FOREIGN FRI

HEALTH AND DISEASE - GENERAL

1996

JANUARY — JULY

Employers will have to provide basic medical aid for all em

Tax shocks lie on health-care

(85 ST 7/11/96)

By PAT SIDLEY

THE ailing health-care system is set for a radical shake-up from April 1 — the target date for the introduction of a new national health plan.

Provincial health ministers are studying the final draft of the plan which will be submitted to cabinet when it resumes its meetings after the Christmas break.

Dr Ayanda Ntsaluba, the deputy director-general of health, says changes should be seen from the start of the new financial year.

The Minister of Health, Dr Nkosazana Zuma, will soon announce which aspects of the long-debated health plan she has decided to adopt.

However, much will depend on the cabinet. Most important is how the changes will be financed and for this Dr Zuma needs the agreement of the Minister of Finance, Chris Liebenberg.

If the plan is adopted:

- All South Africans will have access to free primary health care;
- An essential drugs list will be compiled and a restricted number of drugs will be available for free to primary health care patients;
- Employers will have to provide a basic hospital plan or medical aid plan for all employees;
- Pregnant women, new mothers and children under six will continue receiving free care at primary health care centres; and
- Hospital budgets will be cut and user charges introduced.

The burden of paying for this will fall largely on taxpayers' shoulders after some clever reshuffling of existing expenditure.

Tax subsidies on existing medical aid payments could be reduced or eliminated, saddling individual employees with more tax.

Medical aid schemes would have to qualify for a "community rating" and would be discouraged from excluding high-risk members such as the chronically ill, aged or otherwise infirm.

The tax subsidies on monthly payments would be reduced or stopped if the scheme lost its community rating. The idea would be to reduce the load on the public health system when medical aid funds run out or members cannot afford exorbitant payments.

A portion of the payments for the plan would go into an equalisation fund which would then subsidise those schemes being drained by high-risk members.

The Department of Health hopes to save hundreds of millions of rands on drug costs by introducing an essential drugs list. But its hope of allowing private patients access to cheap drugs on this list is on hold after pressure from pharmaceutical companies.

Hospital budgets are to be cut, but Dr Ntsaluba says the department had to listen to valid criticisms that hospitals would collapse if their budgets were cut too drastically and too quickly before primary health care clinics were up and running.

Several hospitals will become more autonomous from April 1, she says.

Patients needing care at secondary and tertiary hospitals will find themselves being charged at much more commercial rates than at present. The department has been told its hospitals can make an extra R500-million a year by charging more in line with private hospitals.

Where primary health care facilities are not adequately staffed, the district health authorities, which are still to be formed, will be able to contract private doctors to see state patients.

Private patients will be able to seek care much as they did in the past — except they will have the added choice of using the state's primary health care facilities for free.

They will also find that buying medication at pharmacies and dispensing doctors will change — neither will be able to dispense for profit and a professional fee will be charged instead of a percentage mark-up.

Patients will have rights set down in law, including rights to privacy and to their health records and information. There will be complaints procedures and grievance procedures when standards fall.

Some provinces have already started introducing clinics — many funded by the reconstruction and development programme. They will fall under the district health authorities which will form the backbone of health care administration in each province.

Agreements with other countries to provide doctors for underserved areas is part of the plan already under way.

However, the department hopes also to be able to attract local doctors to rural areas with a system of incentives and compulsory service.

To Page 2 ⇨

Health care to undergo major surgery

(85)

⇨ From Page 1

ST 7/11/96

When the system is up and running, all South Africans will be able to get attention for a large but defined range of services at primary health care centres. These include immunisation; family planning; health education; treatment for minor ailments, emergencies and communicable diseases; maternal and child health services; antenatal and postnatal care; deliveries, provision of essential drugs; X-rays; blood tests; physiotherapy, basic oral health care; optometry; and mental health care.

These will be delivered by appropriately trained health care personnel including nurses, pharmacists, midwives, oral hygienists, and doctors and dentists where necessary.

Those that have the means will have paid for these services through taxes and "user charges" but those with no means will also be attended to.

● See Page 4

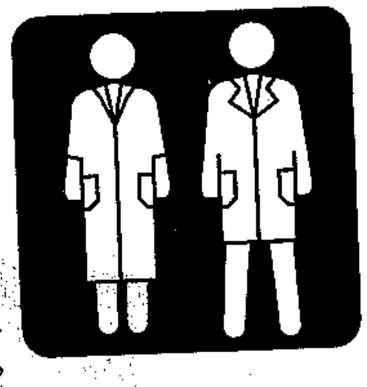
Prescriptions for health care

(85) ST 7/1/96

The new National Health Plan will introduce sweeping changes, reports PAT SIDLEY

DOCTORS AND PRIMARY HEALTH CARE TEAMS

MOST South Africans who can get to a hospital or can afford health care believe they ought to be able to see doctors. But, under the new health care plan, they are more likely to to be seen by a primary health care nurse working in a team of midwives, community health nurses, oral health specialists and, where possible, general practitioners and dentists.



The Department of Health hopes to retain the country's eight medical schools, but intends to have them admit students along demographic lines and train them according to the needs of the country. This, however, is an area of dispute as several medical schools widely seen as producing good doctors and worthwhile research are also seen as having staffed the hospitals and clinics of the United States , Canada, Australia and Britain.

The department is also revising legislation so that other health care professionals, among them optometrists and pharmacists, can take more responsibility in seeing to the health care needs of the population.

DRUGS

THE big guns are out on this one, with the pharmaceutical companies and the departments of Health, Trade and Industry, Finance and Foreign Affairs — as well as other countries' foreign affairs departments — currently doing battle.

There are very rich pickings in this battle over exorbitant prices, which the drug companies would like to keep but the government wants to bring down.

South African drug prices are among the five highest in the world. The state has traditionally bought massive amounts of its drugs through an inefficient state-run procurement body known as Comed.

When the committee investigating the health care plan probed this aspect of health care costs last year, it could find no accurate data of what the government spent or what drugs were bought, what they were used for, or how effective the drugs were. But it did discover that hundreds of millions of rands were filched in massive rackets and that even state tender prices were higher in some instances than overseas.

Pharmaceutical companies claimed they sold to the state at grossly deflated prices and were compelled to make up their "losses" from private health care consumers. Several practices which are seen as unethical also keep prices up. The drug companies get rid of massive amounts of drugs by "sampling and bonusing" some dispensing doctors. They give huge discounts and sometimes free drugs so that doctors will treat patients with their products.

It is also difficult for consumers to rely on cheaper generic drugs (as opposed to brand-name drugs) because pharmacists are not allowed to dispense these unless the doctor has prescribed them — and doctors habitually do not.

Medical aid schemes also claim pharmaceutical companies are bumping up the price of their generics to deal with the onslaught.

The government's plans therefore include:

- An essential drugs list consisting of a vastly reduced number of drugs, many of them generics, to be available in state hospitals. Almost 3 000 were bought by the state. But the new list envisages a maximum of 200;

- Allowing private patients being treated for primary health care-type ailments to receive the drugs on the essential drug list at very low prices. The drug companies' howls of outrage, however, have seen this plan put on hold for at least two years — and it may never see the light of day;
- Stopping the practice of "bonusing and sampling";
- Insisting on being allowed to tender for some of its drugs internationally. But the government faces massive opposition to its plan to allow parallel imports (the importation of drugs which may be made here, but can be found cheaper elsewhere);
- Stopping the percentage mark-up system in the sale of medicines by both doctors and pharmacists and introducing a professional fee to cover costs instead;
- The possibility of allowing stores like Clicks or Pick 'n Pay to operate pharmacies;
- Encouraging generic prescribing and dispensing; and:
- Devising a system which will try to regulate the prices at which drugs leave the factories.

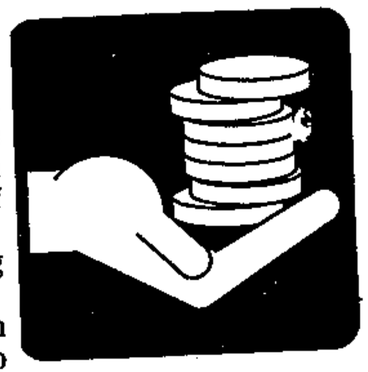
MEDICAL AIDS

THE major reason behind the moves on this front is to redistribute some of the disproportionate resources spent in private health care into the public health care domain. We also need to see to it that private patients do not end up being the state's responsibility.

The Department of Health would like to compel employers to provide a basic health care or hospital plan for all staff. In all probability, this would be paid for by employers and employees. It also looks like a payroll tax, in that the payments would be compulsory and would apply to all on a payroll.

These schemes would cover the basic health care needs of people who are employed.

A portion of the payments made each month would be transferred to an "equalisation fund" which would see to it that those plans could draw on the fund if members were draining its resources.



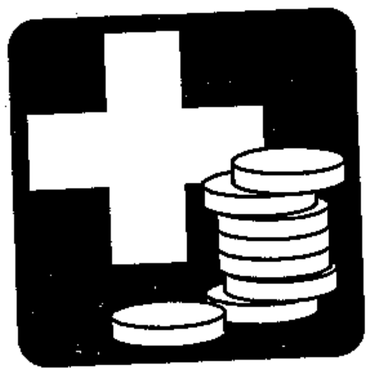
The plan would also seek to regulate all medical aid and insurance funds to ensure that people are not penalised or excluded from cover because they are "high risk" — old or chronically ill.

To do this, schemes would get a "community rating" which would determine their tax status — whether or not they got tax subsidies.

At present, employers' contributions to medical aids on behalf of employees are not taxed as part of the employees' income — but the beady eye of the tax man is on this effective subsidy as another source of income for more pressing health needs.

BUDGET

THE plan envisages having to find money for increasingly large amounts — the gap between what the department can pull in and redistribute, and what it needs to spend to make it all work.



Originally it was estimated that this gap would be more than R3-billion by the year 2000. But the planners have narrowed this gap to R1,4-billion by the turn of the century.

The question facing the budget people is how to get this money — and various options have been presented to them, including a payroll tax, more income tax and dedicated taxes.

Some ideas, apparently, are more palatable than others, including the idea of reducing or abolishing the tax subsidies on medical aid payments.

The Department of Health sees some of the options more simplistically than the Department of Finance, which has pressure on it from several quarters within the health care industry, and from other departments in government.

The Department of Finance does not want to increase the already heavy burden on the small base of taxpayers, but this is seen — particularly by the department and its advisers — as being a useful source of future revenue.

The finance minister has also got to find the money needed to increase the pay packages of doctors, nurses and other public health personnel — or face continuing labour unrest.

Some method will have to be found to increase the tax burden — but it will have to be disguised so it does not really look like a tax.

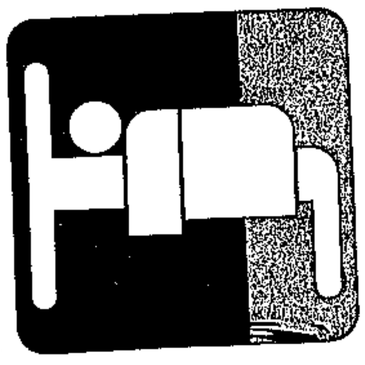
HOSPITALS

THE National Health Plan hopes to be able to divert some private patients from private hospitals to state hospitals and increase competition between the two sectors.

A system, which can be monitored, will be set up whereby the public will no longer simply call in at large state hospitals for medical attention — they will first have to be referred by primary health care facilities. These facilities will be free, and the secondary and tertiary hospitals will charge.

The "user charges", at commercial rates, are to be introduced at state hospitals — hopefully as soon as April 1 — and the department hopes that several hospitals will soon be able to run themselves with much more autonomy.

The budgets at several large hospitals are in the process of being slashed.



However, the Department of Health has had to take seriously criticism that cutting budgets too drastically, too quickly, before the rest of the plan is up and running, would cause the collapse of the hospitals — which remain the mainstay of the public health system.

Private hospitals would remain much as they are present, but would be forced into competition with state hospitals — ideally driving prices down.

The Star ... Monday January 8 1996

Taxpayers to carry burden of health plan

(85)

Budget reshuffling and compulsory employers' health schemes will still leave employees out of pocket

Star 8/1/96

STAFF REPORTER

Taxpayers are expected to carry the bulk of the burden if a long-debated health plan, designed to give South Africa's health-care system a major revamp, is adopted by the Cabinet.

The changes should be seen by the start of the new financial year, once Health Minister Dr Nkosazana Zuma has decided which aspects of the health plan should be adopted, it has been reported.

Finance Minister Chris Liebenberg will have to give the plan his stamp of approval, as the most important unresolved factor is how the plan will be funded.

The final draft of the plan, currently being studied by provincial health MECs, will be submitted to the Cabinet when it resumes its meetings later this month.

If the plan is approved:

- Employers will have to provide a basic hospital or medical aid plan for all employees.
- Every South African will have access to free primary health care.
- An essential-drugs list will be compiled and a restricted number of drugs will be available for free to primary health care patients.
- Pregnant women, new mothers and children under 6 will continue to receive free care at primary health care centres.
- Hospital budgets will be cut and user charges introduced.

Taxpayers will bear the brunt of paying for all this after some reshuffling of existing expenditure.

Tax subsidies on existing medical aid payments could be reduced or eliminated, lumping employees with more tax.

Under the new plan, all medical aid schemes will have to qualify for a "community rating" and will be discouraged from excluding high-risk members such as the chronically ill or aged.

Subsidies on medical aid levies could be cut

A portion of the payments for the plan will go into an equalisation fund which will then subsidise those schemes being drained by high-risk members.

Dr Max Price, dean of the University of the Witwatersrand's medical school, said the problem of finding extra money for health care would be eased by employers providing a basic hospital plan or medical aid scheme for all employees.

"Extra revenue will be generated by people insuring themselves," said Price.

Proposed drug controls slated

Star 9/1/96 (85)

New restrictions will amount to nationalisation, say industry representatives

Drug companies are up in arms over plans for a radical overhaul of South Africa's health care system which they fear will undermine the R5,5-billion-a-year industry and which may trigger disinvestment.

Health Minister Nkosazana Zuma argues that reforms, including controls on the sale and pricing of drugs, are needed to address the inequities of a system inherited from the apartheid era.

But industry officials representing local and international firms said yesterday that her proposals, scheduled to come into effect on April 1, were tantamount to nationalisation.

A final draft of the plan is expected to go before the Cabinet shortly. If adopted, the proposals would:

■ Establish a committee to monitor and regulate drug prices.

■ Create a national essential-drug list, restricting the number of drugs available in the public sector, and eventually extending to the private sector, probably sometime after 1998.

■ Make substitution of generic drugs in place of brand-name products mandatory in both the public and private sectors.

■ Promote parallel importation of medicines from outside South Africa, starting with high-volume essential drugs.

"All of these measures are of concern individually. In concert, they amount to the potential nationalisation of the industry," said Mirryena Deeb, chief executive of the South African Pharmaceutical Manufacturers' Association (PMA).

Deeb argued that experience elsewhere showed price controls were unworkable and ineffective, while limiting drugs to a restricted list was detrimental for patients and would choke off development of new remedies by companies.

Government officials have suggested cutting the number of essential medicines on offer to 500 or even 200. An earlier commission of inquiry suggested the move could save about R500-million.

Nkosazana Zuma ... wants to address inequities.

Deeb said the PMA shared the Government's concern about rising health costs, but that the key to cutting drug prices was reform of the restricted pharmacy distribution system which allowed for markups of 100% between the factory and the patient.

Most major US and European pharmaceutical companies are present in the South African market, with leading international players Glaxo Wellcome plc and SmithKline Beecham plc both holding market shares of 6% each.

The largest single operator, with 15%, is C G Smith Ltd, which owns local manufacturer Adcock Ingram Ltd and Logos, the local agent for Merck and Co Inc.

The influential Pharmaceutical Research and Manufacturers of America group recently entered the fray, warning that drug-makers would now think twice before investing in SA.

"Such disregard for the views of private companies bodes ill for South Africa's ability to retain and encourage the sort of private investment that generates economic development," the organisation said in a statement. – Reuters.

Health tax assurance

CT 9/1/96

85

ANEEZ SALIE

THE taxpayer need not fear huge tax increases to pay for the government's new health plan, national director-general of health Dr Olive Shisana said yesterday.

"The options being examined by the Department of Health include only a small increase of not more than R300-million a year, escalating to slightly more than R1 billion by the year 2000," she said.

"However, additional funds will only be needed as of April 1997. This gives the department sufficient time to consult the National Economic Development and Labour Council (Nedlac) ... if this ends up being the means to close the funding gap," she said.

In the plan everyone will enjoy free primary health care, and contracted general practitioners will provide free service. A hospital insurance scheme — of about R400 a year per person — will be available to the employed.

Dr Shisana said the private medical aid system was extensively abused: "There is a lot of cheating by all involved, which drives up costs. We are terribly unhappy and will clean it up. The effect could be that medical aid members end up paying less for a more efficient service, because we are definitely going to regulate."

Drug prices should also be reduced, she said.

Currently, the state has on tender a list of about 3 000 drugs. This will be replaced by an Essential Drugs List with only 400 drugs, many of them inexpensive generic medicines.

More expensive medicines will not be included, unless there are no substitutes.

The National Health Plan will be finalised this quarter.

CC

Drug firms object to health care proposals

CT (MR) 9/1/96

85

By Ben Hirschler

Johannesburg — Local and international drug firms are up in arms over plans for a radical overhaul of South Africa's health care system which they fear will undermine the R5,5 billion-a-year industry, and may trigger disinvestment.

The minister of health, Nkosazana Zuma, argues that reforms, including controls on the sale and pricing of drugs, are needed. But drug industry officials claimed yesterday that her proposals, set out in a recent policy document and to come into effect on April 1, were tantamount to nationalisation.

A final draft of the plan is expected to go before cabinet shortly. If adopted, the proposals would:

☐ Establish a committee to monitor and regulate drug prices;

☐ Create a national essential drug list, restricting the number of drugs available in the public sector, and eventually extending this to the private sector;

☐ Make substitution of generic drugs in place of brand-name products mandatory in both the public and private sectors; and

☐ Promote parallel importation of medicines from outside South Africa, starting with high-volume essential drugs.

EMBATTLED *The minister of health, Nkosazana Zuma*

"All of these measures are of concern individually. In concert, they amount to the potential nationalisation of the industry," said Mirryena Deeb, the chief executive of the South African Pharmaceutical Manufacturers Association (PMA).

Deeb argued that experience elsewhere showed price controls were unworkable and ineffective, while limiting drugs to a restricted formula was bad for patients and would hamper research.

Government officials have suggested cutting the number of medicines on the essential drug list from 3 000 at present to 500 or even 200.

Deeb said the PMA shared government's concern about rising health costs, but said the key to cutting drug prices was reform of the restricted pharmacy distribution system, which allowed for mark-ups of 100 percent.

It wants to see pharmacies deregulated, allowing the entry of price-competitive retailers, arguing that a similar move in the United States caused retail prices to fall 50 percent.

Most major American and European pharmaceutical companies are in the market, with international players Glaxo Wellcome and SmithKline Beecham holding market shares of 6 percent each. The largest single operator, with 15 percent, is CG Smith, which owns local manufacturer Adcock Ingram.

The Pharmaceutical Research and Manufacturers of America group warned that companies would think twice before investing in South Africa. — Reuters

National health plan comes under fire

(85) CTCBR) 12/1/96

By Maggie Rowley

Cape Town — The government's new national health plan has come under fire from one of the country's largest medical administrators as effectively amounting to yet another company tax.

Robin Melville, managing director of D&E Medical Aid Administrators, a wholly owned subsidiary of Norwich Holdings, said the government needed to seriously consider allowing one deduction for all employee benefits and allowing companies to decide how this deduction was allocated among the various employee benefits.

It was not in the interests of workers to allow tax deductibility for one employee benefit and not for healthcare.

Most companies were concerned about the bottom-line impact of providing a mandatory basic hospital or medical aid plan to all staff, especially if the tax deductibility of medical aid contributions fell away, he said

The government health plan applied "community rating" to ensure that high-risk individuals were not excluded from being given cover and became a liability of the public sector. A portion of all contributions to the basic plan would be channelled into an equalisation fund that would distribute funds to schemes according to their profile of high risk members.

"It is important that this equalisation fund be implemented responsibly and does not result in badly managed schemes being subsidised by the well-managed."

Melville said D&E was also concerned that there had been no further discussion about employers having to offer access to more than one scheme. "Offering staff many options opens societies to anti-selection in that they will select plans according to their own family needs and dilute companies' risk pools. This will be especially problematic for schemes that have been created for specific employer groups."

SA health unit chosen

(85) Sowetan 16/1/96

By Mokgadi Pela

THE World Health Organisation has designated the Medical Research Unit's Health Technology Research Group as its collaborating centre for essential health technologies in Africa.

This follows the successful health-care technology conference hosted by the centre in April last year and attended by 21 African countries.

The collaboration centre will be run in partnership with the Centre for Scientific and Industrial Research and the Department of Biomedical Engineering at the University of Cape Town.

The MRC said the step was "a clear signal of the leading role we play in research and policy development in health technology regionally".

Health campaign preparation for charter

Star 24/1/96 (85)

MEDICAL CORRESPONDENT

A new campaign to improve the quality of contact between health care providers and patients has been launched by the National Progressive Primary Health Care Network.

The "Health Rights are Human Rights" campaign will focus on a series of 90-second radio spots in Sotho, Zulu and Xhosa, in which members of the public describe their experiences of the health services, and inform listeners of their health rights and responsibilities. The clips will be followed by an invitation to call a toll-free number for more information.

The network's national advocacy co-ordinator, Judi Fortuin, said yesterday information gleaned would be used to formulate submissions for a health charter which could be included in the final constitution.

Fortuin said the campaign was the first to ask consumers what they believed health rights were.

Patients to be told about their health care rights

(85) BD 24/1/96

Kathryn Strachan

A CAMPAIGN to make patients aware of their rights in the health system and to demand proper service at health centres was launched yesterday by the National Progressive Primary Healthcare Network.

The campaign, which is aimed primarily at illiterate people, starts with radio messages in four languages.

The messages will be based on real experiences people have had while receiving health care. Some of the stories are positive, others frightening.

"The aim of the campaign is to elicit the concerns of the community and to make them heard," said network executive member Dr Eric Buch. "Transforming the health services is not only about moving budgets; a lot depends on the care and attitudes of health workers ... and it is these kinds of issues that will be fed back to the health services," he said.

The campaign aims to encourage people to say what kind of health rights they would like to see written into a health charter and into SA's constitution.

A charter would spell out exactly what kind of care and service a patient should have.

A toll-free line has been set up to help people in need of advice about health issues and to enable them to say what should be included in the charter.

Among the most important rights that will be highlighted by the campaign are the patient's right to a clear and simple explanation about their illness and treatment, said network advocacy co-ordinator Judi Fortuin.

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Health rights campaign launched

(85)

HEALTH WRITER

CT 24/1/96

YOU no longer have to suffer in silence when you are poorly treated at hospitals and other health care centres.

A national awareness campaign with the slogan, Reach for Your Rights, was launched yesterday to popularise health rights, thus enabling patients to stand up to shoddy treatment.

Run by the National Progressive Primary Health Care Network, the campaign also has a toll-free helpline. Complaints and suggestions on health rights may be made at 0800-117-007.

Some of the basic health rights include the right to confidentiality and a simple explanation of the illness and treatment to be received.

According to a survery conducted for the network late last year, nearly half of patients who responded were dissatisfied with the services rendered.

Among the more common complaints were excessive waiting, consultations that lasted five minutes or less and unnecessary surgery which resulting in maiming and, in rare instances, death.

Improving health care

85 Sowetan 26/1/96

A dedicated doctor is doing everything within his power to reorganise and upgrade the outdated and inefficient healthcare system of the apartheid regime. **Glenn McKenzie** talked to him...

FRANTICALLY SCRIBBLING on a school drawing board, Dr Refik Bismilla suddenly looks up and grins. "You know, it is sometimes difficult to find satisfaction in all these numbers and formulas. But if we are to accomplish great things, these plans are essential," he says.

Bismilla, Gauteng's director of district health for the past seven months, talks in a language of concepts and scientific formulas. He finds it hard to communicate without illustrating his ideas with graphs, flow charts and geometrical drawings.

So it is perhaps fitting that he is charged with the incredibly complicated task of transforming the province's hodgepodge of health services into a coherent unit.

Man with a mission

Like his hero Dr Norman Bethune, a Western doctor who spent several years treating wounded soldiers on the frontlines of Mao Tse-Tung's Chinese revolution, Bismilla comes across as a man with a mission.

But while Bethune healed soldiers' war wounds, Bismilla does not see immediate results from his "mission".

It is a task that can only be judged five to 10 years from now, when South Africa has a district health system in which communities are involved and a countrywide health system for all South Africans.

"In Spain, it took them 12 years to set up a district system. In many African countries, it took up to 10 years," says Bismilla.

The former United Democratic Front activist and health coordinator hopes that eventually all health services in Gauteng will be operated by the communities and districts where they are located. But there are many obstacles to overcome first.

Extremely expensive

Number one is money. It is extremely expensive to modify the management structure of Gauteng's health services. And the payment grades between local and provincial employees vary by as much as 50 percent in some areas.

This was one of the sore points that led to last year's wildcat strikes by nurses. Depending on where nurses worked and for whom, their salaries and working conditions varied radically.

The level of services in Gauteng's communities also varies. Local clinics often provide only preventative health services and treatment for tuberculosis.

Provincial clinics are left to bear the burden of treating the countless thousands of people with diarrhoea, respiratory infections and many other diseases of poverty.

Dr Refik Bismilla ... responsible for transforming Gauteng's health services into a coherent system.

"Eventually all health services in Gauteng will be operated by the communties and districts"

Bismilla hopes that several of Soweto's 12 local authority clinics will be transformed into curative centres later this year. But, first, nurses must be given further training and equipment must be provided.

"If we can transform all 12 local authority clinics, we will have effectively doubled our curative services in Soweto," Bismilla says excitedly.

In turn, he expects several of Gauteng's 22 proposed new districts to take over control of their own health services this year.

"In places like Roodepoort and Germiston, the transition could potentially happen soon because the local and provincial service pay scales are similar," he said.

For the first time, this sort of transition is being carried out with the participation of communities, the Government and health authorities. Each district will have to decide for itself whether it can take over the health services in its region.

The province has committed itself to continue paying provincial wage rates to all provincial staff who are transferred to local authority structures. If their wages need to be adjusted to meet local standards, then the extra funds needed must come from the communities concerned.

"Communities will have to decide what their priorities are. Can they take money from their roads budgets? Or can they raise more funds? These are questions that the new councils will be grappling with very soon," says Bismilla.

But he insists that decisions on health delivery will not be made on a "disastrously *ad hoc* basis" as they were for many years under the apartheid regime.

"We don't want to have to dismantle everything and start all over again a few years down the road," he says.

Bismilla starts scribbling on his drawing board at twice his normal speed. "I have some more information to give you," he says. He then begins to summarise some recent health delivery success stories of the department.

Twenty-four new or upgraded clinics should be finished by April 1. Funds have been solicited from the private sector and funds from the Reconstruction and Development Programme for upgrading local authority clinics should be on the way soon.

"We do have problems from time to time, but I suppose we also have the right to feel good about what we are doing," says Bismilla.

HEALTH

SAME TREATMENT

Drug companies warn that safety and quality standards must be maintained. And the State, as a buyer, should insist on this, they say.

The industry's policy statement was presented to the Health Department this week by the Pharmaceutical Manufacturers Association, the Proprietary Association of SA, the SA Association of Pharmacists and the National Association of Pharmaceutical Manufacturers.

Dealing with drug imports the industry notes that government policyseems inconsistent with the department's objective of promoting the local manufacture of essential drugs for primary health care. However, such importing would only be economically viable to buyers if prices differ, notes the report.

The industry says it supported the removal of tariff barriers in 1994 which exposed it to international competition and allowed foreign companies to enter the local market, thus stimulating competition. But it notes, "duties on raw materials, as opposed to imported finished products are still high and this aspect must be addressed."

As in the past, the industry again advocates the deregulation of the ownership of retail pharmacists to allow medical schemes, hospitals and big business to buy medicines for their own account and to supply members and consumers directly. This move would pass on the benefits of bulk buying power and economies of scale and is the key to bringing down prices.

While the industry supports the department's objective of ensuring an adequate supply of safe, cost-effective drugs of acceptable quality to all South Africans it notes with dismay that sentiments in regard to the deregulation of pharmacists' ownership which had been voiced in the first Broomberg/Shisana Commission report last year now appears to have been discarded.

The industry also supports the department's notion that drugs be acquired at the lowest possible prices and its promotion of generics. But again, it notes with concern, the department's proposal that generic substitution be made mandatory. "We believe that the decision to use a generic must be left with the doctor and patient. This also applies to mandatory generic prescribing because it affects the discretion of the prescribing doctor."

Because chemically identical drugs are not always equivalent, and doctors and patients are the best judges of appropriate therapy, the industry approves of the proposal that the essential drug list be handled with flexibility for "specific patients" in the public sector. And, instead of overruling the doctor's choice in the private sector by mandatory generic substitution, permissive substitution by the pharmacist, if the prescribing doctor agrees, should be the route selected.

The industry remains totally opposed to the extension of the essential drug list to the private sector.

A "pricing committee" to regulate drug prices as proposed by the department is also strongly opposed by the industry, which claims it would, like in Europe, increase costs. Already the manufacturer is hampered by the central buying power of government with consequential distortions elsewhere. Further controls, could therefore damage the industry resulting in plant closures, research shutdowns and job losses. ■

Saints in white provide all-hours health care to settlement

(85) Star 30/1/96

By Janine Simon
Medical Correspondent

When the local clinic is too busy, or closes, the 40 000 people of Themb'elihle, near Lenasia South, know they can turn to the white-shirted band of first-aiders who run the Ukukhanya Komphakathi first aid clinic.

At weekends, the 15 volunteers operate a 24-hour service; during the week, they spend several hours every day making home visits, doing health education and tending to injuries.

All are trained first-aiders, and many have done home-nursing courses or are completing further training in health education, says chairman Rufus Meya.

With Baragwanath Hospital a R7 taxi ride away, the cramped little room of Ukukhanya Komphakathi (Light of the Community) is the only place residents can go for medical assistance after sisters at the local container clinic have stopped working.

THEMBA HADEBE

Proud to be of service ... Mungi Dube helps a local resident.

From November 1994 to November 1995, the group made 291 home visits, treated 40 minor injuries, took 132 patients to hospital and made 28 social work referrals.

Much of the work involves health education, dressing of wounds, treating burns, and assisting the elderly and children.

But among their more seriously injured patients was a toddler who walked on to hot coals, a young soldier who was shot in both legs with an AK-47 while trying to settle an argument, and an 8-year-old who had been accidentally stabbed in the arm.

In all cases, the volunteers were able to stabilise and call for additional help, Meya says. And they have also picked up on community health problems which need broader governmental assistance – teenage pregnancies, child abuse and alcoholism. Eye irritations caused by constant use of paraffin stoves is a common problem.

The group, which also run a small fruit juice business to fund their efforts, started in 1993.

"I used to be a musician, but now I feel so proud that I'm doing something for my community when I go out with my white bag," says one of the dedicated team, Mungi Dube.

The project is one of a cluster fostered by St John Ambulance in at least seven informal settlements across Gauteng over the past two years. "They fill in the gap left by the clinics and hospitals, " says executive director Sandra Miller.

St John, a health organisation specialising in first aid training, eye care and community health work, motivates for funding and provides equipment and subsidised training.

'Gauteng gets raw deal in health budget'

The key mistake in restructuring the health sector is the decision to equalise spending per capita in the provinces within five years, Democratic Party health spokeman Jack Bloom says.

Speaking at the Health Care Structure Conference at the Institute for International Research in Midrand this week, he said Gauteng's health budget was being cut by more than 20%, while provinces like Northern Transvaal had had huge eases.

Bloom said he had yet to see "conclusive evidence" that the extra money to other provinces had been productively absorbed to the benefit of the entire health system.

The Government's focus on achieving efficiency was encouraging, particularly the current audit of facilities, he said. – Medical Reporter.

(85) Star 31/1/96

Timber takes off in the home industry

(199) ARG 9/4/96

DAVID BIGGS
Staff Reporter

ARCHITECTS and builders have shown that timber framed houses can fit comfortably into any surroundings.

They recently submitted entries for the first Timber Frame Building competition which was judged in Cape Town.

The competition, organised by the Timber Frame Builders Association, is set to become an annual event, and is designed to focus attention on this burgeoning branch of the building industry.

Timber framed buildings, long regarded as standard in America and Europe, are becoming increasingly popular in the Cape, now that home loans are more readily available for this type of structure.

Entries ranged from a school sports pavilion to a shopping complex and several attractive houses and home additions.

The versatility of this building method was obvious from the wide range of styles and finishes amoung the entries.

The gracious riverside home of Mr and Mrs A Louw at Bushman's River Mouth won first prize.

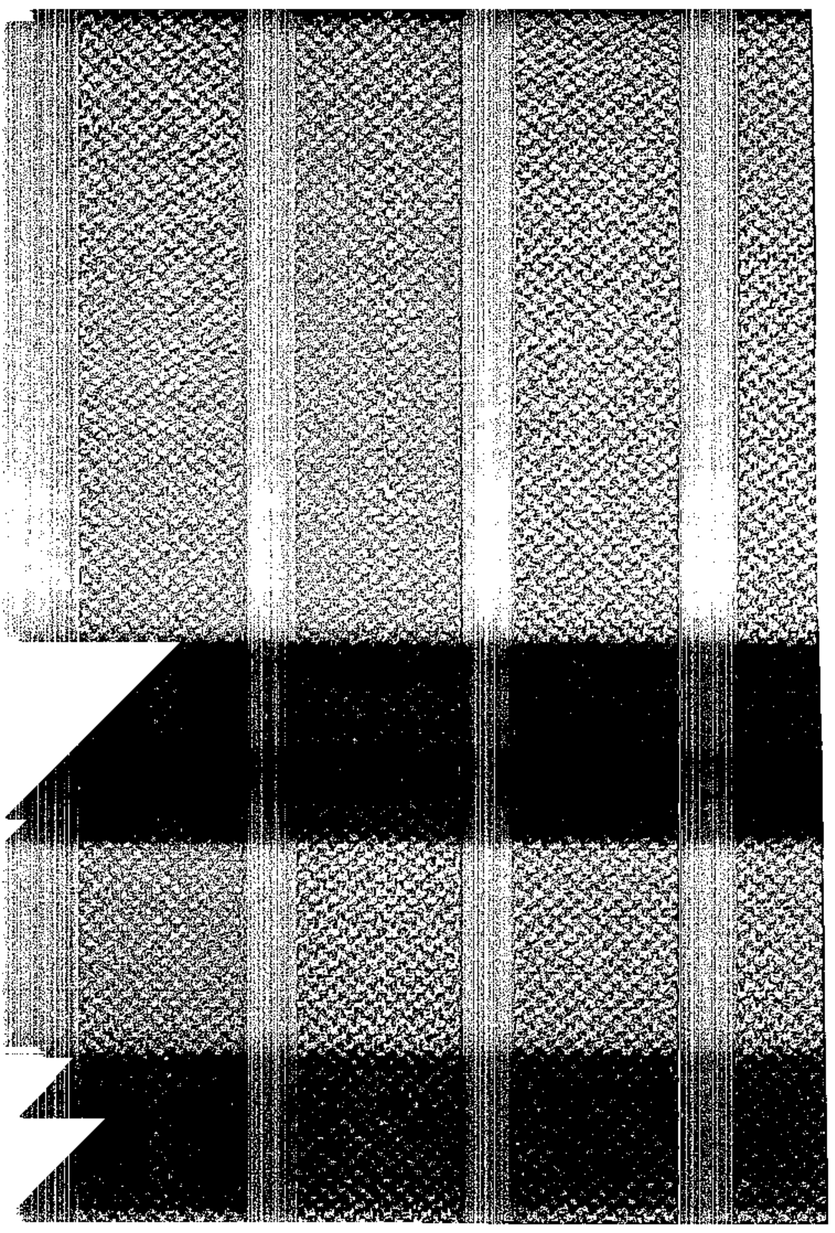
The judges said they liked the way the house nestled unobtrusively into its dense forest surroundings, with a zigzag wooden walkway leading down to the water's edge and plenty of open living area overlooking the spectacular view.

Second place was awarded to a house in Tiersboskloof, overlooking Hout Bay, and built for Mr R Pretorius.

Third prize went to a Fish Hoek home designed by Tom Smuts-Erasmus for the Davies family.

Special mention was made of a timber conversion to a shopping centre in Sedgefield.

While timber frame houses are not significantly less expensive than conventional brick structures, construction takes much less time, resulting in some saving in labour costs. The end result often has a warmer look to it than plastered brick. Timber extentions blend well with existing brick or stone structures.



NATURAL FIT: This award-winning timber frame home at Bushman's River Mouth, left, nestles cosily in its surroundings of dense forest. A winding wooden walkway leads down to the water's edge.

Physician, heal our health care

(85) ST 4/2/96

By PAT SIDLEY

RAYMOND "Bill" Hoffenberg left South Africa in 1968 "as sad as sad could be". He'd been banned in 1967 by John Vorster's government — which not only deprived him of a career at the University of Cape Town's medical school, but deprived the country of a top scientist and gifted teacher.

But now Sir Raymond Hoffenberg — the UK reaped the rewards of his talents and knighted him for his efforts — is back. He is part of a team of top academics asked by the Minister of Health, Nkosazana Zuma, to advise the Department of Health on dealing with medical schools and related issues.

Before he left South Africa he had chaired the Defence and Aid Fund, which helped political prisoners; had been a member of the Liberal Party; and had been involved in the National Union of South African Students — none of which endeared him to the National Party.

It didn't help that he unsuccessfully sued Vorster after the Defence and Aid Fund was banned under the Suppression of Communism Act.

Sir Raymond's friendship with Dr Zuma goes back 20 years, to her own hurried exit from South Africa and exile in Britain, where she trained as a doctor.

The team faces a set of vexed questions, including government threats to penalise "English" medical schools for producing students who emigrate, huge budget cuts to teaching hospitals in Gauteng and the Western Cape, the redeployment of interns to underserved areas, and forcing doctors to do two years of community service.

And the selection of students for medical schools will be made with a large dose of affirmative action. If early proposals are anything to go by, the process of selecting, training and placing doctors is due for a serious overhaul.

"We are exploring a common selection application form and a centralised office to handle all applications, as they have in Britain," Sir Raymond said.

Every applicant to every university would come to the same office and fill out the same application form, listing their choice of medical schools in order of preference.

The central office would handle the logistics but universities would retain full autonomy. Sir Raymond said. This would overcome the chaos in the present selection system.

He said a policy committee might be established to give guidance on such matters, and race and gender issues.

Would this not impede university autonomy? "Twenty percent of whites can't keep producing 80 percent of doctors. We must give people a fair chance," he said.

Sir Raymond said he had not heard of the threat by the director general of health, Dr Olive Shisana, to penalise the English medical schools. The issue had not been raised in two weeks of intensive discussion, he said.

However, he said medical schools were already being penalised for training doctors who left. In the past, the best students were selected to work in top hospital posts but "something's gone wrong".

He dismissed suggestions that students would be trained in such a way that they would not leave the country: "You could not possibly set out to train doctors in a way which would make them unacceptable elsewhere. No government would set out to train doctors to chain them to this country."

Training doctors in skills appropriate to the country's needs, however, was not a debate unique to South Africa, Sir Raymond said.

The debate was practically global and dealt with issues like whether doctors should be good physicists and chemists only or whether they needed communication and management skills too.

Doctors were probably not trained appropriately in the US, Britain or other countries, where there was an emphasis on hi-tech medicine.

"It's important to train doctors to communicate in a basic, non-authoritarian way."

Sir Raymond warned that the trend of good students leaving for the private sector or for overseas inevitably led to standards being threatened.

Role models and potentially good teachers were no longer there, which affected the quality of training and research.

The tough questions have to be asked and some of the uncomfortable issues tackled. Are the right students being selected? Are they being appropriately trained?

And the imbalances of apartheid have to be addressed.

When Sir Raymond was overseas he saw other countries trying to recruit South African doctors.

He said: "I was horrified to see the advertisements from England and the Middle East.

"England has a large number of doctors. To tempt away doctors from a deprived situation is deeply immoral.

"I don't believe that one should overlook the fact that these doctors are trained at public expense."

The advertisements provoked a letter of protest from Dr Zuma.

Sir Raymond trained as a physician and was held in high regard as a scientist, as a researcher and as a teacher.

His academic path in South Africa was interrupted by his banning order, but it continued in Britain. He became the president of Oxford's Wolfson College and the head of the Royal College of Physicians — which earned him a knighthood.

Although he did not take part in émigré politics, his friendships betrayed where his sympathies lay.

And despite the interruption to his career, Sir Raymond said his best achievement was "getting banned".

● Tonight in Cape Town Sir Raymond is to present scholarships in the name of his friend, the late Oliver Tambo, whom he befriended and treated in London in the exile years.

'To tempt away doctors from a deprived situation is deeply immoral. One should not overlook the fact that these doctors are trained at public expense'

STRONG MEDICINE . . . Raymond "Bill" Hoffenberg is part of a team tackling thorny medical issues Picture: CATHY PINNOCK

The Star ... Monday February 5 1996

Private immunisation schemes raise eyebrows

(85)

By Janine Simon
Medical Correspondent

Parents, doctors and the public are confused by the swift emergence of private vaccination companies, one of which is currently offering Gauteng parents the chance to vaccinate their primary school children against hepatitis B for between R80 and R140.

