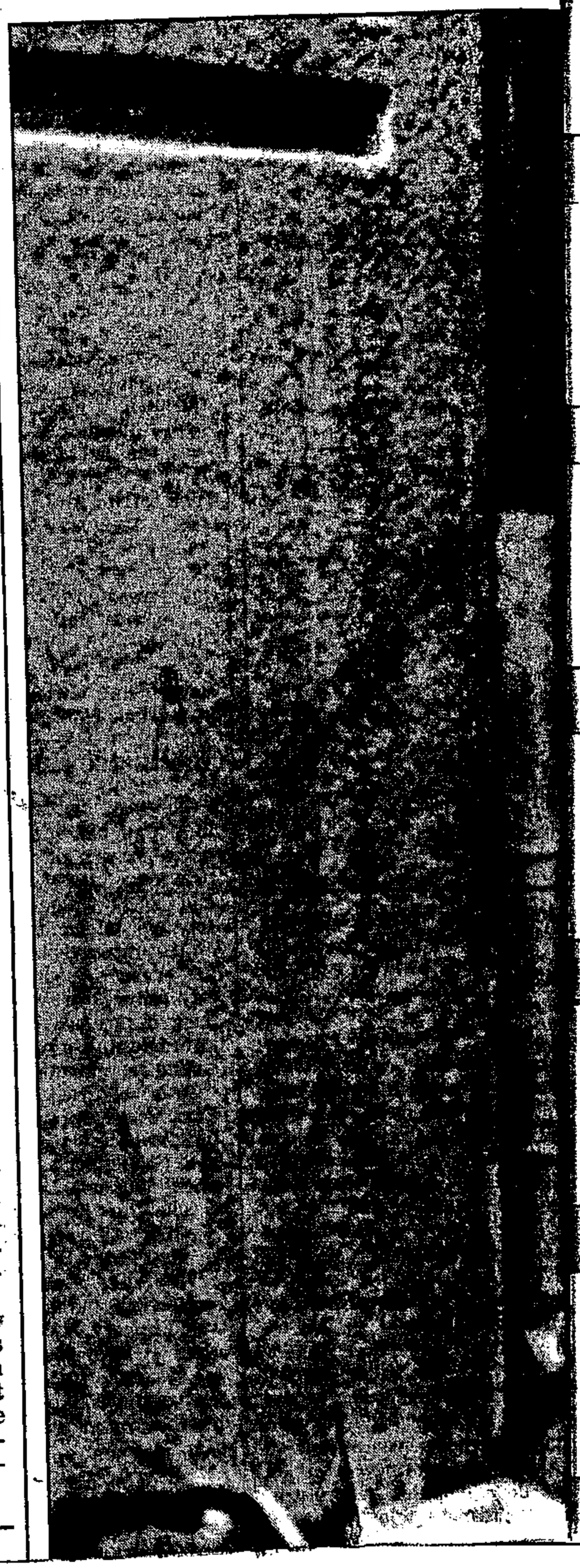
Groote Schuur should be a supra-regional centre as the Government could not condone the dupliction of super-specialities, she said.

She added that it was crucial to rationalise heart transplants in order to promote excellence.

Zuma did not address the question of funding for the cash-strapped Groote Schuur unit, whose subsidy dropped about 30% this year.

Nor did she make mention of the simmering row over whether private hospitals should be allowed to do heart transplants, given the critical shortage of organs.

"Any decision to open new facilities for heart transplants in South Africa will be taken once the existing facilities at Groote Schuur Hospital have reached their maximum capacity in the face of a clearly identifiable need," she said.



The agony before the transplant

WM 21-27/4/95 (85)

It's a slow and miserable death if you can't get a transplant, says **Jacques Magliolo**, whose life was saved by a 'new' kidney

FOR me, it had been bad luck – a car accident had crushed and finally ended all renal function. Living on a kidney machine for 12-hours a week is not an alternative to a transplant. Doctors had explained that these machines are merely a means to support life until an organ is found. Without organ transplantation, life on dialysis is unpleasant, painful and ultimately short.

Time is one factor organ sufferers do not have. After a period of time on a machine, your "healthy" organs begin to deteriorate to a point where – and there is simply no euphemistic way of saying it – you die slowly and excruciatingly.

The nurse comes around with tea and coffee and you are, at least during dialysis, able to enjoy a full cup. Without kidneys your system has no means of getting rid of liquid, so it enters the blood stream where it remains until dialysis removes it. Of course, there are problems which accompany this increase in fluid. Your heart has to expand to accommodate the additional liquid and so doctors restrict your total liquid intake to 500ml per day. Anything more and you could suffer more than mild chest pains, I was told by the renal surgeon.

Renal patients are on a strict diet, which precludes practically anything edible, but under all conditions excludes more than 500g of protein per day. In the nine months of dialysis my weight had dropped from 75kg to 50kg, my hair had fallen out in clumps, I had gone grey-yellowish in colour and literally smelled like rotting meat.

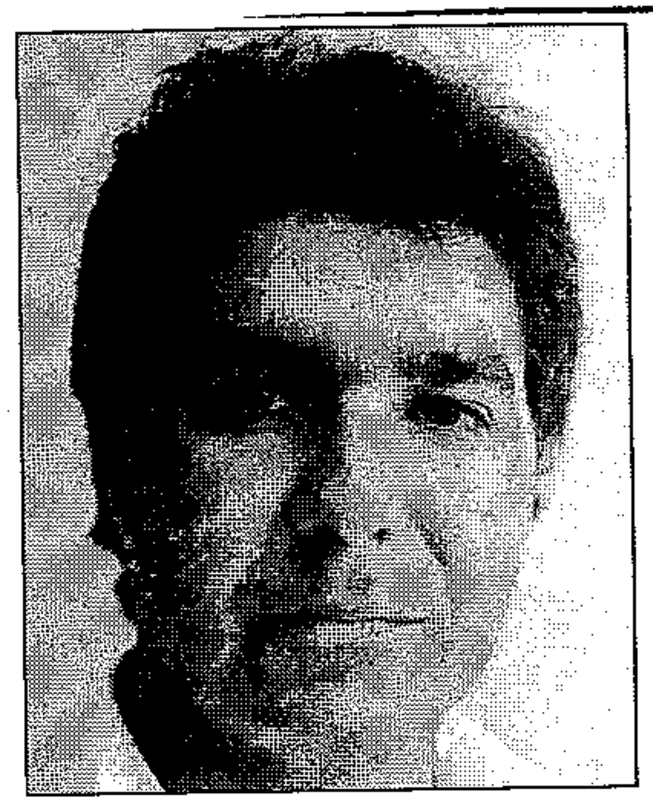
By the fourth hour of dialysis the machine begins to clear not only impurities out of the system, but also essential "salts" and liquids which should not be removed. These are supplemented back into your system manually through the machine. It isn't an exact science, and this is done by calculating your weight between sessions. In this manner the nurse is able to work out – more or less – how much excess liquids you have in your system, and estimate how much to return to your body.

If too much salt is returned, you vomit; if too little, you feel faint.

But I was lucky – my mother was unselfishly donating a kidney – so I didn't have to wait five years for an organ or face further physical deterioration. I was to have the transplant the next day, which meant that I was being given two pints of blood. This would increase my haemoglobin level and prepare me for transplantation.

Once dialysis had been completed, the nurse removed the needles and told me to wait a while before standing up. She then took my weight and helped me onto a wheelchair and pushed me to the transplant ward.

Within the hour the nurse had come into my room and filled in charts on my progress. When she left I picked up the board and looked for my createnine level, which is a means of determining the level of waste product in your system. Any person with normal kidneys should



Jacques Magliolo – a chance to live

a level of between 60 and 120. I forget what my creatine was prior to dialysis, but the level after being on the machine for four hours was still an unbelievable 1013.

In December it will be 10 years since my transplant. I intend to take my family to Cape Town on holiday and to finally climb Devil's Peak.

Foreigners seek free SA health care

(85) CT 21/7/95

OWN CORRESPONDENT

JOHANNESBURG: An estimated 10% of pregnant women and children under six presenting themselves for free health care at Johannesburg Hospital are not South Africans, a hospital spokesman said yesterday.

"Not a day goes by without a foreign patient attempting to get into this hospital," the spokesman said.

Foreigners were nearly always among the 20-odd pregnant women the hospital was forced to turn away from its gynaecology out-patient department because of the lack of facilities.

If they were identified, and could be accommodated, they were asked to put up the cost of the treatment they were going to receive.

This was significantly more than a local would have to pay.

If those who identified themselves as foreigners had to be admitted to the hospital they were referred to their embassies to work out who would pay.

Embassies

Children admitted for treatment were usually seriously ill and their embassies had to make arrangements with the Department of Home Affairs.

A Baragwanath Hospital spokesman said only one percent of patients admitted were from outside South Africa.

A spokesman for Baragwanath's Soweto Community Health Centre, which runs 13 polyclinics in Soweto and the Vaal, said they believed only local residents had benefited from the free services.

Gauteng's head of health Dr Ralph Mgijima said treatment was available for everybody irrespective of race or origin. Hospital staff did not have screening facilities. "We treat people because they are ill, we don't discriminate," he said.

Dr Mohammed Jeenah, chief director of health information services at the Department of Health, said a national health information service was being planned which would mean all details of patients would be known.

His department was evaluating the free health care policy.

MAIL & GUARDIAN
July 21 to 27 1995

The row over high-tech health

WM 21-27/7/95 (85)

South Africa may have to forego its high-tech medical achievements in order to meet the needs of its many citizens. **Rehana Rossouw** reports

HAVE a heart, says the head of Groote Schuur Hospital's transplant unit, Dr Del Khan, to health authorities who are considering clamping down on high-tech surgery across the country.

"Most people might think that a heart transplant costs a hell of a lot, but it's probably cheaper than treating a child with burns or a patient with TB," said Khan, who supervises 36 transplant operations a year.

"I am not disputing that primary care was severely neglected in the past, but the situation can't be improved by taking money and resources away from tertiary care."

Khan's appeal for the continued funding of tertiary medicine at state hospitals followed the furore sparked off by Dr Fanus Serfontein, who recently broke a moratorium on heart transplants by Guateng health authorities when he performed a successful heart and lung transplant on a 22-year-old student.

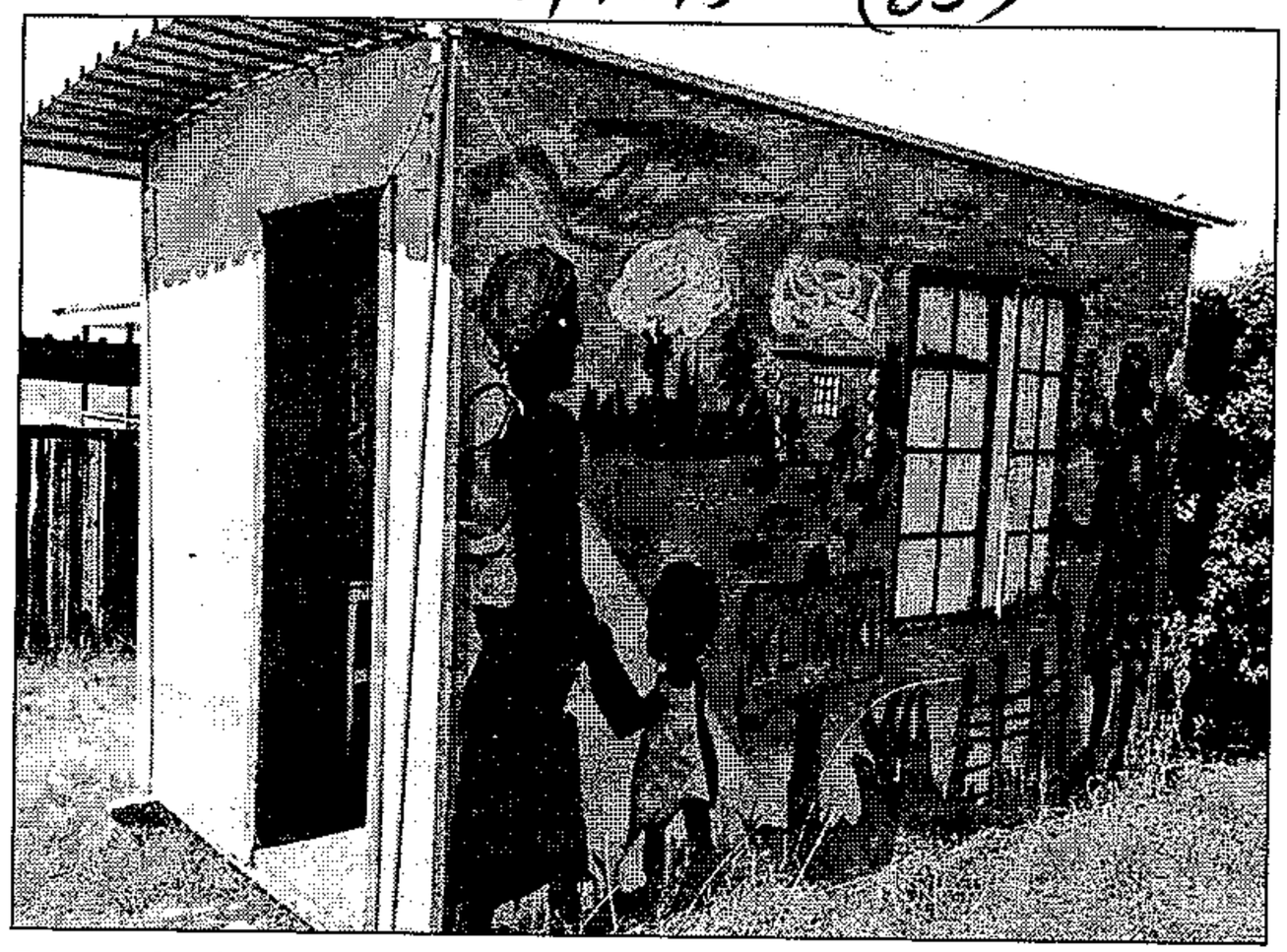
South African health authorities are battling to balance the tricky equation between its wealthier communities who suffer the highest incidence of cardio-vascular disease in the world, and its poorer communities where children still die of preventable and curable diseases.

Health Ministry representative Vincent Hlongwane said Minister Nkosazana Zuma was concerned about the high cost of tertiary care and would issue a directive soon on how much of it South Africa could afford.

"A lot of people still do not have access to the most basic levels of care, and the Ministry has to improve that situation. The aim is not to deliberately disadvantage any person requiring a transplant, but to improve the levels of primary care."

Surprisingly, if Zuma decides to curtail the amount of sophisticated surgery performed in South Africa, she will have the whole-hearted support of Rika de Ruiter, executive director of the Heart Foundation of Southern Africa.

"We should be spending more money and time on preventative programmes rather than transplants," said De Ruiter. "It makes absolute sense that the government spends more on primary health care."



Primary health: A top priority

"The reality is that more white people benefit from heart transplants than black people. South Africa is now this so-called rainbow nation and its health focus and budget should reflect rainbow needs."

This viewpoint is strongly contested by the Organ Donor Foundation. Foundation representative Gudrun Clark said transplants were not crippling the health budget as long-term chronic care was as expensive.

"To keep a person on dialysis could cost as much as R60 000 a year. It would make more sense to for the patient to have a kidney transplant which has become an almost routine procedure with an 80 percent success rate," Clark said.

She also disputed that the selection of patients for transplants was done on a racial basis, saying the country's organs were a national resource, despite the fact that most donors were white.

"There is a major problem at the moment with providing transplants for patients who live in shacks and are illiterate. For instance, a Transkei girl had a heart transplant and her family was unable to assist with post-operative care," Clark said.

"There was no-one at home to make sure that she took her medication every day to prevent rejection of the organ, and in the end the girl was transferred to a convalescent home where she will have to stay until she can take responsibility for herself.

"So the little girl was given a new lease of life after the transplant, but what kind of life is it, if she has to live in an institution for years?

"Politicians can't will medical equity into existence, they have to acknowledge that there are severe problems with medical aftercare in poorer communities."

Khan warned that unless South Africa's transplant programme was retained, the country will not only lose patients — and therefore their revenue — to foreign countries, but its medical staff as well.

"If doctors are not allowed to perform this type of surgery, there is a possibility they will emigrate to other countries and we will see a decline in the standard of medicine in South Africa," he said.

UN mission in the country."

reads through her notes.

Move to ease health-care crisis

ROGER FRIEDMAN
Staff Reporter

MEASURES to take health services to the most far-flung regions of the Western Cape, and simultaneously to reduce the strain on the Peninsula's shaky ambulance service, have been announced by Health Minister Ebrahim Rasool.

At the core of the plan is a move to decentralise health services from Cape Town, to reduce running costs and to improve accessibility.

The Western Cape is to be divided into 24 health districts, which will be served by a clinic for every 2 000 or so inhabitants, with access to "full secondary hospitals" — including 24-hour emergency and obstetrics services.

Mr Rasool expected the scheme would take three years to implement. Work had already started on upgrading the hospital in Ceres, he said.

The almost completed revamp of G F Jooste Hospital on the border of Manenberg and Guguletu would reduce the strain on health services in the Cape metropolitan area.

The hospital would have a specialised trauma facility and its own division of the ambulance service.

And the pilot container clinic scheme, which had operated next to the Guguletu police station since December, could be extended to other townships and informal housing areas.

The implications of all the innovations for the ambulance service were "enormous", Mr Rasool said.

It would ease the strain on personnel and vehicles and, ultimately, substantially improve ambulance response times.

G F Jooste Hospital would include a police office, attached to the Manenberg police station.

"We see this as a major innovation in health services in Cape Town," said Mr Rasool.

He said the clinic for minor ailments housed in a container outside the Guguletu police station gate had been enormously successful.

An ambulance routinely ferries more serious cases to hospital from the clinic.

Ambulance problems 'a boil' coming to head

BACKGROUND TO THE NEWS

ROGER FRIEDMAN, Staff Reporter

Ambulance response times continue to frustrate Western Cape residents. In historically privileged areas, the response time is around eight minutes for extreme emergencies; in other areas between 20 and 30 minutes. Delays of hours are not uncommon.

REGIONAL Health Minister Ebrahim Rasool describes the Cape Town ambulance service as a "boil" which has to be lanced before it can be effectively restructured.

He sees the recent labour strife, which led to the suspension of 38 ambulancemen and the ambulance chief, as a sign that the boil is coming to a head.

He does not want to start allocating money to address perceived problems with the service until he is confident that the money will not be spent in vain.

"We soon realised that before we could clean out the boil it had to burst," he said in an interview yesterday.

Not that the Western Cape is any worse off than other provinces, Mr Rasool stressed.

"Comparatively speaking, there are about five or six other provinces which would give an arm and a leg to have a service such as ours."

Nonetheless, Mr Rasool intends to vigorously tackle problems in the Western Cape — to make the service accessible to all residents, to improve ambulance response times, to improve vehicles and working conditions, to decentralise the service so that all roads do not necessarily lead to Cape Town.

What are the problems?

It depends on who you ask.

Mr Rasool appointed a task team to investigate the service and relies on its findings for his answers.

He believes the relationship between the province (as fiscal provider) and the Cape Town City Council (as service agent) needs to be re-examined, with the council accepting a share of the financial responsibility.

The ambulances are tired, too few, and in constant need of upgrading.

And the service has of late been afflicted by labour strife, work stoppages, and unease between management and workers.

A major problem affecting rural areas is the so-called "one-person crew" system in terms of which a solitary ambulanceman is on standby for 48-hour shifts. Should the ambulanceman have to ferry a patient to Cape Town, there is nobody to take his place.

Ambulance chief Rod Douglas was recently reinstated to his position by the Supreme Court after being suspended by the council following the April takeover of the control room by striking members of the South African Health and Public Service Workers' Union.

The 38 union members remain on suspension

Mr Douglas said it was his opinion that problems in the service were due to a general lack of resources; people and vehicles.

"What needs to happen is that the recommendations made by Mr Rasool's task team should be implemented. But political accountability decisions must be made."

Everyone has a right to a second chance at life, says transplant patient

(85) (69) ARG 22/7/95

ADELE BALETA
Staff Reporter

HEART-SWOP patient Julius Mzimande, who was prepared to be used as a "guinea pig" to be given a second chance to live, hopes lifesaving transplant operations will be offered at all South Africa's major centres in the future.

This follows this week's government announcement that heart transplants are to be confined to Groote Schuur Hospital.

But Mr Mzimande, chief radiographer at Durban's Mshinyeni Hospital, says the heart transplant performed on him at Groote Schuur in September last year saved not only him but his family.

"I support my mother, my unemployed brother's two sons, my sister — who has had a stroke — and her three young daughters. She has no one else to help her," he said.

"They look to me for help. I see that they have mealie pap at the end of the day. They would be starving if I had died. It would mean great suffering for them."

Fortunately, Mr Mzimande's three grown children, ranging in age from 27 to 31, are all employed and although they get "poor salaries" they can support their own families.

"I believe that heart-transplant operations should be available in Gauteng and KwaZulu-Natal. I spent a lot of money keeping body and soul together in Cape Town during the time I was there," he said.

Mr Mzimande's operation was performed on September 2. He spent 12 days in hospital and more than three months convalescing in the city.

"Cape Town is far from home and the accommodation was expensive for me."

Accompanied by his wife Nomusa, Mr Mzimande, 57, stayed with people in Gugulethu.

He had to pay for lodging as well as for groceries for himself, his wife and the owners of the house.

"It would have been easier and less expensive if I could have had the operation in Durban," he said.

Mr Mzimande began receiving treatment for cardiomyopathy — softening of the heart muscle — in 1987.

"In July 1994 I was told I would have to have a transplant and that I would have to travel to Cape Town as there was no other centre that could do it. I wanted the operation to be done immediately. I was short of breath and turning blue.

"My papers had been sent on to Cape Town but there were no beds at the time so I had to wait until I was called.

"I then wrote a personal letter to the professor of cardiology at Durban's Wentworth Hospital. I told him that I did not mind being used as a guinea pig if they could just do the operation there. I was in terrible pain.

"I never received a reply."

Aware of the urgency of his situation he left on a Cape Town-bound plane accompanied by his wife, without a referral letter.

"I was knocking on the grave's door by then. I got to see Dr Worthington. "I was going to die," he said.

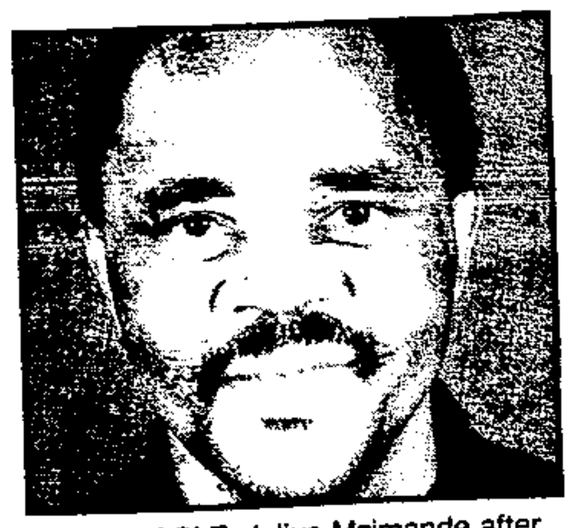
"When the doctors examined me they said: 'Your heart is hopeless. It's not pumping properly anymore. The only thing that can help you is a heart transplant'.

"I was admitted immediately. I felt great. I was also one of the lucky ones for after only two days a donor was found and I got my heart.

"I arrived back in Durban on January 2 and here I am at work performing my duty even better than before."

Describing himself as an ordinary man who does not like getting involved in politics, Mr Mzimande said there should "never" be a moratorium on transplants, no matter what organs they involve.

"As long as the service and expertise is available, everyone — rich or poor — has a right to the resource," he said.



MIRACLE: Julius Mzimande after a heart transplant at Groote Schuur Hospital. "Everything that has happened to me over the past year has been a miracle," he said.

Cape will remain the heart capital

(85)

ARG 22/7/95

ADELE BALETA
Staff Reporter

■ Groote Schuur Hospital which gained international fame after the world's first heart transplant will continue to be the heart centre of the country.

CAPE TOWN is to retain its status as the heart transplant capital of South Africa in terms of government policy announced this week.

And while Cape doctors were overjoyed with the news that the Groote Schuur Hospital's heart transplant unit is no longer under threat, they were quick to point out they hoped similar support would be given for centres in the rest of the country.

Head of Groote Schuur's unit Johan Brink said there was a lot of professional jealousy and he hoped the hospital would not be seen as getting preferential treatment.

"There could be a need for a centre in Gauteng, for example, where there is a bigger donor pool which we cannot logistically tap into. It's always better for patients to be treated nearer home."

Dr Brink said that in the past four years between 30 and 40 heart transplants had been performed at the unit. He belived there was a need for about 100 a year.

National Health Minister Nkosazana Zuma announced this week that Groote Schuur would remain the only heart transplant centre in the country and should be a supra-regional centre.

She added that new facilities would be opened in other parts of the country only when the unit had reached its capacity.

Her decision follows the controversial heart and lung transplant performed at Pretoria's H F Verwoerd Hospital while a moratorium on such procedures existed. Western Cape Health Minister Ebrahim Rasool confirmed that as a supra-regional activity, the money to fund operations at Groote Schuur would come from the national budget and not from the Western Cape budget.

Dr Brink said Dr Zuma's "rational decision" had given great relief".

"The Western Cape health budget is being cut from a current spending of R1,4 billion to R785 million in five years. Despite the support from our national and provincial health ministers, that sort of financial constraint would have meant the unit's services would have been seriously curtailed.

"Receiving more funds would give our understaffed unit a great boost," he said.

Dr Brink believes the controversial Pretoria operation had brought the issue of heart transplants to the fore.

"A spinoff of the furore has meant the recommendations we made during (former health minister) Rina Venter's administration on heart transplantation have been taken off the bottom shelf. Heart transplant operations can be seen as a low priority in terms of health care in general but now it has been addressed."

Dr Brink said it was not true that heart transplants could be done anywhere.

"There are other departments involved in transplant operations, including cardiology, pathology, pharmacology and immunology. Their expertise and experience of dealing with organ transplant cases and hundred of recipients is important in the process," he said.

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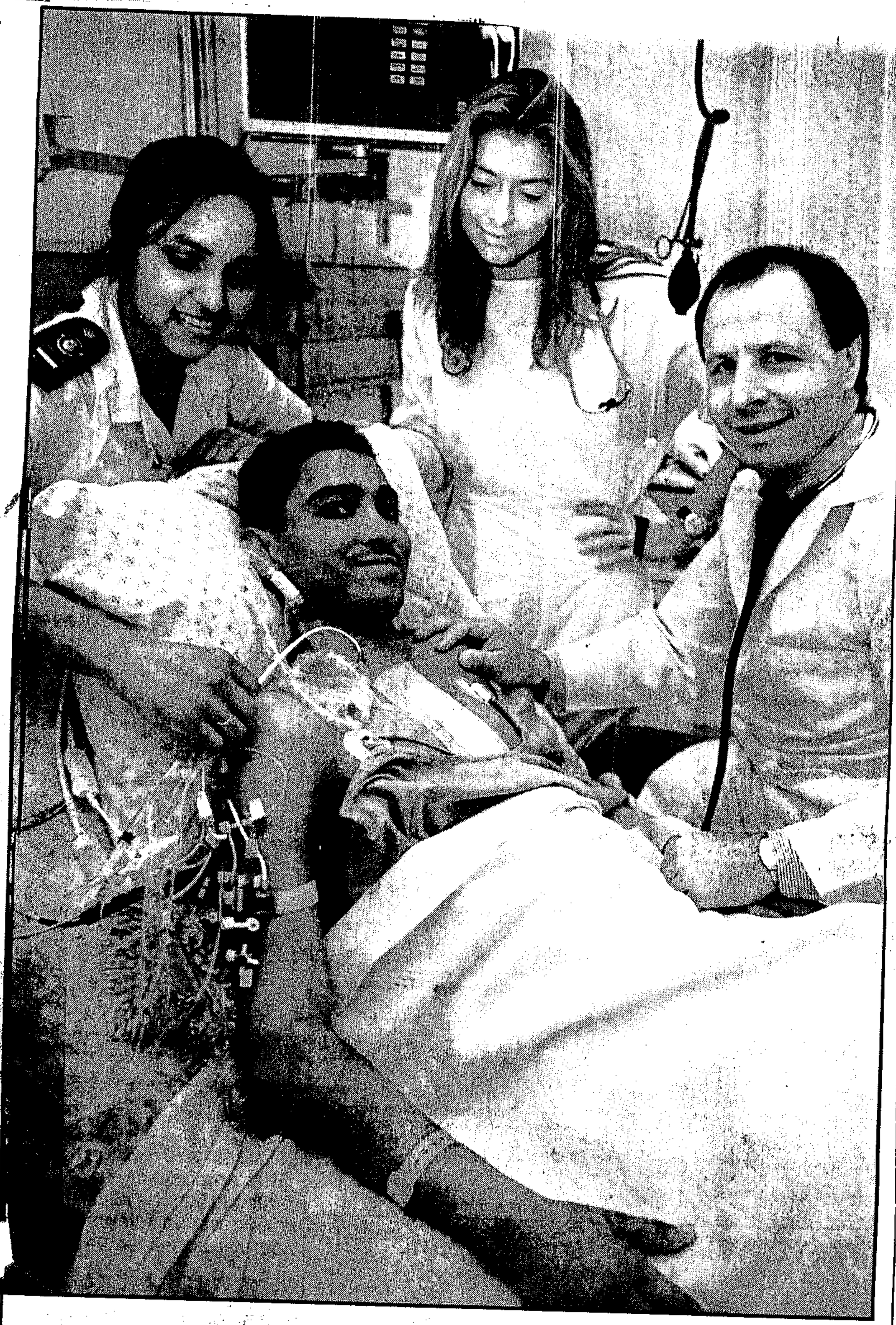


Picture: ROY WIGLEY, Staff Photographer.

☐ **NUMBER 369:** Dr Johan Brink, right, at the bedside of Johan Paulsen, 26, who three days ago was the 369 th patient to have a heart transplant at Groote Schuur Hospital. Sister Sandy Ramlall, left, and Dr Athele Westlake were part of the transplant team.

Experts divided over heart treatment policy

BD 24/7/95

Kathryn Strachan

ABOUT 50 heart experts, including 10 international specialists, failed at the weekend to reach agreement on how to approach the complex and expensive problem of heart disease and of bringing high-tech First World medicine into a Third World setting.

Dr Pinhas Sareli, Baragwanath Hospital cardiology chief, said the message from the talks was that it was not easy to resolve this problem on a professional medical level — and it was further complicated by cost and political decisions.

During four hours of heated debate it emerged that countries' approaches differed vastly, with constraints even in the US and Europe on how many heart transplants could be performed.

A local task group has been set up to find the most appropriate medical approach to heart rhythm disturbance. "The professional implications are very difficult, it won't be easy — but politicians can't write the cheque before they have the right medical information and the correct cost in front of them," said Sareli.

The rate of pacemakers implanted in needy SA people was very low, but this was because many people with heart-rhythm disturbance had not yet been reached.

The overall cost of procedures such as heart transplants and pacemakers could be outweighed by the small number of patients requiring the operation. It all had to be added up, he said.

Another theme that emerged in the debate was the cost of medicine.

While SA as a whole spent more on medicine than most other countries, the cost of medicine in the public sector was much lower than in other countries. This was because medicine prices in the public sector were subsidised by the high price of medicine in the private sector.

Pharmacy companies hardly covered their costs by supplying to state hospitals, but they continued with the practice so that doctors would learn about their products and prescribe them once they moved into private practice.

Sareli said Baragwanath patients often received better medication than that available to patients in private practice.

If local pharmaceutical companies dropped prices to the private sector, then public sector prices would go up. Any increase in the cost of medicine to the needy would be disastrous, said Sareli.

No soft hearts swop policy

(85) Star 24/7/95 (85) (486)

IT IS almost three decades since South Africa's audacious Chris Barnard stunned and mesmerised the world by performing the world's first heart transplant at Groote Schuur Hospital in Cape Town. Yet, as the uproar over an unauthorised transplant at Pretoria's HF Verwoerd Hospital emphasised, we are still without guidelines on transplant programmes, or the equitable use of donor organs. Medical Correspondent JANINE SIMON reports.

It's history ... Chris Barnard celebrates the first heart transplant with subsequent patient Dirk van Zyl.

The heart transplant "market" has changed dramatically since 1993, when Groote Schuur held sway as the country's only heart transplant unit.

To date, at least three private hospitals (of which two are in Gauteng) have conducted heart transplants. Pretoria's HF Verwoerd Hospital thrust itself into a controversial lead as the only other provincial hospital to have done the procedure.

That brief sprint ended on Friday when Health Minister Nkosazama Zuma announced that Cape Town's Groote Schuur Hospital would be South Africa's only supra-regional transplant centre.

The reason, she said, was that duplication of super speciality services could not be condoned.

HF Verwoerd, in fact, never had a transplant unit.

Only one transplant had been conducted there by April 19. This was the date on which Gauteng's health authorities and the province's three medical schools agreed to a moratorium on transplants.

They did so because all three academic complexes had the capacity to do the procedure, but were faced with budget overspends estimated to top R500-million by the end of the year.

Scarce organs

And they'd been asked to rationalise tertiary services and help extend primary care.

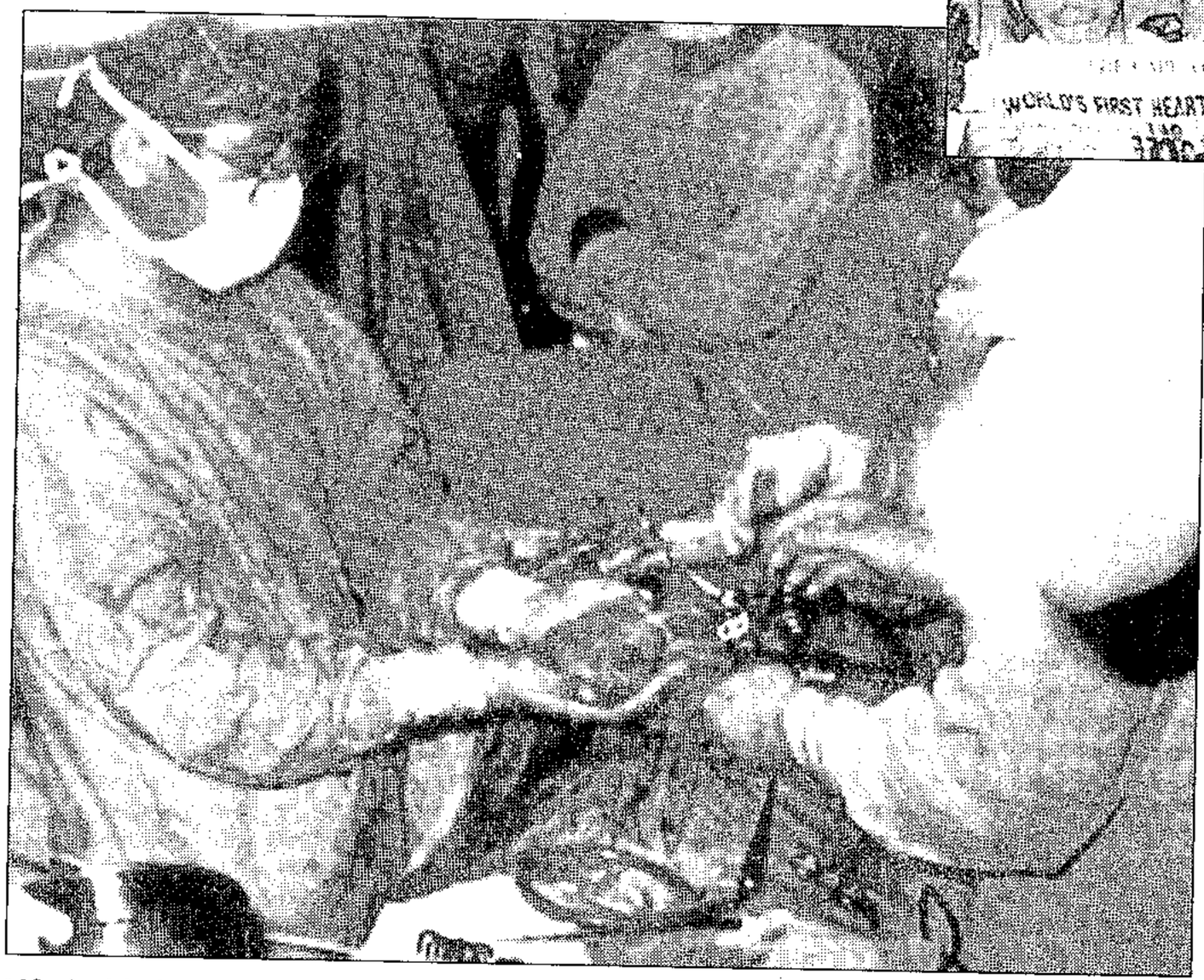
In reality, factors other than budget and surgical skill colour the heart transplant debate.

Today heart transplant surgery is a routine cost-effective treatment able, in pioneer surgeon Chris Barnard's words, "to be performed by any competent team".

What makes it problematic, say doctors and the SA Organ Donor Foundation, is that donor organs are so scarce barely half of the 50 to 100 people who should receive new hearts each year actually get them.

Director Gudrun Clark says donor awareness has increased over the last two years, enabling a record number of hearts to be transplanted in 1994.

"But donor organs are a national resource which should be equitably distributed, and we have no national protocol to do this," she argues.



Life in his hands ... a doctor holds a human heart during a transplant operation.

The second problem is that, hype aside, success of a transplant depends not on the skill of the surgeon, but, according to international studies, on the expertise of the personnel who provide the follow-up care.

Professor Ulrich von Oppell and Dr Johan Brink, who run Groote Schuur's unit, have compared South African success rates .

Groote Schuur's current 30-day mortality rate for the 120 transplants between October 1991 and April 1995 is five, its one-year survival rate 72.

These results are submitted to and conform with the norms of the International Registry for Heart Transplants.

But seven of the 13 patients transplanted outside Groote Schuur died within 30 days – a 54% hospital mortality rate, which is worse than the 47% recorded 27 years ago in 1968 by the string of transplant units opened worldwide to emulate Barnard's example.

These figures, the doctors argue, lend weight to their belief that a transplant unit should be a nationally funded resource benefiting the entire population.

Based on the American recommendaton of one heart transplant unit per 15 million people in different geographical areas, South Africa's 40 million plus population can easily support two heart transplant units.

Gauteng's obviously eager medical professionals and population weight would seem to make it a logical site for a second heart transplant unit.

Minister Zuma's proclamation settles for now the State hospital debate. But without a national organ transplantation policy, like those in place in other Western countries conducting transplants, decisions as to who obtains donor organs, and whether provincial or private hospitals do the procedure, remain **ad hoc**.

An advisory committee on transplantation was appointed in 1992 and reopened in 1994. Its recommendations are still on the table.

NEWS EAST RAND

Local health care boosted

R10 million for training of personnel in all aspects of medical care in Gauteng

By Dan Fuphe

THE Gauteng ministry of health has announced it will spend at least R10 million on the development and training of personnel in all aspects of health care in the province. Gauteng chief director of health service support Dr Bismilla Refik said the extensive programme would run for eight weeks and would start with an initial intake of 160 prospective trainees.

Announcement made

Refik made this announcement during a meeting with the staff of the Etwatwa Health Centre at weekend.

The director, who was appointed to his new position less than a month ago, said the province was working towards the integration of all health services in the region.

He said the move to merge the local and provincial services was at an advanced stage, despite the disparity in salary and working conditions at local health and provincial centres.

Full control

Refik told the staff that his office was not comfortable with the arrangement that allowed the superintendent of the Boksburg-Benoni Hospital full control of the centre's budget.

Demand records

He said until the arrangement was revoked, his office would regularly demand records of the centre's running costs from Boksburg-Benoni Hospital.

Transplant patient dies — doctor hides

CT 26/7/95

(85)

OWN CORRESPONDENT

PRETORIA: Controversial heart transplant specialist Dr Fanus Serfontein has gone into hiding after a transplant operation here was unsuccessful and the patient died.

Dr Serfontein refused to comment on the death of Mr Marius Swanepoel, 28, of Nylstroom, after he had received a new heart and lungs early yesterday at Pretoria Heart Hospital.

Attempts to trace Dr Serfontein last night failed.

The response from people close to the doctor was that it was unlikely he would comment on the operation or Mr Swanepoel's death.

But a second heart transplant operation — carried out using Mr Swanepoel's new heart to replace the faulty heart of a 42-year-old father of four children — was successful.

The second transplant operation was carried out at the Milpark Hospital in Johannesburg by Dr Francois Hitchcock, who trained under heart transplant pioneer Professor Chris Barnard.

Dr Serfontein was not involved in this operation.

Dr Serfontein collected the donor heart and lungs for Mr Swanepoel from Johannesburg General Hospital in the early hours of yesterday.

The double transplant of heart and lungs was carried out because it is apparently easier to do than a heart transplant alone.

After his death Mr Swanepoel's healthy heart was taken back to Johannesburg, where it was transplanted into a patient at Milpark Hospital.

Mr Swanepoel had been transferred from H F Verwoerd Hospital, a Gauteng provincial hospital, to a private hospital because of the moratorium on heart transplants in provincial hospitals.

Last night Dr Serfontein was apparently avoiding press interviews.

A person at his home said he did not think Dr Serfontein would take questions from the press.

Senior staff at Milpark said last night the patient at that hospital was in a stable condition.

In another development, the first patient on the Gauteng waiting list for a new heart, Ms Deborah Mathala, has arrived in Cape Town.

Here she will undergo the operation at Groote Schuur Hospital.

Dr Download – medical marvel

On-line diagnosis marks revolution in primary health care

(85)

ARG 26/7/95

The Argus Correspondent

TELEDIAGNOSTICS, a new concept in medicine launched in South Africa this month, is being touted by its developers as a concept to cut costs and revolutionise the standard of primary health care.

Telediagnostics uses fibre optics, PCs and satellites, or dedicated digital lines, to send high quality colour pictures of, for example, x-rays, slides of tissue samples, or skin lesions, from medical staff in one centre to another, hundreds, or even thousands, of kilometres away.

Transmission can take place in real time, or be stored to be sent in batches when communication lines are less jammed — stretching diagnosis time to a matter of days, at most.

The technology is backed by a multi-lingual medical thesaurus, and codes to ease the secretarial process of typing a diagnostic report and comments.

In practice, it could mean that a patient in a peripheral area will not have to travel to an urban centre to be diagnosed or referred for correct treatment. It also means that rural nurses and general practitioners have direct access to specialist information.

Savings on, for example, time, transport, human resources, and incorrect treatment are enormous, says Pierre Dusserre, medical director of French developer Resintel.

The body, which is funded by among others Harvard Medical School's Medical Science Partner Fund, says telediagnostics has proven worldwide to be a high-quality complement to existing methods of diagnosis.

It was routinely used in Switzerland, Canada, the United States, Germany and Norway to connect peripheral areas to medical experts in the bigger centres, according to John Malherbe, director of the South African agent.

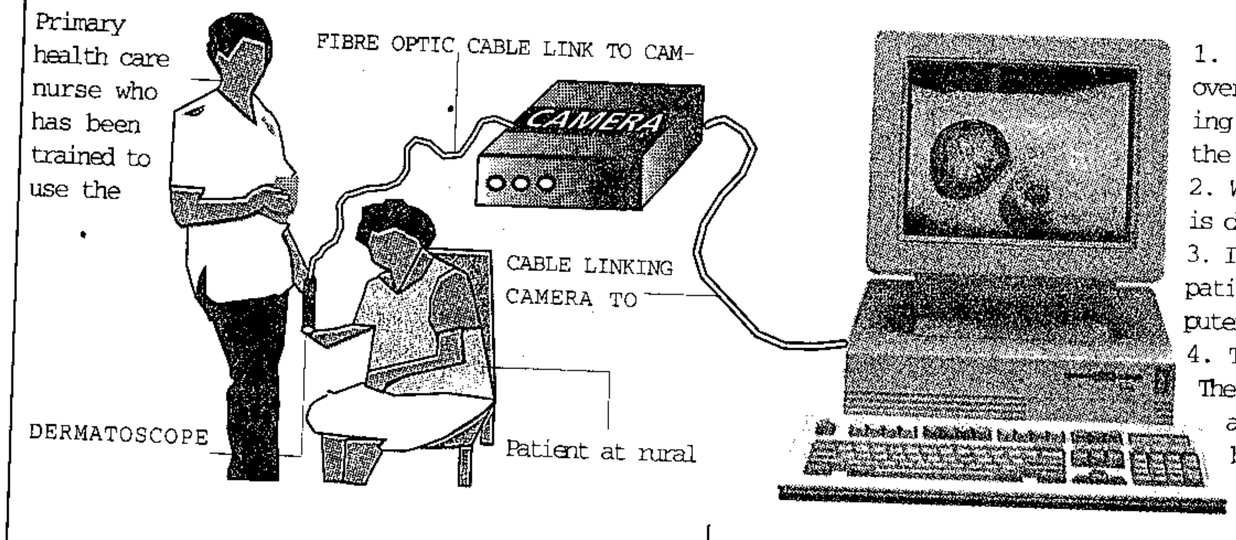
Resintel was also active in Saudi Arabia, and would be in Syria and Morocco before the end of the year.

Mr Malherbe said there was no single cost of the system because it was modular, and could be scaled to the user's requirements.

Other advantages included that patient information was anonymous, and that data could be integrated into existing medical files.

A mobile unit complete with electricity generator and satellite dish for on-line transmission was being developed, and a research agreement had been signed with a major American company to investigate setting up a satellite communication system, he added.

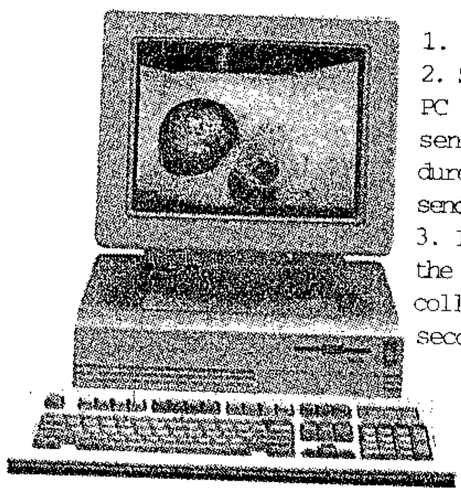
A consultant at Monitor Company, Jonathan Broomberg, said the idea seemed to have great potential, but that cost, logistics, and skill levels of users were issues which needed to be addressed in using telediagnostics in South Africa.



1. Nurse scans dermascope over infected area while viewing the changing image on the monitor.
2. When a satisfactory image is obtained it is frozen.
3. It is stored with the patient's details on the computer.
4. The image is compressed The file containing details and image/s can be sent by a dedicated digital line or, in the future, by

Option for patients at rural hospitals, clinics or communities.
Van equiped with diagnostic unit and generator.

Stores images for downloading over night from sending station.
An option



1. Image is decompressed.
2. Specialist sitting at the PC diagnoses problem and sends treatment procee-dure back to to the sender station.
3. If necessary a copy of the file can be sent to a colleague (overseas) for a second opinion.

- Improves quality of care
- Reduces cost of care
- Saves time
- Saves transport costs for patients /personnel
- Improves access to specialist knowledge
- Decreases incidents of incorrect treatment
- Allows GP's and young doctors access to continuing specialist education.
- Still has to be inter-grated into medical practice
- Still has to be

No easy walk to health

Glenn McKenzie interviewed Dr Kgosi Letlape, a spokesman for the South African Medical and Dental Practitioners Association, and heard some very interesting comments on health policy.

(85) Sowetan 27/7/95

DR KGOSI LETLAPE has an unpopular message that he wishes the Government would deliver: South Africans in general, and Gauteng residents in particular, should not expect improvements in health care for at least five years.

Letlape, who is a spokesman for the largely black South African Medical and Dental Practitioners Association, believes the ANC's health policy gurus have their hands tied. They will not be able to achieve their grand plans — and they should say so.

"Gauteng health MEC Mr Amos Masondo and his team are forced to work with the same management staff that maintained the *status quo* during the days of apartheid. They cannot fire anyone and they cannot help our poor communities as they ought to," he says.

Sitting in his tastefully decorated Hillbrow office, Letlape appears to be an enigma — and unique — in South Africa.

He is one of only three black ophthalmologists (medical doctors who specialise in eye problems) in the entire country. And he believes in Cuban communist health policies ... and heavy private sector involvement in national health.

He is outspoken and independent. He openly criticises the ANC-led Government when he feels criticism is needed. Yet he is also full of praise.

He describes Minister of Health Dr Nkosasana Zuma as a "great woman", and says she is making the right decisions.

Still, he believes some Government officials are not being completely honest about the problems that they face in the health sector.

And the people who voted the ANC into power may soon begin to blame the party for injustices that were created during 40 years of apartheid, he warns. "I really believe that the Government is doing everything they can.

"But they should try to communicate their problems, and what is causing them, to the people," he says.

There are a few rays of hope, according to the doctor. The recent organ transplant controversy was a step in the right direction for the Gauteng government. Organ transplants are luxuries that the public cannot afford.

Letlape (and his 1 000-strong association of doctors) believe Dr Fanus Serfontein, the surgeon who broke the Government's moratorium earlier this month, acted irresponsibly if he was aware of the ban.

Doctors should do what they can to serve communities rather than individuals: "Serfontein should ask himself whether he is abiding by a selective oath to serve certain patients, or whether he is serving South Africa.

"We need taxpayers' money to put penicillin on the shelves of rural clinics. Expensive surgery is something the public cannot afford.

Dr Kgosi Letlape ... doctors must serve communities rather than individuals.
PIC: ELIZABETH SEJAKE

"If we do the right thing, we can prevent cardiac problems in children and save lives."

Letlape's support for Government plans is more than just lip service. He believes health planners were on the right track when they engaged controversial Australian Dr John Deeble to create a universal health system for South Africa.

He predicts that Deeble's plan, which was widely panned in the media and by local medical experts, will make a comeback. South Africa deserves a system based on doctor-based care.

"Some are saying we cannot afford it. But we are the richest country in Africa. And if Cuba can do it, why can't we learn from them?" he says.

Deeble's plan is based on the idea that if the Government pays doctors (both public and private) to serve a certain population group, then doctors will be attracted to the rural areas. And they will also work in the townships.

"As long as you have a public and a private system, you will always have apartheid. We need private providers to serve the nation. If some want to continue serving their prestigious clientele in the northern suburbs, then they can," says Letlape.

"I personally feel that with all the crime in Jo'burg, I would gladly go to these rural places, if the Government makes it economically possible."

Letlape hopes the Government will put up a strong fight against special interest groups that try to maintain the *status quo* (read: apartheid).

The pharmaceutical industry and the Medical Association of South Africa are two powerful instruments that stand between the good intentions of the Government and its ability to deliver.

"Deeble's plan hurts the pharmaceutical industry by cutting the price of medication by 50 percent. Deeble also affects doctors who are worried about losing their elite practices," says Letlape.

"But if you drop Deeble, then you won't serve the communities and the nation properly."

Waiting for a new heart

ET 27/9/95 (95)

STAFF REPORTER

THE first patient awaiting a heart transplant to be transferred to Groote Schuur from Pretoria after last week's government moratorium on state-funded cardiac transplants in Gauteng, arrived at Cape Town airport yesterday.

Mrs Deborah Mathala, a domestic worker, walked off the aircraft looking reasonably fit but said she was "feeling sick" and a bit nervous about her forthcoming operation.

Mrs Mathala said she had no idea when the transplant would take place.

She was met by two post-transplant patients, Mr Gerald Knight and Mrs Lucretia Gweva, with whom she will be sharing accommodation in Observatory until a donor heart becomes available.

Mr Knight said the Heart Foundation had paid for Mrs Mathala's air ticket.

Also there to meet her was the daughter of her employers, Mrs Bernice Bornman.

"I came to Cape Town for a wedding and tried to get on the same flight as Deborah, but I couldn't. I'm so glad to be with her," Mrs Bornman said.

PATIENT FROM GAUTENG : Mrs Deborah Mathala flew yesterday from Pretoria to Cape Town, where she hopes to undergo a heart transplant at Groote Schuur Hospital. Her employers' daughter, Mrs Bernice Bornman, met her at the airport. ***PICTURE: ANNE LAING***

A member of Groote Schuur's heart transplant team, Dr Mike Worthington, said Mrs Mathala would be assessed today.

"Medically, we know nothing about her at this stage. If she gets on to the transplant programme, she will probably have a three-month wait for a suitable donor," Dr Worthington said.

He said Groote Schuur had done 36 heart transplants last year, and could handle about 50 a year. He said about 40% of their patients had come from Gauteng even before the moratorium.

Australian funds for diarrhoea treatments

ARG 29/7/95 (85)

Health Reporter

THE Australian government has given R210 000 to the Medical Research Council for a project to train nurses at rural clinics in two methods of treating diarrhoeal disease and dehydration in babies.

Deaths from diarrhoea account for 27,7 percent of fatalities in children under five in South Africa. Causes of gastroenteritis are linked to the availability of safe water and sanitation, problems which will take some time to address.

The MRC project aims to improve the management of dehydration through two innovative devices.

The Infusofeed balloon system, an Australian invention, rehydrates babies with a nasogastric tube which drips fluid into the child's stomach. Tested in Lesotho, the method has been shown to reduce mortality. As the device does not constrain the child as an intravenous drip would, the baby can be carried and breastfed by the mother during the rehydration process.

The second device — the Manz meter, developed by the MRC's health technology research group — assesses dehydration and the process of rehydration in a safe and sensation-free procedure taking about 20 seconds.

The grant money will be used to train nurses to use these devices on site at six clinics. The nurses will then be responsible for gathering data to evaluate the effectiveness of the devices.

now Peoples Bank: AMANZIMTOTI; ATHLONE; BETHEL; BELLVILLE; BENONI; BETHLEHEM; BLOEMFONTEIN; BO
KEMPTON PARK; KIMBERLEY; KING WILLIAM'S TOWN; KLERKSDORP; KNYSNA; KUILS RIVER; KROONSTAD; KURUM
TGIETERSRUS; PORT ELIZABETH Main Street; PORT SHEPSTONE; POTCHEFSTROOM; ROODEPOORT; RUSTENBURG

Tax — panacea for medical schemes

(85) FM 28/7/95

Private-sector health care could soon cost medical scheme members more if government accepts the Broomberg/Shisana proposal to tax all medical scheme contributions — by employers — as part of the employee's taxable income.

But the short-term hardship such a move will have on the overtaxed scheme member could ultimately make the sector more cost-conscious, efficient and competitive as members think twice about spending their health rand.

Put simply, medical economists around the world argue that tax deductions have the effect of obscuring the true costs of health care. They claim this encourages overuse by patients, overcharging by providers and an absence of bargaining between funders and providers.

Certainly, there's a great deal of inequity under the present dispensation.

The committee argues correctly that making contributions a taxable fringe benefit for employees would be fair to the self-employed, part-time and contract workers, who receive no tax relief for their medical scheme contributions because, under the present Act, only employers qualify for the tax exemption. This reduces the price of high-cost packages disproportionately, encouraging inefficient use and allocation of medical resources.

Fringe benefit

Making employer-paid medical scheme contributions taxable as a fringe benefit by employees would still, however, uphold the principle that the employer's contribution remains a legitimate production cost.

It would also eliminate most of the tax avoidance schemes currently used by many employers and employees to manipulate the proportion of contributions being paid by each.

Says Presmed joint MD and Council for Medical Schemes member Rob Speedie: "Such a reform is certainly consistent with tax policy as it has developed in the last decade — to bring more fringe benefits into the tax net without affecting the employer's ability to treat the contribution as a legitimate business cost."

This was appreciated by the Melamet Commission of Inquiry into the funding of medical schemes that said treating contributions as a taxable fringe benefit for employees could be introduced instantaneously or phased in gradually over a period of years to dilute the shock effect and permit schemes to adjust gradually to the new fiscal arrangement.

The Melamet report claims: "A precedent is available in the phased-in withdrawal of tax privileges awarded to employer-provided housing subsidies in the Eighties. After a seven-year period, all subsidies were taxed in the hands of employees though they remained legitimate employer business expenses."

Wits economics professor Duncan Reekie — also a member of the Melamet Commission — believes the tax deduction for employer contributions must go as this effectively makes health care available at half-price. "It's the biggest single distortion in the market and creates a massive incentive to overspend.

"If it's dropped, employees and employers (pressed for benefits) will put pressure on schemes to keep costs down by improving administration, costs and benefits. Membership would drop initially but the schemes sector will emerge stronger and financially more independent."

Reekie . . . *biggest single distortion in the market*

Speedie doubts whether this would be practical since employers would simply transfer the money they pay for contributions to salaries and wages.

But imposing a fringe benefit tax only on employees will see a drop in after-tax income that could see medical scheme members take less medical aid cover, opt for less comprehensive high-care insurance products or end all medical cover. Employees could also put more pressure on employers to increase salaries.

Says Representative Association of Medical Schemes chairman Keith Hollis: "There could be particularly severe implications for the higher income earners since we don't know what the size of the rebate will be. We hope that final proposals will try to avoid a system that encourages members to buy fewer benefits and thus less cover. Such a scenario would deplete the common risk pool and place a greater burden on State resources."

But Speedie and Hollis agree that the reform could encourage employees to seek out managed health-care options — as yet largely unexplored in SA.

The Broomberg/Shisana Committee does propose some relief for contributions for basic care. The report states: "A number of criteria could be applied for setting the ceiling on tax-deductible contributions.

"For example, the cost of the core package under a mandatory coverage scenario (the committee proposes that all employees be covered for the cost of basic cover at State hospitals) or the amount spent by the State on individuals in the public sector. Alternatively, it could be linked to the level of income or set at a fixed percentage of total income."

Rising costs

The committee also proposes that the present tax relief that allows the deductibility, before tax, of the portion of medical expenses that exceeds 5% of income should be increased.

They say that this relief was intended for households hit by catastrophe. "Rapid escalations in costs of medical care in the private sector mean that this threshold may be too low and that many taxpayers are claiming for routine expenditure. Increasing the threshold would restore this arrangement to its original purpose."

Momentum Health MD Adrian Gore says such a proposal could cause inequity. "While medical costs have risen dramatically, real incomes have not. The test should focus on what is affordable or financially catastrophic rather than what is medically catastrophic."

But the long-term benefits of making medical scheme contributions a fringe benefit taxable in the hands of employees might be negated if government also imposes an additional levy on scheme members to fund the committee's proposed R9bn, five-year, primary health-care fund.

Says Speedie: "A small levy today might well become a big levy tomorrow. And a better option would be a payroll tax — with a broader base — or general taxation." It's an issue the committee has left to the Cabinet and the Department of Finance to decide.

Utilising resources for better health care

(85) Star 31/7/95

The DP in its recently released 'Green Paper' puts the emphasis on primary health care but not at the expense of standards of excellence, writes ***Jack Bloom***

In an effort to stimulate debate on the health crisis in South Africa's richest province, the Democratic Party has released a "Green Paper" on health care in Gauteng.

This document is the outcome of extensive personal interviews and visits to Gauteng health institutions, and seeks to put forward innovative and workable solutions utilising available resources.

A shift of emphasis towards primary health care (PHC) is endorsed, but not at the expense of standards of excellence in the academic hospitals which should filter through to uplift the entire health system.

There is a need to build on existing institutions rather than any centrally dictated theoretical plan.

Mass clinic building exercises and centrally directed PHC training programmes run the strong risk of wasting resources better spent in a more flexible manner attuned to local conditions as determined by genuine bottom-up planning.

Plans for up to 24 health districts in Gauteng are premature and in severe danger of setting up new bureaucracies which absorb scarce resources better spent directly on services.

These districts should be based largely on local authorities, with a strong recognition that the major preventive health achievement lies in the effective provision of adequate shelter, electricity, clean water and sanitation.

A flexible, team-based approach to PHC is advocated which recognises and extends the pivotal role of the family general practitioner (GP) as the intermediary between community health workers and specialists.

This is in line with a recent re-evaluation by the World Health Organisation which endorses the role of family doctors in the provision of good quality primary care, controlling costs by reducing unnecessary and untimely use of specialist services.

Local studies have also shown that effective use of generalist physicians is less costly than a nurse-based system of primary care, challenging the perspective of the Broomberg/Shisana Committee of Enquiry which envisages a massive training programme to fill an estimated need for 9 766 PHC nurses.

As opposed to the hesitant Government approach towards delegation of autonomy to public hospitals and an expanded role for the private health sector, the DP seeks to eliminate in efficiencies and wastage by exploiting to the full the range of new relationships opened by a separation of the policy makers, purchasers and providers in both the public and private sectors.

Private GP practices, occupational health clinics, pharmacists and under-utilised mine hospitals could all be contracted to participate more fully in PHC provision.

Effective utilisation of public sector resources would include the sub-letting of empty wards such as those at Johannesburg Hospital and round-the-clock utilisation of facilities such as operating theatres and specialised equipment.

An under-utilised hospital such as Andrew McColm could be sold to the private sector, whilst private contractual arrangements should include laundry, catering and cleaning services which are plagued by inefficiency and labour problems.

Competitive markets need to be created in the health care sector, so that individuals are served by suppliers who compete vigorously to meet their needs.

An innovative market-oriented solution to the problem of under-served areas is that of Medical Entrerprise Zones (MEZs) deregulating restrictive practices so as to attract medical care to a designated underserviced area.

The role of the community health worker, the nurse and various paramedics will be expanded in such areas including greater discretion for prescription of medicines by pharmacists.

Those who argue for a massive transfer of resources from the private health sector to uplift the poor point to the estimate that 61% of health expenditure is accounted for by the private sector, of benefit to only 23% of the population.

This substantially under-estimates cash payments and assistance to the poor in the private sector, and ignores the work of non-governmental organisations, tax payments by private health providers and a cross-subsidy of medicines in the public sector.

Assistance to the poor should be as direct as possible, with least distortion of the market mechanism and low administration costs, ideally by means of vouchers or smart cards.

The DP believes that the State should be the provider of last resort, its role diminishing as a growing economy with proper incentives enables more individuals to provide for their own health care.

■ Copies of the DP Green Paper are available from DP offices.

Jack Bloom, MPL, is the Democratic Party Gauteng spokesman on health.

No permits, no service for blacks

By Glenn McKenzie

POOR black patients at Brandfort in the Free State are required to obtain "official slips" from the local magistrate before they can receive public health services, residents and health workers have told *Sowetan*.

A highly-placed health department official in Pretoria said patients needed court forms to obtain health services only when their identity or nationality was in question. Services should never be refused to people who did not have the forms.

Brandfort's district surgeon, Dr Gerrit van der Merwe, insisted that in cases of extreme emergency, patients were never turned away from his clinic. Public patients had required court forms to receive medical care since the government instituted the system in the 1980s, he added.

"As far as I understand it, the system is only there to prevent unnecessary cases from coming in. Fifty percent of the people who come in are not really sick," Van der Merwe said.

The controversy over "official slips" emerged following the death of a two-year-old girl on her mother's back while waiting for court permission to see a doctor in Brandfort.

The death, which occurred in April, has been linked to what a health department official called "obstructionist and racist" red tape in the town.

Mr Paul Alberts, employer of the child's father Mr Petrus Hokwana, and residents have accused local doctors of being racist. "In this town there are still two systems of health. One for whites, one for blacks," said Alberts.

Katrina Hokwana died of severe inflammation of the stomach and intestines while her mother Maria spent several hours trying to acquire a "slip" from the magistrate's court in the town.

Neither of the town's two doctors had turned the child away that day, but one doctor allegedly told the child's mother a week earlier never to come for medical service without the forms.

"They told me I must have money or a slip from the magistrate's court," said Maria Hokwana.

Another doctor in the town, who allegedly saw Katrina a week before she died, denied the visit took place.

"As far as I understand it, the system is only there to prevent unnecessary cases from coming in"

Sowetan 31/7/95

Primary health care is on track

Joe Mdhlela reports on an innovative health care system which travels to the people

(85) sowetan 1/8/95

Born in flagstaff, Pondoland, Mrs Lillian Cingo is the first South African woman to be entrusted with the task of managing a train.

Significantly, it is not an ordinary train she manages — it is "a train that gives hope to life", bringing hope to communities whose dreams of getting primary health care would otherwise remain a mirage.

Yet through the Transnet-conceived mobile health care train called Phelophepa, Cingo's effort of reaching out to the poorer communities is made possible.

This train-cum-clinic consists of five cubicles, an administration office, a medical unit, a pharmacy, an eye clinic, a dental and X-ray coach, a laundry and storage coach and four coaches to accommodate 47 people.

The project, a brainchild of Rand Afrikaans University's Professor Jannie Ferreira, was conceived in 1993.

Ferreira had always cherished a vision to provide rural South Africa with primary health care.

But the dream has grown into something big — a mobile centre that traverses the entire country in an effort to bring health and hope to rural inhabitants.

Although the project is targeting young folk, people of all ages benefit from the service.

The eye clinic is a popular unit. It has made it possible for patients to get spectacles at a nominal cost of R30. The normal price of these glasses could otherwise be in excess of R300.

The dental section consists of a consulting room and a special X-ray unit equipped to take X-ray photographs of the mouth.

In addition to this service, patients also receive educational guidance on how to care for their teeth.

The availability of the health care unit at one place is of short duration, usually no more than a week, so attempts are being made to train local health workers. Through a rigorous training programme, these workers are given skills to deal with basic health problems in their communities. The medical clinic is manned by a fulltime pharmacist.

Although the objective of the project is to assist rural people with their health care needs, it also gives final-year medical students an opportunity of relating to communities of diverse cultures.

Also, lecturers who accompany the students on the train get a chance to evaluate current primary health care trends in rural areas.

In so doing, lecturers are given a chance to adapt the medical syllabus to prevailing real-life circumstances.

Although Cingo is proud of the work the mobile clinic is doing, she is emphatic the primary objective "is not to treat the symptoms but rather to focus on preventative measures".

With regard to general health care, registered patients are examined without cost to themselves.

In addition, the centre provides free health education. It also gives free advice on family planning.

Cingo was elated by the fact that Transnet is making it possible for health care to be accessible and affordable to all citizens. "Utilising the Transnet infrastructure and expertise, Phelophepa is able to address the health needs of our people under one roof and thereby simplify matters for the patient," Cingo said. However, Cingo is adamant the services rendered by Phelophepa are merely supplementary.

"The services rendered on the train enhance existing health services to the community. They are not the final answer," she said. The main objective of the clinic was to provide screening and education. "We should inculcate in our people the spirit of wanting to take care of their own health." But who is this energetic woman making it possible for ordinary rural folk to enjoy the privilege of health care? After matriculating at the Kroonstad High School, Cingo trained as a nurse. She spent thirty years of her life in London, England, gaining professional training in medical and paramedical fields. She holds a postgraduate qualification in neurosurgical disciplines. She is also qualified in tropical medicine and holds a diploma in psychology, a certificate in counselling and a master's degree in psychology.

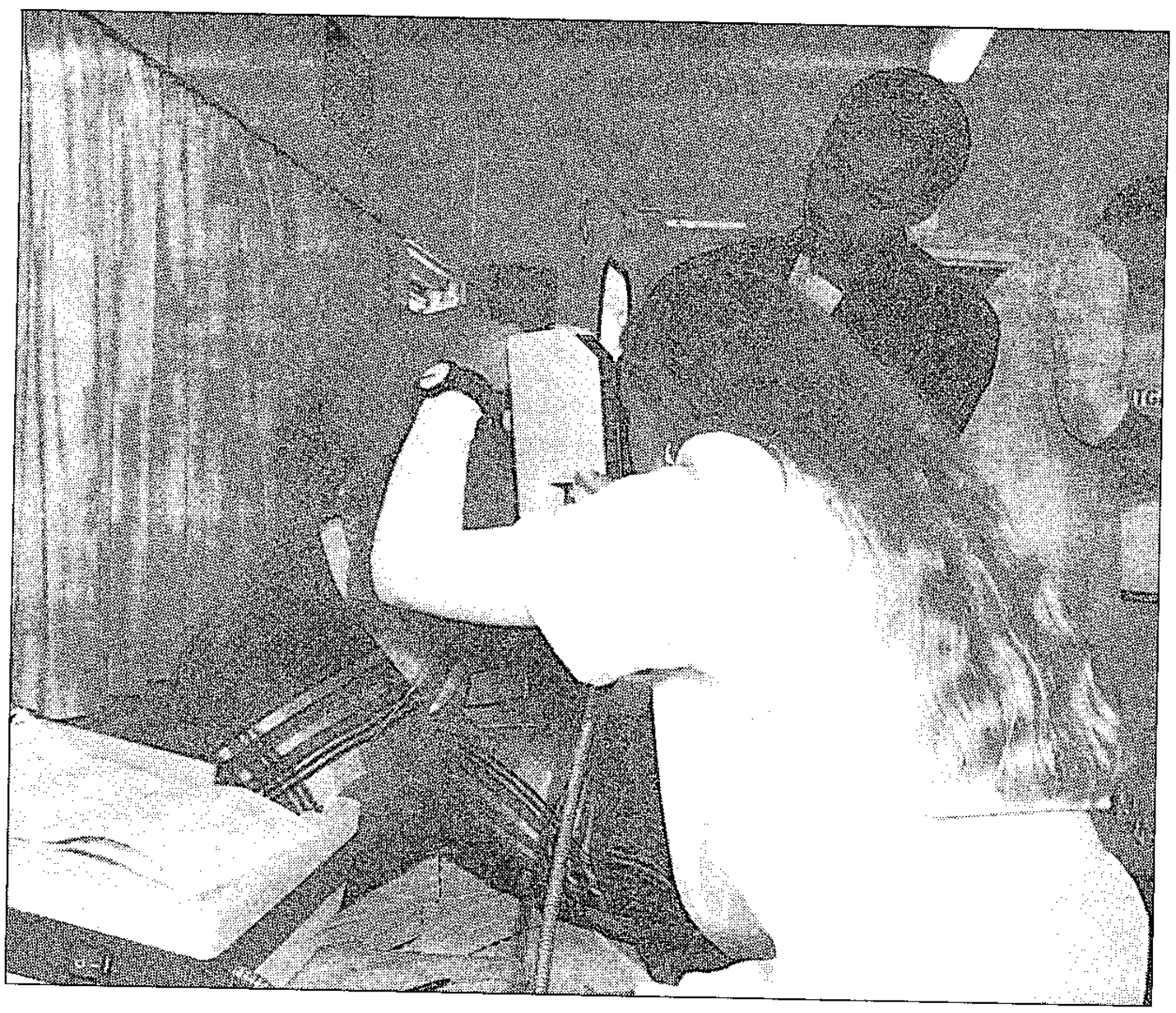
She was twice nominated Nurse of the Year in London in the 1970s.

In 1975, she was presented to the British queen as the best neurosurgical nurse in London.

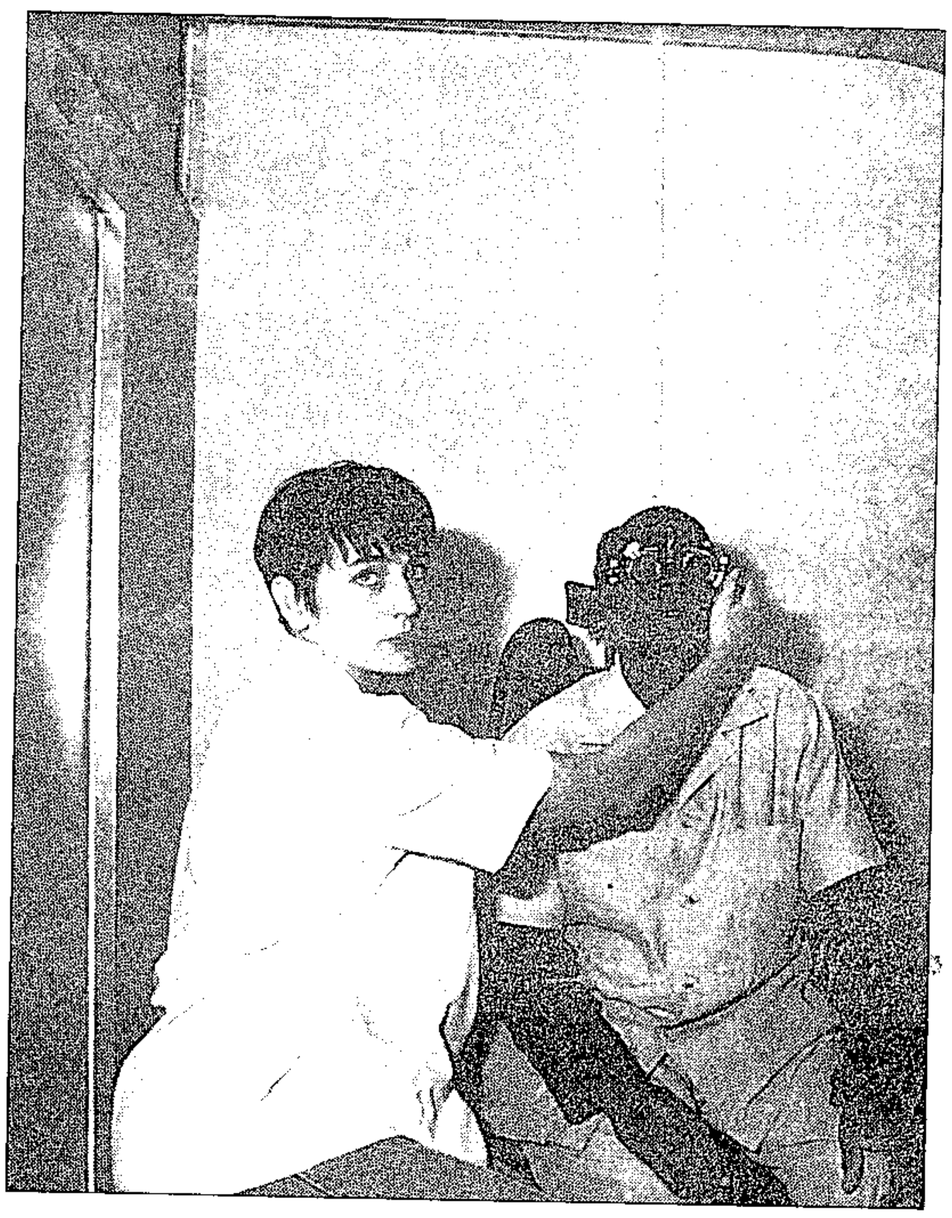
This is the woman Transnet has entrusted with the task of alleviating health needs of disadvantaged communities.

For more on Cingo, watch NNTV at 7.30 tonight.

Lillian Cingo, Phelophepa Train manager



An old woman has her eyes examined.



A rural dweller having glasses fitted.

Surgeon vows to continue heart ops

CT 1/8/95 (98) (85)

OWN CORRESPONDENT

PRETORIA: Local surgeon Dr Fanus Serfontein has accepted Cape Town as transplant capital, but has vowed to continue performing transplants locally.

He was speaking yesterday from H F Verwoerd Hospital where he oversaw the transfer of his latest heart transplant patient, Mrs Yvette Pretorius, 28.

Mrs Pretorius received a new heart at a private clinic here at the weekend as it was forbidden at the state H F Verwoerd Hospital.

Dr Serfontein said: "I know there will be a clampdown on provincial hospital patients needing transplants in Gauteng.

"They will be sent to Cape Town. However, there are patients awaiting transplants who have medical aid and I will continue to do transplants."

He said there were many people needing transplant surgery in Gauteng.

In a bid to curb the bad publicity surrounding the transplant controversy, Gauteng Health Minister Mr Amos Masondo claimed last night he had no knowledge of a long list of transplant patients.

He said Dr Serfontein's claim that he had a long list of patients waiting for new hearts, when the senior management and superintendant at H F Verwoerd Hospital had not been told, raised new questions.

Mr Masondo said if the long list existed, why have the patients not been booked at Groote Schuur Hospital, and why had he not been told.

Private hospital no real solution

State to pick up most of transplant tab

Star 1/8/95

■ **BY JANINE SIMON**
MEDICAL CORRESPONDENT

The State will pay at least another R135 000 over the next seven years to treat Yvette Pretorius a 28-year-old mother who underwent a heart transplant by controversial surgeon Dr Fanus Serfontein at the weekend.

Only about R15 000 was saved by transferring Pretorius to the privately owned Pretoria Heart Hospital for surgery because of the moratorium on heart transplants in Gauteng provincial hospitals, estimated Dr Johan Brink, head of Groote Schuur's heart transplant unit.

The operation was successful and Pretorius, of Greylingstad in the Eastern Transvaal, was transferred to H F Verwoerd Hospital yesterday.

Brink estimated that a heart transplant patient's surgery and post-operative care until discharge, usually at 12 days, cost the State between R35 000 and R40 000. Of that, the surgical costs were between R10 000 and R15 000.

Another R25 000 would be spent in the first year of intensive follow-up treatment.

This included the cost of regular consultations with a doctor, three to four hospitalisations, investigations such as biopsies and radioactive scans of the heart, and immunosuppression drugs.

The cost of drugs dropped to between R15 000 and R20 000 in the second year, and even further, to about R10 000, in subsequent years, said Brink. The average transplant price was about R150 000 over seven years.

Heart transplants consume a relatively small amount of the total State health budget: Groote Schuur estimates its optimum budget would be R6-million — enough to do between 40 and 50 transplants a year and give a reasonable follow-up service around the country to 140 existing transplant patients, transport donor organs, slightly increase unit personnel, and improve facilities for patients and families.

The emotional transplant issue had highlighted the tough debate over hi-tech medicine versus primary health care, Brink added.

The value of a second unit in Gauteng was clear, but limited resources would best be spent in bringing the existing unit up to scratch, he argued.

Both Brink and private heart surgeons agree that although the number of patients needing new hearts will increase, the number of transplants will always be held in check by the limited number of donor hearts.

State and private hospitals combined are doing between 40 and 50 transplants a year.

(85)

Transplant talks end in agreement

ARG 2/8/95

DATELINE: JOHANNESBURG

Gauteng health officials and Pretoria's maverick heart surgeon Fanus Serfontein have settled on a pragmatic solution to the heart transplant controversy.

Gauteng's MEC for Health Amos Masondo announced after a meeting with Dr Serfontein that the parties had emerged with "a common understanding" that all the province's heart transplants — except rare emergencies — would be conducted at Groote Schuur in Cape Town.

They have also agreed to put in place a referral procedure for patients requiring heart transplants to be tranferred to Cape Twon.

All future patients will be reported to the head of department and superintendent of the H F Verwoerd Hospital, and this procedure will be duplicated at all academic hospitals in the province.

For the small number of patients needing emergency transplants, a committee — comprising the superintendent, the head of the cardio-thoracic unit and a representative of the provinicial health authority — will have to give approval.

However, Mr Masondo said the provincial health department was prepared to pursue the establishment of a heart transplant unit in Gauteng after proper investigation.

Dr Serfontein and Gauteng's head of health Ralph Mgijima, blamed the controversy of the last few weeks on "poor communication".

Today's statement came after hours of negotiation on Monday and yesterday between Mr Masondo, Dr Serfontein, H F Verwoerd head of cardio thoracic surgery Dirk du Plessis, Dr Mjigima and Gauteng's hospital services chief director Dr Pieter van den Berg.

The parties were called together by the MEC who was concerned that the raging transplant controversy had begun to damage the image of the Department of Health.

Dr Serfontein said he was happy with the decision and he would not be moving to Cape Town, but staying in Pretoria where there was a much larger population and he could help people with other operations.

Mr Masondo said there was a clear commitment by all participants in the meeting to abide by the existing policies regarding heart transplants.

South Africa is currently performing between 40 and 50 transplants a year. About 36 of these are performed at Groote Schuur and the remainder at three private hospitals and the H F Verwoerd. The number is limited by the problem of obtaining suitable donor organs — an issue which is being studied by a national committee.

Should a Gauteng transplant unit be established, it would, according to Dr Serfontein, operate as a "satellite to the Groote Schuur unit and liaise closely with it".

Professor gets to the heart of the matter

(85) ARG 2/8/95

Heart transplantation raises ethical, emotional and economic questions, especially as the health care system undergoes transformation. Who should have transplants and who should do them? Should we be doing the costly operation at all? At the cutting edge of heart surgery and the transplant debate is ULRICH VON OPPEL, head of cardio-thoracic surgery at the University of Cape Town, Groote Schuur Hospital and the Red Cross Children's Hospital.

INTERFACE

JENNY VIALL talks to Ulrich von Oppel

THE decision by rebel Pretoria surgeon Fanus Serfontein to perform a heart transplant at a Gauteng state hospital in spite of the government moratorium has unleashed a storm of controversy.

And though it is clouded by rhetoric and emotion, Ulrich Von Oppel believes the debate is a good thing.

"It's highlighted and crystallised issues," he says. "Doctors have an obligation to society and its about time that our society was better educated on the issues around transplants."

Transplantation, like medicine itself, is at a critical point, with hidden agendas and vested interests, he says. "As with most things, though, it's a question of balance."

And Professor Von Oppel is well-qualified to do the balancing. After studying medicine and specialising at the University of the Witwatersrand, he came to Cape Town in September 1986, and did a PhD in thoracic (chest) surgery. He was appointed to his current post in June 1993 and has studied overseas.

Tonight he delivers his inaugural lecture on "Academic Heart Surgery — Where to Now?"

Professor Von Oppel talks about the issue of heart transplanation with intensity and candour.

The most important thing people must realise, he says, is that a heart transplant is not just a one-off operation. While the actual procedure is simple, the process, which includes pre-assessment and after-care, is not.

"In effect you're giving the person another disease. A new heart means new problems. For the rest of that person's life you play a juggling game using immunosuppressants to prevent rejection. But of course you also increase the susceptibility of the patient to other diseases. A heart transplant is not an easy solution."

What about performing the expensive operation in a country where primary health care needs are so great? This is not debatable, he says. "Heart transplantation is here to stay. Internationally it's accepted as a good form of therapy for patients with terminal heart disease."

A transplant at Groote Schuur costs around R35 000 for the operation itself; monitoring and treatment in the first year after the transplant costs R35 000; second year costs are R25 000 and every year thereafter R10 000 to R15 000.

The debate gets emotional when considering who should qualify for a new heart. Professor Von Oppel warns against a situation in which the poorer sector of society provides organs for the wealthy.

"We see organs as a national asset, a national resource. We need a national policy as to who should get them."

What Professor Von Oppel would like to see is a national policy on transplants, as is the case in other countries. "We have proposed guidelines, which are with the office of Health Minister Nkosazana Zuma, and we're waiting for them to finalise policy.

"Our guidelines are taken from worldwide recommendations, which are that one transplant unit is needed for every 15 million people."

At the moment, Groote Schuur Hospital is the only state hospital permitted to perform heart transplants.

What about a second unit? "I would welcome one, if it is properly set up and properly funded."

High mortality rates at new units is the reason why transplantation must be regulated. Professor Von Oppel explains: "After Chris Barnard's operation in 1967 many hospitals around the world started programmes. Results were disastrous and all except four units stopped doing transplants."

He points to figures showing a 54 percent mortality rate within 30 days for transplants performed at state and private hospitals outside Groote Schuur, compared to a 7,3 percent rate among patients operated on at Groote Schuur in the same period.

Professor Von Oppel stresses the importance of the team in transplantation. "Transplants are not dependant on a single surgeon. A single surgeon won't be successful."

And this is where Dr Serfontein falls down: "To give credit, he's a young surgeon who has spent time overseas in transplant units. Of all people outside Groote Schuur Hospital, he's the one with the best background training. But I think he underestimates the issues and the need to have institutional backing to make transplants a success."

PATIENTS TO BE TRANSFERRED TO W CAPE

Gauteng may set up heart transplant unit

CT 2/8/95

(85)

JOHANNESBURG: Gauteng's health minister yesterday said the province had agreed to investigate the possibility of setting up a heart transplant unit.

ALL state patients awaiting heart transplants at Pretoria's H F Verwoerd Hospital are to be transferred to Groote Schuur Hospital, Gauteng Health Minister Mr Amos Masondo said yesterday.

The decision was part of an agreement between the Gauteng Health Department and Dr Fanus Serfontein, who has continued to perform transplant operations while a moratorium is in place.

It was announced yesterday that the department was prepared to look into establishing an organ transplant unit in Gauteng if there was proper motivation and a needs analysis was conducted.

A committee would be established to approve any emergency transplants in the province. It would comprise H F Verwoerd Hospital superintendent Dr Mary Jane Small and head of the cardiothoracic unit Prof Dirk du Plessis, as well as a representative of the provincial health authority.

Mr Masondo said approval would have to be sought from the committee as soon as the patient was seen at the hospital.

Emergency cases

Dr Serfontein said emergency cases in Gauteng could arise once or twice a year. These patients could be kept alive on life-support machines until the committee made its decision and a donor organ found.

In such cases the bill would be footed by the hospital where the transplant was performed.

Dr Serfontein has agreed to transfer his remaining five or six awaiting-transplant patients to Groote Schuur Hospital.

Once the operations were completed, the patients would be transferred back to the H F Verwoerd for follow-up care.

Head of Groote Schuur Hospital's heart transplant unit Dr Johan Brink said the unit had been catering for patients from around the country for the past 10 years and he did not expect the additional patients to strain resources.

"We will try to make it the best national service possible but ideally there should be another unit in Gauteng because you can't treat people optimally so far from their homes."

He did not expect a dramatic increase in the number of patients but we would ask for more funds "if we are expected to provide a truly national service".

There are about 10 people awaiting heart transplants at Groote Schuur. Up to six patients are to be transferred from Gauteng.
—Staff Reporter, Sapa-Reuter

health department head Ralph Mgijima. Picture: NICKY DE BLOIS

for taxi warlords to use hired gunmen.

Gauteng might get heart transplant unit of its own

Ingrid Salgado (85) 2/8/95

THE Gauteng health department was prepared to consider establishing a heart transplant unit in the province once a proper motivation and needs analysis had been done, health MEC Amos Masondo said yesterday.

But the province's moratorium on heart transplants would remain in place and all transplants would be conducted at Groote Schuur Hospital in the Western Cape, he said.

This had been agreed to at a meeting between health authorities and Dr Fanus Serfontein, the surgeon who recently defied the province's ban on transplants.

Serfontein said yesterday he was "personally happy" with the agreement. Doctors and health authorities were all part of the same team, although it had previously not seemed so, he said.

Serfontein has performed a handful of heart transplants at the HF Verwoerd Hospital in Pretoria since the ban became effective this year. His last transplant patient, Yvette Pretorius, underwent surgery last Saturday at the Pretoria Heart Hospital. She has since been transferred back to HF Verwoerd.

Masondo said the province would consider establishing a Gauteng heart transplant unit once capacity at Groote Schuur had been exhausted.

Despite the ban, a small number of patients could receive heart transplants in Gauteng if their conditions were deemed "emergency" by a committee of HF Verwoerd Hospital's superintendent and cardio-thoracic unit head and a Gauteng health authority representative, he said.

Procedures to hasten committee meetings were in place in cases of extreme emergency.

Serfontein had also agreed to transfer his five or six patients requiring heart transplants to Groote Schuur at their convenience. Patients who had already been operated on would remain at HF Verwoerd.

Serfontein said emergency transplants were "the exception more than the rule", with a probable maximum of three each year.

The transplant he had performed on Pretorius at the weekend had been an emergency.

The department said the moratorium had been instituted to provide more resources for primary health care, which would reach a larger number of people.

Between December 1993 and May this year, 13 transplants had been performed at private and state hospitals other than Groote Schuur. Of these, seven patients had died within 30 days.

Groote Schuur had performed 54 heart transplants in the same period and of these four patients died within 30 days.

Meanwhile, the SA Institute of Race Relations has called "outrageous" Masondo's call that provincial authorities supply him with the names of heart transplant patients.

This would violate doctor-patient confidentiality and impinge on the individual's right to privacy.

Masondo's action was "a perfect example of a politician abusing his position to the detriment of the rights of citizens" and the provincial government should rescind his call, the institute said.

The town without pity

Glenn McKenzie reports that medical racism still exists in the rural Free State town of Brandfort — despite the Government's recent introduction of free national health care (85) sowetan 3/8/95

IN A RITUAL that began in the 1980s, penniless rural residents, most of whom are black, still trundle off to court every time they need to visit a doctor.

They stand in queues, waiting to receive an official piece of paper that certifies them "indigent" (poor). It is their ticket to enter a district surgeon's office.

Only pregnant women and children under the age of six are allowed to "skip the queue", so to speak, thanks to President Nelson Mandela's free health programme, which was introduced last year everywhere in the country.

Everywhere, that is, except in the Free State town of Brandfort where doctors still demand that young black women and children get their courthouse "ticket" before they can receive free medical care.

Dr Gerritt van der Merwe, the town's district surgeon, said he was unaware that women and children do not have to go to court first in order to see a doctor.

He told *Sowetan*: "As far as I understand it, the system is only there to prevent unnecessary cases from coming in. Fifty percent of the people who visit are not really sick."

Existed unchallenged

Brandfort's unique medical "system" existed unchallenged until tiny two-year-old Katrina Hokwana died on her mother's back while she was acquiring court forms in April.

The baby's mother, Maria, had visited one of the town's doctors a week earlier and was allegedly told unequivocally never to return without "the proper slips".

So when her baby became violently ill and developed an intestinal infection, Hokwana obeyed the orders and went to court. The baby was dead by the time she arrived at the doctor's office.

Some residents in the town say the death is the result of apartheid-era attitudes. Doctors should treat black children and pregnant mothers the same as they do whites, they say.

Petrus and Maria Hokwana (centre) mourn the passing of their tiny daughter Katrina, who died while her mother waited to get official court forms to see a doctor.

PIC: PAUL ALBERTS

"In this town, there are still two systems of health. One for whites, one for blacks," said Mr Paul Alberts, who employs Hokwana.

Van der Merwe, who never saw the child, claims emergency cases are never turned away from his office. The town's other doctor says the same thing.

But when a black *Sowetan* employee took a small boy to Van der Merwe's office, he was told unequivocally that no service would be granted unless he had the proper forms or R25 cash.

A senior Health Department official, who spoke to *Sowetan* on condition of anonymity, said forcing patients to obtain slips before granting medical service was "obstructionist and racist".

"There is no reason to use these slips unless the identity of the patient is in serious doubt. And then the slip should only be used once. Not every time the patient needs treatment," she said.

The official said criminal charges could be laid against any medical officer who denied a patient service because of his or her race.

"These are very serious charges. If they are true, the consequences can also be serious," she said.

Meanwhile, Hokwana and her husband Petrus only hope that their remaining four-year-old son will not meet the same fate if he becomes ill.

"It makes me very sad and angry that my daughter died," says Hokwana simply. She does not want to say more.

Two small clinics for 10 000

IN Majwemasweu, a small township outside Brandfort, there are two small clinics that deliver family planning and very simple community health services.

But the clinics are not primary health care centres by any means, say employees. The nurses are not allowed to prescribe medicines for ailments like pneumonia, tuberculosis or even gastroenteritis (an easily curable disease from which two-year-old Katrina Hokwana died in April).

A nurse who spoke on condition of anonymity said he hoped the Government would upgrade the clinics and allow the nurses to treat more diseases. For now, the clinics are the only source of medical care for many of the township's 10 000 residents.

The nearest hospital is more than 65km away, and Brandfort has only two doctors — both of whom require even babies and pregnant mothers to go to court before they will see them.

R15m to ease plight of W Cape women

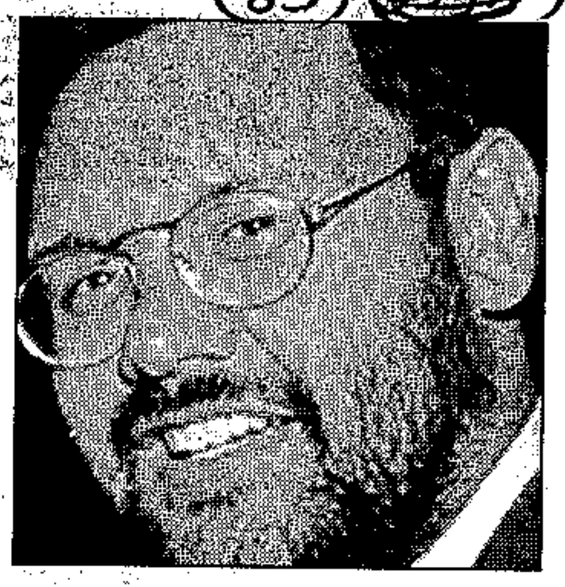
CT 8/9/95 (85)

THE Western Cape has allocated nearly R15 million to improve the welfare of women, regional Minister of Health and Welfare Mr Ebrahim Rasool said yesterday.

He told a news conference, two days ahead of the first national Women's Day, that R14,8m would be spent in focusing on violence against women and improving women's skills.

Almost R500 000 would be spent on skills development, R200 000 on shelters for abused women and R236 000 on care for unmarried mothers.

The largest portion — R14m — would be spent on new creches that would free women to participate more fully in society, Mr Rasool said.



CRECHES: Mr Ebrahim Rasool

Six multi-purpose centres, which would offer women safety and skills and literacy training, would be built this year. — Staff Reporter, Sapa

FREE PRIMARY CARE SERVICES PLANNED

Different options for health care workers

CT 3/8/95 (85)

HEALTH CARE workers may, according to new recommendations, remain in the employ of local authorities rather than transfer to the province. **PETER DENNEHY** reports.

PRIMARY health care workers in the Cape Metropole who are now employed by local authorities may no longer have to be transferred to the Provincial Administration, where the pay is generally worse.

A new report released recently for comment by a commission of inquiry established in January by Health Minister Dr Nkosazana Zuma, recommends three options the provinces can choose from.

Primary health care workers may be under local authorities, or directly under provincial governments, or simply under district health authorities which can be new parastatal bodies separate from both local and provincial government.

The Cape Metro Council's Medical Officer of Health, Dr Stewart Fisher, said different options may be chosen within a single province.

This may resolve a huge dispute which raged a few months ago between officials, like Cape Town's MoH, Dr Michael Popkiss, who want primary health workers to stay with local authorities and various provincial health planners who argue that the best way toward equity in primary health services and employee remuneration is to put all primary health workers under provinces.

Dr Fisher noted that the CMC had expressed a preference for primary health staff to remain under local authorities. In practice, this may mean that day hospitals in the Peninsula, which are now run by the province, may be transferred to the control of local authorities or the CMC.

Some of the lower-level hospitals, like False Bay Hospital, may go the same way.

Dr Fisher said the aim of the district health authority scheme is to provide universal access to basic primary health services.

Free services

These services will be provided free of charge, although there will be fees for the medicines. Drugs used to treat 95% of primary health problems will be provided free to the district health authority which may levy a small charge.

Individuals who want to use private health services will be able to do so. The costs of the proposed scheme are estimated to be R1,36 billion countrywide by 1997 and R3,39 billion by the year 2000.

Council bids to cut legal costs

CT 3/8/95 (125)

MUNICIPAL REPORTER

THE Cape Town City Council is to consider cutting its legal costs by using its own staff to deal with rent arrears and unauthorised occupations of houses, instead of contracting them out.

Figures which would have been placed before the housing committee yesterday, had its meeting not been postponed due to the lack of a quorum, show that the council was charged an average of R508 per arrears case successfully resolved by one firm, and R540 per case by another firm.

One firm dealt with 582 cases in just over three years, involving a total of R1,1m in arrears rentals. Of these, 201 cases were properly resolved and over R400 000 collected, while the fees charged of the council were R102 000.

The council's legal costs are in theory recoverable in full, but it is often not practical to collect these.

The city administrator's office believes using in-house paralegal staff could cut the cost for successful litigation to R135 a case.

Preventing disease . . . Dudusile Maho waits patiently while Sister Griet Cloete gives five-month-old baby Aisha (who is clearly not amused) a polio vaccine at the Highpoint Centre in Hillbrow yesterday. PICTURE: ETIENNE ROTHBART

Children in hundreds crowd in for their polio vaccination

Star 31/8/98 (85)

■ BY PRISCILLA SINGH

Parents took advantage yesterday of the second round in the polio vaccination campaign in Gauteng to have all children under five years old immunised against the disease.

Some came for a follow-up booster, others for their introduction to the vaccine.

Greater Johannesburg's Transitional Metropolitan Council's health workers scouted the streets of Johannesburg with loudhailers, and referred mothers and fathers with babies to the various polio stations for immunisation.

At the Highpoint Centre in Hillbrow, 500 children were immunised in three hours after the service opened at 8.30am.

Sister Griet Cloete said many children were immunised and mothers were co-operative.

"I did not know about this medicine and I am very happy that the nurse gave it to my baby," said passerby Baulina Mabara. This was her baby's first polio vaccine.

Rona August was walking past with granddaughter Danielle (2) when she took advantage of the service.

Doting father Virgil Roberts made sure he brought his 3-year-old son Lorenzo to get his second polio vaccine.

"It was good the health authorities made the vaccine freely available," said Roberts.

About 200 mobile vaccination points had been set up at venues that were easily accessible, in addition to normal clinics.

The TMC's Dr Natalie Mayet commented that the campaign aimed to eradicate polio in SA by 1998.

Target

"We are fervently working towards this target, hopefully with a higher success rate than the first round of immunisation in June," she said.

The immunisation campaign reached more than 180 000 children in the Greater Johannesburg area on June 1 and about 660 000 children in Gauteng.

In the past 50 years polio was one of the major causes of disability in children in SA.

"Many people do not know how to identify polio or what causes it," Mayet said.

The illness is caused by very small germs called poliomyelitis viruses which cannot be seen by the naked eye, she explained.

These bugs are usually passed from person to person through unwashed hands, contaminated food, and in conditions of poor sanitation.

The germs enter the body and attack the nerves, causing weakness or paralysis of limbs. The affected limb does not recover in most cases and the person is permanently paralysed.

The usual time between contact with polio germs and becoming ill is one to three weeks.

"If a child has difficulty standing or walking, or if a baby has a floppy leg, he should be taken to the nearest hospital or clinic to establish if it is polio.

"Parents must immunise their children at birth and at the age of six, 10 and 14 weeks. A further dose should be given at 18 months and again at age five.

"It is essential a child receives all doses early in life to get full protection. One or two doses are not enough," she warned.

All immunisation services are free for children.

Health care expert **Paul Gross** warns that Minister Nkosazana Zuma's health insurance policy is fatally flawed

The health insurance minefield

(85) WM 4-10/8/95

HEALTH Minister Nkosazana Zuma's national health insurance system should have reassured those who expected draconian solutions to problems of access and financing in health care.

But it remains flawed. I have looked at her committee of inquiry's report, and judged their likely impact, based on health care reforms in other countries.

The committee proposed several core recommendations:

● Firstly, that a publicly funded primary health care system provide a comprehensive package of services, given and, to a large extent, determined by certain defined providers, who will serve a defined population. The package may change as time goes by and resources change.

The report rejected the type of cost-effectiveness analysis used in the 1993 World Bank report to define a minimum package of essential preventive and clinical services. Zuma's committee argued that the absence of data in South Africa, as well as the "complex realities of health care provision at the clinical level", and the public sector's role in primary health as "health care provider of last resort", militate against such definitions of a minimum (rather than comprehensive) package.

These arguments are misguided when the costs of "comprehensive" primary health care are calculated. The most likely outcome of this proposal would be a budget deficit of at least R3,5-billion, rising with time; queues at government primary health care facilities; exhausted primary health care drug budgets from day one; and cost-ineffective primary health care brought on by having to rely on the indefensible list of comprehensive services to be made available "free".

A growing, competitive, high-quality, private medical sector would then be guaranteed, average prices of primary health care would rise, and, eventually, government intervention would be guaranteed as the public primary health care system finally admitted the reality of queues, gaps in service access and the growth of the private sector, which would threaten the public sector's role.

● Secondly, primary health care nurses would be the front-line providers of clinical primary health care services within public facilities, with referrals to other health personnel as appropriate. The committee envisaged improvements to conditions of service for these nurses, which may include some combination of salary and capped fee-for-service type payment, or other reimbursement arrangements designed to maximise incentives for efficiency.

The most likely scenario, however, is that the required number of primary health care nurses will not be available on day one of the first year of implementation, private doctors or salaried doctors will not be willing to fill the gap, the average cost of all nursing services in the country will increase because of the stimulus of the increased salaries paid to primary health care nurses, and the consumer may not use public primary health care services as often as has been assumed, until they are sure that primary health care nurses offer care at least equivalent to that given by doctors.

● The third core recommendation is the creation of accredited private providers, envisaged as "... health care teams involving a range of personnel, including medical practitioners, primary health care nurses and allied health personnel". The teams would be expected to provide a defined, comprehensive range of personal services to a registered patient group. The providers would need to be accredited and would then compete for contracts from the district health authorities. These services should ideally be under one roof, preferably as multi-disciplinary group practices. Solo general practitioners (or other health professionals) would not get accreditation because they would generally not be able to offer comprehensive services.

It is likely that private medical practitioners will react slowly to the challenge of accreditation and will not risk their own capital in the creation of dual facilities, as required by the report. Unused space and staff will remain inaccessible, and alternative structures will evolve in many geographical areas with funding from doctors, medical aid schemes and health insurance groups offering high quality primary health care.

● The fourth substantive recommendation is the creation of an essential drugs list, which will deal with 90 to 95 percent of the common and important medical conditions in the country.

The report's endorsement of an under-costed, all too generous, comprehensive primary health care scheme may not improve health outcomes or contain total costs

The option of using cost-effectiveness analysis to select appropriate medicines (an option endorsed in Australia, Canada, the United Kingdom and other European Community nations) is rejected explicitly by the health department committee.

The essential drugs list medicines will be made available, at state tender costs, via retail pharmacies, which would add on a dispensing fee. Individuals choosing to use private practitioners for primary health care services would buy the essential drugs list medicines much cheaper than at present. Other drugs would be bought at the full retail price.

Dispensing doctors would only be able to sell essential drugs list medicines where there were no pharmacies nearby. This, the report estimates, would save R1,2-billion a year.

The committee's consultant estimated that the pharmaceutical manufacturers would lose up to 12 percent of their R500-million turnover "if the national health insurance principle of free drugs was extended to the private sector"; and the 3 500 private pharmacies might lose R46-million (R13 000 per pharmacy) and the 4 000 plus dispensing doctors might lose R40-million (R10 000 per doctor), with both losses partially compensated for by a dispensing fee (R10 assumed by the consultant).

The most likely scenario with this proposal would be a steady decline in the average price of generic drugs, the unavailability of many effective brand-name medicines, and a steady deterioration in the quality of the nation's drug supply if parallel importation of essential drugs list-type drugs is openly endorsed by the government.

● Fifthly, the costing model suggests that the average real (1995 price) cost per treatment falls from R72 in 1996/97 to R66 in 2000/2001 in one scenario, and from R77 to R69 in another. Assumed increases in use heavily outweigh the reduced real cost per treatment, and so total real costs per capita (1995 values) rise from R144 to R230 and from R153 to R240 in the respective scenarios.

Apart from the implications of cost increases (which obviously caused particular problems for the committee, because it could not recommend a particular funding option), one critical estimate in the report is the shortfall in examination rooms. There is an apparent error in the spreadsheet model, which has led to the improbable results shown in one of the tables, where the model appears to predict a rapid increase in the deficit of examination rooms in 1998 and a decline in 1999.

My attempts to reproduce the results by the methodology shown in the relevant appendix gave different results for all years.

● Sixthly, all South Africans would have compulsory coverage for treatment in public hospitals.

Noting that many employed people use public hospitals without paying (even when they can afford to), the committee recommended that at least the costs of use of public hospitals might be covered by indemnity insurance, with the possibility of a specified maximum limit per beneficiary per year.

The committee's costing of this package would mean an average payroll tax of 0,66 percent might be required. This is unrealistic.

In addition to the core package, employees could opt for broader coverage in a discretionary (supplementary) hospital benefits package

This funding proposal would raise an estimated R1,3-billion a year in hospital user charges, with the funds retained by the institutions. The committee believes that hospital governance would thus improve, and competition would evolve between public and private hospitals. Mandatory coverage would "prevent loss of low-risk and higher-income members, at least with respect to the core package, and would thus stabilise the (insurance) market permanently".

This proposal for a basic public hospital insurance scheme emulates one lamentable feature of Australia's current Medicare scheme, now under stress because of excessive government regulation of what must be covered in the "basic" or core hospital benefits package.

If the R1,3-billion tax necessary to fund it is a tax that cannot be avoided (because it is mandatory), and if the core table cannot be used by individuals to pay part of the costs of a similarly-priced level of care in private hospitals (the tax allows access to public hospitals only), then many South Africans will pay for their health care through six channels if they want to maintain their access to private medical and hospital care:

(1) the yet to be revealed (tax) funding for the new primary health care scheme (which, I assume, will be unavoidable); (2) the tax for the core public hospital benefits (unavoidable); (3) user charges for essential drugs list primary health care medicines and at public hospitals if they use such services; (4) out-of-pocket payments for private medical and hospital services (unless such services waive co-payments or deductibles); (5) private health insurance or medical aid scheme premiums; and (6) the substantial tax burden already contributed to general revenue.

● Potential losers include doctors, health insurance and medical aid schemes, employers, private hospitals and pharmaceutical manufacturers. The artificially unreal deadline of August 18 for comments should be relaxed if dialogue is to occur between government and the affected stakeholders.

The threats to employers — and future employment levels — are not easily ignored. The costs to employers of health care for their employees will not decline under the committee's proposals. Employees would be able to argue about the need for employers to cover benefits above the basic hospital insurance package, and the current tax subsidy of employees for health coverage would disappear.

There is at least one offsetting positive message for employers: they could apply for funding to set up primary health care clinics, offering care to their employees and local residents, and collect at least the revenue from the primary health care drug co-payments.

In summary, the report recommends a mix of government policies which will change the economic incentives faced by employers and employees, and the economic behaviour of doctors, pharmacists, private and public hospitals, and drug costs.

There remains one fatal flaw: the report's endorsement of an under-costed, all too generous, comprehensive primary health care scheme that may not improve health outcomes or contain total costs.

Gross is an Australian health care consultant who travels regularly to this country. He has been a professor of administration at the University of Saskatchewan in Canada and a member of the National Hospital and Health Services Commission in Australia. He is currently a director of Australia's first National Health Technology Advisory Panel

CUTTING EDGE New trends in the global village

A whole new ball game

Despite testosterone's he-man image, regular doses may prove to be the male equivalent of the pill. **Terence Monmaney** reports from Los Angeles

JOSEPH VELASCO is no ranting men's libber, no jockstrap-burning revolutionary, no militant masculinist, but since early in 1993, he has been engaged in an often painful struggle to win a measure of equality for men.

Once a week for more than a year, Velasco plunged a 2-inch needle into a thigh muscle, dosing himself with 200 milligrams of testosterone.

The shot kicked like a cranky mule, and Velasco hobbled around his house while his wife, Brenda, teased him about his heroic role in the search for the male eqivalent of the female birth control pill.

Every other week, Velasco (33) visited a Harbor-UCLA Medical Centre clinic and donated semen. After several months of hormone injections, the clinic found that his sperm count had fallen dramatically.

"It was good news," said Velasco, a purchasing agent, explaining that he wouldn't have to wear a condom anymore.

His wife called the clinic. "Are you sure?," she asked, skeptical that the pre-eminent male hormone could halt a process that is synonymous with manhood.

The clinic was sure. Velasco was then a volunteer in the first large clinical study to show that regular doses of testosterone, long regarded as the essence of virility, can act as a contraceptive in the great majority of healthy men.