At least two independent companies offering mass immunisations in schools and other public places have sprung up since March 1995. One operates only in the Western Cape.

They aim to fill the gap between ideal immunisation programmes and what the Department of Health can afford.

In principle, private sector immunisation has the support of researchers such as Prof Barry Schoub, executive director of the National Institute of Virology, and Dr Rudi Eggers, Department of Health national immunisation programme manager.

Targeting schools is common in Europe, compulsory in Italy and recommended in the US as sound preventive strategy; schoolchildren are relatively accessible, and school immunisation is reliable and relatively cheap.

Worldwide, Schoub says, the focus on infant immunisation has resulted in a rising incidence of certain vaccine-preventable diseases in older children.

Young adults are also risk groups for many vaccine-preventable diseases, such as hepatitis B, through sexual activity.

But South Africa's health authorities are still scrambling to catch up with the private initiative.

The oldest of the companies, The Vaccine Bureau (TVB), has been involved in negotiations with various officials for almost a year. But guidelines on issues such as accreditation, and content of information letters supplied, will take several months to finalise, Eggers says.

Meanwhile, Gauteng parents are questioning the safety, cost and advisability of taking up the offer. And many doctors to whom they turn for advice are confused.

"We've had meetings, but we still don't know what state policy on this is. There are parents who can't put food on the table, feeling pressured to find R100 for a vaccine," said one irate Johannesburg paediatrician.

At this point only flu and hepatitis B immunisation is being offered, but TVB – which operates through local pharmacies and nurses – says it plans to extend its service to offer vaccines for measles, mumps, rubella, tetanus and meningitis.

Lots of changes as state gears up to implement primary health care

Star 6/2/96 (85)

Two key staff members from the Representative Association of Medical Aids (RAMS) are to move to leading private health-care concerns, as the private sector gears up to implement managed health care, and the State prepares to effect its primary health-care policy.

This week Professor Alan Rothberg, RAMS director of policy, joins Southern Health Care, a joint venture between Anglo American, Southern Life and American managed-health-care giant, United Health Care.

Caretaker of Rothberg's position for the next two months will be RAMS chairman of medical advisers, Dr Des Sonnenfeld.

RAMS executive director Reg Magennis, the voice of the private sector on the commission of inquiry into a new national health system, takes up a position with the country's largest medical aid administrator, Medscheme, at the end of March.

He is to be replaced by Declan Brennan, chairman of the AECI medical aid society. Brennan is also group manpower manager of AECI, chairman of the South African Chamber of Business (Sacob) health group and a member of the Council for Medical Schemes.

Magennis, who steered medical aids schemes through the deregulation of the last two years, says RAMS is now well positioned to move into its next phase. Both he and Rothberg had had several offers over the past few months.

"We've got a broad range of skills, and 'helicopter vision' of where reform is and should go in the private sector. The cutting edge is managed care."

More than R1 billion had been invested in new technology and systems for medical schemes over the past two years.

"Investors are serious about market share and survival in what promises to be a mother of all competitive battles in 1996-7," Magennis said. – Medical Correspondent.

Looming health policy announcement has tongues wagging in SA

Fears of higher taxation on middle income earners and of disappointment for disadvantaged may be unfounded, writes David Robbins

(85)
Star 6/2/96

Mark April 1 in your diary as the day when the next batch of announcements on health policy and its implementation are to be announced. No one knows for sure what the details will be, but there's a lot of guessing going on.

Listen, for example, to these disparate opinions:

■ "A small and already overloaded tax base will be expected to provide a free health service for the whole country."

■ "The idea of a national health insurance system (NHIS) will probably have disappeared under a welter of compromises."

The first opinion is usually voiced by someone from the middle classes, already paying through the nose for medical scheme membership and now fearful of having tax levels unmercifully increased to pay for free health care for all.

The second comes from people who entertained high hopes of immediately improved state services at the expense of those who have apparently been able to afford waste and over-provision endemic in the private sector.

The most interesting thing about both these opinions, however, is that they are in all probability equally inaccurate. But we need to go back to some of the basics to understand why. In broad outline, it's no secret that South Africa's new health policy is about transforming an unequal and discriminatory system to one of equity and accessibility. This means providing the same chance of the same basic care (whether preventive or curative) to the inhabitants of remote rural villages and well-to-do suburbs alike.

A lot of guessing is going on in lead-up to April 1

The framework of how this is to be achieved has already been laid down: there is to be an emphasis on primary health care (PHC) administered via the district model; and a shifting of resources from the urban curative centre to the periphery.

So far so good. All that remains is to decide how to finance the new policy. That, after all, is what all the speculation is about. Let's look at the possibility of extra or dedicated health taxes first. In June last year, when details of the new health policy were published in the Broomberg-Shisana report, it was estimated that an additional R9-billion would be required over five years. Even then, however, direct taxation was not put forward as a realistic solution, while there appears to be little chance of increasing health's slice of the general fiscus.

Alternative ways of coping with the shortfall will almost certainly be announced on April 1. These measures will probably include: donor and RDP aid for the capital costs of PHC expansion; increased managerial efficiencies at all administrative levels; more realistic cost-recovery pricing at public hospitals and the retention of hospital fees within the public health service; and the introduction of mandatory private insurance for a minimum package of hospital care.

So, health reform is extremely unlikely to force taxes up, although it needs to be added that tax concessions enjoyed on medical aid contributions will probably soon be revised. It's difficult to know which way these reforms will lead – what seems reasonably clear, however, is that some kind of concession will remain.

The anxiety of those who see a fully fledged NHIS going down the drain is, to an extent, understandable. It seems that private hospital insurance, paid for jointly by employers and employees not currently covered by medical schemes, is going to be introduced instead.

Is this a serious deviation from earlier stances taken by the health department or the ANC?

In April 1990, the Maputo Declaration laid down guidelines for the ANC for transforming the existing health services in South Africa into a national health system in which (it was implied) the state controlled both the financing and delivery functions. By 1994, the ANC's health plan was suggesting an NHIS which could be funded and administered in a variety of ways, including by making use of the infrastructure and resources already existing in the private sector.

Clearly, this is what is going to happen.

Reg Magennis, executive director of the Representative Association of Medical Schemes and a member of the Shisana-Broomberg committee last year, talks of the eventual merging of the private and public sectors into one composite health system.

"This merging has already started," he says. "While the public sector is attempting to curtail spending on tertiary care and redistribute resources to primary care, the private sector appears to be doing the opposite by placing limits on basic care delivered through general practitioners and pharmacies, and increasing cover at the secondary and tertiary levels."

'Don't send half the interested parties running'

These complementary processes, explains Magennis, will be given additional momentum when the state uses private insurers to cope with the costs of hospital care while it concentrates its basic fiscal resources on cost-effective PHC.

"It seems clear that this amalgamation of private and public sectors is the course which the health department is embarking on," says Magennis. "It's certainly a course which makes maximum use of all our resources in the evolution of an affordable NHIS in South Africa."

Evolution is the operative word here. It implies gradual change rather than one explosive transformation which sends at least half the interested parties running for cover. Seen against this background, April 1 will be just another stage in the process, rather than a blinding flash of light. Almost certainly, it will be implementation time for free PHC at district level, a process which will require great attention to detail and a steady nerve if it is to succeed.

Attention will probably also focus on the inevitable regulation of the private sector. It's fascinating to see that the previous villain of the piece (the private sector was often blamed for perpetuating the health care inequities of apartheid South Africa) is now being accepted as an important player in universal provision. Naturally enough, though, this acceptance will be coupled with rigorous safeguards in terms of how play will go forward.

Taken overall, the taxation fears of the middle classes and the disappointments of those wishing for genuine equity in health provision should both be at least partially alleviated.

True, individual employees and employers will have to pay for the hospital package; and hospital care for the unemployed will remain the responsibility of the state.

Nevertheless, the gradualist and pragmatic approach which now appears to be emerging will probably be affordable in the short term and sustainable in the future.

Tea packaging company to take Manuel to court

Susan Russell BD 7/2/96

A TEA packaging company is taking Trade and Industry Minister Trevor Manuel to the Constitutional Court next month over legislation which forces them to purchase a quota of the locally grown product before they will be considered for a tea import licence.

YNUICO, which blends and packages tea under the name Red Label Tea for what the company describes as the "price-conscious consumer", are challenging section 2(1)(b) of the Import and Export Control Act which stipulates that tea companies must buy a pro rata percentage of the local product if they wish to apply for an import permit.

The company contends that implementation of this provision in this way violates section 26(1) of the constitution which guarantees the right to "freely engage in economic activity".

YNUICO also contends that the use of the word "freely" in section 26 must encompass the common law right to do so without unlawful interference. According to the company, section 2(1)(b) of the Import and Export Act unlawfully limits the right to import goods and thus curtails the right to economic activity.

The case was referred to the Constitutional Court from the Transvaal Provincial Division last year after YNUICO had applied for an interdict overturning the minister's refusal to grant an import permit unless it bought a pro rata percentage of local tea.

The court will be asked to firstly consider whether, under the disputed provision of the Import and Export Act, there has been a lawful delegation of power to the minister. The second issue the court will be asked to decide is whether the local quota requirement is a reasonable and justifiable limitation as envisaged by the Constitution.

YNUICO claims the provisions of section 2(1)(b) do not empower the minister to impose qualifying conditions to obtain a permit, but that any conditions he may wish to impose must form part of the permit.

Among the reasons advanced by the minister and his corespondents in the original court application justifying the implementation of a local quota requirement was that 18 000 people in rural areas benefited from SA tea estates through employment and ancillary benefits.

Big boost for SA health management

Kathryn Strachan BD 7/2/96 (85)

THE US-based Kaiser Family Foundation and the University of Cape Town have announced the creation of a major new programme aimed at promoting leadership and vision in SA public health management.

To be called the Oliver Tambo Fellowship in Health Leadership, this new initiative will annually allow 20 senior-level managers in the national and provincial health administration to participate in an intensive 18-month training programme.

The programme will be designed and administered by UCT's department of community health in close conjunction with the health department.

The foundation has provided an initial grant of R1,6m.

The goal of the programme is to create an opportunity for those earmarked for senior ranks of government's health administration.

It will not only help in the current transition in the SA health system, but is intended to provide an institutionalised base for health management and leadership development over the long-term.

The programme will combine both SA and international expertise to focus on topics such as change management, public health financing, public policy analysis and creative problem solving.

UCT vice-chancellor Stuart Saunders, said the programme would make a significant contribution to SA health management.

Since the inception of the foundation's SA programme in 1987 it has committed R110m to support efforts establish an equitable health system

Report on market fraud is due this week

Theo Rawana (38) BD 7/2/96

THE investigation into alleged wide-scale fraud and corruption at the Johannesburg Market was complete and a report would be handed to Greater Johannesburg Transitional Metropolitan Council CEO Nicky Padayachee by Friday, the Gauteng provincial auditor's office said yesterday.

The report was expected to be made public after Padayachee had seen it and discussed it with his council, said Shauket Fakie of the Gauteng provincial auditor's office.

The matter was referred to the auditor-general's office in October after council executive committee chairman Colin Matjila and Padayachee were handed a document in which independent investigator Bart Henderson reported "an under-recovery of R400m in under-the-counter cash sales".

The auditor-general's office informed the council last week that the investigation was progressing satisfactorily and that the report was expected to be released on Monday this week.

Fakie said the field work had been completed and his office was "tidying up" the report before handing it over to Padayachee.

Padayachee was expected to report to the auditor's office, and if no adequate steps seemed to be taken, "we will include it in our own financial report in April on how things went — to make the public aware", he said.

Padayachee had been phoned, Fakie said, and the office hoped to discuss the report with him on Friday.

"We will give him time to respond."

First aid needed to rescue health care reforms

Policy-makers must go for small, effective changes instead of a grand plan, writes Jack Bloom

Star 8/2/96

Government policy-makers face a major decision in the 1996/97 Budget concerning the funding of the proposed National Health Insurance System.

An estimated R6-billion is needed over the next five years for the envisaged expansion of primary health-care services.

Options such as a dedicated payroll tax or a levy on medical aids are inescapably an extra tax on the economy with negative effects on fiscal discipline and growth.

Surreptitiously or otherwise, the temptation is to appropriate the resources of the private health sector, with extensive cross-subsidies that will hit the already hard-pressed middle-income earner.

Health department proposals endorse a partnership between the public and private health sectors, but ignore the key issue as to "who swallows whom?"

Either we have creeping socialisation of our health sector, or the more desirable alternative which relegates the Government as funder of last resort as the non-state health sector steadily expands.

The real problem is that over-zealous reformers have their eyes set on a "grand plan", foolishly overestimating the limits of Government to achieve change in a highly complex, sensitive sector.

Far more could have been achieved by focusing on a core of achievable objectives – doing a few things right, rather than many things inadequately.

The real basics are realistic salaries for professional medical personnel in state hospitals, genuine managerial autonomy for these hospitals, and devolution of primary health care to local authorities, reducing fragmentation and duplication of resources.

Slow progress in these areas is arguably attributable to the ideological drive for comprehensive transformation, rather than more realistic incremental change in the existing system.

The unrecognised disaster is that of rapidly collapsing regional hospitals which have suffered most from budget cuts.

Attention to this key intermediate level of our health system would pay real dividends in ensuring that only patients requiring specialist care are referred on to the expensive academic hospitals.

Lack of attention to the basics has contributed to the extremely harmful labour unrest in our hospital sector.

Unhelpful statements such as threats to cut funding to English-speaking medical schools and enforce compulsory rural service have added to the climate of uncertainty and loss of skilled personnel.

The Government proposal for mandatory health cover for a defined hospital benefit package of core services for all those in formal employment has massive implications.

It would be preferable to have mandatory insurance for a minimum financial level topped up where necessary for the poor.

This would maximise consumer choice and discretion, which would in turn encourage cost containment.

As is pointed out by health economist Duncan Reekie, an approved list of diseases, remedies, conditions, or age groups which would qualify for "free" state provision removes choice from the individual.

Our present limited system of free health care urgently needs a rethink to include some form of nominal payment, especially for medicines. User fees are not exclusively a tool to collect revenue, but serve to discourage the culture of entitlement and unnecessary demand for services.

Diminishing the role of Government could be achieved by appropriate deregulation which stimulates innovative responses by the private medical sector.

The health status of our nation depends far more on an economy that provides clean water, electricity, sanitation and housing to the broad mass of citizens, rather than being drained by unproductive government expenditure on health and welfare.

■ *The writer is the Democratic Party Gauteng spokesman for health. The article is based on a speech he delivered at the sixth annual health-care structure conference last week.*

higher gold price had still to filter through to the rest of the economy.

But this growth rate was not nearly enough to dent ballooning unemployment — the chamber expected the number of formal employment opportunities in SA to grow by less than half this year's new job hunters.

It expected the economic climate to be ripe for an interest rate cut by about mid-year — particularly if the Budget reflected a continued firm commitment to fiscal discipline and if the rate of credit extended to the private sector slowed. There were already signs that most consumers had reached their borrowing capacity.

It appeared government's attempts at fiscal discipline were being stymied by its efforts to consolidate the finances part of the country.

Divisions over health compensation

John Dludlu (85) BD 8/2/96

OFFICIALS from Mpumalanga, Northern Province and Northwest were yesterday divided over plans by Gauteng to seek compensation for health care provided to their citizens.

Northwest health department spokesman Aubrey Fenne denied talks had taken place with Gauteng, saying there was no agreement on compensation. Gauteng finance department said yesterday it was negotiating with the provinces for an arrangement that would see Gauteng being compensated for all patients formally referred from hospitals in the provinces.

Gauteng said a draft report of a study commissioned with the three provinces showed that formal and informal referrals cost about R180m.

Mpumalanga government spokesman Oupa Pilane confirmed his province had participated in talks on compensation, but the region felt the scheme could not work. He said his government had a problem with direct inter-provincial compensation.

However, Northern Province finance spokesman Simon Matome confirmed that agreement in principle had been reached for compensation on various services, including health.

The finance department's deputy director-general for inter-government and auxiliary services Flip Rademan said the national treasury had agreed to the concept, but this would be done without involving state expenditure.

The matter was discussed at a meeting of the technical committee on finance, in which all the provinces and the central government were represented, held on January 23.

Financial and fiscal commission chairman Murphy Morobe did not feel compensation arising from consultation would distort budgetary formula.

Business, labour square up to do battle on VAT

BD 8/2/96

Greta Steyn

THE VAT battle will kick off in earnest today when Finance Minister Chris Liebenberg and his deputy Alec Erwin attend a discussion in the National Economic, Development and Labour Council on tax issues in next month's Budget.

Business and labour are expected to table submissions for debate. While government is not likely to take a view, it is understood it wants to test the water for labour's resistance to a VAT hike. Economists expect government to raise the rate by one percentage point to help bring down the fiscal deficit.

Business is expected to call on government today to raise VAT to help finance a drop in corporate taxation, as well as personal income tax. It is expected to argue a hike in VAT cannot be postponed any longer, because of the need to encourage investment.

The business constituency's argument rests heavily on the belief that lower direct taxes will generate a sustained increase in economic growth — and therefore in employment. This should offset the negative effects on the poor of a higher VAT rate. Business also believes the increase can be made more palatable if government can demonstrate the extent to which spending has already been reorientated towards the reconstruction and development programme.

Business representatives are also expected to emphasise the need for government to stick to its commitments of a continued reduction in the deficit, a tax burden of no more than 25% of GDP, no increase in real terms in recurrent spending and a gradual elimination of government "dissaving" — the practice of using long-term loans to finance consumption spending.

John Dludlu reports that business and labour are also expected to respond to government's proposals on supply-side measures.

Government issued a discussion document in November calling for a possible introduction of tax-based incentives for investment and training. It also outlined incentives for work organisation, industrial development finance, technology enhancement, productivity improvement and small business development.

In its initial response, labour expressed disappointment at the document's narrow focus, mainly because it excluded the mining and agricultural sectors.

Government has said the measures will be financed from savings on the general export incentive scheme which is to be terminated next year, but numbers have yet to be discussed.

Nedlac officials said issues such as "investment incentives, sensitive industries and training" would be on the agenda at today's meeting, as would progress reports on the social clause and on the Social Plan Act.

Schools are the key to community health

(85) CT 9/2/96

THE health of communities is set to improve dramatically if an initiative to transform South Africa's 92 000 schools into health promoting centres succeeds.

"We call it the trickle-up effect," says Australian health promotion expert Phil Williams, who has extensive experience in setting up similar models in his home country.

He is involved in a parallel project to link health facilities already in place in privileged or organised schools, and to set up inter-departmental structures to provide an official infrastructure for the scheme.

If all goes according to plan, the two projects will eventually merge to realise one of the most profound effects yet on the grossly unbalanced provision of health — through the schools.

It would also ensure that development around health is centred on children, society's most vulnerable, in a way that directly involves and benefit both them and their parents.

Williams is in Cape Town on study leave, and is attached to the Medical Research Council. Last month he was one of the main speakers at a conference on Health Promoting Schools at the University of the Western Cape.

Williams is now interviewing people to allow him to assist in drawing up a proposal for the state's crucial involvement in the scheme.

He is also assisting with the school-community-professional network in the Western Cape, which will serve as a pilot project for the rest of the country.

He outlines the concept of Health Promoting Schools (HPS):

"Whatever the school does is orientated towards the health of its students, and it involves not just a health education curriculum in the classroom, it involves also the physical environment of the schools ... having clean grounds, where garbage is collected, and where there is good sanitation and water, and so on.

"It also involves the social environment of the schools ... the relationships that students have with each other, with their teachers, and, importantly, with the community, as well as the parent interaction within the school.

ANEEZ SALIE
HEALTH WRITER

"The other area is the creation of health services at the schools."

Williams says the concept has developed because research has shown that health education alone is unlikely to make a major impact on students' behaviour.

"But where that health education is supported by environmental change, it is more likely to be effective. This is the trend in health promotion generally.

"Schools are central to communities, and they can be used to effect change in the community. We call it the trickle-up effect."

Williams issues a warning, however: "While there is a lot of interest and pressure from the health and welfare sectors for schools to do more, just as in Australia, the morale of teachers is low at the moment.

"Teachers are actually being asked to do more and more with fewer and fewer resources."

Williams says South Africa is in a very good position to develop HPS because the country is in a stage of transformation.

"At the schools we were at this week in Mitchells Plain, I saw lots of evidence that things were already happening. There was change ... there was a nice tone in the school. The teachers seemed to be very caring towards the children. In the playgrounds they had planted some nice trees, and generally, things were going on.

"The will and the optimism is really quite startling."

Williams says one of the things that has struck him most forcefully about the South African situation is the huge disparity in incomes and the inequality in health status of communities. He called on schools at the top-end of the market to redistribute their resources to their poorer counterparts.

Williams is a senior lecturer in public health at the University of Newcastle in New South Wales. He began his career as a schoolteacher.

The Star ... Thursd

Star 11/2/96

Initiation rites look to Western medicine

85

Grahamstown – Thanks to a woman's touch, modern medicine is set to alter forever the ancient Xhosa rite of passage to manhood.

In parts of the Eastern Cape, assegais are being traded for scalpels while bark and leaves, traditionally used to dress the wounds of the circumcised initiates, or *abakhweta*, are making way for bandages.

The move to Western medical procedures follows increasing reports of the alarming number of boys mutilated during circumcision, a rising death toll among *abakwetha* and the increased risk of Aids.

In a nine-month period up until March last year, 34 Eastern Cape initiates reportedly died, 13 suffered organ mutilation and a massive 743 were treated in hospitals for septic wounds.

The same report said six *abakwetha* died and 70 were admitted to Eastern Cape hospitals between December 1994 and January 1995 alone.

The provincial government was so concerned that it established a traditional circumcision task team to investigate procedures and make recommendations.

"It is the women who are insisting that the boys be examined before they go into the bush," said Dr Menzeleleli Msauli, head of the circumcision sepsis prevention and intervention programme unit at East London's Cecilia Makiwane Hospital.

Not surprisingly, one of those who initiated major changes to surgical procedures among traditional surgeons (*ingcibi*) and traditional attendants (*ikhankatha*) in Port Elizabeth's sprawling Motherwell township was a woman.

ANC Women's League regional secretary Dr Mamisa Nxiweni said she was spurred into activity in 1991 with the increasing number of post-circumcision patients visiting her Motherwell surgery.

Old ways die hard but some things are changing

Armed with her medical background, Nxiweni set about developing a strategy with the Motherwell community development forum to woo traditional surgeons into adopting more sterile practices.

"Initially it took a while to win them over but, after a lot of discussion, they began to recognise the problems. Subsequently, an association of traditional surgeons and attendants was formed in Motherwell," she said.

Being a woman, a male doctor was called in to take the discussions further with the *ingcibi* and *ikankatha*. Finally, a code of conduct was agreed on, seminars and workshops were conducted, and the association accepted the changes from assegai to scalpel and leaves to bandages.

Working under the motto "one blade, one boy", the association boasted not one casualty among the about 500 *abakwetha* who passed through the sterile hands of the surgeons last year.

"Now we are trying to establish a broader association for the whole of the Port Elizabeth area to bring traditional surgeons in other parts of the city in line with these practices," Nxiweni said.

Last year the Port Elizabeth municipality introduced a policy at clinics to encourage the medical screening of boys before they go to the bush.

According to the municipality's acting medical officer of health Dr Joseph Sepuya, "traditions die hard, but some things are beginning to change". – Ecna.

Health leadership plan

(85) ARG 12/2/96

Health Reporter

A NEW programme to promote leadership and vision in public health management has been set up at the University of Cape Town's Community Health department.

Called the Oliver Tambo Fellowship in Health Leadership, the programme will train 20 senior-level managers in national and provincial health administration in an intensive 18-month training programme.

The programme has been financed by a R1,6-million grant from the Kaiser Family Foundation and will focus on change management, public health financing, public policy analysis and creative problem solving.

The programme has been named after the late Oliver Tambo for his commitment to the training and promotion of South African leaders.

Conference highlights treatment from afar

(85) CT(BR) 13/2/96

BY JOHN FRASER

Brussels — Patients in a rural veld clinic will soon have their health problems diagnosed by a top doctor in Gauteng — across a TV link.

The dramatic project is being planned for a conference organised by the South African government in May that is being sponsored by the EU.

The gathering, called Telematics for Health and Disabled and Elderly People, will bring together several hundred health experts from South Africa, Europe and the rest of Africa.

It will focus on the way in which new technologies have made possible long-distance medical diagnoses, treatment and even surgery.

It will also look at the way new technologies can help the elderly and the disabled.

Just last week, a Belgian doctor in Bruges carried out a hernia operation on a patient more than 100km away in Holland — across a video and computer link.

This sort of remote-control operation, which the Belgians said was a world first, could become commonplace in the future.

However, in the immediate future South Africa will benefit from linking up doctors, clinics, hospitals and planners through a sophisticated computer system.

"It is critical for South African planners to install a national health information system," said Chris Hugo-Hamman, the South African medical attache in Brussels.

This would help planners and would lead to savings of R30 million to R40 million in the first year.

"Without full information it is impossible for planners and managers of health care to ensure that funds are spent in the right place and on the right things. This conference comes at the right time as it will enable key planners to discuss this revolution in tele-medicine and its importance."

The conference will be opened by Nkosazana Zuma, the health minister, and the EU's industry commissioner, Martin Bangemann.

The conference exhibition will show some of the results of the EU's research programme into the use of advanced technology in health care.

"There will also be a number of South African exhibits," said Hugo-Hamman. "It is important that a number of African countries will also be attending, because this technology will help them to leap up the development ladder and not have to crawl up."

He said that many of the technologies already existed.

"It is important to bear in mind that much of what we are talking about is not necessarily new technology, but rather the application of existing technologies," said Hugo-Hamman, who worked as a paediatrician in Cape Town before taking up his diplomatic job in Brussels.

"It is the application of those technologies to health where the challenge lies for South Africa." — Independent Foreign Service

Musical discord and unhealthy alliance

Star 15/2/96 (85)

By David Robbins
Health Writer

Publicity surrounding the play *Sarafina 2* highlights the sometimes awkward relationship between the Department of Health and its corresponding portfolio committee, says Health Writer David Robbins

The current publicity attracted by *Sarafina 2*, an Aids-awareness musical funded by the Department of Health, has highlighted the pivotal nature of the relationship between the department and its corresponding parliamentary portfolio committee.

The Sarafina debate revolves around the expenditure by the Department of Health of more than R14-million on a theatrical production and the determination of the Portfolio Committee to call upon the department to explain its actions.

The situation is still unfolding, but beneath it lie important implications for the development of democracy in South Africa.

Should the relationship between department and portfolio committee be co-operative and partisan, or should a certain tension exist between the designers and administrators' of health policy and a committee of parliamentarians, many of whom are not health experts?

Co-founder ... Director-General Dr Olive Shisana.

Political decisions ... Dr Manto Tshabalala.

Some observers say the committee is insufficiently informed to fulfil its role adequately. Committee members complain of high-handedness and lack of co-operation from the department.

Portfolio committees are made up of public representatives and form an essential ingredient in the democratic process. They are called portfolio committees because they correspond to the ministerial portfolios in the Cabinet. They exist primarily as watchdogs of the governing process. They are a conduit through which public opinion can impact on draft legislation emanating from this department.

The committee has already guided four health-related bills through Parliament, adding amendments which have improved effectiveness or at least brought this draft legislation more into line with the wishes of their broader constituency. For example, the inclusion of community representatives on the South African Medical and Dental Council is the work of a portfolio committee sensitive to the opinions of interested parties on the ground.

On the other hand, specific investigations, for example into conditions in certain Eastern Cape hospitals and the Medunsa training institution, came at a time last year when the Health Department had already taken such conditions into account and was busy implementing mechanisms designed to improve and rationalise the situation in the context of health care reform as a whole.

Such inputs by the committee, especially when they found their way into the media, could conceivably have been seen by the department as disruptive.

But the Department's Director-General, Dr Olive Shisana, says: "Our viewpoint is that portfolio committees are important watchdogs. We have an obligation to answer their questions, and we have always done this.

"If there is friction or tension between us and the committee, there certainly doesn't need to be. At the moment, the committee is ANC dominated. The minister, Nkosazana Zuma, is also ANC. What is this tension?"

Some observers say that a certain amount of tension can only be a good thing. The implication seems clear enough: if there's no tension between policy makers and public representatives, the democratic machinery isn't working as it should.

As Dr Manto Tshabalala, chairman of the Portfolio Health Committee, says: "We see ourselves rather as representatives of civil society. That means taking responsible political decisions to promote equity and access, especially for those who are marginalised."

Committees are watchdogs and may investigate any aspect of their portfolios' departments

Could this attitude be the root cause of the tension existing between the executors of new health policy and the elected representatives of the whole health constituency?

Tshabalala says: "The problem is the department's attitude to us. Of course, we have a lot to learn. Committee members are not necessarily medical people. For this reason it's doubly important to keep the committee fully briefed. But the department isn't doing this."

As an example, Tshabalala cites the importation of doctors (from Cuba and other countries).

"This is an important new policy. But we were given no foreknowledge of its implementation."

Tshabalala, a BA graduate and political activist from Fort Hare, did her medical training in Leningrad, afterwards returning to Africa to become one of the co-founders of the exiled ANC's health department in the mid-1970s. She says that she knew Zuma, now Minister of Health, "very well" when they were both in exile.

Tshabalala says she went to see Zuma early in 1995, "but our meeting did not solve any of the basic problems".

On many occasions, says Tshabalala, copies of policy documents have found their way to the committee via various non-governmental organisations rather than being received direct from the department. Letters complaining of this were sometimes ignored.

Shisana comments: "Is the committee's expectation that the Minister herself should provide the documents? I cannot understand why communication should be so poor. The portfolio committee is represented on the department's functions committee, so they have every opportunity of knowing what's going on."

No solutions ... Minister of Health Dr Zuma had "fruitless" talks with Dr Shisana last year.

But, several committee members have expressed unease, saying that their function is being impeded by the tension which exists between them and the department. It's anyone's guess whether the Sarafina affair will improve this situation.

It's difficult to ignore the health committee's efforts to take itself seriously. It was the only portfolio committee in Parliament to put out an annual report at the end of last year.

The committee has also used foreign funding to employ two researchers. Current research projects are examining school feeding schemes and nurses' unrest.

The committee has also recently undergone a training seminar in an effort to improve its understanding of the role it should be playing.

But, the question of co-operation remains.

I put it to Tshabalala and to Shisana: that an ill-informed portfolio committee could become prey to self-interested pressure groups intent on blocking health reform or manipulating other situations for their own benefit.

Both agreed. But just how far co-operation between Tshabalala's portfolio committee and Shisana's department can be developed before the former becomes a rubber stamp for the latter must be a consideration.

The days ahead may provide some interesting answers, not only in health reform but in the administrative accountability and democratic ways and means.

Health department in good shape despite budget cut

BD 15/2/96 (85)

Kathryn Strachan

THE Gauteng health department has succeeded in staying within its revenue allocation of R3,9bn this year, even though its budget for 1995/96 was cut 13%.

The province was allocated a budget of R3,5bn, but was kept afloat by an additional R550m gained from RDP bridging funds, salary increases and an anticipated payment from neighbouring provinces which refered patients to Gauteng hospitals.

Health department deputy director-general Dr Eric Buch said fiscal discipline and good management had enabled it to cut expenditure to R3,9bn without making any significant cuts in services and care.

The province is now planning a small cut in real terms in its 1996/97 budget.

It is beginning a strategic shift to strengthen primary health care and regional hospitals and, at the same time, to support academic hospitals.

The same gross amount as allocated last year is anticipated in the new budget.

The shift in focus will entail moving more than R100m into district health systems, building 16 new clinics, setting up eight new obstetric services in disadvantaged areas and developing ambulance services in squatter areas.

Redirecting these funds to primary health care will require a 10% cut in funds for academic hospitals. The department has set about finding areas where cuts can be made without compromising patient care.

An analysis of the spending patterns has highlighted many anomalies in hospitals' spending patterns, such as HF Verwoerd employing twice as many administation staff as any other hospital in the province and Johannesburg Hospital spending R200 more a patient per day on non-staff expenditure than HF Verwoerd.

The analysis also showed that in all hospitals, nurses carry the heaviest workloads.

The department has set up a strategy team with medical school deans and hospital superintendents to work out a rational post structure. For the first time, academics are being involved in planning hospital expenditure.

"The department cannot afford to provide hospitals with more nurses, but we can show them the areas where they can make savings and so free resources to employ more nurses," said Buch.

They are being encouraged to look at ways of making hospitals more cost effective by reflecting on their clinical practice.

One way of doing this is to invest in new technology, such as lasers, which in some procedures can replace open surgery and cut down significantly on the period a patient has to stay in hospital.

Aside from cost-effectiveness, the province has many projects for which it it needs funding, and has come up with innovative mechanisms to raise funds.

It needs an extra R300m to meet the huge repair backlog and remove the "apartheid face" from many of its hospitals, and it plans to do this by selling off the tracts of unused land surrounding hospitals to make way for housing.

To rectify the equipment shortage, the department plans to lease equipment instead of buying it. In this way hospitals can get four times as much equipment for the same money, without having to carry the cost of maintenance.

The province's fleet of 450 ambulances is decrepit, says Buch.

By leasing ambulances it will be able to have 150 new ambulances — five times as many as it would have had if it had bought them outright.

Most of the original 450 ambulances (many of which have been driven more than 300 000km) will be scrapped.

Buch estimates that with a fleet of about 200 ambulances the service will be far better because the old ambulances are sitting in repair shops most of the time.

A leasing arrangement will also mean a more appropriate vehicle will be guaranteed.

See Page 14

the US after the shows or the ceremony. Picture: ROBERT BOTHA

Problems in rationalising of Cape medical schools

BD 19/2/96

Kathryn Stracnan

WITH the Western C[illegible] get cuts leaving [illegible] for effectively [illegible] sciences complex. [illegible] Cape Town and Stellenbosch medical schools are having [illegible] two faculties of [illegible]

However, as the two faculties work out how they are going to share the various departments between the two campuses and their associated health facilities, differences are emerging. UCT believes it is the more established institution in terms of research and international standing, while Stellenbosch, which is beginning to make its mark on the global scene, wants to retain its identity.

"But," says UCT deputy vice-chancellor Prof Wieland Gevers, "the two universities have to face up to the resource questions and find [illegible] preserve the excellence [illegible] Cape as a health educational [illegible].

Stellenbosch University rector Prof Andreas van Wyk said the two academic health complexes served very different areas, with Stellenbosch providing for the northern peninsula and right up to the Orange River, while UCT's services extended through to the Eastern Cape. The two also had different "corporate cultures", he said.

"But if we handle it correctly and if there is close co-operation, we will both come out the better for it," he said.

The two medical schools and the regional health department have agreed on a mechanism involving a committee and task groups which would assess the strengths and resources of departments, and decide on the most rational proposals for the services and associated teaching and research activities.

With the expansion of the primary health approach, students from each faculty would, in any case, be travelling to peripheral facilities and possibly to each others' campuses when the rationalisation was complete. Students from UCT, Stellenbosch and those studying health sciences at the University of the Western Cape were likely to have access to the same distributed facilities, but would graduate at their home universities.

The Western Cape has to scale down its academic hospitals by 25% over the next five years. However, Gevers believes budget pressure is being exerted too quickly. The institutions must have sufficient time to produce a result, which can provide the services and educational facilities needed, he said.

Soldiers to be recruited into the SAPS

BD 19/2/96

Wyndham Hartley

CAPE TOWN — The SAPS is planning to recruit members of the SANDF to strengthen its public-order units, Safety and Security Minister Sydney Mufamadi said.

Mufamadi said he had already held talks with the defence ministry over possible transfers of personnel. He said the French government would be assisting with the retraining of any soldiers that transferred to the police.

The French had considerable experience in retraining soldiers to do public-order policing he said.

Increased manpower in the patrolling of SA's borders is also needed, Mufamadi said, because it had to be ensured that the extensive border was properly policed.

Also due for an injection of manpower is the police intelligence arm, the minister said. He pointed out that accurate intelligence was having an effect on controlling crime syndicates of carjackers in Gauteng. He said all the police work was based on intelligence and relied on the national intelligence agency for assistance.

Community's health workers bring hope to a valley of despair

BD 22/2/96 (85)

Kathryn Strachan

IN KWANGCOLOSI, a tribal area deep in the Valley of a Thousand Hills, Abigail Bhengu, a community health worker, explains the damaging effects of alcohol to a group of people gathered in a dilapidated school building.

With the high unemployment rate and the extreme poverty of the community living in the valley's rugged terrain, alcoholism has emerged as one of the main problems disrupting family life. And the community health workers, or "mpilo" as they are known, have set out to tackle the problem by setting up support groups.

Living in the midst of the community, they are known and trusted, and when they detect drinking problems in their routine primary health care visits to homes in their neighbourhood, they encourage people to join their group.

"It hardly ever happens that a person with a drinking problem doesn't want to talk," says Abigail. "We stay with the people so they know us; it's not like an outsider coming in."

Within the group, people share their experiences or they are counselled individually, and if it is necessary they are referred to a clinic.

Amanda Shembe, a postgraduate psychology student, teaches sex education and life skills at Kwabazothini. Picture: KATHRYN STRACHAN

Sex education

The health workers have been trained in counselling as part of the community mental health programme run by the University of Durban-Westville, which aims to identify psychological problems at a lower level through integrating mental health into primary health care. Another aspect of the programme is sex education and support groups for teenage mothers.

Teenage pregnancy has been identified as the other major problem contributing to the turbulence in people's lives, both because of the stigma and because of the difficulties associated with raising a child.

At Kwabazothini High School, the Std 6 class discusses sex and relationships: "They tell us what they need to know ... this is the first time they are in an environment where they are free to talk about it," says Amanda Shembe, one of the students at Westville teaching the programme. After the class, the teenage mothers at the school meet Shembe and share their problems. And for those who have dropped out of school, the "mpilo" bridge the gap, providing sex education along the lines of a manual drawn up by the programme.

Inge Pietersen, a programme lecturer and co-ordinator, explains how the project is trying to develop a model of mental health care at district level.

It starts by determining the extent of mental health problems in the valley, and then develops strategies to restructure the health system and train primary health care workers in the area, so they can deal with mental health problems.

Lecturer Yogan Pillay says once the prevalence of mental illness is known, it is possible to find out whether an intervention has worked.

The epidemiological study found that outpatients with psychological problems came to clinics complaining of aches and pains, rather than expressing their feelings.

This trend shows a need for primary health care personnel to be trained in identifying underlying psychological problems, and in providing counselling. This would also relieve the health system of the cost of inappropriate diagnoses and interventions.

Severe cases are referred to hospital, and those with less serious disturbances do not get dealt with at all.

"The current system has big holes and leaks badly," says Pillay. "Many potential patients fall out of the system or don't get into it at all."

Traditional healers and priests play an important role in counselling. The researchers are trying to build links with them, and with a range of non-governmental organisations, to create a complete network of referral and support for people with mental health problems.

Symptoms

A similar initiative is being run at Khayelitsha, outside Cape Town. A survey by the University of Cape Town medical school showed that 64% of children between six and 16 had one or more symptoms frequently associated with psychiatric disorder.

Karen Ensink, a researcher at UCT's department of psychiatry, said that even if primary care mental health services were developed, it was likely only the most severe psychiatric disorders would be identified and treated at clinics.

A great many children "at risk" or "marginalised" would still be overlooked, she said.

These problems needed to be dealt with in a preventative way from within the community — and a community mental health worker who could treat cases and refer onward those in need of psychiatric services was the solution.

This was the beginning of the Empilweni (Place of Healing) Project which trains community mental health workers who, under supervision by psychologists, are able to treat about 95% of children and adolescents they see. The rest are referred to psychiatrists.

After six months of intensive training, the community mental health workers had the counselling skills and enough psychiatric knowledge to take on most cases of mental problems. These ranged from depression, anxiety and mental handicap to sexual and physical abuse. Many children, especially girls, drop out of school early, and one of the spin-offs of the project is that it has been getting children back to school.

There are a large number of children who have developed severe antisocial behaviour, and a group run by a community member has been set up to provide counselling and support. A group for moderately handicapped children is run with the aid of community members, parents and teachers.

The aim of the project is also to provide counselling and support to families, and to educate the wider community about mental health problems in disadvantaged areas.

The project has found that community mental health workers are more in touch with problems, there are fewer barriers and they are in a better position to play a preventative role than are clinically based psychiatric nurses.

To reach the community, project members drive through the township with a loudhailer, telling people about the service.

Many referrals are from schools and welfare services. The community health workers are also able to help those who have fallen through the welfare net because they did not have the necessary documentation to apply for grants.

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BD 22/2/96 (85)

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Minister faces grilling over R14m play fiasco

By IVOR POWELL

A PRELIMINARY audit by the Department of Health has failed to account for more than R1-million allocated to the playwright Mbongeni Ngema's controversial AIDS play, *Sarafina 2*.

Sources in the department said the audit indicated that not all of Ngema's expenditure on the play could yet be accounted for.

The Minister of Health, Dr Nkosazana Zuma, will face tough questions on Wednesday when she faces a hearing of Dr Manto Tshabalala's parliamentary portfolio committee on health into the R14,27-million sponsorship.

The sponsorship sparked off widespread controversy and protests by health workers.