In the recently completed study, co-ordinated by the World Health Organisation, 357 men in nine countries received weekly injections of testosterone enanthate, a synthetic form of the hormone. The method yielded just a 1,4 percent chance that a woman would become pregnant in a year.

That rivals the 3 percent failure rate of the pill, in its first year of use, and is a vast improvement over that of the condom, the only other reversible male birth control method, which at best fails 12 percent of the time.

A new male method would be unlikely to set off a sexual revolution, as the pill did in the 1960s, the threat of AIDS and sexually transmitted diseases having done away with carefree conjugations. Yet it would probably realign sexual relations in an era increasingly concerned about risks, rights and responsibilities.

Population experts have long referred to men as the "missing 50 percent of family planning."

"The importance of the study is that it shows that a male-directed hormonal contraceptive can be about as effective as the female-directed birth control pill," said Dr Ronald Swerdloff, an endocrinologist at Harbor-UCLA, who was involved in the study.

Susheela Singh, a demographer at the Alan Guttmacher Institute, a family-planning research centre, said she "would be excited if it was a safe, effective, and affordable method. It's something to really go after." But she added that feminists and family planners alike, chastened by years of trying to get men more involved in birth control, "struggle against the underlying male resistance to sharing that responsibility."

Technical and even legal hurdles must be overcome before such a contraceptive ever reaches the market, and researchers are unwilling to predict how long until a form of it becomes widely available. Harbor-UCLA and the University of Washington in Seattle are the two United States centres participating in the WHO study, which was funded largely by the Agency for International Development. A report on the study is due to be published later this year.

It seems a paradox that shots of the ultra-male hormone could suppress sperm production. But scientists are perhaps only taking advantage of a fact that poets, feminists and observers of male sexual behaviour have noted for ages: the brain and the testicles are intimately linked.

'A male-directed hormonal contraceptive can be about as effective as the female-directed birth control pill,' says Dr Ronald Swerdloff

Sperm cells are produced in the testes largely in response to testosterone that is also produced there; but that hormone, in turn, is regulated by hormones from the body's master endocrine organ, the pituitary gland, at the base of the brain.

Testosterone injections raise the blood level of the hormone so high that the pituitary, sensing a testicular surplus, stops stimulating the testes to crank out the hormone. Sperm production dwindles.

The injections can have side effects, the researchers found. Many men gained weight, and some men developed acne.

Previous studies have shown that testosterone injections can alter levels of cholesterol compounds in blood, perhaps increasing the risk of heart disease. And physicians remain deeply concerned about the added risk of prostate cancer, because testosterone stimulates the prostate gland.

"We haven't found any evidence for a prostate problem," Bremner said. "But in fairness," he added, the prostate risk "has to be stated as an unknown."

Among the main virtues of the testosterone contraceptive's effects is its reversibility. "There hasn't been a man yet — knock on wood — who has any suggestion of a failure to return sperm counts to normal," Bremner said. Usually, production rebounds three or four months after the injections stop.

But as promising as these early results seem, the road to a safe, readily available chemical birth control method for men looks bumpy and long.

For one thing, a five cm intramuscular needle is something that a lot of men dread almost as much as unplanned fatherhood.

So researchers are working on testosterone compounds, taken with other drugs, that could suppress sperm for months at a stretch, requiring perhaps only a few injections a year.

Scientists have all but ruled out a testosterone pill, because the digestive system breaks down much of the hormone and huge oral doses can cause liver damage. — *LA Times*

Women may store eggs for 20 years

John Mullin

RESEARCHERS investigating new methods of *in vitro* fertilisation believe they are on the threshold of a big advance in the technique, which would greatly extend a woman's child-bearing years.

Robert Winston, professor of reproductive medicine at Hammersmith Hospital, west London, believes they will find a way, possibly by the end of the century, to remove and freeze ovarian tissue using liquid nitrogen.

Each sample would contain hundreds of eggs, which could be matured in the laboratory for IVF treatment as many as 20 years after the original biopsy.

As well as helping women to achieve career goals before having children, the process would have vital benefits for women about to undergo cancer treatment, Winston told BBC Radio last week. "Women with breast cancer, leukaemia or Hodgkin's disease run the risk of sterility when they begin treatment. So this would given them a chance of having children."

Initial findings of the research, which began two years ago, will be published soon. Specialists have taken from women's ovaries microscopic follicles containing eggs, and have so far grown eggs to the antral stage, the first yardstick of maturity necessary before IVF can succeed.

Winston said: "We are looking at five to 10 years before it might be applicable. IVF treatment would be one fifth the cost, much more accessible and much less intrusive, involving only a minor biopsy. There would be no drugs involved and no monitoring of a patient."

Some critics recommend improved arrangements for child care to allow career women to have fulfilling family lives at the age nature intended, rather than delaying childbirth until they felt secure enough in their profession. — *Guardian*

Bruce Cohen
WEB FEET
Notes from the Internet

'Net-workers unite!

AND you thought the 'Net was just a playground for the bourgeoisie. A fresh visit to the ANC WWW site will be a revelation: both Cosatu and the SA Communist Party have come on-line. You can read the latest issue of the *African Communist*, and coming soon is Cosatu's organ *Shop Steward*.

Check them out at:
http://www.anc.org.za/sacp/sacp.html
http://www.anc.org.za/cosatu/cosatu.html

Heavens, Gates!

■ TALKING about workers, Microsoft's Bill Gates seems to be richer than a teamsters' union.

***MacWorld* magazine has compared his net worth with the gross national product of some countries:**

Kuwait	**$15,3-billion**
Bill Gates	**$12,9-billion**
Sudan	**$5,2-billion**
Jordan	**$3,6-billion**
Nicaragua	**$1,7-billion**

Wake up call ...

■ WHILST most of us are hanging onto our seatbelts as the 'Net blasts us into uncharted space, farmer, scholar and catastrophy guru Stephen Talbott brings us down to earth. In his just-published tome *The Future Does Not Compute: Transcending The Machines In Our Midst*, Talbott says the 'Net "is the most powerful invitation to remain asleep we have ever faced ... it dwarfs television in its power to induce passivity, to scatter our minds, to destroy imaginations, and to make us forget our humanity."

Good judgment

■ HATS off to Wits Law School. They have placed all judgments of the Constitutional Court on the Web. Find them at http://www.law.wits.ac.za/lawreps.html

Good idea.

■ THE World Bank is putting the 'Net to good use. It's latest offering is an experimental database of the bank's Social Indicators of Development.

A simple forms-based inquiry lets you retrieve data on 170 countries using criteria such as population growth (including data on fertility and infant mortality); labour force; education and illiteracy; natural resources; income and poverty; expenditure on food, housing, fuel and power; transport and communication; and investment in medical care and education.

Find it at
http://www.ciesin.org/IC/wbank/sid-home.html

The bank is also offering its *Trends in Developing Economies* report at
http://www.ciesin.org/IC/wbank/tde-home.html

Hard news

■ THE Number One jumpsite to on-line media is NewsLink:
(http://www.newslink.org)
Newslink will connect you to over 1 500 on-line newspapers, magazines, news services and broadcasters.

Cool news

■ JAZZ fans should jump to JazzNet (http://www.dnai.com:80/~lmcohen/index.html) This is a solid site offering an on-line version of *JazzNow* magazine, links to record companies, festivals, book stores and a few dozen other cool places in the Global Jazz Village.

Last word

■ FASCINATING, who comes to visit these days. We logged two days of "hits" to the *Mail & Guardian* WWW site (http://www.is.co.za/services/wmail/) last week and found that 3 Norwegians, 15 Canadians, 11 Swiss, two members of the US Military and a solitary Japanese had found their way in. Must be our on-line HP Inkjet Printer contest

Comments and queries to wmail@is.co.za

Province revises health proposal

(85)

CLAIRE BISSEKER CT 7/18/95

THE Western Cape health department has backed down from its proposal that a new district health system be governed by the province.

The proposal, contained in the province's draft health plan, unleashed a storm of protest from members of the Cape Town City Council, who objected to the province taking over services they said were being run successfully by local government.

The department proposed a new provincial health system, based on districts within which all public sector health personnel would be employed by a single authority.

Wasteful

This would end the "inefficient and wasteful fragmentation" of the current health system in which a large number of different authorities delivered different aspects of health care, it said.

Instead the province would be divided into 24 districts each governed by a district health authority.

This would require the transfer of the facilities and staff of all services in the district to a single administration — in the short term, the department said, itself.

However, in the revised health plan released at the weekend, the department proposed that a decision be delayed until after the local government elections.

The plan said the possibility that district health authorities be independent of both provincial and local authorities was being explored at a national level.

'Participation slows services'

STAFF REPORTER

THE government would be unable to deliver services if it did not change its public participation strategy, which was delaying development, the Director-General of Health, Dr Olive Shisana, said yesterday.

Speaking at an International Health Policy Conference in Somerset West, Dr Shisana said public participation should not be allowed to become a "stumbling block" in providing services.

Although she believed communities should be consulted about the opening times and services to be provided by clinics, they did not need to have a say in where clinics should be located or in their daily management.

MONDAY
★AUGUST 7, 1995

Promise to keep job losses down

(85) CT 7/8/95

CLAIRE BISSEKER

THE plan to restructure provincial health services has serious implications for staff, but the Western Cape Health Department has said retrenchments will be considered only as a last resort.

The revised provincial health plan released at the weekend reveals that significant resources will have to be diverted from academic hospitals to regional and district services.

The provincial health budget will also have to be trimmed by 1% each year up to the year 2000.

As far as possible staff reductions would be brought about through the abolition of vacant posts, attrition, voluntary retirement and transfers, the plan said. Retrenchments would be considered only as a "last resort".

All changes would be fully discussed with professional organisations, labour unions and employee associations, the plan said, and an "effective" affirmative action policy would be implemented to correct racial and gender imbalances.

Curricula at medical and dental schools, universities, technikons and nursing colleges would be reviewed in the light of the shift towards primary health care.

NEW PROVINCIAL HEALTH PLAN

City hospitals saved

(85)

CT 7/8/95

VICTORIA, Tygerberg, Karl Bremer and Conradie hospitals have been reprieved in terms of a new health plan. **CLAIRE BISSEKER** reports.

A SUBSTANTIAL rethink of the Provincial Health Plan has saved Tygerberg Hospital from being downgraded and could mean the re-opening of several hospitals across the Peninsula.

The revised Provincial Health Plan, released at the weekend, is still committed to eliminating duplication in the academic hospitals but no longer prescribes the levels of care they should provide.

The draft plan proposed that Tygerberg Hospital be downgraded to a level two hospital and that its sub-specialist facilities be transferred to Groote Schuur.

The revised plan still aims to eliminate the duplication of small, expensive sub-specialities at the academic hospitals, but no longer assumes that all sophisticated services will be located at Groote Schuur.

A "dispassionate group" would have to investigate each sub-speciality, the new plan said.

The region could also not afford two sets of teaching facilities for the universities of Stellenbosch and Cape Town and in future these would be "uncoupled" from the teaching hospitals.

These changes were necessary for the Western Cape to effect a 1,5% shift in expenditure away from academic hospitals and a 1% reduction in total health expenditure each year up to the year 2000.

The revised plan, completed after three months of discussion during which 300 written submissions were received, will be presented to the cabinet by the end of the month.

In a complete about-turn, the revised plan proposes that Karl Bremer Hospital be re-opened as soon as possible and take on an additional 120 general beds from Conradie Hospital.

Victoria Hospital will remain at its present site until it is replaced in the year 2000 by a full regional hospital at an as yet undetermined site in the south west Peninsula. Staffing will be upgraded immediately to regional hospital levels.

New proposals, still subject to consultation, are:

- That part of Conradie Hospital be retained for a 24-hour community health care centre and a 280-bed tuberculosis unit that would be relocated from the DP Marais TB centre, which would close.
- That the Westlake Rehabilitation Centre close and long-term patients be relocated to Woodstock Hospital.
- That Princess Alice Hospital act as a referral rehabilitation facility.
- That Lady Michaelis Hospital return to the purpose for which it was built: A paediatric centre for orthopaedic surgery, rheumatology and rehabilitation.
- That Valkenberg and Lentegeur hospitals be the two psychiatric hospitals in the metropole and Stikland hospital change its role to accommodate chronically ill patients.
- That Groote Schuur take some Conradie Hospital spinal cord injury patients as well as adult orthopaedic and rheumatology patients from Princess Alice.

Concern over health care, clinics crisis

Somerset West — Community consultation was delaying the building of primary health care clinics in rural areas, health director-general Olive Shisana said yesterday.

She told a health policy conference that R228-million had been allocated for clinic-building "which we haven't been able to spend" (96) (85)

Such work could take up to 18 months because communities had to be consulted. Shisana questioned why consultation was needed on "basic things" like water, taps, houses and clinics.

She urged MPLs to return to their provinces and to lobby their health MECs to build clinics in underserviced areas.

On the shortage of medical practitioners in the public service, she said: "The gap is growing every day because of poor salaries," adding that SA's health care system was collapsing and "we have a crisis".

Shisana also said more than 10 000 primary health care nurses would soon be needed. — Sapa.

Star 7/8/95

Final Cape health plan leaves Tygerberg, Victoria intact

ARG 8/8/95 (85)(00)

☐ *R22,9-m cut in annual budget allocation*

JENNY VIALL
Health Reporter

TYGERBERG Hospital will no longer be downgraded to a secondary hospital, Karl Bremer Hospital will be re-opened and Victoria Hospital will remain open, according to the final health plan for the Western Cape.

The final version differs significantly from the draft proposal.

Consensus on restructuring academic hospitals — a contentious issue — has not been reached, but there is a move away from the rigid proposals in the draft plan.

Instead, a set of principles will guide the management of these services.

The question of who should manage the new district health system remains undecided.

The report notes the lack of consensus on this issue and proposes that this decision be delayed until local government elections.

Cuts in the provincial health budget — amounting to R22,9-million this year and each year until the year 2000 — shifting posts, and closing and altering some hospitals will lead to a cut in personnel, notes the report.

Wherever possible, this will be done through attrition, voluntary retirement, abolishing vacant posts and transfers. Retrenchments will be a last resort.

Any major changes from the draft proposals will have to be negotiated, said regional Health Minister Ebrahim Rasool at a Press conference to announce the final plan.

This had been compiled after consideration of 300 submissions on the draft plan.

The presciptive approach of the draft plan had been sacrificed in the new plan, without changing bottom-line objectives, he said.

These objectives were effecting savings, getting rid of duplication, providing a good service and co-ordinating teaching and research.

Areas of consensus had been identified and dates set for their implementation.

Areas of major change would be subject to negotiation. At the regional level, these were:

● Most of Conradie Hospital, which has major infrastructure problems, should close. The spinal cord injuries unit for acute patients will move to Groote Schuur Hospital and then to Princess Alice.

General beds will move to Karl Bremer and post-acute neurosurgical patients will be accommodated at Woodstock.

Long-term patients will be accommodated at Stikland.

The refurbished wards will be used for tuberculosis patients. There also will be a 24-hour community health centre;

● Woodstock Hospital will re-open to house the 170 chronic patients from Westlake — whose TB centre will close.

Proposals for which there was sufficient consensus were:

● Somerest Hospital's North Block will be sold and the *funds used to build a 200-bed hospital in the Philippi area.*

The West block will be a smaller, regional hospital;

● Karl Bremer Hospital will re-open as soon as possible, without a trauma or emergency unit initially;

● Victoria Hospital will remain at its present site until it is replaced by the year 2000 by a full regional hospital at a still-to-be-determined site;

● St Monica's will have its role redefined to operate as a midwife obstetric unit;

● Mowbray Maternity Hospital will remain as it is;

● G F Jooste Hospital will be opened as soon as possible as an acute general hospital;

● Hottentots Holland Hospital will be upgraded to a full regional hospital; and

● New 200-bed hospitals will open in Phillipi, Blue Downs, south-west Peninsula and Helderberg.

Proposals are that Lentegeur and Alexandra hospitals should stay unaltered, while new proposals have been put forward for:

● Princess Alice Hospital which will be converted into a rehabilitation facility;

● Lady Michaelis, which will revert to a paediatric centre for orthopaedic surgery, rheumatology and rehabilitation;

● Groote Schuur Hospital, which will get spinal chord injury patients and adult orthopaedic and rheumatology patients from Princess Alice; and

● Stikland, Valkenberg and Lentegeur — there will be two acute psychiatric hospitals and one will change its role to *accommodate chronic patients.*

The plan notes that Department of Health would like to see co-operation with the private sector.

The final plan would be submitted to the provincial cabinet at the end of the month for approval, said Mr Rasool.

'Bosberaad' planned on academic hospitals

Health Reporter

A "BOSBERAAD" on health education takes place this weekend in an attempt to work out how to match needs with what the provincial government is able to provide.

Representatives of the universities of Cape Town, Stellenbosch and the Western Cape and the provincial health department will work out how they fit into the new health plan.

The health budget requires a shift of R37,4 million from academic hospitals to regional and district services and the province can no longer afford two medical faculties.

The final plan for health services in the Western Cape, released this week, envisages a single health sciences faculty evolving over several years.

But the province says it will not prescribe this goal.

According to the final plan, health facilities for training and research will no longer be located mainly at the present academic hospitals.

Adequate consensus between UCT and Stellenbosch University on a single faculty could not be reached.

The final report says provincial health services will be driven primarily by healthcare needs rather than those of the academic institutions.

"The province cannot now or in the future afford to provide *two separate and complete sets* of teaching facilities.

"Individual hospitals will no longer be regarded as 'belonging' to a particular university.

"Small and expensive subspecialities will be provided through a single department and will be shared."

Suitable balance must be struck in health care

DM 8/8/95 (85)

Kathryn Strachan

THE furore around heart transplants has highlighted the unique position of SA falling at the interface of First and Third World realities.

Thirty years after the first heart transplant was pioneered in Cape Town, SA still has one of the highest rates of infant mortality in Africa. The rate is almost twice as high as countries of similar GNP.

These are stark indicators that SA has in the past neglected the basics of health care such as providing clean water, for the sake of hi-tech medicine.

But in redressing the past mistakes and shifting the emphasis in the direction of providing primary health care to deprived communities, health experts agree that the pendulum should not swing to the other extreme.

Health needs to strike the correct balance between high level and primary care.

"There is a tendency to separate First and Third World medicine, but it is a false dichotomy.

"The two elements should be seen as a continuum of health care," says Dr Irwin Friedman, director of the National Progressive Primary Healthcare Network.

But choices have to be made about where resources could be best spent. Even in the most advanced nations, difficult choices have to be made.

For this reason, the network supports the position of the Health Ministry which states that heart transplants be centralised for the time being at Groote Schuur where there is already proven excellence.

An example of where more high level care is needed is in kidney failure. SA does not have nearly enough kidney dialysis machines to deal with the need, but more machines cannot be afforded.

While there has been a great public outcry over the transplants, there is silence over the thousands of children who die each year of diarrhoea and other easily preventable diseases, says Friedman.

Yet health authorities are being accused of being callous because they have to balance the interests of hundreds of people's lives against a single life.

Another area of huge unmet need is that of mental health services. Given the levels of trauma in SA society, the country is hopelessly underserved when it comes to mental health.

With his work in Cape Town's Red Cross Children's Hospital intensive care unit and his involvement in the network, Dr Louis Reynolds straddles the gap between high level and primary care.

"The two are not in conflict. If we want highly specialised medicine we need a strong foundation of primary health care," he says.

"If we don't have this base, high level care becomes unsustainable and it will collapse — as it has threatened to do."

Another who lives in both worlds and is trying to find ways to bring them together is Prof Pinhas Sareli, head of cardiology at Baragwanath Hospital.

Sareli believes there is a place for sophisticated heart surgery but priorities need to be made.

"Health is a pyramid and we need a strong foundation of primary health care to support advanced medical care," says Sareli.

"We have to take every field of medicine and find ways of dealing with it at the primary level."

'A luxury'

While there is a place for hi-tech medicine, careful calculations have to be made to find out whether heart transplants are affordable in the face of other health demands, he says. Other forms of heart surgery such as coronary bypasses and valve replacement are far more cost effective than heart transplants.

"Heart transplants are a luxury," he says.

It is also necessary to provide challenges to encourage doctors to stay in the country, but heart transplants are not among the most difficult procedures. There are other operations such as heart valve replacements and coronary bypasses which are far more difficult and in much greater demand.

The high incidence of rheumatic fever among blacks leads to a lot of heart valve disease.

Milpark Hospital cardiologist Prof Obel says that even at the Boston Massachusetts General Hospital — the most sophisticated hospital in the world — heart-lung transplants are never carried out.

Because of the shortage of donors, a patient can either have only a heart or one lung so that organs can be spread between more patients.

"Even at the most advanced hospital in the world, priorities have to be made," he says, "people have to be realistic about the problem."

SA has to balance out its problems with staff shortages in hospitals leading to children dying in queues while waiting for flu treatment at Natalspruit Hospital, on the one hand, and with R100 000 being spent on a single heart transplant, on the other.

Wits University Centre for Health Policy researcher Alex van den Heever believes that because there was never any administrative or financial control over what specialists did in the past, a distortion towards high level care was created.

Jane Doherty, a researcher at the centre, says that because of the resource contraints a trade-off has to be made.

Once a proper process of identifying needs and resources has been done, it will probably turn out that the health authorities cannot afford to provide all the care that they want and priorities will have to be made.

In terms of heart transplants, hospitals will have to look at how many units can be sustained, how many patients can be accomodated and whether other heart surgery is more important.

"There is a role for high level care both in terms of need and in terms of generating expertise and skills that trickle down to other levels, but it has to be seen in the context of health priorities."

But all agree that both ends of the spectrum of health care need the other. Primary health care is rejuvenated by the expertise that flows down from the higher levels, and specialised care depends on the foundation of a strong basic level of care.

But, as Friedman points out, it is always the story of the individual that raises more concern, than the story of hundreds of people.

"It is just as immoral to say no to the poor rural woman who needs basic health care — her story is just as pitiful as the person who needs a heart transplant."

Gauteng woman gets first heart under new rules

(85) (SE) ARG 9/8/95

Staff Reporter and Sapa

THE first heart transplant patient to be transferred to Groote Schuur Hospital from Gauteng after the moratorium on the operations is in a satisfactory condition in intensive care after she received a heart from a Port Elizabeth donor.

Debia Matlala, 58, a domestic worker and mother-of-two from Pretoria, was given a new heart during a four-hour operation at the hospital last night.

This morning a hospital spokesman decribed Mrs Matlala's condition as stable.

"She is doing well and the operation was very successful."

The transplant was done by surgeon Johan Brink whose medical team was described as "very enthusiastic" and "happy with the operation".

A transplant team spokesman said the donor organ was fetched from Port Elizabeth on a scheduled South African Airways flight by cardiothoracic surgeon Willie Koen.

Heart transplant unit medical social worker, Lynette Barr, described Ms Matlala before the operation as "emotionally ready, relaxed and motivated". She said Ms Matlala had remarked: "The quicker, the better. I want to be home before Christmas."

The heart transplant, the 17th performed by the Groote Schuur team this year, follows almost two weeks of detailed inter-departmental and multidisciplinary tests on Ms Matlala, who was a patient at Pretoria's H F Verwoerd Hospital.

Her flight to Cape town last month was paid for by the South African Society of Heart Transplant Recipients.

Two kidney tranplants will also be performed by the renal transplant team today using the Port Elizabeth donor's organs.

THE NATION

The Argu

Spotlight on public sector health crisis

ARG 10/8/95

85

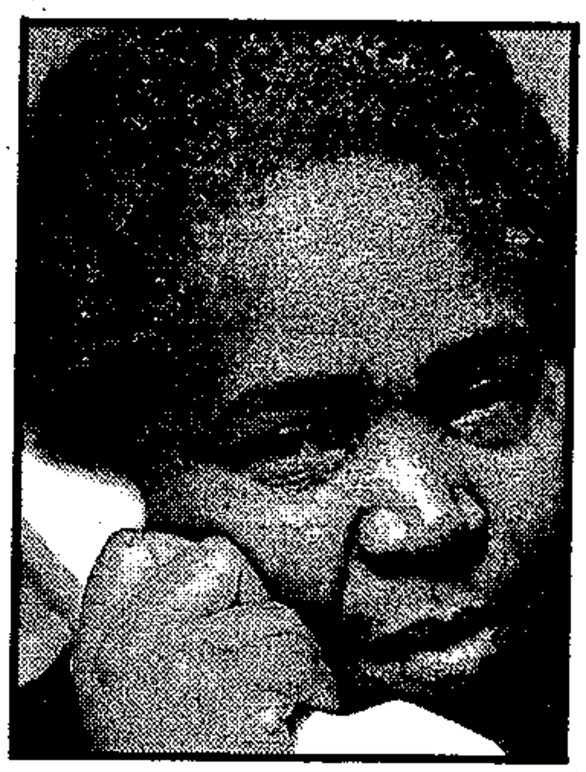
☐ *Concern over doctors' working conditions*

PRETORIA. — The working conditions of doctors in the public sector were under review, the Medical Association of South Africa said.

Reacting to media reports of an imminent collapse in public health services and of resignations by doctors, Masa's Dave Morrell said the association and the department of health were addressing the issues as a matter of urgency.

Health Minister Nkosazana Zuma had appointed a working group to investigate deteriorating conditions, growing workloads, severe budget cuts and staff shortages, Professor Morrell said.

"In representing the medical profession Masa is committed to enhancing health care for the people of South Africa and strengthening public services," Professor Morrell said.



Dr Nkosazana Zuma

"We are especially committed to the doctors who, while struggling to maintain services in extremely adverse circumstances, are often blamed by patients for the inadequacies of the system."

He added that doctors' morale was at an all-time low. They were despondent about the poor prospect for improved conditions in the near future.

"The objective of the working group is therefore to address issues peculiar to doctors with a view to making realistic and constructive recommendations concerning career opportunities and incentives to attract and retain doctors in the public health sector," Professor Morrell said.

"Priorities on the agenda are mechanisms for improving doctors' negotiating position since they do not have the leverage of strike action, service contracts and working conditions, disparities and the low level of overtime pay, the issue of community service and the redistribution of intern posts in 1996." — Sapa.

Have a heart – health is for all

(85) WM 11-17/8/95

Dr Paul Davis questions the behaviour of heart transplant surgeon Dr Fanus Serfontein, and suggests there may be a better way to deal with this issue

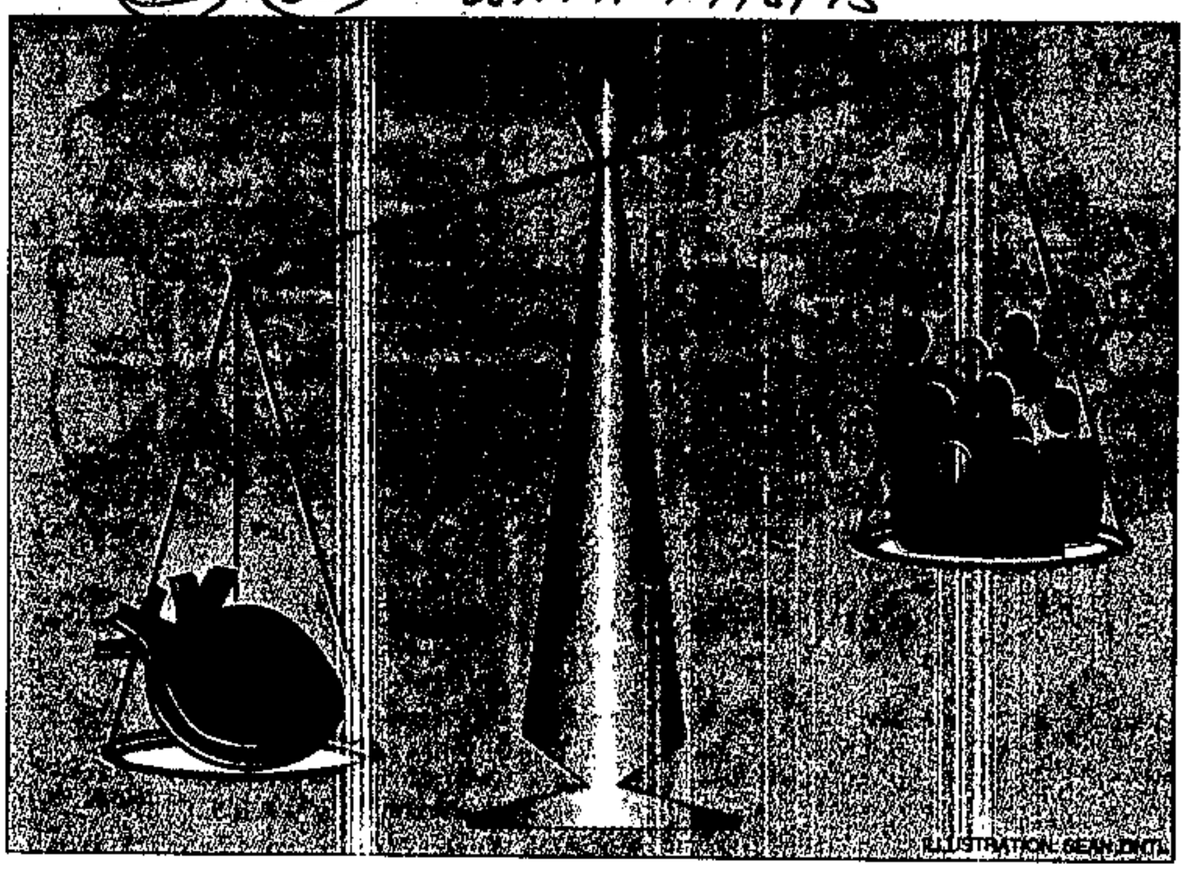


ILLUSTRATION: SEAN DIGBY

ONE has to ask why Dr Fanus Serfontein chose to confront the provincial government over heart transplants in the way he did.

If the Pretoria Medical School, the HF Verwoerd Hospital and the province had agreed to a moratorium on cardiac transplantation, then clearly Serfontein and the university were in direct and flagrant breach of that agreement. The university's apology to the province after the first transplant seems to indicate that this was the case.

The second transplant would then have been a further disregard of the moratorium.

The most recent case, when the operation was done at a private hospital after which the patient was transferred back to the provincial hospital, is nothing but subterfuge. The province still has to pick up the aftercare.

The moratorium was agreed to by people of high standing in the profession and in the province, and they must have considered the ethical and moral problems as part of the decision-making process. So Serfontein's actions make one question his reasons for confronting the province in this way. In the normal course of events the matter should have been referred back to those parties who had agreed to the moratorium before those procedures were undertaken.

Serfontein and the university will have to live with the decision they made which may now deprive many other citizens of South Africa of their lives. Perhaps there is still a lingering notion that "white" lives are worth more than other lives.

In the face of economic constraints and limited resources, painful and difficult decisions were made. The previous government made decisions that favoured the few. This government is beginning to make decisions which will benefit the many.

I also cannot agree totally with Health Minister Dr Nkosazana Zuma's decision to only sanction cardiac hospitalisation in Cape Town. The expertise to do this operation and the necessary follow-up does reside in other centres in South Africa, and there is already a long backlog in Cape Town for transplants. Sometimes the case may be so urgent that transfer to Cape Town is not possible.

In some cases, the heart recipient may have to remain under direct and continuous care of the treating team. This may mean permanent relocation of the patient and his or her family to an area in the vicinity of Cape Town. This may not be possible or destrable — beautiful as the Cape is.

Even if the patient is able to return home, he or she would still have to see the transplant team on a regular basis. This means frequent trips to Cape Town, with accommodation and related costs. Who will pay?

There is too much emotion surrounding heart transplants, which probably cost the same or less than kidney transplants. They are a routine, acceptable form of treatment for certain cardiac conditions.

It is quite clear that there is an increasing demand for this type of surgery, which, in all respects — financial and medical — exceeds our current ability to provide. We are not alone in this awful dilemma. Most countries have to face the problem of limited resources and excessive demand which leads to a prioritisation of services. So what is the fate of high-level or tertiary care in South Africa?

There is too much emotion surrounding heart transplants. They are a routine, acceptable form of treatment for certain cardiac conditions

We spend the equivalent of $156 on the health of each person each year. If this is broken down into what is spent in the private sector and the public sector, the answer is even more revealing: approximately $390 per capita per annum is spent in the private sector and only $97 per capita per annum in the public sector.

Compare this to the USA's $2 763 and $1 039 respectively, and Germany's $1 511.

There are millions of people in South Africa who have very little access to health care. Crude statistics show starkly that things like neo-natal and foetal mortality rates and life expectancy are divided along socio-economic and racial lines. Tuberculosis is rife, Aids is on the march, and 50 percent of the working population is jobless.

On top of this we have a public health system designed for the control of health rather than its delivery. Its structure is not designed to provide health care and is not sensitive to community needs. One only has to note the irrational and provocative distribution of services.

Despite this, we should not destroy what we have. In making changes to the system, the starting point must be to begin with what we have got, and this includes cardiac transplantation.

Our health care delivery system is far too precious and fragile to withstand immediate and fundamental shifts of policy. We must apply our great brains to making the new health initiative work without destroying the whole. I believe the new administration is deeply committed to this principle.

Much can be achieved by enacting change from within the system which should have no adverse consequences for the function of the health service, but would do much to improve it. Hospital and academic facilities are hopelessly inefficient in terms of staffing, service and function. Vast amounts can be saved by properly resourced management without changing the hospitals' current levels of functioning and service.

A new hospital ethos of responsibility and accountability must be stimulated and the whole system decentralised. The hospital systems must be flexible and sensitive enough to be able to respond to changing medical and community needs.

A detailed and ongoing evaluation and registration of all the medical and health facilities in the country should be instituted. In many instances, there is an enormous unused capacity in the hospital sector — for example in Johannesburg Hospital ,which is using about 500 of its 2 000 beds, and the private sector, where there is about 60 percent bed occupancy.

We need immediate and effective loss-control systems: for example, R1,5-billion of drugs bought by the state are not accounted for. Recently the state was informed of the theft of more than R4-million worth of drugs that it was not even aware was missing.

There could also be selective use of the private sector to achieve short- and medium-term Department of Health objectives. The private sector can use easily accessible existing resources and expertise; it has a large capacity-building potential for a more efficient public system; it has an ability to rapidly implement approved projects, side-stepping cumbersome and obstructive bureaucracy; it can source funding from non-government sources.

The structure and functioning of the health system needs to be radically changed to allow for different employment strategies and employment categories; voluntary participation and service; hospitals and clinics to form local alliances and contracts; and community participation in all decisions that affect health care delivery in the area.

There are also compelling reasons to create a special category of service for heart and renal transplantation, the care of cancer, trauma units and even emergency services. These are all expensive to set up and maintain and they require a high level of skill and expertise which is in short supply in South Africa. These services should not be competitive between the private and public sectors as this will dilute their ability to function properly.

Their usage is relatively low. However, their life-saving potential is high and the country does have the required level of expertise. The value of these services to ourselves and our neighbours is immense.

Thus I moot this special category, which I call a quaternary or combined care facility. It combines the resources of both the private and public sectors in a unique and free-standing arrangement where the patient's needs are the only admission criteria. These facilities are not for profit. The real cost of the procedure would be paid from that sector of the economy from which the patient comes.

A private patient using this facility would pay for it privately, and a patient referred from the public sector would be paid for by that sector. Medical control of these facilities would lie best with academic institutions.

Private from private sources, state from state sources. These facilities and their resident skills are national treasures and must be rationally and regionally located so that all in need have access to them.

Dr Davis is the chairman of Medical Rescue International

Medical students barred from top teaching hospitals

ST 13/8/95

By CAS St LEGER

HUNDREDS of medical students about to write their final exams have been told they will not be allowed to complete their training at the country's top teaching hospitals.

With less than four months to go until they are due to take up posts for their crucial internship year, they have been told to reapply to smaller hospitals in underserved areas such as Kwazulu Natal and Northern Province.

The traditional allocation of interns has been changed by a government health restructuring committee.

Popular teaching hospitals like Groote Schuur and Tygerberg have had their intern intake slashed by a third. Baragwanath and Johannesburg hospitals have lost more than a tenth of their intern posts — a cut of eight posts at Bara alone.

In the absence of a list of vacancies, hundreds have no idea where to re-apply.

One of the students' prime concerns is that the exodus of consultants and senior doctors will mean that they might be working unsupervised at country hospitals — risking the loss of lives.

Wits Medical School, which has 200 sixth-year students, is drafting an appeal to the Department of Health, said the dean of students, Professor Ahmed Wadee.

"We're furious at the way we've been treated," said a Wits final-year student, Nick van As, speaking for up to 20 students at Wits.

The students have pieced together the fact that they have no internships from rumour and missing names from assignment lists on varsity noticeboards.

"At least 15 of our students have no idea where they are going."

He said some students had been told they had a post — and then learnt, by accident or by telephone call, that they had to re-apply.

Six weeks ago, after being inundated by worried students, Mr van As contacted Dr Ayanda Ntsaluba, the deputy director general of health and head of the provincial health restructuring committee.

He was told the assignment of interns would be worked out according to the needs of a province — and not on the number of hospital beds as in the past. Dr Ntsaluba was not available for comment.

Countrywide, 1 014 medical students will graduate at the end of this year. There are 1 312 hospital posts at about 50 hospitals accredited for internship by the SA Medical and Dental Council (SAMDC) — in theory, more than enough jobs for all. But an unknown number of these posts are frozen.

Dr Jonny Taitz, who heads the Junior Doctors' Association of SA (Judasa), said he and the Medical Association of SA (Masa) asked the restructuring committee for a moratorium on implementing the new system until 1997 — but were told it was too late for this year.

He said Judasa supported servicing disadvantaged areas — provided the policy was phased in and investigated fully.

Dr Taitz said: "The intern year is a training year. What they learn then, they put into practice the rest of their lives. We are going to get a set of cowboy doctors."

The reduction in intern posts would mean that junior doctors — already often working 100 hours or more a week — would be even more overworked, he said.

He and Masa have asked the Health Department to provide a list of available posts urgently.

"The teaching hospitals will have fewer interns than they need," said Professor Dave Morrell, the chairman of Masa's committee for public service doctors.

Peter Brewer, Masa's head of full-time practice, said there was also concern interns might be used "as bodies to do the work rather than as students in training".

Officially, the matter is still under discussion. Vincent Hlongwane, the spokesman for the Minister of Health, Dr Nkosazana Zuma, said the concern of the young doctors was "premature". He said reallocations were "not definite for 1996" and August 18 was the deadline for submissions.

Dr Lennox Mathews, a restructuring committee member and an official in the Health Department's secondary and tertiary health directorate, said: "All interns will get posts and it will be under supervision."

Brain op done

A WOMAN who had brain surgery through an incision in her leg has left [illegible] hospital without stitches or [illegible]adache only two days after the operation.

Pauline Tones, 52, was the first patient to have surgery using a new £700 000 (R3,9-million) machine at Newcastle General Hospital. She had four aneurysms — weak points on blood vessels in the brain which swell and eventually burst, often killing the victim.

Surgeons treated the abnormalities in the blood vessels of her brain by pushing a catheter into an artery in her groin and

District teams form basis of health care

ET 15/8/95 (85)

THE northern sub-structure is likely to adopt a system of district management teams to deliver health care, according to a spokesman.

Residents and health workers in the greater Milnerton area met last night to discuss the election of community health committees that would give communities a say in health care and report to the district management teams.

The system is in line with proposals by the Strategic Management Team for Health in the Western Cape. — Staff Reporter

Ban on heart swops to stay

ET 16/8/95

JOHANNESBURG: The moratorium on heart transplants in Gauteng's state hospitals will not be lifted.

The province's standing committee on health decided yesterday to accept the Gauteng government's argument to maintain the moratorium, committee chairperson Ms Maggie Magubane said.

The decision may lead controversial heart surgeon Dr Fanus Serfontein to leave the public health sector.

"I'm looking at other options," he said. "I think there's no future for me in the public sector."

He circumvented the moratorium by performing transplants in private hospitals.

Ms Magubane said the committee did not hear arguments from any doctors opposed to the moratorium. — Sapa

'No battle' between govt and surgeon

(85)(88) BD 16/8/95

Nomavenda Mathiane

THERE was no battle between the Gauteng health department and Pretoria surgeon Dr Fanus Serfontein, Gauteng health deputy director Dr Eric Buch said yesterday.

Serfontein performed heart transplants at the HF Verwoerd hospital in defiance of a moratorium in government hospitals.

The government had not sacrificed the health of people by imposing a moratorium on organ transplants, Buch told a briefing on the Gauteng health standing committee on government policy regarding organ transplant operations.

He said Serfontein was manipulative and flouted the agreements made between government and academic hospitals.

After Serfontein conducted a transplant in March, a meeting was called on April 18 where it was agreed that patients needing major organ transplants would be referred to Groote Schuur Hospital in Cape Town.

Only emergency cases would be done in local hospitals, after the surgeons concerned had received permission from health MEC Amos Masondo.

Heart transplant moratorium to stay

(85) (98) Star 16/8/95

The moratorium on heart transplants in Gauteng's state hospitals will not be lifted.

The province's standing committee on health met in Johannesburg yesterday to consider the issue, and decided to accept the Gauteng government's argument to maintain the moratorium, committee chairman Maggie Magubane said.

The committee was addressed by Dr Erich Buch of the Gauteng health department but did not hear argument from any doctors opposed to the moratorium.

The decision in all probability means heart surgeon Dr Fanus Serfontein will be lost to the public health sector.

Approached for comment, Serfontein said: "I'm busy looking at other options. I think there's no future for me in the public sector."

Serfontein caused a furore recently when he circumvented the moratorium by performing heart transplants in private hospitals and then transferring his patients back to the H F Verwoerd Hospital in Pretoria. He did not charge for these operations.

Serfontein is employed by the state-run H F Verwoerd, but also sees private patients. He has performed six transplants since the moratorium was introduced.

Obviously disappointed, Serfontein said: "It's no surprise to me ... I think I'll celebrate this news with another transplant," when told about the committee's decision.

He said he still had a few patients who needed transplants. His last two transplant patients, Danie de Bruyn and Evette Pretorius, were both reported to be doing well.

At a meeting between Serfontein and Gauteng health authorities earlier this month, it was agreed that he would transfer his remaining awaiting transplant patients to the Groote Schuur Hospital in Cape Town, the only official state heart transplant institution in the country.

The authorities said emergency heart transplant operations could be performed at the H F Verwoerd, provided Serfontein obtained permission from a committee comprising the hospital's superintendent, the head of the cardio-thoracic unit and a Gauteng health department representative.

Gauteng health authorities feel that the money spent on heart transplants should be appropriated to primary health care. — Sapa.

Department/Provincial Administration/Organisational Component/Education and Culture Service of Ex Own Affairs Administration	*The number of posts created during the period 1 July to 31 December 1994*	*The number of posts abolished during the period 1 July to 31 December 1994*
Department of Agriculture	24	0
Department of Arts, Culture, Science and Technology	26	5
Department of Constitutional Development	0	0
Department of Correctional Services	11	14
Department of Education	135	0
Department of Environmental Affairs and Tourism	74	15
Department of Finance	0	0
Department of Foreign Affairs	15	0
Department of Health	49	40
Department of Home Affairs	33	14
Department of Housing	0	0
Department of Justice	29	29
Department of Labour	35	39
Department of Land Affairs	653	252
Department of Mineral and Energy Affairs	2	206
Department of Public Works	0	0
Department of Sport and Recreation	19	62
Department of State Expenditure	5	2
Department of Trade and Industry	12	0
Department of Transport	10	0
Department of Water Affairs and Forestry	11	0
Department of Welfare	0	0
National Defence Force[1]		
National Intelligence Agency[1]		
Office of the President	9	15
Office of the Public Service Commission	7	2
Provincial Administration: Eastern Cape	0	0
Provincial Administration: Eastern Transvaal	0	0
Provincial Administration: KwaZulu-Natal	1 280	1 091
Provincial Administration: Northern Cape	727	0
Provincial Administration: Northern Transvaal	638	39
Provincial Administration: North West	7	0
Provincial Administration: Orange Free State	130	44

Department/Provincial Administration/Organisational Component/Education and Culture Service of Ex Own Affairs Administration	*The number of posts created during the period 1 July to 31 December 1994*	*The number of posts abolished during the period 1 July to 31 December 1994*
Provincial Administration: Pretoria-Witwatersrand-Vereeniging	378	308
Provincial Administration: Western Cape	888	933
South African Police Service	0	0
South African Secret Service[1]		
Central Economic Advisory Service	15	0
Central Statistical Service	0	0
Office of the Executive Deputy President	9	0
Office of the Executive Deputy President from the Largest Minority Party	15	2
Office for Public Enterprises	0	0
South African Communication Service	27	21
Education and Culture Service (Ex Administration: House of Assembly)	0	20
Education and Culture Service (Ex Administration: House of Delegates)	0	4
Education and Culture Service (Ex Administration: House of Representatives)	123	52

[1] The relevant information is classified and has not been made available.

Infant mortality rate in each population group

70. Sen Dr G W KOORNHOF asked the Minister for Health:

What was the infant mortality rate in respect of the (a)(i) Black, (ii) Coloured, (iii) Asian and (iv) White population groups and (b) Republic in the latest two calendar years for which figures are available?

S145E

The MINISTER FOR HEALTH:

(a) We believe that the figures that we have for Infant Mortality Rates are not reliable and that the true figures are higher. This is because we believe that there is under-recording of births and infant deaths, particularly in the rural areas.

With this caveat the Infant Mortality Rate per 1 000 live births in 1994 for each of the nine provinces were:

Western Cape	27
Northern Cape	32
Gauteng	36
Eastern Transvaal	41
North West	43
KwaZulu-Natal	46
Free State	46
North Province	57
Eastern Cape	58

Source: "South Africa's nine provinces: A human development profile". Development Bank for Southern Africa.

(b) The same caution must be exercised in interpreting the national data for population groups with a high proportion living in rural areas.

The data available gives the following Infant Mortality Rates per 1 000 live births:

	1993	1994
Black	53	52
Coloured	33	30
Asian	9	9
White	8	8
OVERALL	44	43

Department of Transport: advisers/ consultants appointed

90. Sen J SELFE asked the Minister of Transport:

(1) Whether he has appointed any (a) advisers and/or (b) consultants to advise him or his Department; if so, (i) what (aa) is the name and (bb) are the qualification of each adviser and/or consultant, (ii) for what (aa) purpose and (bb) period was each appointed and (iii) what remuneration package and/or other fee is being paid in respect of each;

(2) whether any fringe benefits are payable to any such advisers and/or consultants; if so, what are the relevant details in each case;

(3) whether any advisers and/or consultants are advising or assisting him or his Department at no cost to the State; if so, (a) what (i) is the name and (ii) are the qualifications of each such adviser and/or consultant and (b) what function is each performing within this Department;

(4) whether any (a) organisations, (b) bodies and/or (c) persons are paying the costs of the advisers and/or consultants referred to in paragraph (3); if not, what is the position in this regard; if so, what are their names? S170E

The MINISTER OF TRANSPORT:

(1) (a) Yes, three.

(b) Yes.

Advisers (i)(aa) Dr C F Scheepers
Mr J D Cowburn
*Dr E A Hopkins

(bb) Dr Scheepers: DCom
Mr Cowburn: C A

Dr Hopkins: DPhil

(ii)(aa) Dr Scheepers: To perform a specific advisory service to the Minister of Transport

Mr Cowburn: To evaluate tender documents regarding risk financing/control in respect of the State Subsidised Motor Transport Scheme.

Dr Hopkins: To act as Specialist Adviser in the Chief Directorate: Financial Management.

*Subject to approval of State Expenditure.

(bb) Dr Scheepers: 1/2/95 to 31/7/95
Mr Cowburn: 25/1/95 to 9/2/95
Dr Hopkins: 11/4/95 to 10/4/98

(iii) Dr Scheepers: R175 per hour (limited to a maximum of 40 hours per week)
Mr Cowburn: R7 347
Dr Hopkins: Minor travelling expenses

Consultants: See Annexures A to C

(2) No.

(3) No.

(a) (i) (ii) (b) Falls away.

(4) (a) (b) (c) No. If any organisation, body and/or person offers to pay the cost for such services, the Department will consider such an offer.

* Please note that Dr Hopkins is an employee of the Government of the United Kingdom. Her services to the Department has been made possible by means of an agreement. She is however still being remunerated by the United Kingdom, although minor travelling expenses are being paid by this Department.

ANNEXURE A

CONSULTANTS THAT ARE REMUNERATED

Name	*Qualification*	*Purpose*	*Period of appointment*	*Remuneration package (hourly tariff)*
G J Jordaan	do	do	6 months	R250,00
H J Stander	MSc (Eng)	do	do	R250,00
J I de Wet	BA, LLB	Road Traffic Legislation	01/04/95 to 30/06/96	R246,00
A M Swanepoel	BProc	do	do	R185,00
J H Botha	BIuris, LLB	do	do	R185,00
L K Statham	BLC, LLB	do	do	R157,00
R A G van Pittius	BLC	do	do	R123,00
J Vorster	BLC	do	do	R137,25
J Bron	MCom	do	do	R147,15
S Coetzee	BLC, LLB	Overborder road traffic and road transportation	do	R248,29
R C Botha	LLM (cum laude)	do	do	R193,12
G A M Radesich	BLC (cum laude), LLD and Advanced Management Course (Diploma cum laude)	do	do	R193,12
S Labuschagne	BSC, LLB	do	do	R 93,80
L Burns	BLC, LLB	do	do	R 93,80
E C Kieck	BIuris, LLB	do	do	R137,94
M N de Kock	BLC (cum laude), LLB (cum laude)	do	do	R 93,80
W de Villiers	BLC (cum laude), LLB	do	do	R 93,80
Z Nqoro	BA (Law)	do	do	R 85,27
R de Bruyn	Senior Certificate	do	do	R 68,40
I B Charlton	BSc (Mech Eng) (Hons)	do	do	R175,60
N H Newsome	BSc (Mech Eng) (Hons)	do	do	R175,60
A P Wright	National Diploma for Technicians	Overborder road traffic and road transportation	01/04/95 to 30/06/96	R138,00
M Krug	National Diploma for Technicians	do	do	R138,00
G L Dehlen	PhD (Engineering)	Civil Engineering Consultant	01/01/95 to 31/12/95	R250,00 (with a maximum of R120 000)
B G Evans	BSc (Civil Eng)	Transportation and Traffic Engineers	01/04/95 to 30/06/96	R210,59

Shock at medical expert's resignation from institute

(85) Star 17/8/95

■ BY PRISCILLA SINGH

The sudden resignation of a South African Institute for Medical Research director last week has sent shock waves through the medical science fraternity, according to institute members.

The SAIMR's Professor Jan van den Ende was reported to have announced his resignation last week, and it is to become effective on August 28.

A member of the institute, who wished to remain anonymous, said: "He has quoted personal reasons for his resignation, but there is a lot of speculation surrounding the suddeness of his decision.

"Everybody is shocked at his resignation, especially since he just completed a round trip of all the laboratories, where he presented strategic plans for the institute in the future."

SAIMR board of management chairman At du Plessis said the organisation was very sorry to lose Van den Ende, and pointed to a reason for the surprise move: "An arrangement that would allow him his maximum retirement benefits, which was made some time ago, necessitated his resignation.

"However, he is willing to continue until a proper replacement can be found, and a special board meeting will take place today to discuss a replacement and Van den Ende's resignation," Du Plessis said.

Van den Ende has been with the SAIMR since December 1989, and he is a member of several professional organisations, including the University of the Witwatersrand medical school dean's advisory committee on AIDS of which he is chairman. He also serves on the executive of the SA AIDS Advisory Group.

He has also published a number of scientific papers in national and international journals.

It is not known who will succeed the director.

National Institute of Virology head Barry Schub said Van den Ende was a valuable contributor to health care, and it was very sad to see him leave his post.

"I am not sure of the terms of his resignation, but I hope he will still stay on at the SAIMR," said Schub.

Van den Ende could not be reached for comment.

Toxic waste sails for SA

Star 17/8/95

The Government has approved the import of 500 tons of toxic waste originating from the US and exported by Finland, Earthlife Africa claimed today.

In a statement in Johannesburg it quoted Finnish exporter Kikkola Chemicals as saying this was the first of several shipments totalling 3 000 tons for recycling by a Benoni company.

It is due in Durban in less than a week.

The Department of Environmental Affairs and Tourism said the material was toxic but would not be dumped. "It will be used in manufacturing processes," a spokesman said.

The department's dangerous-substances deputy director, Willem Scott, said the department had taken several safety steps.

The department had to convince Finland that nothing would be done contrary to the Basel Convention, which directed that all imports and exports of toxic material had to be carefully monitored.

Scott, who heads the Basel committee, added that the country had to present a report of its activities in this regard to the Basel Convention's secretariat each year.

Earthlife said KwaZulu-Natal environment committee chairman Ina Cronje was planning to object to the waste coming through Durban.

Earthlife Africa is exploring legal means to stop the shipment. — Sapa.

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"I am not sure of the terms of his resignation, but I hope he will still stay on at the SAIMR," said Schub.

Van den Ende could not be reached for comment.

Infant mortality lowest in Cape

ET 18/8/95 (85)

THE infant mortality rate in the Western Cape was the lowest in South Africa. The mortality rate was the highest in the Eastern Cape, the Minister of Health, Dr Nkosazana Zuma, said yesterday.

NOW LEADING A BUSY LIFE: Paul Thesen, who provides jobs for 30 people PHOTOGRAPH: FIONA SMITH

Piggy-back heart man makes plea for programme to continue

IsPaw 19/8/95 (85)

By FIONA SMITH

Knysna – The suspension of heart transplant programmes would be like imposing a death sentence on people whose lives depend on them, says the longest surviving patient of the programme, Paul Thesen.

Thesen (29), a Knysna property developer, has been on the transplant programme at Groote Schuur Hospital for 16 years after undergoing two heterotopic (piggyback) heart transplants performed by Dr Marius Barnard.

Reacting to the controversy surrounding a moratorium on heart transplants in Gauteng, Thesen says he is indebted to the programme not merely as a means of survival but also for allowing him to lead an active, healthy life.

"The cost of the immunosuppressive drugs which I have to take daily is exorbitant and I could not afford them without the State's help," he explains.

Paul made history when, at the age of 12, he was the youngest person to undergo a heart transplant.

He had been diagnosed as having a severe heart condition called myocarditis (inflammation of the muscular wall of the heart). His mother died of the same disease when Paul was a toddler.

But three years later his diseased heart, which the doctors had hoped would recover with the aid of the donor heart, had deteriorated so much that another transplant was needed.

He has been living on immuno suppressive drugs ever since.

"When I was young I was very ill but the transplants changed that," he says. "I am now able to run a successful property development business, employing 30 people who, in turn, support about 130. I am politically active in the ANC branch in Knysna.

Dilemma

"I live a very busy life and it would be impossible without the programme."

According to Dr Johan Brink, head of the transplant unit at Groote Schuur, a month to six weeks' supply of cyclosporin, the immunosuppressive drug used in post-operative treatment, costs about R1 000.

Brink explained that the cost of a heart transplant at Groote Schuur under the programme was R35 000 whereas the same operation performed privately would cost the patient about R100 000. The dilemma of the patient is that no medical aid scheme will cover a transplant patient, which means that without state aid, the patient would have to pay for the entire operation and post-operative treatment.

Paul contends "it would take monumental sacrifices to afford just the drugs without state aid".

His argument is that the programme has allowed him to continue contributing to society instead of being a burden on it.

Brink agrees: "The aim of the programme is to allow patients to continue actively contributing to society and to enable them to enjoy a quality of life which would otherwise have been denied them."

And having lived in the twilight zone of hope and uncertainty, Paul talks about regaining an appreciation for life, making plans and living to the full.

"It is very restricting to dwell on the past, and the best cure is just to get on with living," he says "I sometimes forget that I have two hearts beating inside me," says the man who, as a teenager, took up sports such as motocross and parachuting. He also spent a number of years in Malawi and Botswana as a safari tour guide. As a politically motivated person, which he attributes to the guidance of his father, Charles Thesen, Paul says he understands the importance of primary health care.

Programme

"But if medical research is stymied and development in these fields is stalled, there will be no incentives for doctors to stay in this country. We are talking about the difference between life and death."

Brink said recommendations had been made at ministerial level to adopt a national policy regarding the transplant programme at Groote Schuur and that a "super-regional" funding of the programme should be considered as it was open to all citizens in the country.

Scientific sangomas

(85) CP 20/8/95

By BENISON MAKELE

JOINING FORCES . . . Traditional healers learn about basic diagnosis, Aids prevention and health care from Sister Saracia Fuzile at the Zola Clinic in Soweto.

■ Pic: MIKE MZILENI

THOSE who consult African traditional doctors shouldn't demand their money back if the "amakhosi" refers them to a clinic.

A new breed of sangomas at ease with the western way of diagnosing disease is being churned out by the Soweto primary health care services through township clinics.

The process of integrating traditional methods of treating disease with western methodology was started after clinic nurses realised that people resorted to "modern" medicine after developing complications from treatment by traditional healers.

City Press visited the Zola clinic in Soweto and found a class full of colourfully-dressed traditional doctors from all over the township.

The tutor, Sister Saracia Fuzile, said the programme was started in 1993 after it was discovered that traditional doctors were not knowledgeable about signs and symptoms of disease.

To date the clinic has issued 43 traditional doctors with primary health care certificates and has 15 doctors currently taking the six-month course.

The course includes awareness lessons about urinal tract infections, congestive cardinal failure, gastro-enteritis and stillbirths.

"For example, we know that the use of 'isihlambeza' – a liquid mixed with muti – induces labour pains but has to be used at the right moment. If used before the membrane has ruptured during labour pains, it may cause complications resulting in stillbirths," Sister Fuzile explained.

A former student at the clinic, Mathafeni Langa, said the education she got there had helped her to identify disease symptoms correctly, spread Aids education and avoid issuing overdoses of prescribed medicines.

Another student, Themba Mpondombi, said they have been able to teach people about Aids and other diseases.

The clinic's matron, Duduzile Mthombeni, says she is very happy with the results of the programme.

"It has worked wonders for us because they not only accept us but also refer patients they cannot treat to us," she said.

RDP-funded rural clinics project ready to begin

BD 21/8/95

Kathryn Strachan

THE construction and upgrading of about 176 clinics in underserved areas around SA will begin within the next month, health department director-general Dr Olive Shisana said on Friday.

The projects will be funded by the R90m allocated by the reconstruction and development programme during the past two financial years.

The department previously lacked the capacity and infrastructure to proceed with the clinic building programme, but now that structures were in place "we are poised to act", she said.

"We will see an improvement in the near future," she said. The date for the completion of the clinic projects, including upgrading and building, is July 12 next year.

The process was given a kick-start with the appointment earlier this month of health facilities planning director Malcolm Jones, who will employ "fast-track" methods to build and equip clinics.

Discussions have been held between the health ministry, provincial MECs and the public works department to unblock any obstacles that could delay building.

A further R163m, retrieved when the budget for academic hospitals was cut by 5%, was available for runing the clinics.

Shisana said that while the first allocation for clinic building was made last year, the department had lacked the capacity to absorb the funds and few clinics had been built. Now that key appointments had been made, it was possible to get the process going.

It was not possible to carry out projects such as this until the various health authorities had been amalgamated into a single department and people were placed in positions to steer the projects.

Umtata district community health officer Dr Costa Gazi said clinics in rural areas had been neglected while the health department focused on sorting out its structures and key staff. He argued that while the department created its new bureaucracy it should have used existing structures to carry out much needed projects such as clinic building.

Shisana responded that most provinces had appointed heads of health departments only in the past four to five months and before this there was no one in a position to make key decisions and to sign over the money.

Unless there was a person in a position of responsibility, there was little control over the money that was thrown into projects.

Health demands a R1,25bn headache (85)

BD 21/8/95

Kathryn Strachan

ACHIEVING parity in health personnel salaries is emerging as one of the main difficulties in integrating the fragmented health system, and a new study shows that it would cost the health department R1,25bn if all personnel employed by the various authorities were raised to the higher of the two relevant scales.

The disparity between salaries has been the cause of the strike in Soweto provincial authority clinics, which started on Thursday. Workers demanded to be paid wages equal to employees of Soweto's local authority clinics. The protesting workers were given a 5% wage increase last week, while local authority clinic workers received between 6% and 12% increases.

Workers, who rejected the 5% offer, ended their protest action on Saturday.

Sapa reports that Gauteng premier Tokyo Sexwale met striking health workers in Soweto on Saturday in a bid to end the crisis at some 13 clinics in the township. He was joined by health MEC Amos Masondo as well as representatives of the health workers' forum.

The premier told the striking workers not to expect too much, and urged them to "work towards a solution and be willing to make compromises".

In Soweto — as in the rest of the country — clinics fall under either the provincial health authority or the local authority.

One of the main obstacles in bringing all the various clinics under a single district health authority therefore is the question of salaries, as local authority staff, who are paid more, are opposed to dropping their salaries to the level of provincial staff. Local authority clinics also argue that as they are in the front line of primary health care, they should be allowed to retain their higher salaries in order to attract well qualified staff.

Another major obstacle in the integration process is being caused by the delay in setting up local authority boundaries, which are needed before a district health authority can be created.

Author of the report, Bupendra Makan, who is a researcher at the University of Cape Town's health economics unit, said government could not afford to pay R1,25bn to raise all salaries in the country to the higher of the two scales, so clearly there had to be a phasing mechanism.

This affected 11% of the workforce (about 8 000 people) and would be necessary to ensure fairness with integration.

Makan said there were cases where health personnel employed by local authorities earned 78% more than their colleagues in the provincial adminstration who had the same qualifications, experience and responsibilities.

He said it was possible that this seemingly insurmountable stumbling block could be the catalyst for the creation of an entirely new structure for health personnel. This would solve the problems not only of disparities, but also of incentives for the improvement of public sector conditions.

Health workers from clinics in Soweto protest outside Baragwanath Hospital on Friday over wages and working conditions. The workers, from 13 clinics in the township, ended their protest action at the weekend. Picture: SALLY SHORKEND

Police 'used UBS' for cover-up

Stephané Bothma

PRETORIA — A sworn statement by a United Building Society manager, based on incomplete documentation presented to him by police detective Krappies Engelbrecht, was used to support a top-level cover-up of the 1985 abduction, assault and murder of Japie Maponya.

Engelbrecht was the investigating officer into claims in 1989 by former Vlakplaas police officer Almond Nofomela that his unit had kidnapped UBS security guard Japie Maponya, who was murdered.

Evidence last week in the Transvaal Supreme Court murder trial of former Vlakplaas C10 commander

[illegible] would decide which

the leave card was incorrectly amended after Maponya failed to report for work on September 26.

"I could recall at the time that for two days before his leave was due, Maponya failed to report for work," Cloete testified. This resulted in him making an affidavit stating that Maponya's last day of work had been September 23.

"Such allegations are in my opinion devoid of all truth and I am convinced that Maponya had fled the country to join his brother and the ANC," Engelbrecht stated at the time.

His "conviction" was based on a R10 withdrawal from Maponya's bank account on September 24, "after he was already supposed to be dead by Nofo-

REGULATORY BODY POSITIONS UP FOR GRABS

Alternative health experts in row

CT 23/8/95 (85)

AS THE appointment of a regulatory body is awaited, alternative health experts have told the Senate about their exclusion over the years. **THANDEKA GQUBULE** reports.

ALTERNATIVE health practitioners are embroiled in a controversy as they lobby for inclusion in the new statutory body that will regulate homeopaths, chiropractors and allied health services.

In their presentation to the Senate committee on health recently, the South African Vitalistic Chiropractic Association said their medical and academic credentials were questioned, their practices raided by police, the attorney-general was encouraged by the previous board to prosecute them and they were forced to practise underground.

But Dr A Milan, representing the old council, told the committee he felt demonised by his adversaries and denied most of the accusations.

However, he argued that the bodies that made oral submissions, including the association, should not be included on the council, and that the councils of the previous TBVC states be rationalised and one council formed.

The association said some of them had been forced into exile or to emigrate as it became impossible for them to practise.

'Fruitless'

In their plea for inclusion, they said all previous approaches to the government had been in vain.

"Health ministers Dr N van der Merwe and Dr L Munnik were approached. All our attempts were fruitless as the NP was unwilling to challenge the board's totalitarian rule."

Health minister Dr Nkosazana Zuma must still decide whom to appoint to the statutory council.

Dr Patricia Tsotetsi, of the Homeopathic and Allied Health Practitioners Association, said: "We can't wait to see who the minister will appoint, as her appointments will indicate whether there is to be fair play in the future or if we are all back to square one."

Feuding

Health department director-general Dr Olive Shisana said the new board should "try to be more accommodative and inclusive".

The jostling for positions on the board comes after years of bitter feuding in these professions, as those who were denied registration rallied together and accused the boards elected under previous ministers of health of dictatorial and autocratic behaviour.

Those previously excluded also claimed they were deprived of registration, denied access to medical aid and harassed.

Sources close to Dr Zuma said she was aware that thousands of South Africans consulted practitioners of alternative medicine and there was a need for these practitioners to be legitimised.

Dr Zuma was not available for comment.

aware of their infection, as will the prison authorities.

Because of such treatment, 14 prisoners at the Pietermaritzburg prison, who are HIV positive, have started litigation against the Department of Correctional Services.

This brings me to the unavailability of condoms. From the Minister's response last year and other responses from the Department of Correctional Services, it would seem that disapproval of homosexuality is the basis for refusing to make condoms available.

Homophobia, whether in Zimbabwe or in South Africa, can be no substitute for rational and sensible policies. Arguments based on so-called moral disapproval simply misses the point. The call for condom distribution in prisons must be seen in the light of disease control and protecting society from the further spread of HIV.

Whether one approves or not, sexual intercourse occurs in prison. In all honesty, the Minister and the Department of Correctional services will have to admit . . .

The SPEAKER: Order! I regret to inform the hon member that his time has expired.

Mr C G NIEHAUS: I will proceed later.

Mr H M NEERAHOO: Madam Speaker, I have no problem with the HIV-positive prisoners being separated from the other prisoners who are incarcerated. I believe that the normal health plan should apply in prisons.

I am not in agreement with the hon the chairperson of the Portfolio Committee on Correctional Services that we should aid and abet deviant sexual behaviour in prisons. I am sure that there are better ways of containing this type of behaviour than by making condoms freely available there. I tend to agree with the hon the Minister that, instead of making condoms freely available, we should educate our prisoners to refrain from this type of deviant sexual behaviour. [Interjections.] One way of doing so is to keep them busy in the workplace instead of keeping them busy at night. [Interjections.]

The cost constraints on upgrading prisons are enormous. Maybe one day, with the help of the hon member Mr Niehaus and with the persuasion of the ANC, we might distribute condoms. Then, however, it is going to cost us a hell of a lot of money to upgrade prisons, to make separate compartments for the deviant sexual behaviour to take place. It does not take place in front of other prisoners.

If that situation does arise, I am sure the ANC will also allow conjugal visits in prisons. We cannot treat one group of prisoners differently from the others. They are all prisoners and they should be treated alike. If we make provision for condoms for one set of prisoners, why should we not do the same for the rest, and allow the rest to enjoy themselves as well? [Interjections.] [Time expired.]

The MINISTER OF CORRECTIONAL SERVICES: Madam Speaker, I must say that I am rather perplexed by the fixation, or perhaps it is a fascination, with certain body parts of prison inmates. [Interjections.]

I think that the question of Aids and HIV is a serious question. There are 15 members prisoners who have Aids. They need our compassion and our understanding. They do not need to be made a political football in Parliament. There are 504 prisoners who are HIV positive. They too need proper understanding, and the issues need to be dealt with in their complexity. To come here, pretending that we are serving the interests of people who are ill, when in fact we want to further our own political ambitions, is a scandal, and should be stopped. [Interjections.]

Dr T S FARISANI: Madam Speaker, I want to address three issues.

Aids is not a disease reserved for prisoners. The whole of humanity is vulnerable to this threat, including the legislature, the executive and the judiciary, as well as the hon members who sit here. [Interjections.] Let us place ourselves in the boots of those who are suffering. Perhaps we will then learn to understand sympathy. To gather holy stones to destroy this unfortunate woman will invite the intervention of God who will come and say: "those of you who are free from sin, be the first to throw a stone".

Let us stop apartheid in disease. Some children have been discriminated against because of HIV or Aids symptoms; women have suffered.

Now we are looking for solutions, not for wise political talk. We need adequately trained staff in our prisons to handle this problem. We need a public and social health policy to handle this problem. We need to bring our policy and practice in line with the World Health Organisation's

programme to combat Aids, and not to practise apartheid against our prisoners, who are already very vulnerable people.

I believe in education. I also believe in preaching, but I am a realist. I know that in spite of my good sermons and my education, people still suffer from many kinds of diseases, including HIV. We need to provide solutions to this problem, such as condoms, to help our prisoners. [Time expired.] [Applause.]

Mr C G NIEHAUS: Madam Speaker, it surprises me that we have to be faced with a situation in which it is termed "scandalous" when one raises in this House one of the most important issues that we can possibly discuss in South Africa at this stage. I am definitely not going to apologise for asking the Minister of Correctional Services and all members of this House, including Mr Neerahoo, to be realistic about the situation which we are faced with. I repeat what I said earlier. Whether one approves or not—the Minister must please accept this—sexual intercourse occurs in prison, whether one likes it or not.

In all honesty, the Minister and the department will have to admit that in spite of the strictest measures, one cannot prevent it from taking place, especially not in our overcrowded prisons. One also has to take our Constitution seriously. It specifies that there should be freedom of sexual choice. [Time expired.]

The MINISTER OF CORRECTIONAL SERVICES: Madam Speaker, the Department of Correctional Services has set up a task force to look into the whole question of the treatment of people in prisons who either have Aids or are HIV positive. We do this in consultation with experts from other countries, and are waiting for a full report which will be presented to us in November.

I have to emphasise once more that, as a country and as a Government, we have as yet no National Health Plan which gives us full direction on how to deal with the question of Aids. If we want to deal with this matter responsibly, we must do so on the basis of fact, not on the basis of fiction and emotion.

Debate concluded.

High-technology health services

2. Dr W A ODENDAAL asked the Minister for Health:

Whether it is the policy of the Government of National Unity to scale down high-technology health services in South Africa; if not, what is the position in this regard; if so, what are the relevant details? (85)

N1095E.INT

The MINISTER FOR HEALTH: Madam Speaker, hon members, health care reform in this country and in other countries is focusing on the development of primary health care and the reduction of high-level hospital care services. This is the case mainly because an improvement in the health care status of a population does not result from the availability of high-tech medicine found in academic or tertiary health centres. What improves the health status of a population is access to clean water, the prevention of disease, the promotion of health, and the availability of curative services in the communities in which people live.

Countries that have expensive technological systems that are operated from tertiary hospitals do not necessarily have better health indicators, such as a low infant mortality rate or a high life expectancy. The USA is a very clear example in this regard. However, countries that have good primary health care services have a better health status. I refer here, for example, to the United Kingdom and Cuba. [Interjections.]

Most of the health care needs of the average South African can be met at a primary or secondary health care level. It is only when those centres cannot handle a health problem that a need for highly specialised care arises. However, in stating that the use of expensive technology in tertiary and academic health centres does not improve the health of the population, I am not implying that these hospitals do not play an important role in health care delivery. They do, in fact, play an important role, but the emphasis should be on primary health care which is supported by a good system in terms of which patients are referred from the primary level to the secondary and tertiary levels.

The issue at stake is what degree of academic health care versus primary health care there should be. We have to get a balance that, in the end, will result in the improvement of the health status of the people of this country. [Time expired.]

Dr W A ODENDAAL: Madam Speaker, the ANC truly excels in incompetence. It took a commu-

nist, socialist regime 10 years to destroy the health care system of Mozambique. Millions of Mozambicans fled their country to seek food and health care from a NP government in South Africa. The ANC communist-dominated regime is going to do the same to South Africa, but in a record time of two years. [Interjections.]

The wheels of our country's health care system are already coming off. Doctors are forced to stop operating. The health system in the Eastern Cape has all but ceased to function. The Thaba Nchu and Botshabelo hospitals in the Free State are on the point of closing down. The HF Verwoerd and Tygerberg academic hospitals are in a shambles. Almost half a billion rands worth of budgeted money will not be spent on primary health care clinics this year, and that is because the ANC Government is incompetent to manage the health care system in our country. [Interjections.]

The school feeding scheme in the Eastern Cape and the Free State has come to a standstill because of unbridled corruption, and the ANC is doing nothing about it. The ANC promised the people of this country houses and health care, but they cannot deliver because of their incompetence. The people know that the NP can do this job; it has a proven record in this regard. The time has come for the NP to take over the Government again. [Interjections.]

Mr M J ELLIS: Madam Speaker, I was not aware of the fact that this was a humorous interpellation. [Laughter.] Obviously, Dr Odendaal's input suggests that it is. I want to say to the hon the Minister that she may well be right about the importance of the provision of primary health care to all South Africans. However, let me say to her, too, that it would be tragic to begin a scaling-down of high-technology health care in South Africa. She probably is right, too, that a balance between high-tech health care and primary health care is absolutely necessary.

However, let me say that what is really required in South Africa is not so much a scaling-down of high-technology health care, but the proper management and utilisation of it in this country. This refers to both the private and the public sectors. In fact, let me say that there must be a complete interaction between these two sectors, the private and the public sector, in the area of health care, in order to make high-technology health care as cost-effective as possible.

We all know that equipment in the area of high-technology health care is expensive. Also, because of the rapid changes that take place in computerised equipment, it has the ability to age very quickly, and to become obsolete as well. Consequently, in a country like South Africa where the health budget is tight, there is a need to ensure that a minimum of equipment is purchased, but that this equipment is utilised to its maximum.

This means that what exists in the private sector must be available to the public sector as well, on a fee-for-service basis if necessary, and of course, vice versa. However, we must avoid the overpurchasing of equipment which will then stand idle, and lead to the need for the overservicing of patients on the part of the owners of the equipment, in an attempt to recover costs—something that has been happening in this country for a long time.

However, I urge the hon the Minister not to cut back on high-tech health services. This will be detrimental to the entire health care programme in South Africa because there is no doubt that health care technology, if utilised appropriately and cost-effectively, will contribute significantly to the success of our health care programmes in this country. [Time expired.]

The MINISTER FOR HEALTH: Madam Speaker, I agree with the hon Mr Ellis that we should retain high-tech health care. However, what I am saying is, there has to be a balance: Primary health care has to be introduced.

If one inherits a system which is exclusively high-tech, and one wants to introduce primary health care, but does not have double the resources in terms of one's budget, it means that one has to reprioritise. That is what common sense will tell one, unless there is an unlimited amount of money given to me to create the primary health care system without interfering with anything else.

I would like to say to the hon Minister Odendaal that ... the hon member Mr Odendaal ... [Laughter] ... that it took him and his NP colleagues 10 years to fund Renamo to destroy the health care system in Mozambique. [Interjections.]

That is what destroyed the health care system in Mozambique. Those people sitting on the other side of the House funded Renamo to destabilise Mozambique. [Interjections.] He must not come

and tell us about socialism having destroyed the health care system in Mozambique.

Furthermore, I would like to say that health care in the Eastern Cape reflects years of neglect of the homelands by the previous government of apartheid. The corruption we see there did not start on 27 April. It started a long time ago. What started on 27 April is the exposure of that corruption. [Applause.]

Ms N E MASANGO: Madam Speaker, I would like to ask the Minister how her department is going to address the corruption in the Eastern Cape. An amount of R133 882 360 has been allocated for the year 1995 and they have already consumed R114 million in only four months' time. As a result, 1,9 million children have been deprived and the quality of food has deteriorated drastically as well.

The NP puts it to the Minister that because of negligence on her part, this noble project was implemented hastily and haphazardly without a clear sense of what was required and how to go about it. If the answer is no, she must please supply South Africa with a remedy for this chaotic situation or give the task to those who can and will find a way to deal with the mess promptly and without further depletion of the RDP Fund.

*Dr W A ODENDAAL: Madam Speaker, this afternoon I witnessed the most bizarre thing I have ever seen in this Parliament. The hon the Minister of Correctional Services said the Minister for Health did not have a health plan in place yet, and that is why he could not supply condoms in prisons. This hon Minister for Health told Mr Niehaus sitting there behind her that such a health plan is on the table. Who is lying to us? [Interjections.] Which one of these two Ministers is telling the truth?

I say the hon the Minister for Health does not only have a policy problem; she also has a managerial problem. She does not know what is going on in her department. It has been clear for a long time that the corruption with regard to the school feeding programme is getting out of hand. What has she done about that? She is going back to the Cabinet to ask for more money to waste. I think the time has come for her to resign. [Time expired.]

The MINISTER FOR HEALTH: Madam Speaker, unfortunately my equipment was not working so I did not hear much of what Dr Odendaal said. Let me say that where we found corruption we made sure people were arrested and justice took its course.

I want to say to Her Master's Voice ... [Laughter] ... and repeat that what we are seeing at the moment are a lot of problems such as hospitals in the Eastern Cape that are dilapidated and hospitals that have not been maintained properly. We are seeing areas that are not properly resourced by health personnel, but this is what we inherited. [Interjections.]

The SPEAKER: Order!

The MINISTER: Well, in Zulu they say the truth pricks. We can see who is being pricked by the truth right now. [Interjections.] What I would like to say then to Her Master's Voice is that we have committed money, and we are repairing the hospitals. Work has started on repairs to some of the hospitals in the Eastern Cape. We have advertised for doctors to go and work in the Eastern Cape. [Interjections.] Yes, if we do not get South African doctors, we shall get Cuban doctors. [Interjections.] [Applause.] What we are concerned with is the health of the people of South Africa. [Time expired.]

Debate concluded.

Funding for the performing arts

3. Mr M F CASSIM asked the Minister of Arts, Culture, Science and Technology:

Whether any additional funding for the performing arts in particular and all other arts in general is being envisaged; if not, why not; if so, what are the relevant details?

N1094E.INT

The MINISTER OF ARTS, CULTURE, SCIENCE AND TECHNOLOGY: Madam Speaker, unfortunately additional funding for the performing arts in particular, and for other arts in general is not going to be forthcoming at this stage. This is an unfortunate situation, since the argument for making additional funds available to the arts during this period of reconstruction is rather a compelling one. For this reason, my Ministry is currently exploring ways of raising additional funding, because we see it as crucial bridging funding in the process of transforming the arts sector.

The process of transforming our cultural dispensation from one that serves the cultural interests of a few to one that meets the needs of all South Africans is one that requires funding. In the past

Problem areas need more searching talks

Aim is health care for everybody

BY JANINE SIMON
MEDICAL CORRESPONDENT

Extending free health care to the elderly was among the many public responses to the proposed National Health Insurance System (NHIS), Director-General of Health, Dr Olive Shisana, says.

The NHIS document spells out mechanisms to achieve universal access to primary-health care, which will cost an additional R3,39-billion over the next five years.

It was released in June and the period for public comment on its proposals closed on Friday August 18.

Although proposals such as an essential drugs list, accredited private providers and mandatory insurance for a hospital benefit package are far from implementation, health departments are already falling in line with the equity principle.

Some examples include the controversial decision to re-work the national formula for allocating intern posts, the limiting of heart and lung transplants to Groote Schuur hospital and the decision to limit spending on advanced life-support services to make intermediate-level emergency care available to all.

Shisana says an integrated report on the comments is expected to be made public and presented to Health Minister Dr Nkosazana Zuma and MECs by October.

Shisana, who co-chaired the commission with health economist Dr Jonathan Broomberg, said she was pleased with the level of communication and public participation in the process.

Grassroots organisations made submissions, and the committee has toured all provinces.

The overall reaction had been positive but there were some problematic areas on which health authorities needed to negotiate further.

'Wild allegations' denied

Sowetan 24/8/95

Sowetan allegations not true, says East Cape health spokesman (85)

By Mzimasi Ngudle

A SPOKESMAN for the Eastern Cape health department Mr Khululekile Bata yesterday said reports that four directors in the department earned two monthly payments were unfounded.

"The fact is that these wild allegations are not true. The department became aware of this because it was informed by these officials," he said in response to Monday's *Sowetan* report on double payments to some Eastern Cape officials.

"No director went home with two cheques. They brought them back and cancelled them," Bata said.

However, Bata confirmed that Ms Susan Siwahla, director of primary health care, Ms Nomawethu Jordan, director of social welfare and population development, Mr Mmeli Sixaba, a regional director and Mr Malungisa Dingiswayo, director for social security, were some of the 14 directors whose monthly payments were under scrutiny.

Bata said additional payments were due to administrative problems in "unifying the former homeland payrolls into one computerised system".

'Payments authorised'

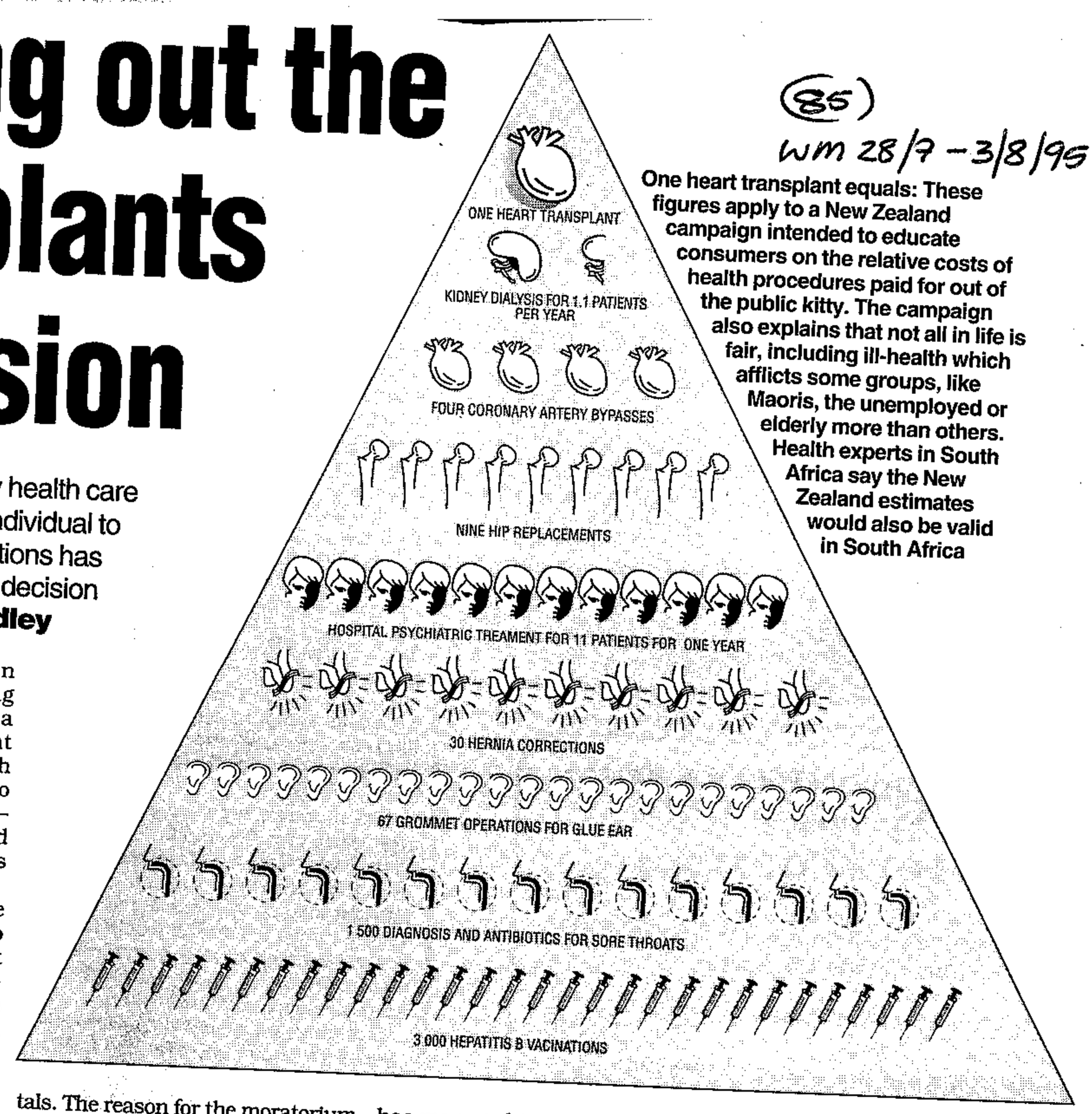
Responding to allegations in the same report that three senior government officials seconded from Transkei were still earning their secondment payments, the chairman of the Public Service Commission Mr Mabandla Tsengiwe said the payments were authorised by the premier on their secondment to Bisho and that the matter was being reviewed, according to an East London daily newspaper.

One of the officials, Mr Sintu Mpambani, was appointed as the permanent secretary in the premier's office in March but was still receiving the additional allowance.

The other two, Mr Zam Titus and Mr Mawethu Ntshongwana, were still seconded and do not yet have permanent positions.

Cutting out the transplants confusion

The battle between primary health care needs and the right of the individual to expensive transplant operations has forced a government policy decision on the issue, writes **Pat Sidley**



One heart transplant equals: These figures apply to a New Zealand campaign intended to educate consumers on the relative costs of health procedures paid for out of the public kitty. The campaign also explains that not all in life is fair, including ill-health which afflicts some groups, like Maoris, the unemployed or elderly more than others. Health experts in South Africa say the New Zealand estimates would also be valid in South Africa

(85)
WM 28/7 - 3/8/95

A NATIONAL policy on transplants is being thrashed out — with a draft at the moment before Minister of Health Nkosazana Zuma. Talks leading to the policy began earlier this year — but the process has been speeded up by events of the past two weeks in the heart transplant world.

The policy is expected to provide guidelines on who will be able to receive an organ and under what conditions, in the private and public health sectors. Donor organs may be treated as a national resource (which is not the case at present) and their use could be dictated by need, and not on a first come, first serve basis, or by ability to pay.

The Department of Health official co-ordinating the issue, Dr Lennox Matthews, said donor organs covered by such a policy would include hearts, livers, kidneys and corneas. But he preferred not to be drawn further on detail until the minister had decided on policy.

The guidelines were discussed at a meeting of department officials and private health care interests in April.

The policy would also regulate some difficult areas, like excluding certain people who because of a poor prognosis, or being too old, would not be seen as suitable recipients.

The present confusion, exacerbated by accusations that surgeons are looking at their career paths rather than broader health care needs, is pushing all involved to make an enforceable, binding policy decision soon.

This week, Fanus Serfontein, the controversial Pretoria surgeon at the heart of the storm, performed a second (and unsuccessful) heart/lung transplant, this time in a private hospital not covered by the Gauteng moratorium on transplants in the province.

This followed Serfontein's action the week before when he broke the moratorium agreed to by the Gauteng Department of Health, academic health professionals, and hospitals. The reason for the moratorium had been to formulate a policy for the region, which suffered severe budget cuts in health, and has no reliable figures on what transplants actually cost.

No adequate costing of such procedures has been carried out in the past in the state health sector.

Several thorny issues have been raised by the row — which is likely to rage on beyond any policy decisions — as it does in several other countries.

Among them are political issues as well as legal issues such as medical malpractice, and the right of a consumer to have a transplant vs the authority's right to cut back on those facilities it offers (see box).

In New Zealand, according to Dr Alan Rothberg, director of policy at RAMS (the representative body of medical aids schemes) , when the government wished to revise its national health policies and priorities, it did not as a first move, stop transplants or other expensive high-tech procedures.

The government decided instead to educate the public about the costs involved in such procedures, so that a prospective patient would know that one transplant's costs were the equivalent of several dialysis machines and the same cost as a facility to treat hundreds of people at some other level of care.

Politically, a sophisticated lobby has managed to portray the ANC-dominated health administrators as heartless, willing to sacrifice lives on the altar of new political imperatives.

Zuma's hand has been forced and she was compelled late last week to pronounce that Groote Schuur is to be the only facility for heart transplants for the time being.

In the Western Cape, Gauteng's heart transplant issue has resonated in a debate between the ANC's health ministry, the National Party-dominated administration and the doctors at Tygerberg and Groote Schuur.

The plan drawn up by the department of health in the Western Cape would have Groote Schuur performing all transplants and "super specialties" while Tygerberg would relinquish its liver and other transplant functions in favour of a different, more community-oriented service.

Ebrahim Rasool, the province's ANC MEC for health, said the Gauteng row showed the effective lobbying of the medical establishment which did not want to face changed health care needs and priorities.

Referring to the lack of good health information systems, Rasool says while the transplant moguls manage to get much vociferous publicity, nobody manages to quantify the effect that living for five months a year in a water-logged squatter camp has on a community. Hundreds of those types of deaths are being put down to natural causes, he says. They should be preventable, if enough resources could get to those people.

Zuma, in her statement last week, noted that heart transplants had not been undertaken in Gauteng's public hospitals before this year.

Statistically, the longer a transplant facility does a particular transplant, the longer the recipients survive — causing eyebrows to be raised at the actions of Serfontein and the teams of doctors at HF Verwoerd.

Meanwhile, legally speaking, the family in Pretoria who lost a member this week under the knife of Serfontein, may have a malpractice suit against the doctors involved and possibly the hospital.

The question that would have to be asked legally, says law Professor Dennis Davis, is whether any reasonable doctor would have performed this operation under these circumstances.

Was the patient offered the opportunity of going to Groote Schuur? Was there a need to take his healthy heart out? Was the hospital in which he had the operation, the correct place to be? Davis believed these and other questions raised the possibility of a successful malpractice claim. "It was "high time", he said, that legal principles were adopted which would render doctors more accountable to the public.

Right to life, and to sue

WM 28/7 - 3/8/95

Pat Sidley (85)

IT'S midnight, you're on the table at HF Verwoerd hospital. You've been told that your life has been severely limited by your ailing heart and lungs.

In a shooting on the Ben Schoeman highway, a perfectly good set of heart and lungs has become available — but your surgeon cannot go ahead and save your life because the province has decided to halt heart transplants.

Your surgeon decides to put the province, Dr Ralph Mgijima, on the superintendent-general of the line and interrupts his dinner party with a telephone call to his house asking permission to save your life with the transplant operation.

He, however, has had enough of the midnight calls and besides, he has had to suspend plans to build a primary health care facility in Phola Park, as the province has run out of money.

So he says "no". Your surgeon then sews your ill-functioning heart and lungs back into your body and sends you back to the ward. You regain consciousness enough the next day to believe your rights have been seriously infringed by the province.

The facility is there, you're the breadwinner in a family with six children and you are now likely to die as a result of this decision. The family will be left destitute.

Besides this, the new Constitution has enshrined your right to life. The province however, has taken action which would deny that very right. You would like to know what chance you have of succeeding in a legal action.

There have been precedents in the United Kingdom in which the courts have held that before stopping a procedure, the health authority ought to have consulted properly with the local community, and other precedents where patients have been denied major operations because they are heavy smokers and this conflicts with health authority policy which limits major operations in a setting of insufficient cash available.

According to law Professor Dennis Davis, you would probably have a chance of succeeding in the action, both in the civil courts (claiming damages and perhaps forcing the granting of the operation) and you may have a chance in the Constitutional Court as your right to life is clearly being breached.

You may be able to use the constitutional argument to bolster your civil court claim — but he says, so far there does not seem to be room to claim damages in the Constitutional Court if your rights have been infringed.

The onus, he says, on the health authority in the civil claim, would be to show that their limitation on spending which stopped your transplant was justifiable. It would not be enough to say simply "we could not afford it". And they would have to deal with their apparent obligation to preserve life as enshrined in the Constitution.

5-year plan for health pay parity

CT 30/8/95

CAROL CAMPBELL

A PAY-FREEZE for health care workers in local authorities and gradual increases over five years for their colleagues in the public sector was one way to reduce the vast differences in their salaries, a University of Cape Town report said.

The differences in salaries between the health workers has become a major obstacle to uniting South Africa's fragmented health services.

The UCT document, compiled by researchers in the Health Economics Unit for the Health Systems Trust, said unifying the health system would be too expensive if all salaries were bumped up to the local authorities' rate.

The estimated cost of R1,15 billion was "unaffordable".

They also recommend that, in line with the government drive to improve primary health care, workers in this sector should have their salaries raised.

The estimated cost of this was R258 million but this would attract health care staff to primary health care services in under-served facilities and rural areas.

85

Black GPs support Deeble plan

(85) WM 25-31/8/95

White doctors spoke out vociferously against the 'Deeble plan' for national health insurance. Black doctors, however, are upset that this plan is being diluted, reports Pat Sidley

JOHN DEEBLE'S virtues, or lack of them, are in the eye of the beholder. To many general practitioners in this country, the Australian health care expert's original ideas for a South African health system would have wrested any vestige of control from their hands, and placed it in the hands of the state.

The GPs with that vision of Deeble were largely white. Many others, however, see him differently.

He was flown out this weekend — courtesy of SA Druggists — to address the annual conference of the largely black South African Medical and Dental Practitioners' Association, which was hoping to see his original plan adopted in this country.

To these GPs, most of them working among disadvantaged communities, a system which imposed a payroll tax on the employed and self-employed, and paid doctors in a lump-sum per registered patient, seemed a useful and moral way through the health care mess in this country. Better still, it would mean a guaranteed, quality service at minimal cost to patients, while guaranteeing a reasonable income for doctors, paid for by a dedicated tax.

It would have meant, in its ideal form, the incorporation into a single health system of all black GPs in private practice — a group who have traditionally been excluded from the health establishment. This was expressed in a heckle by Dr Gees Abram, who said: "What we need is a minister of one health system, not a minister of private health care and a minister of public health care."

Older GPs at the conference related their experiences of not being allowed to work at black hospitals like Baragwanath, and of being paid amounts so low it would make the average, overworked registrar of today seem overpaid.

Deeble shared a platform with Health Minister Dr Nkosazana Dlamini-Zuma. While she was sympathetic to his original plan, the report she commissioned, and which he helped put together, is different in crucial respects from his plan.

The main point of difference is the entrenchment of the private and public sectors, with an accreditation plan to bring some doctors into contracted state service.

Accrediting private practitioners was one area of severe criticism from the GPs. If implemented in the way the plan proposes, it would require a large capital outlay and other costs for private doctors to be placed in a position where they can be contracted as accredited practitioners.

But a major area of contention the doctors expressed was around the availability of cheaper drugs through an essential drugs list (EDL). Many of these doctors have thriving relationships with pharmaceutical companies and dispense these drugs themselves. Dispensing by doctors has also fallen under the critical eye of the National Health Insurance plan.

It's a battle the doctors are not likely to win, points out Deeble, who notes that South Africa's drug prices are among the highest in the world.

For several of those present, Zuma and her team had come under the influence of the large private health care players in the system — and this had diluted what Deeble had had to offer.

Deeble himself believes much of what he originally suggested has a better chance of succeeding here than the more complex arrangements mooted by the plan he co-authored.

A chord which struck deep resonance among the GPs came from the persistent heckling from East Rand doctor Gees Abram, who believed it incorrect to have a two-tier health system with both a public and private sector: it should all be one, he bellowed at the minister.

He, like many others in the gathering, works in his private surgery as well as giving time at nearby public health facilities. This week he said that at this time of the year, when medical aid ceilings have long since been reached, patients who prefer using private general practitioners are "dumped" into the public health system as their funds dry up.

In this criticism of the present NHI plan, he is joined by many other critics who believe that it's likely that many patients who start out in private care will end up "dumped" on the state at some stage.

Zuma, who handled the heckling with some aplomb, had to face an important constituency which believes she should not have ditched Deeble's plan, and which is hoping to put it back on to the Health Ministry's agenda.

Saliem Fakir heads a natural resource management programme at the Land and Agricultural Policy Centre in Johannesburg

Sangomas get legal wise

(35) WM 25-31/8/95

Meshack Mabogoane

THE Traditional Doctors' Association (TDA), among the largest of 200 similar organisations in the country, is beginning to devise ways to protect the "intellectual property" of its members.

Innocent Brown, public relations officer for the TDA, told the *Mail & Guardian* this week his organisation had been approached by four pharmaceutical companies — two international and two local — that are interested in working with sangomas on research and development into traditional medicine.

Brown welcomes the move as belated recognition of the inyangas' expertise in medicinal herbs.

"We are prepared to assist as we believe that muti can contribute towards alleviating human suffering. This demonstrates that our traditional societies have genuine expertise to deal with various ailments. Now even the West is taking cognizance of this."

He warns, however, that there should be no "adulteration or exploitation" of this information. Any large-scale commercial use of *muti* should be protected by patents that benefit the individuals who have made specific discoveries and provide collective rewards to the black community as a whole for commonly known herbs.

The TDA is working with lawyers to protect both types of patents. Brown stresses that patents should do more than credit existing knowledge. If research leads to the discovery of "active ingredients" not hitherto known "these must be credited to the original discoverer or a trust".

The formation of a trust was originally suggested by a pharmaceutical company as most of the muti knowledge is now part of the nyangas' collective heritage. The proceeds of the trust would be used for both further research and community development. As yet no details have been worked out.

The main task of the TDA, says Brown, is to inform its members and other nyangas about the legal implications associated with approaches they may receive from research institutes and companies.

At last, it seems, there is going to be a close link between *nyangas* in the bush and the research in laboratories. This could close the gap between traditional medicine and modern technology.

HEALTH & DISEASE – ~~NURSES~~ GENERAL

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healthy continent

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(85)

SA joins Africa in joint look at a

■ BY DAVID ROBBINS

Delegates from all over sub-Saharan Africa gather tomorrow in the Gabon capital of Libreville for the 45th annual conference of the World Health Organisation's Africa Region – and for the second year in succession South Africa will be there.

On the agenda is AIDS prevention and control, tobacco and health in the African region, malaria control, expanded immunisation programmes and youth and adolescent health.

South Africa's delegation will be headed by Dr Joe Phaahla, the MEC for health in the Northern Province.

The MECs from the North West Province and the Western Cape have also been included in the delegation.

Among the senior civil servants who have flown to Central Africa for the week-long conference are Dr Harm Pretorius, Deputy Director-General of Health; Ms Quarraisha Abdool-Karim, director of AIDS prevention; Dr Neil Cameron, director of communicable disease control; and Dr Eddie Mhlanga, director of maternal and child care.

Dr Pretorius suggested that the most important work in Libreville would probably be accomplished through "lobbying in the corridors rather than in the conference itself".

"This is only the second time that South Africa will be represented at these conferences," he said.

"We are consequently new at the game. Yes, Africa's expectations of us are high. But we need to proceed carefully. It is not our intention to upset other member countries.

"In any case, our first responsibility must be to our own people. Then we can begin to look at co-operation and actual interventions in the southern African region as a whole."

It is no secret, however, that WHO is hoping that South Africa's scientific expertise, especially in the pharmaceutical arena, can be harnessed to further Africa's pursuit of self-reliance and independence from the Developed World in a. range of issues of vital concern to the continent as a whole, and to South Africa in particular.

In return, many African countries could provide South Africa with valuable experience in primary health care programmes and the district health model of health care governance.

At the heart of South Africa's new health policy stands a concept known as district health, which could play a vital role in improving the quality of care for ordinary people. But what is district health? ***David Robbins*** *provides some answers.*

Putting health care on the map

(85) Star 5/9/95

Looking after the ordinary people ... communities themselves will decide what is necessary for the maintenance of good health in their district.

At certain levels, district health is a maddeningly elusive idea. Phrases like "wall-to-wall care" and "community participation" are frequently thrown into the discussion, but more often than not with confusing results.

Perhaps the best way to grasp the reality of district health is to compare it with what currently exists. The provision of health facilities can be visualised as a pyramid, with academic health complexes at the top, regional and district hospitals lower down, and health centres and clinics forming the base. Administratively, it's a top-down affair, and also a bit of a jumble, with provincial health authorities running some facilities and local authorities running others, while the private sector and various non-governmental organisations (NGOs) also play a part.

Most importantly, the current situation is largely curative. Apart from the usual immunisation programmes and a lot of talk about preventive and promotive programmes, patients need to get to the facility before health care can start. In practice, this means that being sick is the basic condition for entering the health care service. Add the widespread problems of transport and also the disparities in health-care spending between different areas in the old South Africa and a clear picture begins to emerge of the inequities which bedevil the existing system.

Enter district health. Here, instead of providing clinics, which those in need must attend, the emphasis shifts to responsibility for all within a specific area. These areas (or districts) are contiguous, which means that the whole of South Africa will be covered, with no individual or community left out.

To this must be added another perception which is basic to the district health philosophy: that the whole population within a district, whether ill or healthy, is the responsibility of the district health-care providers. This brings preventive and promotive efforts into a direct relationship with curative care for the first time in South Africa, with such efforts having an obvious impact on curative workloads.

In a nutshell, prevention is preferable, and much more cost effective.

The term "wall-to-wall care" now begins to make sense, with every area and every person brought into the ambit of the district health care responsibility. There will be no bare or neglected patches anywhere.

But how to administer this system in such a way that bare patches don't ultimately appear. With the best will in the world, patches of relative neglect inevitably appear in a system which is administered from the top.

District health changes all that. The communities themselves are given the power to decide what is necessary for maintaining good health in their district – and the financial and administrative powers to achieve this goal.

Let's take a closer look at district A, for example. It's so demarcated as to be contiguous with districts B, C, D, E, with no neglected patches falling between. District A has a democratically elected district health authority (DHA), which decides on courses of action to deal with the most pressing health problems in the district as well as offering the full range of health services (preventive, promotive and curative) from clinic to district hospital level.

The DHA will control the budget and the administration of the service, elements of which it would be free to purchase from NGOs, the private sector, or the State. Administrative work will be done by actual service providers: doctors, matrons, and nursing sisters especially trained in the relevant skills.

So much for the theory, but how close is district health to implementation in South Africa?

Ray Mabope, chief director of Health Systems Development in the Department of Health, is confident that pilot projects will be in place early next year.

"Each province should have at least one by then," he says.

"But we're not concentrating on one model only. We recognise the wide differences of conditions across the provinces, and therefore the need for developing various options."

One of the options being closely examined by Mabope in conjunction with the provincial health authorities is the setting up of advisory committees comprising NGOs, professional associations and the private sector to advise the elected DHAs as they administer health services which have been specifically tailored to cope with the needs of their particular district.

"A lot of these people have been closely involved in the local communities for a long time," explains Mabope.

"And we believe that they should accept joint responsibility with the State by serving on these advisory committees. Clearly, this also spells improved democracy."

Work is already going ahead to establish (by using available data) what exactly is available in terms of staff and facilities in each district; as well as developing the mechanisms for the collation of community and epidemiological profiles without which the effective management of health districts would be impossible.

Undoubtedly, the introduction of district health into South African cities and the often neglected hinterland is going to be a major transformation. Although Mabope is adamant that inter-district borders will not be rigid to begin with, and that the size of the districts remains "fluid" at this stage, international experience suggests that populations of no more than 250 000 will form the basis of individual districts.

This means that South Africa will ultimately be divided into between 160 and 200 health districts.

"We've commissioned the CSIR to produce a map showing all the latest local government demarcations," Mabope says.

"It obviously makes sense to match health district boundaries with the demarcations already made in preparation for the upcoming local government elections. In fact, we're currently holding meetings with the Department of Provincial Affairs and Constitutional Development to ensure that we do not complicate matters at community level."

Indeed, many observers now see the new health governance plans (via the district model) as serving a pathfinding role for the establishment of grassroots democracy generally. The links being forged between the designers of the forthcoming elections and health planners like Mabope are not coincidental.

"We see our task more and more clearly as designing a district health authority which is generic in character," he explains.

"District authorities are where we must end up. And these bodies must be as capable of administering welfare budgets, housing and development, RDP programmes, and even education, as they are of coping with the demands of district health."

Although the concept of devolving power to a district level looks good on paper, what about the risk of creating yet another bureaucratic level in a country already over populated with bureaucrats?

"There will be few bureaucrats at a local level who are not also providing a service. Matron/managers and sister/administrators will be trained to maintain the records required for the elected DHA to make its decisions," says Mabope.

"Yes, of course funds will be channelled through the provincial departments. And the provincial departments will be charged with establishing intra-provincial equity between their various districts. But with time, obviously, the provincial departments will shrink as districts take on more and more of their own administrative functions; and also as the responsibility for the country's large academic hospitals shifts upwards to a national level."

Like any major transformation, the introduction of district health in South Africa will bring with it its own set of peculiar problems. If the process is wisely driven, however, the rewards should far outweigh these problems.

Not least among the rewards will be a strengthening of civil society and community-level democratic institutions.

This could well be as crucial for the future of the country and, by example, for Africa as a whole, as will be the health status improvements of millions of South Africans.

Progress in heath care

Dr Ralph Mgijima, Gauteng director-general of health, speaks to **Glenn McKenzie** about problems that have surfaced in the province's health sector

(85) Sowetan 7/9/95

Question: Many doctors, nurses and other health workers in Gauteng are disillusioned and their morale is low. They feel they have been neglected in the transition process. What message do you have for them?

Answer: The Minister of Health and our MEC for health Mr Amos Masondo have both expressed their appreciation for the work being done by health workers under very trying conditions. Low salaries, overcrowded institutions, long working hours and a poor working environment have all been hazards for health workers.

The question of salaries and overtime payments are being addressed urgently at national level by the Public Service Commission and the National Cabinet. Building a primary health care infrastructure is hopefully addressing the question of overcrowded hospitals.

Q: Many people in the townships, squatter camps and other impoverished communities of Gauteng still haven't seen an improvement in health care. In many cases, health care has deteriorated since the elections. What is your response to this comment?

A: In a way, substantial improvements in health care delivery were never expected in a short time. This is for several reasons. One is that legitimate local governments are crucial to delivering primary health care.

Also, the new provincial health administration is still not in place. Only the top managers have been appointed. Most of the restructuring of the department, in particular of institutions, hospitals and clinics, will only be completed by 1996.

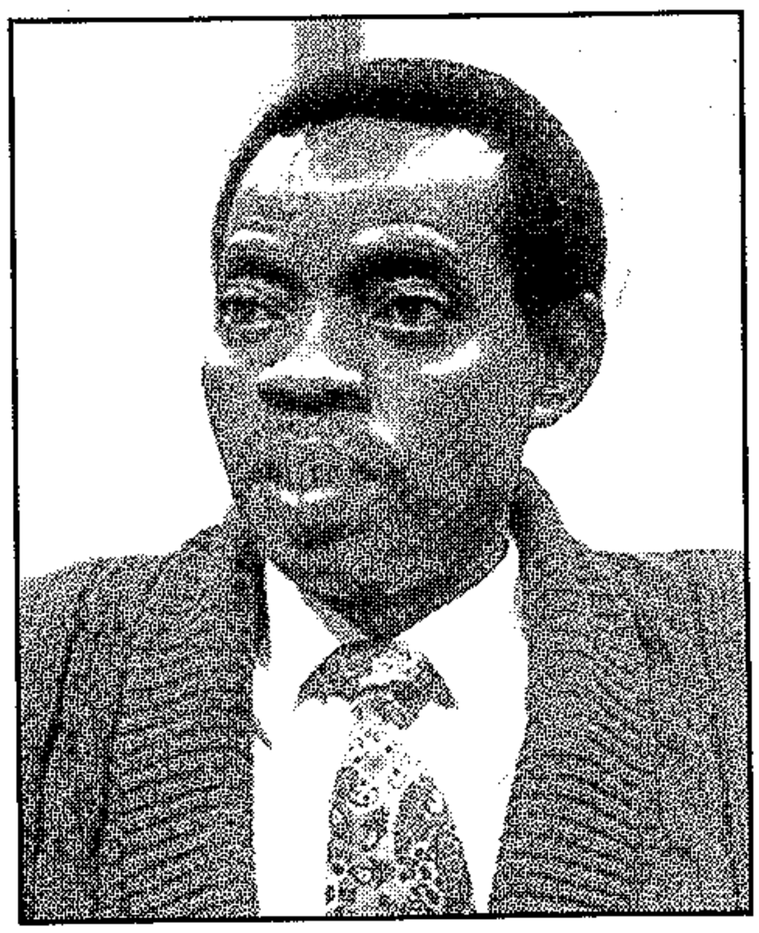
To complicate matters, the health care system inherited by the new administration is quite bizarre and is not geared to rapid delivery of primary health care.