The uproar over the funding of *Sarafina 2* deepened this week when the European Union ambassador denied EU funds had been allocated to the play. The Health Ministry has insisted that the money allocated to Ngema came from an EU grant.

The Sunday Times has also learnt that the decision to fund the project was taken while the head of the ministry's AIDS directorate was out of the country.

This week's hearing could see senior ministry officials sacked from office.

"If it is proved that money has been misallocated or that the proper procedures have been flouted, we will certainly call for action to be taken," the health spokesman for the Democratic Party, Mike Ellis, said.

President Nelson Mandela met Dr Zuma last week shortly before she was scheduled to appear before the parliamentary portfolio committee.

NKOSAZANA ZUMA

He then summoned Dr Tshabalala and the meeting was called off. Mr Mandela met ANC portfolio committee members the next day in a bid to resolve the crisis.

This week, after pressure from other parliamentary parties, it was announced that Dr Zuma would be called to appear before the committee.

The EU ambassador, Irwin Fourere, this week denied that EU funds had been authorised for Ngema's play.

"We have no record whatever of Ngema's play among the projects we have agreed to finance," Mr Fourere said. He said the EU had earmarked R48-million for AIDS awareness, but insisted there were stringent checks and balances in place to ensure that the money was properly used.

"We have itemised budgets, listing every project and activity that the EU is supporting. An AIDS theatre project is not among them, nor was *Sarafina 2* ever discussed with us as it would have had to be," he said.

Meanwhile, sources in the Health Department told the Sunday Times that a preliminary audit by the department's finance directorate suggested that, of the R9-million already paid out to Ngema, more than R1-million had yet to be properly accounted for.

Ngema is due to get another R5,27-million as a proposed nationwide tour gets under way.

The audit could lead to the plug being pulled on the project. Dr Zuma has assured health workers that, should irregularities be detected, she will not hesitate to institute criminal proceedings.

Meanwhile the Sunday Times has learnt that some members of the cast are being paid only a fraction of the amount allocated for staff salaries.

According to the budget submitted as part of the tender requirement, members of the "chorus" would be paid R700 a week, while principals would get R2 000 a week and sub-principals R1 200.

Other questions on Wednesday may centre on the absence of the director of the AIDS directorate, Quarraisha Abdul Kareem, from a meeting last August at which Ngema's tender was accepted. Sources said Ms Abdul Kareem learnt of her department's sponsorship of the play only in November.

Sarafina 2 attempts to use the Ngema formula of music, dance and dialogue to promote AIDS awareness. But the play has not been well received by health workers and critics.

The show is supposed to tour nationally for a year, but so far it has had only limited exposure, with a handful of performances in and around Durban.

Though repeated attempts were made this week to contact both Dr Zuma's spokesman at the ministry and Ngema, neither was available for comment.

Health-care workers risk injury

~~1994~~ 85

At least 170 South African health-care workers were injured on duty at hospitals last year, a National Occupational Safety Association (Nosa) study has found.

Back and hand injuries were most common, at 38% and 39% respectively.

Increasing demand for health-care services, and nursing and medical staff shortages, increased the risk of injury, says Nosa's occupational health consultant Nell Browne.

Nosa has since launched a programme to help hospitals, clinics and medical stations maintain a safe and healthy working environment. – Medical Correspondent.

Istar 28/2/96

Health ministry for delivery?

Many people are being consulted on the development of health policy

THE DEPARTMENT OF HEALTH has during 1994-95 put tremendous effort into the implementation of the RDP Presidential Lead Projects, which include free Health Services to children under 6 years and pregnant women, the prevention of HIV-Aids, the clinic build programme and the primary school nutrition programme.

These projects are already under way and the department is committed to taking them further to ensure health care is accessible to all the people of South Africa, especially the disadvantaged.

Free Health Care

The policy of the provision of free health care for pregnant mothers and children under the age of 6 years was implemented immediately after it was announced by the President in 1994. This project is highly appreciated by the disadvantaged and proved that the fee for service system actually prevented a substantial number of people from having access to health services.

The inability and unpreparedness of hospitals and clinics to deal with the influx of patients created problems for providers and consumers.

But when the redistribution of resources to the PHC level takes effect,the congestion of the services should be relieved.

Prevention of HIV-Aids

The HIV-AIDS and STD Programme has identified five key strategies for *1995-96. Two of these strategies are:*

Increasing access to barrier methods and the use of mass media to popularise key prevention concepts in Aids.

Ninety seven million condoms will be procured for the 1995-96 financial year.

About 17 million condoms have already been procured, of which 12 million have already been distributed. Over 300 billboards bearing HIV-Aids messages have been contracted and [illegible] township, central business districts and airports.

[illegible] billboards are paid for by the Department of Health and the remaining 100 are sponsored by the rental agencies. Over the next 14 months, Sesotho themes will be utilised.

This will form the backdrop of other planned media activities such as posters, TV and radio spots, and provincial activities from within and outside of government.

R90 million for clinics

To date, R90 million has been allocated from the RDP fund (R25 million in 1994-95 and R65 million in 1995-96) for the National Clinic Upgrading and Building Programme (CUBP).

A total of 173 upgrading and building projects have been approved which account for 98 percent of the 25 million component of the allocation.

A programme for site identification, selection of clinic options, tendering and the construction of clinics has been prepared.

This programme confirms the feasibility of completing the required number of clinics within this financial year.

Nutrition Programme

The primary school nutrition programme (PSNP) was implemented on September 1 1994 following the announcement by President Mandela in his State of the Nation Address on May 24 1994.

It was one of the Presidential Lead Projects intended to lead the nation into the Reconstruction and Development Programme (RDP).

The PSNP has had to operate with insufficient finances, a shortage of staff and a lack of clearly defined policies and strategies.

The uncertainties related to this have had a negative impact on continuity, staff commitment and morale.

The lack of clarity in the responsibilities between the provinces and the national office has also led to confusion.

While the Department of Health acknowledges the problems associated with this programme, there have also been a number of positive aspects.

The programme has been operational in all nine provinces, feeding 5 million children in 14 000 schools. With the recent suspension of the programme in the Eastern Cape Province, it will now be operational in 8 500 schools, feeding 3,1 million children.

Policy development

Shortly after assuming office Dr Nkosazana Dlamini-Zuma appointed a number of expert committees to develop policy proposals that would form the basis of discussion and consultation.

The consultative process around the development of new policies are in its final stages. A wide range of stakeholders are being consulted on the development of health policies. Some of the policies being developed are in the areas of:

Human resources – developing a national drug policy – developing a national health information system - developing an integrated nutrition strategy, child and Women's health.

Human Resources

In order to develop health workers who are caring, well trained and efficient, the Department of Heath adopted a policy that will guarantee all South Africans access to skilled

Minister of Health Dr Nkosazana Zuma.

profes[illegible]nals.

Human resources will be developed through:

- Utilising skills and expertise of all health personnel to ensure maximum coverage and cost-effectiveness;
- Distributing health care personnel in an equitable manner;
- Implementation and training programmes aimed at recruiting and developing personnel who are competent to respond appropriately to health care needs;
- New policies and strategies for human resource development which addresses priority education;
- Decentralising management authority to provincial and district level to allow a greater degree of autonomy; and
- Evaluation procedures and techniques to assess management efficiency at all levels of the health service.

Restructuring health care services in SA

HEALTH care in South Africa has undergone many changes since the appointment of the Government of National Unity. The department of health has initiated and been an integral part of the restructuring and planning process.

The restructuring of the National Health System (NHS) is based on the dictates of the Constitution and the Reconstruction and Development Programme (RDP).

This resulted in the amalgamation of 14 fragmented departments of health into a single NHS, with one national department and nine provincial health departments.

The health department has made substantial progress in restructuring the fragmented system of the past, as well as in the redistribution and utilisation of resources to support the principles spelled out in the RDP.

A few of the strategies utilised to reduce inequality in the health services have been budget reprioritisation, the development of the National Health System and improved delivery of health services.

The maldistribution of resources between and in the various provinces, and between the various levels of health care services, necessitated drastic steps to ensure equality and an appropriate health care delivery system, that will ensure access to comprehensive health care service for all the people of South Africa.

A formula for the reallocation of funds between the various provinces and the national department was developed.

Reprioritisation of programmes were done following the directive of the RDP.

Zero-based budgeting was accepted by the spending agencies as a principle for the budget reprioritisation and they were requested to prioritise their expenditure in their budgeting process. The following criteria were agreed upon for the budgeting process:

- Services were to reach the majority of the population based on primary health care (PHCP) principles, with a focus on the most vulnerable groups especially women and children, the rural, and the peri-urban poor;
- Services should have a maximum impact on the health of the population with emphasis on women and children, based on cost-effective interventions and targeting areas with the highest infant mortality rate (IMR) under five mortality and maternal mortality rate;
- Comprehensive and integrated services to be provided;
- Prioritisation should take into account the: acceptability, capacity and existing resources;
- The services to be provided should contribute to the empowerment of communities especially women and involve other partners including the private sector; and
- The services should promote capacity building and the targeted levels.It was recommended that the reallocation formula be implemented over five years with the biggest shift of 30 percent in the first year (1995-1996) and 17 per annum in the following four years period.

The department is currently looking at ways of refining the formula to allow for a positive impact on academic medicine, cross-border flows and capital spending needs.

Safe high quality drugs for all in SA

A NATIONAL Drug Policy has been developed to ensure an adequate supply of effective, safe and affordable drugs of good quality to all South Africans.

An essential drug programme will also ensure drugs are used rationally by both prescriber and consumer.

Human resources and expertise will be expanded at schools of pharmacy, medicine and nursing, aimed at greater acceptance and strengthening drug concept.

The national systems of medicine regulation and control should be improved. The use of safe traditional medicines that address common conditions encountered in PHC should be encouraged.

National Health Information System (NHIS)

The National health Information System should be coordinated in order to facilitate the measurement and monitoring of the health status of the South African population and should support effective management of services at all levels of the health system.

The NHIS should be used to monitor both the degree to which the health priorities of the RDP are addressed, and the success of the health component of the RDP itself. There should be timeliness, accuracy and clear dissemination of the NHIS data at all levels.

Integrated Nutrition Strategy

Good nutrition for all South Africans is a basic human right and act as an integral component and outcome measure of the country's social and economic development.

Nutrition programmes should be integrated, sustainable, environmentally sound, community-driven and must be targeted at the most vulnerable groups, particularly among children and women.

Promotion of nutritional well-being should occur and be monitored within nationally defined goals, with a clear nutrition information strategy and with economic and technical co-operation between countries and international agencies.

Nutrition policies, strategies and programmes are dependent on the development of human and institutional capacities and the provision of adequate financial resources.

Maternal, Child and Women's Health (MCWH)

MCWH services should reach all mothers, children, adolescents and women, with priority focus on the most vulnerable.

The MCWH services should be comprehensive and integrated.

Bright outlook for health care groups on back of state policy

(85) ST (BT) 3/3/96

JULIE WALKER

DIAGONAL STREET

THE government's final policy document on health care, issued a week ago, recommends that employers of the nation's formally employed yet medically uninsured workforce provide a limited degree of hospital cover for them and their dependants. The number of people this involves is estimated at five to six million and the bill to employers could be as much as R2-billion a year for compulsory hospital cover only.

Trade unions representing these workers — usually those at the bottom of the hierarchy — are pushing for access to private health care such as is enjoyed by the upper echelons.

Yet the private medical aid contribution payable for an employee earning R1 500 to R2 000 a month with only one dependant amounts to around R550 a month. Employer and employee usually go halves, and a deduction of R275 a month off a starting salary of R1 500 is sure to meet resistance.

The policy document also recommends a standard core package of health care benefits, as yet to be defined, to be provided by employers to employees.

It will be obligatory for medical schemes to provide this to their members. The question of extending these benefits to dependants of employees has not been addressed but the fact is that many businesses won't be able to meet all these financial demands.

Is there anything the private health care sector can do to tap a potential market of five million people?

Carl Grillenberger, joint managing director of Presmed, believes the answer lies in managed health care schemes.

Presmed was listed 10 years ago and a pyramid, Preshold, was listed in 1993. The focus was on reducing the cost of medical care while maintaining the quality through the use of day clinics instead of overnight hospitals. In 1993, Mr Grillenberger recruited Rob Speedie, an authority on medical aid schemes, to join Presmed as joint managing director.

Preshold's role as a pyramid lost its importance and the group decided last year to distribute Presmed in the ratio 43 Presmed per 100 Preshold. This left Preshold as a cash shell worth R8-million. The shares were consolidated four for one, renamed Managed Care SA, and are worth 81c a share and trade at 285c.

This week, Mancare announced an R11-million amalgamation with the Carecorp group of companies, to be settled by the issue of Mancare shares at 210c and subject to a profit warranty. A R12-million rights issue will be made by Mancare, to be abbreviated Care and transferred to the JSE's Development Stage sector.

Eenhede, a company controlled by Mr Grillenberger, has a substantial holding in Care. Eenhede will renounce part of its entitlement to the Care rights offer at no consideration to selected medical practitioners and medical schemes to increase the spread of shareholders. Other rights will be sold and the proceeds applied by Eenhede to follow its rights.

Carecorp has already done the groundwork in developing a managed health care system, incurring costs of research, start-up, computerisation and clinical quality-assurance systems. It has contracted several large clients including Nissan, Volkswagen and the D & E Medical Aid Administrators. To expand, it needs money, and the deal with Mancare provides an opportunity to go forward with R20-million of capital.

Managed health care was embraced by the US from the mid-80s as a means of controlling costs.

In South Africa, several large groups have entered the field: SA Druggists has earmarked R300-million via Medicross, Anglo American, Southern Life and US Health Care are in a R140-million joint venture, Medimo is operated by Afrox and MediClinic. Smith-Kline Beecham is believed to have spent R100-million aligning itself in the local market, according to Care's circular.

Managed health care is a system of health care delivery which influences the use and cost of services and measures performance. The goal is a system that delivers value by giving people access to quality, cost-effective health care.

Widespread abuse of the medical aid system is a major reason why costs are so high. The lending of membership cards — even renting them out for a fee, over-servicing and over-medication are but a few examples. In the US, managed health care reduced the incidence of fee-for-service from 85% to 30% of total spend.

"The existing fee-for-service system causes cost escalations and inefficiencies which are to the detriment of the patient and the payer," says Mr Grillenberger. "Practitioners have been selected for our managed care business because they are conservative, cost-conscious, clinically skilled and keen to develop the system."

The government policy document notes a tendency among general practitioners to prescribe medicines because they make a high return on dispensing. Few patients query their doctor's opinion or choice of medication even if cheaper alternatives are available. The government intends dispensing doctors to be restricted to areas where pharmacies are scarce.

Presmed and a number of independent hospitals are forming a national network of private hospitals and day clinics with the aim of establishing better accessibility and a closer link with community-based general practitioners.

Presmed itself already has eight hospitals and 14 day clinics.

Mr Grillenberger says Presmed's principle of keeping costs down was a little ahead of its time when it was established. "But last year, private hospitals substantially increased their fees for high-tech services such as intensive care. This and other increases focused the minds of the health care industry on affordability."

Mr Speedie points out that within 10 years the treatment of AIDS sufferers could absorb three quarters of the nation's public health budget, leaving little for other patients.

"The private health care sector has a bright future," says Mr Grillenberger, who believes his group has even better prospects because it is more cost-effective than other groups.

The leading listed managed health care companies in the US have shown an average compound growth rate in operating income of 50% a year over the past three to five years in an environment of low inflation. Care's directors expect at least 30% a year growth in income.

I have long been a Presmed fan and would keep it at 640c. I would also get in on the ground floor of Care at 285c and take the ride — the risk-reward scenario appeals to me.

fill the vacancy. automated trading.

W Cape seeks savings on health

(85) 04/3/96

Linda Ensor

CAPE TOWN — The Western Cape health department planned to achieve savings of R115m in the 1996/97 year but would still overspend its budget by R106m, health department head Dr Tom Sutcliffe disclosed in an interview at the weekend.

This deficit would, however, total R329m were the province to fully implement its plans to expand services in the primary health care sector.

In the 1995/96 fiscal year, the province's health department received R171m over and above its budgeted allocation.

Sutcliffe said that while the department planned to run health services within budget in the long term, this could not be achieved all at once without having to cut services and close hospitals. There was already an underprovision of services and shortage of beds in some areas.

The budgetary constraints would mean R108m would be lopped off the planned expansion of the primary health care sector to R720m. However, by "doing things smarter", there would hopefully not be retrenchments of existing health workers, who were overworked and stretched to capacity. Staff numbers would be reduced by natural attrition and redeployment.

Outlining the department's plans to cut spending while restructuring services, Sutcliffe said the province would get a health budget of R2,134bn from the state for the 1996/97 year, of which R151m would be bridging finance for transformation.

One area where savings could be achieved was in administration, where a 10% saving (R14,3m) from an allocation of R143m was envisaged.

The R612m budget for primary health care would make no year-on-year provision for inflation and this would therefore decline in real terms by 6%. Expenditure of the R70m earmarked for new primary health services would be prioritised in terms of greatest need, Sutcliffe said.

A R22m cut in expenditure on academic hospitals was planned and R34m of current expenditure would be shifted for use for primary health care sector services, giving it a total of R656m for this sector.

Sutcliffe said the department was working with the three medical schools in the Western Cape to rationalise the academic hospitals in terms of a clearly defined strategy which took into account patient care, training and research needs. Duplication of sophisticated services would be eliminated.

Further rationalisation in dental faculties (R3m), laboratory (R10m) and psychiatric services (R5m) would save R18m.

Sutcliffe said the health department hoped to redistribute resources away from urban areas to rural areas, where there was a dire need for primary health care centres.

The department's five-year financial strategy was to reduce overall expenditure by at best 12,5% by 1999. In addition to achieving savings, it hoped to boost revenue by attracting private patients, who paid fees, back to state hospitals.

"We have gone into bilateral discussions with some medical aids to be given preferred provider status for the treatment of certain conditions, such as renal dialysis ... to generate revenue to keep services going for the indigent patient. We must make the retention of high-tech medical services a paying proposition," Sutcliffe said.

Ombudsman's baptism of fire

Star 5/3/96 ~~30(A~~ (85)

Dealing with medical complaints by customers in new era of transparency

By Janine Simon
Medical Correspondent

South Africa's pioneering medical ombudsman had a hectic first day yesterday as he got to grips with calls from a steady stream of consumers dissatisfied with service delivered by their doctors.

"It's going like a Boeing," said the laconic Prof Olliver Ransome, who has been appointed to the post by the Medical Association of South Africa (Masa) as part of a pilot project to give consumers access to an independent third party for advice on standards of service received from their doctors.

The move is one of a myriad of new initiatives in health care, and comes as the state prepares to implement primary health care and mandatory health insurance.

Ransome, a paediatrician who retired as deputy dean of Pretoria University's Faculty of Medicine last year, said he had received 12 calls in just three hours.

Complaints had included medical aids, fees, poor communication, prescribing over the phone and rudeness.

However, unlike the British medical ombudsman, who has a £7-million budget (R42-million) and statutory powers, he had no punitive powers.

"I take notes, tell callers what I think they should do and refer them in the right direction, for example to Masa's branch council's peer review systems," said Ransome, whose career includes 12 years as a general practitioner.

He said despite the increase in the number of legal actions against doctors, he believed the majority of problems could be solved with a sympathetic ear. "Most patients don't want to go to court, they want doctors to be upfront and open, and not aggressively defensive."

However, both patients and professionals would have to learn about the concept of informed consent – for example regarding post-operative procedures – and the process of granting it needed to be formalised.

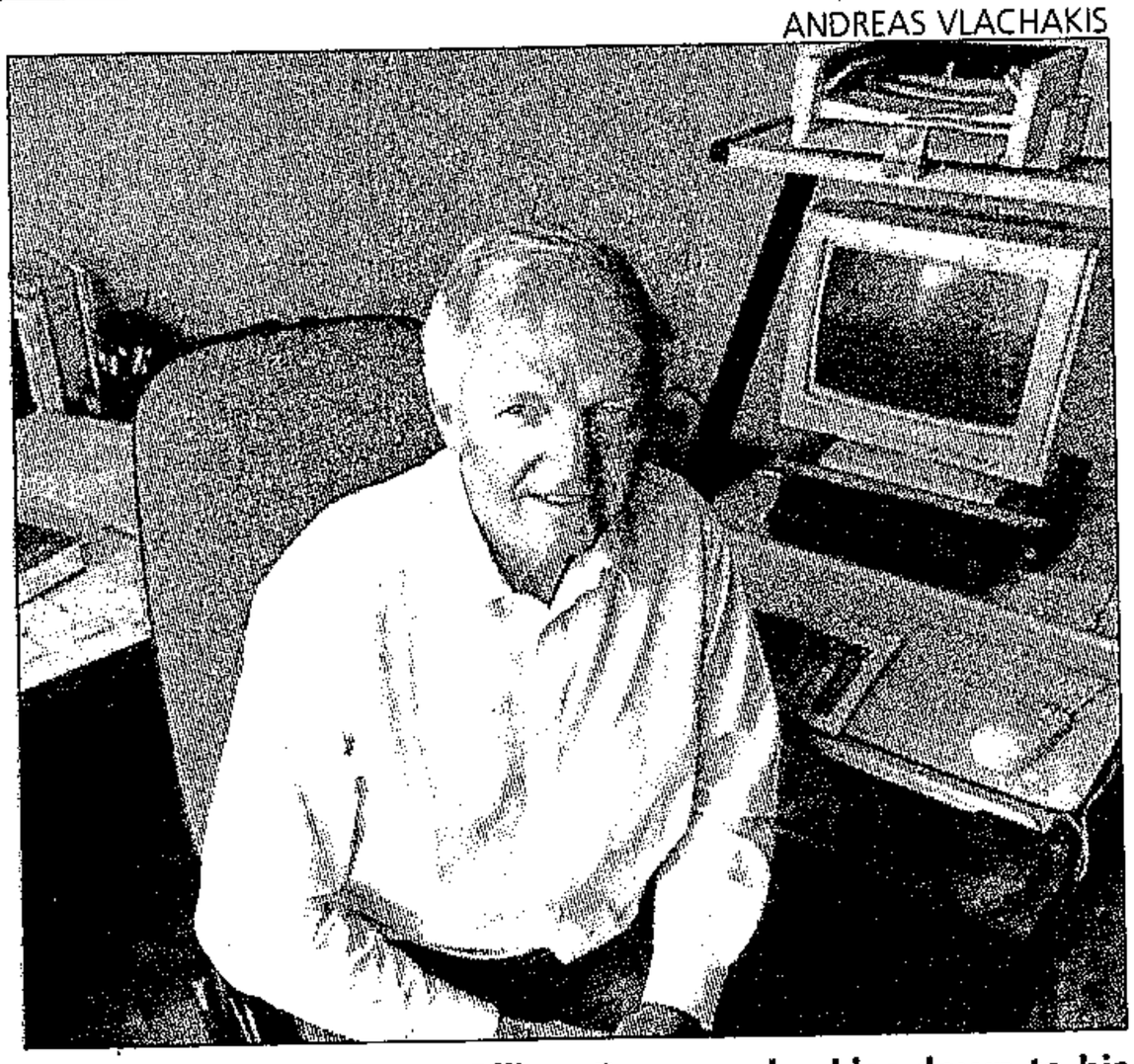
This was the time of transparency and accountability, the right time to launch an ombudsman, he said.

The ombudsman's mandate, according to a Masa statement, is to act as advocate for patient complaints, hear impartially both sides, evaluate the possibility of conciliation, inform patients of existing complaints management options, and refer them to other appropriate sources.

"Good relations between doctors and their patients are very important to us," said Dr Bernard Mandell, chairman of Masa's Federal Council.

Contact Prof Ransome toll-free at 0800-119-820 during office hours.

ANDREAS VLACHAKIS



Arbitration ... Professor Olliver Ransome buckles down to his first day on the job as new medical ombudsman.

NUMBER OF BIRTHS DECLINING

Infant mortality rate down again in city

(85) ET 8/3/96

THE INFANT MORTALITY rate in Cape Town municipality has fallen from 19 in 1 000 seven years ago to 16 in 1 000 last year.

THE infant mortality rate in Cape Town municipality has fallen again, Medical Officer of Health Dr Michael Popkiss says in his latest annual report.

In his first report seven years ago, Popkiss reported that 19 babies per 1 000 born in Cape Town died in their first year. By 1994/5, the year under review, the figure had fallen to 16.

It is expected that when Cape Town's municipal boundaries change to include poorer areas, such as parts of Langa, Nyanga and Crossroads, the infant mortality rate will be higher.

Popkiss also reports that the annual number of births in Cape Town is dropping, as is the birth rate (number of births in relation to the total number of people).

Seven years ago there were 22 747 births in the year. In the year to mid-1995 there were 19 806 births, and the birth rate has dropped from 20,74 per 1 000 of the population, to 15,32 per 1 000.

Popkiss said the ability of parents to provide adequately for their children is more easily accomplished in small families. A drop in births and the birth rate was therefore gratifying.

On the other hand, there is no room for complacency about tuberculosis, or about the HIV virus. Over 90 000 attendances at TB clinics were reported last year, and the trend is still upwards.

It is estimated that countrywide there are over a million people infected with the HIV virus. More than 28 000 of them are babies.

The Western Cape is fortunate to have the lowest prevalence rate in the country. Just over one person in a hundred in the Western Cape is HIV-positive.

Popkiss also reported that all indications are that his health department will be able to retain its staff. At one stage there had been a suggestion that they should all be transferred to the provincial health department. The matter is to be reviewed after the local elections.

The reason advanced for the transfer to the province, Popkiss reported, was that some local government staff are better paid than staff in equivalent provincial posts.

After several years without money for new clinics, more was now forthcoming from the government.

Nearly R500 000 has been spent on extending Manenberg clinic, and a similar amount on building a new satellite clinic at Seawind, near Lavender Hill. A new clinic called Vuyani, in Guguletu, was completed last year, as was a R1,5m polyclinic in Tafelsig, Mitchells Plain. — Staff Writer

Health ministry transfers R75m to Western Cape

Linda Ensor

BD 28/3/96 (35)

CAPE TOWN — The national health department has agreed to transfer an additional R75m to Western Cape, wiping out the province's deficit for the 1995/96 financial year.

However, the news, announced yesterday by health MEC Ebrahim Rasool, was accompanied by warnings of a breakdown in medical services at hospitals and clinics if a three-month moratorium on key posts involving the delivery of care was applied.

The freeze on posts and capital projects was announced on Tuesday by finance MEC Kobus Meiring in his speech on the supplementary budget in the legislature, and already protests were being heard from overstretched doctors and nurses, Rasool said.

Three university rectors planned to speak to premier Hernus Kriel about the moratorium and staff at Groote Schuur had met to express their grievances over the issue.

Cabinet took the moratorium decision in the absence of both the health and public works MECs — the departments most affected by it. Rasool said he felt cheated by the decision.

Last night health department head Tom Sutcliffe and other health officials met the treasury committee, and it was decided to appoint a committee to provide guidelines for the exclusion of medical and health workers from the moratorium. He hoped the committee would agree to an ex post facto approval of appointments to these posts. If this bid did not succeed, Rasool said he would take the fight to Cabinet.

Wonder drugs or sangoma's muti?

Traditional African medicine plays an important role in the lives of many millions of South Africans. But will it continue to do so now that the nation is poised for the introduction of free and more widely accessible helath care of the Western variety? DAVID ROBBINS reports.

(85) ARG 12/3/96

IN Mali, one of Africa's poorest countries, the programmes imposed by the IMF are having an unexpected result. As budgets for social services shrink, so do fees for basic medical care at clinics and hospitals rise. This has turned increasing numbers of cash-strapped Malians back to the traditional medicine option.

A development aid worker in Mali told me recently that the current estimate was that more than 90 percent of Mali's population once more consult traditional healers for their basic health needs.

What are the implications for South Africa?

Here, unimpeded by IMF programmes, the whole point of current policy reform is to make health care cheaper and more accessible.

Hundreds of millions of rands are being spent on improving services in the remotest areas, and from April 1, primary health care will be free to all.

TRADITIONAL MUTI: Patients drink a concoction which makes them vomit while a sangoma picks through the mess with a stick to detect what is making them ill.

Does this mean that the importance of traditional medicine is set to decline?

"It's difficult to believe that it will, certainly not in the immediate future," says Engela Pretorius, an expert on traditional healers, who is attached to the department of sociology at Free State University.

A survey undertaken by the University of Pretoria in 1994 indicated that 80 percent of black South Africans still make regular use of traditional healers.

Even nurses are not excluded: 50 percent of them consult sangomas (healers) or inyangas (herbalists) for personal or family health problems before turning to the Western expertise in which they are trained.

Dr Pretorius lists several reasons to support her conviction that the influence of traditional medicine is not set to decline.

"Rapid urbanisation and the attendant culture shock, as well as the socio-economic legacy of apartheid, have all combined to create great difficulties for individuals.

"Under such conditions, traditional healers have an important role to play.

They definitely provide a soothing influence on people living in unstable situations. In addition, the dual utilisation pattern, where people use traditional and Western medicine, is well established and unlikely to be disrupted by introduction of free primary health care."

Of course, the debate concerning the comparative efficacies of traditional and Western medicine continues.

It's not simply a contest between bark and monkey paws on one hand, and hygiene and hypodermics on the other.

Each system has its strengths: Western medicine has hi-tech equipment and wonder drugs; its traditional counterpart provides a much more holistic approach to ill-health which embraces the socio-cultural and religious dimensions of the patient's condition.

But should the two systems be regarded as complementary?

Many people do regard them thus.

Provincial health authorities are providing special primary health care training for traditional healers, while the Medical Association of South Africa has formulated guidelines for co-operation (especially in the field of mutual referrals) between doctors and their traditional counterparts.

Even national health policy makes vague noises about the need to investigate the incorporation of traditional medicine into the national health system.

But there's no final word yet about how the tens of thousands of traditional healers should be controlled (as Western-trained practitioners are by the SA Medical and Dental Council), nor about the financial implications of incorporating them in the overall health-care system.

Perhaps they never will be formally incorporated but this does not mean they won't be widely used by millions of ordinary South Africans . But should ordinary South Africans be offered some form of assistance in paying for such services?

"Yes," is the emphatic reply from Ian McLaren, marketing executive of Traditional Healers Worker Benefit Scheme. "

This scheme has been devised to address the needs of formally employed black workers who use traditional healers."

The monthly contribution is between R128 and R348. Half of this could be paid by employers, as they do for medical aid contributions.

For the full amount the member gets the following:

- Two membership cards,, one for himself, the other for family members if they live away from the member, for example in outlying rural areas.
- A monthly credit of between R100 and R300 with which to pay for the services of traditional healers. This comes in the form of vouchers which only registered traditional healers can redeem from THWBS.

These monthly credits can be accumulated and used at any time, even after the member has left his employment or has terminated his membership of the scheme.

- The member and his dependents receive immediate funeral cover, and on his death his beneficiaries are entitled to a further 10 years of monthly credits to use on the services of traditional healers.

> Many believe the two systems can work hand in hand

With regard to the registration of the healers, McLaren explains that the Traditional Healers' Organisation of South Africa and smaller local associations, have elaborate methods by which individual healers are accepted into the fraternity.

"We generally go along with their recommendations. We established a committee comprising members of some of the associations to advise on registrations."

McLaren said scheme had already registered "tens of thousands" of the estimated 100 000 healers in the country. "

One of the problems is that there are probably an equal number of charlatans. Adequate registration criteria are clearly vital to protect our members from these people, and to ensure that only reputable healers get paid."

More than 80 commercial companies have been approached with a view to interesting them in offering the benefits of the scheme to their employees. Time will tell whether they take the opportunity.

Pretorius comments: "I think that the plan is quite feasible. It's one of several schemes attempting to finance the use of traditional healers and it may well serve as a pilot for the shape of things to come."

One hindrance to a widespread acceptance of this and similar schemes, however, must be the pending proposals for the introduction of a mandatory hospital benefits package for which employers and employees will be jointly expected to pay.

Will they also then be able to afford the services of traditional healers?

Testing time for primary health care

(85) Star 12/3/96

How well prepared is Gauteng for the introduction of free health care for all?

A new policy initiative, likely to be introduced next month, should go a long way towards improving health services in the province. But it's going to require major adjustments to ensure success. Health Writer David Robbins reports.

When free health care for pregnant women and children under six was introduced in 1994, hospital outpatient departments (OPDs) all over the country staggered under increased loads. Gauteng hospitals were no exception.

Now, the introduction of free primary health care (PHC) for all is soon to be announced. April 1 is the date on everyone's lips. But what's going to happen to our hospitals this time, especially in Gauteng, where the majority of people have always used hospital OPDs as their point of entry into the health-care system?

Gauteng health department's Dr Rafik Bismilla – chief director of district health services support – admits to some anxiety. "The way we handle the new situation will be crucial," he says.

"Our ultimate intention is to divert PHC patients away from hospitals and into the clinics. But it can't happen overnight. We have already started on a process of education among our own staff and, hopefully, extra resources will be made available to cushion the impact of the new policy during the transitional stage."

At the centre of the new policy lies the conviction that the old system was essentially unfair and inaccessible to many, being curative and urban-based: in other words, centred on town and city hospitals rather than peripheral preventive and promotive services. In fact, over 75% of the national health budget has traditionally been swallowed by hospitals.

The turmoil in our hospitals over the past 18 months has been caused largely by straitened budgets as resources are shifted into PHC facilities will be facilitated by the eventual introduction of a fee of around R50 levied on patients attending a hospital OPD.

"But obviously the fee will not be introduced immediately," he says. "We will adopt a humane and phased approach. No patients will be turned away, and we will make certain that sufficient PHC facilities are available before we impose a fee at those hospitals operating in areas where there are no clinics."

Considerable efforts have already been made to improve PHC services on the periphery.

During the 1995/6 financial year, more than R20-million was spent in Gauteng on building and equipping seven maternity and obstetric units and 22 clinics. These will provide accessible PHC to a further 2,5 million people.

In addition, equipment has been upgraded and backlogs in the provision of devices like crutches and wheelchairs have been eradicated throughout the province. Personnel requirements have not been ignored. This year alone, 80 PHC nurses with basic diagnostic skills are being trained.

But these improvements in themselves are not enough to cope with the shift away from Gauteng's hospitals to peripheral PHC. There are problems in the existing clinics which must be speedily resolved.

Bismilla explains: "Although on paper we have 305 clinics in Gauteng, only 40 of them are provincial clinics offering curative

Primary care should shrink load on hospitals

to upgrade the local authority clinics as soon as we can."

This imperative is complicated by several factors, however. One of the most thorny concerns the differing salary scales, not only between provincial and local authority nurses and doctors, but also between local authorities of widely differing economic resources.

"Certainly, we are working on this problem," says Bismilla. "We are also looking at the upgrading of the equipment at preventive and promotive clinics to provide a curative service as well as expanding PHC services. In fact, we've budgeted over R100-million for this purpose during 1996/7."

Crucial to the success of increased PHC coverage is the establishment of rational management systems to help "unscramble the fragmentation of the past", says Bismilla.

The system adopted is the so-called district model. This requires a high degree of community participation in health management, and the division of the entire province into geographically contiguous districts, where the emphasis is on providing health care for the entire population rather than providing facilities to which people can come when they feel they need treatment.

"This approach is as concerned with keeping people healthy as it is with caring for them when they become ill," Bismilla says.

to subdivide these regions into districts.

The thinking thus far is that health districts must correspond with local authority boundaries, but not necessarily on a one-to-one basis. This means that although there are 45 local authorities in the province, some of these will be placed together in the 25 health districts envisaged.

There are already 30 people drawn from provincial and local authority structures attending management courses on PHC and district development. Another 30 will be trained during the second half of the year.

"By June," says Bismilla, "each region will establish interim district management teams whose task will be to unscramble the apartheid egg, while at the same time training for capacity building at a district level and service delivery. During the second half of the year it is planned that pilot districts, including community participation via district health authorities, will be established in each region.

"I'll be extremely happy if we have three out of five pilots functioning well by December," Bismilla comments. "Thereafter, we can move forward to full implementation of the district system."

All this is what underpins the introduction of free PHC for all next month. It could be a rough ride, and pressure could build up in hospitals and in curative provincial clinics. But the policy has been carefully thought through and the end result will almost certainly be positive.

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Primary health care

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The turmoil in our hospitals over the past 18 months has been caused largely by straitened budgets as resources are shifted into PHC facilities and staff. Now, with the introduction of free PHC, the time has come to shrink hospital patient loads accordingly.

The diverting of patients to PHC facilities will be facilitated by the eventual introduction of a fee of around R50 levied on patients attending a hospital OPD.

"But obviously the fee will not be introduced immediately," he says. "We will adopt a humane and phased approach. No patients will be turned away, and we will make certain that sufficient PHC facilities are available before we impose a fee at those hospitals operating in areas where there are no clinics."

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Primary care should shrink load on hospitals

But these improvements in themselves are not enough to cope with the shift away from Gauteng's hospitals to peripheral PHC. There are problems in the existing clinics which must be speedily resolved.

Bismilla explains: "Although on paper we have 305 clinics in Gauteng, only 40 of them are provincial clinics offering curative services. The remainder are local authority clinics competent to do preventive work only. A large part of my anxiety over the free PHC concerns the overloading of the 40 curative clinics. Clearly, we need to upgrade the local authority clinics as soon as we can."

This imperative is complicated by several factors, however. One of the most thorny concerns the differing salary scales, not only between provincial and local authority nurses and doctors, but also between local authorities of widely differing economic resources.

"Certainly, we are working on this problem," says Bismilla. "We are also looking at the upgrading of the equipment at preventive and promotive clinics to provide a curative service as well as expanding PHC services. In fact, we've budgeted over R100-million for this purpose during 1996/7."

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"This approach is as concerned with keeping people healthy as it is with caring for them when they become ill," Bismilla explains.

With this end in mind, Gauteng has already been divided into five regions: Central Wits, Pretoria, West Rand, East Rand, and Vaal in the south. The task now is to subdivide these regions into districts.

The thinking thus far is that health districts must correspond with local authority boundaries, but not necessarily on a one-to-one basis. This means that although there are 45 local authorities in the province, some of these will be placed together in the 25 health districts envisaged.

There are already 30 people drawn from provincial and local authority structures attending management courses on PHC and district development. Another 30 will be trained during the second half of the year.

"By June," says Bismilla, "each region will establish interim district management teams whose task will be to unscramble the apartheid egg, while at the same time training for capacity building at a district level and service delivery. During the second half of the year it is planned that pilot districts, including community participation via district health authorities, will be established in each region.

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All this is what underpins the introduction of free PHC for all next month. It could be a rough ride, and pressure could build up in hospitals and in curative provincial clinics. But the policy has been carefully thought through and the end result will almost certainly be positive.

"If we can maintain the political commitment to pumping resources into PHC, while at the same time improving efficiency at our hospitals, in five years we should be seeing real and measurable improvements in the overall health status of all Gauteng's people," concludes Bismilla.

Health fears over Athlone power station reopening

ARG 13/3/96

ANDREA WEISS
Municipal Reporter

PEOPLE living near the Athlone Power station fear their health will be threatened when the power station returns to full operation during the next three years.

The Legal Resources Centre (LRC) has asked for a special interview with the Cape Town City Council's amenities and health committee to present the views of the Athlone RDP forum and the Langa development forum.

In a memo addressed to the council, the LRC says that the coal-fired power station is "virtually surrounded by residential neighbourhoods, including Athlone and Langa, both areas with a perceived high rate of tuberculosis, asthma and other respiratory problems".

The council had "admitted" to not consulting the public when deciding to recommission the plant, and had not undertaken any environmental impact assessments.

The LRC said that coal-burning power plants emitted three main pollutants of concern to human health, namely particulates (PM-10), sulphur dioxide, and nitrogen oxide.

Sulphur dioxide reacted with moisture in the air to form sulphuric acid which caused mucous secretions in the lungs, reduced lung function and increased the risk of infection.

Nitrogen oxides caused acid rain and ground-level ozone (also known as brown haze).

The LRC states that the emissions from the power station will exceed international pollution standards.

It points to concerns raised by Pinelands residents around the removal of asbestos at the power station.

After meeting the city electrical engineering and health departments, the LRC decided to ask for a meeting with the amenities and health committee on April 1.

In addition, the medical officer of health, city electrical engineer and the city legal adviser have been asked to comment on the concerns laid out in the LRC's memo.

The council wants to use the power station to cut down on the amount of energy bought from Eskom at peak times.

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'Flying doctors' in trial to assess medical air service

BD 14/3/96

Kathryn Strachan

THE "flying doctors" began their service in the Northern Cape last week, finally reaching remote parts of the Kalahari and Karoo which have rarely seen a doctor.

To reach the vast province's outlying areas, the health administration has loaned a plane from Pilatus and, in a joint project with the Red Cross, will conduct a six-month study to assess the feasibility of a medical air service.

Each day the plane will leave Kimberley for a different district, taking doctors and specialists to outlying clinics and bringing back patients that need to be referred to Kimberley Hospital. Supplies will also be airlifted, ensuring medicines such as vaccines are kept cold. At present medicine often goes unrefrigerated when being delivered to outlying clinics.

Northern Cape deputy health director-general Barry Kristnasamy believes the flying service is the answer to the province's main obstacle — the immense distances and small communities.

Another boost for outlying clinics in the province is the arrival of 11 Cuban doctors. At present there are no full-time state doctors serving in these areas.

The provincial administration has other ambitious plans to boost its health services. The most important is upgrading the Kimberley Hospital and linking it to the Free State University by June.

The Kimberley Hospital will have an overhaul of R4,5m to upgrade it to offer nine specialities and, by linking it up with the medical school, it will become a satellite secondary hospital where specialists from the Free State will make regular visits. The Free State specialists will also make use of the plane service to visit outlying Northern Cape facilities.

Last week the Medical Research Council signed an agreement to set up its fourth research base in the country in Kimberley — a development which will further strengthen academic links and provide support to Northern Cape health services.

The province needs all the help it can get in extending its health services. It faces the second-highest TB rate in the country, and the highest smoking rate.

With nuclear waste sites in the Kalahari, asbestos mines, agricultural pesticides and the Vaal River bringing mining metals from Gauteng, the province faces many environmental hazards.

It is investigating the exact health effects of these hazards and drawing up interventions — particularly in light of people wanting to reclaim land which could have been used for nuclear testing.

The boundary dividing the Northern Cape and the Northwest is also posing a problem for health authorities as it cuts across natural health districts. The town of Kuruman, for example, falls in the Northern Cape while its satellite townships fall in the Northwest. Health authorities from both provinces are devising a rational referral system where people will go to the clinic nearest to them, even if it does lie across the provincial border.

The final task facing the province is stamping out the racial separation which still exists in some of its hospitals. Kakamas Hospital — with its two casualty departments, two outpatients sections, two labour wards and two entrances all within a 30-bed hospital — is but one of the examples of these relics from the past.

Gauteng to add fluoride to its water

(85) BD 14/3/96

Kathryn Strachan

GAUTENG is set to save R7,9m in dental health costs when fluoride is added to its water supplies in the near future.

As correct fluoride levels in the water reduce tooth decay by up to 50%, the health department is in the process of issuing regulations to have it added at water purification systems across the country.

Once the water and environmental affairs ministries have passed the regulations, they will be circulated for public comment.

Wits department of community dentistry specialist Usuf Chikte said yesterday water fluoridation had proved to be the most cost-effective prevention strategy for tooth decay.

The cost of adding fluoride to water supplies costs less than R1 per person a year.

This makes it at least 18 times more cost-effective than fluoridated toothpaste (and for many poor people, toothpaste is a luxury), and 61 times more cost-effective than visiting a dentist to have a tooth filled.

The initial outlay for the Rand Water Board will cost about R50m, and will benefit 9-million people in six provinces.

For every R1 invested in water fluoridation, government will save between R16 to R55 which would otherwise have been spent on providing curative dental care.

It is also estimated that in Gauteng almost 1 028 job year equivalents are lost to the labour market every year because of the time lost in visiting dental clinics.

All natural sources of water contain the mineral fluoride — which reaches the rivers through rocks and soil — and when a balance is struck between the level of fluoride and the level of water it protects teeth against decay.

In parts of the country where the natural fluoride levels are high enough, fluoride will not have to be added.

As increasing urbanisation and sugar consumption has led to a dramatic rise in tooth decay over the past two decades in SA , it has become vital for the health authorities to take steps to prevent tooth decay — which affects mostly children, women, the elderly and the poor.

Provinces to administer health budgets

(85) BD 14/3/96

Kathryn Strachan

A PROJECTED R17,12bn will be allocated to health services this year, amounting to an 8% increase over last year's amount.

Finance director-general Estian Calitz said in his budget review yesterday that the national health budget had been substantially reduced from last year's R1,5bn to R712m since provinces were now providing most of the health services.

Each province will be given a global amount by the finance department, and each will have full responsibility in deciding how much of that amount it will allocate to health. The projected provincial health budgets, which have been negotiated with the state expenditure department, show there is now far more realism in reallocating health resources between the provinces.

UCT health economist Di McIntyre said the provincial projections showed a definite slowing of the pace of achieving equity.

While Northern Province was given a 30% increase last year, Western Cape and Gauteng were left with severe cuts.

Because Northern Province could not spend all the money allocated to it last year, it has been given a 10% increase this year, while Gauteng received a health budget increase of 11,4% and Western Cape an increase of 3,2%. Eastern Cape, which received no increase last year, will get a 27% boost this year to address the appalling health problems and neglected services in the former Transkei. Mpumalanga has the biggest increase at 36%.

ZUMA

The movement of funds away from the national department to the provinces was a visible sign of government's commitment to decentralisation, said McIntyre. But the allocation still left the health sector "quite strapped", and she was concerned about whether the increase was enough for the wage increases promised to nurses.

The projections are that Gauteng would get the most with R3,7bn, followed by KwaZulu-Natal (R3,1bn), Eastern Cape (R2,5bn), Western Cape (R2,1bn), Northern Province (R1,5bn), Free State (R1,2bn), Northwest (R1,1bn), Mpumalanga (R783m) and Northern Cape (R289m).

An allocation of R310m for improvements to capital equipment in facilities, which was included in the national department's budget, would be distributed to provinces on the basis of a national audit of facilities, said Calitz.

Carry-through costs of RDP projects on the national health vote amounted to R69m, mainly for clinic building.

The budget also included R40m of the amount provided for the new RDP AIDS awareness project. Allocations of RDP funds to the provinces would include R680m for free health services, R500m for primary school nutrition schemes, and R450m for the costs of restructuring hospitals from tertiary to primary care.

Wits University economist Alex van den Heever said that in theory these last three items would expire next year, which could leave the health sector with major financial problems in the future.

These amounts have also declined in real terms over the last year.

Wyndham Hartley reports that in the national health budget, R18m is provided for national systems, and a similar amount is provided for academic health centres and hospital development.

The budget for combating AIDS and HIV infection, after being doubled to R42m in the current budget, receives a further boost which takes it to a total of R60m. In addition, assistance to nongovernmental organisations working in the AIDS/HIV field is increased from R6,7m to R20m.

NEW DEAL ON JOBS

Revolt over health vacancies averted (85)

CT 15/3/96

THE PROVINCIAL Health Department will now be allowed to fill 62,5% of its vacant posts, Health Writer **ANEEZ SALIE** reports.

A REVOLT by Western Cape hospital staff against a unilateral moratorium by the province on the filling of vacant posts has been averted.

Provincial Health Department head Dr Tom Sutcliffe said they are now allowed to fill 62,5% of the vacant posts without prior approval.

"It is a major breakthrough which will boost the morale of staff and provide the flexibility our managers need to run our hospitals properly," he said yesterday.

Earlier Mr Ebrahim Rasool, the Western Cape executive council member responsible for Health and Welfare, warned of "resistance at the coalface".

Staff and management at health centres were close to rebellion, he said.

WARNING: Health and Welfare MEC Mr Ebrahim Rasool

He would stand by them, Rasool pledged.

At issue was a provincial ban on capital expenditure and a freeze on vacant posts imposed in Rasool's absence.

Ironically, it came at a time when they had wiped out their budget deficit, Rasool said.

They had managed to save some R75 million, which was matched by the same amount they received from the national health department.

The department found itself in situation of having the money to employ badly needed staff, but being prevented from doing so by red tape.

Sutcliffe had been given the task of persuading the provincial Treasury Committee to bypass the moratorium for the health department because of the social consequences.

Staff were not only unhappy about having to work under unacceptable pressure because many vacancies were not filled, but many were leaving key posts, further aggravating the situation.

Sutcliffe said the Treasury Committee not only agreed on Tuesday evening to the 62,5%, but his department could approach them to lift that ceiling if the situation warranted it.

"It is a great relief for the Department of Health," he said.

Health info 'wholly inadequate'

(85) MTG 15-21/3/96

Gaye Davis

A NATIONAL survey of political responses to last year's nurses' strike has revealed that "wholly inadequate" health information systems are hindering the government's ability to communicate with employees and deal with industrial action.

Parliament's Portfolio Committee on Health canvassed the national and provincial health departments for information about the nature and extent of industrial action, its financial impact, nurses' grievances, communities affected and their responses.

Its report, released this week, says what emerged was a wide degree of variation between national and provincial figures on the number of health centres affected and the level of strike action — even though provincial departments were in daily contact with the national department.

Only two provinces reflected on the strike, noting there had been no evaluation of the way the strike was handled at national and provincial level and no feedback on the outcome of bargaining chamber discussions which saw its eventual resolution, nor on the costs of the strike.

Footing the bill for basic health care

(85)

Basic health services will soon be free in South Africa. The costs involved are understandably high, but to judge by the latest Budget, the treasury won't be paying for it. How, then, are the books to be balanced?

Star 21/3/96

By David Robbins
Health Writer

The main intention of health policy reform in South Africa is to bring quality preventive and curative services to the greatest number of citizens. April 1 will mark the introduction of the district model of free primary health care (PHC) in pursuance of this ideal.

This will necessitate an increase of billions in PHC spending over the next five years. In 1995 money (a term which means that inflation has not been taken into account), it is estimated that PHC spending will increase from R4,8 billion (in 1995/6) to R7,3 billion by the turn of the century, giving an average annual increase of more than 8%.

Over the same period, the total health demand from the Treasury will rise much less, from a total figure of R16,8-billion provided in 1995/6 to R17,3-billion in 2000/01. This represents an increase of only 0,6% each year (again excluding inflation).

These provisional figures are contained in a new policy document from the Department of Health entitled "Restructuring the National Health System for Universal Primary Health Care". The financial details are contained in an appendix to this document which deals with public health expenditure from 1995/6 to 2000/1.

The obvious question is: how can such large increases in PHC spending be achieved without raiding the fiscus?

At least part of the answer lies at the core of health policy reform. In the past, South Africa's system was powerfully skewed towards curative care in urban areas. Big city hospitals and smaller town-based hospitals consumed more than 75% of the national and provincial health budgets, leaving precious little for the care of the other 50% of the population who lived in the countryside. The result was often some of the poorest health status indicators (like infant and under-five mortality rates) in Africa.

Clearly, the way forward is to correct these imbalances by shifting resources away from the hospitals towards the neglected rural areas. Hence the new emphasis on PHC delivered through a district model which aims for blanket geographical coverage of the whole country and high community participation.

Resources will be shifted to rural areas

Is this not merely a case of robbing Peter to pay Paul, while the overall budget remains more or less the same?

The figures reveal some fascinating answers.

In the 1995/6 financial year, academic hospitals cost R4,1-billion (not much less than the total PHC package of R4,8-billion) while provincial hospitals consumed R2,6-billion, inpatients at district hospitals R2,2-billion, and special hospitals (mental institutions for example) R391-million.

That's a total of R9,2-billion, projected to increase to not much more than R9,7-billion by 2000/01. That's an average annual increase of 1,5% (as opposed to PHC's 8,3%) with academic hospital expenditure increasing by only 0,5%, and district and special hospitals by 2,1%.

Certainly, the hospitals are going to be squeezed financially. To counter this, however, we need to bear in mind that the rapid development of PHC facilities, and the introduction of incentives to use them, will take considerable pressure off the hospitals.

But when the projected figures for 2000/01 are added up, the books don't seem to balance. In spite of a considerable shifting of resources from hospital care to PHC, the cost of health is still projected to rise. In fact, total expenditure across the 5-year period increases from the current R16,8-billion to R19,8-billion, an average annual change of 3,4%. This is a lot higher than is being sought from the Treasury which, as we have seen, starts at the current R16,8-billion but rises to only R17,3-billion in five years' time.

The shortfall over the five years works out at around R7,5-billion. According the department, however, this shortfall can be made up from three specific sources.

- An estimated R950-million from overseas donors is to be used exclusively for PHC capital development.
- Hospital fee retention will be established within the public health sector. At the moment, hospital fees disappear into provincial coffers, providing little incentive for efficient costing or collection.

The gradual introduction of actual cost recovery (charging patients the real cost of their hospital stay, as happens in the private sector) and the retention of revenue at the generating hospital, should rake in an impressive R4-billion over the next five years.

- The third source of additional revenue is the possible introduction of what the document calls "mandatory hospital insurance cover to provide for a minimum package of treatment benefits at hospitals". This insurance would be paid for jointly by employees and employers currently not included in the private sector's medical scheme system.

The estimate is that between five and six million people could be covered in this way, thus relieving the state of the responsibility of financing hospital care for this sector. Over the five-year period, another R2,5-billion would in this way have been added to health's financial resources.

This mandatory hospital insurance could prove to be controversial. Will employees and employers want to pay?

Legislation will obviously be required to introduce the scheme, and draft legislation will pass through the National Economic Development and Labour Council (Nedlac) where all interested parties will be able to influence the situation. Yet it's difficult to see the idea being squashed. Preliminary calculations indicate that although premiums will vary quite widely, the average will be around R400 a year, of which employees will pay half, or only about R17 a month per employee not currently covered by a medical scheme.

Taken as a totality, the health reform package – including the introduction of free PHC and basic hospital cover for an additional five million South Africans – makes good sense. It could signal real improvements in basic health care, especially for the most disadvantaged groups.

But the best news of all seems to be that the package is capable of becoming effective in a short space of time and at modest cost to the ordinary taxpayer.

streets of Mmabatho were overtaken by an eerie quiet ... the policeman, but Smit says the EE has misinterpreted his ... (née Van der Merwe), for what

Department of Health challenges NP and DP over contracts and allegations

(85) Star 23/3/96

By CLIVE SAWYER

The Department of Health has challenged the National Party and Democratic Party to provide proof that the award of two contracts was irregular. It has also challeged allegations against Health Director-General Dr Olive Shisana.

Earlier, NP health spokesman Willem Odendaal claimed the contract awards were not done in terms of proper procedures, while DP spokesman Mike Ellis said Shisana was "the source of the problem" in awarding the tenders.

The department said yesterday the contracts were for the National Health Information System, which was currently with the State Tender Board, and for the Hospital Strategy Project, which was signed before Shisana took office. "The department officials involved in the tendering assured me that they followed the procedures according to required State Tender Board procedures," Shisana said.

She did not believe Odendaal and Ellis could prove their allegations. "Their report is fraught with inaccuracies and contains very little factual information," she said.

Shisana said she was seeking legal advice about the reports. The Hospital Strategy Project was funded by European Union money, she said. "It is not true it was funded from RDP money to the tune of R6-million, as stated by Dr Odendaal."

The panel that recommended and awarded this contract consisted of an EU representative, two members of the Health Policy Co-ordinating Unit and two Health Department representatives. The department wanted to point out that Jonathan Broomberg had no formal relationship with it, bar being an adviser to the Hospital Strategy Project.

The contract for the National Health Information System was overseen by the chief director of health information, the chief director of support services and nine provincial representatives.

Members of the Public Service Commission were observers and the World Health Organisation had an advisory role. "Health Minister Nkosazana Zuma and Dr Shisana were not part of this panel."

The State Tender Board had not yet decided yesterday to whom the contract for the National Health Information System should go.

Shisana said that, in the face of these unsubstantiated claims, she had recommitted herself to transforming the health service to ensure health care was accessible to all South Africans.

Scheme to cost state R5,31bn

Govt launches free primary health care

BD 27/3/96 (85)

Tim Cohen

CAPE TOWN — Health Minister Nkosazana Zuma has announced the implementation of the first phase of the primary health care plan from April 1, resulting in state provision of a range of free health care services at a cost of R5,31bn.

Zuma said the plan to provide a state-subsidised universal basic health care system would begin with substantial changes in the public health sector, to be implemented immediately.

The launch of the scheme in the public sector would allow for further development of regulatory reform of the private health sector during the year, which could include a compulsory health care insurance scheme.

Phase one of the plan allows for a range of primary health care facilities, such as clinics, community health care centres and municipal clinics to provide services free of charge. Patients will have to visit primary health care facilities first before being referred to a hospital where necessary.

All personal consultation services and a range of medicines on the essential drugs list for primary care will be free in the public sector from April 1.

Where patients bypass the public health care system and go directly to public hospitals they will be charged — except in emergencies, where public health care facilities are not available or where they are pregnant mothers or under six years old.

The services to be provided by primary health care workers include immunisation, maternity care, communicable and endemic disease prevention, accident and emergency services and family planning.

Zuma said regulatory reforms in the private sector were being finalised and draft legislation was being prepared, some of which would be incorporated into the new National Health Bill.

Medical schemes and private health insurance would not be affected in the first phase and doctors who chose not to participate in the national health system would be paid directly by patients or by medical aid schemes.

Continued on Page 2

Health

Continued from Page 1

BD 27/3/96

Zuma said funding for the scheme in the 1996/97 financial year would come from the department's own budget, but documentation issued by the health department indicated that additional funds would be required.

Zuma said full implementation of the plan, to achieve full access to quality health care countrywide, would take up to 10 years — double the time originally planned.

Bigger allocations from the department's budget would have to be devoted to primary health care, but this should not be done at the expense of stability and the standard of the hospital system, departmental documents said. Additional funds for capital expenditure would have to be sought in the form of international assistance, with Zuma estimating about R208m would be supplied this year.

Zuma said the new scheme would be meaningless unless facilities were accessible countrywide. A clinic upgrading and building programme would see 343 new clinics completed and a further 58 upgraded this year.

Kathryn Strachan reports Gauteng health MEC Amos Masondo welcomed the plan yesterday, saying it would cost the province R16m over the next year.

Careful reprioritisation of spending was needed to accommodate the change and this funding would come from cuts to the hospital sector.

Nurses had been consulted and there was excitement about the plan. In all 40 Gauteng clinics patient fees would be abolished from April 1.

Hospital out-patient departments' fees would still be charged and patients would be encouraged to consider local clinics as the first option.

The province was anticipating an estimated 430 000 extra visits during the year. Staff were already being transferred from hospitals, vacant posts were being filled, sessions worked by doctors were being increased and overtime was being negotiated with professional staff.

Free Gauteng health care plan unveiled

(85) Star 27/3/96

By Patrick Phosa

Patient fees are to be scrapped at Gauteng clinics from April 1 and patients will be encouraged to look to local clinics for treatment.

Gauteng MEC for Health Amos Masondo announced this yesterday in unveiling a free, comprehensive primary health care programme costing about R16-million.

He said at a press conference in Johannesburg that half the money would come from the health budget and the other half "from all over".

At all 40 provincial clinics, patients would be treated free of charge for their primary health care needs.

Masondo said the implementation of this service was a further stride forward in providing primary health care and that measures were in place to overcome any problems.

"Our ultimate vision for the delivery of primary health care is a district health system, with a range of preventive services at health centres and satellite clinics."

The level of staffing at clinics would be stepped up by transferring staff from overstaffed hospitals and negotiating overtime work with professional staff.

Emergency transport services for referred patients would be available at all times.

Masondo said 16 clinics and eight upgraded services would open and 200 graduates would be employed each year to provide free curative primary health care.

R5-bn for free health centres

Star 27/3/96

(98)(85)

Mandatory insurance scheme for employees without medical aid

By Patrick Bulger
Political Correspondent

Cape Town – Health Minister Nkosazana Zuma has proposed far-reaching private health sector reforms and a new mandatory health insurance scheme to make free primary health care available to all over the next eight years – at a cost of R5,31 billion.

Free primary health care (PHC) would be introduced at all PHC centres, including clinics, mobile clinics, day hospitals, and community health centres from April 1. Up to 350 clinics will be built this year and 58 are being upgraded.

Zuma also announced that "essential drugs" would be made available free of charge at PHC centres from the same date and that a R50 penalty fee would be levied on patients who went directly to a public hospital without a referral letter from a PHC centre.

The recommendations are contained in the third report of the Committee of Inquiry into a National Health Insurance System which began work in January last year to devise proposals to make universal primary health care available free of charge.

The report, released in Parliament yesterday, has dropped a widely criticised proposal to levy a tax on employer payrolls, substituting it with "mandatory health insurance coverage" for people not covered by private medical aid schemes. Linked to this are longer-term proposals which argue for an "equalisation fund" which would channel resources from richer to poorer and from high-risk to low-risk medical aid schemes.

The mandatory insurance for everybody in formal employment (excluding those who have private medical aid cover) would affect up to 6 million people and could generate up to R2-billion in hospital use charges. The insurance could cost up to R400 per person a year, provided that the equalisation proposal received cabinet and medical industry approval.

The mandatory coverage would not oblige anybody to use a public hospital, but they would have to pay for certain basic-level hospital treatment, even if they chose not to make use of that treatment. Individual employers and employees would have to negotiate what portion of the insurance each would pay.

The report notes that "it is a well-established precedent, both locally and internationally, that users should pay for some part of the costs of their care in public hospitals".

Other longer-term recommen-

► ... To Page 2

New health care for all plan (85)

► From Page 1

Star 27/3/96

dations are a proposal to compel medical interns to serve two years in public health care facilities and the reform of the tax system as it affects medical aid contributions.

In the shorter term, moves are under way to shift resources from richer to poorer areas and from hi-tech hospitals to PHC centres. Vacant posts at these centres will be filled and doctors might also be shifted.

It is envisaged that the new system will be in place by April 1997, but will take up to eight years to be made fully comprehensive. The cost will be R5,31-billion in this financial year, rising to R7,25-billion in 2001/2.

Birth of national health plan on Monday

(85)

TYRONE SEALE
Political Staff

ARG 28/3/96

THE private health sector is to undergo major legislative surgery as part of a government strategy to guarantee efficient, affordable health care for all South Africans.

Measures under discussion between the department of health and stakeholders in the private health sector include a proposal by the department that the national minister of health should be responsible for authorising the construction of new private hospitals and for regulating supply of expensive technology in both the sectors.

These proposals emerged yesterday as Health Minister Nkosazana Zuma announced a dramatic new package of public-sector health benefits designed to place South Africa's primary health care system, marked by race-based inequities to the present, on the road to recovery, with effect from Monday.

Dr Zuma unveiled the National Health System (NHS) for Universal Primary Health Care which has been given the go-ahead by the cabinet for implementation.

Public primary health care facilities such as clinics, community health centres and local authority centres will provide services free to children and pregnant mothers

KwaZulu-Natal and Northern Province have begun.

The system should be fully implemented by July 1, according to Dr Zuma.

Monday also sees a new Essential Drugs List (EDL) for primary care, comprising medicines critically required for use in the public sector for the prevention and management of 90 to 95 percent of the common and important conditions in the country.

EDL medicines will be available free from Monday.

Primary care: How patients can use it

(85)

Staff Reporter

ARG 28/3/96

USING the new primary health care system – in the new national health package announced by the governement – is a simple procedure, provided the service, or the means to get there, exists.

Patients will first go to a primary care centre, that is: a clinic, day hospital, community health centre or small district hospital. Every patient will first be attended to by a specially trained health care nurse. Depending on the size and situation of the primary care centre, there may also be other health care workers to make sure every patient receives a comprehensive health service.

Patients with complicated problems will be referred to doctors, dentists or psychologists.

Initially, doctors may not be stationed at all the primary care centres. In time, government-approved private health care providers will be able to offer the same services in their own primary care centres.

The government will pay such approved private providers for services rendered to patients.

Patients who require further treatment which is not available at the primary care centre will be referred to specialist — the large regional, tertiary or teaching — hospitals.

If patients bypass the primary care centre and go to a large hospital, they will be charged a fee, except in emergencies, or where primary care centres are closed. The government believes this is important, considering it costs roughly R30 to care for a patient at a clinic, compared to about R70 for the same problem at an outpatient department of a regional hospital and nearly R120 at a teaching hospital.

The government feels that if costs are to be contained, then people who skip primary care centres have to be charged. No one will be forced to go to publicly funded health care centres. If they have money or belong to a medical scheme, they will be entitled to private healthcare

Essential drugs list is significant step in health care revamp

KATHRYN STRACHAN (85)

BD 28/3/96

ON APRIL 1 the health department takes the most significant step in its restructuring programme when it introduces an essential drugs list for state primary health centres.

By setting up the list, which streamlines an existing range of about 3 000 drugs to a package of about 400, government will ensure the cost of drugs in primary clinics will be greatly reduced and that outlying centres will be assured of a reliable supply. Of all the department's initiatives, the new list holds the most promise for improving health services.

But it will have far-reaching effects and the pharmaceutical industry is concerned that the list policy might be extended to private sector health care.

National Association of Pharmaceutical Manufacturers executive director Barney Sachs says such a move would have "potentially disastrous consequences".

While the pharmaceutical industry accepts implementation of the list in state clinics, the potential for it to be applied in the private sector has sparked controversy and been the subject of many behind-the-scenes meetings.

While the health department has shelved its proposals to extend the list to the private sector, whether they are revived later will depend on the private sector's ability to contain spiralling medicine costs. Between the lines, the department is saying that unless the private sector takes steps to reduce medicine costs, it will have to intervene.

But pharmaceutical multinational Glaxo's CEO Andrew Whittey believes health department intervention will not be necessary as the drug manufacturing industry is already rapidly changing the trajectory of price increases. In the past year, six of the 10 multinationals have increased their prices by 6%, below the annual increase in the consumer price index, he says. Glaxo managed to get by with a 3% hike in medicine prices.

The high medicine bill is partly a function of price, says Whittey, but much is due to using wrong drugs and to over-utilisation. For this reason, his firm is developing a system to help doctors and pharmacists prescribe the appropriate medicines.

"In three years, private sector health care will be completely different," he says. Plans to extend exports to about 25 countries will enable pharmaceutical manufacturers to lower prices.

Whittey says it makes sense to rationalise the range of drugs in the public sector, but warns that a private sector essential drugs list is illogical. At present, the private sector buys drugs at about six to 15 times the price offered to the public sector, and extending the list to the private sector would upset this balance. The private sector would no longer be subsidising the public sector and the low prices offered to the state would end.

"This would not be a sensible move to make at a time when government should be diverting wealth," says Whittey.

Representative Association of Medical Schemes (Rams) executive director Reg Magennis says an essential drugs list will work only in a system of private sector managed health care where contracts between the medical schemes and doctors are more specific than at present, and there is agreement on the medicines used and treatment guidelines. The private health sector is moving towards such managed care, he says, and the list could be a useful element in this system.

In the domain of the public sector, the list could have a big effect on medical schemes. If patients found the list met their requirements, they could choose to drop their medical aid and go to the clinics where medicines were dispensed free. However, if the list was too "basic", they would stick with the medical schemes.

Rams is taking the approach of waiting to see the response of patients to the new list.

Another effect of the essential drugs list on medical schemes could be that if the public sector succeeds in dramatically cutting prices, pharmaceutical manufacturers could seek to increase prices to the private sector even further to recover losses.

And pharmaceutical manufacturers would be tempted to drop their public sector prices to rock-bottom to ensure their products were included on the list.

"The essential drugs list will need time to grow and evolve," says Sachs. "Changes to the list will have to be made along the way, and local pharmaceutical manufacturers, too, will have to learn to adjust to the changing health needs if they are to survive."

Trade and industry department chemical and applied industries director David Walwyn is encouraged by the new drug policy's aim of promoting local manufacturing. There is a long way to go in terms of producing a viable SA pharmaceutical manufacturing industry, he says, but the new policy offers two factors which are keys to assisting the process.

Firstly, the list provides a focus for the local industry which allows it to concentrate on improving the quality of selected drugs. Secondly, a selective procurement policy is a stated objective of the new drugs policy. This 15% price preference for local manufacturers means they get the tender even if their product is more expensive than an imported product.

Walwyn says the multinational manufacturers have complained that there is too much regulation in the new system. And he does not believe the health department will stop at implementing a drugs list in the public sector.

He says the local pharmaceutical industry does not generate a lot of profit or revenue in terms of taxes. Because the cost of raw materials is high, little value is added in the local manufacturing process, so the profits are low.

Dr Des Theron, medical officer for the Bo-Karoo district in Northern Cape, says rural doctors are enthusiatic about the new plan's promise to ensure medicines are delivered to outlying clinics.

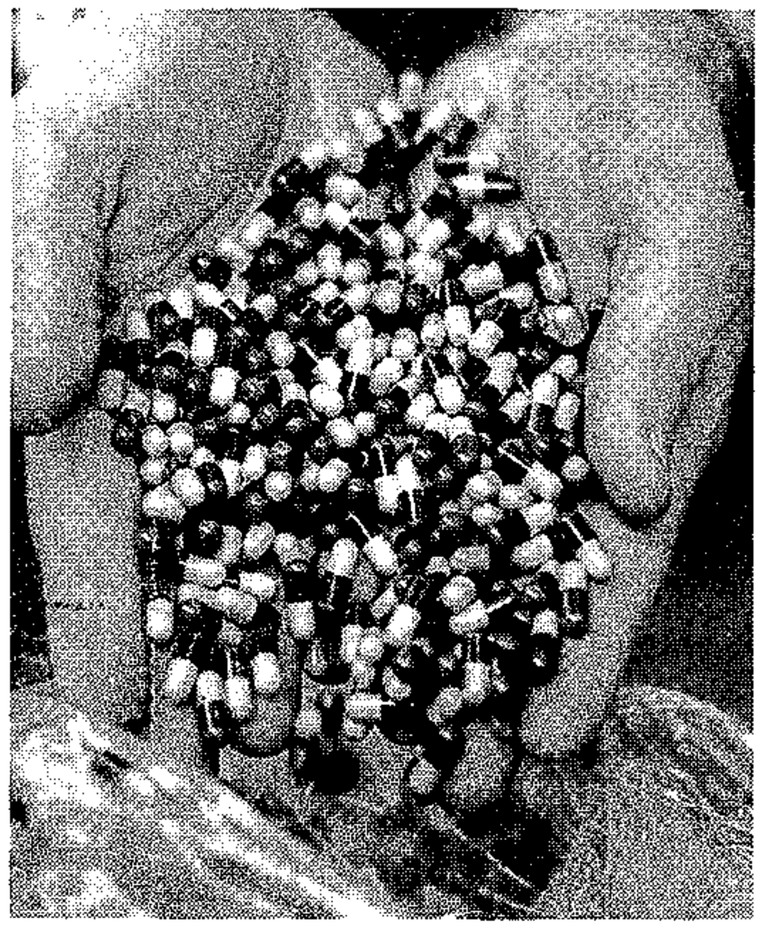
When the nearest pharmacy or supplier is 400km away, reliable distribution is central to health delivery, he says, and a single essential drugs list package will be far easier to deliver than ordering thousands of different drugs from various points.

The list will also boost the primary health care nurse practitioner scheme, he says. In the new health system, nurse practitioners are being trained to a level where they can screen patients on their arrival at the health centre. They diagnose and treat the patients they can deal with, and refer the rest to the doctor — thereby reducing the heavy workload of rural doctors.

And with a streamlined list of about 400 drugs, rather than the previous 3 000, the nurse practitioner will have a better grasp of available drugs.

District councils will also save a lot as they will now get medicines directly through the province at the state price, as opposed to the previous tender system involving dealing directly with separate pharmaceutical manufacturers.

In general, doctors have welcomed the concept, but they are reserving judgment until they know how it will work in practice, the accompanying treatment guidelines, and exactly what drugs are on the list. Among items under scrutiny will be medicines used by traditional healers, which will be investigated for safety and quality with a view to incorporating them in the health system in the future.



There is concern that an essential drugs list will be applied to the private sector.

POLITICS

Health department opts for limited cover plan

(85)

BD 28/3/96

Kathryn Strachan

THE health department's final recommendation for a health insurance system limited to covering those in formal employment was a more affordable alternative, health director-general Olive Shisana said yesterday.

The report, released in Parliament this week, has dropped a controversial proposal to levy a tax on employer payrolls, and opted instead for mandatory health insurance coverage for all in employment (except those who are covered by medical schemes).

Shisana said this decision was made after the department had analysed the concerns of the public — in particular the concerns of labour unions and employer groups who felt the payroll tax (which would amount to a 2% tax increase) would be too costly.

Whether this proposal would finally be implemented depended on Cabinet's decision and on further consultation with stakeholders. It is envisaged that the new system will be in place by April next year, but will take up to eight years to be made fully comprehensive.

But the decision took health circles by surprise as most expected the payroll tax option.

Cape Town University health economist Di McIntyre said the mandatory health insurance system was the more popular alternative as people paying into the health insurance were offered a definite package, and there was a direct link between their contribution and the insurance cover they received in return.

She said a dedicated tax imposed on their salaries, which would be spread out to improve health services for everyone whether employed or not, was less popular. It would also have increased the costs of labour quite significantly and been difficult to implement in a country with such high unemployment.

While the mandatory health insurance system would cover the hospital expenses of its contributors, people not in formal employment would still be charged hospitals fees.

But the plan is expected to make health care more affordable to poorer people in the end. The mandatory insurance for all in formal employment (excluding those who have private medical cover) will affect up to 6-million people and could generate up to R2bn in hospital user charges. The insurance could cost up to R400 a person a year.

As hospitals will now generate their own revenue, the health department resources will be freed and can be shifted to primary health clinics — where services will be free to everyone from next week. The existing situation where the very poor are exempt from paying hospital fees will be retained.

See Page 16

(85)

Free health plan too costly'

ST(M) 31/3/96

By JESSICA BEZUIDENHOUT

THE Western Cape Health Department, currently operating on a budget deficit of more than R300-million, has been dealt another financial blow following the announcement of free health care by Minister Nkosazana Zuma earlier this week.

Dr Zuma's plan for primary health care would cost the province an additional R50-million, the Western Cape Minister of Health and Social Services, Ebrahim Rasool, said on Friday.

Preliminary estimates of the financial impact of the new plan on the province's budget, indicated a loss in revenue of about R15-million, Mr Rasool said. An additional R35-million would have to be ploughed into primary health care to provide additional services, including staff and drugs.

The department was not in a position to implement the free health care plan at qualifying Western Cape institutions as from tomorrow, Mr Rasool said.

While the nine provinces had been given three months to implement the free care system, expectations had been raised and people were already expecting the services to be free.

Dr Zuma puts private health (85) control on hold

ST 31/3/96

By PAT SIDLEY

THE primary health care plan launched by the government this week has been toned down considerably from the original draft, with the private sector being given a reprieve from planned regulation.

Part one of the plan, the provision of free primary health care at public facilities such as clinics, community health care centres and local authority clinics, will be implemented from tomorrow.

The reform of the private health sector, the most controversial part of the original plan, needs legislation before it can be implemented and is going to be thrashed out in discussions between industry bodies, the government and Nedlac over the next few months.

Kwazulu Natal and the Northern Province have already been providing free services at their clinics, and these should be fully implemented in other provinces by July 1.

Any drugs on a list called the Essential Drugs List for Primary Care will also be issued free.

South Africans will, however, have to pay for being treated in a hospital — and patients will face a penalty of about R50 for going straight to a hospital instead of calling first at a nearby primary health care centre.

This move is intended to help the larger hospitals, which are groaning under the pressure. Payment at hospitals will be on a sliding scale, much the same as it is currently, and no one will be refused treatment if they cannot afford to pay.

In provinces like Gauteng or the Western Cape, which have suffered budget cuts, the scheme will cost millions of rands to implement. Gauteng estimates it will cost around R16-million, including losses of revenue from the collection of fees for primary health care.

Training of health professionals is being revised, and Health Minister Dr Nkosazana Zuma said doctors, nurses and health professionals in the civil service would be paid substantially more from the middle of the year.

NKOSAZANA ZUMA
Health plan launched

It was a timely leak of the government's payment intentions, for it is most likely that the work loads of doctors, nurses and others in the health system will increase markedly.

Despite the announcement of the cabinet's acceptance of the system, the plan has some way to go.

The system will require funding of about R5-billion which will come out of the budget allocation of around R17-billion for the coming financial year.

Exactly where the money will come from and how it will be spent has not yet been properly worked out. The district health authorities, around which the system will operate, have not been set up, and the laws to provide the legal framework for the system are only now being drafted.

The implementation of the regulation of the private sector (medical aids, insurance, regulating of doctors and private medicine) will have to wait for more discussion.

But Dr Olive Shisana, the Director General of Health, is adamant that this section will be dealt with in the draft National Health Act which she intends to have ready for Parliament by mid-year.

Of the about R30-billion spent on health care in 1992/93, more than 60 percent of it came from the private sector, which only catered for 20 percent of the population.

The government is seeking some way of redistributing this resource.

The Ministry of Health has, with its experts, come up with an elaborate set of proposals, some of which have already met with criticism from many in the private sector.

These include:

- A proposal for all employed people to buy mandatory basic hospital plans to pay for hospital treatment for them and their dependants;
- A system to ensure that medical schemes are discouraged from "risk rating", the process of weeding out members who were seen as high risk like the chronically ill, the elderly or infirm. This may include penalising those that continue to risk rate by taxing them;
- An equalisation fund which would see part of the contributions from the medical scheme paid into it so that it could fund schemes with "high-risk" groups of people; and
- All existing medical aid contributions (both the employers' and employees' portion) would be considered part of an employees' taxable income.

Basic health care now free in N/West

By DAN DHLAMINI (85) LP 31/3/96

NORTH West MEC for Health and Developmental Social Welfare Dr Paul Sefularo announced this week that primary health care would be provided free as from tomorrow.

He said fees at all clinics and community health centres should be eliminated and a "bypass fee" should be introduced at all hospitals, over and above the normal charge for whatever hospital service was used.

Sefularo said patients who were referred to hospitals from a health care facility should not be charged the "bypass fee".

His announcement of the new, free health system came shortly after his colleague, MEC for Finance and Economic Affairs Martin Kuscus, allocated his department R1,181 billion in the province's budget.

Sefularo told reporters that free health care would be provided at all community health centres in the province because his department wanted to make it easy for people to get medical help.

He also announced that as from tomorrow all public primary health care facilities would be open from 7 am to 7 pm, and during peak hours all staff should attend to patients. He said lunch hours should be readjusted so that patients could be treated without delays.

"All the drugs on the new Essential Drugs List (EDL) will be available at all Primary Health Care (PHC) facilities from April 15, 1996. If patients are to be successfully diverted away from hospitals, it will not be acceptable for clinics to run out of medicines at any time," said Sefularo.

Sefularo also emphasised that needles, syringes and all disposable medical products would be made available, as are medicines.

He said at least one ambulance would be stationed at the clinic serving any given community.

Mr R K SIZANI: Mr Speaker, arising from the Minister's question . . .

The DEPUTY SPEAKER: Order! You mean "reply". I hope the Minister did not put a question to you!

Mr R K SIZANI: Yes, arising from the Minister's reply, if the information that he has given us is correct, why is he instituting an inquiry into the fishing quotas and corruption under a judge?

The MINISTER: Mr Speaker, the hon member has not listened to the details of the investigation which has been instituted. The allegations investigated concern members of the quota board who are not qualified in terms of the Act—that is the allegation—to serve on the quota board. It has nothing whatsoever to do with public servants. [Interjections.]

The DEPUTY SPEAKER: Order! Are there any further questions? Mrs De Lille, are you happy?

Mrs P DE LILLE: No, Mr Speaker. I will engage the services of the *Mail and Guardian*. I think they will help me to get those names.

The DEPUTY SPEAKER: That is a great pity, because this is perhaps a better forum. Be that as it may, we have to be friendly to the press.

List of State assets

*7. Mr C A WYNGAARD asked the Minister for Public Enterprises:

(1) Whether her Department is compiling a list of all State assets; if not, why not; if so, when will the task be completed;

(2) whether such list is to be tabled in Parliament; if not, why not; if so, what are the relevant details:

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

N256E

The MINISTER FOR PUBLIC ENTERPRISES:

(1) Yes. We are dealing with two aspects here, namely:

— State assets of a non-commercial nature; and

— State assets of a commercial nature.

In so far as the assets of a commercial nature are concerned my Department is compiling a list of these assets. With regard to what I might call physical assets, the responsibility lies with the Ministers of Public Works and of Land Affairs.

(2) Although it has not been requested by Parliament, I am willing to table it when the list is completed.

(3) No.

Business interrupted in accordance with Rule 199(3) of the Standing Rules for the National Assembly.

Prisoners: previous convictions

*9. Mr A J LEON asked the Minister of Correctional Services:

(a) How many persons currently in South African prisons had previously been convicted of other offences, (b) what percentage of the total prison population does this constitute and (c) in respect of what date is this information furnished?

N259E

The MINISTER OF CORRECTIONAL SERVICES:

(a) The figures in prisons country-wide are not readily available and can only be obtained through a time-consuming, expensive and manpower-intensive national survey. However, the following figures applicable to sentenced prisoners at three of the country's prisons have been made available in order to provide some perspective on the matter:

- Pretoria Local Prison — 571
- Pretoria Central Prison — 750
- Pretoria Maximum Prison — 192

(b) 57,5% of the total prison population at Pretoria Local Prison
67,3% of the total prison population at Pretoria Central Prison
61% of the total prison population at Pretoria Maximum Prison.

(c) Pretoria Local Prison — 96/03/18
Pretoria Central Prison — 96/03/06
Pretoria Maximum Prison — 96/03/06

Primary School Nutrition Programme: amount budgeted

*10. Mr M J ELLIS asked the Minister for Health:

(1) What amount was budgeted in the 1995/96 financial year for each child to be fed in terms of the Primary School Nutrition Programme;

(2) whether her Department and/or any provincial departments have established the actual cost per child of this programme; if not, why not; if so, what is the cost?

N260E

The MINISTER FOR HEALTH:

The following table reflects the situation per province and at national level.