The salaries paid by the former TPA, Department of National Health and Local Authorities to their employees differ and sometimes vary from area to area.

Our key performance indicators should not be whether we bring major improvements in health care delivery, but whether we can make progress in setting up a unified health care system.

Nevertheless, I assure you that we have made progress. Twenty-eight new clinics are being erected. And district facilitation committees have been appointed to offer comprehensive health care.

In a few areas, better health care is already being offered. For example, emergency services have been expanded from serving only metropolitan areas to places like Orange Farm and Thokoza. Also, the Primary School Nutritional Programme has provided crucial snacks for over 70 000 children in Gauteng's farming areas.



Dr Ralph Mgijima ... the question of low salaries and overtime payments are being addressed. PIC: GLENN MCKENZIE

And we have set up 15 mobile clinics around the province to provide primary health services in the short term.

Q: Gauteng has had budget cuts to enable poorer provinces can beef up their health services. But is it wise to sacrifice services at hospitals like Natalspruit and Baragwanath in the name of primary health care services that do not exist yet?

A: The real question is: Can we achieve equity in the face of a national health budget that is not increasing in real terms? The answer is probably no, unless we find ways of mobilising extra resources.

The Gauteng Health Administration is committed to continue providing the high quality services you mentioned. Toward this end, bridging finance from the RDP National Office is being sought.

More cost-effective ways of running hospitals are being looked at. And security measures against theft and wastage are on the cards.

Q: Gauteng treats patients from all the other provinces. Shouldn't these provinces pay for those services?

A: We are trying to thrash out a formula whereby other provinces would give us transfer payments for treating their residents. In many cases, patients from other provinces are sent to Baragwanath Hospital or Johannesburg with broken ankles. These patients could easily be treated in their own provinces.

Q: More than a year into the Government of National Unity, what would you say are your biggest successes? And challenges for the future?

A: There is no doubt that our biggest success has been the work of the strategic management team in drafting policy proposals and plans for the new administration.

We now have a restructured Health Department and that implies that there is a single health authority in the province.

Despite some of the problems we experienced initially with this programme, there is no doubt that the Free Health Care service for pregnant mothers and children under six has led to many people having access to badly needed health care. In the past, this was not possible.

Another success that needs to be mentioned is that there was a lot of animosity, tension and suspicion between various authorities in the province, in particular with those parts of the province which were newly acquired.

It has been quite inspiring to see how the various authorities have grown to trust one another and have grown to understand each other better. This can be seen not only at management level but also on the ground.

The biggest challenge for the Health Department has been in the budget. We are forced to find ways and means of acquiring extra resources in order to provide services not provided before.

Labour relations continue to be another challenge for the province and this is based, of course, on expectations of workers in the light of changes taking place in the country.

Another challenge and constraint has been, of course, a lack of information. It is not clear where we are spending most of our money, what are the most common diseases and which institutions are the most disadvantaged. This is because our information systems are either nonexistent or uncoordinated.

We also lack computers to keep track of day to day activities. There is wastage as a result. We are working with the Department of Safety and Security to ensure that thefts in hospitals are reported and prosecuted.

Picture: ANDREW INGRAM, The Argus.

BURSARY BOOST: British consul Leslie Buchanan presents City Medical Officer of Health Michael Popkiss with a cheque for £5 000 from the Royal Society for Health.

British boost for health care in South Africa

(85) ARG 8/9/95

Staff Reporter

CAPE TOWN Medical Officer of Health Michael Popkiss has been made an honorary member of the Royal Society for Health — and has collected a cheque for £5 000 (about R30 000) from the society to boost the society's South African bursary fund.

British consul Leslie Buchanan presented Dr Popkiss with a citation for his work in the public health field — and the cheque — in the mayor's parlour yesterday.

Mr Buchanan said the citation and cheque were symbolic of South Africa's return to the international community.

Its support came mainly from public health officials, health inspectors, public health nurses and medical officers of health.

The society was active in the training of public health officials, jointly setting examination papers for health inspectors with the South African government.

The joint examination board was dis-established in 1976 — and the surplus funds available at that time were used to start a bursary fund.

Since 1979, Cape Town's MoHs have held seats on the bursary fund's administration board.

Dr Popkiss said it was thanks to the changed political dispensation in South Africa that the Royal Society had renewed its interest in public health in the country.

"This is very encouraging given the imperatives for the country of concentrating its health efforts on comprehensive primary health care, including environmental health.

"It is with pride and humility that I thank the Royal Society for the honour they have bestowed upon me."

Health minister under attack from own party

EWN 8-14/9/95 (85)

Gavin Du Venage

THE Eastern Cape may lose another provincial minister after Health Minister Dr Gertrude Thomas came under attack from within her own party, the ANC, over the poor performance of her ministry.

If she goes, Thomas will be the third Eastern Cape cabinet member to lose her job since the establishment of the administration. Two previous ministers, Neela Hoesain and Dr Maliza Mphehle, were also fired after pressure from the ANC caucus.

Thomas is being blamed for the poor control of the state school feeding scheme which has collapsed in the Eastern Cape after rampant fraud resulted in almost R5-million going missing.

Thomas is also under attack from health care workers for the rapidly declining state of provincial hospitals. A report tabled in the Eastern Cape parliament last week revealed the abysmal conditions in the region's hospitals, and a relationship between Thomas and provincial doctors that has deteriorated to the point of hostility.

In the report, doctors claim costly X-rays and blood tests must often be repeated because the originals get lost. Doctors also fear for their safety and claim they are frequently attacked while at work.

Hospitals are forced to accept an increasing number of patients from the former Transkei, where health services have all but collapsed. In spite of the pressure on overloaded hospitals, up to 40 percent of patients being treated are TB sufferers who could easily be treated in clinics. However, clinics in the region provide only the most rudimentary care. In some instances, clinics are abandoned because of a lack of staff.

Thomas has angered her own party as well as opposition by steadfastly refusing to acknowledge the crisis.

Her handling of the problem has embarrassed the government of Premier Raymond Mhlaba and led to calls from within the ANC for her replacement.

At last week's debate on the report, not one ANC MP rose to her defence. Thomas' threat to replace local doctors who refused to co-operate with her with Cubans was condemned by ANC MPs as well as the opposition.

Mhlaba is himself under pressure to clean up the province's administration or resign.

There are indications that senior ANC officials believe Mhlaba can't handle the crisis. Earlier this week a special committee was established to look into the crisis, reportedly on the orders of President Nelson Mandela.

The committee will comprise national ANC figures with Mhlaba as the lone provincial representative. Sports Minister Steve Tshwete, Deputy Environmental Affairs Minister Bantu Holomisa and Public Enterprises Minister Stella Sigcau will sit on the committee. Senate chairman Govan Mbeki will also participate.

Although it is unlikely Mhlaba will lose his post any time soon, Thomas may be forced to go in an effort to appease the provincial government's critics.

Last week provincial Agriculture Minister Tertius Delport appealed to Mhlaba to "ignore the advice" of his top aids who, he said, were leading the premier deeper into the crisis.

HEALTH CARE (85) FM 8/9/95

Nursing a grievance

Though Australian academic John Deeble's plan to nationalise all GP services has been formally discarded by government, the SA Medical and Dental Practitioners (SAMDP), a largely black medical body, believes Deeble's proposals are preferable to those presented by the Broomberg/Shisana committee, of which Deeble was also a member.

Says SAMDP chairman Tebogo Letlape: "We are particularly concerned that the Broomberg/Shisana report plans to replace doctors with nurses by allowing specially trained nurses to act as primary health-care practitioners. We feel that a clinical model should always be doctor-based. Certainly nurses can be successfully deployed, under supervision, as part of the health-care team to ensure greater access to health care."

He adds that this proposal effectively entrenches apartheid since privately funded patients — mainly white — would still be able to receive primary care from doctors. At the same time, patients relying on the public sector — mainly black — would have to accept treatment from nurses.

"This proposal does not address the problem that there is a shortage of doctors — a problem that can be addressed only by using more private practitioners and by training and retaining more doctors. As it stands, the Broomberg/Shisana proposal could create a shortage of nurses."

By contrast, Deeble proposed that primary health care would be dispensed by existing GPs in private practice on a pre-paid fee, based on a fixed annual fee per patient. Letlape says this proposal would guarantee patients quality care and not see them discarded to overburdened State facilities when medical aid benefits run out — a reality that affects many black patients, he claims. It would also guarantee doctors a fixed annual income.

Letlape is not concerned that Deeble also planned to effectively nationalise all GP services by barring the private sector from funding primary health care outside the State fund. "This is something that could have been negotiated. Doctors would have accepted such a proposal were it limited to a fixed and defined package of benefits rather than applied to all GP services."

Whether such a compromise would have made the Deeble model more affordable and acceptable is unlikely. The Deeble proposal was costed at around R6bn a year, based on the assumption that the average person would require only three annual visits and could be treated at R60 a visit, including prescription drugs. These calculations were thrown out by industry experts.

Letlape and the SAMDP are angry that the Broomberg/Shisana proposals would allow only private doctors to qualify as accredited State providers provided they don't treat private patients at the same facility. Doctors would also be required to form multidisciplinary practices, for accreditation, that they fear would incur unaffordable additional costs. Supporters of the Broomberg/Shisana report believe strict accreditation is the only mechanism to make use of private doctors without allowing them to syphon off State funds.

Another gripe is that the proposed Essential Drug List for the private sector could deprive black dispensing doctors of large incomes that are possible with the special deals they receive from drug manufacturers on drugs that will be included on the list. Letlape, however, says the SAMDP welcomes the extension of the drug list to the private sector as a mechanism to reduce the cost of these drugs.

"We are aware of the additional incomes generated by dispensing doctors, but while we believe that doctors need to earn a living, we are not married to the concept of dispensing doctors. Doctors have come to depend on dispensing because of the unsatisfactory manner in which medical schemes presently reward doctors."

The SAMDP is not impressed with a proposal that could place an additional levy on medical scheme members to fund the proposed national health system. Says Letlape: "This would make medical aid cover less affordable as would any additional tax." ■

Plan for one health faculty rejected

(85) CT 12/9/95

CHRIS BATEMAN

THE Western Cape's health chiefs yesterday rejected immediate plans for a single health sciences faculty for the three major local universities.

The move is a setback for plans to reshape the province's apartheid health structure through a R35 million shifting of resources, severing of traditional university ties and the creation of a single teaching platform.

Early this year Health and Welfare Minister Mr Ebrahim Rasool unveiled the plan designed to stop cut-backs from plunging health care into a crisis.

This included transferring specialist teams at the three academic hospitals to George, Worcester and Paarl. Groote Schuur and the Red Cross Children's Hospital would convert to specialist referral centres and academic beds would be converted to secondary-care teaching beds. These plans are still on track, with the exception of a single teaching platform.

Yesterday's workshop included representatives of Tygerberg, Groote Schuur and Red Cross hospitals and the three universities.

A joint statement accepted the need for restructuring health services,

HEALTH PLAN: Mr Ebrahim Rasool.

but said there was an "essential role" for the health science faculties at all three universities. The statement did not rule out a single health science faculty in the future.

It said the proposed R35m shift of resources from academic hospitals this year, while necessary for the RDP and the new plan, was "unlikely to be reached within the time frame".

They expressed "grave concern" about the effect of the R22m budget cut and vowed to lobby politicians.

US company in SA health-care deal

Star 13/9/95 (85)

■ BY JOHN SPIRA

In a deal involving R140 million, the United States' largest health care management organisation has teamed up with Anglo American and Southern Life to form a company which aims to revolutionise South Africa's health care system.

The new business, to be known as Southern HealthCare JV, will be jointly owned by Anglo American and Southern Life, each with a 40 percent stake, and America's United HealthCare Corporation, which will own the remaining 20 percent.

The project will require an investment of R140 million.

Anglo and Southern will acquire their stake in the company by providing the development funding, while United HealthCare will earn its stake by reinvesting the royalties and fees received for providing technical and commercial know-how for managing the new business.

In addition, United will have the option to convert its rights to royalties into an additional equity interest that would make it an equal partner with Anglo and Southern.

Southern HealthCare JV plans to be operational by July next year and will be based in Johannesburg.

Kathy Walstead-Plumb, a senior vice president of United, will relocate to Johannesburg as the chief executive.

United, formed 21 years ago, offers a broad range of products through 21 owned and managed health plans with enrolment of nearly 4 million.

Its non-geographically bound speciality-care management companies serve the needs of an additional 25 million lives. Last year, United generated revenues of $3,8 billion.

It ranked 11th overall and first among health care companies in the most recent Fortune magazine survey of America's most admired corporations.

Walstead-Plumb said this was United's first venture outside the United States.

"We've done the deal because South Africa is an ideal fit, with conditions in the managed health care industry similar to those which prevailed in United States in the 1970s.

"We bring not only our expertise and experience to the deal but also our information technology network, developed at a cost of $300 million."

The Southern HealthCare JV initiative is expected to create 350 jobs in its first year of operation, building up to 1 000 jobs in its fifth year.

Southern Life's Arrie van der Zwan believes there is considerable scope to bring down health care costs in South Africa. "This is what Southern Healthcare JV aims to achieve."

A new health system needed

(85) sowetan 13/9/95

Budget cuts have undermined good quality care

By Glenn McKenzie

PROFESSOR JEFFREY LIPMAN has been in the frontline of South African public health care for many years.

As head of Baragwanath Hospital's world-famous intensive care unit, he has seen suffering and needless death. And he has fought for private funding to keep quality services alive in the Soweto hospital.

But last week's crippling nurses strike was something new for Lipman. Something frightening. It caused him to worry publicly about the future of public health care at the hospital.

"This is a tragedy for the hospital, the community and South Africa as a whole," he said.

For the first time in Bara's history, wards were forced to close last week. Patients were airlifted out; others were discharged and abandoned.

Doctors have suggested that some patients died as a result of the strike, although the exact figure may never be known.

Now nurses have grudgingly returned to work. But many people are asking the question: will Bara ever be the same?

One senior paediatrician who supported the grievances of the striking nurses said she no longer felt it was safe to admit children to the hospital's wards.

ON THE BOIL ... Baragwanath Hospital was forced to close its wards last week when nurses went on strike.

Low staff morale and budget cuts had caused the quality of health care in the hospital to drop steadily since last year, she said. During apartheid the hospital was underprivileged, but now it fought even greater challenges with fewer resources.

"I believe strongly in the idea of primary health care. But our hospital is falling apart and we are left carrying the can," she said.

While there are many opinions about what caused the nurses' strike, one unanimous sentiment seems to prevail – underprivileged hospitals (including Bara) and their employees do not receive enough funding.

Some health professionals claim that in an effort to redistribute resources, South Africa's democratically elected Government has unwittingly undermined the facilities that serve the majority of its people.

A case in point: Bara's funding has been slashed by 25 percent this year. Other hospitals received similar cuts.

These same doctors and nurses say the Government has also unwittingly crushed the morale of nurses. Rightly or wrongly, nurses are bitter at the health ministries (in both national and provincial governments) for not improving their salaries.

During the strike, nurses waved placards with vicious messages to the same African National Congress leaders they had voted for. "Nelson Mandela, you are arrogant!" read one sign. "Zuma must resign!" read another.

The National Health and Allied Workers Union has alleged that the strike was organised by sinister forces who are eager to undermine the new Government.

But who are they? Both the National Party and the Democratic Party came out strongly against the strike. So did the Hospital Personnel Trade Union, an organisation that has allegedly had conservative white ties (read: NP) in the past.

The only major political parties that supported the strikers were the Pan-Africanist Congress and the Azanian People's Organisation.

In all probability, the strike was not initiated by political forces but by nurses fighting for nurses. The fact remains that nurses in the public sector — some of whom hold up to three degrees — earn a pittance compared to their private service colleagues.

Ms Rose Jacobs is a case in point. She holds three degrees, three diplomas and 15 years of experience – yet earns only R1 168 a month after deductions.

"We voted for this Government and we want them to listen to us," one picketing nurse told *Sowetan*.

Lipman puts 80 percent of the blame for the strike on the former apartheid regime. Ten percent should fall on management (both hospital and government managers).

"Unrealistic promises made by the ANC" accounts for the final 10 percent of the blame, he believes.

The Government must surely take some of the blame for changing its tune. During the Soweto clinics strike last month, Gauteng officials said they would push to reopen labour talks in the national bargaining chamber.

But by last week both Gauteng premier Tokyo Sexwale and President Nelson Mandela were saying unequivocally: "There is no money."

Whatever the case, the Government is now faced with the challenge of rebuilding the sagging morale of health workers. It is also facing the prospect of building a new national health system with workers who are underpaid and overworked.

"We hear about millions of rands disappearing from school-feeding schemes, we see officials in the Northern Province driving expensive cars, and meanwhile we (Baragwanath staff) are being told to tighten our belts. It is not fair and it does not make sense," said one doctor.

Department of Health director-general Dr Olive Shisana suggests that a new proposed national health plan will solve some of the problems that caused the nurses strike. But this plan will take time to implement.

Meanwhile, Bara and other hospitals like Sebokeng and Natalspruit continue to suffer overcrowding and poor facilities.

HEALTH CARE (85) (~~357~~)

Rosy glow

FM 15/9/95

Medical schemes appear to be looking healthier as the benefits of deregulation start kicking in, claims a survey released this week by the Representative Association of Medical Schemes (Rams).

According to the survey that analysed 147 of the 221 schemes registered with the Registrar for Medical Schemes, accumulated funds per member strengthened from R1 067 to R1 308 — representing an improvement of 23% or R522m. As a percentage of contributions, accumulated funds increased from 18,9% in 1993 to 23,3% in 1994. The registrar recommends accumulated funds amount to 25% of contributions.

Says Rams CE Reg Magennis: "The savings can mostly be attributed to the greater use of managed health-care practices for medicine script management. Limited general practitioner and dental benefits have also affected savings since it is at these levels of health care that the greatest wastage or abuse usually takes place."

Scheme membership is also up by 3,6% for the same period and a 6,3% growth in open (public) scheme membership is expected to contribute to the financial strength of these schemes, states the report. Magennis says the ratios show that in-house or closed and State schemes continued their sound performances — a factor he attributes to a strict matching of benefits with contributions, higher accumulated fund levels and tighter cost management.

Open or public scheme reserves, however, are still below the 25% recommended minimum at 19,4%. "But their reserves have increased from R697m to R919m — a 28,2% improvement in accumulated funds per member," adds Magennis.

Ironically, the good news comes when government is considering reregulating medical schemes which it claims are in crisis because of the deregulation since last January when the Medical Schemes Amendment Act took force. The Act ended guaranteed payments and minimum benefits and gave schemes the go-ahead to risk-rate (according to age and sex) rather than community-rate — a move government now wants to reverse.

Magennis denies risk-rating has contributed much to the improved performances. "Employers still control scheme benefits and have in general not allowed a significantly greater use of risk-rating."

He believes the proposals to reintroduce community-rating are geared mainly to ensure that the young are covered now and later — an argument that's rejected by insurers and actuaries who claim that the young simply can't afford to cross-subsidise the aged and ill and consequently won't take cover. ■

Crisis in health sector is also a problem for unions

(85) CT(BR) 15/9/95

SHOP FLOOR

BY KARL VON HOLDT

Strong representation at national level is vital if nurses are to be heard

Nurses at Baragwanath Hospital in Soweto launched a strike for better pay. The next day the strike spread to other hospitals in Gauteng.

Newspapers reported doctors working themselves into the ground, some patients dying, others transferred to private clinics. But in the press and on television doctors said nurses should not back down. "We know what it's like to be screwed by the authorities," said one.

Cosatu's National Education, Health and Allied Workers Union (Nehawu) attacked the nurses for their "reactionary" behaviour and urged them to return to work.

President Nelson Mandela warned the strikers to "go back to work or leave the nursing profession". In response, the strike spread to Bloemfontein and angry nurses demanded that Mandela apologise.

The Gauteng MEC for health, who does not have the power to negotiate conditions and pay, does apparently have the power to dismiss. He gave the workers an ultimatum to return to work or be fired. They ignored him.

What does all of this mean?

These events are another sign of the profound crisis in the health care system. They signal serious problems in the constitution and working of the public-sector bargaining council and they point to the chaos that ensues when frustrated workers have no powerful national organisation to represent them.

The crisis has deep roots in the health sector. Apartheid created a health system which was not designed to cater for the needs of the black population. As influx control became unworkable, more black people crawled into the cities, increasing the strain on all social services.

About the same time, the National Party government began to run down the public health care system and encourage the shift in resources to the private health care system. Budget cuts, flight of staff, erosion of administration, and a lack of leadership paralysed the hospitals. These conditions meshed with the crisis of apartheid management confronted a poorly paid, desperately overworked and increasingly militant black staff.

The crisis of the health system has worsened under the new government. At the same time as it has increased access under the free care for mothers and children, it has slashed funding to hospitals and provinces with more highly developed health care infrastructure.

Meanwhile, old-style unilateralism has collapsed. But it has not been replaced by an active approach. Instead the health administration has abdicated its responsibility to provide direction.

Adding to these problems, in the case of the nurses, is that they lack a credible voice in the public-sector bargaining council. The South African Nursing Association lost credibility with black nurses when it failed to challenge apartheid.

Nehawu is the biggest health-sector union among black workers. But outside the homelands it has generally failed to recruit nurses. It tends to be regarded as a blue-collar union, with little understanding of the grievances, ethos or professional aspirations of nurses.

The question as to whether professionals are best organised in the same union as blue-collar workers, or whether they should organise in separate organisations, has never been properly debated in Cosatu. Nehawu asserts that they belong in one union.

Having no organisational representation in negotiations, nurses do not feel bound to agreements. Nehawu and others negotiated substantial increases for their lowest-paid members, nurses got 5 percent. Locally organised strikes are the result — but they do not compensate for the lack of sustained influence at national level.

Several parties have blundered in response to the crisis. Mandela simply added to nurses' frustrations with his comments. Nehawu damaged its prospects of ever organising nurses with its comments.

The health department needs to focus on hands-on management which can provide leadership and direction, rather than relying on financial re-allocation to do its restructuring for it.

There is also an urgent need for nurses to form a national organisation. While nurses themselves may take this initiative, Cosatu in particular, needs to open a serious discussion with them about the best structure of such an organisation

Nurses have a vital role in the new health dispensation mooted by the health minister. Only through national organisation can they move beyond being a symptom of crisis to helping shape its resolution.

The rolling wildcat action in the hospitals last week should make it clear that in South Africa it is impossible to govern without strong unions. A strong labour movement is crucial for the reconstruction of our society.

☐ *Karl von Holdt is consulting editor with the SA Labour Bulletin*

R1-bn nurses' pay crunch

(85) (88) (152) ARG 16/9/95

■ The disparity in salaries for health workers who have the same training and responsibility is a major stumbling-block to integrating a fragmented health system and a root cause of resentment among nurses.

ADELE BALETA
Staff Reporter

IT will cost the government more than R1 billion to satisfy nurses' demands for equal pay for equal work for health workers which they made in the wave of country-wide strikes that crippled several hospitals.

That's according to Bupendra Makan the co-author of a 10-month final report on pay across health services in South Africa, drawn up by the economics unit at the University of Cape Town's community health department.

The strikes have induced the first meeting of the nursing sub-committee of the national health consultative forum in Gauteng to iron out key issues including parity.

It was the disparity in recent wage hikes — five percent for state-employed nurses and between up to 12 percent for those employed by local authorities — that sparked the strike in Soweto last month.

Major resentment has resulted among health workers because of the average discrepancy of 35 percent in salaries across all posts paid by the various authorities.

Mr Makan says government cannot afford some R1,16 billion needed to satisfy nurses' demands and this was not on the cards given government's commitment to cut state expenditure.

Instead the report funded by the Health Systems Trust, among other options, suggests fixing nursing salaries in the highest paying authorities, and a phased increase over three or five years for nurses in the lowest paying state authorities to close the gap.

Another option is restricting salary increases to personnel in primary care in line with the goverment's intention to bolster primary health care.

But researchers have conceded this would have negative consequences in that workers in clinics would get more than

Picture: OBED ZILWA, Staff Photographer.

☐ **HEALTH REPORT:** UCT researchers Dale McMurchy and Bupendra Makan with their final report on remuneration in health services.

workers in hospitals. The estimated cost of this would be R258 million. A total of 74 percent (R192 million) would go to nursing personnel nationally.

This option is based on the assumption that only 20 percent of provincial administration personnel are invovled in primary health care.

In general the state sector pays lower salaries to health care personnel than local authorities — which employ only seven percent of the workforce.

Nurses salaries for example in local authorities in the Cape Metropolitan area are between 10 percent and 78 percent higher than those of the Western Cape Provincial authorities.

This means that nurses with the same qualifications and responsibility and who in some cases work side by side in the same building (for example the Nolungile clinic Khayelitsha) earn vastly different salaries. This has had a divisive effect on personnel.

Using 1993/94 salary scales, the report cites the following examples: A professional nurse in the provincial department earned R30 273 a year while her counterpart in the local authority earned R46 736. This represented a 54 percent difference. The respective figures for a nursing assistant was R13 890 compared to R25 467 (83 percent difference) and doctors R52 170 compared to R98 571 (47 percent).

A major obstacle in the integration process is being caused by delay in setting up local authority boundaries which are needed before a district health authority can be set up.

Mr Makan says a political decision has to be made on who will take ultimate responsibility for district health services to remedy the situation.

"So far the problem has been passed around like a hot potato from the departments of health, to finance to constitutional development to the public service commission".

John Frankish of the provincial ministry of health agrees that there has to be a national decision that all local authorities do the same, that they become part of the department of health and become a key functionary within th health district model.

He says that if the local authority assumes responsibility, then attention has to be focussed on how one integrates the public service scales in a current local authority system whose grading system is determined by the Town Clerks Act. An added problem is that there is no uniformity among the local authorities.

"In larger metropolitan areas the salaries will be higher than in the rural areas making it difficult to attract staff to peripheral areas in line with the stated government intention to staff underserviced rural areas," he said.

There have been calls to repeal the Towns Clerk Act and the grading system amid allegations that local authorites are bent on empire building.

As a source explained, because salaries of the entire local authority are linked to grading, it's in their interests to upgrade their authority.

If George took over comprehensive district health services, for example, their budget would increase significantly as would their grades and therefor salaries.

The opposite is also true that there is the danger for local authorties that if their current responsibility for health gets taken away, their grading will drop and they see this as a threat to their current status and salaries.

Mr Makan said the government could not afford to spend R1,16 billion to achieve parity because of its comitment not to increase state expenditure.

But he said that decreasing all health personnel salaries to the lowest current salary scale would particulary affect local authority personnel bringing them down to the unsatisfactory public service level. Anyway it would be an unfair labour practice , he said.

"The insurmountable stumbling block could be the catalyst for the creation of an entirely new strucutre for conditions of service within the health sector," he said.

Health care boost 19/9/95 BD

NORTHERN Province's health department would spend millions of rands to provide affordable, effective health care, superintendent-general Nicolas Crisp said at the weekend.

Crisp said the various measures would add R60m to the department's annual running costs. About R22m would be spent on filling vacancies.

(85) BO 19/9/95

Gauteng backing for national health plan

(85) BD 19/9/95

Kathryn Strachan

THE Gauteng legislature's health standing committee yesterday expressed support for the aims and objectives of the proposed National Health Insurance (NHI) system.

The response to the NHI report forms part of a process where stakeholders can make their comments before the plan is passed.

While it supported the plan, the standing committee forwarded to the health ministry suggestions on improvments to the system.

One proposal was that all stakeholders should be involved in the health care delivery system. Emphasis should be placed on harnessing the potential of non-governmental organisations and enabling them to play a role in the health care delivery system.

Transplant chief warns against cuts

(85) (88) CT 19/9/95

ANY reduction in organ transplants would have an adverse effect on South African medicine, Southern African Transplantation Society president Prof Rowal van Zyl-Smit said yesterday.

Opening the society's biennial congress at Langebaan, he called for the maximum use of organ transplant services.

Also at the congress, Dr Johan Brink of the transplant unit at Groote Schuur Hospital said the survival rate of heart transplant patients at the hospital up to six months after their operations was on a par with that internationally.

However, the survival rate after one year was 70%, compared with 80% internationally, he said.

This increased mortality had not been fully explained, but contributing factors included difficulty in adequate long-term follow-up of those heart recipients who lived far from Cape Town and the disadvantaged background of some patients, he said. — Sapa

Price is attached to medical folklore

BD 21/9/95 (85)

LOCAL and multinational pharmaceutical companies are scrambling for access to medical knowledge that SA's traditional healers have gathered over the centuries.

In the process they are whipping up an ethical debate over who should benefit from the country's healing folklore.

Until recently, the work of sangomas and nyangas (the two main types of healers found in SA) was regarded by most practitioners of Western medicine as mumbo-jumbo.

Yet in the past few months at least four pharmaceutical companies have visited the offices of the Traditional Doctors' Association in Johannesburg to enlist help in finding plants that could be used to make new medicines.

"Traditional healers in this country have used various plants, about 3 000 different species, for the cure or remedy of various ailments," says Saliem Fakir, who heads a natural resource management project at the Land and Agricultural Policy Centre.

"With new developments in chemical analysis, this can generate millions for pharmaceutical companies."

In May researchers from Shaman Pharmaceuticals, a California-based company, arrived in SA and made contact with traditional healers' associations, botanists, anthropologists and research departments at universities.

About 200 big pharmaceutical companies are in the race to develop new drugs from natural resources.

At least 122 prescription drugs — including the muscle relaxant curare, malaria-treating quinine and vinblastine, derived from Madagascar's almost extinct rosy periwinkle to treat lymphoma, are based on substances found in plants and other wild species.

Most of these were developed in the 1960s when international drug development from plants ground to a halt because it was difficult to analyse thousands of species for their chemical and pharmacological properties.

But DNA technology has now made it possible to screen the therapeutic effects of plants quite rapidly.

As a result there has been a new generation of drugs. Shaman has developed a drug called SP-303 that was derived from an as yet secret plant found in South America.

A drug called Taxol is manufactured from the Pacific yew tree and has recently been approved in the US for treating cancer.

But scientists have analysed only 1% of the world's 250 000 known plant species, and mass screening of all these is virtually impossible. Hence the value of indigenous healers.

"The efficiency of screening plants for medicinal purposes increases by more than 400% through the use of knowledge in the possession of sangomas and other healers," says Fakir.

"The current value of medicinal products derived through leads given by traditional doctors is valued worldwide at about $43bn."

Many companies involved in what has become known as "bioprospecting" for plants and pharmacological knowledge have begun to develop ethical guidelines designed to ensure that host countries and their healers benefit from royalties, patents and technologies developed.

But there have been cases of abuse. Madagascar's rosy periwinkle is now being artificially cultivated in Texas, where the company Eli Lilly has never paid a cent to Madagascar.

"Academic institutions and commercial companies must negotiate equitable contracts with traditional healers before using their skills."

Galvanised by the apparent proliferation of genetic research into the pharmaceutical use of SA's plant life, Fakir's organisation has set up a project that will draft regulations and a statutory framework to ensure ethical use of the country's biological riches.

Meanwhile, some of the 200 traditional healers' organisations in SA are beginning to debate and educate their members about the ethical issues involved in bioprospecting.

The Traditional Doctors' Association has engaged lawyers to work on contracts and patents for members approached by big firms for help. —Sapa.

Health ministry to talk to unions

BD 21/9/95 (85)

Kevin O'Grady

EAST LONDON — The appointment of senior administrative and managerial staff including medical superintendents at Eastern Cape hospitals has been stalled until the process is discussed with the trade unions.

Provincial health and welfare ministry spokesman Khululekile Bata said the posts were initially advertised "but now the feeling is that advertising the posts outside the civil service could bring problems".

He said a meeting between employer and employee representatives would take place today and tomorrow to "discuss their feelings as to how managerial and all other posts must be filled".

Bata said it would not make sense to employ people from outside the public service when it was already bloated and in need of rationalisation.

However, the posts for 183 doctors needed in the province could be filled immediately and government was offering incentives to attract them to the public service.

These included overtime pay for work over and above the normal 56 hours a week, recruitment allowances and limited private practice, he said.

Meanwhile, the primary schools feeding scheme, which collapsed at the end of the second term because of fraud and mismanagement, had restarted in the Eastern Cape, Bata said.

Checks and balances had been instituted to prevent a repeat of events, including greater community involvement to prevent inflated food claims.

Schools in urban areas would receive 53c a pupil a day and rural schools 68c. The scheme had R37m left and it was hoped this would last until the end of the school year.

Central government would be asked to supply funds to continue the scheme from the beginning of next year to the end of the financial year, he said.

US to help improve health care in SA

(85)

AAG 21/9/95

☐ *Black medical schools to aid the disadvantaged*

WASHINGTON. — The involvement of American expertise and experience in solving South Africa's health care problems has moved a major step nearer to reality.

In a brief ceremony at the South African Embassy in Washington this week, officials of four black American medical schools signed a memorandum of understanding pledging to help their South African counterparts improve the health of the disadvantaged in South Africa.

Former United States Secretary of Health Louis Sullivan said the initiative was in response to an appeal by President Mandela to African-Americans to help build the new South Africa.

"Black medical schools in the United States have had to struggle with the very issues with which their South African counterparts are now contending," Dr Sullivan said.

US officials said USAID (an American aid agency) and private financial funding would also be sought.

Dr Sullivan is president of the Morehouse School of Medicine in Atlanta.

Other medical schools in the group are Howard University in Washington, Meharry in Nashville, Drew in Los Angeles and the Virginia Commonwealth University School of Medicine.

The programme — called the SA Health Care Initiative — will be administered by John Chettle of the Medical University of South Africa (Medunsa) Trust in the US.

Dr Allen Herman will co-direct the project. He said US medical schools had already held intensive discussions with South African doctors to determine the best areas for American help. — Sapa.

Traditional medical knowledge in demand

Healers' lore must be protected

(85) Star 22/9/95

■ BYEDDIE KOCH

Local and multinational pharmaceutical companies are scrambling for access to medical knowledge that South Africa's traditional healers have gathered over the centuries.

In the process they are whipping up an ethical debate over who should benefit from the country's healing folklore.

Until recently, the work of sangomas and nyangas (the two main types of healers found in South Africa) was regarded by most practitioners of Western medicine as mumbo-jumbo.

Yet in the past few months at least four pharmaceutical companies have visited the offices of the Traditional Doctors' Association in downtown Johannesburg to enlist help in finding plants that could be used to make new medicines.

"Traditional healers in this country have used about 3 000 different species, for the cure or remedy of various ailments," says Saliem Fakir, who heads a natural resource management project at the Land and Agricultural Policy Centre (Laps).

"South Africa, because of its rich biodiversity, is now attracting international companies in search of plant material that has medicinal value. But this biological and human wealth is still regarded as a free resource," Fakir points out.

In May this year researchers from Shaman Pharmaceuticals, a California-based company, arrived in South Africa and made contact with numerous traditional healers' associations, botanists, anthropologists and research outfits at various universities.

Shaman is at the cutting edge of a new international wave of ethnobotany.

At least 200 big pharmaceutical companies are in the race to develop new drugs from natural resources such as frogs' skins, tree bark and spider venom.

Local pharmaceutical firm Noristan, which has just been taken over by multinational Hoechst, conducted pioneering research in the 1980s on traditional pharmacopoeias with a view to using this data in state-of-the-art drug development. Noristan has since stopped this work and handed its database to a medical school in Cape Town.

At least 122 prescription drugs – including the muscle relaxant curare, malaria treating quinine and vinblastine, derived from Madagascar's almost extinct rosy periwinkle to treat lymphoma – are based on substances found in plants and other wild species.

Most of these were developed in the 1960s when international drug development from plants ground to a halt because it was extremely difficult to analyse thousands of new species for their pharmacological properties.

DNA technology has now made it possible for scientists to screen the therapeutic effects of plants quite rapidly by artificially creating enzymes and cell receptors and then exposing these to botanical substances.

But scientists have analysed only 1% of the world's 250 000 known plant species and mass screening of all these is virtually impossible. Hence the great value of indigenous healers. Their ancient knowledge provides vital leads that allow the pharmaceutical firms to select plants most likely to produce results.

Many companies involved in what has become known as "bio-prospecting" for plants have begun to develop ethical guidelines designed to ensure that host countries and their healers benefit from royalties, patents and technologies developed.

But there have been cases of extreme abuse. Madagascar's rosy periwinkle, for example, is almost extinct on the Indian Ocean island and is now being artificially cultivated in Texas. The company, Eli Lilly, has never paid a cent to Madagascar.

"South Africans now have an onus to ensure that the vast riches that lie hidden in our natural resources, and the way they have been used by local people for centuries, are protected," says Fakir.

"We should move away from a temptation to sell our raw material and intellectual heritage for easy and quick profit."

Galvanised by the apparent proliferation of genetic research into the pharmaceutical use of the country's plant life, Fakir's LAPC has set up a project that will draft regulations and a statutory framework to ensure ethical use of the country's biological riches.

Meanwhile some of the 200 traditional healers' organisations are beginning to debate and educate their members about the ethical issues involved in bio-prospecting. The Traditional Doctors' Association, for example, has engaged lawyers to work on contracts and patents for members approached by big firms for help. – Sapa.

Demands of health workers to get urgent attention

PRETORIA. — The national and nine provincial health departments say they will urgently address health workers' grievances.

The national Department of Health said it had been agreed that solutions to problems of salaries, promotions and working conditions must be found.

"The plan is to speed up solutions to immediate problems and address specific complaints which include salaries, promotions and the conditions under which nurses work," a statement from the department said.

A meeting of all the departments in Pretoria set up task teams to look into the problems and to make recommendations to improve health services and the conditions of health workers.

Thousands of nurses in Gauteng went on strike earlier this month to back demands for wage increases and better working conditions, forcing the provincial government to take steps in terms of the Public Service Labour Relations Act and warn nurses to return to work or face dismissal.

Nurses agreed to go back to work after the government promised it would urgently address their concerns.

The statement said Health Minister Nkosazana Zuma would brief the cabinet next week on the national health services crisis.

"Channels of communication are being opened between the national and provincial departments of health to monitor the situation. The department is also initiating contact with health workers to address their problems," it added. — Reuter.

South Africa's cure allure

Multinational pharmaceutical companies are scrambling to tap traditional healers' wisdom around the world. South Africa has not escaped the trend, writes

Eddie Koch (85)
WM 25-31/8/95

IT took the Pondo *sangoma*, Mercy Manci, exactly 40 minutes after walking through a thicket of thorn trees at the entrance of the Klipriviersberg nature reserve south of Johannesburg to locate a plant called *ugobo* whose root bulbs are used by members of her profession to treat sexually transmitted diseases, and to collect a supply of *phuzile mlambo* fruits which she mixes into a potion that can cure epilepsy.

Until recently, these forays into the veld were considered by scholars to be part of a tradition that relies on mumbo jumbo rather than medical science to treat ailments ranging from diarrhoea to dementia. Yet in the last few months at least four pharmaceutical companies have visited the downtown Johannesburg offices of the Traditional Doctors' Association, of which Manci is a member, to ask for help in identifying plants that can be used to manufacture new drugs and medicines.

This sudden interest by mainstream science in the pharmacopeia that South Africa's healers have gathered over the centuries is part of a multi-billion dollar research drive by drug companies to learn the secrets of traditional healers around the world before they and the plants they use are lost to history.

At least 200 big pharmaceutical firms, mostly from wealthy nations in the Northern Hemisphere, are involved in a research race to develop new drugs based on biological riches as diverse as spider venom, tree bark and frogs' skins that are fast disappearing in the south — and, in the process, they have whipped up an ethical debate that is beginning to make itself felt in South Africa.

In May this year, for example, researchers from a California-based company called Shaman Pharmaceuticals arrived in this country and made contact with a number of local botanists, research institutes and traditional healers' associations. Shaman is one of the companies at the cutting edge of the new wave of ethnobotany — and the company admits that South Africa's fantastically rich store of flora along with its thriving healing profession have become a major area of interest.

Shaman has a research team of physicians, anthropologists and botanists who travel the globe in an effort to uncover — much like Sean Connery did in the film *Medicine Man* — the pharmacological knowledge that lies embedded in the minds of traditional doctors. When they find a plant that at least three groups use for similar treatments, they send samples home for analysis.

According to a recent article in *Newsweek*, entitled *The Sorcerer's Apprentices*, Shaman's researchers are also combing the ruins of pre-Colombian civilisations in Latin America for clues that could lead to the creation of new drugs. "A lot of drug testing has already been done over the centuries," says Steven King, Shaman's head of research.

And by drawing on this store of ancient science, the firm has already patented a compound known as SP-303 which is derived from a common — but so far secret — South American plant. It is also testing an anti-flu and herpes drug that could earn the company billions of dollars a year and is in the advanced stages of research with an anti-fungal medicine that makes use of compounds found in a still-unnamed African plant.

Under the microscope: Traditional herbal remedies
PHOTO: HENNER FRANKENFELD

Shaman's chief medical anthropologist, Alondra Oubré, held extensive talks with a traditional healers' organisation in the Transkei. It has explored the possibility of funnelling some $2 000 to this association, in exchange for collaborative research with these healers and botanists from the University of Transkei.

Industry sources say chemicals giant Glaxo is also currently prospecting for South African plants and local knowledge about how these can be used for the treatment of human ailments as part of a massive drug-development programme.

Local pharmaceutical firm Noristan, which has just been bought out by Hoechst, also conducted pioneering research in the 1980s on traditional pharmacopeias in South Africa with a view to using the information for state-of-the-art drug development.

Noristan has since stopped this programme and handed its database — which contains Southern Africa's most comprehensive collection of folk medicine data including 46 000 anecdotes and the results of in-house tests on 350 plant species — to the University of Cape Town. That university's medical school has set up a traditional medicines project, known as Tramed, to systematically collect information on the chemical, toxic and pharmacological properties of local plants.

Tramed researchers have established working links with organisations such as the African National Healers' Association and Western Cape Traditional Healers. They plan to publish a register of indigenous medicinal remedies as well as a vernacular manual for use by traditional healers. A division of the CSIR called Foodtech plans to set up a bio-prospecting unit that will gather data about the uses indigenous plants have for medicine but also horticulture and food manufacturing.

"Almost every other university now has some form of research relating to traditional medicines in their botany, pharmacology or anthropology departments," says a scientist from a major local company working in the field.

At least 122 prescription drugs — including the muscle relaxant curare, malaria-treating quinine and vinblastine derived from Madagascar's now almost extinct rosy periwinkle to treat lymphoma — are based on substances found in plants.

But most of these were developed before the 1960s when research stopped because plants were then extremely difficult to screen and analyse for their medical properties, mainly because researchers relied on painstaking trial-and-error experiments on laboratory animals.

But DNA technology has now made it possible for scientists to screen the therapeutic effects of plants by artificially creating enzymes and cell-receptors that govern diseases and then exposing these to botanical substances. The effects can then be monitored using spectroscopes and powerful computers.

The result: a generation of new drugs such as Shaman's SP-303 derived from a secret plant that may cure herpes and influenza, Taxol which is manufactured from Pacific Yew trees in North America and has recently been approved for treating ovarian cancer, and another compound called CP-02 from a South American plant that is undergoing trials for healing serious wounds.

But scientists have only analysed one percent of the world's 250 000 known plant species and mass-screening is nigh impossible. Hence the great value of indigenous healers and their ancient knowledge of pharmacy. These practitioners provide the vital leads that allow the multinationals to select plants most likely to produce development results.

According to Saliem Fakir, head of a natural resource management programme at the Land and Agricultural Policy Centre (LAPC) in Johannesburg, the efficiency of screening plants for medicinal purposes increases by more than 400 percent through the use of knowledge in the possession on *sangomas* and other healers. "The current value of medicinal products derived through leads given by traditional doctors is valued worldwide to be about $43-billion," adds Fakir.

Many companies involved in prospecting for the plants and knowledge that are located in poor nations, including Shaman and Glaxo, have begun to develop ethical guidelines designed to ensure that host countries and their healers benefit from royalties, patents and technologies that are developed.

But there have been cases of extreme exploitation. Madagascar's rosy periwinkle, for example, is almost extinct on the island's coastline and is now being artificially cultivated in Texas where the company Eli Lilly has never paid a cent to Madagascar for the resource.

Some Third World countries are cracking down on potential abuse of their "bioresources" by corporations. Brazil and Mexico have banned all exports of plants while other countries are involved in a tussle with the United States, which in 1992 rejected a biodiversity treaty, that would have given underdeveloped countries a share in profits and products developed from their resources (see accompanying story).

The South African government has, however, hardly begun to examine these issues even though there appears to be an explosion of genetic engineering research in the country. Galvanised by Shaman's visit to South Africa, and the proliferation of genetic research into the pharmaceutical use of the country's plant life, the LAPC is co-ordinating a project designed to produce regulations

Muti mama: X[illegible] sangoma Mercy Manci [illegible] her healing crafts in Transkei
PHOTOGRA[illegible]

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on bioprospecting in Feb[illegible] that will help devise poli[illegible] field.

In the meantime, heal[illegible] will continue to gather t[illegible] and bark from the veld. [illegible] that big business will ne[illegible] the spiritual and cultura[illegible] their profession so popul[illegible] Says Manci: "You have g[illegible] value system, to be psych[illegible] the spiritual beliefs, for [illegible] work effectively. I am n[illegible] tablets can do that."

Talking about traditional medicines: Vivienne Williams, a MSc student at Wits University, discusses with three Gauteng traditional leaders the risk plants face by being harvested for the herbal medicine trade

PHOTOGRAPH: HENNER FRANKENFELD

Surgeon may quit over transplants

CT 26/9/95

OWN CORRESPONDENT

PRETORIA: Gauteng and South Africa are on the verge of losing one of the country's brightest medical talents.

Brilliant cardio-thoracic surgeon Dr Fanus Serfontein has lost heart with the attitude of Gauteng provincial health authorities and is actively seeking work elsewhere.

One of the last straws for the young Pretoria surgeon, who first incurred the wrath of provincial health authorities when he broke the moratorium on heart transplants in Gauteng, was the arguing at H.F Verwoerd Hospital when one of his latest transplant patients was refused admission at the weekend.

"I was shocked. How can they treat a sick person this way?" Dr Serfontein asked.

The patient — 54-year-old Mr Peter Bekker — was admitted while the furore about his admission was going on.

Dr Serfontein said yesterday it was becoming impossible for him to continue working at H F Verwoerd.

He added he would leave the country if the right opportunity arose.

HEALTH

A risky prescription

FM 29/9/95

Nationalisation of private health care may still be an option

(85)

There's a deathly silence about the future of private-sector health care in SA notwithstanding the fact that government is contemplating introducing stringent regulations that could well cripple the entire sector.

At issue are the proposals of the Broomberg/Shisana committee that earlier this year investigated a national health insurance system for primary health care. The committee proposals to extend primary health care to all are mostly sound, though potentially undercosted.

But its recommendations for the private sector — including an end to all risk-rating, compulsory hospital cover, licensing of doctors, hospitals and equipment — amount to a reversal of recent gains made by legislation designed specifically to end a decade-long cost spiral caused by over-regulation and legislative protectionism.

That the recommendations for the private sector — contained in Chapter 8 of the report — were unsolicited by Health Minister Nkosazana Zuma and were made without input from the public or stakeholders is another concern. Committee co-chairman Dr Jonathan Broomberg has said stakeholders will be consulted, but he stresses that government is keen to end the consultations and begin negotiating around the proposals in Chapter 8.

Certainly, some of the proposals contained in Chapter 8 are welcome. Long overdue is the acceptance that pharmacy ownership needs to be deregulated to allow nonpharmacists — particularly medical schemes, big business and hospitals — to sell drugs directly to the public, cutting out the antiquated distribution system that allows wholesalers and retail pharmacists to mark up drugs by as much as 100% from the time they leave the manufacturer. Drug costs make up around 40% of the private health care bill in SA, and similar moves in the US saw big business use its purchasing power and economies of scale to discount drugs to the public by up to 50%.

Letlape

Also welcome is the proposal to treat medical scheme contributions — from employer and employee — as part of an employee's taxable income, also a recommendation of the Melamet Commission. Though this means an immediate hardship for the already over-taxed wage-earner, the tax is likely to result in a more cost-conscious, competitive and efficient sector as members think twice about spending money on their health. Put differently, medical economists internationally argue tax deductions have the effect of obscuring the true costs of health care, resulting in overuse by patients, overcharging by providers and an absence of bargaining between providers and funders. In the SA context, the proposed reform would also end the inequity which denies the self-employed, part-time and contract worker tax relief for contributions since the present dispensation allows only employers to qualify for a tax deduction. Presmed joint-MD Rob Speedie suggests the tax reform might also spur employers and employees to investigate managed health care options, still largely unexplored in SA.

Van der Merwe

Broomberg

Another recommendation is to allow members to move freely between schemes, a possibility identified by Melamet as fostering competition among schemes to provide better service and benefits.

It is a proposal that requires careful consideration. For in an economy where education is limited and health costs masked by tax deductibility and distorted by regulation, the ability of consumers to be able to make a rational choice between schemes cannot be taken for granted. The answer may be for members in the meantime to have more say in the employers' choice of an appropriate scheme.

But Chapter 8's greatest shortcoming is that it is based on the false assumption that medical schemes are in crisis because of the recent deregulation ushered in by the Medical Schemes Amendment Act, which allows schemes to end minimum benefits and guaranteed payments and use more risk-rating of members according to criteria such as age, sex and claiming history.

The committee, therefore, proposes that: "Schemes may not exclude any individual on the basis of his or her health risk. There should be open enrolment, guaranteed renewal and transferability of members between schemes."

But recent figures and research indicate that deregulation, with co-payments, deductibles and prior authorisations as well as managed health care principles, is beginning to improve the solvency margins of schemes, particularly the open or public schemes.

Momentum Health MD Adrian Gore stresses that guaranteed membership and enforced community rating cannot work for benefits that are chosen voluntarily or beyond mandatory package, because though they may be desirable from a social perspective they are simply not sustainable financially. He explains: "People would buy cover only when they are sick and market innovation would be stifled since any scheme that offered superior benefits would attract mainly the sick and ultimately fail."

Broomberg counters this with the claim that the deregulatory changes have merely bailed out the system. He stresses: "There is an invisible slide in quality of cover. Innovation has simply led to a proliferation of schemes offering fewer benefits that have let employers and schemes off the hook. Without deregulation, cost pressures would have pushed schemes into real management of care structures." Certainly the deregulated dispensation, which ended protectionism, has seen some casualties as a dispassionate market reallocated resources, but it must be stressed that nearly 60% of all medical scheme members belong to closed or in-house schemes whose reserves average around 28%. This compares favourably with the Registrar for Medical Schemes' recommended minimum 25%.

Says Gore: "It is deregulation that has enabled schemes to change benefit structures and avert insolvency."

But it is also likely that insufficient deregulation has retarded the transforma-

Continued on page 31

Continued from page 26

tion of the sector from a highly protected market to a competitive one. While the new Act formally empowers schemes to run their own pharmacies, for example, the Pharmacy Act continues to prohibit anyone other than a retail pharmacist (and dispensing doctor) from selling drugs direct to the public. The new Act also enables schemes to employ doctors, nurses, pharmacists and other providers in a multidisciplinary environment that would enable schemes to practise the type of managed health care that has cut health bills by 40% in the US and extended affordable private cover to most Americans. The SA Medical and Dental Council rules still, however, prohibit these multidisciplinary practices.

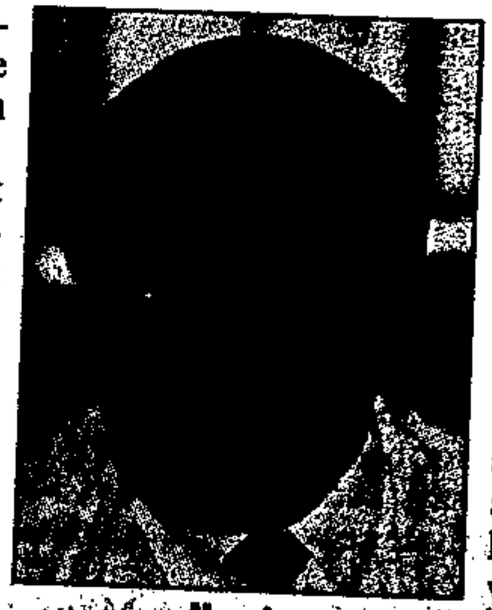
Says schemes administrator Amalgamated Medical Administrators Roly Buys: "Incomplete deregulation has been hampered by the fact that the Representative Association of Medical Schemes has also persisted with special negotiations with providers that effectively subvert the new legislation by continuing to guarantee minimum benefits and guaranteed payments." Managed care principles have, however, cut script charges by up to 40% and a number of managed health care options are taking root.

Understandably, the Broomberg/Shisana committee is concerned with the increasing number of uncovered pensioners and is keen to prescribe pre-funding requirements in addition to community rating.

Gore says this is simply not feasible. "The industry is facing a long-term solvency crisis resulting from a pay-as-you-go system set on community rating. The market is now developing actuarial-based solutions to avert the crisis as well as sound accounting practices to ensure adequate funding during an employee's active lifetime to provide for retirement." Gore suggests government should rather legislate to protect only the estimated 390 000 present pensioners and leave the market to create costing and funding mechanisms to ensure that future pensioners are properly funded.