	(1)	(2)
Province	*Average budget allocation per child*	*Average actual cost per child*
Western Cape	50c per child per day	Fixed allocation of 50c per child per day irrespective of actual cost
Northern Cape	88c per child per day	150c per child per day
Eastern Cape	53c per child per day in urban areas 68c per child per day in rural areas	61c per child per day
Free State	25c per child per day	25c per child per day
KwaZulu-Natal	55c per child per day	Fixed allocation of 55c per child per day irrespective of actual cost
Gauteng	88c per child per day	96c per child per day
North West	76c per child per day	58c per child per day
Mpumalanga	68c per child per day	Fixed allocation of 68c per child per day irrespective of actual cost
Northern Province	73c per child per day	73c per child per day
National Average	64c per child per day	71c per child per day

Health care: restructuring

*11. Mr M J ELLIS asked the Minister for Health:

(1) Whether her Department produced any documentation in 1995 in regard to the restructuring of health care in South Africa; if so, (a) what was the name of each such document produced and (b) on what date was each document released;

(2) whether such documents were made available to the Portfolio Committee on Health; if not, why not; if so, on what dates;

(3) whether the said Committee is being fully and timeously briefed in regard to such documents and other activities of her Department; if not, why not, if so, what are the relevant details?

N261E

The MINISTER FOR HEALTH:

Yes; (a) and (b).

(1) Restructuring the National Health System for Universal Primary Health Care (Draft); released on 19 June 1995.

(2) Position Paper on the Decentralisation of Hospital Management (Draft); released on 8 December 1995.

(3) Towards a National Health System (Draft); released on 3 November 1995.

Conditions in mental hospitals

*14. Mrs D GOVENDER asked the Minister for Health:†

(1) Whether she has been informed about the alleged appalling conditions prevailing in mental hospitals; if so,

(2) whether she intends taking any action in this regard; if not, why not; if so, what action;

HEALTH POLICY

ZUMA PLUNGES INTO RENEWED CONTROVERSY

(85) FM 22/5/96

A new tax by another name

While *Sarafina 2* plays itself out in the public view, Health Minister Nkosazana Zuma is privately contriving to rush her national health policy through the Cabinet before April 1. If she is successful — and Finance Minister Chris Liebenberg's Budget speech intimates that she might already have been — the fiscus is in for a shock. For her spending estimates are way below what the experts say will be the true cost.

***Jonathan Broomberg** . . . new cost estimates*

The proposals are not new. The policy document before the Cabinet encompasses the final version of the report of the National Committee of Inquiry into a National Health Insurance System — better known as the Broomberg/Shisana report. Convened in January 1995, the committee issued its first report last June which recommends:

- ❑ Free and universal access to primary health-care services within five years through a system of local district health authorities;
- ❑ A stronger public health sector — to be achieved by increasing the number of health facilities and personnel (through more specially trained nurses);
- ❑ A dramatically scaled down medicine bill for the public and private sectors — to be achieved mainly by buying only essential or "listed" drugs;
- ❑ Mandatory hospital cover for all employees to cover a basic package of hospital benefits; and
- ❑ Stringent regulations for the private sector.

The first report was well received except for serious reservations over the plan's cost, which was underestimated. But it also proposed a payroll tax and would threaten the cost savings and financial stability achieved in the private sector through the deregulation of medical schemes.

The final proposal does little to address these concerns.

A comparison of the two reports shows that the costing of the entire plan has undergone a radical overhaul — probably to satisfy the Finance Department. The latest report states that over the period 1996-1997 to 2000-2001 the total cost of primary health care will be R4,9bn less than the more modest model costed in the first report.

Another peculiarity is the decline in the projected funding gap or shortfall between available government funds and the amount needed to fund the primary health-care plan. In the first report, the cumulative shortfall of the five-year plan totalled R9,2bn. In another document, this amount appears to decline by R6,75bn to only R2,45bn while the list of services to be provided under the plan increases.

Nkosazana Zuma *. . . pressing ahead with new policy*

The updated report explains that the period for implementing the plan has been extended from five years to eight, though none of the calculations in the final report appears to have been adjusted to allow for this extended period of implementation.

There's also a substantial drop in projected usage — that is, the estimated number of public health-care visits. The first report estimated that the average number of visits would rise from two in 1997-1998 to 3,5 in 2000-2001.

The second report is costed on the assumption that the average number of visits would rise from only 1,8 to 2,8 in this period. Can these figures cater for an HIV infection rate doubling every year?

Their accuracy is, of course, crucial to the entire model since it underpins the fundamental costing. If the model is under-costed, any tax or levy in any part of the model would simply be raised by a government desperate to appease health-care expectations.

The alternative is that public services would be slashed, resulting in queuing and crude rationing.

This fear is exacerbated by capital expenditure having been cut back by R1,185bn in the final report. A breakdown shows:

- ❑ For 1996-1997, Broomberg/Shisana report number 1 (BS1) earmarks R327m for capex, BS2 sets aside only R175m;
- ❑ In 1997-1998, BS1 provides R365m and BS2 only R182m;
- ❑ For 1998-1999, BS1 seeks R417m and BS2 just R189m;
- ❑ The 1999-2000 period sees BS1 budgeting for R476m and BS2 R196m; and
- ❑ For 2000-2001, BS1 sets aside R546m and BS2 R204m.

The second report optimistically relies on the expectation that it will receive a substantial amount of foreign aid. And it clearly depends heavily on proposed mandatory hospital cover and retained user charges at public hospitals as sources of additional revenue.

States the report: "Total public health expenditure is expected to grow from R16,8bn in 1995-1996 to R19,8bn in 2000-2001, representing an average real increase of 3,4% a year.

"However, because of the other proposed sources of finance, the growth of funds from government votes need increase at an average rate of only 0,6% a year (excluding any real increases in public health workers' salaries)."

But it is the proposed mandatory package that poses the greatest problems for the plan and, indeed, for total public- and private-sector health-care expenditure.

Put succinctly, the fear is that such a package is little more than a blueprint for a payroll tax because the greatest contributors are not likely to use State facilities.

The proposal — for "mandatory health insurance coverage for a defined hospital benefits package" is intended by the committee to ensure that all employed individuals and their families be covered for "at least the costs of their use of the public hospital system."

This, states the report, might take the form of indemnity coverage, with the possibility of a specified maximum limit per beneficiary each year.

The report says that the mandatory package would not require that those covered be treated in a public hospital. So employers and medical schemes would be free to negotiate favourable rates with private hospitals. But it suggests that part of the coverage be reserved in case of treatment in public hospitals.

Contributions — to be determined on a sliding scale — would not necessarily go into an existing medical scheme but might instead be channelled through a new State-sponsored hospital plan which would be administered either by a private-sector or a State administrator.

Olive Shisana *. . . co-author of revised report*

Says Momentum Health MD Adrian Gore: "The reality is that people who can afford private-sector health care will not use public hospitals. As the proposal relies on contributions to the mandatory package to be income cross-subsidised, we get back to the situation that the Department of Health is trying to avoid — namely, that those who use public hospitals are not the ones who are paying for the service.

"In such a guise, this is merely a tax that will be used to finance public-sector health spending. It would be more appropriate and more equitable to use general taxation."

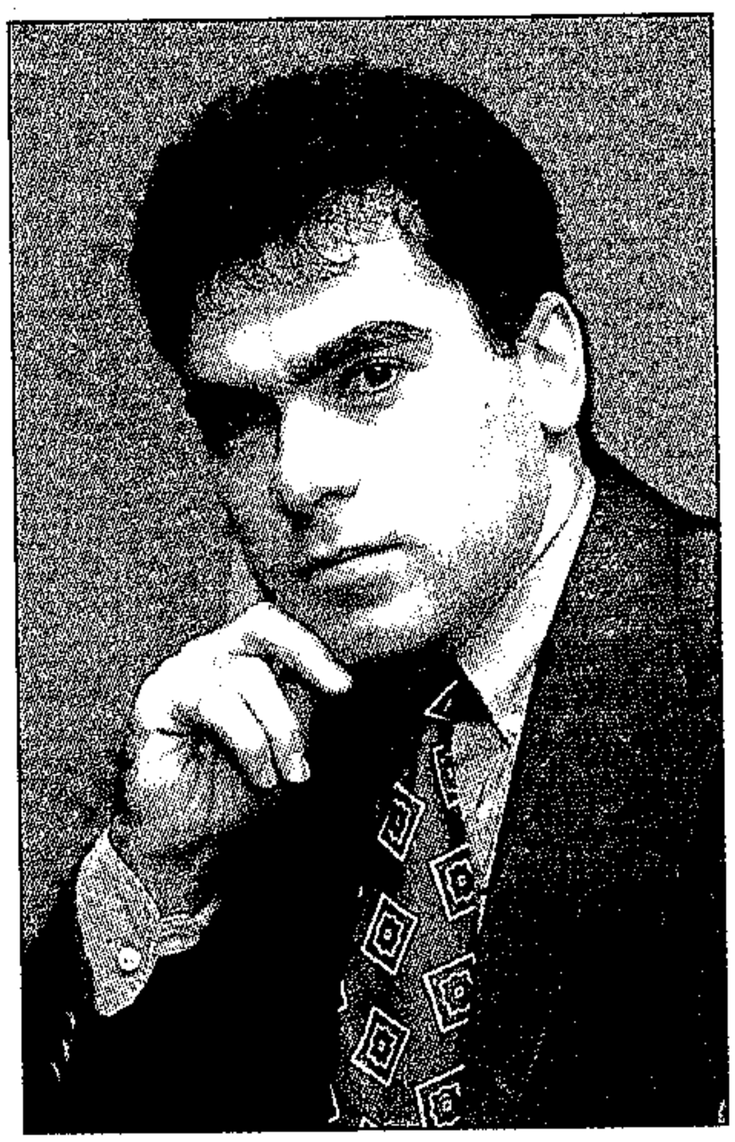
Little insight is given in the proposal as to how the costs of the mandatory package are to be controlled, except for statements about competition between public and private hospitals being encouraged alongside managed care techniques.

"The problem, though, is that the State could have a monopoly as seller of services through the mandatory coverage, whereas managed care techniques rely on the ability to make markets out of health-care providers. This does not bode well for cost containment."

Gore, an actuary, also rejects the notion that the package will stabilise the medical scheme environment.

"The workings of the mandatory package are extremely complex, especially considering the requirements of government's proposed equalisation fund which is geared to cross-subsidise schemes with high-risk members from the schemes with low-risk members," he says.

Gore stresses that any cross-subsidisation within the mandatory package should not spill over to other benefits offered by medical schemes and health insurers. So one needs to evaluate the financing of the mandatory package in isolation and ensure this is sustainable.



Adrian Gore *. . . mandatory costs likely to increase*

The first Broomberg/Shisana report's assumptions that deregulation had caused the financial crisis among private medical schemes continues to underpin the proposals in the latest report.

And despite recent figures proving that deregulation of the industry has brought about cost savings and greater stability, the latest report proposes to reverse many of these gains by prohibiting risk-rating.

The report recommends the deregulation of pharmacy ownership, potentially allowing for medical schemes and business to enter the retail market — a move that has shaved costs elsewhere.

The end to the tax deductibility of employer contributions for medical scheme payments could have advantages.

However, the report proposes greater government controls over the supply of hi-tech equipment, private hospital and practitioner licences — deliberately defying general economic rules which prove that an adequate supply of services fosters competition for prices and service.

Zuma must know the proposals are as incomplete as they are controversial since she is seeking immediate Cabinet approval only for the proposals that directly affect public health care.

But the document does say that the Health Department will urgently seek to enshrine in legislation the principles proposed in the papers for the private sector — leaving the details for secondary legislation. This may be neither prudent nor constitutional. ■

tion; if so, what are the relevant details; if not, why not?

N377E

The DEPUTY MINISTER FOR SAFETY AND SECURITY:

(1) Yes.

(2) Yes. After his acquittal in the criminal case on a charge of statutory rape the officer was charged in a disciplinary trial with the contravention of regulation 58(4) "Conducts himself in an improper manner or in a manner unbecoming a member of his rank". He paid an admission of guilt fine of R150 on 2 September 1993.

(3) Yes. To lieutenant.

(4) Yes. The officer was due for promotion on 1 January 1993 which was held back for the period of 12 months as a result of the charge. He was promoted to the rank of lieutenant on 1 January 1994.

With the implementation of the new ranking structure he was appointed as captain. This was, however, not a promotion.

Mr D H M GIBSON: Mr Chairperson, arising out of the hon the Deputy Minister's reply, could a finding by an inquiry board of guilty on a charge of conduct unbecoming his rank possibly justify his being promoted to a higher rank a year later, and then being adjusted again to captain automatically? Does the hon the Deputy Minister approve of promotions in circumstances such as these?

The DEPUTY MINISTER FOR SAFETY AND SECURITY: Mr Chairman, the hon member has asked for my opinion, which I decline to give. However, this was a matter which occurred under a previous dispensation. There are a lot of things which occurred under the previous dispensation of which I do not approve.

Incentives encouraging smaller families

*9. Mr M J ELLIS asked the Minister for Welfare and Population Development:

Whether he intends introducing incentives aimed at encouraging smaller families; if so, what incentives; if not, why not? N378E

The DEPUTY MINISTER FOR WELFARE AND POPULATION DEVELOPMENT:

No. There is strong international consensus that coercive measures, such as laws and other measures enforcing a small family norm, are not culturally and politically acceptable and therefore also not successful in the longer run. Moreover, the implementation of incentives and disincentives to influence population trends violates internationally accepted basic human rights—and definitely, in our case, national human rights as well—such as the right of individuals and couples to decide freely and responsibly on the number, spacing and timing of their children and to have the information and means to do so. The consideration of implementing incentives or disincentives of any nature also necessitates the consideration of ethical, cost and administrative implications in this regard.

Governments are therefore encouraged to focus most of their efforts on meeting their population and development objectives through education and voluntary measures rather than schemes involving incentives and disincentives. The content of these should be developed by each country according to prevailing local conditions. It should be clear that suggestions regarding possible incentives and disincentives to influence population trends in South Africa are definitely not the most apt intervention method.

Mr K M ANDREW: Mr Chairperson, arising out of the hon the Deputy Minister's reply, could she tell us what education programmes in this regard are in place at present? What was the amount spent during the past financial year on those programmes?

The DEPUTY MINISTER FOR WELFARE AND POPULATION DEVELOPMENT: Mr Chairperson, with regard to the amount spent, that is not a question that I was required to answer today, and hence I do not have the specific figures here now. However, if the hon member can present that in writing, we will give a reply in writing.

With regard to the first component of the question, about the information and education programmes in place in South Africa right now, the hon member should be quite conscious of the fact that we are in the process of reformulating the population policy as a whole. We have just had a major meeting at which we looked at this new policy. With regard to the concrete programmes, we will give that hon member the new, because I do not think we want to harp on the old.

Hansard

Free health care (85)

*10. Mr M J ELLIS asked the Minister for Health:

(1) Whether the policy of free health care to pregnant women and children under the age of six years is being reviewed; if not, why not; if so, why;

(2) whether this policy is to be extended to (a) the aged, (b) the handicapped and/or (c) any other categories; if not, why not; if so, what are the relevant details;

(3) whether she will make a statement on the matter? N379E

The MINISTER FOR HEALTH:

(1) No. Children under six and pregnant women will continue to receive free health care at all public health institutions—primary, secondary and tertiary.

(2) The policy of free health care is to be extended to all people living legally in South Africa who use publicly-funded primary health care centres.

(3) Yes. It is the belief of the department and of the Government of National Unity that health is important and should not be a privilege for the rich. It should be accessible to everybody, irrespective of their means. We are therefore extending free primary health care to the rest of the population.

We are mindful of the fact that there are people who can afford to pay, but those do not use the public clinics anyway. They tend to use their medical aid schemes and go to private doctors.

We also believe that health is not only a matter of dealing with disease, or with people who are ill. We think it is broader than that. It should include health promotion and preventive health, and we will not be able to achieve that if we say that people must pay in order to have contact with health workers. Primary health care must be available freely in this country if we are to make an impact in improving the health of the population.

Mr W A ODENDAAL: Mr Chairperson, arising out of the reply of the hon the Minister, since I received my concerned calls from the Free State today from people who say that the infrastructure as it exists is not capable of dealing with what the Minister has just announced, is she certain that there will not be chaos in these clinics?

The MINISTER FOR HEALTH: Mr Chairperson, I think chaos in the clinics was last seen before the April 1994 elections. Having said that, this has been canvassed very widely. There has been wide consultation with the provinces, members of the public and all stakeholders since January last year. We have consulted with local authorities. Everybody is happy that they can accommodate this, and the policy has been phased in. Two provinces have already started and others will start in April. Everybody is expected to have implemented this by 1 July 1996.

We believe that if there is a problem, it will not be because of the policy, but because there are not enough facilities. To this end we are completing more than 300 new clinics this year and upgrading many more in order to deal with the problem, so that it will not be a case of a few clinics having to take the whole load. For the next five years we will be building more clinics to ensure that everybody has access to a clinic.

African Bank: branches

*11. Mr K M ANDREW asked the Minister of Finance:

Whether, in September 1995, the African Bank had branches or provided financial services at any places in South Africa where no other bank or financial institution had branches or provided services; if so, (a) at which places and (b) how far away in each case was the nearest place where a bank or financial institution had a branch or provided financial services. N380E

The MINISTER OF FINANCE:

Yes. To the best of our knowledge, The African Bank Limited had branches in the following places, where the said branch was the only bank/financial service provider:

(a)	*(b)*
Branch	Distance to nearest other bank
Lebowakgomo	12 kilometres
Mamelodi	4 kilometres
Soshanguve	8 kilometres
Acornhoek	30 kilometres

Free primary health care at Gauteng clinics from today

(85) Star 1/4/96

Primary health care at 40 curative clinics in Gauteng will be free from today.

"We have been planning this for the past month. We are prepared, staff have been consulted, drugs are in place and we don't anticipate any problems," said the province's health spokesman Popo Maya.

"It's not yet winter and there probably won't be a flood of patients," he added.

It is expected to cost the department R16-million for the 1996-97 financial year and generate an extra 430 000 visits a year.

Most of the 40 clinics are in the central region (20), with the remainder on the East Rand (12), West Rand (three), Vaal (two) and Pretoria (three).

The Hospital Personnel Trade Union (Hospersa) welcomed the principle of free primary health care but condemned Health Minister Dr Nkosazana Zuma.

Hospersa had not been properly consulted about the plan, and there was considerable dissatisfaction with the timing, the union said.

Neither staffing structures nor conditions of employment had been sufficiently altered to compensate for the expected increase in workload.

There were insufficient primary health care nurses and the district health system was not yet in place, it said. – Medical Correspondent.

Free health scheme to cost W Cape 'extra R50m a year'

ET 11/4/96

HARD-PRESSED staff at clinics, community health centres and day hospitals in the Western Cape are bracing themselves for a dramatically increased workload once the free health scheme is added to the present free treatment for pregnant women and children under six. (85)

An exco decision is expected on April 10.

Health and Welfare MEC Ebrahim Rasool estimates the scheme will cost the province an extra R50 million a year and has appealed to Pretoria for financial back-up.

Health services to be developed this year

BD 2/4/96 (85)

Kathryn Strachan

HEALTH Minister Dr Nkosazana Zuma is confident the transformation of health services will take off this year.

Until now the focus has fallen on restructuring services and on policy development, but this year will see more emphasis on improving delivery and implementing new policies.

"We first had to get the instrument right before we could develop health services," says Zuma.

With the previously fragmented structure of health care now integrated into a single rational entity, and with about 400 new clinics built, the foundation for the country's new health service is in place.

The first priority is to develop local authorities to put them in a position to deliver these services.

ZUMA

While the new structure was being developed, a number of practical steps were taken in the interim. The school feeding scheme and free primary health care for children under six and pregnant women were launched, new tobacco regulations were introduced and AIDS was given far more attention.

A strategy to provide free primary health care for all was announced this week.

"We may say primary health care is now free for all, but unless the clinics are there, the concept is meaningless," says Zuma. For this reason, the clinic building project has been a priority. At present, consultation fees range from R2 to R10, and this, added to transport fares, presents a burden for many poor families.

Also on the cards is the plan to introduce an "essential" drugs list on April 1. The list is intended to reduce the cost of medicines and ensure that clinics do not run out of medicines.

Another focus is changing the structure of hospitals. While criticism has been levelled at the department for focusing on primary health care at the expense of hospital care, Zuma believes that a balance has to be struck between the two. There cannot be a strong primary health care service without back-up from the other levels of health provision, she says.

By the end of March, an audit will be completed of all the facilities in hospitals around the country, excluding academic hospitals, and of how much it will cost to upgrade them. Once this figure is available, the department will be able to set about finding ways to fund the upgrading.

One option is to promote cost containment at hospitals by giving hospital managers more autonomy and allowing them to take decisions which will lead to savings and improved quality, and by allowing hospitals to retain some of the revenue collected through fees, they will be given greater incentive to operate cost effectively. The feasibility of this option is under investigation, and a conclusion is expected in June.

Feeding scheme

While the schools feeding scheme reaches primary school pupils, preschool children are still not catered for, and there are plans to help families develop food security through small-scale and collective farming projects.

The next challenge is to transform the way health workers are trained in order to make them more receptive to the health needs of the country.

A team is visiting medical schools nationwide and once the tour is completed it will propose changes to the admission policy, the curriculum and the process of training students.

It will also look at making medical training accessible to people from disadvantaged backgrounds through providing bursaries.

By bringing in students from deprived communities, these students will have a closer understanding of the needs of their communities and will be more likely to serve in these areas once they are graduated.

These proposals, together with improved conditions for doctors in the public sector, will hopefully address the scarcity of doctors — particularly in more outlying areas. Zuma believes that one of the major boosts for health reform this year is the salary increase given to health workers.

Salary improvements for public sector doctors will lift their morale, and will hopefully attract private doctors in to the public sector.

Other incentives being investigated to draw doctors to rural areas include awarding rural working experience academic status by counting it as a credit for postgraduate studies. Academic links can also be strengthened by setting up information networks to connect rural hospitals with consultants in the larger centres.

This will be explored next month when health workers get together to look at using information highways in health.

By setting up technology which can send X-rays and ECGs from outlying clinics to central hospitals, health workers in rural areas will have the backup of academic medicine.

But Zuma believes that it will take time before all these improvements, and incentives, lead to a marked increase in the number of doctors in outlying areas.

In the meantime, it is necessary to ease the workload of the few doctors still serving in these areas by bringing in foreign doctors to share the workload, she says. Discussions are underway with the Swiss and German health departments, and with the UN volunteer service.

"It would be naive to think we will see doctors rushing to the public sector. It will be a gradual change, and we will be relying on foreign doctors for quite a while because we will never be able to offer private sector salaries," she says.

For this reason, she regards the Cuban doctors not as an alternative to local doctors, but as a support to overstretched doctors working in outlying areas. The nurse practitioner scheme which is upgrading the skills of selected nurses to enable them to play a greater clinical role will also spread out the workload at rural clinics.

The department is also considering drawing private doctors to underserved areas through a system of issuing licences for new practices.

While private doctors at present can practice where they choose, the proposal is that the department would distribute licences through rural areas and townships — and doctors would be able to open new practices only in areas where there are licences available. This proposal would not affect existing practices.

These mechanisms for redistributing health resources to under-served areas all fall under the fundamental plan to shift funds between provinces. While the initial aim was to reallocate funds between provinces to achieve per capita equity over five years, Zuma believes that the disparities between the provinces are too large and it will take at least 10 years to reach this goal.

The task of redistributing resources and of transforming health services from a curative approach to a more preventative focus has not been quick or easy. "There have been a lot of vested interests, but we have to look at the global picture — our main task is to look after the health of the population."

The high cost of medicines, the lack of infrastructure, the scarcity of resources and the escalating number of AIDS cases have all presented their obstacles. "But even within the constraint of our budget I believe we will achieve a lot this year," says Zuma.

"We have credited ourselves with beginning to change the concept of health services. It is no longer a market commodity, but something that government has to take full responsibility for.

"But if after five years there is still widespread kwashiorkor and marasmus, I do not think we can really say we have transformed health."

The Star ... Tuesday April 2 1996

Free primary health care a shot in the arm for nurses

(85) (88) Star 2/4/96

Much fanfare as clinics drop R8 fee, which about 40% of patients weren't able to pay

MEDICAL CORRESPONDENT

Dancers and an SAPS band were the highlights of the festivities at Zola Clinic in Soweto yesterday to officially mark the launch of the provision of free primary health care services.

Dropping of the R8 fee for treatment was expected to make a major impact on surrounding areas, said Dr Soomati Natha, director of the 15 primary health care clinics under which Zola falls.

"About 40% of patients weren't able to pay the fees anyway. Many others, especially chronically ill people, used to default on their treatment because they couldn't afford the fee," she said.

To ensure the smooth introduction of the new service, Gauteng has recruited 40 volunteers to assist clinic staff, offered nursing staff the option of working paid overtime, and recruited general practitioners to do shifts in the clinics.

Nurses were highly enthusiastic about the move, and the overtime option for nurses meant the province could immediately increase its staffing by 25%, said Gauteng's deputy director-general of health Dr Eric Buch.

National Director-General of Health Dr Olive Shisana said a national clinic-building programme would see 343 new clinics finished this year, 58 upgraded and 3 000 given a minor facelift.

Fully funded vacant posts, especially at primary care level, would be filled and improved salaries and working conditions would hopefully attract doctors back to the public sector, Shisana said.

Effective primary health care was cost-effective health care, but it would take 10 years to achieve full access to health care countrywide.

■ The Freedom Front said the free health care was an expensive disaster that would cost the country dearly. FF spokesman for health B J van der Walt said SA's health care infrastructure was too weak to execute the plan successfully.

Lack of consultation about the execution could lead to future labour unrest among nurses as they battled to adjust to massive new workloads, he warned.

Bringing health to the people

(85) Star 2/4/96

The South African system is characterised by distortions, writes Ayanda Ntsaluba

The South African health care delivery system is facing numerous challenges. Elements of our system offer some of us services comparable to the best in the world, while millions of our compatriots are destitute and without access to the most basic services. Surely such a scenario is incompatible with the fundamental tenets of the caring democratic dispensation that we all aspire to establish.

The greatest ch lenge revolves around our ability to preserve and develop the positive aspects of the system whilst ensuring improved access to the multitudes hitherto marginalised. This has to be done within the Government's overall macro economic policy, centred around fiscal discipline and the realisation that our resources are limited.

Those who have followed debates on health policy over the past few years will realise that the relationship between cost, quality and access is not always harmonious. Painful choices have to be made – but our decisions must at all times be based on sound scientific exploration of all the options available to deal with our particular circumstances.

It is estimated that we already spend 8,5% of the Gross National Product (GDP) on health.

This is a hefty allocation and South Africa cannot afford any significant increase in this sector's expenditure. Policy-makers, administrators, providers and consumers have to ensure that we maximise benefits from within existing resources.

With the infant mortality rate in some communities at between 90 and 100 per 1 000 live births and maternity mortality at between 80 and 90 per 100 000 live births – most of these due to preventable causes – there is enormous scope for significant improvements.

This applies to both the private and public sectors.

Our health system is characterised by serious distortions which have combined to precipitate a tendency towards unsustainable cost escalation. Irrational prescribing patterns, high costs of medicine, inappropriate use of technology, reverse incentives resulting from the fee for service reimbursement system and a highly unregulated third party system are some of the ills of our private health care system. The public sector is characterised by archaic management structures which, combined with a deteriorating work ethic, ensures that the roads to some of our facilities are travelled only by the most desperate.

The way forward: It is internationally accepted that one of the most important determinants of the improved health status of a nation is universal access to health care, especially at the primary level. The policy of a national health system for universal primary care aims to remove all barriers to access to and utilisation of services at the primary level.

These include personnel, drug and facility availability, as well as price.

The Department of Health has embarked on a clinic building and upgrading programme which aims at ensuring facility availability with a reasonable distance of communities. Apart from the convenience this brings, it also reduces the hidden costs such as transport and time away from home.

This activity will be complemented in due course by a structured partnership between the public and private sectors to ensure private sector resource utilisation where appropriate.

The public sector can then direct its limited resources in a more focused manner to the areas which have no facilities at all.

The recently released national drug policy spells out a coherent strategy to ensure continued availability of appropriate drugs at each level of care. The policy offers concrete solutions to the problems we have had so far in the procurement, distribution and storage of drugs.

It further suggests ways that would reduce pilferage and ensure the maintenance of quality and good prescribing patterns.

Improving the effectiveness of our human resources needs a series of interventions. Career paths which recognise the importance of work in primary care settings and general support in community hospitals need to be opened.

An alternative framework based on the devolution of power and decision-making for management of our entire health system will release the creative energies of many of our managers which have been stifled by bureaucratic restrictions.

Another key basis for the proposed model is greater community participation in running facilities and, equally, greater responsiveness to community needs. We believe this will go a long way towards ensuring a caring ethos in our services.

The move to decentralised management, however, has to avoid reinventing the fragmentation which characterised our health system in the past.

The challenge we face is not insurmountable.

It needs clarity of thought, determination to succeed and, of course, a national commitment. In the Department of Health we are ready to play our part.

■ *Dr Ayanda Ntsaluba is the Deputy Director-General of Health (policy and planning).*

Free care 'extra burden for nurses'

Health Reporter

FREE health care will mean an additional workload for already-overburdened nurses, and the Nursing Association has expressed concern that people's raised expectations may not be met.

The South African Nursing Association (Sana), while welcoming the announcement of free health care at primary level, says nurses were not consulted on the feasibility of the plan, which still needs to be examined. Sana president Marie Muller said in a statement that the additional workload of nurses, as well as possible unmet expectations, were of great concern to the association.

"Clinics are already overburdened and understaffed since the implementation of free health services for children under six and expectant mothers," she said.

Sana did not believe penalties to patients who used hospital facilities rather than primary care facilities would bring immediate relief to hospitals.

"We are also worried that the administrative task of penalties might become part of the nurses' workload.

"Another concern is that immediate implementation of this plan in rural clinics may lead to nurses being used outside their scope of practice."

Sana has called on health authorities to supply enough well-equipped clinics and to empower primary health care personnel to deliver the service.

● Free health care at clinics, primary health care centres and day hospitals in the Western Cape will be implemented only once the provincial cabinet has given its consent. Notice will be given to patients when free health care becomes available.

Free health care in the Western Cape will not be available to members of medical aid schemes and those assessed as private patients due to their income.

NEWS POLITICS

Healers want political clout

(85) Sowetan 3/4/96

Contralesa suggests formation of a special ministry for traditional authority

By Joe Mdhlela Political Reporter

FOR traditional leaders to have any political clout, there must be a ministry responsible for traditional affairs, Congress of Traditional Leaders of South Africa spokesman, Chief Cedric Mhinga said yesterday.

In an exclusive interview with *Sowetan*, Mhinga said a national ministry for traditional authority was central to addressing "the 101 problems facing traditional institution in South Africa".

Remain marginalised

Mhinga argued that for as long as the institution fell under the Ministry of Provincial Affairs and Constitutional Development, traditional leaders would remain marginalised.

"The point is that the incumbent minister and his deputy cannot be objective because they know very little about issues around traditional leadership.

"Indeed, it would be foolhardy to expect the fate of traditional leaders to rest in the hands of white officials who know very little about the institution.

"Anybody who is not of African descent, and lacks the traditional background, cannot be expected to address himself or herself adequately to the issue involving traditional leadership," he said.

He said Contralesa would insist on a national minister to represent the interests of traditional leaders.

Mhinga also condemned the "deliberate" exclusion of traditional leaders in the constitution-making process.

"This is contrary to the resolution taken at the World Trade Centre constitutional talks where it was agreed that the Council of Traditional Leaders would participate in the constitution-making process," he said.

Contralesa is expected to send a delegation for talks with Constitutional Assembly chairman Mr Cyril Ramaphosa on the need for traditional leadership to influence the final constitution.

Meanwhile, Contralesa has condemned the African National Congress for hauling its president, Chief Phathekile Holomisa, before its disciplinary committee.

At its AGM at the weekend, Contrale-

West Cape health allocation highest

(86) CT 3/4/96

BARRY STREEK
POLITICAL WRITER

THE national health allocation per head of population in the Western Cape dropped by 11,6% during the 1995/6 financial year but was still the highest in the country, Health Minister Dr Nkosazana Zuma said yesterday.

Expenditure in the Western Cape dropped from R579,37 to R512,26 a head, she said in reply to Senator William Mnisi (DP).

Expenditure per capita also dropped in Gauteng from R514,44 to R462,95 and in the Free State from R378,52 to R366,25.

But it increased in all other provinces, to R282,45 in the Eastern Cape, R200,98 in Mpumalanga, R303,57 in the Northern Cape, R264,50 in the Northern Province, R249,05 in North West and R327,66 in KwaZulu-Natal.

The most significant increase was in the Northern Province, where the expenditure was R213,24 a head in 1994/5.

The Western Cape figures are inflated because of the academic hospitals at Groote Schuur and Tygerberg and the country's only children's hospital, Red Cross, which serve the whole country and treat patients from outside South Africa.

Nurses: 'primary health care policy ill prepared'

The National Society of Community Nurses has slammed the implementation of the new Primary Health Care Policy at the beginning of this month because it was introduced prematurely.

"We regard the implementation of the Primary Health Care (PHC) policy as premature and not in the interest of our patients," said a statement released by the society's president, Marietjie Greyling, yesterday.

Greyling said the clinics were not equipped to handle large numbers of people, the budgets had not been increased to make provision for PHC medication, the medication stipulated on the essential drug list was not available and extra staff needed to manage the clinics had not yet been allocated.

She said the society was "surprised" at the policy's announcement in Parliament last month.

"If health services are not planned before implementation, the health care practitioner could face ethical dilemmas," said Greyling.

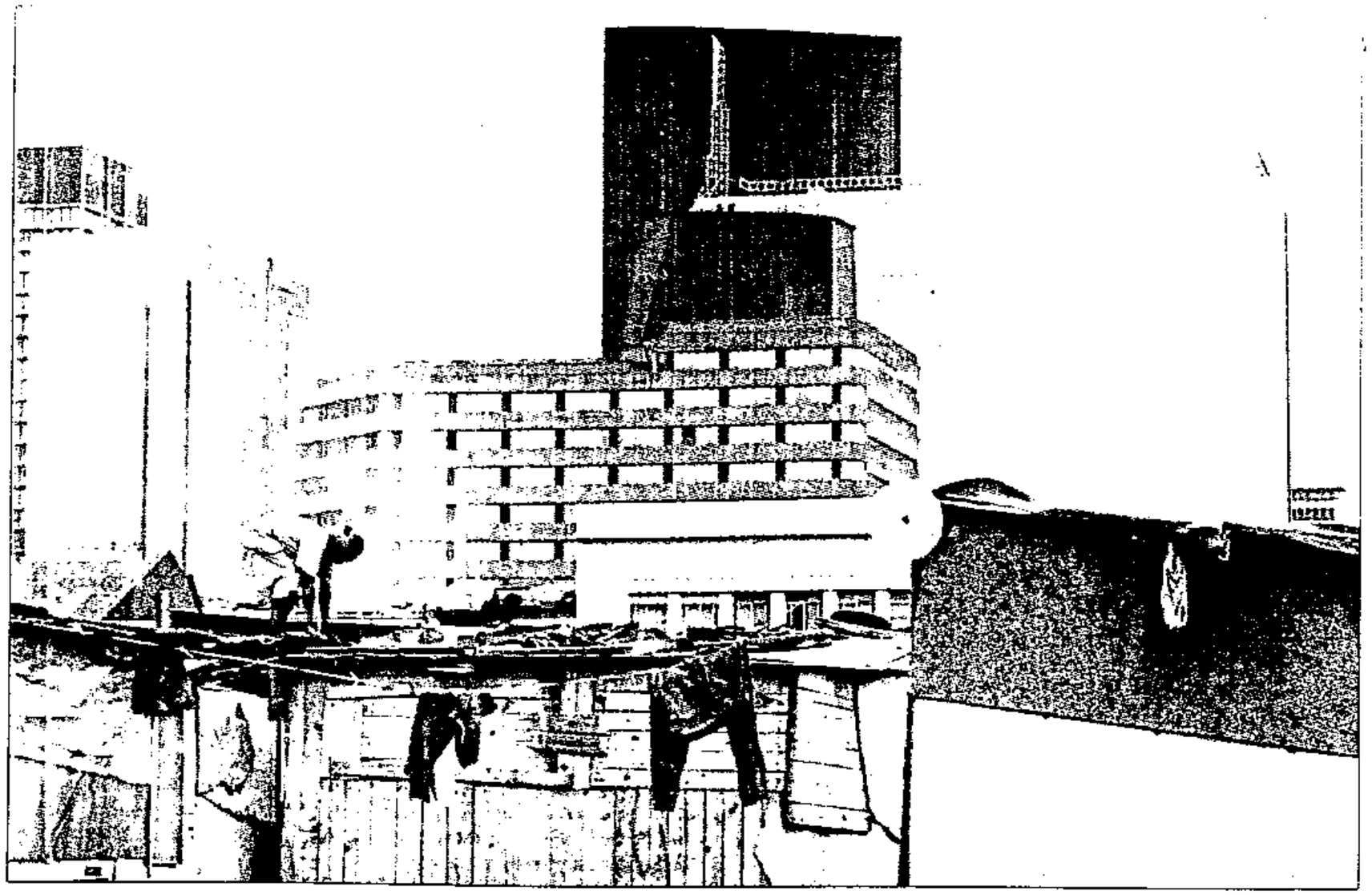
The society has called on Minister of Health Nkosazana Zuma to consult with health care personnel before taking "drastic steps". – Staff Reporter.

(85) (85) Star 4/4/96

Rapid urbanisation a major health hazard

Star 4/4/96 (87)

In just 15 years 25 cities will have populations of 20 million, creating daunting social and sanitary problems. Johannesburg must prepare its defences now



Future imperfect ... squatter shacks, not in the veld but atop a city building, highlight the impact of uncontrolled urban growth.

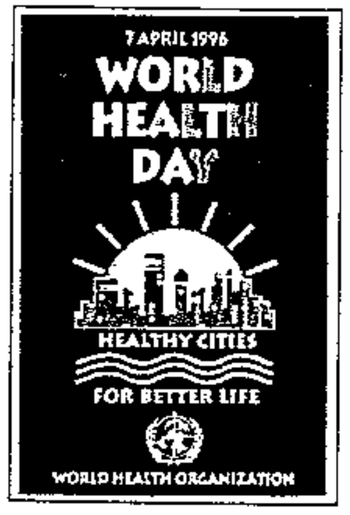
By David Robbins
Health Writer

By the time the next century is 10 years old, 25 cities in the world will hold more than 20-million people each. That's double the present size of the whole of Gauteng, currently Africa's third largest urban conurbation behind Cairo and Lagos. We're living at the dawn of the age of the megalopolis.

The health problems involved are obvious.

Listen to Dr Hiroshi Nakajima, director-general of the World Health Organisation (WHO): "The health of at least 600-million people living in cities in developing countries is being threatened by lack of food, clean water and shelter. Overcrowding, inadequate waste disposal, hazardous working conditions, polluted air and street violence are all contributing to what have now become the routine risks of city life. And the situation isn't getting any better."

Nor is it getting smaller. By the year 2000, more than half the population of the developing world will be living in urban areas. For South Africa, read closer to 60%. And many of these new "urbanites", as they are now being called, will be living in conditions that are, quite frankly, life threatening.



In response to these deteriorating conditions in the world's cities, WHO launched the Healthy Cities Programme (HCP). That was in 1987. Today, more than 1 000 cities are involved, and metropolitan Johannesburg is one of them.

Dr Yasmin von Schirnding, director of environmental health for the Greater Johannesburg Transitional Metropolitan Council, sketches the background: "We first started in 1992 when the former Johannesburg city council approved our involvement, and we started in a small way.

"The establishment of the TMC has certainly helped to increase the scale and scope of our activities to include the whole conurbation, and we are now in a position to get health and the environment on to the agendas of transport, waste and housing decision makers as never before."

But the process is as important as the desired outcome, she says. "International experience shows us that there are no blanket solutions to urban health problems. It is vital, therefore, that communities are encouraged to participate in solving their own problems. Local authorities can provide material and logistical support, but the people themselves need to buy into a participative approach."

As examples of this new approach, Von Schirnding describes three specific projects, all of which should be regarded as pilots, that are currently under way in Johannesburg.

■ Healthy schools. Launched last year at one school, this programme has now expanded to schools in different settings: one in an informal settlement, one in a high-density urban area, the third in a typical Johannesburg suburb. The pupils and teachers themselves decide on what they want to do about their school and broader environments. Waste disposal, air pollution, and testing for lead contamination are examples of activities undertaken.

■ Healthy homes. A building in Hillbrow was chosen for this pilot project. The building was run down, with faulty plumbing and electricity systems. A health inspector has became a community facilitator, surveying the health status of those living in the building and deliberately linking prevailing health problems with environmental problems in and around the building. Next step was to establish what skills the occupants had, and these were then mustered for the improvement of the building which improved the environment which in turn improved the health status of the occupants.

■ Healthy markets. A specially equipped caravan is being used to instruct street vendors in the basics of food hygiene. The classroom goes to where the vendors operate, and a system of evaluation and knowledge testing has also been worked out: to date more than 100 certificates have been issued to fresh or cooked food vendors in Hillbrow and downtown Johannesburg.

"These may seem like small projects when confronted by the enormity of some of the health problems which we face in metropolitan Johannesburg," says Von Schirnding. "But as pilot projects they will be capable of rapid replication once we have learnt the necessary lessons of community participation and action.

"An important element of all these projects is that they must challenge existing policy and be capable of changing people's perceptions and traditional ways of doing things."

It is at least in part the quality of the Healthy City projects in Johannesburg, and the approach being adopted here, which has prompted WHO to establish a world collaborating centre for urban health in South Africa.

The ultimate responsibility for driving this important function rests with the Medical Research Council-based National Urbanisation and Health Research Programme in Cape Town, but in partnership with the Department of Community Health at Wits and the Health, Housing and Urbanisation Directorate of the Greater Johannesburg Transitional Metropolitan Council. This is the first time that a local authority has been included in a WHO collaborating centre.

The significance of this appointment is that South Africa will be expected to collaborate in the development of urban health and environmental policy, and, according to the terms of reference, "to promote health programmes (such as HCP) as evolving models for inter-sectoral collaboration and health advocacy".

"This means that what we succeed in doing here in greater Johannesburg could impact favourably on cities all over sub-Saharan Africa," says Von Schirnding. "Already, African cities are in frequent contact with us."

In addition to the HCP projects, Johannesburg is one of 14 cities worldwide recently selected to contribute to what is being called the "model community programme", a participatory initiative to implement Agenda 21, which is an action plan emanating from the Earth Summit held in Brazil in 1992. The Agenda 21 initiative and those of the HCP are likely to merge, and they will almost certainly form the basis of a "city summit" to be held in greater Johannesburg later this year.

But Von Schirnding has no illusions about the enormity of the task and the responsibility which these new international roles places on Johannesburg's efforts to succeed.

"This is probably our last chance to get it right from an environmental and urban point of view. A look at cities across the world presents a frightening picture. But I do feel confident. Johannesburg has tremendous potential. It's got the political will to succeed in these vital projects.

"It's also got the resources and now the appropriate mechanisms to equitably distribute them. And it's most certainly got the health and environmental problems on which our projects can impact."

Aggressive drive aims to extend provision of basic health care

(85) Star 6/4/96

By MICHAEL MORRIS

Doctors, nurses and paramedical personnel are to be targeted in an aggressive new Health Department campaign to provide basic health services for more South Africans.

A shortage of medical professionals has led the department to increase the number of personnel trained, as well as offering incentives to attract graduates to underserviced areas.

The long-term vision entails restructuring health care as a whole over the next eight years, possibly introducing a mandatory health insurance scheme and compelling medical graduates to serve in the public sector before entering private practice.

Regulations may be drawn up to increase the efficiency and competitiveness of medical aid schemes, the building of private hospitals, the supply of expensive technology, and reform of the present tax treatment of medical scheme contributions.

The immediate benefit of the new health policy is free treatment at clinics for all permanent residents of South Africa.

A Health Department document says the decision to drop charges for basic services "is based on the view that the potential dangers of abuse of the primary health care system are outweighed by the need to reduce financial barriers to access to the system".

Removing the price barrier was "likely to increase utilisation to the point where it eliminates unmet need, rather than resulting in excessive and unnecessary utilisation". This would also remove the costly and cumbersome task of collecting and administering payments at clinics. Instead, there would be a "bypass" charge levied at hospitals where patients sought treatment they could have obtained at a clinic.

Restructuring

Steps will be taken to improve salaries for nurses and doctors, train more of them, and attract them to areas where they are most needed.

The second, long-term, phase of the national health system involves restructuring private health care. Departmental proposals will be the subject of consultation and negotiation with "relevant stakeholders".

Chief among the proposals – for which the Government intends introducing enabling legislation this year – is the introduction of mandatory health insurance coverage for a defined hospital benefit package.

There is also a proposal that all medical schemes participate in an equalisation fund that receives money from some schemes and redistributes it to others according to the risk profile of each scheme's members.

While many of these policies and schemes have yet to be implemented, the "man on the ground" is already able to take advantage of the free health care offer. More than 150 drugs for illnesses and ailments ranging from heart disease and tuberculosis to eczema and constipation are being handed out free to patients at primary health care clinics under the new system.

To match its commitment to create an equitable, efficient national health system, total government funding for primary health care over the next five years is expected to grow on average by 7,7%, while total spending will increase annually by about 8,3%.

The fundamental source of funding will remain "general revenues", supplemented by revenue from the mandatory health insurance scheme.

Sana slams health sector

(85) Sowetan 9/4/96

By Wilson Ramothata

THE South African Nursing Association (Sana), is angry with the Gauteng health department for not attending to its grievances.

Addressing a Press conference at Edenvale Hospital last week, spokeswoman Mrs Jackie Weel, said her association had been completely ignored by health authorities.

She said several letters containing their grievances had been sent to the authorities but that no response had been forthcoming.

Weel said Sana was also concerned about how its members were "continuously badly" treated by members of the National Education Health and Allied Workers Union (Nehawu) at the hospital.

"Our members have on several occasions been physically threatened with attack by Nehawu members," she said.

Mrs Mary Jwaai, Sana's regional manager in Gauteng, told the Press conference that a task group consisting of Sana, Horspesa, Nehawu and Public Workers Association was established late last year with the aim of resolving an "explosive situation" at the hospital.

However, she said, Nehawu withdrew from the group because it could not "manipulate other organisations" represented.

At the time of going to press, Nehawu was not available for comment.

AG TO SCAN HEALTH PROJECTS

(85) FM 12/4/96

The Auditor-General has launched an investigation into the tender procedures of the Department of Health in respect of all foreign aid. This will include the R300m National Health Information Services (NHIS) project, now with the State Tender Board. Also under the spotlight is the R5,5m Hospital Strategy Project.

Corporate executive manager at the AG's office, Wally van Heerden says the probe follows DP and NP allegations made in parliament of irregularities in tendering procedures.

Health Department DG Olive Shisana has not yet received written notification of the investigation. Van Heerden says she will soon be forwarded a copy of the letter sent to NP health spokesman Willem Odendaal, who called for an inquest into the procedures. He alleges that the tender procedures to award the two contracts were irregular.

Olive Shisana

He was recently quoted in *FM* sister publication *Computing SA* saying that the Health Department started the project with EU funding which was subsequently withdrawn when specifications for the project were changed. "They were allegedly offered R60m for the project by the EU and then it became clear the project could cost R120m after they changed the specifications."

Odendaal was unavailable for comment.

It is understood that the EU never provided money for the project. Someone close to the project, who does not wish to be named, says the EU allocated about R6m for a low-end system. "The EU funding is small. It is a practical hands-on system, offering the first level of information management for district hospitals and clinics." It is up to each district to get the system up and running.

It is also understood that the Health Department had initially claimed the EU's R6m donation was for the NHIS project — a mammoth system which will link 4 000 clinics and hospitals. "It had to retract. The EU is not interested in funding a system that incorporates all the bells and whistles of the NHIS project."

The ambitious project aims to standardise and co-ordinate health resources. It will consist of a number of integrated modules which will manage patient information, human resources, finances, facilities and equipment. Pharmaceutical systems, disease and socio-demographic monitoring systems will also be integrated.

Last November, 20 companies including Deloitte & Touche, HPS, IBM, ICL, NCR, Denel, Unysis, Sapsa, MediTech, Olivetti and Persetel tendered for the first phase of the project. No decision has been taken by the State Tender Board yet. Many at provincial level maintain the system is too sophisticated for their needs.

According to the Health Department, neither Sishana nor Health Minister Dr Nkosazana Zuma were part of the panel which oversaw the NHIS contract. This panel was made up of the chief director of Health Information, Evaluation & Research; chief director of Support Services; and nine provincial representatives. Representatives from the Public Services Commission were observers and the World Health Organisation played an advisory role.

The department adds that the Hospital Strategy Project is funded by EU money and is worth R5,5m.

It is not funded from the RDP, as stated by Odendaal. "The contract was signed by the previous director-general and not by Dr Shisana as alleged by the DP and NP," it says. ■

Hot on the heels of the Sarafina 2 *Aids play debacle, the Department of Health is once again under the Auditor-General's spotlight. Following allegations of irregular tender procedures, the AG will investigate the proposed R300m National Health Information Systems project and the R5,5m Hospital Strategy Project.*

CELLULAR PHONES: WRONG NUMBER?

With more than half a million cellular phone users in SA, the industry has been lauded as a success story. Yet cellular telephony remains too expensive for most people. Now some are questioning whether network operators MTN and Vodacom are really competing head on.

Talk of an arrangement between the two have been denied. Vodacom's head of legal services Neville Jordan says to say that his company and MTN "are colluding is defamatory and is denied as having no foundation in fact or law." He claims the allegation is not fair comment, nor in the public interest.

But the talk continues. Autopage Cellular sales and marketing director Stephen Hughes says: "Over the past year we have seen the incentive levels between the two operators maintained at an identical level." He adds that for the past five months the two companies have been purchasing handsets in bulk and selling them to their chosen service providers.

In this way they are controlling the price of handsets and, in

Language row: councillors take Nats to task

ARG 13/4/96

MICHAEL MORRIS
Staff Reporter

STELLENBOSCH councillors are angry that a "practical" arrangement to have preliminary budget documents published in Afrikaans and Xhosa only – rather than in English only – has been "prematurely" criticised by the National Party.

The move was seen in some quarters as part of the campaign to resist the diminution of Afrikaans as an official language, but Stellenbosch councillors have dismissed this as "nonsense".

Stellenbosch Ratepayers' Association councillor Koos Oosthuizen said the issue had been "blown out of proportion".

"Last year all the preliminary budget documents were published in English because it was considered to be cheaper and easier that way.

"When the officials suggested the same this year, the six councillors responsible for dealing with the documents in this preliminary phase felt that this was not right.

"I also felt it was not acceptable, especially since all six of us are either Afrikaans or Xhosa-speaking. The important point is that, all along, the intention was to publish the final budget in English, Afrikaans and Xhosa.

"That is in line with the council's language policy, which is that all three languages must have equal recognition."

The move drew criticism from the National Party in the Cape Town central substructure, which called on the Stellenbosch Council to rescind the decision "and adopt a policy which supports the language provisions of the constitution".

David Erleigh, NP spokesman in the Cape Town central substructure, said the Stellenbosch decision "needs to be carefully reviewed

"We do not accept council documentation being prepared only in Xhosa and Afrikaans, as every effort should be made to ensure the three major languages in use in the Western Cape should be used as far as is reasonably possible in all council documentation and council business in municipalities."

However, Mr Oosthuizen hit back, saying he took "the strongest exception" to the NP's premature response.

He said the councillors dealing with the budget had objected to preliminary reports being published only in English, partly on the basis that only six percent of Stellenbosch residents were English-speaking.

"About 70 percent of residents are Afrikaans-speaking and 23 percent Xhosa-speaking."

He added: "Even so, English is used widely in debates and we have facilities for interpretation so that councillors can use whatever language they choose.

"We agreed by consensus to use Afrikaans and Xhosa only in the preliminary budgetary phase.

Free healthcare in Pretoria

ARG 13/4/96 (85)

PRETORIA. – Most provincial clinics in Pretoria and its surrounds have provided free primary healthcare since the new health plan was launched by the government.

The regional director, Lyn Völkwyn, said extended working hours and more staff appointments would depend on the response of patients and the department was closely monitoring the situation.

Other clinics in the area have been given until July 1 to introduce free primary healthcare.

March on PM's office

MBABANE . – About 100 members of the Swaziland Democratic Alliance marched to the offices of Prime Minister Prince Mbilini Dlamini here to hand over a memorandum demanding the repeal of the Royal Decree of 1973.

It was the 23rd anniversary of the decree which banned all political parties in Swaziland.

Human Rights Association of Swaziland executive Simon Noge said the alliance wanted the decree repealed "in the same manner that the independence constitution was repealed in 1973". – Sapa

(85)

HEALTH CARE ISSUES UNDER THE MICROSCOPE

APPEARING IN PRETORIA NEWS, ARGUS AND THE DAILY NEWS

The South African health care industry is in a state of flux with the Government's stated intention to provide basic health care as a fundamental right.

EDITORIAL: Alf James
ADVERTISING: Chiron Dishy

Alarming increase in malaria blamed on recent heavy rainfall

There has been an alarming increase in the number of malaria cases in southern Africa this year. Over 600 lives have been lost to malaria in Zimbabwe, South Africa and Swaziland.

This increase is attributed to the high rainfall in the malaria areas in the last four months.

More than 250 000 cases of the mosquito-borne disease have been reported in Zimbabwe where 500 people have died since the beginning of the year, while in South Africa and Swaziland 14 000 cases have been reported and 136 people have died.

The distribution of malaria in South Africa has not changed but its higher incidence is being reported from the low altitude areas of Northern Province, Mpumalanga and north-eastern KwaZulu Natal.

The Department of Health says since the risk of contracting malaria in South Africa is high at present people should protect themselves against it.

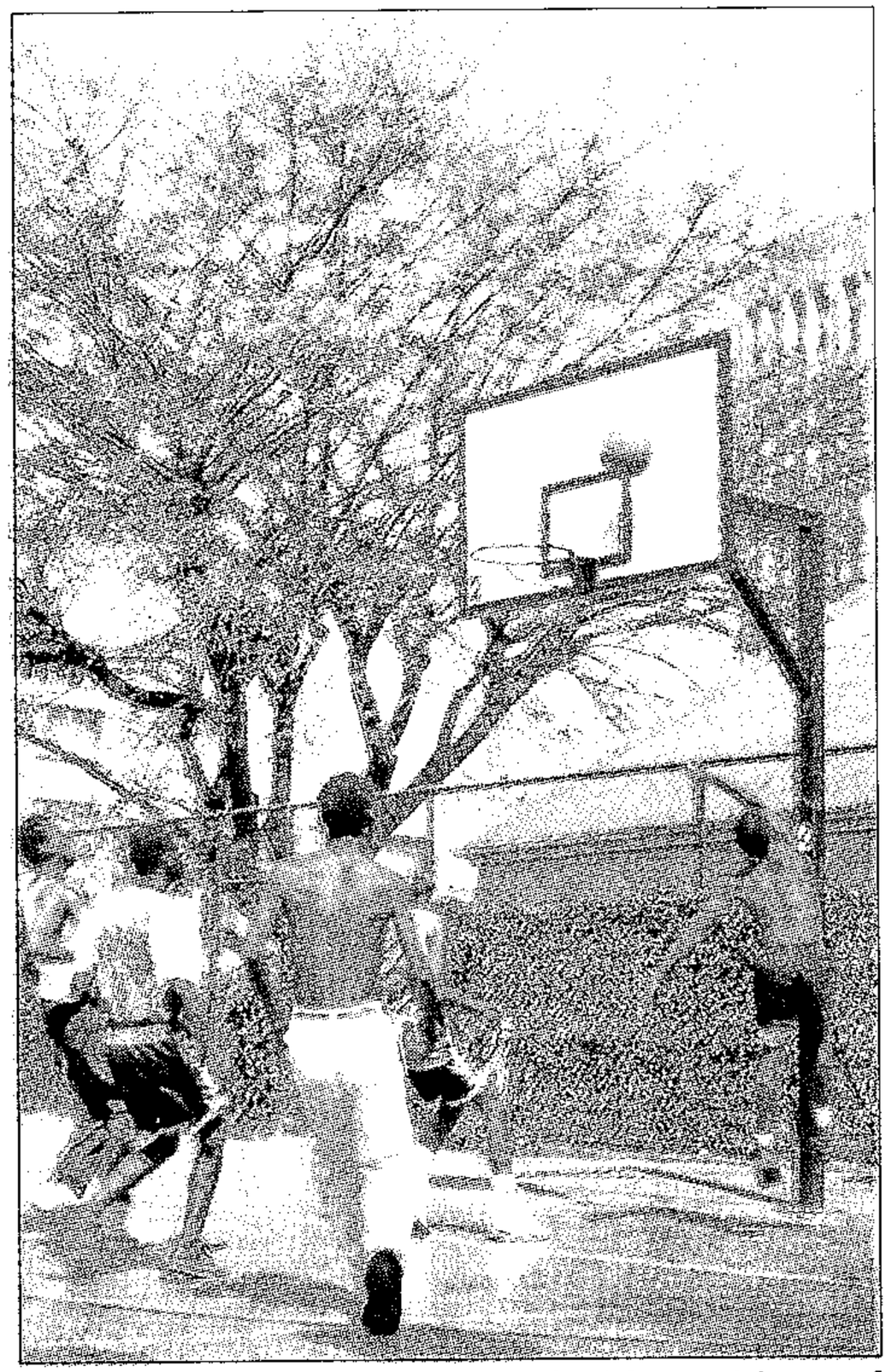
After the holiday season there is always a possibility of infection in visitors returning from malaria areas. People with flu-like symptoms (fever, headache, coughing, sweating, tiredness,) should seek medical attention immediately.

Since no prophylactic drug is 100% effective, people may still contract malaria although prophylactic medicines have been taken.

Measures to prevent mosquito bites include remaining indoors between dusk and dawn, wearing long-sleeved clothing, long pants and socks when going out and applying an insect repellent to exposed skin; sealing doors and windows with screens; using a mosquito bed net, spraying inside the house with insecticide at dusk, and burning mosquito coils or mats in bedrooms at night.

In the high-risk areas chloroquine (trade names – Anoclor, Daramal, Nivaquine or Plasmoquine) should be taken together with proguanil (trade name – Paludrine) which are available without a prescription. Chloroquine should be taken every seven days starting one week before entering the area, weekly in the area and weekly for four weeks after leaving. Proguanil must be taken daily starting one day before entering the area, daily in the area and daily for four weeks after leaving.

An alternative is mefloquine (trade name – Lariam) which requires a prescription. Mefloquine should be taken every seven days, a week before entering the area, weekly in the area and weekly for four weeks after leaving the area.



A health boost ... regular exercise, whether it be a social game of basketball or a workout in a gym, improves one's health, ability to perform, reduces stress and enhances one's self image.

Commitment to basic health care for all

(85) ARG 18/4/96

Components of the National Health System for Universal Primary Health Care being implemented now

The Government is determined to provide basic health care as a fundemental right which should be enjoyed by all South Africans and not reserved for those who can afford to pay, said Dr Olive Shisana, Director-General of the Department of Health at the launch of free primary health care services at the beginning of the month.

"A committee was appointed in January 1995 to develop a plan for the provision of health care services at primary health care level, explained Shisana.

"After extensive consultations were held, the National Health System for Universal Primary Health Care was developed and subsequently submitted to the Cabinetfor approval.

"Cabinet approved implementation of Part 1, which deals with free health care and free medicines onintroduction of Essential Drug List (EDL) of the plan as of April 1, 1996. Part 2, which consists of regulatory reform of the private health sector, will require legislation and in some cases, drafting amendments to regulations before implementation," she explained.

The following components of the National Health System for Universal Primary Health Care will be implemented now:

- free services at public primary health care facilities, such as clinics, community health care centres and local authority clinics, will be phased in and should be fully implemented by July;
- free health care for pregnant women and children under six, will continue as is at the moment;
- medicines on the EDL for primary care will be available for free in the public sector.

Shisana said the free primary health care service would be meaningless unless facilities are accessible countrywide. So a clinic upgrading and building programme will see 343 new clinics finished this year and 58 are being upgraded to address this, an additional 73 are being equipped, while 3 000 clinics will receive a minor facelift for an average of R10 000.

"Once we have an accessible and effective primary health care system in place we will have a more cost-effective form of health care. At the moment hospitals are doing heart valve replacements which could have been avoided through the prompt provision of penicillin for tonsillitis as patients only seek treatment when their illness is advanced," said Shisana.

> **"Health budget represents 10% of total budget"**

However, Shisana believes it will take up to 10 years to achieve full access to quality health care countrywide.

The Government will also introduce a new grading system which will significantly increase the salaries of all health workers especially nurses, doctors and other professionals.

"Fully funded vacant posts, especially at the primary health care level, will be filled to ease the workload of health personnel. The improved salaries and working conditions will hopefully attract doctors back to the public sector," said Shisana.

During 1996/7 this will be funded out of the Department's budget, excluding the salary increases which will be implemented on July 1, 1996.

The Department of Health's budget is up from last year's R15,4-billion to R17,1-billion, which represents almost 10% of the total Budget.

Shisana said the implementation of the plan would be monitored to measure the impact on health services, the health status of the nation and the long-term financial implications.

"The regulatory reforms in the private sector will not be implemented from the beginning of April as discussions are currently being finalised and draft legislation being prepared. Some of these reforms will be incorporated into the proposed National Health Bill.

A further recommendation of the report of the Committee of Inquiry into a National Health Insurance System is for mandatory health insurance for people not covered by private medical aid schemes. Linked to this are longer-term proposals which argue for an equalisation fund, which would channel resources from richer to poorer and from high-risk to low-risk schemes.

The mandatory insurance for everybody in formal employment (excluding those who have private medical aid cover) would affect up to six million people and could generate up to R2-billion in hospital use charges.

Govt planning to regulate the private health sector

(85)

CT 24/4/96

A LEADING HEALTH LEGISLATOR revealed yesterday that the government feels the uncontrolled licensing of private hospitals and clinics has harmed the public sector. **ANEEZ SALIE** reports.

THE government is considering extensive regulation of the private health sector because of the "devastating effect" it has on the provision of public health services.

This was said yesterday by Dr Siyabonga Cwele, chairperson of the Senate Select Committee on Health, Welfare, Population Development and Home Affairs.

He dropped this bombshell when he and his committee toured Tygerberg Hospital and the University of the Western Cape's medical and dental facilities.

Tygerberg Hospital was a good example of the sort of "devastation" he had in mind, he said.

Where once Tygerberg had received significant revenue from private patients, it had lost out badly to private hospitals, which had creamed off key staff with higher salaries that the state could not match.

Cwele said there had been uncontrolled licensing of private hospitals and clinics, but that this would have to change if the government was to realise its goal of accessible and affordable care for all, through the equitable provision of services and resources.

But even before such regulation took effect, the private health sector could co-operate with state institutions by contracting these to provide a variety of services, and by sharing expensive equipment, he said.

His inspection of Cape Town's academic health complexes (he visited Red Cross Children's Hospital and Groote Schuur on Monday) was to investigate the near collapse of a number of services brought about by rationalisation.

While he assured long-suffering staff and patients of some relief, the government remained committed to making drastic cuts to ensure equity among the provinces.

Cwele said the visits were part of the Senate's countrywide assessment of the grossly unequal provision of health services.

He said the committee had been informed that Tygerberg and other teaching hospitals were close to collapse.

They were deeply concerned and would compile an urgent report to the Senate and the provincial legislature.

He warned, though, that while he had every sympathy for problems encountered in the Western Cape, other provinces were in much deeper crises.

He told of a similar tour of KwaZulu-Natal last month, where at a hospital north of Ulundi there was "not even a drop of water to drink".

Cape Town, by contrast, had more than enough facilities, although the city had a unique problem in that those facilities had been distributed inequitably by apartheid and mostly served the white upper classes.

"There are sufficient hospitals in Cape Town, but unfortunately they are in the wrong places, far from the poor, who need them most," Cwele said.

The city has three universities (Stellenbosch, Cape Town and Western Cape) which run costly but essential tertiary health facilities, from which there has been a major shift of financial and other support by the government in favour of primary and secondary care, because of accessibility and cost.

What had severely aggravated matters was the delay in putting in place the primary health care system intended to absorb most patients, and thereby take the heat off the far more expensive teaching hospitals.

Finance needed for health programme

BD 25/4/96 (85)

Linda Ensor

CAPE TOWN — Cabinet is to be asked by the provinces to assist with the national implementation of the free primary health care scheme, Western Cape health MEC Ebrahim Rasool said at a briefing yesterday.

A task team consisting of representatives of provincial treasuries and provincial health departments was set up this week following a meeting with state expenditure officials. The task team's function would be to estimate the cost of the programme throughout the country (estimated at about R5,3bn) and to ask Cabinet for an additional allocation to fund it.

Rasool said this development was a "major advance" on the initial position of Health Minister Nkosazana Zuma that provinces must fund the programme from their own budgets.

The Western Cape cabinet decided yesterday to support the implementation of the programme in the province from May 1 on the condition that it be funded by the national department.

Rasool said Zuma would be informed that the costs of the programme had not been budgeted for and that the Western Cape would be submitting an account for it to the national department before the end of the year. The Western Cape, faced with a declining health budget, suffered financial constraints and was already budgeting for a deficit by year-end.

The cost of implementation in the province was estimated at R47m — R20m in lost revenue and R27m in staff and resources which would have to be shifted from tertiary hospitals to primary health centres.

Rasool said additional finance of about R35m would be derived from increasing hospital tariffs in secondary and tertiary hospitals.

Expectations

Also, the R19m inflator for services rendered by local authorities which was included in the R80m earmarked for primary health care this year would not be allocated.

This would be used to offset the effects of introducing the free primary health care programme.

Rasool said Zuma's announcement of free primary health care had created "enormous" expectations in the province as well as a great deal of confusion as local authorities implemented it immediately whereas provincial institutions did not.

There was an intensifying movement not to pay, he said.

Pupils attack SAPS station

Bonile Ngqiyaza

POLICE fired rubber bullets and stun grenades to disperse about 700 pupils after they attacked a satellite police station at a taxi rank in Vryburg yesterday, police spokesman Pieter du Plessis said.

This followed a march organised by the Congress of SA Students to nearby Vryburg High School to demand that the school admit more black pupils.

The school had agreed to admit black pupils, but only a limited number could be accommodated, Du Plessis said.

Several petrol-bombing and stone-throwing incidents had been investigated by the police. No arrests were made.

The provincial chairman of the student body and local community policing forum member Wilson Modise had requested a meeting with the police yesterday afternoon, but the meeting failed to materialise due to his failure to attend.

Teachers' union to stage work stoppage tomorrow

BD 25/4/96

Kevin O'Grady

THE SA Democratic Teachers' Union (Sadtu) in Northwest will stage a one-day work stoppage tomorrow and will attend a rally to protest against the alleged unilateral retrenchment of teachers by the provincial government.

Sadtu spokesman Seth Ramagaga said teachers would report to schools before proceeding to Mmabatho's Montshioa Stadium for an 11am rally to "highlight problems that teachers and the union have been experiencing in this province".

Problems included the retrenchment of teachers, failure to pay teachers' salaries "consistently and on agreed dates" as well as the unilateral extension of expatriate teachers' contracts which "created a duplication of posts", Ramagaga said.

He claimed that the Northwest provincial education department had also used "union-bashing tactics".

He said about 300 teachers had been retrenched since the beginning of the year without the education department having consulted the union.

There were also about 600 foreign teachers employed in the province, filling posts that could be filled by South Africans, Ramagaga said.

The union was demanding that all retrenched teachers be reinstated immediately, that teachers who had not been paid since January be paid by tomorrow and that a moratorium on the cancellation of expatriate teachers' contracts be lifted and their contracts cancelled, he said.

After the rally teachers planned to march to the education department's offices to hand over a memorandum outlining their grievances, Ramagaga said.

Free primary health care is here

85

ARG 25/4/96

JENNY VIALL
Health Reporter

THERE will be free primary health care at all clinics and community health centres in the Western Cape from May 1.

This was announced yesterday by Western Cape Health Minister Ebrahim Rasool after the cabinet approved ways to fund the estimated R47 million a year needed to provide free health care in the province.

Health care will be free at all clinics, community health centres and day hospitals, and part-time district surgeons. Patients referred from clinics to community hospital outpatient departments will also get free care, which includes consultation and medicines from the essential drugs list.

Exempt from free care are those with medical aids and households earning more than R35 000 a year. The Western Cape is the only province to make this stipulation.

The Western Cape is the last of the nine provinces to implement free care.

Provinces were caught unawares by the announcement, and the Western Cape, already labouring under severe budget cuts, had to find ways to finance free primary health care.

Mr Rasool said the cabinet yesterday approved three measures to finance free primary health care. These are: Significantly increased tariffs at secondary and tertiary hospitals, which will by and large make up for loss of revenue; accelerating the move from tertiary to primary care by moving R80 million to primary health care facilities; and requesting additional funds from a national task team set up to investigate the funding of free health care.

Mr Rasool asked people to use primary health care facilities so that only referrals would be seen at hospitals.

He said he was confident that an adequate infrastructure for primary health care was in place or being built to cope with demand.

E Cape health crippled

(86) Sowetan 26/4/96

By Stuart Wright

THE Eastern Cape inherited a health care system crippled with problems, but it is 20 percent down the road to recovery, Health MEC Dr Trudi Thomas told the province's parliament this week.

Thomas was reacting to a 92-page parliamentary committee report on the state of primary health care, academic institutions and psychiatric hospitals.

She said African National Congress health activists had formulated a health plan before they came to government because "their work brought them into daily contact with the conditions described in the committee report".

Thomas said the success of the ANC's five-year plan should be measured by how much the Government had implemented the plan and not by the deficiencies that remained.

About half of the province's clinics were in good condition but more than a quarter, almost exclusively in former Transkei, were in such a state of disrepair they needed to be replaced.

Nursing accommodation at rural clinics was unacceptable or non-existent.

"It is clear much needs to be done before an accessible, affordable primary health service is achieved. We aim for a miracle of transformation to obtain optimal essential primary health care within no longer than five years," Thomas said.

She intended building at least 20 new clinics a year and replacing at least 20 of the 162 condemned clinics every year as well as providing mobile clinics "where gaps remain".

Crosshead here

The building of clinics at a cost of about R1,2 million a building started in January after delays with the Tender Board and the Public Works Department, but the five-year clinic plan was on course.

Thomas said former Cape Provincial Administration (CPA) and Ciskei clinics had reliable communication networks and generally had basic equipment.

Former CPA clinics had reliable sources of water and power. This was starkly contrasted by former Transkei clinics.

She said all new clinics would have reliable water supplies, but to "provide a comprehensive communication infrastructure for the whole of Transkei is expected to take a full five years".

Thomas said R11 000 was allocated for each Transkei clinic to address equipment deficiencies, but many clinics had yet to send orders for equipment and drugs.

She also said the lack of adequate roads to rural clinics had been presented to the Public Works Department, which was reviewing the situation. She denied a claim in the report that clinics were suffering from severe staff shortages.

The low salaries of nurses and uniform allowances was the responsibility of the provincial Public Service Commission and could not be blamed on the Health Department.

Thomas also said complaints of health worker training at the province's universities had no bearing on her department and she directed queries to the national education department.

She said the design and condition of the province's psychiatric hospitals were "unsatisfactory" and currently under review by the hospital directorate. – *Ecna.*

State of disrepair ... Matron Rosabella Jele points to the dilapidated ceiling at St Lucy's Hospital in Tsolo in the former Transkei.

Health care service 'must be improved'

BD 10/5/96 (85)

Linda Ensor and Kathryn Strachan

CAPE TOWN — The policy of providing free primary health care to pregnant women and children younger than six had been implemented successfully but there was a need to improve the quality of the service, the Durban-based Health Systems Trust concluded in a research report.

The report was handed to Health Minister Nkosazana Zuma yesterday. Author Dr David McCoy said the programme had brought about an increase in the number of patients using public sector health facilities, which suggested user fees were a deterrent.

Zuma agreed there was a need to improve the quality of service and increase the number of primary health care facilities. She noted that most problems were related to the sudden, unplanned way in which the policy had to be implemented after President Nelson Mandela announced it in May 1994. Zuma did not think extension to all of the free primary health care programme, implemented on April 1, would add considerably to the burden on the service as the biggest users of primary health care facilities were pregnant women and small children.

She was adamant, however, that the national health department would not give provincial departments additional money to fund their free primary health care programmes, saying they should do so from of their own budgets.

McCoy noted the sharp rise in the number of paediatric patients since the policy was implemented. There had also been a significant reduction in "unbooked" deliveries (birth without antenatal care). This meant the number of new-born infant deaths would drop. All these were positive trends for health, he said, but were offset by overcrowding of health facilities, long waiting pe-

Continued on Page 2

Health report (86)

Continued from Page 1

BD 10/5/96

riods and drug shortages.

The overall cost of implementing the policy was minimal, leaving staffing — the biggest item on the health budget — largely unaffected. There had also been a minimal effect on drug expenditure (less than 1% of the total budget) while the 30% drop in fee revenue was estimated to represent only about 1,5% of the entire budget.

However, the limited change in public sector expenditure probably reflected the inflexibility of budgets rather than the ability of existing personnel and drug supplies to deal with and absorb the increased demand.

The survey showed that most health workers supported the policy in principle but its sudden implementation and poor planning had stretched the resources of primary health care facilities. As a result patients had used referral hospitals inappropriately.

Seventy percent of health workers interviewed believed the policy had helped prevent serious illness or death among pregnant women and small children. However, the dominant opinion was that the policy had aggravated problems within the service such as poor working conditions, low pay, a shortage of drugs, overcrowding and poor staff morale, the report said.

Free health care wins new patients

(85). CT 10/5/96

ANEEZ SALIE
HEALTH WRITER

MANY more children and pregnant women are receiving decent health care now that it is free, a scientific study has confirmed.

Health Minister Dr Nkosazana Zuma announced the findings of the impact assessment of free health care for pregnant women and children under six, by the Child Health Unit for the Healthy Systems Trust, yesterday. The study was funded by the Henry J Kaiser Family Foundation in the US.

"When President Nelson Mandela made the announcement on May 24, 1994 (on the free care) we in the Department of Health fully embraced the announcement and braced ourselves for the challenge ahead.

"We were fully aware of our shortcomings — a fragmented health service, lack of facilities particularly in rural areas, management that was not representative of the South African society and a lot more problems," she said.

"The co-operation we received from the health personnel, who had to work long hours under unfavourable conditions, was amazing ... We are proud of our achievements."

The study found that the free health care policy had led to:

- A rise in attendance at most public sector facilities, suggesting that user fees were a deterrent to use of public health services;
- More attendance at ante-natal clinics, and a decline in the number of "unbooked" deliveries;
- More attendances, at two of the three tertiary hospitals studied, for problems which could have been handled at a lower level of care;
- Little change in public sector expenditure, probably reflecting an inflexibility of budgets rather than the ability of existing resources to cope with increased demand; and
- A 30% reduction in revenue from user fees (although such revenue only constitutes 1,5% of total budget).

Health workers were generally supportive in principle, but felt that the policy had aggravated a number of existing problems within the health services, the study confirmed. At many facilities, the same understaffed and under-resourced teams have had to cope with the increased demand.

Zuma committed her department to urgently alleviating their load.

ET 15/5/96 (85)

Free primary health care 'short-sighted'

ANEEZ SALIE
HEALTH WRITER

CAPE TOWN's teaching hospitals, where a quarter of the country's doctors are trained, have been dealt a further blow with the implementation of free primary health care, according to the Democratic Party.

Western Cape DP leader Mr Hennie Bester said the announcement by Health Minister Nkosazana Zuma that her department would not give additional funds to the provinces for providing free primary health care, was a devastating blow to health services in the Western Cape and in South Africa.

"The free primary health care policy was sprung on the Western Cape with little warning and no budget determination," he said.

"The Western Cape health budget has already been reduced to such an extent that the budgets of our academic hospitals for the current financial year are being reduced by 21%."

Bester said the consequence, in all likelihood, was that the allocations to academic hospitals would be cut further to finance free primary health care.

"Whereas the policy of free primary health care to the indigent is laudable, financing it in this way would be extremely short-sighted.

"A further cut could spell the end of decent academic education at these institutions.

"That would be a loss to the country as a whole as about 25% of all medical students in SA are trained in the Western Cape.

"We call upon Zuma to reconsider the position of the Western Cape now. Uncertainty exports doctors and we simply cannot afford it. Robbing Peter to pay Paul will cost us our health system."

EU to assist SA in plan for health technology

BD 17/5/96 (85)

Kathryn Strachan

STATE-of-the-art computer systems allowing a rural clinic nurse to transmit an ECG across the country to a medical specialist for diagnosis formed part of the new health technology on offer to SA health services at an exhibition in Midrand yesterday.

The exhibition was not only a sales opportunity for European computer companies, but also the start of a major joint venture between the EU and the SA health department to develop information systems and communication links for health.

The EU's information project has been operating in EU member states, and the project with SA, launched by EU parliamentary member Glenys Kinnock yesterday, is the EU's first outside its own borders.

The EU will give financial and logistic assistance to the SA health department in getting its computer-based information system up and running and will use its SA experience as a basis for expanding the project to other countries.

Kinnock said the EU's aid programme in SA, which contributed R130m this year, was by far its largest programme. This focus came through the EU's desire to continue its support for transition in SA and to develop a strong base for growth in the rest of Africa.

The exhibition focuses on providing health services with computer channels which will transmit medical images such as X-rays and expert diagnosis and assistance, as well as at information management systems where records and treatment guidelines can be accessed.

The emphasis at the exhibition is on finding technology which is appropriate to rural areas. However, the lack of telecommunications in rural SA still presents a problem for extending this technology.

SA doctors can now ride superhighway

(85) CT 17/5/96

HEALTH WRITER

LOCAL doctors can now ride the information superhighway in a development set to change the face of medicine.

The Medical Association of South Africa (MASA) has just obtained a site on the Internet, and has launched MASAnet, the first locally designed electronic medical information network.

This allows medics easy and immediate access to health care information, the exchange of information locally and internationally, as well as continued medical education.

MASA secretary-general Mr Hendrik Hanekom believes this move will assist the medical profession to heal the nation — which is part of their mission.

"Through MASAnet we can provide doctors with reliable, trusted and peer-reviewed clinical and practice management information to deliver cost-effective quality care.

"In this age of information overload, it is important that doctors should see MASA as a knowledge-based source of relevant information, which will not indiscriminately dump information on them", says Hanekom.

With this objective in mind, the introduction of a patient information service with advice on common medical queries, is another priority.

Current information (some of which is available on subscription only) includes indexes and editorials of MASA publications, clinical and ethical guidelines, drug and product information, a diary of local medical congresses.

MASAnet can be found on the Worldwide Web site http://www.masa.co.za

A new health book designed for women

CT 29/5/96 (85)

JOHANNESBURG: South African women now have a reference book to advise them on healthy eating habits, birth control, common ailments and workers' rights.

"This book puts into practice what we all talk about doing, but somehow never end up doing," Health Minister Dr Nkosazana Zuma said yesterday at the launch of the Women's Health Book.

Modelled on its American counterpart, the book identifies problems South African women face, offers solutions and at the end of each chapter, supplies the addresses of places to go for help.

Zuma says the book is user-friendly because of its layout and story-telling excerpts.

She said the 516-page text could be used both as a community book and as a teaching text for nurses and doctors.

In its violence section, the book defines various forms of abuse, including name-calling, battery, rape and sexual harassment.

It offers tips on how to break out of an abusive relationship, how to apply for interdicts and self-protection, and also gives details of shelters, clinics, rape crisis centres and free legal clinics.

In its health section, anatomy is explained with graphics. Common ailments such as headaches and diabetes are defined and their causes and possible cures listed.

Dangerous products such as skin lighteners are talked about, as well as drug-addiction and how to get help.

Growing up and sex feature in the book's priorities.

Among the must-knows for women are how to insert tampons, dealing with menstruation, how to have a healthy sex life, and what reproductive diseases to watch for, such as cervical cancer.

Several pages are also devoted to various types of birth control and their advantages and disadvantages.

Other sections in the book deal with pregnancy, parenting, rights for the disabled, lesbianism and health care.

The book, published by Oxford University Press, retails at R89,95. — Sapa

New process to rationalise W Cape health services

(85) ARG 31/5/96

Health Reporter

A PROCESS to rationalise academic health centres in the Western Cape has started, with universities, heads of hospital departments and provincial health administrators working together to eliminate unnecessary duplication of services.

Tom Sutcliffe, head of the Western Cape Department of Health, said all players in the process were on equal terms in defining final solutions.

The officials had agreed that every department and health discipline would be investigated, with a view to providing more efficient training, research and health services and eliminating unnecessary duplication. A full audit of resources would be done at each department of each hospital.

After this, task teams would formulate recommendations for rationalisation, or models for optimal co-ordination if two or more similar centres were to be retained.

Dr Sutcliffe said there was a spirit of great co-operation and ownership of the financial problems facing the province.

"There is also support for the basic tenets of the provincial health plan with regard to establishing comprehensive health services and with emphasis at primary and secondary level."

He said a report in an Afrikaans daily newspaper, regarding the future status of Tygerberg Hospital, was misleading and unfortunate.

The future status of Groote Schuur and Tygerberg hospitals was not yet known, he said. All stakeholders involved would decide this.

Primary health benefits from funding reallocation

(85) BD 31/5/96

Ingrid Salgado

THE bulk of savings resulting from reduced allocations to Gauteng's eight academic hospitals would be ploughed into primary health care and would finance cuts in this year's health budget, Gauteng health MEC Amos Masondo said yesterday.

The hospitals would receive R200m less this year, down to less than R2bn. This was a drop from more than half of Gauteng's health bill last year to 46% of the budget in 1996/97, he told the provincial legislature during debate on the health budget vote.

He said that R90m of the savings would be used to finance free health care for adults, build new clinics, subsidise primary health care, purchase drugs and equipment for local authorities and start a polio and measles immunisation campaign.

The remainder would finance an R80m reduction in this year's budget while R30m would be spent on improving staffing conditions in previously deprived psychiatric hospitals.

Masondo said he was pleased the R4,033bn health budget would be supplemented by an unspecified amount from central government to cover salary increases.

However, he was concerned at the speed at which funding equity between the provinces was proceeding.

Five-year target allocations for provinces were based on medical aid membership and population estimates adjusted for per capita income. Low population figures had been used for Gauteng (6,9-million people) while a high medical aid membership was ascribed.

The department faced an "onerous" challenge in taking health services to previously deprived people without collapsing other services, considering that its operating budget had declined R259m in real terms and it was faced with a huge capital deficit.