The committee proposes that all employees take mandatory health insurance cover for a defined hospital benefit package of core services. While the workings of this proposal are uncertain, the report states that such cover is to be geared to cover, at least, the cost of care at State hospitals.

The danger is that a mandatory requirement will prompt higher wage claims which, in turn, will result in higher costs of doing business. The consequences of that will be to entrench unemployment.



Norris

It could also discourage membership of medical schemes if scheme members feel they are paying for duplicated cover, says National Association of Private Hospitals executive director Dr Annette van der Merwe. She adds that the costing of cover at R400 per family a year is hopelessly underestimated, which will mean that State funds for the indigent will be depleted.

Contributions will be income-related (another tax burden) and the report indicates that they will be pooled into a State fund which could be administered by existing private sector scheme administrators. That the report makes no recommendations to improve the professional accountability of administrators, however, is a further concern. Also requiring attention is the practice that continues to reward many administrators on a percentage basis of contributions.

Linked to the compulsory cover is a proposed equalisation fund that would take money from some schemes and redistribute it to others according to the risk profile of each scheme's members. Health consultant Tony Leveton believes such a fund would

reward inefficient management and penalise schemes and administrators who make savings. Gore suggests it would afford arbitrage opportunities for niche marketing.

One of the gravest concerns is the proposed extension of an Essential Drug List (EDL) to the private sector. Pharmaceutical Manufacturers Association president Mike Norris points out that it is highly unusual for the State to involve itself in the procurement and supply of drugs for both the private and public sector. He says such a practice could undermine the private sector, particularly by hampering its ability to recoup discounts given to the public sector in the private sector. He warns also that extending the essential drug list to the private sector would push up the State's costs.

The committee's proposed licensing of doctors, hospitals and hi-tech equipment resurrects old ANC policy that was supposedly discarded along with notions of nationalisation. It amounts to the State allocating resources which inevitably will lead to waste and corruption. The danger is that it will also foster nationalisation.

The insistence that private practitioners will only be accredited to serve State patients if they form themselves into multidisciplinary practices which see only State patients at those premises has incensed the SA Medical and Dental Practitioners (SAMDP), a largely black doctors' lobby. Says SAMDP chairman Tebogo Letlape: "The cost involved in setting up and keeping separate rooms will be prohibitive."

The committee is still silent on the critical question of how the estimated R6bn shortfall for its five-year health plan will be funded. Among the proposals submitted to Cabinet is a levy on scheme members. If this transpires, the burden on members could well result in their switching from private to public health care — compounding cost pressures on public health.

There is too much of Chapter 8 that smacks of a collectivist mentality. It could be used by the unscrupulous to hinder reforms that would reduce medical costs and foster instead a conspiracy to introduce a nationalised health system. ■

Patients rejected by hospitals have 'nowhere to go'

(85) ARG 29/9/95

JENNY VIALL
Health Reporter

SPECIALIST doctors are concerned that patients turned away from academic hospitals like Groote Schuur and Tygerberg are being "lost" because primary health care services are not yet up and running.

Linda-Gail Bekker, chairwoman of the Registrars' Association of Medical Faculties of South Africa (RAMFSA), said her organisation supported the move to primary health care, but was worried that people turned away from academic hospitals had nowhere to go.

The final Western Cape provincial health plan has called for the restructuring of academic hospitals to fall in line with the primary health care approach.

R200 million will be diverted from academic to regional and district services during the next five years. In this financial year, R37,4 million will be transferred from academic hospitals, and expenditure will have to be reduced by R22,9 million.

"It's a time-scale problem," said Dr Bekker, adding that cuts in budgets and moving staff to peripheral areas meant fewer beds were available for patients.

"When beds are full, they're full. As doctors we have to divert people to primary health centres. Until these are established, we're turning people away.

"We are doctors because we care for people. Our patients are suffering."

Dr Bekker said junior doctors were having to act as gatekeepers, turning patients away. "There's nothing else we can do. It's damaging the image of doctors, and doctors don't like doing it," she said. "The public needs to know it's not us doing it."

Wynand van der Merwe, chairman of the Academic Doctors' Group, said discussions were still taking place to identify posts at academic hospitals which should move to the periphery. "This will certainly influence academic hospitals.

"The Western Cape provincial health department hopes that shifting posts will provide a buffeting mechanism, that people will be treated on the periphery. That's still theory, however.

"In practice, morale is low. There are fewer personnel and specialists are left to fill the gaps. Academic time is eroded. That's why specialists are here — for teaching and research."

Malady surrounds health costs

WM (BM) 29/9-5/10/95 (85)

Health care can cost an arm and a leg and is a grave concern for the employers of today, reports Karen Harverson

THE cost of health care has been identified as the priority issue facing employers in the 1995 health care benefits survey undertaken by Old Mutual.

Yet the survey also revealed that more than 70 percent of employers could not quantify their total health care costs.

In many cases, a portion of the cost was hidden in general overheads or salary bills, especially where benefits such as on-site clinics and first aid stations are offered.

The survey included respondents from the top 300 listed companies and the top 200 unlisted companies which together represent 660 000 active employees and 36 000 pensioners in South Africa.

Concern over costs has led to 63 percent of small companies changing their medical aid scheme within the last five years to find new cost-effective solutions.

Assistant general manager Barry Crookes believes that many of the changes were more acts of desperation than carefully considered strategies, judging from the lack of adequate management information.

The figure was more stable for large companies as most have self-managed schemes which have undergone dramatic changes more recently than the commercial schemes.

However, the percentage of large companies, with more than 10 000 employees, which had had the same medical aid scheme for more than 10 years, dropped from 72 percent in 1994 to 38 percent this year.

Consultant Heather McLeod says there is a growing trend towards managed care, changing member incentives and the use of savings plans to break the cost spiral.

Managed care entails influencing the supply side, through contracts with hospitals, general practitioners and medicine suppliers.

An analysis of the total cost of medical services indicates that medicines and hospital services together account for almost half the total bill.

The survey reports that pensioners belonging to medical aid schemes are relatively well-treated compared to elsewhere in the world, where benefits have been reduced, or even removed, in recent years.

Cross-subsidisation, whereby the young and the healthy subsidise the costs of the old and the sick, is under pressure because of the ageing profile of medical aid schemes. Despite this, the survey found that an increasing number of employers support this approach.

McLeod believes it is because there appears to be no other real solution to the problem. However, she adds that there is a move by most funds to pre-fund for future pensioner liabilities.

Pre-funding entails members paying more now — usually into some form of savings scheme — to build up a lump sum to fund retirement benefits later.

Although only a few employers assist employees with pre-funding, almost three-quarters said they intended to pre-fund in future.

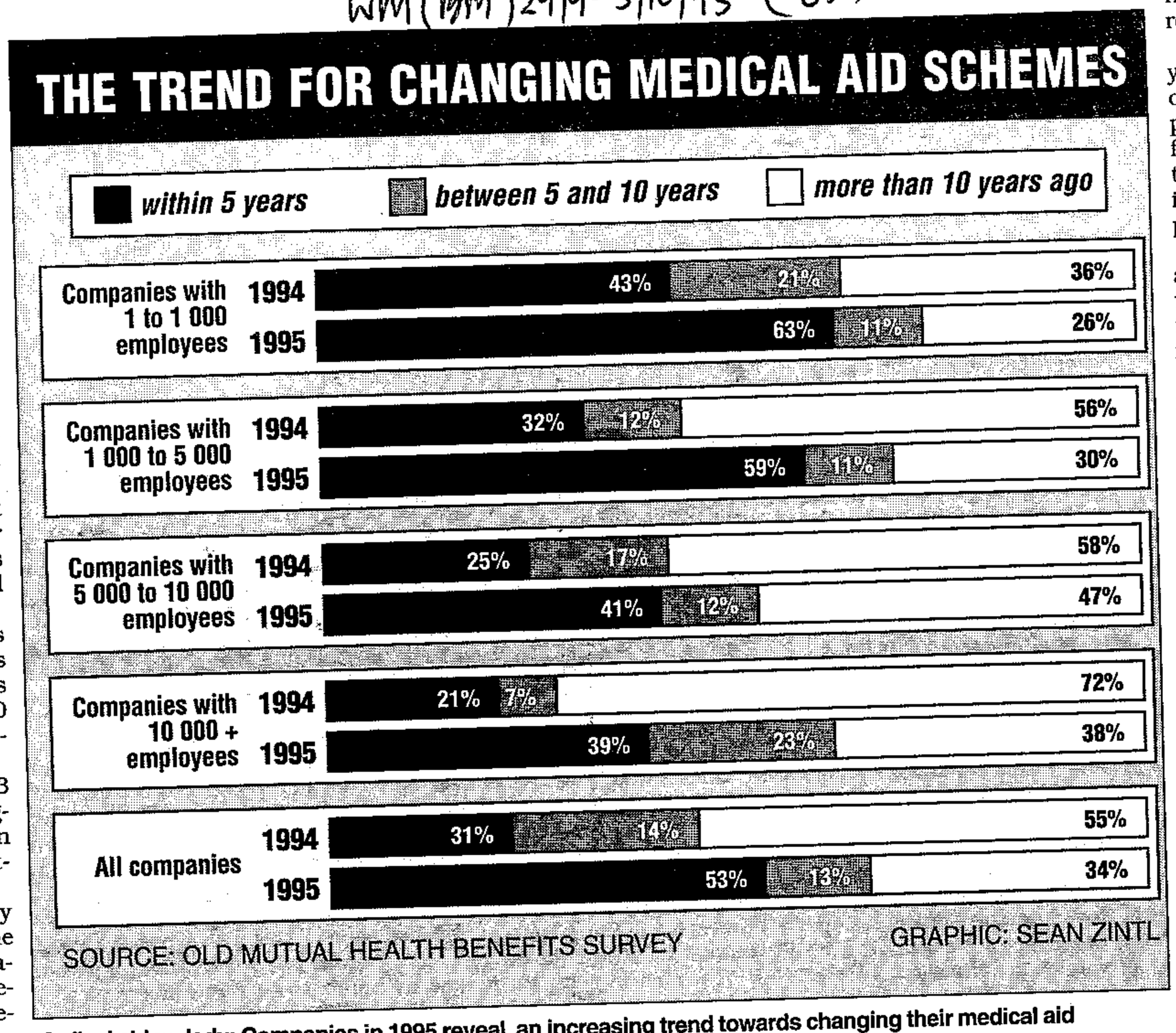
"This trend was given added impetus by the release of accounting opinion AC305 in July," says McLeod.

The accounting profession has stated that, as has happened in other countries, companies will need to reflect the present cost of health care for future pensioners in their financial statements.

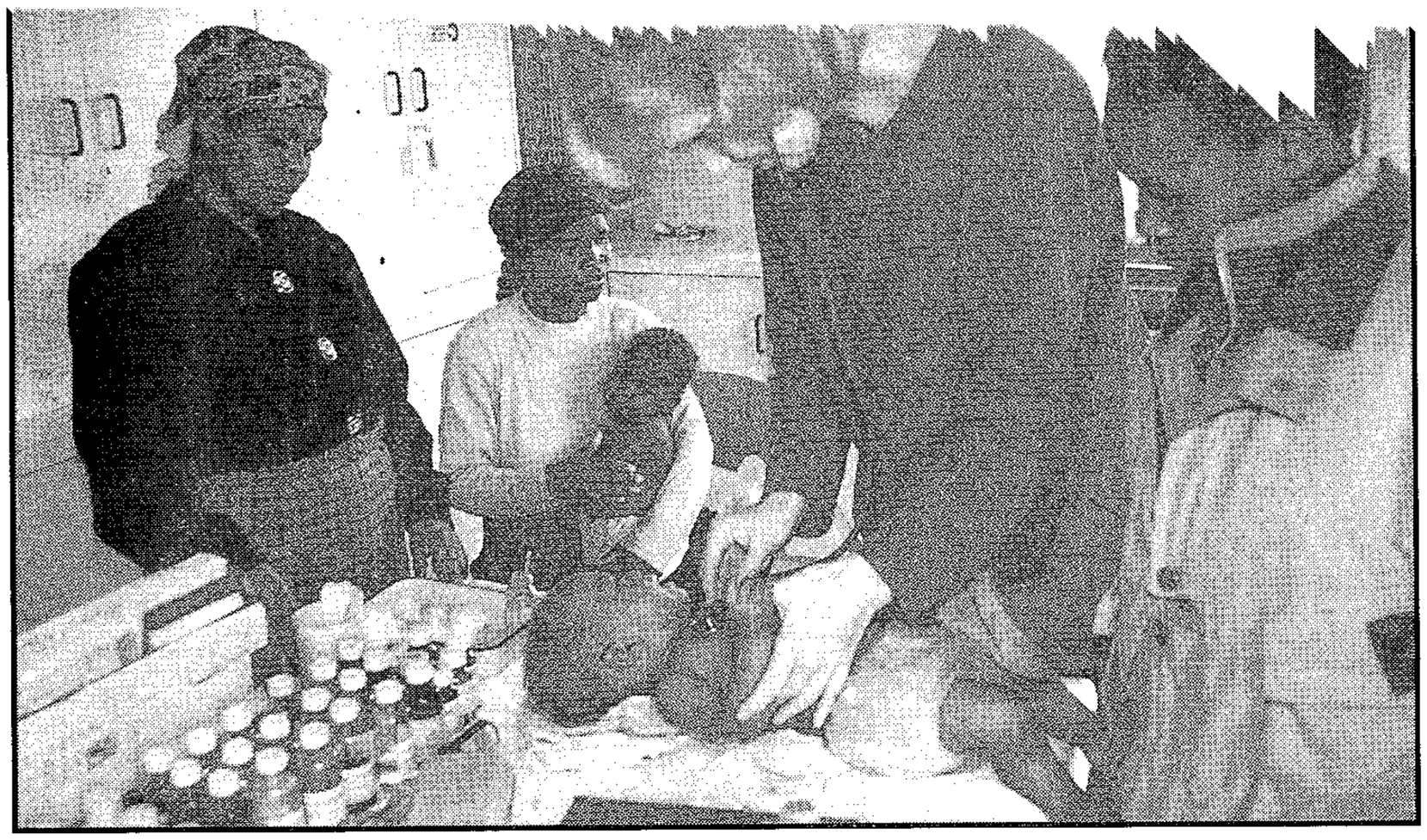
"In essence, medical benefits should be treated like retirement benefits and paid for while the employee still works for the company," says McLeod.

She says the liabilities for health care for pensioners totals about R35-billion but the available assets are only at R1-billion. "The remaining R34-billion needs to be split between all the companies and funded in the medium term."

Attitudes towards Aids have also changed in the past 12 months with 78 percent of respondents compared to 57 percent in 1994 now having some form of Aids policy in place.



Medical aid malady: Companies in 1995 reveal an increasing trend towards changing their medical aid schemes on a more frequent basis



Pictures: OBED ZILWA, Staff Photographer.

□ **HELPING HAND:** Flats township doctor Ingrid Le Roux examines one-year-old Lunga Genu while his 16-year-old mother Noyomi, right, looks on. Philani Centre worker Nongabadela Zibi is on the left and waiting her turn is Vulelwa Sihle, who has her baby Goqwana on her lap.

Seeking a right to good health

ARG 30/9/95 (86)

■ An ad hoc grouping of organisations has spearheaded a campaign to have health included as a fundamental right in the new constitution.

ADELE BALETA
Staff Reporter

THERE are up to 25 000 children under the age of six who are chronically malnourished and at least 4 000 with tuberculosis living on Cape Town's doorstep.

That is according to a comprehensive survey by community health workers who last year interviewed and assessed children and adults in every 50th household in Khayelitsha with its 400 000 inhabitants.

Malnutrition, TB and diarrhoea are some of the health problem affecting many South Africans and a group of organisations — mainly legal, development, housing and health — have made submissions to the constitutional assembly to have health included in the constitution as a fundamental right.

The intention of this group, which advocates a multi-sectoral approach to health, is to ensure government progressively creates the conditions that would give the best possible health status for all South Africans.

Flats township doctor Ingrid Le Roux says chronically malnourished children who are stunted may gain weight with rehabilitation but they never reach their full potential.

Poverty, unemployment, instability and violence are central to life experiences of township and squatter communities, she says. As a result there are large numbers of malnourished children and destitute mothers.

Dr Le Roux spreads her work between the six community-based Philani nutrition centres — four in Khayelitsha, one in Crossroads and one at Brown's Farm — whose aim is the rehabilitation of underweight children so as to limit the crippling effect of malnutrition on their health and development.

The centres serve an estimated population of 500 000 people living in dense informal settlements spread over an area of 3 200 hectares.

A third of the children seen by the centres have undiagnosed TB. The remaining two thirds are given a drug to cover them for possible TB inefection.

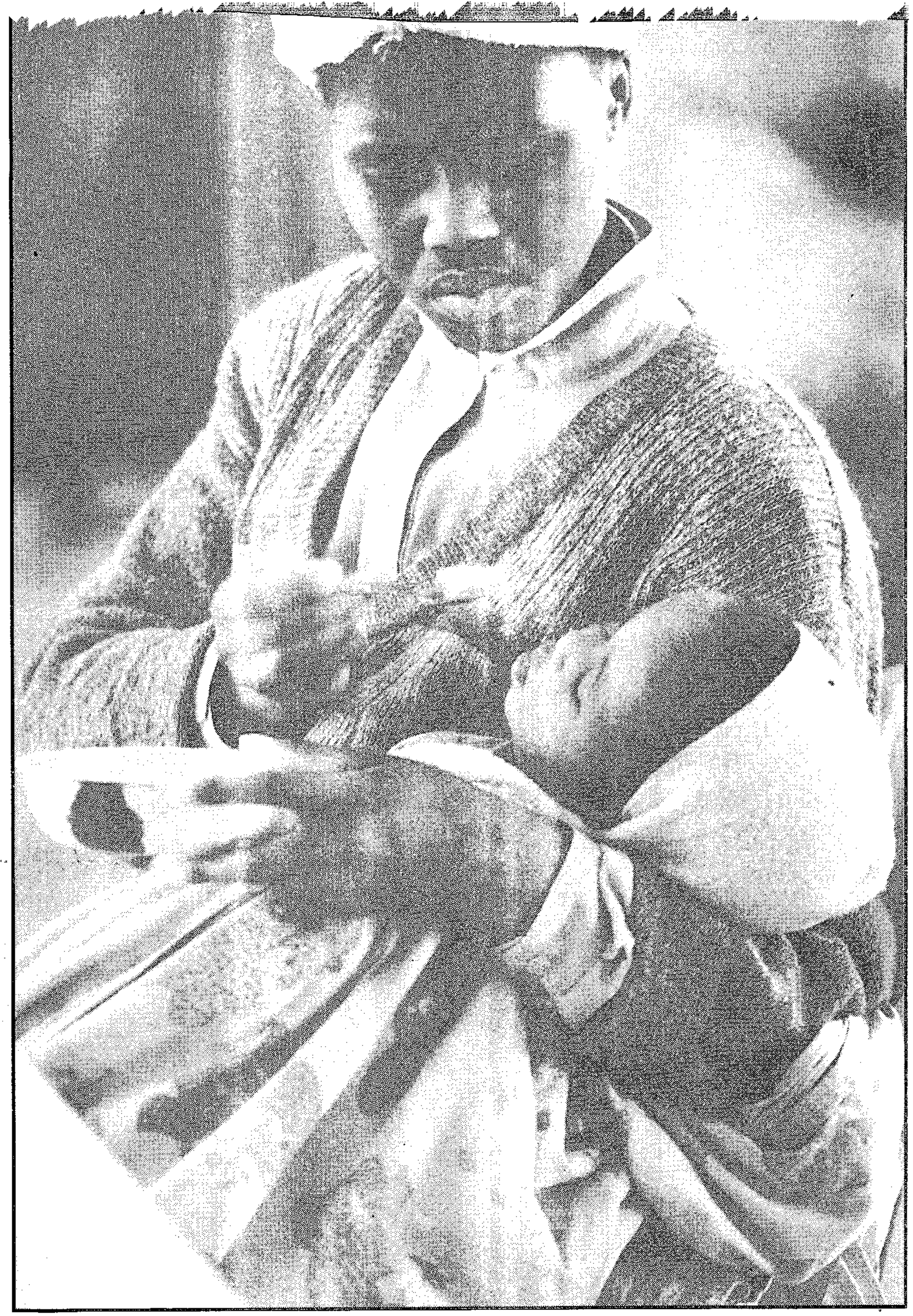
While on a guided tour to the centres Dr Le Roux points to a group of children sitting on a pavement carpeted with litter and garbage.

"The right to health cannot be divorced from the right to clean healthy surroundings. People have a right to municipal services. They have a right to clean water and sanitation. The have a right to a home too," she says.

The Philani nutrition centres are committed to the protection of the rights of each child to proper nutrition and health care.

Dr Le Roux opens the file of a mother and child waiting to be seen at the Philani Nutrition centre in Crossroads. The case is typical, she says.

The child is 2½ kilograms below his ideal weight. His mother who is being treated for TB is unemployed and the child's diet consists of porridge only. Her child will be screened for TB.



□ **MOTHER AND CHILD:** A Crossroads mother feeds her child at the Philani Centre.

Health sector should get more money – DP

Sowetan 3/10/95 (85)

By Glenn McKenzie

DISGRUNTLED nurses were not optimistic about reaching an agreement in today's negotiations between the Government and public sector unions, several spokesmen for the health-workers at Baragwanath Hospital said.

Ms Cynthia Sadike, a spokeswoman for the nurses' movement that initiated recent strikes at Baragwanath, said nurses did not trust the Government and unions to negotiate a fair deal for them.

The Government and public sector unions are meeting in a national bargaining chamber at an unknown location in Gauteng today to discuss salaries and working conditions.

It is not clear whether the nurses' new labour movement, often referred to as the "Health Workers Forum" will be allowed to participate in the talks.

Gauteng health spokesman Mr Popo Maja said only recognised labour unions with written constitutions could negotiate in the forum.

In recent public statements, Government health officials have promised nurses a "substantial package" which could come into effect in April 1996. But if grassroots nursing movements do not agree to this package, it could lead to further work stoppages.

Sapa reports that hundreds of nurses marched on the Union Buildings in Pretoria yesterday to demand 33 percent pay increases. They handed a memorandum to a government administrative secretary, and said they would return to work on a work-to-rule basis.

Work to rule

"Nurses will clock in but will not provide quality treatment," said Gauteng Nurses Forum spokesman Mr Stephen Matlaila.

GaRankuwa hospital superintendent Dr Reg Brokemann said about 500 nurses from his hospital left yesterday morning to take part in the march. Two busloads of nurses from Baragwanath Hospital were also among the demonstrators.

Meanwhile at Baragwanath Hospital yesterday, Democratic Party leader Mr Tony Leon suggested the Government should transfer more funds to the health sector in future.

Leon, who visited the hospital to investigate health conditions, said the Government had spent "a lot of funds" in projects such as Sasol, state intelligence services and private consultants.

DP Gauteng health spokesman Mr Jack Bloom suggested that Baragwanath could be made into a Reconstruction and Development Programme project.

"Money is being sent back to Europe because there are no mechanisms in place to use the money. This is ridiculous. We have a huge need right here," said Bloom.

On several occasions last month, nurses have walked out of hospitals and clinics around the country. Trade unions have denounced the strikes, saying they had already negotiated a deal for the nurses earlier this year.

SA's first standard health reference work released

Star 4/10/95 (85)

BY JANINE SIMON

The South African Health Review, the first of what is expected to become the standard annual reference work on the health sector, was released in Johannesburg yesterday.

The Review, published jointly by the Durban-based Health Systems Trust (HST), and a private US trust, the Henry J Kaiser Family Foundation, gathers together the work of more than 20 authors and 30 reviewers, and is seen as a milestone in the reform of SA's health system.

It had three main aims, HST executive director David Harrison said yesterday.

The first was to tackle the dearth of health data with a systematic presentation of health and related information; the second to detail the current state of the health services; and the third to use this information to evaluate policy and identify priorities.

Information about health care was not only poorly developed, it was often not used by the health workers who collected and analysed it, Harrison said.

The review's strength was that it tackled one of the most difficult issues in health care, comparative costs, with detailed tables of health and related indicators across race and across province, he said.

While an estimated R30-billion was spent on health care in 1992 (8,5% of GDP), South Africans were not getting the best returns for their money – infant mortality rates, life expectancy and incidence of tuberculosis compared badly with countries at similar levels of economic development, such as Hungary, or Malaysia, which spent far less of their GDP.

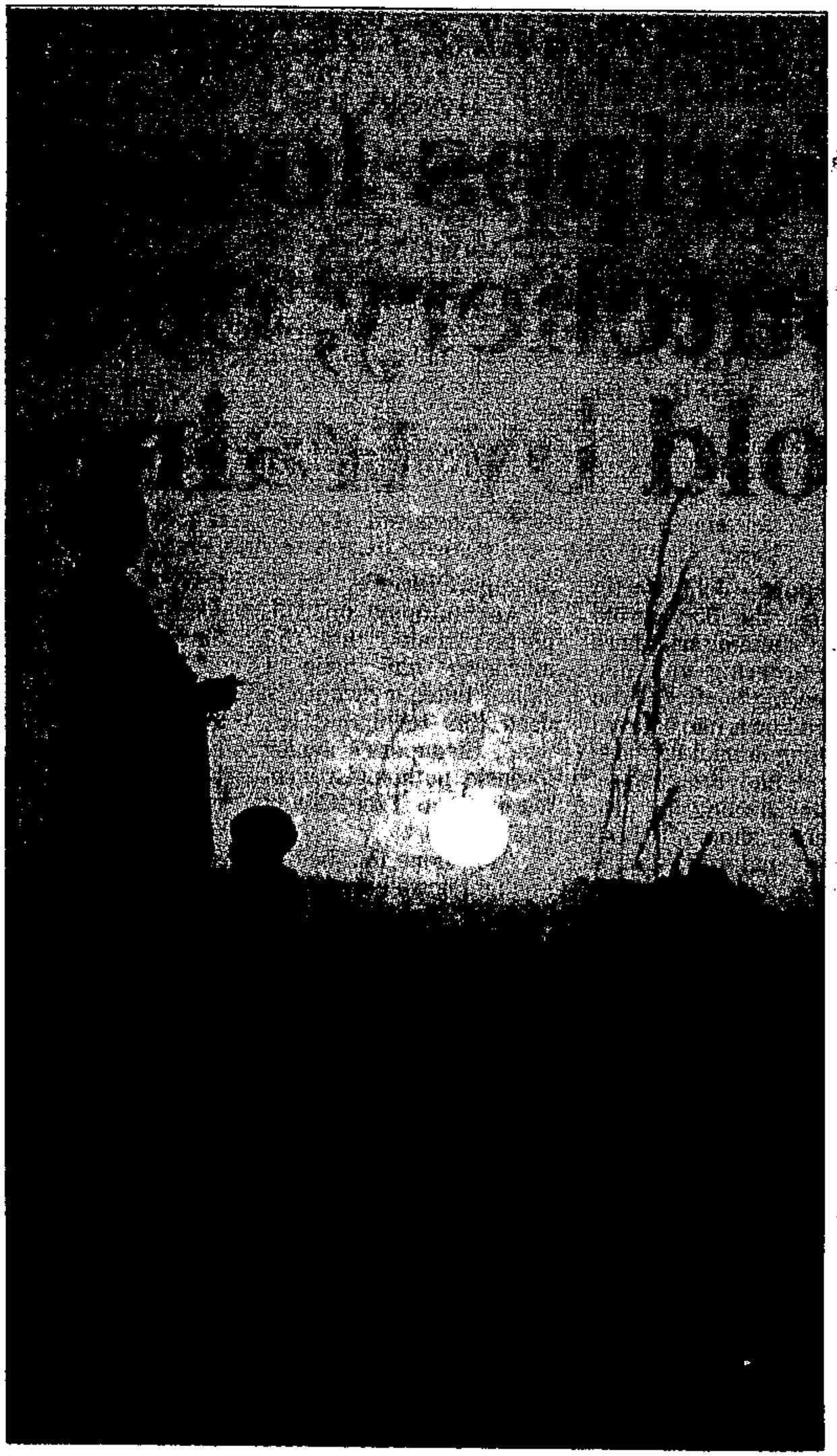
Medical schemes spent 15 times more per person on their beneficiaries than the Government spent on a person using public health facilities in any of SA's poorest magisterial districts.

The review identified 10 important health indicators for SA, from deaths of children under five (16,3% of total), to the incidence of HIV among pregnant women (7,57%), tuberculosis (225,8 per 100 000), the proportion of adults who smoke (34%) and total trauma attendances at public and private health facilities.

Preventable causes of death, illness and disability formed a large component of the total burden of disease in SA, although major childhood illnesses were steadily declining, it pointed out.

By contrast, prevalence of HIV infection was rising rapidly, with 1,8-million currently infected. Tobacco- and alcohol-related diseases were also increasing.

The causes of potential years of life lost through premature deaths varied between provinces with homicide being a major problem in Gauteng.



k ... a new health study has found that about one-third of in rural areas travel more than one hour to their closest cility.

60% have no electricity, a quarter earn less than R300

Blacks worse off – survey

(24) (85) Star 4/10/95

■ BY JANINE SIMON
MEDICAL CORRESPONDENT

A new health study handed to the Department of Health yesterday has underscored how dramatically worse off the majority of the black population in South Africa is in almost every aspect of their life.

A national household survey of health inequalities in South Africa was commissioned in June 1994 by the private United States philanthropic trust, the Henry J Kaiser Family Foundation.

It was carried out by the Community Agency for Social Enquiry (CASE).

Among the findings of the survey were that only about 20% of black households have a water tap inside the home, 16% have no toilet of any kind, and nearly 60% have no electricity.

NEARLY half of all South Africans are dissatisfied with public health services, study finds

Almost two thirds of all black households (and more than three quarters of black households in rural areas) have monthly incomes below the minimum living level of R900. Nearly a quarter have a monthly income below R300.

Nearly two thirds of white households have a monthly income in excess of R2 000.

Most South Africans report for their first treatment at a public hospital, or private doctor, probably because clinics were scarce, inaccessible, had restricted hours and were thought to offer a poorer quality of care.

While nearly half of all South Africans are dissatisfied with public health services, dissatisfaction among black people is much higher (46%) than is the case with other population groups.

About one third of black South Africans in rural areas travel more than one hour to their closest health facility, wait for more than two hours, and are then consulted for five minutes or less.

Immunisation rates of all children under five was low, but the health of black children under five was most at risk, the study showed.

Almost a quarter of blacks said they were too poor to properly feed their pre-school children, but only 8% reported receiving food supplies from a health facility.

Close on 60% of black children do not have a birth certificate.

Most respondents (92%) had heard of the Government's introduction of free care for children under six and pregnant women.

Blacks and coloured people reported this had made access easier and improved quality of care, although those in urban areas said services had worsened because of increased congestion.

The Government's primary school feeding programme is not reaching a substantial proportion of the children from the 75% of rural black households with incomes under R900.

About 85% of South Africans believed community health workers would help improve the health service, the study found.

Blacks 'live in worst condition'

(85)

BARRY STREEK
POLITICAL STAFF

CT 4/10/95

BLACKS continued to live in worse conditions than other segments of the South African population, a new health survey, which was released yesterday, has found.

"Poverty and poor health conditions — overcrowded housing, lack of accessible drinking water and sanitation — make blacks most vulnerable to ill health," said Dr Michael Sinclair, of the Henry J Kaiser Family Foundation which sponsored the survey.

"Yet those who are at the greatest risk have the most difficulty using health services and are treated shabbily when they do."

Dr Sinclair made these comments when he handed over a copy of the 200-page report, National Household Survey of Health Inequalities in South Africa, to Health Minister Dr Nkosazana Zuma in Johannesburg yesterday.

The survey involved 4 000 households across the spectrum of the South African population.

The survey found most blacks relied on the public health service, whereas whites and Indians relied almost entirely on private care.

Over 40% of South Africans from all race groups thought the existing health service served them poorly, with black disatisfaction (46%) being the highest.

The government's primary school feeding programme was not reaching a large part of the children from the three-quarters of rural black households living below the minimum wage level.

Nearly two-thirds of black children did not have birth certificates, the survey found.

SA blacks worst off says survey

Sowetan 5/10/95

By *Sowetan* Correspondent

A STUDY handed to the Department of Health yesterday underscored how much worse off the majority of the black population in South Africa is in almost every aspect of their lives.

The national household survey of health inequalities in South Africa was commissioned in June 1994 by a United States philanthropic trust, the Henry J Kaiser Family Foundation. It was carried out by the Community Agency for Social Enquiry (CASE).

Among the findings of the survey were that only 20 percent of black households have a water tap inside of the home, 16 percent have no toilet and nearly 60 percent have no access to electricity.

Nearly two thirds of all black households (and more than three quarters of black households in rural areas) have monthly incomes below the minimum living level of R900. By contrast two thirds of white households have monthly incomes in excess of R2 000.

A third of rural inhabitants travel more than one hour to the closest health facility, wait for two hours, and are consulted for five minutes or less.

HEALTH SERVICE TRENDS

(85)
FM 6/10/95

More than 40% of South Africans think public health services are poor, inaccessible and costly, claims a survey presented to government this week. Philanthropic trust, US-based Kaiser Family Foundation performed the survey.

Geared to establish a baseline from which to measure the improvements in health and services for the poor, the survey confirms that poverty combined with poor public health services, overcrowded housing, and lack of accessible drinking water and sanitation, makes blacks most vulnerable to ill health.

The survey, based on a sample of 4 000 households from all population groups, shows that waiting times at public health facilities are excessive while consultation times are too short to be effective. The survey states: "This is symptomatic of the extent to which the public health service is overburdened and understaffed."

According to the survey, 92% of respondents had heard of government's free care for children under six and pregnant women. Blacks and coloureds felt the programme had made access easier and improved quality of care, while whites said access and care quality had remained the same. Urban respondents were more critical of falling standards at public facilities since the introduction of the free-care programme.

Health "outreach" services, including ambulance services and care for the aged and disabled, are poor for all population groups and almost nonexistent for blacks.

Most patients, says the survey, do not report for their first treatment at a public clinic, but rather at a public hospital or private doctor. This finding could undermine proposals for a national primary health insurance system that plans to penalise patients for bypassing primary health-care clinics and accredited practitioners.

Legacy of shocking statistics

(85) CP 8/10/95

A first-ever survey paints a tragic picture of the miserable living conditions which the majority of African kids have inherited

Seven out of 10 African children aged five or under live in homes without electricity; one in three live in homes where someone fetches water daily from a river, stream or borehole; and one in five live in homes where there are no toilet facilities.

OLIVE SHISANA... Wants free health care for all. ■ Pic: THULANI SITHOLE

By JUSTICE MOHALE

MORE than 2,7 million African children aged five years or less in the country's rural areas live below the breadline.

This startling fact was revealed by the first survey conducted of living conditions in South Africa.

The survey was carried out on behalf of the philanthropic US-based Kaiser Family Foundation by the Community Agency for Social Enquiry (CASE).

The survey found that 70 percent of 3 147 000 African children aged five or under lived in rural areas, and that 76 percent of these lived in households that lived at below the minimum family subsistence level of R900 a month.

Only three in 10 African children below the age of five live in metropolitan areas, where they are normally better fed and have greater access to health services, while the majority of whites, Indians and coloureds live in urban areas.

One in four of the young children living below the breadline live in the rural areas of KwaZulu/Natal.

About one in five live in the Eastern Cape and Northern Transvaal, and about one in 10 live in the Gauteng rural areas.

The Northern Cape has only one in a hundred living children in such poor rural conditions and the Western Cape has one in fifty.

Whereas most of the white, coloured and Indian children live in formal brick houses throughout the country, a little more than one in two African kids do.

The reason for this is the high proportion of African children living in rural areas, according to the survey.

Almost one in three African children live in traditional dwellings and 11 in 100 live in shacks.

Almost two-thirds of African children and more than half (57 percent) of coloured children live in overcrowded households, while fewer than one in five Indians (17 percent) and one in 100 whites do likewise.

Nearly two-thirds of traditional dwellings are overcrowded.

Seven out of 10 African infants and young children live in households without electricity; one in three live in households where someone fetches water daily from a river, stream or borehole; and one in five live in households where there are no toilet facilities.

Only one in five African households have indoor running water while all white households have it.

The survey revealed that one in four of all African households have a monthly income of less than R300, and that close to two thirds of African households have monthly incomes below the R900 minimum living wage.

This can be compared with white households where nearly two thirds of them have a monthly income of more than R2 000.

Public health care

Most Africans rely on the public health system while whites and Indians rely almost entirely on private care.

More than four in ten South Africans – in the case of Africans nearly half – believe the existing health service serves them badly.

Olive Shisana, director-general of the Health Ministry, said when the findings of the survey were released this week that the purpose of the survey was to provide a basis from which to launch a Health Ministry plan to provide free health care to all.

She said this was a priority.

"About two-thirds of our African population is affected by poor health conditions, overcrowding, lack of electricity, clean water and sanitation," said Shisana.

She said that poverty, combined with poor public health conditions, made Africans most vulnerable to ill health.

The survey revealed that malnutrition in children under 15 made them vulnerable to disease.

The agency recommended that feeding children at school was the best way to fight malnutrition.

However, it found that the Government's primary feeding programme was not reaching a substantial proportion of children in the schools in rural areas.

No reason was given for this finding.

The agency recommended that children be given breakfast in the morning to help them build up their health and concentrate on their school work.

According to the survey, most African children in the Western Cape and KwaZulu/Natal received free food at school, but this was not the case in the Northern Province, Gauteng and Mpumalanga.

Free food

The survey also revealed that children living in traditional huts were more likely to receive free food at school than those in other dwellings.

Michael Sinclair, vice-president of the agency, said that most Africans had difficulty reaching health services and were treated very shabbily when they did.

He said more than one in three Africans reported that they had to travel more than an hour to the nearest health care facility and had to wait long periods for a consultation that often lasted less than five minutes.

"Most people of all races are dissatisfied with the present health services.

"Ambulance services and services for the aged and poor are bad for all groups, and are almost non-existent for blacks," said Sinclair.

WE SHOW THE WORLD HOW TO KEEP DONATED HEARTS ON ICE

By JANINE EILERS

SOUTH AFRICA has again been catapulted to the forefront of heart transplant technology, with a breakthrough that could allow donated organs to be preserved indefinitely.

Until now, donor hearts had to be transplanted within four hours or the tissues degenerated, rendering the organs unusable.

But a new formula has the potential to extend the life of donor hearts indefinitely.

Hearts are saturated in the cryo-preservant formula before being frozen in liquid nitrogen.

The formula has been developed by Olga Visser, a cardio-vascular perfusionist at Pretoria's H F Verwoerd hospital, working under the guidance of its head of cardio-thoracic surgery, Professor Dirk du Plessis, bio-medical engineer Professor Pierre Cilliers, and physiology professor Chris Steinman.

While much testing lies ahead, indications are that the formula will allow for the freezing of a donor heart for years, after which it will be unfrozen, made to beat and save the life of a needy recipient.

Ms Visser, 37, says: "Scientists have for years tried this and got nowhere and here I started and there were no huge setbacks."

Until now there has been success in reviving only single cells which have been frozen, such as sperm and eggs. Attempts to freeze whole organs in liquid nitrogen have failed because cells have been destroyed in the process.

As well as developing the formula, the South African scientists have succeeded in saturating the cells, using the heart's blood vessels.

The formula changes the properties of the water in cells and this prevents damaging expansion as the heart freezes.

The team of medical scientists is cautious about celebrating prematurely, but their discovery arguably matches, or even surpasses, the first heart transplant performed by Professor Chris Barnard in 1967.

Ms Visser says: "It is unbelievable, the concept is perfect. But we still have many months of research and hard work ahead of us before we can perfect it to such an extent that it can be used in human transplants."

The breakthough means that transplant surgeons will eventually be able to establish heart banks from which they will simply select the appropriate organ for the recipient the moment it is required.

Patients will no longer have to wait for months, or depend on bypass machines for their survival.

And Professor du Plessis says there is every likelihood that with further research their formula will be used to preserve other transplantable organs such as kidneys, lungs and corneas.

Ill patients will also no longer be bankrupted by the costs of life-sustaining procedures.

Professor Cilliers, 42, says in the short term the new technology could be used in cases where longer than four hours are needed to transport a heart and perform a transplant.

Ms Visser has been working on the concept for two years. She embarked on the project while assisting a surgeon in establishing a heart valve bank.

"Then I thought, if you can freeze valves to minus 196°C, why not hearts," he says.

On advice from various surgeons and specialists, she read all the material available on previous research into cryo-preservation and then started experimenting.

"A lot of my work was done after working hours and at weekends. I often worked until two or three in the morning."

Her big breakthrough came in May this year when she perfected the chemical composition of the formula, following a protocol she and Professor du Plessis drew up.

The first tests on animal hearts were conducted in August and produced encouraging results.

A pig's heart was frozen to stasis — the state of biological limbo — and then unfrozen. Tests on the heart showed signs of electro-cardiographic activity. Ms Visser said they could not warm the heart sufficiently for it to start beating steadily. However, the cells were undamaged.

This encouraged the team to test tissue from a human heart, and once again there was no sign of cell damage.

Next a rat heart was frozen, unfrozen and then warmed by a special process ... and started beating. This was the moment of victory for Ms Visser.

She telephoned Professor du Plessis and shouted: "My heart is beating, my heart is beating."

Professor du Plessis understood perfectly and shared in her joy.

The little heart beat for 45 minutes before the scientists shut it down. They had seen enough. — *Sapa.*

First for SA

8/10/95

Transplant

(85) BT

UPBEAT ... scientist Olga Visser's discovery of a way to preserve donor hearts could revolutionise transplant surgery Picture: RUVAN BOSHOFF

National health assets audit will cost R15m

(86) BT 8/10/95

By CAS St LEGER

EVERY clinic and hospital in South Africa will undergo an audit over the next few months to assess the state of the buildings and equipment.

The aim is to find out just what is available, what needs painting or knocking down, or what needs to be built.

RDP minister Jay Naidoo is providing R15-million to the Department of Health to fund this investigation into health care facilities.

Ben Theron, the man in charge of the RDP health project, said that over the past seven years, health facilities ranging from country clinics to Cape Town's Groote Schuur hospital had become run-down and neglected.

"In transferring to the new health care system, we need to know what we have. We need to know what the condition is of the current system," said Mr Theron.

He said the huge audit would be put out to tender soon. The job was expected to take from two to five months.

The audit will cover buildings and equipment only. Each of the country's 350 larger referral hospitals had been allocated R350 000 in the audit. For community hospitals and clinics, R23 500 each had been set aside, Mr Theron said.

He was aware that a hospital audit could be interpreted as a check on the pilfering of millions of rands worth of drugs, linen and other equipment but said health director general Dr Olive Shisana had given the assurance this week that a new system to stem these thefts was being put in place.

Former Minister of Health denies placenta exports

(85) ST 8/10/95

By CAS St LEGER

THE former Health Minister, Dr Rina Venter, has denied claims by the Department of Health that she approved the sale of human placentas for export during her term of office.

Vincent Hlongwane, spokesman for the Minister of Health, Dr Nkosazana Zuma, said on Friday that Dr Venter had "consented in February 1991 to the export of placentas" to a French pharmaceutical company, Bochnech Organic Materials

Mr Hlongwane said a permit was issued in 1992 for the material to be exported to Bochnech. He did not know who the local agent was.

When this came to Dr Zuma's attention last October, he said, she instructed the immediate withdrawal of the licence.

"The department is investigating the matter to ensure the implementation of Dr Zuma's directive," said Mr Hlongwane.

But Dr Venter said this week that she had no recollection of signing her consent.

"If a document containing the word 'placenta' had been put before me for signature I would not have signed it," she said.

After investigating the issue with former colleagues on Friday, Dr Venter said the document in question had referred to "organic matter", which she had not interpreted to mean human body parts.

Dr Venter, who is now an adviser to Deputy President F W de Klerk, said she had signed the document after an investigation by the health department's policy management body.

"In the past, organic material was dumped," she said.

"The World Health Organisation said it should not be considered human tissue but, under South African law, it was.

"The Health Department decided it was unacceptable for us to make this material available for commercial purposes."

Dr Venter said it had then been argued by the policy managers that South Africa should import blood and medical products obtained from this material and that the country should contribute towards its production.

It had been decided that South Africa would provide the organic matter only for medical products and not for cosmetic purposes.

"The standpoint was that we would not make money out of it," Dr Venter said.

This week, Ann Brown, the acting national director of the Women's National Coalition, alleged that former "decision-makers" in the Health Department had entered into a long-term agreement with Waste-tech, a waste collection company, to dispose of body parts from 103 state hospitals.

"It appears that a further process takes place by a third party that collects placenta on a weekly basis. This is where the violation occurs," Miss Brown said.

Cathi Albertyn, the coalition's legal counsellor, said the French company apparently extracted enzymes from the placentas for cosmetic purposes.

But Jenny Orr, a manager at Waste-tech, denied that any body parts collected by her company were exported or sold.

PHC must be a partnership

Developments in Cameroon and the Congo in recent years are pointing the way towards the overhaul of primary health care in central Africa. Are there lessons to be learnt for South Africa, itself in the process of health care reconstruction? *Health Writer* David Robbins reports on a recent visit to these countries.

In South Africa, the talk in health circles is all about effective primary care, a national health insurance system which will render such care free at the point of service, and the idea of the district governance of health care structures based on community participation.

In central Africa, the talk is not dissimilar, but with some important differences.

"You can't provide free health care and then expect effective community participation in the management of that care," a Cameroon doctor said bluntly.

Does this mean that South Africa is barking up the wrong tree? It would be simplistic in the extreme to answer either yes or no. Yet it's a fascinating question; and it certainly warrants a closer examination of the fortunes of primary health care (PHC) in central Africa – and here at home.

PHC, with its emphasis on promotive and preventive programmes as well as basic curative services at community level, first gained international recognition through a conference held at Alma-Ata (in the USSR) in 1978. Not surprisingly, South Africa did not attend. PHC only began to be officially talked about here in the second half of the 1980s, but its implementation was thwarted by a fragmented system and a budget skewed by the dominance of urban-based curative care.

In most of the rest of Africa, the course of events was strikingly different. PHC a la Alma-Ata fitted perfectly into the provision of free health services established in Africa since the rush to independence in the early 1960s. In theory, at any rate. Due to shrinking economies and hard-pressed budgets, not to mention wars and droughts, free PHC in not a few African countries had fallen into disrepair by the mid-1980s.

Africa's response was to hold a conference of its own, this time in Bamako, capital of Mali, which resulted in the emergence of the Bamako Initiative. Again, South Africa did not attend. Indeed, the Bamako Initiative is rarely talked about here, even in the new South Africa.

The result is something of a time warp. While South Africa pushes ahead with the implementation of PHC and district health, many countries in Africa are already talking about the reorientation of PHC, or the introduction of a system known as "integrated PHC", based on the principles of the Bamako Initiative.

So, what is this initiative? Although Alma-Ata stresses community involvement in health management, Bamako takes such involvement a step further. "In a sentence," Dr John Lebga told me in Cameroon recently, "Bamako is about the co-management *and co-financing* of PHC. It's a partnership between the community and the State, a way of making the principles of Alma-Ata sustainable in countries with ailing economies."

Dr Lebga is a health project officer with the United Nations Children's Fund (Unicef), and he's been closely involved with the reorientation of PHC in Cameroon, a process which began with 40 pilot projects in November 1991.

"You need to understand what we were dealing with," he said. "Free health care had virtually collapsed. Buildings had fallen into disrepair, staff was demoralised, drugs were in short supply. In addition, there were high levels of wastage and an irrational use of resources. There was, to put it bluntly, no effective management of PHC anywhere in the country."

Cameroon was divided into 123 health districts, each one containing between 50 000 and 90 000 people. The districts were further divided into catchment areas with populations up to 10 000; and it was at this most basic level, and in the rural areas that the pilot projects were installed.

"The management of these areas is by means of what we call dialogue structures," Lebga explained. "There's a health committee comprising two representatives from each village in the catchment, a man and a woman to ensure gender equality. The head nurse from the catchment clinic (paid for by the State) serves as technical adviser to this committee, which in turn functions as the general policy making body. Then there's a health management committee, which acts as the executive."

Unicef helped with the social mobilisation and training required to establish these structures. But what was to be managed? The answer: a total health package for the entire catchment. What made the pilots different from the old system was that drugs, when they were actually available, would no longer be distributed free.

Unicef stepped in to provide each of the 40 pilot catchments with basic equipment kits and sufficient essential drugs to last six months. These were sold for a modest profit, to allow the health management committees to generate sufficient revenue not only to replace the drugs, but to pay for the services of a Unicef-trained dispenser, and other running costs.

Lebga said: "We limited the markups to around 35%, and after the initial six months we evaluated progress. Only three of the 40 pilots needed additional help."

To facilitate drug replacement, Unicef established a pharmaceuticals store in the capital city of Yaounde. Although Unicef subsidises the bulk transport costs from their European suppliers to Yaounde, the various health committees pay for transport from this central store to their respective catchment areas. Profits are also generated at the central stores, and these are paid out, like dividends, on the basis of how well individual catchment areas perform in the health and financial management fields.

"Of course there have been problems," Lebga admitted. "There were to begin with a lot of abuses, a lot of embezzlement of funds and disappearing treasurers. But the committees themselves have been able to resolve some of these abuses; and we've worked on tightening the management systems surrounding the collection of money.

"Generally, though, the system is working. We now have 71 pilots; in several areas these now comprise complete districts with the attendant committee and management structures; and at the moment two entire provinces are being introduced to this form of re-orientated PHC. This means that by January next year about a third of Cameroon's 13-million people will be exposed to the new system."

I asked Dr Lebga some questions.

■ Is the new system making a difference to health status indicators?

"It's too early to tell. At the catchment level, however, local data collection is suggesting improvements in immunisation percentages and a reduction in certain basic diseases. What is also coming through is the system's cost-effectiveness. To treat a case of malaria under the old 'free' system required between 5 000 and 10 000 CFA (R37 and R74). It's now costing around 400 CFA (R3). That's an enormous saving, even when you add Unicef's subsidy of pharmaceutical transport costs."

■ What about that section of the population which can't afford to pay even the small amounts charged for medicines?

"An interesting response to this problem has been a strengthening of those structures – family and kinship and so on – which would provide assistance to individual people in need."

■ What happens in the urban areas where these structures are likely to be weaker?

"Our work has so far been in rural areas only. We'll be moving into the cities of Douala and Yaounde next year."

But further south in Brazzaville, the Congolese capital, I found ample evidence of the impact the Bamako Initiative is having on the reorientation of PHC in an urban situation. Health catchment areas now comprise a certain number of city blocks. While details differ, the same principles of co-management and co-financing established in Cameroon have been applied.

In a city plagued by serious civil disturbance between 1993 and 1994 , the Brazzaville clinics are a revelation. The old "free" clinics are run down, in some cases damaged, and with very few drugs on the shelves. More often than not patients are obliged to use expensive private sector pharmacies to supply prescribed medicines . By contrast, the Bamako-reformed clinics are clean, well-kept, and fully stocked with essential drugs.

And the people are more than happy to pay. "We know that the medicines are here," a waiting woman said. "It is worth coming. We do not mind the payment because it is less than the pharmacies."

While only 13 of the city's clinics have been transformed so far, again with the assistance of Unicef, already a positive impact is being felt.

In 1993, at the height of the political feuding, immunisation levels had dropped to below 60%; by the end of 1994 they were already averaging above 80%. People come to the clinics for curative treatment, and at the same time they receive vaccinations and health education.

But there are implementation problems which appear to be unique to urban areas. Jacqueline Peters, Unicef's representative in Congo, listed some of them.

"Because of the violence here, rehabilitation of the physical infrastructure has proved costly. Even so we are converting urban clinics to Bamako principles at an average cost of just over $45 000 each, of which $25 000 goes on physical rehabilitation, the remainder being for that first injection of drugs, essential equipment, social mobilisation programmes and training.

"Also, the high mobility of urban populations means that people are moving in and out of catchment areas all the time. This poses administrative and financial problems, and it also weakens the sense of involvement on which community participation is based. Nevertheless, the reformed clinics are working. In fact, most of them are too successful, which means that people stream to them from those catchments not yet involved in the reform process."

Peters responded briskly concerning those who cannot afford to pay the charges being levied. "In the free health system, people died because the availability of drugs was erratic. In the reformed system, people are definitely not dying because they cannot afford the small amounts necessary to access a reliable supply. Let me tell you that most people are finding the amounts necessary.

"I've got a lot of hope for the system," she went on. "I think the central point is this: if PHC is free, there's a lot of waste and over-usage of resources; and anyway what incentive can there be for communities to manage it? The management of community money is the key to community involvement in efficient health care management. And the charging of fees almost completely eradicates waste."

Peters also provided an added dimension when she suggested that the social mobilisation required to encourage communities to manage their own health care structures could aid the cause of democracy.

It is tempting to add that this is all part of the quiet revolution against the dictatorships and bureaucratic corruption which have hampered African development for so long.