'Privatise hospital laundries' — DP

(98) (BD) BD 31/5/96

Ingrid Salgado

THE DP urged the Gauteng government to privatise the province's seven hospital laundry services yesterday and insisted that privatisation could occur without the more than 1 000 employees losing their jobs.

The services, which had a running cost of about R50m a year, were beset by perpetual labour unrest and bad management, leading to glitches in heath care services, Gauteng DP health spokesman Jack Bloom told the provincial legislature.

Already hard-pressed hospitals constantly had to reschedule and delay operations due to shortages of clean linen, he said. "Only last week Baragwanath Hospital (in Soweto) was disrupted for this very reason, to the great distress of patients."

Privatisation of the laundry services had great potential for revenue generation and would improve hospital efficiency. The Gauteng health department was "not in the business of running laundry services but of running health", Bloom said.

ANC member Firoz Cachalia questioned the ability of the private sector to guarantee job retention and to provide laundry services at affordable cost to government.

One-third of SA children deficient in vital vitamin A

Kathryn Strachan

A NEW study shows that a third of SA children are deficient in vitamin A, which according to the World Health Organisation represents a significant health problem for the country.

The study by the Medical Research Council also showed that one in five children was anaemic and almost one in four children was stunted, while one in 10 was underweight.

Vitamin A is one of the vital elements in strengthening resistance to diseases, and its widespread deficiency in SA children means that they are more susceptible to disease.

As a result of the study the council is looking at supplementing vitamin A to prevent childhood TB.

A study at the University of Natal is looking at the role vitamin A supplements can play in lessening maternal-infant transmission of HIV.

Another important conclusion in the research report is that simple treatment of river water before drinking it would reduce hepatitis E infection in rural communities by about 66%. A study in the Western and Eastern Cape provinces found that 10% of people in these areas were infected with hepatitis E.

isting waste be stored in environmentally secure warehousing until a solution could be found.

National health programmes director Geraldine Mtshali, left, giving a keynote address on the implementation of district-based health care systems, while women from a cross section of SA society, top right, sing at the start of an SA Council of Churches conference held in Johannesburg, where posters on the prevention of child abuse were distributed to delegates. Pictures: ROBERT BOTHA

District health care tier has a key role — govt

Mduduzi ka Harvey (86) BD 10/6/96

SUBSTANTIAL progress had been made in the setting up of a district-based health care system, national health programmes director Geraldine Mtshali said at the weekend.

At an SA Council of Churches annual women's conference, attended by delegates from African countries, she said it was envisaged that the district health authority would play a key administrative role as the lowest tier of government within the primary health care system.

She said that until the district health authority was competent to assume its full responsibilities, the provincial and local government authorities would play this role.

The improvement of public sector governance was a crucial component of the strategy of strengthening the primary health care system, she said. In the envisaged model, the district health authority would be the purchaser of services and all providers, public or private, would ultimately be contracted to the district health authority.

She said that in practise the system would retain a substantial component of direct public sector provision of services, such as district hospital services, environmental health services as well as other district services.

In the case of ambulance services there would be greater long-term opportunities to contract with a combination of public and accredited private providers. This approach would also address the maladministration of resources.

Primary health care nurses were envisaged as the front-line providers of clinical services within public facilities, with referral to medical and other allied health personnel. Detailed training programmes were also in the pipeline for the nurses.

The gaps in medical staff requirements would best be filled through substantial increases in the number of full-time doctors working in public facilities, Mtshali said.

Health care slice goes to minority

(85)

Bonile Ngqiyaza

BD 11/6/96

LESS than 10% of the population — the "really sick" — were likely to account for between 40% and 50% of the cost to medical schemes for chronic diseases, medical practitioner Tony Zappa said yesterday.

Addressing 350 delegates to the Representative Association of Medical Schemes national conference on the Wild Coast yesterday, he said that if the cost could be reduced without affecting patient care in any way, it would introduce "considerable savings" to both the private and the public health care systems.

Zappa said that if such "really sick" patients could be identified before they actually became ill and were placed in intensive individualised management programmes, substantial savings and an improved quality of life would result.

Collectively called disease management, the programmes could now be offered not only by managed health care companies but drug companies, hospitals and other suppliers as well, he said.

Disease management techniques could conservatively reduce costs of chronic patients to private medical schemes by R300m.

He said that the estimated total annual costs of chronic patients to private medical schemes in SA was at least R3bn.

Use of the techniques would have a similar impact on the public sector bill, Zappa said.

Vital disease control projects could close

(85)
BD 12/6/96

Louise Cook

A R20m budget cut for animal health in the Eastern Cape was expected to result in a shutdown of vital disease control programmes next month.

This could leave the province exposed to killer diseases including rabies, anthrax, tuberculosis and brucellosis which are transmitted by infected animals, the agriculture department said yesterday.

Agriculture department animal health director Griffith Bawati said a major outbreak of any one of the diseases could spread to other provinces.

The 25% cut to the budget had left only R60m for animal health in the coming year.

"A rabies crisis is looming in the rural areas of the former Ciskei and Transkei unless central government steps in urgently with bridging finance," he said.

"The annual anti-rabies campaign will not get off the ground next month — at least 400 000 animals in rural areas are vaccinated against rabies at state expense every July," Bawati said.

However, Eastern Cape Agricultural Union president Pieter Erasmus said more money would trigger higher taxes. "Drastic rationalisation" in the province's agriculture department was needed, Erasmus said.

Bawati said he planned a 35% reduction in administrative costs within a year.

"We need the staff. Without manpower we cannot reach out to the people and provide a service," he said.

The R373m Eastern Cape agriculture budget, tabled last week, provided R240m for personnel and administration, 94% of the total budget.

Eastern Cape agricultural MEC Natemba Sigwela told the legislature the 6% left for running costs meant there would be no money for sheep scab control or other animal dipping or vaccination programmes.

"The control of detrimental diseases that effect human health such as tuberculosis, brucellosis, anthrax and rabies will not be addressed at all."

He said there was no money to run vehicles or buy medicines and laboratory accessories.

Training and farmer-support would come to a "temporary" halt — support services for communal farmers would stop in most areas, he said.

FRIDAY
JUNE 14, 1996 ★

RASOOL GIVES ASSURANCE

No West Cape health workers to be axed

LT 14/6/96 (85) (87)

"IN TRYING to implement reforms we could run the real risk of collapsing our academic health centres," Health and Welfare MEC Ebrahim Rasool said yesterday. Health Writer **ANEEZ SALIE** reports.

NO health workers in the Western Cape will be retrenched this year despite deep budget cuts, says Health and Welfare MEC Ebrahim Rasool.

This has been achieved through shifts in staff, voluntary severance, cutting duplication among teaching hospitals and drastic belt-tightening across the board.

The reassurance for thousands of health sector employees was contained in Rasool's budget speech to the Western Cape provincial legislature yesterday.

It should help ease a deep-seated uncertainty about the future of health services, he said.

The total projected expenditure for the year is R2,5 billion. It is characterised by the need to drastically adjust spending between and within provinces from the rich to the poor.

The Western Cape, with its three tertiary hospitals and other facilities, is comparably well-resourced, although the centres are in the wrong places, far from the poor, because of apartheid planning.

Although his department was committed to equity, Rasool warned that the pace and scale of the prescribed changes were not manageable.

"In essence I believe that we are underestimating the cost of transformation, and in trying to implement reforms we could run the real risk of collapsing our academic health centres," he said.

He further warned that there were limits to reductions, "and we are very much on the edge of those limits".

Academic hospitals have been given R97,5m less for the current financial year. This will be managed in two ways.

First, a shift of resources, mainly staff, to primary and secondary health centres, which will account for R52,8m, of which R47m has already been shifted, even though the financial year is not yet a quarter way through.

Secondly, R44,7m will have to be divided pro rata between the three academic hospitals, and will have to be achieved by ending the costly duplication of services and facilities, and by general belt-tightening.

This process is being undertaken by the management and staff of the three centres, in consultation with the health department.

Rasool stressed that none of the institutions would be favoured for political or any other reasons (he is an ANC leader).

Specifically, he denied that Tygerberg had been punished because it was in an NP area, as alleged in an Afrikaans daily.

A decade or two ago, a member of a medical aid fund could sleep soundly at night, safe in the knowledge that if you landed up in hospital, or needed the on-going help of a medical specialist, the bills would be paid by your medical aid fund. Today, medical aid funds no longer pay as freely, member contributions have sky-rocketed, and there is a myriad of new insurance and other health products on the market combined with the government's restructure of the national health system. In a series on the health industry, Personal Finance untangles the maze by explaining the different types of health products and how they should best be used. This week, on page 15, Leigh Roberts takes a look at medical aid funds.

Health care shake-up on cards

Argus 15/6/96 (85)

BRUCE CAMERON

THE proposed new national health care system is likely to speed up the current revolution taking place in the medical aid industry.

Already major changes are underway to traditional medical aids as a result of soaring costs, with employers and employees considering alternatives.

The alternatives include "new generation cover" with more responsibility placed on the member to contain costs.

The trend is now towards providing a combination of insurance against major trauma, including hospitalisation, supplemented by individual medical savings schemes through which a member assumes responsibility for day-to-day health care problems on the basis of "use it" or "save it" for later years.

The new generation cover, however, has major consequences for low income individuals as well as the elderly as it effectively reduces the current cross-subsidisation by the healthy of the ill; the young of the old and the high earners of the low earners.

Neil Lilford, health care consultant at Ginsburg Malan and Carsons Consultants & Actuaries, said in an analysis of the proposed national health care system that there will not be an immediate impact on existing cover but there were medium-term implications.

There was not sufficient definition on how the proposed regulations would apply to full benefit packages. A major influence would be to speed up the changes that are already taking place.

Lilford said there were still many gaps in the proposed scheme which would affect both employers and employees.

These included: Proposed changes to the tax deductibility of medical aid contributions; the cost of a proposed mandatory health care core package, especially for employees who were not scheme members; and the cost of any dedicated health care tax required to supplement any shortfall in the government's proposed package.

The key to the proposed system was the mandatory core package, providing basic trauma cover for everyone.

Lilford said this did not mean that employers would be able to use the state package to cop out of medical aid provision, particularly for salaried staff.

"It is important to note that the mandatory core package will only provide basic hospital benefits and will cover public and to some degree private hospitals at a level inappropriate and unacceptable for most current medical aid members."

Lilford said there were three important factors in deciding the level of health care cover. These were: Access to medical services; the costs of the services; and the quality of the services. These would have to be weighed up against each other but one could not be ignored at the expense of another.

The proposed government scheme did not provide solutions for employees who were not members of a medical scheme. An Old Mutual medical aid survey showed that, in 1995, about 92 percent of all formal sector employees were members of medical schemes – up from 82 percent in 1994.

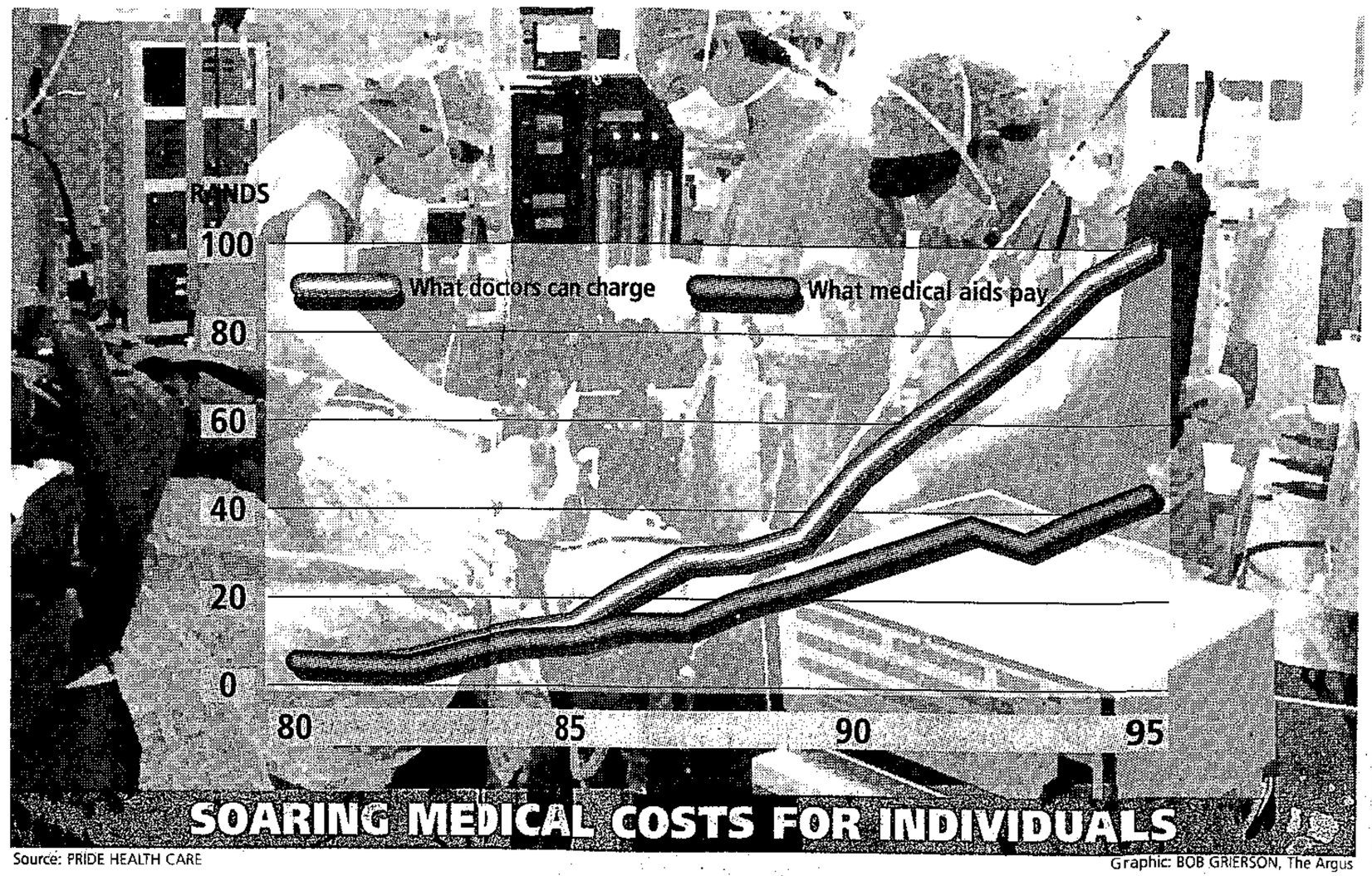
However, labour union members had 24 percent membership of medical schemes and the unions, in the interests of equal employment practices, were pressing for inclusion of all employees. This could prove costly for employers, particularly small businesses.

Lilford said employers would have to look to other methods to provide affordable cover. This included managed health care initiatives with agreements with health care providers, possibly in combination with public hospitals and the state's primary facilities.

Employers had to have a better understanding of health care costs and to take a holistic view of health care, integrating all aspects of health services to employees. This would include on-site clinics, occupational health and first aid facilities and medical aid.

Lilford said reports about the removal of dispensing rights for doctors, the removal of mark-ups on drugs and replacement of dispensing fees, ownership of pharmacies and a two-year limited period of registration for doctors – which could all impact on costs and services – were all speculative at this stage but health care providers should make provision for such possible changes. At the earliest there would not be clarity before next month.

Lilford said a major advantage of the national scheme was the involvement of the Financial Services Board, which was important to ensure the financial soundness and long-term stability of medical schemes.



Source: PRIDE HEALTH CARE

Graphic: BOB GRIERSON, The Argus

'Only access to clean water by all will assure a healthy nation'

Star 17/6/96 3 85

By Shirley Woodgate

About 70% of children admitted to a Sekhukhuneland hospital suffered from water-related illnesses, said Northern Province social worker Rose Mazibuko, addressing the three-day "Children, Water and Development" conference in Midrand this weekend.

Stressing the time wasted by rural women and children forced to fetch buckets of water from taps and springs many kilometres away from their homes, she said vibrant villages housing healthy people would only arise in the parched areas once the RDP ensured proper access to water for everyone.

Earlier, Forestry and Water Affairs Minister Kader Asmal told the conference hosted by the UN Children's Fund (Unicef): "It is not mining that is truly the backbone of the SA economy, but water. Because without water there is no processing of minerals, no industry, not even life.

"If we want to see the country develop, if we want to see a healthy economy and a healthy nation, we have to ensure everyone has enough water."

Stressing the link between children who lacked water or who were forced to drink polluted water, he said: "Diarrhoea (which is mainly caused by lack of clean water in the home) is one of the major killers in SA, accounting for a fifth of the children who died under age four from 1986 to 1989.

"In 1989, nearly one in five youngsters died before reaching age five, with nine African children, two Asian and five coloured children dying for every white child."

Blacks undoubtedly suffered most through lack of water, with Africans accounting for most of the 12 million people without clean, safe water in or near their houses, he said.

Urging the adoption of future environmental policies that would be relevant for the next seven generations, he called for an end to water pollution and wastage, industrial growth that polluted water, and use of river water which resulted in the death of rivers and wetlands.

Unicef representative in SA, Scholastica Kimaryo, said a joint programme which had been forged with the Government covering the period 1997 to 2001, would be submitted for approval to the organisation's executive board meeting in September.

Highlights of the planned programme included recognition that the critical situation of SA's children was not the result of national poverty, but of the social-economic duality and inherent disparity in access to basic services and productive resources.

Kader Asmal ... water the true backbone of South Africa.

inst apartheid. — Sapa.

Thursday. — Sapa.

Africans seek solutions to health care quagmire

BD 25/6/96

85

Kathryn Strachan

DELEGATES from 10 southern African countries have converged on Johannesburg this week to find solutions to the most pressing challenges facing health on the continent.

The challenge is how to mobilise funds to provide health services for rapidly growing populations, to make better use of available resources, and to lessen inequalities in service access.

The countries — Angola, Botswana, Lesotho, Malawi, Mozambique, Swaziland, Tanzania, Zambia, Zimbabwe and SA — spent almost $7bn annually on health in the early 1990s. SA is a relatively big spender in this group — $158 per capita, whereas others such as Tanzania spend $10 per capita.

However, according to the World Bank, much of this money is used inefficiently, wasted or mismanaged in relatively rich and poor countries alike. In addition, more money needs to be mobilised to provide better care for more people, through creative forms of revenue mobilisation and private sector development.

One of the main focuses of the seminar will be reallocating resources to primary and preventive care. Currently about 30% to 50% of scarce government funding goes to expensive medical technologies and urban care. Yet those who benefit most from this trend tend to be the relatively wealthy.

The delegates will also look at new forms of gaining revenue for state facilities. Fiscal shortages are typically blamed when government coffers fail to cover costs. In contrast, says the World Bank, quality care appears to be stronger among private health providers, where clients share the costs through user fees, pre-payment schemes, or insurance.

Further, surveys in African countries reveal that many people are willing and able to pay for quality health services. New methods of financing and cost-sharing are therefore gaining attention with greater emphasis being placed on social health insurance financed by payroll taxes, and other forms of user charges.

New endeavours are also being launched to broaden the scope of public-private sector collaboration, including more extensive use of subcontracting, greater autonomy in the management of health facilities, and stimulus to competitive markets supplying drugs and other medical inputs.

ANC

Rural area sets tone for curative health

(85) Star 25/6/96

By David Robbins
Health Writer

At the heart of South Africa's new health policy stands a concept known as district health. It's a radical departure from the top-down curative approach of the past where being sick was more often than not the basic condition for entering the health care system.

District health changes all this by placing the responsibility for healthy communities on new partnerships between health care personnel and the community itself. Promotive and preventive programmes come into their own, and decision making and budgeting is devolved to the lowest possible level.

So much for the theory. Implementation is another matter entirely.

As Dr Kathy Kahn points out: "Although attempts are now being made to implement the new ideas, the old structures and social problems remain essentially the same".

Practice site has been developing for six years

Kahn should know. For the past six years she's worked for the Wits-affiliated Health Systems Development Unit (HSDU) in the neglected Bushbuckridge area bordering the Kruger National Park.

"These are the basic questions for anyone trying to implement district health," she says: "How do you deliver a better service with more or less the same input of staff and money as in the past? How do you get communities inured to old authoritarian structures involved in health care and health management functions?"

These are crucial questions for health authorities throughout the country. Since April this year, primary health care (PHC) has been free for all South African residents. And district health is the vehicle by which this service is supposed to be delivered.

But while provincial health departments struggle with new organograms and the delimitation of their provinces into regions and districts, health care conditions on the ground haven't changed much.

The cynical may well ask: does anyone out there have any idea what an efficient district health care structure is supposed to look like?

The HSDU's Elizabeth Malomane provides an immediate answer: "In Bushbuckridge – in an area called Agincourt, to be precise – we've been developing a practice site for the past six years. In fact, it's small enough for us to have been able to make mistakes without blowing the budget. Now it's proving to be an invaluable resource – call it a living laboratory, if you like."

Like most rural areas in South Africa, Agincourt was characterised by poor management systems, inadequate infrastructure and equipment, a lack of staff skills, poor morale and staff shortages. Nurses literally disappeared into the bush, working in ill-equipped clinics with inadequate communication, transport and medical support systems.

One of the problems of the top-down curative approach has always been a lack of knowledge of actual health conditions in the community. Since effective district health programmes are dependent on such knowledge, a detailed mapping and census exercise was undertaken to establish where the people lived and what the main health problems were that were being experienced.

Kahn takes up the story. "We used a technique known as verbal autopsy to establish the main causes of death across a population of 60 000 rural people. At the same time we looked at the health services traditionally provided for these people. Then we began to ask the central question: without significant inputs of money and other resources – in fact, by using what was available – how could we improve the relevance of the service to actual conditions in the Agincourt district?"

Over the past few years, and in close collaboration with the community and Tintswalo health service, the main HSDU endeavours at Agincourt have moved in three general directions.

■ First, health services have been gradually reorganised.

At the root of all reorganisation has been the change in responsibility from those patients who come themselves to the various clinics to responsibility over a clearly defined geographic area and catchment population. In practice, this has meant a rationalisation of skills across the whole district, with a network of health centres and satellite clinics comprising a sub-district health system.

In this way, the health centre provides a "step-up" of care, with a greater range of services provided by more highly skilled staff. Referral patterns between clinic and health centre have resulted, replacing unnecessary referrals to hospital. This has necessitated the decentralisation of some services traditionally housed in hospitals (for instance, laboratory services) and an emphasis on staff training, supportive supervision, and the development of effective managerial structures. In addition, a multi-disciplinary sub-district team, with community representation, undertakes co-ordinated planning for the catchment area as a whole.

■ Second, communities have become directly involved in the management of their own health care.

Health teams have been built up which include community components. People have been trained in committee work, and encouraged to participate in the identification and solution of local health problems. Social mobilisation programmes have been developed to improve awareness of health problems and their solutions (an example is that local sports teams have been harnessed to the overall Aids-awareness programme) and these programmes are being compared to the community health worker approach. Now the clinics are being transformed from a facility dealing exclusively with ill-health to a "health and development unit" where more general health problems such as sanitation, water, and revenue creation are jointly tackled by the community, health workers, government departments, and non-governmental organisations working in the area.

Call it a living laboratory, if you like

■ Third, the vital information services of the initial Agincourt census have been maintained.

"The updating of the district data base has taken place on an annual basis," explains Obed Mokoena, supervisor of the field team responsible. "The data base is serving an increasingly useful function as the community becomes more involved in the governance of their own health services."

Mokoena points out that the data collected are widely applicable and would be essential to the planning of education or any other social service, as well as the planning of economic or infrastructural development. "For this reason, local authorities could eventually be responsible for maintaining much of the data base."

While the work at Agincourt continues, its value as a practice site (or field laboratory) is being increasingly realised. The entire Mpumalanga health department recently spent time there; and health officials from the Northern Province see Agincourt as a useful model for the setting up of their own practice site.

Mpumalanga's director for primary health care, Nomonde Bam, comments that the success of Agincourt lies in the courage and commitment of the community and health care providers in the area. "They did not wait for macro-environmental change and political will. Instead, they are showing us the way, despite major obstacles and with limited resources and support."

"It is becoming abundantly clear," says Steve Tollman, director of the HSDU, "that each province needs a practice site to test and improve their district health policies. The HSDU, the Agincourt communities, and the Tintswalo health service, would be delighted to share their experience with anyone grappling with the manifold problems of transforming health care services into forms that more adequately cater to the needs of the people."

Pulling wisdoms may not be so wise

Staff Reporter

THINK again if you are on the verge of having your children's wisdom teeth pulled out. New research shows that impacted wisdom teeth need only be extracted if there are other symptoms present, or should be treated by an orthodontist.

The surgical removal of wisdom teeth was a common operation, but the question of whether they should be was asked in the study carried out by the Medical Research Council (MRC).

This indicated that the possible development of cysts and future infection was not a valid argument for removing impacted, unerupted third molars.

The likelihood of problems other than normal decay was so low that a conservative approach to removing wisdom teeth was recommended.

Good reasons for removal were infection, non-restorable decay, cysts, tumours, and the destruction of adjacent teeth and bone, according to the National Institute of Health in the United States.

But if teeth were deeply impacted, there was a risk of jaw fracture.

SA medical research gets a boost

(85)

ARG 27/6/96

More funds and restructuring of science councils ushers in new era for study of health issues

LINDSAY BARNES
Staff Reporter

MEDICAL research has not come to a standstill in South Africa, contrary to some reports, and nor has parliamentary debate on the subject, according to the Medical Research Council (MRC).

In fact, medical research was on the brink of a new era, judging by the MRC's budget increase of more than R7 million and the proposed restructuring of the science councils in terms of the draft white paper on science and technology, said MRC president Walter Prozesky.

The MRC got an extra R5 million from the Department of Arts, Culture, Science and Technology earlier this year.

And the Department of Health has since set aside R2 million for the accelerated development of medical and health scientists keen on permanent careers in science and technology in South Africa.

More meaningful research should be undertaken as a result of these developments, said Dr Prozesky.

The MRC held workshops on the release of the white paper on 20 key areas of national medical research to plan for the future, and in an effort to adopt the most integrated approach to South Africa's most pressing health problems.

The MRC reported a string of successes in recent research.

Last year the council established a research unit to work on pneumococcal diseases, which are a major killer of infants and small children.

The unit co-ordinated a study that showed that a new drug, meropenem, was safe and effective in the treatment of bacterial meningitis.

Pneumococcus, the most important cause of bacterial meningitis, had become resistant to many drugs in use, but the new agent had remained active against the resistant strains.

The MRC's Liver Research Centre at the University of Cape Town had found that the simple treatment of river water before drinking it would reduce hepatitis E infection in rural communities by 66 percent.

Almost 11 percent of adult blacks living in the Western and Eastern Cape provinces were infected with the hepatitis E virus.

Ralph Kirsch, a professor at the centre, said: "The scientific component that identified the virus and its source has allowed us to educate the community and to empower it to prevent this potentially dangerous disease."

And in another development an MRC scientist had found that plain aspirin – acetylsalicylic acid or ASA – resulted in reduced cell growth in prostate cancer.

This scientist's preliminary results would improve understanding of the anti-tumour capabilities of ASA on prostatic cancer, which was one of the most common forms of cancer in men, and fatal in most developing countries.

Medical Council gets R7-m shot in the arm

(86) Star 28/6/96

Medical research will enter a new era with a R7-million boost for the Medical Research Council (MRC) and the proposed restructuring of the science councils, says MRC president Dr Walter Prozesky.

He said the MRC had received R5-million from the Department of Arts, Culture, Science and Technology, and R2-million for capacity building from the Department of Health.

Contract research ventures were increasing annually, and researchers were looking forward to doing even more meaningful research, he said.

"The proposed white paper on science and technology filled researchers with hope because restructuring will give new scope to the academic councils," he said.

"The MRC had organised workshops on 20 key areas of national medical research to plan the most integrated approach to South Africa's pressing health problems."

The MRC had also met the Department of Health to discuss ways to increase collaboration, grounded in the excellence of its scientific research.

Workshops on 20 key areas organised

One example of improved interaction was the MRC's participation in the national TB review, which had revealed South Africa's epidemic to be the worst in the world.

The Department had also requested the MRC to bring out more policy briefs to keep policymakers abreast of research results and allow them to make decisions based on hard data, he said. – Medical Correspondent.

Job crisis at medical nerve centre of the Cape

(85)

■ The Health Department has stepped in over a crisis at the Cape Medical Depot — the nerve centre for the delivery of drugs to over 500 health facilities in the Western and Northern Cape.

ARG 29/6/96

ADELE BALETA
Staff Reporter

THE Health Department has launched an urgent investigation into the creation of posts at the Cape Medical Depot, which has a week-long backlog in the delivery of drugs to more than 500 health facilities in the Western and Northern Cape.

The depot supplies medicines to tertiary and secondary hospitals, community health centres, clinics and district surgeons in both provinces.

In an interview with SATURDAY Argus several disgruntled staff members said heavier demands had been placed on the depot since the announcement of free healthcare in 1994, while at the same time posts had been frozen.

One staffer said: "We cannot get the drugs out fast enough without help. We receive faxes on a regular basis from various health outlets in the Peninsula and from the rural areas saying they are out of stock and unless we help them they will have to close down."

A major concern was supplying drugs to the rural areas because it took longer to get them to their destination.

But Fareed Abdullah, the Western Cape Health Department's chief director of healthcare, said there appeared to be a need for more staff and that the creation of posts, particularly for storekeepers, would be investigated in the next three weeks.

He said staff from other areas would be seconded in the meantime to help out with the backlog, which had already been reduced from 10 days to seven.

"The lack of staff has been exacerbated by a week-long strike about three weeks ago," he said.

Dr Abdullah said that while surgical supplies were on track, the delivery of drugs was behind.

He added that a mechanism was in place to deal with emergency cases where, for example, facilities or district surgeons ran out of drugs.

Vivian Titus, principal pharmacist of the Community Health Services Organisation in the Western Cape which handles the needs of community health centres (former day hospitals), said the situation was critical.

"We are running out of stock and there is not a community health centre that is unaffected," he said. "I get phone calls every day and I want to appeal to people to be tolerant."

Bill Munro, chief pharmacist of the Northern Cape and stationed in Kimberley, said outlets throughout the provinces had been affected and deliveries were up to three weeks behind.

"We are completely dependent on the depot in Cape Town and are not getting stocks up here.

"Every outlet is affected, from Colesberg to De Aar to Prieska — everywhere."

He said a feasibility study was being conducted on setting up a depot in the Northern Cape.

Staff at the depot in Chiappini Street said the demand on their services began increasing when in July 1994 all children under the age of six and pregnant mothers were given free medical care.

This was followed with the announcement on April 1 that the depot would be responsible for the delivery of medicines to 200 old-age homes.

The pressure was increased again with the instruction that from May 1 free medicine would be given to all members of families whose annual income was less than R35 000.

"More clinics and day hospitals have been built and that means more facilities to handle.

"The bottom line is that the number of orders have trebled since May 1 and yet the posts have been frozen," an employee said.

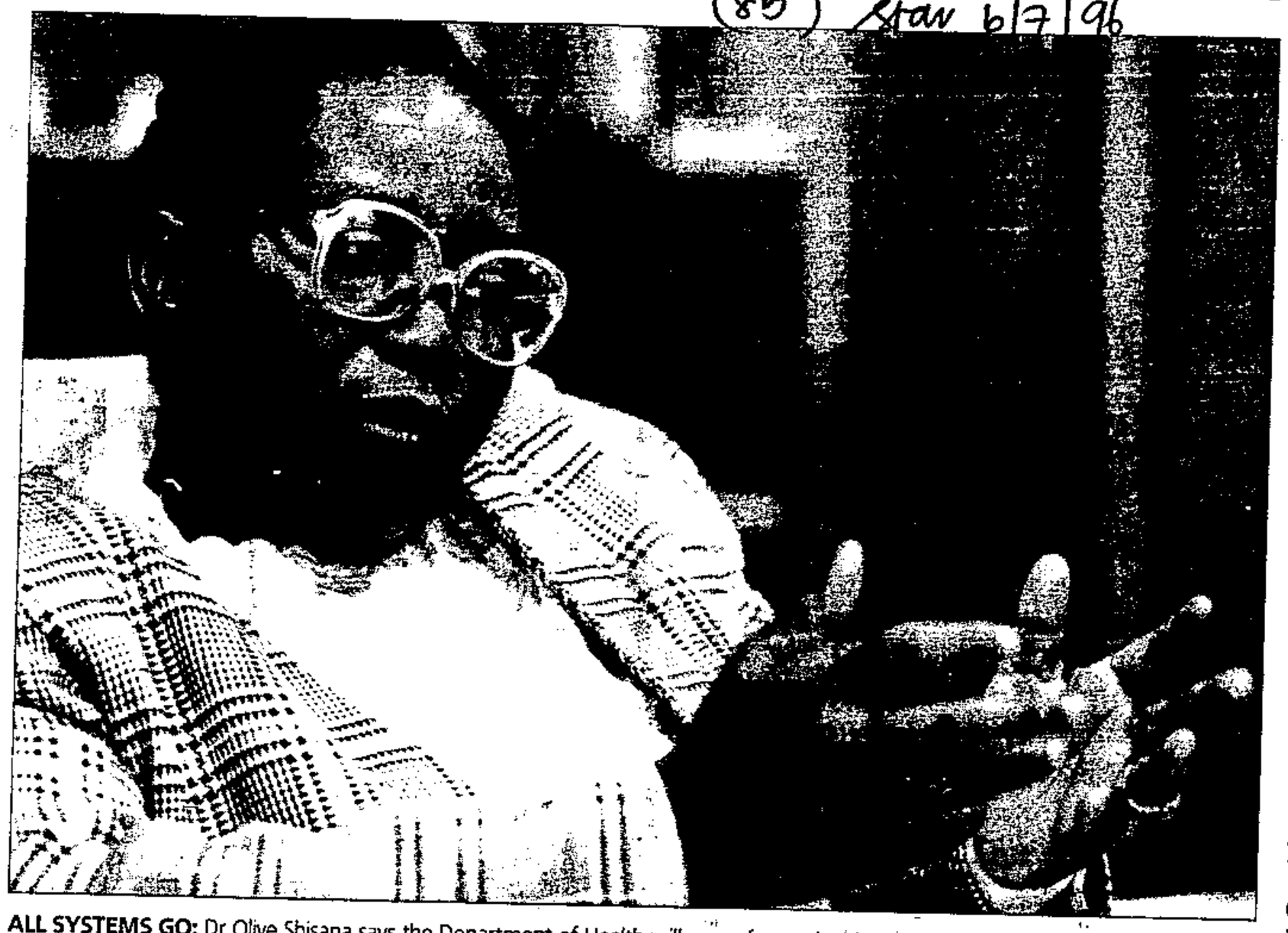
Employees said they needed more pharmacists, storekeepers and general assistants.

Saturday Star
July 6 1996

Shisana bounces back from a virulent bout of publicity

(85) Star 6/7/96

Dr Olive Shisana, director-general of the Health Department, says she is determined to curb all the criticism and suggestions that she step down because of the *Sarafina 2* debacle, writes **NEWTON KANHEMA**



ALL SYSTEMS GO: Dr Olive Shisana says the Department of Health will surge forward with renewed optimism from now on

Long live *Sarafina 2*. The scandal surrounding the production is dead and buried – at least as far as the Department of Health is concerned.

The department's director-general, Dr Olive Shisana, says she has accepted administrative and management responsibility for the *Sarafina* debacle and wants to apologise to the taxpayer. Now, she says, the department is leaving all that behind and moving ahead with determination.

"I have gone out and said sorry. I take responsibility for all the mistakes and promise that it won't happen again," she says from her Pretoria office.

Shisana has notched up a few firsts in her time: she was the first woman to be appointed a director-general by both the present and previous governments and is also the first non-medical person to be appointed a director-general of the Department of Health.

"I came back from exile with one important objective – to make a contribution to my country. I think I am doing that and I am not about to stop," she says.

Shisana is determined to curb the criticism and suggestions that she step down because of the rumblings about *Sarafina 2*.

How is she coping following the (largely negative) reports that reflected poorly on her department's performance?

Shisana shakes her head dismissively and says she has "the privilege" of knowing the truth in all its finer details. Therefore she has not been affected as much as those "ignorant of the circumstances".

"I am not saying *Sarafina 2* was not a big deal ... but the debacle was exaggerated. Clearly there were problems surrounding the project.

"As a department we could have done better, but the criticism we received was harsh and clearly unwarranted.

"It was also very clear from the public protector's report that there was no malice on our part. I agree with the notion that when you are in government you should be prepared for criticism because you are dealing with public money, but those who criticise should at least be justified in their attacks," she says.

As a department we could have done better, but the criticism we received was harsh and clearly unwarranted

Shisana finalised the cancellation of the contract with playwright Mbongeni Ngema and expects the new sponsors to pay her department the R14.2-million spent on the project. But who is the new sponsor?

"I don't know the new sponsor. The minister told me that the new donors were "concerned South Africans".

"I have not been told and I am happy to tell you that with a clear conscience."

Shisana says she expects to be paid with a bank-certified cheque in order to avoid the identification of the sponsor.

She says the accounts of *Sarafina 2* have not been audited to the extent that would satisfy her, but a proper audit can be done only once she has received the full amount from the new sponsor.

Shisana is very critical of the Government Tender Board, which either approves or turns down applications to fund projects put to tender.

"This Government has a mandate and we have to deliver. But when one looks at the time it takes for the Tender Board to approve our application, one tends to see the Tender Board as hampering our good intention to deliver.

"I have a problem with the time it takes to get a reply from the Tender Board, and their answer is not necessarily positive. All of us who have come to Government have a mandate to deliver, and people have been waiting for that delivery.

"At the moment we are asking how long our people have to wait," she says angrily.

She adds there is always criticism when a department has money rolled over into the following financial year, but she explains that this is due to delays from the Tender Board.

Sometimes her department has deadlines but the deadlines – although achievable – are frustrated by the the tendering process.

"I am not saying we should do away with the Tender Board, but we should streamline the procedures. I am not the kind of person who says: 'as long as my salary comes at the end of the month then everything is fine'.

"There must be a sense of urgency in addressing the legacy of apartheid. People should understand where we are coming from.

"I think Tender Board procedures should be simplified," Shisana adds.

She says Tender Board rules are technical and that new civil servants, unaccustomed to "governese" – the legal, complicated procedures and language used – are getting bogged down and lost in the labyrinth of procedure. "We come in, we read proposals and tenders, and we have to implement them," she says.

"We are new to this – yet the old civil servants have been working with these rules for many years. We encounter problems in the process, but I think that is quite understandable."

Shisana says there are certain exciting projects that have been abandoned because of frustrations from the Tender Board. "Delivery has been hampered by procedure."

Shisana believes that if the successes of her department received as much publicity as *Sarafina 2*, then it would be shown that the department's success had far exceeded the few mistakes pointed out in the public protector's report.

At present, the Department of Health is building 340 new clinics throughout the country.

The department has also audited 405 hospitals to determine their condition and assess how they might be improved.

"This will help us to budget better. We can prioritise our money with the full knowledge of the consequences.

"Today we can proudly say that there is free primary health care in South Africa. I challenge you to tell me the number of countries that can boast that.

"I would not want to claim that our country is number one in the world – there are other countries with very good systems in place, such as Cuba.

"I know that Cuba is well ahead of us and the rest of the world on primary health care, but we would never turn away any patient requiring primary care," she says.

I am not saying that Sarafina 2 was not a big deal, but the debacle was exaggerated

Shisana is not in favour of depending on donor money.

"I believe that no country in the world should depend on donated money for its health budget.

"Whatever we get from donors should be complementary to our major projects. I have seen other countries drawing their budget from donations and when those donations do not arrive there is a crisis.

"I think the Government should take full responsibility for the entire population's health. I think it would be a disaster if we planned according to donations," she says.

However, she appreciates all the efforts made by donor communities. One of the greatest benefits from donors are ideas – because of their widespread experience. Organisations such as the World Health Organisation send experts from other countries.

She denies that donors are shying away from her department because of *Sarafina 2*.

Shisana says she has received several letters of support from the donor community. She has had one letter from the European Union in which it expressed its commitment to the department's Aids programme.

"I don't think that *Sarafina 2* has affected us. We have received two donations from the British Overseas Development Administration totalling £5,5-million to assist us in training our staff.

"The European Union is helping us to bring in young doctors from Europe. I have met with the Kellogg Foundation which will be looking at assisting us in the rehabilitation of our hospitals.

"The Kaiser Family Foundation will be helping us to co-ordinate district health research systems. USAid has funded us to the tune of $50-million on an equity project which will be a pilot one.

"I think this proves that we have the support of the donor countries."

Shisana says her biggest achievement was the fulfilment of one of the clauses of the 1955 Freedom Charter – the programme of primary health care.

AIDS, violence obstacles to setting up health system

BD 8/7/96

85

Kathryn Strachan

WITH soaring AIDS levels and relentless violence, KwaZulu-Natal is up against daunting obstacles in its task of building up the health care system.

Violence is draining hospitals, with many intensive care unit beds taken up by patients who have been shot or stabbed.

"Trauma is costing us a lot," says the province's superintendent-general, Dr Ronnie Green-Thompson. "Several clinics have stopped their night services because of attacks, and vehicle hijackings are interfering with our emergency health services."

With the rise in crime, the province is looking at ways to tighten up security at all its hospitals and clinics.