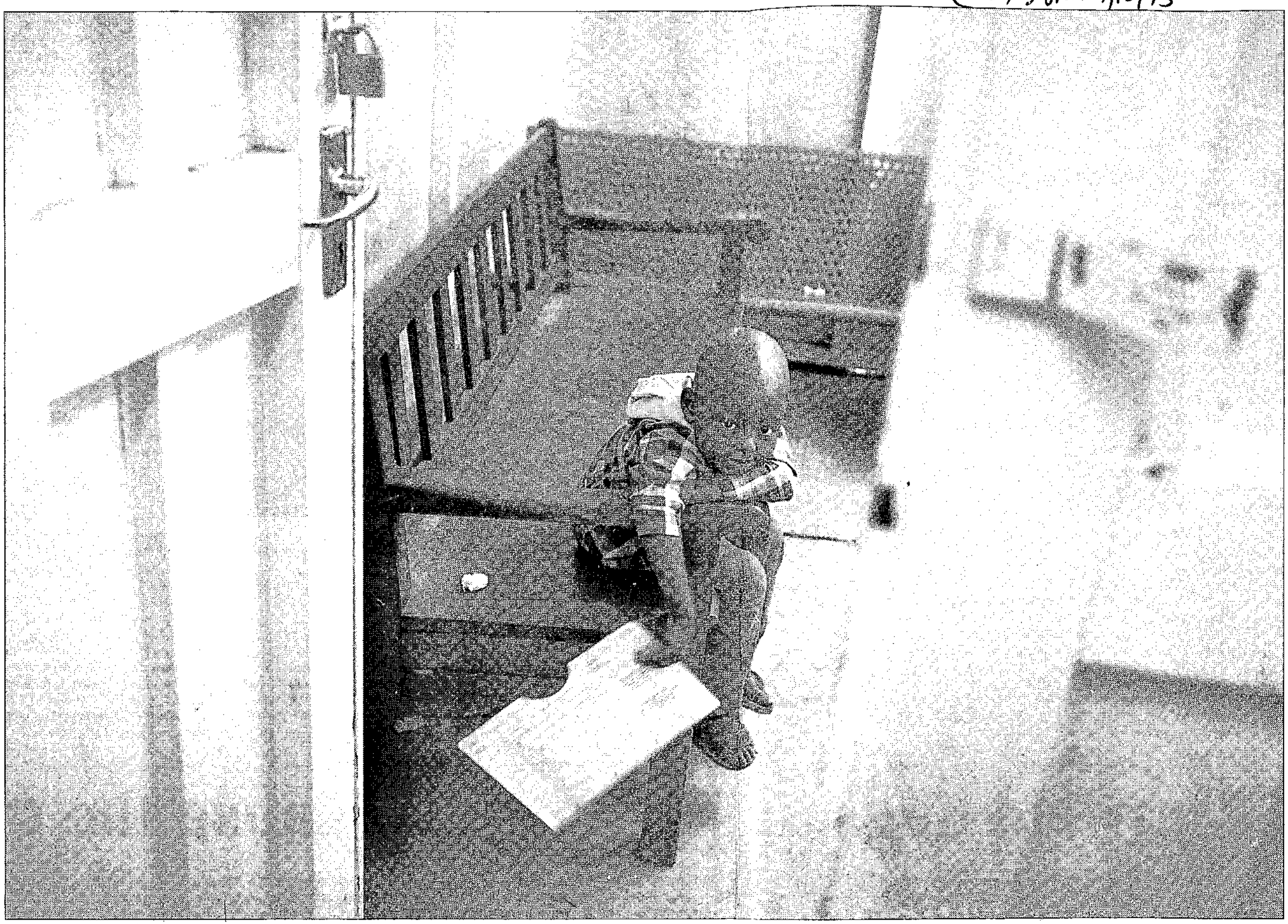
What relevance does the Bamako Initiative have for South Africa? Certainly, there are obvious differences between us and these central African countries.

Firstly, for all the deficiencies of our health system, it has not actually collapsed, even though it could be argued that for millions of South Africans, especially those living in the old homelands, the difference between inaccessibility and collapse is purely academic. Secondly, there's the question of South Africa's broad socio-economic range, and the urge for cross-subsidisation between the upper and lower levels within that range.

But even when these issues have been taken into account, it is difficult to ignore some of the messages coming from developments in central Africa.

Free health care is essentially wasteful and liable to unnecessary over-use. Even more important, the advantages of real community participation may well be lost without the sense of ownership which payment provides.

(85) Star 9/10/95



Patient patient ... a child waits for treatment at Soweto's Baragwanath Hospital: has Africa got anything to teach South Africa about the delivery of primary health care?

PICTURE:
MYKEL NICOLAOU

A South African has been chosen to guide a rapidly changing world towards improved primary care for all in the 21st century. Health Writer ***David Robbins*** *spoke to Dr Derek Yach in central Africa recently.*

He has designs on our health

(85) Star 13/10/95

"The job I've taken on," Dr Derek Yach told me, "is to head the World Health Organisation's redesign of its 'health for all' strategy.

"The strategy has been going since 1978, but now there are major changes in the international political and economic spheres which need to be taken into account. And that's what I'll be trying to do over the next two-and-a-half years."

We sat in the mercifully air-conditioned foyer of Libreville's *Palais de Conference*. The view through large windows was obscured by the usual equatorial haze. We were taking a break from the 45th annual meeting of the World Health Organisation's (WHO's) Africa region.

I had just listened to Yach address the assembly, consisting largely of representatives of 46 health ministries around the continent. He had talked of the need to place health issues high on national political and development agendas.

He had looked quite small behind the podium, quite sombre in his dark suit; and it had been unusual to hear the unhurried accent of a white Capetonian in such a setting.

I listened to the same accent, as he admitted: "Yes, it is a bit daunting. But I wouldn't have accepted the job if I hadn't felt I could make a contribution."

Yach, now 40, is certainly used to being in deep water. He's one of those adventurous people to have swum the English Channel; and he's made the rough crossing from the mainland to Robben Island and back several times.

Latterly he is perhaps best known in South Africa as an articulate anti-tobacco lobbyist. He heads up the Tobacco Control Group for the African continent.

By training, he's a specialist epidemiologist; and for the past few years he's held the position of group executive of the Medical Research Council's community health research effort.

"Now I'll be based at WHO headquarters in Geneva for the term of my contract," he said.

I asked him to give me some background to WHO's "health for all" goal.

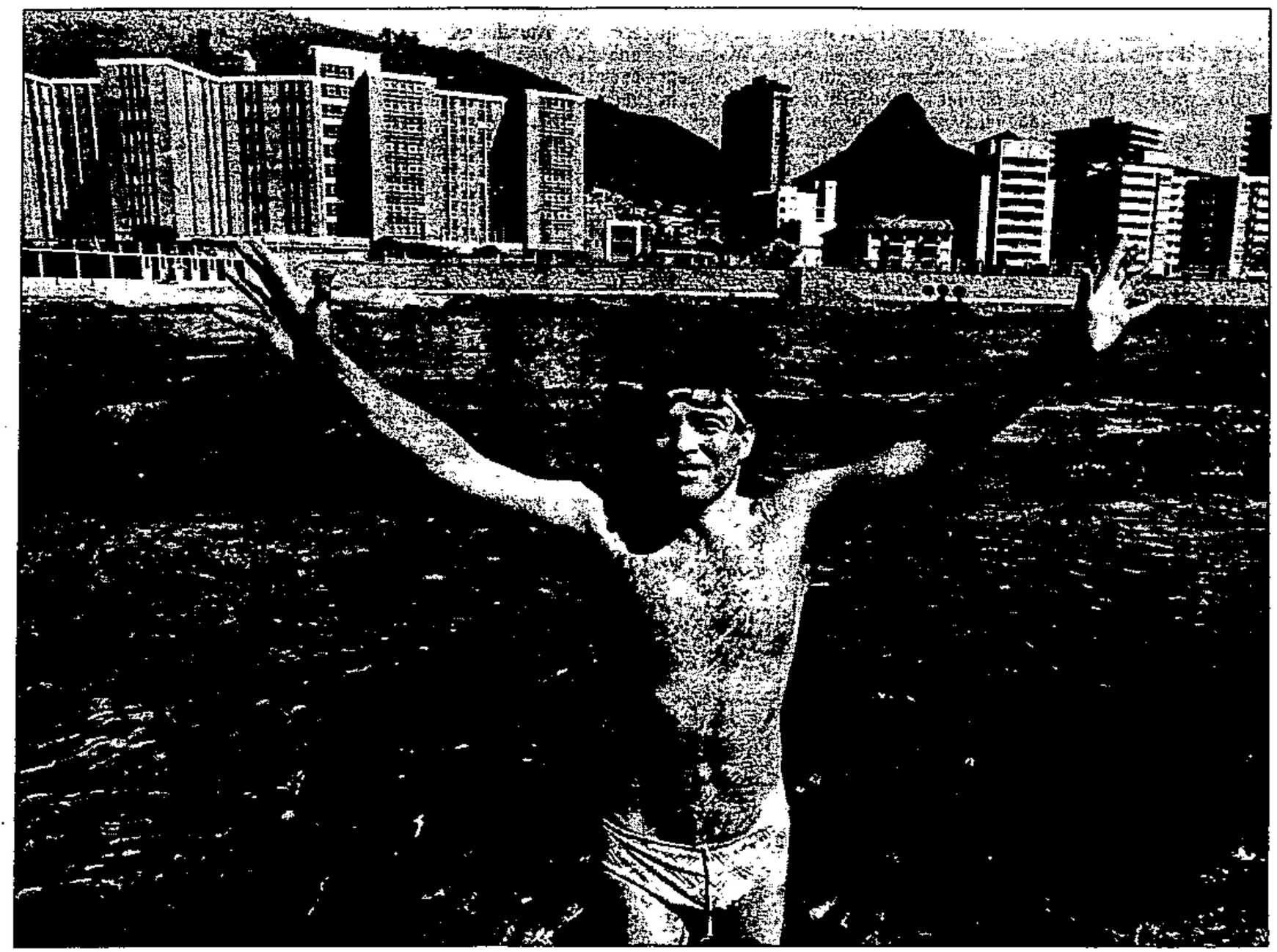
He replied that the goal was first articulated at the now-famous international conference held in the Soviet city of Alma-Ata in 1978, and that the strategy by which it was to be achieved was the implementation of the concept of primary health care (PHC) systems throughout the developing world.

"The late '70s was quite a positive period in the world generally," Yach said.

"Although the Cold War was in full swing, with enormous distrust between East and West, on the health front there was considerable optimism.

"The world had just succeeded in eradicating smallpox, and was looking to do the same with other diseases. But of course a lot has changed since 1978; hence WHO's desire for a renewal of their 'health for all' strategy."

In 1978, Yach told me, he was at the University of Cape Town studying medicine, but he was not insensible to what was happening in Alma-Ata. Two years previously, the events in Soweto, and then the murder of black activist Steve Biko while in police detention, had heightened the political consciousness of the young medical student, and he had joined the National Medical and Dental Association (Namda), a then new political grouping for progressive health workers.



1983 Cape triumph ... Derek Yach holds his tired arms up in victory after swimming from Three Anchor Bay to Robben Island and back to Mouille Point in just over seven-and-a-half hours. He has also swum the English Channel.

Namda espoused the Alma-Ata principles of PHC at a time when such principles – including an emphasis on preventive and promotive programmes and community participation – had a distinctly subversive flavour in apartheid South Africa.

"A series of working groups will be testing these principles now," Yach said.

"I think what we will find, though, is that the PHC message which Alma-Ata produced is for the most part sound in itself. But we need to test it now against the rapidly changing environment of today's world."

Yach listed some of the characteristics of this world as: shrinking WHO and national health budgets, especially among the developing nations; increasing populations; the ending of the Cold War; and declining economic growth throughout the world.

"The ending of the Cold War has now enabled the world to shed some of the ideological baggage of the past," Yach observed.

"The debate has consequently shifted from the idea of an all-providing State to the much more fruitful realm of partnerships between states, communities, non-government organisations, and the big international funding and the technical agencies.

"And since budgets are shrinking everywhere, we will be examining ways of achieving greater co-operation between those bodies which will in turn increase value for money on the ground.

"Naturally enough, in 1978, no consideration was given to the role of the private sector and free market forces in the creation of healthier populations.

"Now these roles are increasingly being acknowledged.

"Economic well-being and good health are inseparable, and all the international agencies now acknowledge that health is a crucial development tool, and vice-versa."

All these factors will be brought into the melting pot of Yach's brief to renew WHO's strategy of "health for all".

This melting pot is to take the form of working groups, seminars and consultations, all culminating in an international health summit attended by the world's heads of state planned for 1998.

"The result will be a new global health policy, and a set of plans for its successful implementation," Yach explained.

A bell was ringing and it was time for us to return to the conference hall. I had time to ask a final question: had Yach's South African background helped to equip him for the difficult task that awaited him?

He replied: "I think that the South African experience could be pivotal for the the rest of the world. By opting for a PHC approach, the new health ministry has involved the whole country in its own evaluation of Alma-Ata in a modern context.

"In addition, our moves towards an intersectoral approach to improving health status, and especially the interaction developing between health and the Reconstruction and Development Programme, will also be of major international significance."

Gauteng to spend R39m on upgrading health care

BD 19/10/95 (85)

Ingrid Salgado

THE Gauteng government would spend R12,27m from RDP funds in the 1995/6 financial year to build and upgrade more than 20 clinics in the province and had allocated a further R22,98m for their running costs, the provincial health department said yesterday.

An additional R4,3m had been allocated for upgrading and maintaining existing clinics.

Maternal and neonatal units, health care centres and upgrading of equipment were also in the pipeline. Six projects in the Vaal area were planned, five each in Central Witwatersrand and the East Rand, two in Pretoria, seven on the West Rand and three on the North-East Rand.

The department had embarked on a needs analysis in identifying priority areas and extensive consultation with community organisations was used to identify facilities, it said.

Identified projects included maternal and child health, HIV/AIDS and communicable diseases, mental health, chronic disease and rehabilitation services. Projects which would cost large amounts had been prioritised and would be funded from shifts in the budget.

Additional maternity and obstetric units would result in about 15 000 women being able to have their babies delivered in their own community health centres.

Gauteng had a "major problem" with an inadequate network of clinics and health centres and this had contributed to overloading in hospitals, the department said.

Elections could be postponed in five Eastern Cape districts

BD 19/10/95 (30 ~~62~~ 63)

EAST LONDON — Local government elections in five Eastern Cape rural districts could be postponed until November 29 to sort out several technical hitches which have disqualified the ANC from taking part in these areas.

The Algoa Regional Services Council has asked for the November 1 poll to be delayed for 23 000 rural voters in Alexandria, Bathurst, Albany, Port Elizabeth and Uitenhage.

The council's application was formally endorsed by the Eastern Cape executive council yesterday.

It would now go to Provincial Affairs and Constitutional Development Minister Roelf Meyer for a final decision, Eastern Cape election manager Keith Wattrus said.

The ANC was disqualified after infringing on Local Government Transition Act regulations. In terms of the regulations, parties are required to submit a list of office bearers and their addresses in the rural districts they are contesting.

The ANC slipped up in Alexandria by giving the names of office bearers living in town instead of the adjacent rural areas. Similar mistakes were made in Uitenhage, Port Elizabeth and Bathurst rural areas.

In Albany, ANC candidates and not the party were disqualified because they stood for election to the rural council despite living in town. The regional services council had asked for the postponement in order to avoid holding an illegitimate poll. — Sapa.

R12-m RDP boost for health services

(85) Star 19/10/95

■ BY KARIN SCHIMKE
GAUTENG REPORTER

Health in Gauteng has received a major boost from the Reconstruction and Development Programme and as a result 12 new clinics will be built over the next six months, while various other hospitals will be upgraded.

R12,27-million has been made available to the Gauteng government's health department this year, health MEC Amos Masondo said yesterday. R4,3-million from RDP funds was also allocated for the current year for upgrading and maintenance of existing clinics, while an additional R22,98-million was set aside for running costs. Masondo said health care in the province was mainly hospital-based.

"The building of these clinics marks a departure from tertiary hospital domination to care within the community. There are places in this province where people have no access to hospitals. The clinics will bring health closer to those people."

He said the provincial government would continue trying to bring primary health care to mothers and children. He hoped the building of the clinics would also ease the workload of nurses at state-run hospitals and help steer the province clear of the crisis it recently experienced.

"We would also like to train as many nurses as possible in primary health care over the next few months.

"With the money made available to us we will be able to upgrade health care in this province in a very short time."

Doctors seek service gaps

ET 19/10/95 (85)

TWO Cape Flats doctors have established a health development institute to collect data while providing primary health care to disadvantaged communities.

Dr Mxolisi Mankazana and Dr Oscar Setsubi hope to identify gaps in health services through health projects.

Their projects include free cervical screening for patients, measles vaccinations in backyard or unregistered township crèches and hypertension research.

Data collected from projects will be stored and will be available to health providers. — Staff Reporter

Picture: DOUG PITHEY, Staff Photographer.

☐ **DOCS ON CALL:** Private doctors Oscar Setsubi, left, and Mxolisi Mankazana are ready and willing to deliver a much needed service.

Prevention is better, say GPs

ARG 21/10/95

ADELE BALETA
Staff Reporter

■ A pair of private doctors have figured out a way to stay in business by investing in primary care.

(85)

THERE are too many politically correct people who think that private doctors "stink" because they are seen to be lining their own pockets and not contributing to primary health care.

That's the view of Mxolisi Mankazana, a private doctor who together with another GP, Oscar Setsubi, has realised a dream of offering primary health care to disadvantaged communities. At the same time the pair will be doing research to link up with public health efforts.

The doctors, who practice in Langa and Mitchell's Plain, joined forces to establish a Health Development Institute (HDI) to focus on preventative health care and community-based research.

The HDI was made possible by the injection of R250 000 from D & E Medical Administrators.

The research will determine what is needed in disadvantagd areas and appropriate programmes will deal with specific problems.

HDI projectsinclude cervical screening involving 261 women over the past eight months, a measles update programme in backyard creches, hypertension research by a community pharmacist and a community needs assessment research project.

Dr Mankazana, 56, who spent several years in England said: "There has been a tendency to look down on doctors in private practice, but we are delivering primary health care. We are moving ahead, in line with the RDP. We have been looking for a different way of delivering health care and we are showing everyone we can do it."

Dr Setsubi, 31, got his degree in Natal in 1986. Two years later he opened a practice at Mbekweni in Paarl.

"Things were volatile in the townhip at the time. I treated a lot of cases relating to police and domestic violence and other common ailments.

"I have always enjoyed my independence as a GP and have never wanted to go into hospitals.

"The difficulty for me as a private practioner was running a business and becoming involved in preventive treatment. A large part of GP's work is curative.

"What do you do when you are faced with an outbreak of measles? You can continue to treat the individual patients which would not be bad for business, or liaise with the schools and organise the children to be isolated, and sort the problem out."

In 1990, he came to Cape Town and joined a practice of doctors working in Langa, Khayelitsha and Guguletu.

Dr Mankazana qualified in 1966 in Natal. He practised medicine at at mission hospitals in Zululand

USAfrica to return to SA

Theo Rawana

DIRECT flights between North America and southern Africa will get a boost with USAfrica Airways' resumption of this service in December, following its co-operation agreement with Continental Airlines.

The two airlines recently agreed on a comprehensive marketing and operational alliance to support USAfrica's reintroduction of a direct service between North America and west and southern Africa.

Flights would be from Newark or New York to Johannesburg, with an intermediate stop in Dakar, Senegal.

Flights were discontinued last January.

Health cover proposals 'unlikely to be approved'

Edward West (85) BD 23/10/95

CAPE TOWN — The national health insurance system recommendations for cover beyond the mandatory benefit package for employers is unworkable and many recommendations on the private health care sector are unlikely to be passed in Parliament, says Momentum Health MD Adrian Gore.

In an Institute for Life and Pensions Advisers publication, Gore said the recommendations for cover beyond the mandatory benefit package were unworkable as cover could be purchased free of underwriting and the consumer could buy cover only when sick.

The recommendations would also stifle innovation among insurers. Schemes would be forced to charge rates that did not reflect the underlying health risk, which would discourage prefunding or post-retirement health care, even though Health Minister Nkosazana Zuma's committee had encouraged prefunding.

Implications of the recommendations from a private sector health care funding perspective were that the extension of a mandatory package to all employed would force the employer to bear part of the cost.

Smit linked to Dorbyl probe

Renee Grawitzky

FORMER SAP deputy commissioner Gen Basie Smit, who was named in testimony at Goldstone commission hearings on third force activities, worked for Investment Surveys — the company commissioned by Dorbyl to investigate internal fraud.

Investment Surveys was named last week in connection with a document it allegedly compiled outlining strategies to destabilise the National Union of Metalworkers of SA (Numsa). The document allegedly commissioned by Dorbyl's bus division, Busaf, was circulated to Numsa, Cosatu and transport ministry officials.

Dorbyl said the document was a forgery. Sources within the industry pointed to the possibility of rival bus companies using the document in an attempt to discredit Dorbyl.

Numsa general secretary Enoch Godongwana said that irrespective of whether Dorbyl's competitors were responsible for the document, "both sides have used people who were involved in dirty-trick activities within the security establishment".

Given this background, he said, it could prove difficult to ascertain the origins of the document.

Smit went on early retirement in May last year after the Goldstone commission found evidence of unlawful activity by a number of police generals.

Investment Surveys director Peter Grant confirmed that Smit had worked for the company from August last year until August this year as a consultant.

Dorbyl said it was unaware when it engaged Investment Surveys' services of Smit's connection with the company.

Numsa has agreed to work with Dorbyl to ascertain the origins of the document. Investment Surveys has also promised to help with the probe.

BD 23/10/95

African healers' holistic methods 'could help doctors'

(85) ARG 24/10/95

JENNY VIALL
Health Reporter

DOCTORS can learn much from the holistic approach of African traditional healers, who see illness as a mind-spirit continuum, and treat the person for physical, psychological and social symptoms.

This is the view of Professor Jan van der Merwe, dean of the faculty of medicine at the University of Pretoria.

Speaking at the British Medical Association's Overseas Clinical Congress in Cape Town yesterday, he said the goal of medicine was the relief of suffering, and communication was at the heart of all aspects of medicine.

Communication problems in medical practice were common. Studies showed that 54 percent of patient complaints and 45 percent of patients' concerns were not elicited by doctors.

Language used by doctors was often unclear, both as regards jargon and in relation to a lack of the expected shared meanings of relatively common terms.

Furthermore, only a low proportion of visits included any patient education and a high proportion of patients did not understand or remember what the doctor told them about diagnosis and treatment.

"One study showed that patients were interrupted by doctors so soon after they began describing their problems, on average within 18 seconds, that patients failed to disclose their significant concern."

Communication, which resulted in mutual understanding, facilitated healing, said Professor Van der Merwe. Empathy was an important aspect of communication.

"During medical education, we first teach the students science and then we teach them detachment. To these barriers to human understanding they later add the armour of pride and the fortress of a desk between themselves and their patients.

"As I know them, college students start out with much empathy and genuine love, a real desire to help other people. In medical school, however, they learn to mask their feelings, or worse, to deny them. They learn detachment and equanimity."

Professor Van der Merwe said biomedicine often was seen as treating the disease, but traditional African healers treated the person who happened to be ill. Traditional healing was still very much part of the every-day experience of the vast majority of African patients.

"We have to remember that African traditional healing is focused on restoring the system to a state of physical, social and psychological equilibrium. It emphasises interpersonal relationships.

"The traditional belief system is so fundamental that any form of healing which ignores these beliefs is not only psychologically unsatisfactory, but even socially unacceptable.

"We can learn from the traditional healers. We do not need to meddle with ancestral spirits, but we can learn from their holistic approach, dealing with the patient as an integrated social entity, providing treatment for physical, psychological and social symptoms."

Scientific training and a more humanistic schooling were not incompatible, and might produce better and happier doctors.

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(85) ART 24/10/95

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Isolated health workers to join network

(85) BD 26/10/95

Kathryn Strachan

AN AMBITIOUS new project to connect health workers in remote rural areas to a computer network is expected to reap great benefits in improving health services in these neglected areas.

While information channels have tended to flow only between health centres and the provincial or national offices, and even that flow has been unreliable, the new computer information system called HealthLink will bring the most isolated health workers into the fold.

The most urgent restructuring is needed at the level of districts, and by putting doctors and other health workers at this level in touch with each other, ideas and solutions can be shared.

Funded by the Health Systems Trust, the R1,5m project is starting by focusing on the most rural areas of Northern Province, the Umtata and Mdantsane districts in the Eastern Cape, and the Free State.

In this way the project hopes to use electronic mail in improving the management of health services, providing health workers with access to information resources and training people in the use of computers.

Ordering drugs, sending out laboratory results and transmitting statistics can be done more efficiently by e-mail. But the project looks to be going beyond the routine transmission of data, to setting up a dialogue between health workers at the level of districts.

It has proved much easier to set up an e-mail where there are existing information channels, for example in the case of ordering drugs. Setting up a system where there are no existing pathways is more of a challenge. So the task is not only to set up technical computer links but to foster a flow of communication.

To do this there has to be a process of getting people at the level of districts in touch with each other.

Tighter controls for foreign doctors

(85) BD 26/10/95

Kathryn Strachan

SA HAS tightened up its control of foreign doctors entering the country in order to prevent the country draining neighbouring states of their doctors' vital skills.

The interim Medical and Dental Council of SA accepted a proposal that placed a moratorium on the limited registration of individual doctors who had qualified in foreign countries.

The council is investigating instead the possibilities of limited registration for groups of doctors recruited to work in particular areas in terms of government-to-government agreements.

This decision would make it much more difficult for doctors from neighbouring countries to work in SA unless they are sent by their own government.

The health department said yesterday a major reason for the proposal was to halt the flood of applications for limited registration coming from doctors in countries which were themselves short of medical personnel.

Many of SA's rural health systems depend almost entirely on the services of foreign doctors.

MONDAY
★ OCTOBER 23, 1995

SA's private medicine (85) questioned

CT 23/10/95

STAFF REPORTER

THE government had allowed private medical practice and the establishment of private hospitals to grow in an uncontrolled way in the 1980s, with the purchase of costly equipment in excess of needs, UCT vice-chancellor Dr Stuart Saunders said last night.

Speaking at the opening of the Overseas Congress of the British Medical Association in the city, he said there were more CT scanning machines in Johannesburg than in the whole of the United Kingdom.

At the same time, funding for the teaching hospitals and for secondary hospitals was short and there was great difficulty in getting new equipment and in maintaining equipment already owned.

Curriculum

The university had endorsed the decision of Health Minister Dr Nkosazana Zuma to emphasise primary health care and was revising its curriculum accordingly.

Care had to be taken, however, that the development of health care did not damage teaching hospitals, Dr Saunders said.

A closer partnership was needed between the private and the public sectors, he added. He was a strong advocate of full-time services in the public sector and believed doctors in academic medicine should not be distracted from their primary tasks by practising private medicine, unless this was done in such a way that it was confined to the teaching hospital and was carefully controlled.

However, unless the conditions of service in academic medicine were attractive, academic medicine would wither and the quality of patient care would fall, Dr Saunders warned.

(85) Sowetan 31/10/95

Doctors realise their vision

By Glenn McKenzie

TWO public-spirited doctors who joined forces to establish a Health Development Institute (HDI) to focus on preventative health care and community-based research have realised their vision thanks to major funding from a top medical aid administrator.

Dr Mxolisi Mankazana and Dr Oscar Setsubi, general practitioners in Mitchells Plain and Langa near Cape Town, recently took the wraps off their dream project of introducing research data bases into private medical practices.

D&E Medical Aid Administrators – which is one of the country's largest medical aid administrators, servicing over 450 000 members and dependents – has put its full weight behind the project and donated R250 000 for the initial start-up and administration costs.

The company currently cares for 130 000 South African families through its medical aid schemes.

The HDI has as its main objectives to respond to the needs of the community through practical research, serving as a facility for health care professionals and providing a multi-disciplinary range of services.

Mankazana said the major activity of the HDI will be conducting practical community-based research. But the unit will also be very active in the development and self-fulfilment of medical practitioners and others.

Setsubi emphasised the multi-disciplinary nature of the HDI and its focus on providing a holistic health care programme in previously deprived areas.

Health care workers who strike may be fired – Rasool

CT 31/10/95 (85) (95)

STAFF REPORTER

HEALTH care workers who go on strike could be fired, local Minister of Health Mr Ebrahim Rasool has warned.

"It has come to my attention that a possibility exists that some health care workers may want to recommence with strike action in solidarity with nurses dismissed in the Transkei," he said.

According to reports, about 8 000 nurses were dismissed in Transkei after a recent strike. Mr Rasool said a workable solution was being arrived at with the dismissed nurses, leading to re-employment.

"It would be regrettable if we in the Western Cape were left with no alternative but to implement the national decision to dismiss with immediate effect any participant in such a strike."

The Provincial Administration put up notices yesterday at all its health institutions in the Western Cape, warning that anyone who takes part in a strike will face immediate dismissal.

Provincial health spokesman Mr Mark Hill said there had been rumours of a possible strike at Groote Schuur and Tygerberg hospitals, where some individuals had been very angry. Nobody has gone on strike yet.

Indigenous medicine needs structures to survive today

(283) (85) Star 2/11/95

■ BY PATRICK WADULA

Traditional healers continue to practise without legal protection and remain subject to discrimination and abuse because no legislation regarding the practice of traditional medicine exists.

This was an observation made by Dr Thabo Fako of the University of Botswana this week during a workshop on traditional medicine and healers at Wits Medical School.

He said policies governing the development of traditional medicine in many African countries were either ill-defined or non-existent.

Fako pointed out that when drafting a policy, the need for individuals to choose between health practitioners from recognised systems of health care should be taken into account, while ensuring that they were protected from malpractice.

In order for traditional and modern medicine to operate effectively together in any given country, Fako advised that traditional medicine be formalised to a considerable degree.

"There is also a need for a formal relationship with the Ministry of Health," said Fako.

He suggested the formation of a National Association of Traditional Healers, since there was a lack of a competent body to register, regulate, supervise, discipline and control the practise of traditional medicine.

Fako called for the standardisation of training of the different categories of traditional practitioners.

He saw this as facilitated by the establishment of recognised administrative structures for the screening of traditional healers as well as conventional medical practitioners.

Another need was for the establishment of a competent advisory body and other administrative bodies mandated to regulate, co-ordinate and supervise research and the development of traditional medicine.

Indigenous

"Since traditional healers make important contributions to medical knowledge, governments should facilitate the promotion, protection, preservation and development of all indigenous medicinal plants, materials and preparations that are deemed to be of medicinal value," said Fako.

However, he stressed there should be strict regulations regarding the exploration, exploitation and exportation for commercial use of natural resources.

Initiative to protect healers from exploitation

Traditional healers have launched an initiative to protect their ancient knowledge and medicinal plants from exploitation by multinational drug companies.

They held a workshop attended by pharmacists, botanists, marine biologists, traditional healers and representatives from government agencies and universities in Botswana and South Africa at the Wits Medical School on Tuesday.

Professor Indres Moodley, the head of the Department of Pharmacy at Wits, said that in many parts of the world, plants and herbs were used extensively by traditional healers. Therefore these plants lay within the domain of the intellectual property of traditional healers.

He said that in view of recent changes in the structure of the national health system in South Africa there were indications that traditional medicines could be incorporated into the national health structures as was in the case of Zimbabwe.

Moodley said that the pharmaceutical industry in the country was underdeveloped and did not have the infrastructure to match those of multinational companies to engage in research and development.

There was a great interest from multinational and smaller overseas companies in exploiting the natural resources of South Africa for commercial gain.

He said this was often done through contact with traditional healers or universities.

"I believe that collectively we have the necessary expertise to exploit our own natural resources for the benefit of South Africa. We need to be very careful that we derive the maximum benefit and that our people are also protected," Moodley said.

More emphasis would be put on the study of natural products from plants. It would become an area of research and study that would form a major and integral part of the training of pharmacists in the future, he said.

Varsity course for folk healers

Sowetan 6/11/95

By Glenn McKenzie

Do you wish to increase your skills as an inyanga? Do you have a calling to be a sangoma?

If you are a traditional healer, you can now go to University to learn new skills, as well as acquire basic methods of modern health care.

Rand Afrikaans University (RAU) is offering a unique three-year diploma programme in traditional health care for practising inyangas and sangomas. It is believed to be the first programme of its kind in South Africa and possibly the only one in the world.

For R1 800 a year, practising traditional healers can take classes in botany, herbology, pharmacology and even entrepreneurship. Also offered are classes in anatomy, chemistry, management and law. The programme is conducted as a "guided self-learning" course which means the traditional healers will gather for lectures approximately four times a year.

At the end of the course, the university will grant traditional healers a university diploma and "official accreditation," despite the fact that traditional healing is still illegal everywhere in South Africa except the province of KwaZulu-Natal.

Aspiring students must be able to read and write English or Afrikaans.

RAU public relations spokesman Ms Wilna De Beer said the course was designed to "give traditional healers the opportunity to make more informed decisions about their remedies."

The course will also give healers basic skills in modern medicine, including hygiene, the use of sterilised tools, etc. Students will be required to write three two-hour examinations in the third year.

The course will be launched in January, 1996.

New heart transplant protocol among doctors

(85) (85) (85) Star 7/11/95

By Janine Simon
Medical Correspondent

The dash to collect a heart from a road accident victim in East London for a desperately ill Pretoria businessman was the result of a new spirit of commitment between transplant surgeons.

St Dominic's Hospital in East London first alerted Cape Town's Groote Schuur Hospital transplant team about the available organ, according to a hospital spokesman.

But Groote Schuur had no suitable recipient, and forwarded the information first to a private hospital in Cape Town and then to one in Johannesburg before the donor heart was finally matched to Barry van Rensburg (40) at Medforum, a private hospital in Pretoria.

Van Rensburg is now in a stable condition in intensive care, Medforum's Dr Bert von Wielligh said yesterday.

This swift co-operation has replaced the tension which flared when private surgeons first entered the transplant "market" in 1993, and when Dr Fanus Serfontein attempted to set up a second State heart transplant unit at Pretoria's H F Verwoerd Hospital earlier this year.

Health Minister Nkosazana Zuma dampened the hopes for another transplant unit with a decision that only Groote Schuur should conduct State transplants.

But private surgeons continued doing transplants in Gauteng as well as Cape Town and the shortage of donor organs remained.

According to the Organ Donor Foundation, barely half of the people who need transplants actually get them.

The troubling issues were whether hearts from private patients were being passed on to State patients, organ collecting costs and whether patients from the same region as a donor should get preference, said transplant surgeon and Organ Donor Foundation chairman Dr Elmin Steyn.

"Its been a nightmare, but we've made definite progress," says Lynn Botha, national transplant co-ordinator for Clinic Holdings, which has spearheaded the agreement.

"We've agreed to follow set criteria and, if no match is found in the region, to refer out of it. The closest, best-suited patient, most in need gets the organ," she said.

The agreements are still fresh but has all the signs of a fledgling protocol among doctors on the use of a scarce resource.

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Strife-weary Thokoza has a new healer

(85)

Kathryn Strachan

BD 9/11/95

AS THE dust begins to settle in wartorn Thokoza, Dr Zola Njongwe is setting out to rebuild the devastated health services in the area.

Venturing into parts of Thokoza that are still "no-go zones", Germiston council's new deputy medical officer is able to reach into the areas that are most in need of health services.

"But still I don't go in with impunity. I slip in and out on the back roads without anyone noticing," she says.

Njongwe has been set the task of rebuilding the threadbare health services in Thokoza, Katlehong and Vosloorus, and the informal settlement in Zonkizizwe.

Due to the severe setbacks health services in these areas suffered as a result of violence, an overwhelming assortment of health problems has emerged.

Those in direst need are the many women and children who have come to join their men in the hostels. They, and other desperate relatives who have come to join them, live a cooped-up life in the hostels — they are completely isolated from the wider community and do not know where to go for help when they are sick.

The people flooding from the country's rural areas, as well as from outside the borders, to Zonkizizwe squatter camp, are also in need of health care. They can't get to schools or to Natalspruit Hospital, because they have to pass through the "no-go zones" to get there.

The violence and the trauma has left the entire community with a lot of inwardly directed problems such as child abuse, domestic violence, alcoholism, drug abuse and crime.

There are also many stress-related diseases and, as the violence smoulders on, the need for trauma units and specialised spinal injury units remains.

Before establishing new health services, Njongwe's first task is to find out exactly what the health problems are and where new health centres are most needed.

With Germiston's health budget already overstretched, she got funding from the Durban-based Health Systems Trust to carry out a survey — aided by community health committees and local nurses — of the area's greatest health needs.

She will now devise a strategy based on the most urgent priorities.

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Vaccine units to be privatised

BD 15/11/95

Kathryn Strachan

A PLAN to combine SA's state and private vaccine-producing facilities into a single private firm early next year is expected to put SA in a position to break into the world vaccine market.

The company, SA Vaccine Producers — wholly owned by the independent SA Institute of Medical Research — is searching for an international partner to boost its research capacity. Four leading research institutes from Europe and the US have been shortlisted as possible partners.

By joining forces the local vaccine units, with their foreign partner, plan to double production capacity and to export half their products.

The institute recently made its vaccine unit a wholly owned private subsidiary. The plan is for the two state units to join that company, which will mean they will fall under the institute.

Company director James Southern said yesterday that while the health department had agreed in principle to

Continued on Page 2

Vaccine

Continued from Page 1

BD 15/11/95

the plan, red tape was holding up the process. It was also a politically loaded decision, as it involved giving control of state assets to an outside body. The final decision lay with the department.

While the institute is independent, the health department does have some influence in that it approves appointment of the institute's board members.

The private vaccine company would generate its own revenue and would continue to produce public health products such as those needed for government's child immunisation programmes, rather than go into the more expensive private products such as flu vaccine for adults. This would mean its returns would be relatively small.

Currently the vaccine facilities produce only for SA. The new arrangement would enable them to move into Africa and other developing countries.

Southern said the facilities tended to duplicate functions. By merging and rationalising operations, they would be more cost effective. They would retain their bases — two in Johannesburg and one in Cape Town. The polio vaccine unit at the institute's premises in Johannesburg was getting a R20m revamp to bolster the initiative.

Southern said the foreign partner would bring marketing and management skills, as well as global access to research and development.

The facilities, producing vaccines for diptheria, tetanus, whooping cough, polio, tuberculosis and rabies, hoped to expand their product range.

Measles and hepatitis B vaccines are currently imported.

The Star ... Thursday November 16 1995

SA's 3 vaccine manufacturers merge to remain competitive

(~~453~~) (85) Star 16/11/95

MEDICAL CORRESPONDENT

South Africa's three state-supported vaccine producers will launch a single commercial organisation next year to secure local production, reduce costs and position the country for vaccine exports.

Vaccines have been produced in the country for about a century, according to Dr James Southern, director of the new company, SA Vaccine Producers.

Southern said in a statement that the three existing South African producers, Cape Town's State Vaccine Institute, the National Institute for Virology and the South African Institute for Medical Research (SAIMR), were besieged by low-cost imported vaccines, and the ever escalating costs of local production and research.

Last year, with technical assistance of the World Health Organisation (WHO), the SAIMR and Department of Health commissioned a Swiss-based management organisation to evaluate the problems.

The findings were that SA could sustain local vaccine production if human vaccine producers merged, set up a partnership with a leading international manufacturer, and exported as much vaccine as was used locally.

A National Control Laboratory also had to be set up to ensure the required high quality.

The findings were accepted in principle by health minister Dr Nkosazana Zuma in December 1994, and were in the process of being implemented, Southern said.

Management of the new company was in place, and staff and functions of state facilities would be transferred during 1996.

Negotiations with international producers were under way, and technology to improve production was being developed, with WHO guidance on design and quality.

The Medicines Control Council was also in the process of establishing a National Control Laboratory.

Vaccination was the most cost effective health intervention available, and SA the most appropriate African country for vaccine development, Southern concluded.

Local development would ensure products and deliveries best suited for local conditions.

WHO chooses SA partner

Kathryn Strachan

BD 17/11/95

THE World Health Organisation (WHO) has chosen the SA Medical Research Council as one of its partners in developing health technologies for Africa.

The council saw this as a sign of the leading role it could play in research into health technology.

The collaborating centre will be run by the council on a partnership basis with the CSIR and UCT's biomedical engineering department.

Council executive for health technology research Dr Nico Walters said: "SA is a country which has considerable technological expertise and a strong industrial sector to design and manufacture health care technologies appropriate for the sub-Saharan region. The designation of the WHO collaborating centre here is a recognition of the catalytic role we can play in bringing together key players on the continent in an effort to find appropriate and lasting regional solutions."

The centre will be responsible for giving out information on important local and global health technology to governments and training institutions, and it will also assess how new technology can improve the quality and cost-effectiveness of health care.

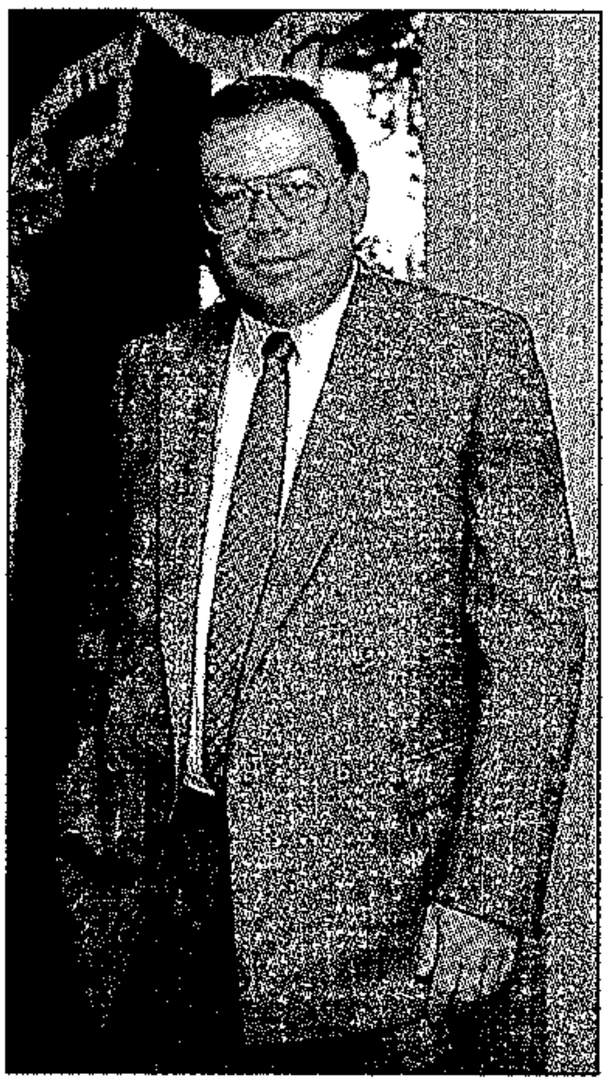
What the doctor ordered

(85) (299) FM 17/11/95

A review of drug usage and disease management could help contain spiralling medical costs.

Both are principles of managed health care, which propounds a multi-disciplinary approach rather than the present ad hoc, symptom-based one. The philosophy also seeks to replace the inflationary fee-for-service method with options such as fixed fees and capitation (fee per patient) charges — geared to end over-usage.

Reviews of drug usage were pioneered here by Quality Health Services. Its Cape Town-based doctor, John Cowlin, says the programmes have succeeded in the management of "chronic" (long-term) medication, cutting bills by up to 40%.



Cowlin . . . *medical bills cut by 40%*

Using computer-based peer review protocols to determine suitable regimes for chronic drug users, reviewers can decide whether a prescription is appropriate and cost-effective. They may, for example, decide that an older, cheaper drug is as clinically effective as a newer but more expensive one. Or they may recommend that a cheaper generic is as effective as a more expensive, patented drug.

Says Cowlin: "We may even recommend the use of the latest, most expensive drug where such treatment would effectively eradicate an ailment that would otherwise require surgery. We could also recommend a drug that needs to be taken only once a day, as opposed to four times a day, to ensure the highest level of efficacy and greatest cost-effectiveness."

Of course, the medical reviewer's verdict of what constitutes the most cost-effective and appropriate drug could have dire consequences for drug manufacturers that don't make the grade.

Cowlin says manufacturers are given every opportunity to argue the suitability of their drugs. He adds that the decision to use or not to authorise a particular drug is taken after an investigation that is assisted by the medical faculty at the University of Cape Town. He stresses that his company is independent and does not trade in drugs.

Cowlin says initial manual scanning of scripts — Quality Health Services processes 600 000 a year — often shows incorrect dosages, adverse drug reactions and unnecessary prescriptions.

Most of the main script managers or assessors are linked to major medical scheme administrators or hospital groups; or (more recently) drug manufacturers and their customers are medical schemes and other health-care funders.

Quality Health Services, jointly owned by medical schemes administrator Medscheme, has a brief to review the chronic medication scripts for members of schemes administered by Medscheme and Cowlin.

In practice, members who know they need medication for longer than three months are asked to apply for extended medicine benefits and usually qualify when they undergo a GP examination that will determine the likely extent of the additional benefits that will be needed. From that point, members will have their scripts routinely evaluated and will have reasonable access to drug information and assistance where needed.

Where reviewers encounter problems with scripts — overdosing, drug interaction, incorrect medication — the GP is notified and the matter sorted out quickly. Where repeated abuses or problems arise, further action may be required including the medical scheme's refusal to reimburse any bills emanating from the practitioner involved. Difficult cases are assessed by specialists, including pharmacological experts. So standards of peer review are high.

Other players in the marketplace now include Mediscor's Chronimed (SA Druggists-owned), Afrox affiliated Direct Medicines and Total Support Management (including Pharmarama, Optimum, Interpharm) — recently acquired by Smith Kline Beecham subsidiary Diversified Pharmaceuticals.

Health-care management is no longer confined to drug usage. For hospital bills, some assessors already boast savings of 43% on ward charges, 29% on theatre fees and 27% on dispensing costs. If these claims are accurate, one might well ask what role medical scheme administrators perform.

There is criticism that savings are seldom passed on to members but used instead to offset administrative costs. And where assessors are linked to drug manufacturers, there are fears that drug usage reviews could be used to promote products — a concern that is likely to be addressed by the Competition Board investigation into vertical integration in the drug industry.

Though a drug usage review promises substantial savings on medicines, disease management could be the point of departure for the control of the total health-care bill.

A patient-directed programme, it provides disease-specific guidelines for quality health care in a cost-effective way.

Says Glaxo pharmaco-economist Francois Wessels: "Disease management should focus on the patient, not only the medication. The best management practices for specific diseases will now be evaluated and therapeutic and diagnostic guidelines developed by clinical experts."

This exercise can succeed only if the latest information is built into the programme. So information technology support will be crucial, says Wessels. Continual monitoring of the medical, financial and quality-of-life-implications of therapeutic guidelines will also be important.

Lastly, patient education is needed. This could involve teaching an asthma patient, for example, about the ailment and how to use inhalers and other devices to ensure proper, responsible medication — and perhaps recommending a change in lifestyle.

"The patient would become a more responsible co-manager of his or her disease. And the futility of trying to manage individual components of the health-care bill would be avoided."

Northern Province health services get the kiss of life

BD 20/11/95 (85)

Kathryn Strachan

HEALTH services in the Northern Province which are threadbare after years of neglect are gradually being revived.

Contractors are already on site, and before March next year 26 new clinics will be built with RDP funding. The existing 250 clinics are also being upgraded, and advertisements which appeared last Monday for 776 new nursing posts for rural clinics are expected to bring great changes to rural health services. The posts will be filled by the end of the month.

Health department spokesman Tsepo Mashima said yesterday that R170m had been allocated for upgrading hospitals and clinics. The 250 rural clinics had been given R50 000 each, the 32 community hospitals R2,5m each, the 20 health centres R250 000 each and the seven provincial hospitals R5m each.

These funds had already been passed on to each of the centres, and it was up to each health authority to decide on what was most needed for their facility.

Most funds were spent on upgrading the dilapidated buildings and buying new equipment. In rural clinics, a lot of money had been spent on security to allow clinics to stay open 24 hours a day.

The health department was also assessing the additional staff needs of each hospital.

Health MEC Joe Phaahla said many facilities in the province were in a poor state and it would take between 10 to 15 years to correct most of them.

"If democracy is to be a success, its effect should be felt in the areas which bore the brunt of apartheid neglect, namely the Northern Province and the Eastern Cape," he said.

Health lines

Health superintendent-general Dr Nicholas Crisp said setting up new health structures depended to a large extent on local authority boundaries. The new local authority boundaries followed old homeland lines, which were inappropriate for health.

The health department had been meeting local councils, new regional office managements and community representatives in each region in an attempt to set up district health authorities. But the issue of district health authorities was not high on local government agendas and this was holding up the process.

The complexities surrounding the issue of land — for example that tribal land cannot be cut up — was another obstacle in setting up district health authorities.

A new initiative in the province is implementing a hospital information system and creating a computer system which will allow sectors such as health, agriculture and education to share information and forge links. There is also a new AIDS strategy being designed for the region.

A major project has been launched between Medunsa and the provincial health department to develop tertiary capacity by concentrating specialists in five regional hospitals. This has been a significant step in developing a hierarchy for health.

The reason behind the move is that equipment is in such a disastrous state, that it is necessary to concentrate specialists in a few centres where they have the back-up of working equipment, and the support of services such as occupational therapists.

There has been excellent co-operation from private practitioners in the province. The province has also had a R300m donation from the Overseas Development Agency for training staff.

The relentless drought is the main problem working against improving health. A few weeks ago tankers started taking water to clinics in drought-stricken outlying areas where it was kept in the clinic reservoirs for the community to use.

Health care diploma for traditional healers

(85) Sowetan 20/11/95

By Glenn McKenzie

TRADITIONAL healers could soon be "rolling the bones" and analysing ancient remedies in university classrooms.

Next January, Rand Afrikaans University (RAU) will kick off a unique three-year traditional health care diploma programme for practising *inyangas* and *sangomas*.

It is believed to be the first course of its kind in South Africa and possibly the only one in the world.

Traditional doctor Seth Seroka says the programme will "improve the standard" of the craft by giving healers a practical knowledge of modern disciplines like primary health care, anatomy, physiology and botany.

Seroka, who is a board member of the African National Healers' Association (ANHA), has "a few complaints" about taking traditional medicine into the lecture hall. For one thing, he claims healers were not consulted when RAU developed the course's new curriculum.

Still, he is optimistic about the course and has already enrolled. According to university officials, about 300 other healers have also expressed interest since the course was first announced in *Sowetan* last month.

"We would have started our own institute of learning a long time ago if we had the funds," he said.

Seroka believes it is important that the RAU programme should not tamper with the "spirituality" of the craft.

Traditional healers will still develop contacts with their ancestors in time-honoured ways (outside the classroom).

"We will leave the spiritual realm where it belongs," said Seroka. "In the university, we want to learn about primary health care and botany."

Don't forget herbology, chemistry, pharmacology, law, management and entrepreneurship. And for those who gather herbs and other medicines, there will be classes in environment-friendly harvesting techniques.

The programme, which costs about R1 800 a year, is good value for a healer's money, says Seroka. Students will gather for lectures about four times each year.

Much of the course will be conducted through the post.

At the end of the programme, the university will give healers a university diploma and "official accreditation" with the ANHA.

(This is in spite of the fact that traditional healing is technically still illegal in South Africa except in KwaZulu-Natal. Recently, the African National Congress promised to include traditional medicine in national health strategies).

Aspiring traditional medical students must be able to read and write English or Afrikaans.

They must also be fully-fledged "practising healers".

RAU public relations spokeswoman Ms Wilna de Beer said the course is designed to "give traditional doctors the opportunity to make more informed decisions about their remedies".

In addition to the above classes, the programme will also teach basic medical practices, including hygiene, the use of sterilised implements, and so on.

Graduates will be required to write three two-hour papers in the third year.

Classes will begin in late January or early February 1996, according to university administrators. "We must consult the healers before we make a firm date," said nursing professor Dr Hester Klopper.

Traditional healer Seth Seroka ... learning about primary health.

"We will leave the spiritual realm where it belongs"

FOCUS ON TRADITIONAL HEALTH

The graduation ceremony of a group of traditional healers after having completed a course at the Tshiawelo clinic. PIC: EUGENE SITHOLE

Valuable course for healers

(86) Sowetan 20/11/95

By Eugene Sithole

RECENTLY traditional practitioners, professional doctors, civic association members and other community members gathered at the township clinic in Tshiawelo, Soweto, to celebrate the graduation of a yet another group of traditional healers who had enrolled for a course at the local clinic.

Tshiawelo clinic is one of only a handful of health facilities which have started teaching traditional healers about Aids, tuberculosis, leprosy and other common diseases.

Nurses at the clinic use videos and lectures to communicate primary health care messages to the healers.

"The aim of the training is for all of us to learn from one another," says Mrs Margaret Seleso, a nurse and a course instructor.

"In other words, we are learning from traditional practitioners and they are also learning more about diseases and sicknesses. It is a blessing to see traditional practitioners working with us."

At first, Seleso battled to teach the healers because she was forced to translate information from English into Sotho, Venda, Tsonga, Zulu and other languages.

The training course, which began in 1994, is offered free of charge.

Over 50 traditional practitioners graduated last year.

Another 50 traditional graduates underwent training and received certificates this year.

Mrs Tshinakalo, a traditional healer who graduated last year, says one benefit of the programme is that she now refers some of her patients to the clinics or Baragwanath Hospital.

"No one knows everything. There are diseases and sicknesses which I cannot heal. The sicknesses I am able to cure are cancer, diarrhoea, and stomach aches," she claims. "If a patient needs an X-ray, I refer them to the hospital or clinic."

Mr Peter van Zyl, a traditional healer, says the health profession needs to distinguish between bad and good traditional doctors. Failure to do so will mean good healers do not receive the recognition they deserve.

"Being a traditional doctor is never easy. When it comes to white society, it is difficult to live freely as a traditional doctor. I have suffered a lot," he says.

"There are people who used to throw stones at me because I was a traditional doctor. But there are also many people who come to me when things go wrong."

Van Zyl adds: "I believe in the spirit of humanity. Without *ubuntu* many people become evil and start cutting people's bodies apart to make *muti*."

Tshiawelo Civic Association spokesperson Mr Simon Baloyi says traditional doctors and professional doctors could play an important role in raising the standard of health in the community.

He says: "I think it's about time people started taking traditional doctors seriously. And traditional doctors have a duty to prove to the community that they have what it takes when it comes to healing."

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Price heads Wits health faculty

(85)

BY JANINE SIMON

Medical Correspondent

Star 24/11/95

Max Price, director of the Centre for Health Policy, has been appointed dean of the University of Witwatersrand's Faculty of Health Sciences.

The appointment of the activist-turned-academic has been welcomed by professionals who say he is well-briefed on every major challenge facing the medical school and its six affiliated hospitals.

Price, whose five-year deanship begins on January 1, is the first long-term appointment to the post in almost 10 years. His identified priority will be the restoration of the medical school's faded public image

"The faculty can and should be pre-eminent on the continent and one of the world's leading health faculties, but to do so it needs to regain its self-respect. This is fundamentally the task of the dean," Price said.

Health gets cash boost

(85)

ep 26/11/95

More clinics, better hospitals, more jobs

By ROCKY MOKOENA

HEALTH SERVICES in the Northern Province received an injection of R170 million to build more than 26 community clinics before the end of March next year and to upgrade existing health facilities.

About 250 rural clinics will receive R50 000 each, health centres R250 000 and community hospitals will receive over R2 million each.

Most of the funds will be spent on upgrading the dilapidated buildings and buying new equipment.

Rural clinics plan to invest their money on security to allow them to operate for 24 hours.

The cash injection will also create job opportunities for more people as 776 nursing posts have already been advertised.

Health superintendent Dr Nicholas Crisp said many health facilities in the province were in an unhealthy state and "will need more than 10 years to be improved".

Crisp also said the new local authority boundaries followed the old homelands system "which were inappropriate for health".

The complexity surrounding the issue of land was another obstacle in setting up district health authorities as tribal land cannot be sub-divided, he said.

A new initiative in the province is to implement a hospital information system and create a computer system which will allow sectors such as health, agriculture and education to share information and forge links. There is also a new AIDS strategy designed for the region.

With the shortage of doctors in the province, a donation of R300 million from the Overseas Development Agency has also been made available for training extra staff.

Another major project will also be to develop tertiary capacity by concentrating specialists in the five regional hospitals, he said.

"If democracy is to be a success, its effect should be felt in the areas which have borne the brunt of apartheid neglect", said Crisp.

The relentless drought is another problem working against the improvement of health as many hospitals are experiencing water shortages, he said.

Inherited red tape blocks Northwest health reform

BD 28/11/95 (2656C) (35)

Kathryn Strachan

ATTEMPTS to rebuild health services in Northwest, particularly in the neglected Bophuthatswana, are being blocked by the impossibly cumbersome civil service the new administration inherited from the former homeland.

While other provinces were forging ahead with new health plans, initiatives in Northwest were being throttled by the provincial services commission whose "slavish attitude" to the bureaucracy it had built up meant very few projects got off the ground, said provincial health MEC Paul Sefularo.

Former Bophuthatswana ruler Lucas Mangope's cumbersome bureaucracy, designed to be tightly controlled from the top so that he could make all appointments and decisions, haunted efforts to get things done, said health services chief director David Rob.

"It requires central government intervention to free health service delivery from bureaucratic procedures designed to run a clerical ticket office, not to set up a new health system," said Rob.

As a result, service delivery in clinics and hospitals had got a lot worse. Clinics in many areas were deserted; in others, they could not function due to lack of medicines or equipment.

While the process of appointing their new managers lumbered on, R60m hospitals were being run without managers or accountants.

Any repair above R5 000 had to be referred to the public works department, which in turn referred it to the Tender Board — which took at least three months to get a project under way.

"The result is that nothing gets fixed," said Rob. "In June Rustenburg Hospital applied for the generator of its X-ray machine to be replaced, and six months later they have still not got it."

Another example of the complete lack of any system, he said, was that 50% of the health department's vehicle stock was unaccounted for after being sent to the government garage for repairs.

"Unless we change the administration, a lot of things we want will not be done," said Sefularo. "We need to put districts in a position where they can make their own decisions.

"This is our second Christmas and we have only spent 14,6% of our development budget," he said. Only R8,4m out of a total health budget of R57m had been spent.

Health facilities in the former Bophuthatswana, which makes up half of the new province, were in a state of decay. The health status of communities in the former homeland was also far worse than elsewhere, with its high incidence of chronic malnutrition and other diseases of poverty.

After hard bargaining with local authorities, health districts have been established in the province. District health forums will soon be set up to run their districts and, as they prove their competence, will be given the status of full authorities. Once these forums are set up, the pace of development should quicken.

"But so far it has been extremely frustrating," said Sefularo. Rob echoed him: "We've done a bit of clinic building, we've done a bit of hospital planning to the architectural stage, and we've made a few appointments — that's what we've done in 18 months."

Transkei health services in crisis

ARG 1/12/95 (85)

BISHO. — Health services in Transkei should be declared in crisis, the Eastern Cape standing committee on health said in a report due to be discussed in the legislature on Monday.

The committee would then recommend a report detailing the shocking state of most provincial hospitals be submitted to President Mandela.

The two-day meeting in Bisho is about the state of hospitals and health care in the Eastern Cape.

The report was compiled after a two-month investigation which included detailed fact-finding tours of all 26 hospitals in the province.

Almost all hospitals were understaffed. — Sapa.

Rewards in return for loyal doctors — Shisana

BD 1/12/95

Kathryn Strachan

GOVERNMENT had to look at offering incentives to medical schools which produced graduates who stayed in the country, health director-general Olive Shisana said yesterday.

There had been many documentations in the SA Medical Journal that emigration was the highest among English-speaking white doctors. In finding long-term solutions to the shortage of doctors in neglected rural areas, one had to look at which students tended to emigrate.

With the great need for doctors in the public sector and in rural areas, medical schools had to find people who were committed and caring. Shisana said certain medical schools had a far higher rate of students emigrating on graduation than others.

She said the question of rewarding those medical schools who had more Afrikaans-speaking and black students was a point of discussion and not government policy. She said the idea was not discriminatory, it simply rewarded institutions who trained people who stayed in SA.

DP leader Tony Leon said yesterday that his party was appalled by government plans to shift funding from English-speaking students to black and Afrikaans-speaking students.

"The proposal, if implemented, would amount to racism and social engineering of the most blatant kind.... The real answer to the brain drain ... is for government to take urgent steps to arrest the slide towards anarchy in SA which is the root cause of professionals emigrating," he said.

Cost of free health care

85

Nomavenda Mathiane

BD 1/12/95

THE Gauteng health department would spend R383m on free health care for pregnant women and children, health MEC Amos Masondo said yesterday.

He was replying to questions by DP provincial MP Jack Bloom who responded that it was a large amount which still did not appear to be enough to alleviate the problems experienced by medical staff.

He said it was puzzling that only 22% (R85m) of the budgeted amount had been spent at this stage of the year.

The DP was unconvinced that an appropriate balance had been found in countering the destabilising effects of the top-down initiation of free health care categories which were in fact compounding the difficulties of restructuring the health services.

Accords to boost US-SA ties

BD 1/12/95

Tim Cohen

CAPE TOWN — Four co-operative agreements between SA and the US were due to be signed during US vice-president Al Gore's visit to SA next week, while the American and President Nelson Mandela were due to discuss the Nigerian question, officials said yesterday.

Government officials are confident that SA-US relations will be significantly boosted by the signing of the agreements, although two major outstanding problem areas are unlikely to be resolved during the three-day visit.

A finance department spokesman said a double taxation agreement between the US and SA was still under discussion, while the court case in which Armscor has been charged for violations under US sanctions legislation is still pending.

Gore and several other US officials are visiting SA at the invitation of Deputy President Thabo Mbeki, who is a co-chairmen of the US-SA binational commission set up during Mbeki's visit to the US in March.

The commission — one of three binational commissions set up by the US with SA, Russia and Egypt — is aimed at developing business, education and science and technology contacts.

The four agreements due to be signed deal with: the national youth development plan; a programme concerning the peace core; a framework agreement on scientific and environmental issues; and an economic and technical agreement.

Accompanying Gore will be Commerce Secretary Ron Brown and Energy Secretary Hazel O'Leary. They have visited SA before, to develop bilateral relations in their specific areas.

Also present will be Interior Secretary Bruce Babbit, Clinton science and technology aide John Gibbons, and Peace Corps representatives.

US and SA officials confirmed the issue of Nigeria will be discussed when Gore meets Mandela, but remained tight-lipped on what might be decided.

Reports from the US suggest Gore and Mandela will begin to iron out a workable strategy against the military regime in Nigeria, although the two governments are currently adopting very different stances on an appropriate response to the Nigerian question.

Mandela has been pressing the US which buys about 40% of Nigeria's total crude oil output, to impose an oil embargo in response to the execution of writer Ken Saro-Wiwa and eight other minority rights activists.

The US has been adopting a much softer stance, partly for fear of substantial petrol price increases in the US.

Bid to lure patients to clinics

(98) (85) ST 3/12/95

By JUSTIN ARENSTEIN

MPUMALANGA'S health and welfare department has pledged free medical care for up to 85 percent of the province's population in an attempt to persuade patients to use clinics instead of hospitals.

The scheme, to be implemented in April next year, will offer provincial patients free medical aid if they report to any of the province's 211 clinics for treatment instead of going to one of only four hospitals in the region.

"The province doesn't have many hospitals and these are being swamped by cases that could easily be treated at our clinics," said Dr Gulam Karim, the head of Mpumalanga Health Services.

He denied the policy would strain an already under-budgeted service, saying the costs of collecting and administrating fees at the clinics exceeded the revenue collected. "The small amounts of money we collect and the security and administration requirements just aren't worth the cost."

Although health care would theoretically be free to all residents of the province, Dr Karim said only those without private medical-aid schemes and other "public-sector" patients tended to use government hospitals and clinics.

"You wouldn't be able to get cosmetic surgery free. This is for those who really need free medicine and doctors. If the ailment is serious enough to need hospital or other specialist treatment, then we'll refer patients to hospitals where their treatment will also be free — but only if they come through the clinics first," he said. Dr Karim estimated that up to 85 percent of Mpumalanga's population qualified as potential "public-sector" patients.

To make the scheme as efficient as possible, the department is demanding full control of all health facilities that it subsidises.

In areas with a mix of urban and rural population centres, such as Mpumalanga, clinics and hospitals are run by Regional Services Councils, municipalities, the health department and even the Department of Environmental Affairs.

"It's crazy. The government is paying for all of these structures to offer similar services," Dr Karim said. His department intends consolidating the various services under a single administration in 23 districts.

Dr Karim said superintendents of hospitals and clinics would cease being "glorified clerks" and return to being supervising doctors under the system.

The department is also negotiating agreements with the University of Pretoria and Medunsa to set up teaching and support units at the province's hospitals. "Doctors trained in pristine universities are often lost when they come to the bush. So we're going to train them here," Dr Karim said.

More blacks in top health posts

THE number of whites in senior managerial posts in the health department has been nearly halved over the past 12 months as part of a major restructuring of government health services, Health Minister Nkosazana Zuma said yesterday. Sowetan 4/12/95

Speaking at the opening of the 11th triennial Commonwealth Health Ministers' conference at Stellenbosch University, Zuma said the department's top management structure had changed from one that was 90 percent white and 95 percent male.

Of the 34 senior managers, only 47 percent were now white and 30 percent of the managers were now women. More than four-fifths of the management is new.

"A great deal of new blood has been brought in and the management culture has changed," she said.

Also at the opening was Commonwealth Secretary-General Emeka Anyaoku, who said the conference was a sequel to last month's Commonwealth heads of government meeting in New Zealand, which had endorsed a plan of action on gender and development.

The four-day conference gets under way today and will see health ministers and senior officials from more than 30 Commonwealth countries debating a three-year action plan to enhance the health of women. – *Sapa.*

Health Dept rings the changes

Star 4/12/95 (85)

Women and blacks now hold many more top managerial posts, Zuma tells Commonwealth conference

SAPA
Stellenbosch

The number of whites in senior managerial posts in the Health Department has been nearly halved over the past 12 months as part of a major restructuring of the services, Health Minister Nkosazana Zuma said in Stellenbosch yesterday.

Speaking at the opening of the 11th triennial Commonwealth health ministers' conference at Stellenbosch University, Zuma said the department's top management structure had changed from one that was 90% white and 95% male.

Of the 34 senior managers, only 47% were now white and 30% of the managers were now women. More than four-fifths of the management was new.

"A great deal of new blood has been brought in and the management culture has changed."

Also at the opening were Deputy President Thabo Mbeki and Commonwealth secretary-general Chief Emeka Anyaoku.

The four-day conference, which gets under way today, will see health ministers and senior officials from more than 30 Commonwealth countries debating a three-year action plan to enhance the general health of women.

The conference, organised under the banner Women and Health, was the first Commonwealth meeting to be held in South Africa since its return to the international body, Anyaoku said.

He said the conference was a sequel to last month's Commonwealth Heads of Government meeting in New Zealand, which had endorsed a plan of action on gender and development.

"Our challenge here is to move beyond words to deeds," he said.

Bleak statistics indicated that millions of women were suffering from malnutrition, anaemia and a host of other preventable diseases and disabilities. "This is a product in part of the disadvantaged situation of women who are overrepresented in the lowest socio-economic levels of society."

Zuma said that if South Africa could overcome apartheid, then a solution could also be found to gender discrimination, which existed in every part of the world.

WOMEN NOW 30% OF MANAGEMENT

Whites in top health jobs halved in a year

(85)

CT 4/12/95

COMMONWEALTH HEALTH MINISTERS were told yesterday that the number of white males in Health Department senior management had been slashed. **CHRIS BATEMAN** reports.

THE number of whites in senior managerial posts in the Health Department had been nearly halved over the past 12 months as part of a major restructuring of government health services, Health Minister Dr Nkosazana Zuma told her international counterparts yesterday.

Speaking at the opening of the 11th triennial Commonwealth Health Ministers' conference in Stellenbosch, Dr Zuma said her top management structure had changed from being 90% white and 95% male.

Of the 34 present senior managers, only 47% were white and 30% were women.

More than four-fifths of the management was new.

"Most dramatic are changes in the attitudes of people who previously would never have talked to each other, but who now work comfortably together," she said.

The Women and Health conference is the first Commonwealth meeting to be held in South Africa since its return to the international body.

Deputy President Thabo Mbeki stood in for President Nelson Mandela, who has been ordered to rest by his doctor because of an inflamed shoulder joint, and Commonwealth secretary-general Chief Emeka Anyaoku and Canadian Health Minister Ms Diane Marleau shared the podium with him.

The four-day conference begins today and aims to create a three-year plan to enhance the health of women, who it recognises as natural health workers in every sphere.

"It's not a sisterhood conference but one in which the role of women in health care is looked at in broad perspective," Mr Michael Fathers, a spokesman for Chief Anyaoku said.

Health ministers and officials from more than 30 Commonwealth countries are attending.

Suffered

Chief Anyaoku said millions of women suffered from malnutrition, anaemia and a host of preventable diseases and disabilities.

"Women have traditionally been held responsible for nutrition, agricultural work and the treatment of sickness and injuries, as well as care of the disabled or dependent ... their real contribution is not recognised," Chief Anyaoku said.

LAUDING AND LAMBASTING: This young Zulu praise singer had harsh words for Nigerian military ruler General Sani Abacha, but praise for Health Minister Dr Nkosazana Zuma at yesterday's openihg of the Commonwealth health summit in Stellenbosch. Behind (from left) are Mr Ebrahim Rasool, Western Cape Minister for Health, Dr Zuma, Commonwealth secretary-general Chief Emeka Anyaoku and Deputy President Thabo Mbeki.

PICTURE: CHRIS BATEMAN

men when out on bail. Gang members fired shots into the air and set a car alight.

Picture: AP

BD 4/12/95

Fewer whites in top posts

STELLENBOSCH — The number of whites in senior managerial posts in the health department had been nearly halved in the past year as part of a restructuring of the health services, Health Minister Nkosazana Zuma said.

At the opening of the 11th triennial Commonwealth Health Ministers' conference yesterday, she said the department's top management structure had changed from one that was 90% white and 95% male.

Of the 34 senior managers, 47% were now white and 30% of the managers were women. More than four-fifths of management was new.

The conference will see health ministers and officials from more than 30 Commonwealth countries debating a three-year action plan to enhance the general health of women. — Sapa.

'Military co-operated in investigation of Malan'

BD 4/12/95

Nicola Jenvey

DURBAN — Co-operation from military intelligence enabled the Investigation Task Unit to obtain the vital dossier to charge former defence minister Magnus Malan and 19 others with the 1987 KwaMakutha massacre.

Unit commander Frank Dutton said at the weekend the investigating team knew of the dossier's existence and received a warrant to search the military intelligence offices in Pretoria, to obtain the dossier retrieved on June 5.

"It was not a situation where we went in against their will and found these documents hidden in somebody's safe. We went in with a search warrant and after negotiation the documents were handed over," Dutton said.

During Friday's 20-minute court appearance apartheid's top securocrats, former KwaZulu policemen and IFP deputy secretary general Zakhele Khumalo were charged with 13 counts of murder, four of attempted murder, and one of conspiracy to murder.

The State alleges that the 13 people were massacred in KwaMakutha house 1866 eight years ago, after a group of highly-trained Inkatha supporters became "restless and wanted to practice their training".

IFP leader and Home Affairs Minister Mangosuthu Buthelezi — then KwaZulu government chief minister — requested security force assistance against life threats to himself and his supporters by the ANC and United Democratic Front.

Code-named "Operation Marion", a paramilitary training base in the western Caprivi Strip was set up, with the constitutional development and planning department assuming overall coordination. The State claimed 200 IFP supporters underwent four months' specialist training there.

Only people whose deaths would "positively impact" on the IFP could be targets. Victor Ntuli, with "the most comprehensive" dossier, was selected.

The attack was carried out and although Ntuli was not home, the operation was considered "a success".

The accused were not asked to plead and the case was scheduled for March 4 in the Durban Supreme Court.

Practitioners prepare to petition minister over health-care reforms

(85) Star 5/12/95

MEDICAL REPORTER

The Society of Dispensing Family Practitioners (SDFP) is to petition the Minister of Health in protest against the process and details of proposed health-care reforms.

At an urgent meeting held in Sandton on Sunday, the SDFP slammed the department's investigating committees for arrogance, lack of transparency and token consultation with medical and dental practitioners.

"At every meeting they listen and thank us for our submissions. But when the proposals come out, none of our submissions are included," said SDFP chairman Dr Mohammed Adam.

The SDFP, which represents 1 000 doctors, but is affiliated with other organisations representing more than double that number, said the proposed National Health Insurance System (NHIS) was marginalising doctors and ignoring patients' freedom of choice.

The proposed system meant patients would not always have the right to see their own doctors, and doctors' rights to dispense to their own patients was being restricted.

The NHIS proposes that nurse-run primary health-care centres be the core of future health services for state patients, to be funded by a payroll tax costing the State R72 a visit, and nurses would decide whom and where to refer, Adam said.

Zuma outlines SA health problems

(85)

JENNY VIALL, Health Reporter

SOUTH Africa's poorer neighbours have far more accessible health facilities than this country, says Health Minister Nkosazana Zuma. ARG 5/12/95

South Africa, with its combination of poverty and opulence, had more serious health problems than most other Commonwealth countries.

Dr Zuma was speaking at a Press conference yesterday at the Commonwealth Health Ministers meeting in Somerset West. She said South Africa was faced with diseases of affluence and poverty.

Dr Zuma was elected chairperson of the conference, which has as its theme, *Women And Health*. Delegates from more than 30 countries will discuss the role of women in health and women's experience of health.

They also will formulate practical steps to be taken by Commonwealth countries in the health field.

Dr Zuma said free health care for pregnant mothers and children was only the first step to bringing down the infant mortality rate and had to be combined with better nutrition and sanitation and accessible services.

South Africa still had a long way to go to provide services within five to 10km of where people lived, a recommendation of the World Health Organisation.

The conference ends on Thusday.

Health concerns avert water cut-off

ARG 5/12/95

Municipal Reporter

A MOVE to cut off the water supplies of people who have defaulted on their water accounts has been averted following an objection by medical officer of health Michael Popkiss.

Dr Popkiss objected to a proposal that water supplies be cut off on the grounds that this would be a health risk.

He raised his objections at a meeting of the Cape Town City Council's amenities and health committee.

Dr Popkiss said that in terms of the Health Act the council had a duty to prevent nuisances, among which was the occupation of a dwelling for which a pure water supply was not available within a reasonable distance.

He said cutting off water would not only punish defaulters, but their children and families as well.

He said there should be other means to collect money for water accounts.

The committee has asked the city engineer to investigate the current method used against defaulters — namely reducing water to a "trickle" supply — to see whether it could be made even more efficient.

This recommendation arose after it was suggested that some people in arrears for water were willing to live with the trickle supply without paying up.

Transkei health crisis

85 48

Own Correspondent

BD 5/12/95

BISHO — A crisis situation should be declared in former Transkei health services, says a report which has been submitted to President Nelson Mandela and which was presented to the Eastern Cape government yesterday.

Urgent attention should be given to improving dilapidated hospital structures, beefing up security and improving departmental communication channels to address hospital workers' grievances, the provincial standing committee on health recommended in the report.

The report was compiled after a tour of 26 hospitals throughout the Eastern Cape.

It said almost all hospitals suffered from under-staffing problems, absenteeism, poor security, a lack of equipment, insufficient drugs and disintegrating services.

It recommended the involvement of all relevant government departments and the establishment of a departmental labour-relations unit to assist in labour issues.

Other key problem areas included inadequate transport facilities, poor roads and chaotic conditions at mortuaries.

Pharming out

FM 8/12/95

A shake-up is expected in the health-care industry following US giant Diversified Pharmaceutical Services' acquisition of four local companies. By using state-of-the-art technology, Diversified intends to implement managed health care and drive down costs for both patients and medical aid schemes.

The US company bought an 80% stake in Computerkit, a supplier of dispensing and point-of-sale systems to the pharmaceutical industry; 100% of Interpharm, the medical aid electronic clearing office; 100% of Diseases Management Information Services (DMIS), which provides information and statistics on managed health care; and 100% of health education company Optimum. It also gained management control of Home Medication Services. Financial details of the deals were not disclosed.

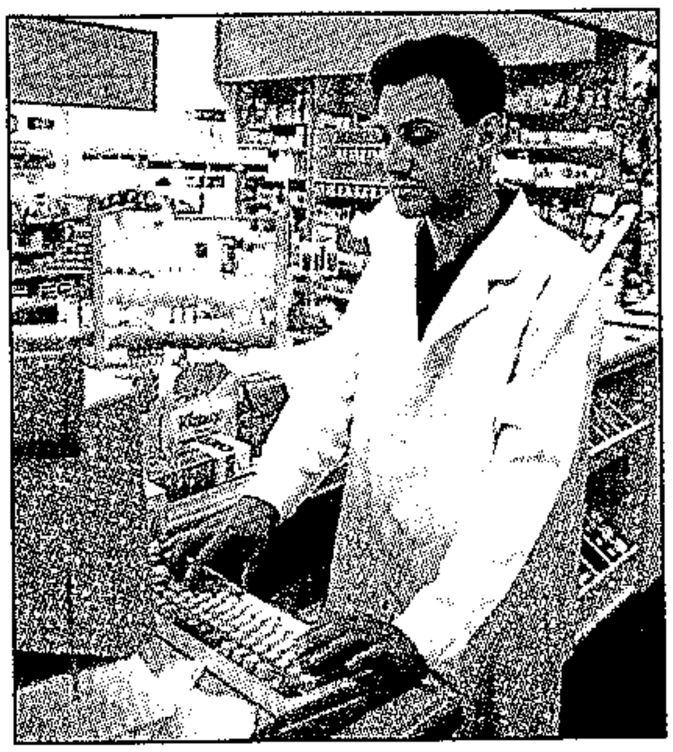
The third largest managed health-care group in the US, Diversified has a staff of 800 and manages more than 24m patients and US$3bn worth of claims each year. Diversified recently embarked on a global

expansion plan.

Trading as Diversified Health Services SA, the local operation will mirror the activities of its parent company, says new MD Anthony Zappa.

As in the US, the group will employ its own doctors, nurses and pharmacists. Their primary job is to regulate the progress of medical aid members and their usage of medicines and drugs.

Resident "health-care advisers" will liaise with medical aid schemes and prescribing doctors to reduce the cost of health care to both patient and medical aid.



Pharmacist . . . *logging in for fast payment*

If, for instance, the company discovers that a chronic patient is being prescribed a drug that is both expensive and has the potential for side effects, it will investigate generic and other alternatives in consultation with the patient and prescribing doctor.

By working closely with research agencies and universities, health specialists are well placed to suggest an alternative drug that is cheaper and does not exhibit long-term side effects, says Zappa. Both the patient's and the medical aid's costs can be dramatically reduced.

"The SA health-care industry is undergoing the same changes we experienced in the US 12 years ago," says Zappa. "It is relatively easy to transfer the US concepts and programmes to SA."

He says modern computer systems are integral for managed health care and that Diversified chose Interpharm as its vehicle to enter SA, largely because the electronic clearing bureau is not burdened with obsolete technology.

Formed one year ago, Interpharm accepts medical aid claims from pharmacies and transmits these claims to medical aid schemes through a national electronic data interchange (EDI) network. Payment to pharmacies is guaranteed within 72 hours.

Interpharm competes against more established clearing bureaus Mediscor and MediKredit. Its objective is to reduce paper-based transactions by electronically processing and reconciling medical aid claims for pharmacies.

Also integral to Diversified's plans for SA is computer company Computerkit.

Computerkit's PC-based systems link pharmacies to the Interpharm electronic clearing house, which then transmits claims to medical aids via EDI.

Besides linking to Interpharm, the Computerkit dispensing system integrates point-of-sale information with back office stock, conducts drug analyses, provides on-line debtor information and patient medical aid details.

Computerkit was founded 10 years ago by Gordon Matheson and Ken Venn, who each retain a 10% share in the company. It recently took over the client bases of former competitors Computer Capsules and Computerlinks. The expanded client base now exceeds more than 300 pharmacies.

Matheson says while Computerkit will continue to trade autonomously, it will benefit significantly thanks to the added financial muscle and expertise of its new parent.

With the cost of medicine and health care in SA among the most expensive the world, the entry of global companies such as Diversified is certain to increase competition. Other US giants are likely to enter the local health-care market. ■

Female circumcision, tobacco top health ministers' agenda

ARG 8/12/95 (85)

JENNY VIALL
Health Reporter

THE Commonwealth could not ban female circumcision — entrenched in certain cultures — although there was a great sensitivity to the issue among health ministers.

This emerged from a Press briefing at the end of the Commonwealth Health Ministers' Conference, at which smoking, reproductive health and female circumcision were discussed.

Health Minister Nkosazana Zuma, chairwoman of the conference, said it was important for women to come out loud and clear on female genital mutilation and if they felt strongly, to take action. Women needed a lot of support on this issue and ministers of health would support them, she said.

The conference recommended that while there was agreement that female genital mutilation practices were unhealthy, it was not seen as feasible to eradicate the practice outright because of its deep cultural roots. Changing the practice was beyond government intervention.

Some countries felt the practice of female genital mutilation was so entrenched that its eradication should come about through dialogue within countries, rather than legislation. Others felt the Commonwealth should take a stand for the victims, who could not speak for themselves.

A recommendation on men's role in women's reproductive and sexual health, accepted by all countries except Malta, called for the promotion of male fertility control methods, such as condoms and vasectomy.

Tobacco was another controversial issue at the conference, said Humphrey Maud, Deputy-Secretary General of the Commonwealth secretariat.

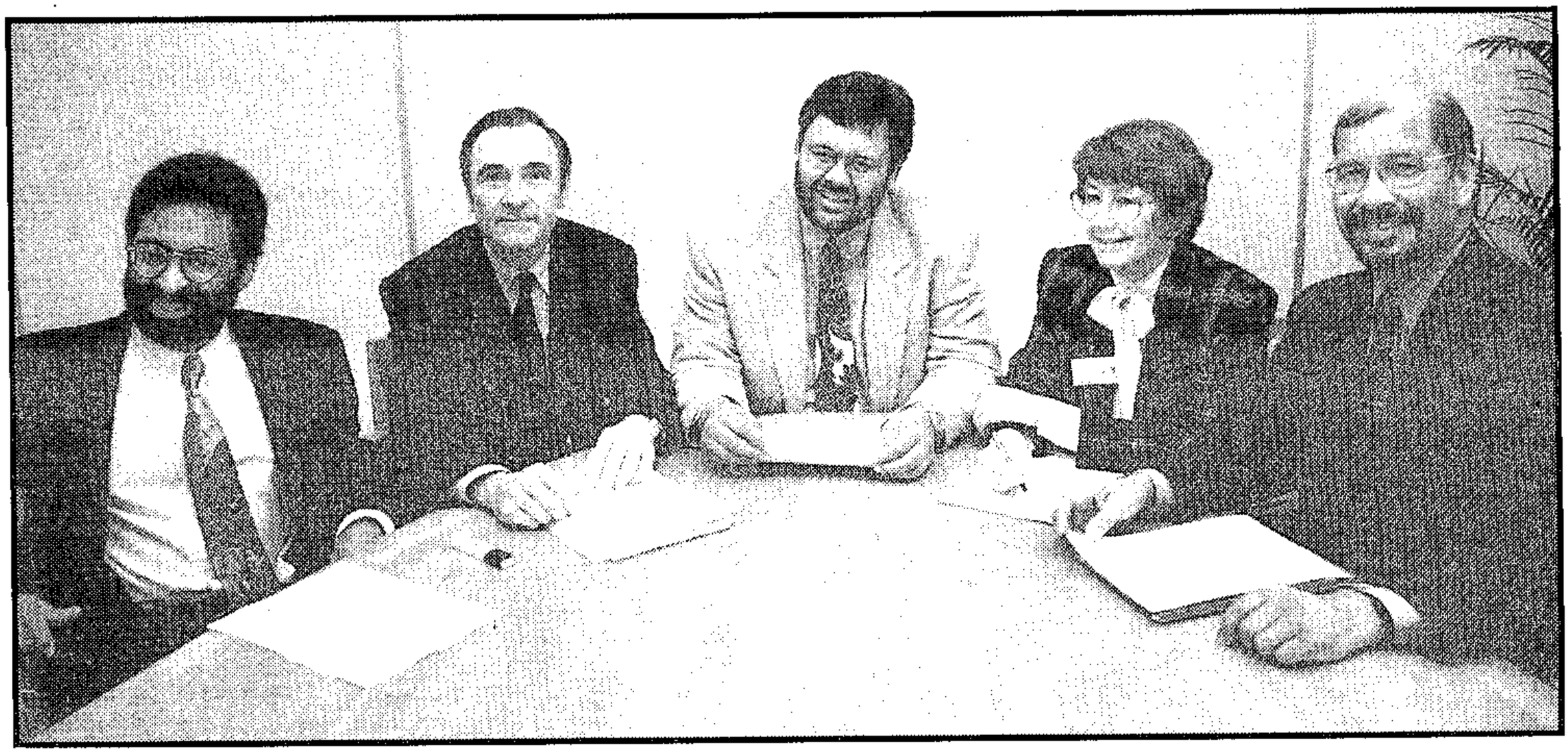
While Commonwealth health ministers, including those from tobacco producing countries such as Malawi, Zimbabwe and Zambia, recognised the health implications of smoking, there was concern as to how to move from tobacco to other crops.

Sir Humphrey said ministers were concerned that tobacco countries were targeting developing countries, particularly young people.

Among recommendations on the tobacco issue were that money given to governments to promote tobacco production be redistributed to finance crop substitution. Countries were also urged to look at ways of reducing tobacco use.

The conference made extensive recommendations on women as nurses and midwives, recognising the need for leadership development in this sector of health care workers. The Secretary General of the Commonwealth Secretariat will be asked to establish a technical support group for "Women and Health" to give member states assistance where needed.

THE CAPE



TOP POSTS: Minister of Health in the Western Cape Ebrahim Rasool, centre, has announced his top management team. From left, Faried Abdullah, Tom Sutcliffe, Jocelyn Kane-Berman, Gilbert Lawrence.

Directors appointed to run West Cape's Health Department

Health Reporter (85) ARG 9/12/95

THREE chief directors and twelve directors have been appointed in the Western Cape Health Department.

The appointment of Tom Sutcliffe as Deputy-Director General has been confirmed.

Dr Sutcliffe heads the Department of Health while chief directors are Faried Abdullah, Health Care; Gilbert Lawrence, Supra Regional Hospitals; and Jocelyn Kane-Berman, Administrative Services.

Ebrahim Rasool, Minister of Health and Social Services in the Western Cape, said he had confidence that the new team, chosen on merit and representivity, would do an excellent job.

Candidates were chosen from over 770 applicants and were selected for their strong community health or business and administrative expertise.

Directors of Health Care in the four regions are: John Frankish, Metropole; Mike Hendricks, Southern Cape/Karoo; Joseph Cupido, West Coast and Frans Krige, Boland/Overberg.

Some directors are already in service, and others will start next year.

Other directors are Krish Vallabhjee, policy and planning; Florence Bhunu, programme development; Ann Brand, Health Care Support; Paul Von Zeuner, Information Management; Andy Cunningham, Engineering and Technical Support; Johan Jooste, Finacial Management, Piet Koornhof, Personnel and Management. The post of director of Human Resource Development has not been finalised.

Call to legalise dagga in medicine

(87) (85)
CT 12/12/95

DAGGA should be decriminalised in South Africa for medical use, an article in the latest issue of the SA Medical Journal argues.

Valkenberg Hospital's Prof Frances Ames says dagga has apparent therapeutic properties, including reducing nausea associated with chemotherapy, promoting appetite and weight gain in Aids patients, reducing intra-ocular pressure in glaucoma and as an anti-convulsant in epilepsy.

However, Prof Tuviah Zabow of the UCT Forensic Psychiatry Unit said: "Cannabis is a potentially dangerous drug and as such a public health concern." — Sapa

UCT course for health staff

UCT is to introduce a course from February to train senior health administrators.

It will be known as the Oliver Tambo Fellowship Programme in Public Health Management, convener Dr Brigid Strachan said.

The programme was aimed at enabling senior managers to be more effective in implementing the new health system.

It would be managed by the community health department and be funded for two years by the Henry J Kaiser Family Foundation of America.

— Sapa.

ARG 13/12/95

Playing it safe with health finances

MHG(BM)15-21/12/85

Karen Harverson

THE National Occupational and Safety Association (Nosa) may lose the R10-million a year in funding it receives from the Department of Labour next year.

Director General of Labour Sipho Pityana, speaking at a press briefing on Tuesday, said it was unlikely that the department would confirm that level of funding to Nosa in 1996.

"In the area of occupational health and safety, we are looking for more proactive inspectors to train health and safety stewards which means we would have to review the funding given to Nosa." He added that there was no justification to give money to Nosa which is linked to business when the department is committed to the concept of a social partnership.

"We would rather focus on providing resources to train health and safety stewards in whose interests it is to have a safe working environment."

Nosa manager (communications) Marius Garbers said the R10-million from the department accounted for less than 25 percent of the organisation's turnover. "So it will not really influence our activities if we didn't receive it. Future government funds should rather be directed towards the Reconstruction and Development Programme."

He added that from March 1996, the organisation was moving away from providing free industry training and audit grading services to paid services according to market related prices.

"A survey indicated that the majority of our clients would be more than willing to pay for the services we provide."

Pityana said in the past, the department's inspectors had only dealt with issues affecting labour but that now they would be trained to pick up on issues of health and safety. "We want to make maximum use of our resources and are looking to develop one-stop inspection services by restructuring the whole inspection system."

On the training of unemployed people, Pityana said the department would focus on 'demand driven' training.

There must be a relationship between the training provided and the skills required by the economy

"Over past 10 years, the government spent R770-million on training about 1,9-million unemployed people of which only 22,5 percent are reported to have found jobs."

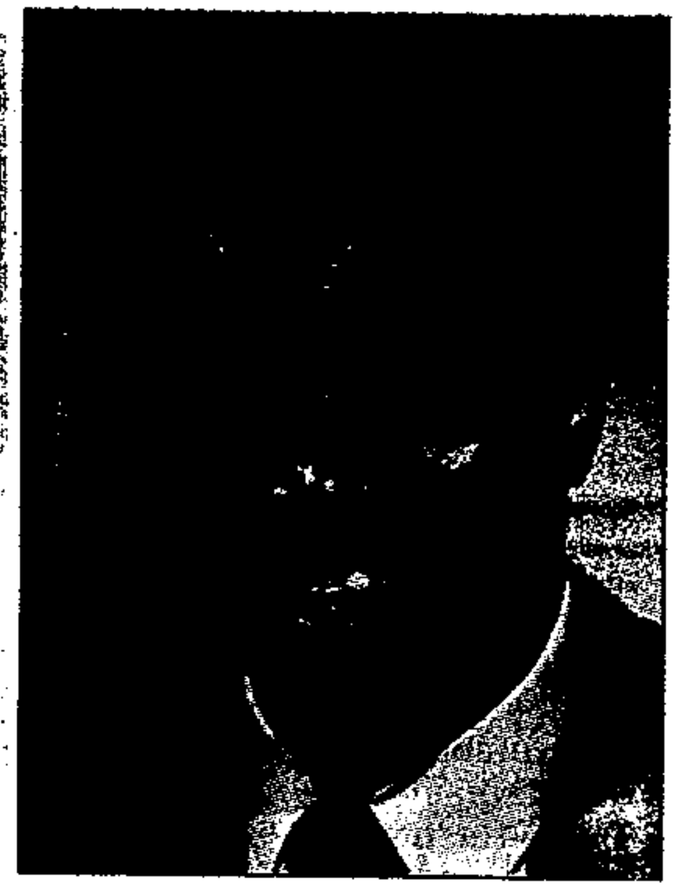
He questioned whether such investment was justifiable. "There must be a relationship between the training provided and the skills required by the economy."

Pityana said the department, which had budgeted to spend some R100-million on training next year, was reviewing all training contracts and scrutinising the quality of service provided.

He said his first priority on being appointed 10 months ago was to restructure the department and redefine and fill the positions which were frozen in October 1994 when the new Public Services Act was passed. "In terms of that law, each department had to start establishing a new organisational structure, fill the positions and at the same time, consider those people who were already in the employ of the civil service."

He added that the number of top-level management positions were reduced and the demographic profile — previously white and male — changed.

"We now have 30 percent of management made up of women, and 62 percent made up of blacks," said Pityana. He emphasised that these appointments were not made on affirmative action principles although the department was committed to the policy.



Sipho Pityana: We have to review the funding given to Nosa

R4-m for child survival drive in KwaZulu Natal

(85)

BY MATTHEW BUCKLAND

Star 19/12/95

More than R4-million is to be pumped into a project to improve health services and educate the underprivileged communities of the impoverished Bergville district of KwaZulu Natal over the next four years.

The project, which is a result of a joint initiative by World Vision, a Christian development and relief organisation, and USaid, an American agency for international development, is expected to be implemented around March.

Project manager Monika Holst said the project, dubbed the Child Survival Programme, aimed primarily at improving infant mortality and morbidity rates in the region through a widespread education campaign that specifically targets mothers and children.

The project, which will affect about 3 000 children and their families, will involve sending community "health promoters" and "motivators" into rural villages and schools with "clear and simple health messages".

"We will be bringing in outside consultants and setting up health centres where communities want them. Health information systems will also be set up to capture information from the community and feed it back to the community to be used," she said.

Working closely with the KwaZulu Natal department of health, the project also aimed to train government health staff and provide technical support for existing government activities in order to sustain the project in the future.

"In the old administrations there were people working separately for the national, Natal provincial, KwaZulu homeland, municipal and private health services. We hope to bring these all together under one health system. We see this project as a catalyst to establishing a pilot district health system like they have in England. It is the new way that national health policy is going," Holst said.

Making our health service better for all

(85) Star 20/12/95

When attempting to assess the performance of South Africa's new Health Department over the past year, the tendency is to assume that most news will be bad. A closer examination, however, reveals some heartening surprises

By David Robbins
Health Writer

Nurses' strikes, underfunded hospitals, abuses in the school feeding scheme, and now there's talk of doctors streaming in from foreign lands. What's our Health Department coming to?

A more sensible question to ask would be: Where's our Health Department going?

It's surprising how some of the thorniest problems become more manageable when they are placed in the context of an overall policy direction. It's been said before, but it cannot be repeated too many times: our Health Department has been primarily concerned with changing a curative/hospital-based health care system which favoured white and other urban dwellers to one which is accessible and affordable to all.

No need to go into the rationale for such a transformation, except to say that under the old apartheid system some of South Africa's basic health status indicators, like infant and child mortality rates and the incidence of preventable diseases, were a national disgrace.

Much more pertinent to our current assessment are the mechanics of such a transformation, because that's what our Health Department has spent a lot of its time and energy on over the past 12 months.

The plan is well-known, but let's repeat some of the basic nuts and bolts. Shift resources from the curative centre to the periphery. Make health care accessible by developing clinics at which primary care will be free to all at the point of service.

Involve communities in the governance of health care via the district health model. Create an integrated national health system in which both private and public sectors can play their part to increase access and quality and the cost efficiency of various levels of service, not least in the nation's hard-pressed hospitals.

"Yes, yes," say the sceptics, "we've heard all this before. *But what has actually been done?*"

I persuaded the Health Department's Director-General, Dr Olive Shisana, to tackle this question.

"It's taken time to get through a planning process based on wide consultation," she replied. "We're now through that process.

"Our overall plan will soon be released. But implementation of many of the basics has already begun, especially with regard to the re-allocation of finance, and the development of human resources."

Here's a summary of the practical steps already taken in pursuance of the new health policy as outlined above:

■ Considerable resources have been shifted away from the major academic hospital complexes in Gauteng and the Western Cape, and channelled towards primary health care (PHC), especially in traditionally underserved provinces. This has resulted in the creation of 700 new PHC posts. At the same time, medical school internships have been re-organised to spread trainee-doctor expertise into hitherto underserved areas.

■ R220-million of RDP funding is being used to build 143 clinics, to upgrade 60 more, and to re-equip a further 73. In addition, 142 mobile clinics have been purchased, and general improvements made to a further 3 141 clinics across the country.

■ During 1995, 50 PHC-nurse trainers from all nine provinces have been equipped to train 10 nurses each next year. This means that 500 professional PHC nurses will be trained annually from this one programme alone. District health managers (most of them nurses) are also being trained: 62 in KwaZulu Natal, 60 in North West Province, 80 in Mpumalanga, and 30 in Gauteng.

All this looks good from the point of view of shifting resources to the periphery. But what about the poor hospitals in the centre?

"It's a question of timing now," says Shisana. "As PHC in the communities improves, hospitals will need to think of shutting down or at least curtailing their own PHC services which they have been compelled to offer simply because the whole system was so hospital-centred in the past.

"We're also determined to help hospitals to become more efficient. We've already tendered for one component of our computerised health information system. This will facilitate the efficient billing of patients. It's been estimated that up to R360-million a year is currently being lost by inefficient billing systems. The idea is to recover this and then start talking about revenue retention to bolster individual hospital budgets. The computers will also combine cost and result statistics to establish outcome efficiencies, an invaluable hospital management tool."

The recruitment of overseas doctors will also take some of the pressure off hospitals. In the Northern Province alone, Shisana points out, there are 97 fully funded doctor posts which are currently unfilled.

"Our overall policy objective is obviously to encourage South African doctors to serve for periods in the rural areas. We're currently working with the Medical Association (Masa) on improving service conditions for doctors, including incentives to work in the underserved areas.

"In the interim, however, we are entering into government-to-government agreements with several countries which have an excess of trained doctors. These countries include Cuba, Britain, Belgium, and Ireland. Doctors will come on a three-year contract, and then return to their country of origin. Several hundred doctors will be arriving early next year; and they will make an immediate positive impact on health care across the entire country."

And what about the nurses whose industrial action disrupted 18% of the country's hospitals during the year?

Shisana admits immediately that this is a major problem which has not yet been resolved. "Nurses perform an essential service. Obviously, we would like to see them better paid, and we'll be pushing very hard for a dedicated health-sector bargaining chamber in the Public Service Commission. One problem lies in the capacity of several provincial administrations, especially those incorporating former homelands, to ensure that nurses are renumerated according to their years of service and the various allowances due.

"But we'd prefer to see problems resolved by arbitration rather than by strike."

Shisana is candid about the school feeding scheme as well.

"Yes, there has been corruption. An amount of R2,3-million has been lost in this way, due largely to a lack of infrastructure and control-mechanisms on the ground.

"But the vast bulk of the allocated R500-million has reached its target. More than 5-million children in 14 000 schools have benefited from the scheme."

Other 1995 achievements include:

■ A new pharmaceuticals policy, incorporating essential drugs lists, has been put in place; and South Africa's pharmaceuticals manufacturers have been informed that unless they can reduce their prices within a set time they will face competition from imports. "We have an obligation to our people, whether they're in the public or the private sector," Shisana says.

■ Negotiations with the Education Department have resulted in the introduction of an HIV-Aids component in the Std 5 to 7 syllabuses of all schools in the country. The Health Department has also produced an Aids-awareness booklet which will be provided free to all school leavers from next year.

■ Polio vaccinations were administered to 3,4-million South African children in a drive to free the country of the disease; and protection against Hepatitis-B became part of the vaccination package for all children born in 1995.

But is all this making an impact on ordinary South Africans? It seems so. A recent national survey established that 63% say they have easier access to health care than before.

"That's a good indication that we're succeeding in our goal," says Shisana. "Of course there'll be hiccups and difficulties as the transformation continues. But, generally, I feel pretty confident about the future."

Doctor may set up a fund to help heart transplant patients

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TUCKED away on the northern side of Pretoria's H F Verwoerd Hospital is Tuks faculty of medicine — and the office used by Dr Fanus Serfontein, probably the city's best-known medical personality.

And he's going to remain in the Jacaranda City — "I have no intention of leaving South Africa".

Here the cardio-thoracic surgeon plies the out-of-theatre side of his profession in an environment probably best described as "organised chaos".

This is the domain of the man who incurred the wrath of national health authorities when he broke a moratorium on organ — more specifically heart — transplants, in March this year.

And he is adamant he will continue to use his skills in South Africa — more particularly Pretoria and Gauteng, the country's most prosperous province — to prolong life, even if it means the intricate transplant procedures have to be performed at private hospitals with follow-up care done at HF.

Dr Serfontein's positive feelings about publicity given to transplant surgery have raised the possibility of a transplant fund.

"The cost of transplant procedures is and will always be expensive.

"I am toying with the idea of setting up some sort of fund which will assist in meeting the expenses of transplant patients.

"It's still in the early stages and I'm not sure how exactly it will be structured but I will give it more thought in the new year."

With 14 heart transplants under his belt this year — four of them involving heart and lungs — he is a medical man in the true Hippocratic sense.

☐ *No intention of leaving SA, says Fanus Serfontein*

"It hasn't been an easy year but on the plus side I have been able to help people who might otherwise not have had a chance.

"I want to heal sick people and will carry on."

When a storm broke about him using provincial hospital facilities and equipment to perform transplants earlier this year he refused to be bowed and took his skills to the Pretoria Heart Hospital where more life-prolonging surgical procedures were performed.

"It's not the ideal situation, but if lives can be saved and donor organs are available I will use the facilities at private hospitals."

He would much prefer to perform transplants at HF Verwoerd, an academic and provincial hospital, but the moratorium on transplants in Gauteng and ageing equipment leave him no option.

"My patients all come to HF for post-operative care, treatment and medication," he said soon after having seen yet another patient in his cluttered suite of offices overlooking the hospital complex.

Dr Serfontein dearly wants a fully operational cardio-thoracic unit at HF Verwoerd — but knows this is an unlikely possibility.

"Primary health care is number one on the provincial and national health budget and there will not be funds available to upgrade equipment at HF.

"As an example, some of the monitors in the hospital's cardio-thoracic unit are more than 20 years old and it's going to take a lot of money to upgrade the unit to current standards."

He appreciates and understands the need for primary health care as a priority but does not see why his chosen field should be neglected.

"The change in emphasis by national and provincial health authorities has forced me to use private hospital facilities to perform transplant procedures.

"There is a Mafia

P. T.O.

among private doctors. It's a closed shop and many of them are directors of private hospitals. They use and refer patients to their hospitals and in my case my work at private hospitals becomes an advertisement for the hospital.

"After all they are financially driven and have to provide a return on investment."

But Dr Serfontein's feelings on private medical institutions will not deter him from using their facilities to carry on performing his life-extending operations.

"I have worked at the Pretoria Heart Hospital this year and am looking at other private hospitals both in Pretoria and Johannesburg to use for surgical procedures," he said, insisting he had no intention of leaving South Africa.

Rumours of his leaving South Africa, moving to 1 Military Hospital or taking up a position with the Groote Schuur transplant unit were "just that".

"The Groote Schuur transplant unit is fully staffed and, as for going into private practice, I will have to either become part of the Mafia or I won't get in.

"No, I'm staying here,' he said firmly.

Notwithstanding the difficulties under which he has to work Dr Serfontein is confident there will be an ever-increasing demand for his skills in the year to come.

"With people having to wait shorter periods for suitable donor organs, I am sure I will be kept busy in the new year."

Apart from donor organs for children his experience is that the maximum waiting time is about three months and this can drop to a few weeks.

"The publicity given to transplants has raised public awareness enormously — and many more people are prepared to donate organs now than previously."

SURGEON: Controversial doctor Fanus Serfontein, who incurred the wrath of national health authorities when he broke a moratorium on organ transplants in March this year, says he has no intention of leaving the country.

Violence upsets health services in Eastern Cape

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Kathryn Strachan

VIOLENCE is emerging as one of the main factors breaking apart health services in Eastern Cape, particularly in former Transkei, according to a report by the Eastern Cape legislature's health standing committee.

"The situation deteriorates daily," says the report, which paints a dismal picture of hospital services in the province. At Dora Nginza Hospital near Port Elizabeth gangs regularly enter casualty to "finish off" their victims, using nurses as human shields. A pharmacy student was recently killed in the staff quarters.

At St Barnabas in Libode, Eastern Cape, gun-wielding gangs burst into the hospital, threatening doctors and nurses. Staff have feared for their safety since a patient was killed there and they appealed to the health department in Bisho for security measures. They have received no response.

At Humansdorp Hospital a nurse was raped on the premises recently.

At Canzibe Hospital in Ngqeleni, Transkei, two women who had caesarian section operations had to share a bed on the first day after surgery. The next day they were moved on to the floor to make way for new patients.

Their babies were in the nursery where four babies shared a cot.

There are 12 beds for 50 patients, so patients sleep together or on mattresses on the floor. Patients have to bring their own blankets. The water is not fit for human consumption because there is no water purification system.

Canzibe Hospital is typical of the hospitals visited — all of which are overcrowded and have critical staff shortages, broken equipment, dilapidated buildings with broken windows and roofs and floors which have caved in. But a lack of medicines and linen is the most recurrent theme in the report.

At Dora Nginza, patients lie on bare

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mattresses because there is no linen. There are no porters to remove the corpses which lie in the wards, sometimes for hours, until nurses or doctors can remove them.

The report said mortuaries in the province were generally in a "terrible state". Bodies often went missing.

At Settlers Hospital in Grahamstown, negligence in the maternity ward had resulted in the death of 11 babies, the report said.

Many of the hospitals described burnt-out staff who had to cope with high levels of tension. Empilisweni Hospital in Sterkspruit said the health department's unclear labour policies meant they could not retrench "incompetent and disobedient" employees.

Submitting the report to the legislature, the standing committee called for the state of health services in Transkei to be declared a crisis.

Violence killing our kids — hospital chief

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IT HURTS . . . One of the many youngsters who are treated by the Red Cross hospital's trauma unit Picture: JUSTIN SHOLK

By CHARL DE VILLIERS

SOUTH African children are being swept up in an epidemic of violent injury that is killing more youngsters than any other cause — but which is largely preventable.

This is the blunt message from Red Cross Children's Hospital trauma chief David Bass, whose unit is the only of its kind in Sub-Saharan Africa and which treats up to 15 000 young patients a year.

While motor vehicle accidents involving young pedestrians and passengers account for most of the 3 000 to 4 000 deaths a year, gunshot injuries and sexual abuse are an increasingly alarming trend, says Dr Bass.

"Not a day goes by that we don't have at least one child in our beds because of assault or intentional injury. Children are not becoming more violent — but more kids are becoming victims," he says.

Red Cross trauma unit staff have treated at least 12 patients with gunshot wounds this year, many of them caught in the cross-fire between warring street gangs.

"This is something we never used to see before. There are a hell of a lot of guns around and children are now as much at risk as adults. Gunshot-related mortality and disability rates are high," he adds.

At least half of the abuse cases treated at the hospital took place within the family, and usually involved the victim's father or mother's boyfriend.

"The rest involves strangers, and is usually rape. These types of non-accidental injuries account for about 10 percent of hospitalised patients," says Dr Bass.

While organisations such as the Child Accident Prevention Foundation of South Africa were doing stirling work in using education to prevent children's trauma, injuries to youngsters had to be taken up as a national issue by the government, he says.

"Trauma is an epidemic in this country, and a huge killer of children. Education can be effective because it makes people aware that injuries are not something to be dealt with fatalistically — they are preventable," he says.

Trauma has become an overwhelming problem for cash-strapped state hospitals, which have experienced a 400 percent increase in patients with gunshot injuries in the past two years, says Red Cross medical superintendent Dr Rod Marshall.

"Our resources cannot cope anymore and some weekends the situation is acute. This is an appalling reflection on society," says Dr Marshall.

Red Cross at times did not have the staff to deal with multiple trauma cases and ambulances sometimes had to be re-routed elsewhere because of the patient load.

"As a hospital manager, I find it distressing that I can't provide more staff. But that's not the solution — we have to address the violence," he says.

The Red Cross out-patients department saw up to 1 000 patients daily — for 24 hours a day, 365 days of the year.

The hospital has 353 beds, of which 10 are devoted to trauma cases.