KwaZulu-Natal also faces the highest incidence of AIDS in the country, brought about mainly by its proximity to Mozambique, reliance on migrant labour and the transport routes running through to the ports.

According to Green-Thompson, the latest survey of pregnant women attending the ante-natal clinic at King Edward Hospital in Durban shows that between 18% and 23% are HIV-positive.

This will cause a massive drain on resources, since AIDS has brought with it a dramatic rise in tuberculosis, exacerbated by the increase in drug-resistant strains of tuberculosis.

While it is a largely rural province, KwaZulu-Natal is densely populated, with 25% of the country's population estimated to be living in the province.

Green-Thompson says the scattering of major administrative functions between Maritzburg, Durban and Ulundi makes coordination difficult. Plans to rationalise are expected to boost efficiency and morale.

The province is focusing on bringing the health systems, which were fragmented under homeland policy, into a single structure. Nearly all the posts for health department directors are now filled and the province is well on its way to filling 2 000 vacant nursing posts.

The problem that remains is how to fill vacant doctors' posts, especially in rural areas. Discussions are under way with training institutions to ensure broader training, which will allow health workers to play a more useful role in rural settings.

The province has lagged others in setting up district health systems, but Green-Thompson is confident that with local governments now elected, this process is set to take off.

Building clinics has been difficult in the province's hilly terrain but despite this, the clinic programme is well under way. The province decided in September to introduce free primary health care at all rural and mobile clinics. This free service is now being extended to urban clinics.

A regional hospital network will get into gear when the new Durban academic hospital, with 800 beds, opens in 2000.

Union slams Masondo

Maria van Daniel Gauteng regional organiser of the South African Municipal Worker's Union, accuses Gauteng department of health of insensitivity to the disadvantaged

Sowetan 10/9/96

ON JUNE 24, the Gauteng government's Health Department broke off negotiations with the South African Municipal Workers' Union to proceed with the privatisation of ambulance services.

Negotiations had started on March 29 after a journalist leaked the privatisation proposal to Samwu.

Health MEC Amos Masondo was forced to agree to a moratorium on ambulance privatisation as the union was not consulted, and was given the opportunity to develop an alternative plan to transform the ambulance service.

Based on a democratic process involving shop stewards and workers from all Gauteng's ambulance depots, a vision statement was developed to transform the service and was handed to the province on June 20.

The vision statement is the first step of a three-phase process. The second phase of an emergency plan to save the service from further deterioration will be adoption. The third phase will be the implementation of a long-term plan to transform the service.

On June 24 the province dismissed Samwu's request to use its vision as a basis to consult the broader community on the transformation of the ambulance service.

Samwu believes a principled agreement on strategic goals is necessary before we embark on short-term measures to save the service. This will ensure that strategic goals for transformed service are not undermined.

Samwu opposes privatisation completely because we are committed to improving the quality of life of historically disadvantaged communities.

Privatisation cannot address the legacies of the past as private companies are not accountable to communities and are not efficient providers of social services.

Only an elite benefits from social services run on a profit basis. The examples of the British experience is clear: the wealthy become more wealthy while the public suffer inaccessibility and unaffordability of services.

Only public ownership of social services can ensure better services for all. This is particularly important in South Africa where we need a long-term vision to ensure the extension of a sustained and affordable service.

The privatisation of ambulances will also undermine the Government's goal to make health care accessible to all. In the new Constitution the right to health care services is guaranteed.

It further says the state must take reasonable measures to achieve the progressive realisation of these rights. This proposal therefore violates the spirit of the new Constitution.

Gauteng Health MEC Amos Masondo ... under fire for planning to privatise ambulance services.

In its privatisation proposals only one element, the leasing of vehicles, is held up for public scrutiny. Other important elements are hidden from the public.

Another element of the provincial plan is the lack of consultation with communities and other stakeholders. Senior management, like ambulance and fire chiefs, were not consulted.

The workers in the service and the unions were also not consulted. This is one of the many violations of national health policy.

Lack of research

There was also no audit of the ambulance service, no relevant research on users' needs, and no holistic planning to relate this to primary health care (PHC).

The lack of research shows there is no serious consideration of the possible effects of privatisation on people.

The situation has deteriorated since 1994, as local government now covers an increased population, including informal settlements, and covers much larger distances.

But no additional services have been allocated to the ambulance service and this has caused a severe strain on the service. The service has only survived because if its dedicated workforce.

The province proposes a staff freeze; no vacancies will be filled. Advanced Life Support (ALS) will be eliminated and handed over to the private sector.

The proposal to lease vehicles also shows the province is not committed to building infrastructure and transforming the service.

When taken together with the decision to eliminate ALS, it is clear that leasing is the first step towards complete elimination of the ambulance services.

Given the exodus of staff that will be triggered by the elimination of ALS, leasing vehicles will ensure the province can easily close down the service.

Its point of departure is crude and unmotivated "financial and economic" constraints. This approach is even more irresponsible when no attempts were made to achieve savings in the existing service.

This is in stark contrast to the spirit of the national health policy on PHC, which Samwu adopted as the basis of its vision for transforming the ambulance service.

PHC, which includes ambulances and other health services, must be close to where people live. To promote PHC accessibility, the national Health Department says it must be free and financed through national taxes.

This will result in an increased use of the service, leading to overall costs falling. Ironic as it may seem, a free service will not only ensure universal access, but will also lower unit costs in the service.

In contrast, the province's proposal will not only lead to a cost-inefficient service, but will also impose a higher tax burden on Gauteng residents.

This is because the province's proposal also makes provision for increases in rates and taxes to subsidise private companies.

In effect people will be charged twice: at the point of service and through increased rates and taxes.

The ambulance services need to be more developed and integrated within the PHC.

This allows improvement from community and union participation, and represents a progressive attempt to address the legacies of the past.

The province has completely ignored national policy and rushed to privatise ambulances.

Health care services 'to control spending'

Business Day Reporter (85) BD 12/7/96

CAPE TOWN — Health care services would soon be beyond the reach of ordinary salaried people if service providers, medical schemes and patients did not exercise greater discipline over spending, MetHealth MD Piet Scannell said on his return from an International Federation of Health Funds congress in Boston.

"The need to curtail health-care expenditure is not only a Third World phenomenon, but applies as much to the First World," Scannell said. SA's health-care expenditure in 1994 was 7,1% of GNP, on a par with the UK.

Scannell was encouraged to learn how successful the US had been in containing costs. Health maintenance organisations had been set up to develop the infrastructure and monitoring procedures to ensure health-care services and facilities were being used more efficiently and productively.

He said such a service would become increasingly necessary in SA as more people were drawn into the health service, placing a greater burden on the health system.

Gauteng plan 'violates national health policy'

BD 16/7/96 (85)

Maria van Driel

NEGOTIATIONS on Gauteng's proposal to privatise the ambulance service began on March 29 after a journalist leaked the proposal to the SA Municipal Workers' Union.

The province was forced to agree to a moratorium on ambulance privatisation, while Samwu was given time to develop an alternative plan. The union developed a vision statement to transform the service.

The vision statement is the first step of a three-phase process. The second phase will be the adoption of an emergency plan to save the service from further deterioration. The third phase will be the implementation of a long-term plan to transform the service.

Samwu is opposed to privatisation because it is committed to improving the quality of life of historically disadvantaged communities. Privatisation cannot address the legacies of the past, and only an elite benefits from social services run on a profit basis. The examples of the British experience are clear: The wealthy become more wealthy; the public suffers a deterioration of services which become inaccessible and unaffordable.

Privatisation of the ambulance service will undermine, also, government's goal of making health care accessible to all. This aim forms the basis of the national health department's policy of Primary Health Care. In its privatisation proposal only one element, the leasing of vehicles, is held up for public scrutiny. Other elements also need to be brought to light.

A major weakness of the Gauteng plan is the lack of consultation with communities and other stake holders. Workers and their organisations, management, and communities have not been consulted. The province has done no audit of the ambulance service, no relevant research on users' needs and no wholistic planning to relate this to Primary Health Care. This failure shows that there is no serious consideration of the possible effects of privatisation on the people.

Since 1992 budget cuts have strangled the service. The situation has deteriorated since 1994; as democratic local government now covers an increased population, including informal settlements, and covers much larger distances. The only reason the service has continued is due to its dedicated workforce. The province's proposal will run the service down even further.

Gauteng proposes a staff freeze. Advanced Life Support will be eliminated and handed over to the private sector.

Experienced staff will leave the service for private companies.

The province's approach is irresponsible when one considers that no attempts have been made to achieve savings within the existing service.

For example, in one local authority the service at present spends about R400 000 on billing patients and recovers R200 000 for their efforts.

The primary health care approach, on which the union's vision is based, says that health care must be promotive, preventive and curative and must include fundamental elements like the provision of clean water, sanitation, education and housing.

This approach recognises the crucial role of the community if primary health care is to be successful: the national health system must strengthen the needs and rights of users and empower communities to participate in governance of the health system.

Primary health care, which includes ambulance and other health services, must be close to where people live. To promote accessibility of primary health care the national department says it must be free at the point of service and should be financed through national taxes. This will result in an increased use of the service, leading to overall costs falling.

Ironic as it may seem, a free service will not only ensure universal access, but will also lower unit costs in the service. This shows that a public service is indeed more cost effective, and thus efficient if run well, than a private service.

In contrast to this, Gauteng's proposal will not only lead to a cost-inefficient service, but it will impose also a higher tax burden on the residents of Gauteng. This is because the province makes provision for increases in rates and taxes to subsidise private companies. In effect people will be charged twice, at the point of service and also through increased rates and taxes.

The national department places the role of the private sector within a clear framework. Firstly, it says that with the present historical inequalities and fragmentation within the health services, bringing in the private sector now would undermine public health and the primary health care approach.

Secondly, private providers must be accredited and introduced gradually and experimentally, to ensure competent provision of service.

This means that a national accreditation framework must first be drawn up. Such a framework does not exist.

Thirdly, the department requires that a national contractual framework be drawn up, which at the moment does not exist. An important basis of such a framework is that private providers contracted by the department cannot charge at point of sale. These are just a few of the provisions of national health policy that are violated by Gauteng's proposal. What is needed now is not an approach that avoids the issues, but one that takes up the challenges posed by our democratisation process, and the need to transform the public service into an efficient service. The former is the province's approach, and the latter is the union's approach.

□ **Van Driel is Gauteng regional organiser of the SA Municipal Workers' Union**

'COMPETITION FOR ORGANS MUST END'

Donor scramble 'not in interests of patients'

(85) CT 18/7/96

A LEADING heart specialist has called for a national database of organ donors and recipients to be set up urgently, saying the current system is competitive and not in the best interests of patients. Health Writer **ANEEZ SALIE** reports.

COMPETITION for donated organs must end in the interests of patients, says Cape Town's leading private heart transplant specialist Dr Susan Vosloo.

Vosloo, who completed a seven-hour heart transplant on former deputy minister of defence Mr Wynand Breytenbach on Tuesday, said the time to set up a national organ-sharing database was long overdue.

It required urgent attention at the highest level.

The operation was a success and Breytenbach, 61, was doing well, said City Park Hospital spokesperson Ms Dawn Young.

Vosloo heads the cardio-thoracic unit at the hospital, where all private heart transplants in the city are done (Groote Schuur is its state equivalent). Breytenbach was the eighth recipient since January 1995, when the service was first introduced.

Vosloo said the present competitive nature of organ transplantation would end if a central register of prospective recipients and donors was independently run, autonomous and had funding not aligned to any sector of the medical service.

The current practice was for transplant co-ordinators at hospitals around the country to contact each other when a brain-dead patient whose organs were suitable for harvesting was presented. This was not always the most efficient method, Vosloo said.

"Improved allocation of donor organs based on set selection criteria increases the survival of grafts, and may also decrease the amount of immuno-suppression required, resulting in a better outcome at reduced costs," said Vosloo, who has also set out her views in the latest edition of the Cardiovascular Journal.

Although the Organ Donor Foundation had increased awareness many brain-dead patients were still not recognised as potential donors.

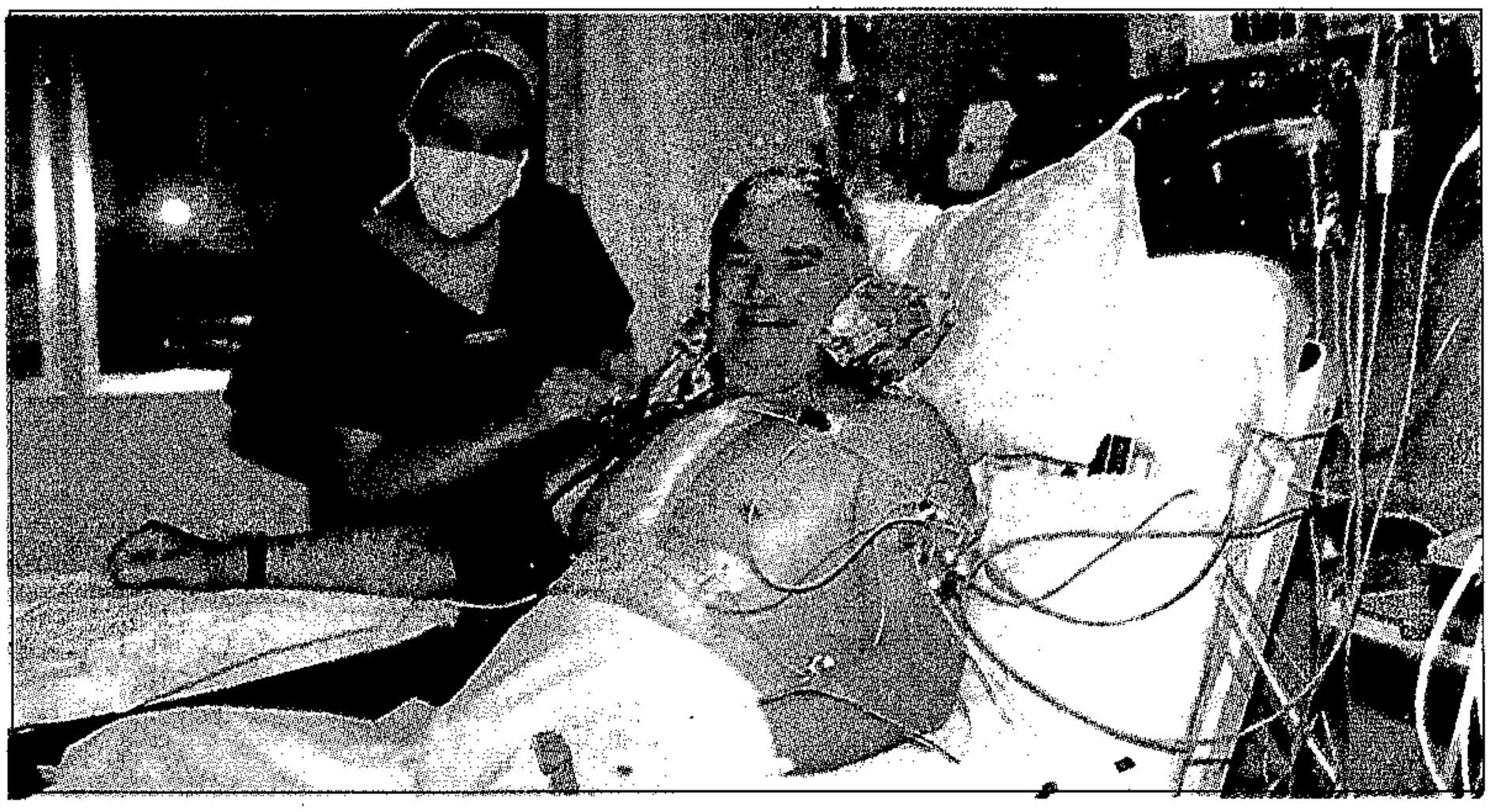
In addition, organs were not always used to the best effect.

The lack of a central and equitable allocation of organs was particularly disturbing in view of South Africa's pioneering role in heart transplants, Vosloo said. Three decades after Professor Chris Barnard performed the first heart transplant operation there was little progress towards national co-ordination and facilitation of the service.

Most other countries and regions had since established organisations to ensure the equitable distribution of organs.

Active participation by the private sector in transplants started in 1993 at the Milpark Clinic in Johannesburg. At that stage Milpark accounted for 2,7% of such procedures. Last year the private sector performed almost half (24 out of 51).

Last night the Department of Health had not responded.



HEARTY: Former Deputy Minister of Defence Mr Wynand Breytenbach was all smiles yesterday, a day after receiving a new heart. Sister Kim Stancey ensured all the equipment was working well. ***PICTURE: CLIVE SMITH***

Processes should therefore encourage public, private and community partnerships, and the involvement of joint commitment of the public and private sectors and the metropolitan stakeholders. people in decision-making.

R13-m boost for health drama

(85) Star 19/7/96

BY JANINE SIMON
Medical Correspondent

The European Union has committed R13-million over the next two years to *Soul City*, the smash-hit health drama television and radio series which caused almost a million people to change their behaviour to protect their health.

EU participation was confirmed by project leader Dr Garth Japhet at this week's launch of the 13-part *Soul City 2*

Cast, crew and researchers say the series has planted a seed of health promotion in the film industry.

Dr Shireen Usdin, researcher and development manager on the first series, and Neo Matsunyane, assistant director of the second, have both quit smoking, leading the move by crew to change their health habits.

The series has made the artists consider more carefully the issue of gratuitous violence without consequence, adds development manager Dr Sue Goldstein.

Producer/director Bobby Heaney says it has also prompted the industry to consider the viability of health drama, though he warns that copycat productions may fall short without the extensive research which supports the *Soul City* series.

The R8,2-million *Soul City 1*, which focused on maternal and child health, is currently being rescreened on SABC1.

Evaluations by the Community Agency for Social Enquiry showed the 1994 series had a market penetration of 79% for television, 93% for radio and 56% for newsprint, and that it caused more than a million people to change their behaviour – a cost-to-audience-reach ratio unheard of anywhere else in the world, according to Unicef's Ian McLeod.

The 13-part, R16-million *Soul City 2*, which has the health themes of HIV/Aids, TB, smoking, land and youth, will be screened on SABC1 from August 6 at the prime viewing time of 8pm.

Eighteen months of research went into scripting the series, beginning with broad consultation with interest groups to define the health messages, and moving through repeated consultations and checking processes to refine the script, Goldstein says.

Soul City's strength, according to scriptwriters Harry Dugmore and Steven Francis of Madam and Eve fame, is that health messages are absorbed by osmosis: they piggy-back on an entertaining, character-driven plot, in the gritty realism genre of TV dramas such as *LA Law* and *NYPD*.

Says Heaney: "*Soul City* is completely different to anything I've ever worked on. There are deaths, but there is always a message of hope."

Revolutionary praises local health system

(85) MHG 19-25/9/96

Ann Eveleth

DR LUIS PERAZA has seen enough examples of post-revolutionary health care in his 61 years to convince him that South Africa's current staffing crisis is little more than a "growing pain".

One of 99 Cuban doctors deployed in February to bolster South Africa's overstretched medical system, the snowy-bearded doctor-revolutionary has worked in Angola, Guinea-Bissau and Ethiopia.

After five months of often gruelling surgery marathons at Pietermaritzburg's Grey's Hospital, Peraza says "South Africa has a very good health system. The problem — the shortage of medical officers — I think that will settle and in time you won't need foreign doctors.

"We had the same problem in Cuba in 1959," he says. "When the revolution came we had 6 000 doctors and half of them left because they were afraid for their positions. In 20 years we were able to change everything and today we have 52 000 doctors."

Peraza admits Cuba's health system travelled a long road to get where it is today: "The government invested a huge sum in health care and first tried to cover the rural areas. We introduced a programme of social rural medicine where medical students would spend three years working in a rural area," he says.

South African doctors have balked at similar proposals, but Peraza claims that in Cuba most doctors volunteer for rural service, which is considered "a great honour".

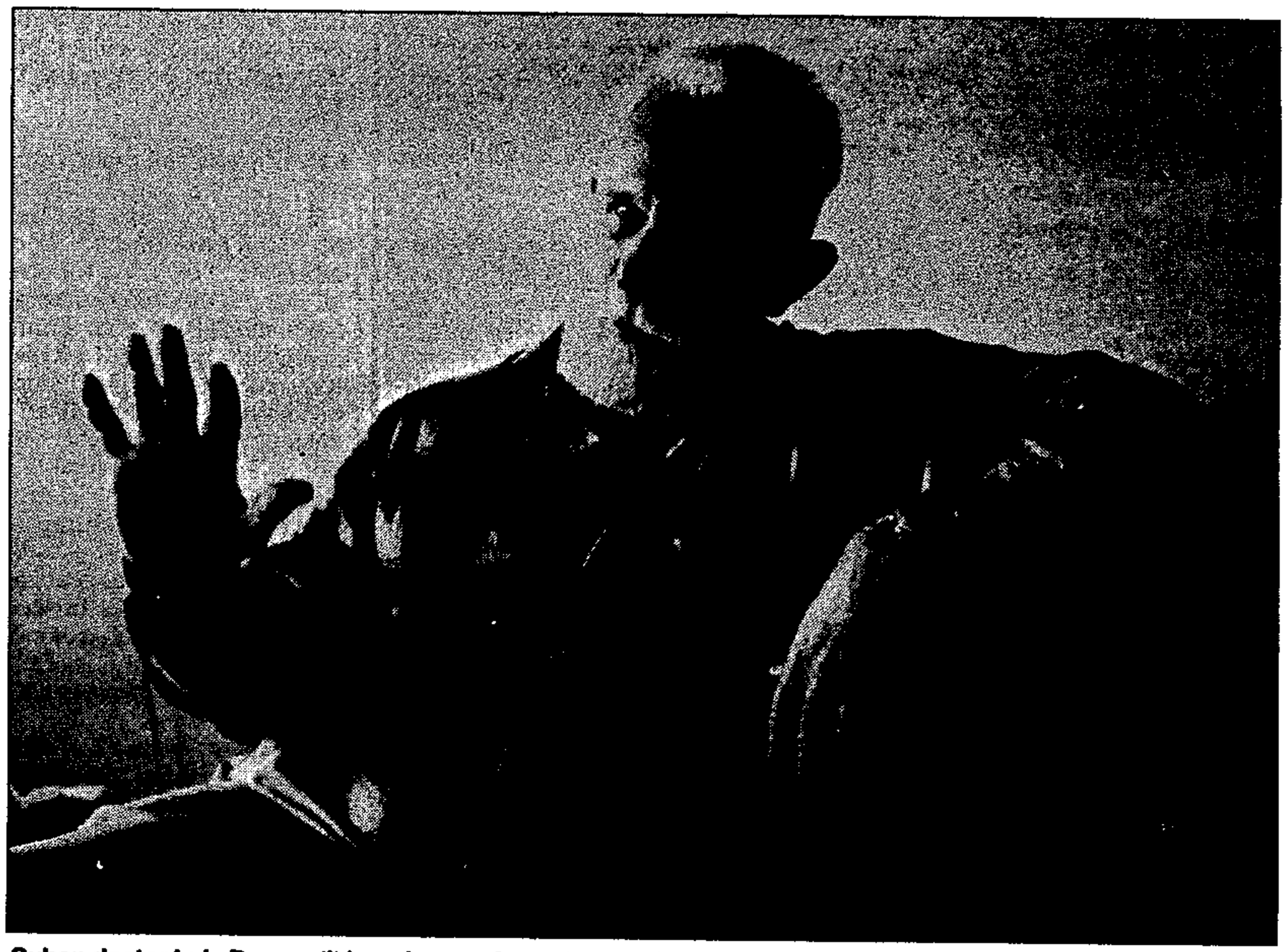
A self-confessed *idealista*, the Cuban Communist Party central committee member says he is optimistic about the prospects for South Africa's "social revolution": "I was surprised to find that racial integration has come so quickly," he says, pointing to the number of black patients at the formerly white hospital.

After years of contact with Southern Africa's liberation struggle, delivering medical services to victims of the war in Angola and training African National Congress doctors in Havana — including one who later cared for the late Oliver Tambo in exile — Peraza was eager to join the Cuban medical detachment to South Africa: "I wanted to see [the new South Africa] for myself," he says.

Born into a revolutionary family, Peraza was a member of Cuban President Fidel Castro's 26 July Movement, which ousted US-backed dictator General Fulgencio Batista in 1959. Despite his family's apparent anti-US sentiment, Peraza's father sent him to study there. Returning to Cuba three years later, Peraza joined a student cell of the 26 July Movement. "We blew up 20 or 30 post offices," he says.

Peraza, his mother, father and one brother were imprisoned and tortured, while a second brother fled to Mexico and joined Castro and Argentinian revolutionary Ernesto "Che" Guevara's guerrilla army. Upon his release, Peraza joined his brother in Mexico. He later received military training himself from Guevara.

"I only did what everybody my age did in Cuba," he says. "We were involved in the struggle against colonialism and it is an honour for us to serve in that struggle. Many Cubans died in Angola and in Ethiopia but some people were crying because they couldn't go. When the CIA killed two Cuban teachers in Nicaragua, the next day 20 000 teachers wanted to take their place."



Cuban doctor Luis Peraza: 'It is an honour for us to serve'

PHOTOGRAPH: DAVE BUZZARD

Warning on flaws in the SA health service

(85)
BD 22/7/96

Bonile Ngqiyaza

MANAGED health care could fail miserably if doctors and other health care providers are not given adequate incentives, says economist and health care specialist Dr Peter Hilsenrath.

At a recent breakfast organised in Cape Town by one of the country's largest medical aid administrator groups, D&E Health Benefits, Hilsenrath said managed health care was "the best solution for health care reform in SA".

Cost increases, Hilsenrath said, had created massive pressure to introduce stronger cost containment measures and the recently passed Medical Schemes Amendment Bill was encouraging private insurance companies to provide their own health services.

The Bill had also empowered insurers to open the door to health management organisations.

He said he foresaw "major fundamental changes" in SA's private sector which would result in a shakeout in the medical scheme industry, "forcing many smaller organisations to exit".

D&E Health Benefits MD Robin Melville said health insurers in SA were currently discussing options that would include staffing hospitals with salaried physicians, nurses, pharmacists and other health professionals, just like in the US.

"Payment to these health providers would rely on fixed rates instead of fee-for-service reimbursement, Melville said.

"Studies in the US show that a shift from fee-for-service medicine can be expected to reduce premiums by approximately 15%."

Savings, he said, were also brought about by a more efficient use of primary care providers and a less intensive use of expensive hospital services. "A study found health management schemes resulted in reduced length of hospital stays."

New scheme to cut health care costs

Star 24/4/96 (85)

By Audrey Sekwakwa

Out-patient Parenteral Antibiotic Therapy (Opat), an advanced method of administering antibiotics, is now in use in the health sector in South Africa.

The new method, acquired in the United States, cuts out lengthy stays in hospital and reduces costs.

Patients pay for the initial consultation, diagnosis and the Opat regimen, which may be used for the treatment of serious infectious diseases, like pneumonia, meningitis and bone or joint infections, before being treated in hospital for the critical period.

After that, the patient is allowed to go home and report to the hospital, clinic or doctor once a day for an injection.

Cost comparisons done recently by Roche Products showed that use of the regimen had the potential, if used by private and state health care centres, to bring down health costs significantly and to free beds in overcrowded facilities.

Professor J Trowbridge, vice-president of Clinical Effectiveness, at the Santa Rosa Memorial Hospital, said South Africa needed the regimen and people could be served without more hospitals. He said the regimen was seen by many as a way of delivering quality health care.

He said to prevent overcharging patients on medical aids, the system of charges would have to be changed. Doctors would be given the cost to treat a particular disease and, if the costs after treatment exceeded the given costs, the doctors would pay the difference.

Living in hope for a normal life

(86) Sowetan 25/7/96

By Sonti Maseko

PADWELL Nyukane was 20 years old and still at school when he developed kidney disease about six years ago.

Then, he was a young man with dreams and an equal chance to all the possibilities that life could offer to a boy at Bushbuckridge in Northern Province.

But once he was diagnosed with chronic renal failure, he lost all control of his future. Today, his future is dictated by a kidney disease. His sole preoccupation these days is to stay alive.

And staying alive has meant he is at home with his mother for only one full day in a week, on Saturdays.

As Bushbuckridge is a rural area, local hospitals have to refer patients such as Nyukane to a bigger hospital, which in his case is in GaRankuwa near Pretoria.

Each Sunday afternoon, Nyukane boards a train to GaRankuwa. It travels for the whole night and he reaches the hospital at 6am. At 7am he is put on the dialysis machine to purify his blood.

The machine performs the function of his failed kidneys. It takes four hours at a time and, for the rest of the day, he waits at the hospital to be on dialysis on Tuesday.

He is free on Wednesday but cannot go home as he has to be back on the machine on Thursday morning. On Thursday afternoon he boards a train back home to Bushbuckridge and arrives there on Friday.

It costs him R100 to travel by train each week plus an extra R12 in taxi fares. The hospital has obtained a railway warrant which permits him free travel, but the weekly R12 taxi fare comes from his pensioner mother.

Being on dialysis three times a week has also meant that Nyukane cannot hold down a job. While being on a dialysis machine has kept him alive, it has also meant he is constantly anaemic and tired.

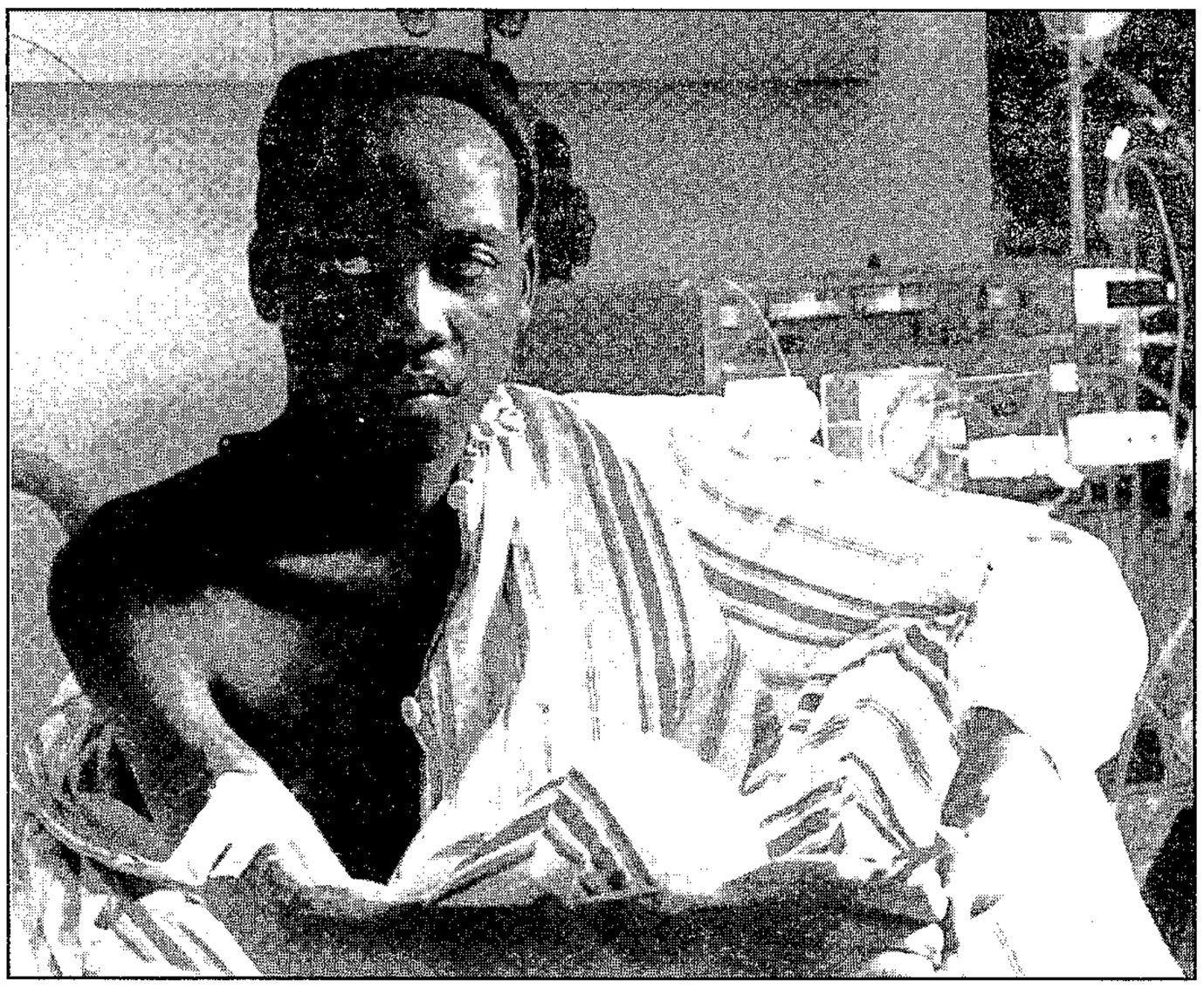
There are stringent dietary restrictions as well. He is not supposed to take more than 500ml of any liquid a day and he has to eat specific foods.

A new life

Nyukane says he has come to accept this way of life, but he lives in hope that one day there will be a kidney donor. "Every day I am waiting. The hospital can call me back anytime, even if I am at home, once there is a kidney available," he says.

A new kidney will give him a new life. If this happens, he will then only have to report to hospital about once a month and can go back to studying or having a steady job.

Last year his sister offered to give him a kidney, but doctors found after tests that the transplant could not be done. "My other brothers are scared. They have wives," he says.



Padwell Nyukane ... his sole preoccupation these days is to stay alive. PICS: LEN KUMALO

Struggling to keep sick people alive

Sonti Maseko looks at the problems faced by S Africans with kidney failure

PROFESSOR Anthony Meyers speaks in a soft voice. His manner is easy: he sits comfortably in a lounge chair with his legs crossed and says casually: "I kill nine out of 10 patients a week."

But Meyers is no angel of death who visits patients in their sleep and kills them. He is just being practical.

"If a patient comes with kidney failure, I say sorry, I'm full, let them die. I have no machine to put them on."

He adds in despair: "Until black people give more kidneys, this will not change."

Meyers heads the Department of Kidney Diseases at Wits University and is vice-chairman of the National Kidney Foundation.

To save more lives, he needs to change the perceptions of millions in this country – mostly black – towards organ donation.

Kidney failure

Each year more than 8 000 South Africans experience kidney failure, with the incidence of kidney disease higher in blacks than in whites. In Gauteng alone, 3 000 people experience kidney failure each year.

In fact, kidney disease is one of the most common causes of death among young blacks, with the incidence being three to four times higher than in whites.

Meyers adds that while kidney disease is one of the diseases that can be treated, the tragic reality is that thousands die from it every year. There are not enough kidneys for transplants because of resistance among black people to the idea.

While there is a relatively high degree of organ donation, particularly from the white and coloured communities, there are not enough kidneys for transplant nationally because the two communities constitute a very small percentage of the population.

"How many dead donors can you get in a population?" he asks. "You only get 40 kidneys (20 people) per million people per year," he answers himself.

The crisis over the shortage of kidneys can easily be solved by using organs from "our monstrously high rate" of deaths from violence and car accidents.

Meyers says South Africa should not be struggling for kidneys. Instead, "we should be giving kidneys to the whole world. Each year there are 4 000 autopsies on deaths from accidents; that is 8 000 kidneys".

However, it is the refusal by families of victims to donate organs that quashes the hopes for a normal life for thousands of kidney sufferers, Meyers says.

He stresses that there are excuses – not reasons – that most black families give when approached for consent over the use of organs from a body certified as brain dead.

"They say 'no' because the head of the family (who must give consent) is far away, that it is not the tradition of black people. Or they superstitiously say that we need our organs when we are born again (resurrection)."

In an almost cruel manner, Meyers attacks the latter form of reasoning by giving a glimpse into what really happens in the rooms of pathologists.

"By law, if you have a violent death, there should be a postmortem. Livers and kidneys are just thrown back into the bodies; they are minced and there is no way these kidneys will ever work if you are born again."

It is not only from the brain dead that kidneys can be obtained. A person can live a full life – up to 90 years – with one kidney, Meyers asserts. One kidney will not affect a person's sexual or reproductive life and a person can even play soccer without hindrance with one kidney.

"Why the good God gave us two kidneys instead of one, I don't know," he adds, shaking his head at the generosity over the number of "spares" in the human body.

Because of the shortage, kidney transplants from a living donor are usually done between parent and child, brothers and sisters, relatives, close friends and husbands and wives with a better chance of success. Tests can be done weeks ahead to determine this.

Dialysis machine

The only hope for people with kidney failure is to be put on a dialysis machine three times a week. The machine does the functions of the kidneys for the patient, cleaning the blood of impurities.

Meyers says if all 10 patients who report to the hospital a week were put on a dialysis machine, there would be no space for anything else at the hospital. That is why some patients are turned away.

The pain of sending people home to die when they can be saved has made the unit at Johannesburg Hospital the most unattractive ward and left Meyers feeling pretty much alone.

"I cannot get doctors to work in my unit anymore because they do not like to see what is happening," he says.

Blacks opposed to organ donations

By Sonti Maseko

THE attitudes of black people towards organ donation in South Africa are threatening to cripple the country's organ transplant programme.

Thousands of South Africans have been put on waiting lists, some for as long as 10 years, while thousands more are turned away to die because there are no donors.

Medical staff involved with organ donations all say there is strong resistance in the black community towards organ donation and almost all organs received for transplant come from whites.

However, the irony is that more black people need organs than whites, mostly because of kidney failure resulting from high blood pressure, which is more prevalent in black people than in whites.

Dr Andrew Kobryn

As a result, kidney failure is three to four times higher in black people than in whites. In Gauteng alone, 3 000 people a year suffer from kidney failure.

Patients with kidney failure who are awaiting transplants are put on dialysis machines but hospitals say that increasing the number of machines is not the answer.

Donors have to be found so patients can be moved off dialysis to make way for new ones. "What we need is more kidneys, not more machines," says Professor Anthony Meyers of the National Kidney Foundation.

Organs currently being used in transplants come not from victims of violent deaths but from living donors. Many families refuse to allow organs from their loved ones to be used in transplants.

GaRankuwa Hospital transplant surgeon Dr Andrew Kobryn puts it bluntly: "They are burying the organs but in a place like this we should be having between 30 to 50 donors a year."

The shortage of donors is so bad that GaRankuwa Hospital, a referral hospital serving about four million people in North West and Northern Province, is considering closing down its only transplant programme.

Chief medical superintendent Dr Reginald Broekman says the hospital will temporarily suspend its transplant programme as there are not enough cases to keep the unit "jacked up".

"We should do at least a hundred transplants a year to keep the unit. The demand is there and if donors came forward, we would do that. (But) we are doing about half a dozen a year ... it is not a viable programme."

Other hospitals such as Addington Hospital in Durban have done as few as two transplants this year, according to figures compiled by the Organ Donor Foundation.

Its transplant coordinator, Mrs Lynn Botha, says the few recipients of organs are the lucky ones who get onto the waiting list. "Thousands more who don't are sent home to die. It's a tragic situation," she says.

Botha says black people are reluctant to donate organs because of widespread beliefs that these will be used as muti and also because they believe the medical profession takes organs without permission anyway.

Others are reluctant on cultural grounds or because of a lack of education.

Some believe they cannot donate their organs because they have to be buried in one piece.

Dear editor

Short letters are preferred and none is considered unless it is signed, with the writer's full address. You may indicate if you want to use a pseudonym but these are not encouraged.

Write to: The Editor, *Sowetan*, P.O. Box 6663, Johannesburg 2000

Teanet story poorly done

WE HAVE noted with great disappointment and shock the way your journalist Khathu Mamaila handled the Peta Teanet story.

In the first place we believe that it's uncalled for for him to delve into the personal affairs of the late Shangaan music king.

Though we respect the fact that there is Press freedom, we believe that every individual has got a private life.

If was none of Mamaila's business to investigate whether Teanet failed to pay telephone bills or whether there was any furniture in his house.

Tragic death

We, however, believe that his responsibility was to report the singer's tragic death and not expose the goings on in the Teanet household.

Mamaila must not abuse the privilege of working for a newspaper to expose sensitive details about Teanet, more especially as his family and friends are still grieving.

By the look of things, Mamaila seems to be using *Sowetan* to settle personal differences that he might have had with the late Teanet.

How would it be if another journalist delved into Mamaila's failures. Could it have made an interesting story for the *Review* newspaper in Pietersburg or the *Sowetan*?

He must not forget where he comes from and what he has achieved so far as a journalist. He should not forget that for every going up there is a coming down.

In the *Sowetan* of July 19 he wrote: "If Teanet was successful, why did he have to promote his records in a hotel?" This paragraph was obviously uncalled for.

WORRIED JOURNALIST,
Pietersburg

African TV for Africans

I WROTE an open letter to the SABC last year complaining about the lack of Africanism in this medium.

I had hoped that when the SABC was reformed, it would change its image and educate the former oppressed masses of occupied Azania about themselves.

While it failed to Africanise its image, the SABC now promises to prosecute viewers who fail to pay their TV licences. It fails to look at the reasons why people cannot pay.

It is disheartening to watch television which fails to recognise the languages of this country. The colonial languages are still given precedence over the African languages. There are still other African languages which are not given viewing time on the SABC while others are relegated to provincial switch over slots.

African languages

But the use of the language does not actually mean anything more than the message that is being transmitted.

We have seen in the past how programmes that were conducted in African languages have been used to sell a message that is un-African.

Most of the dramas shown on television teach a culture of imperialism.

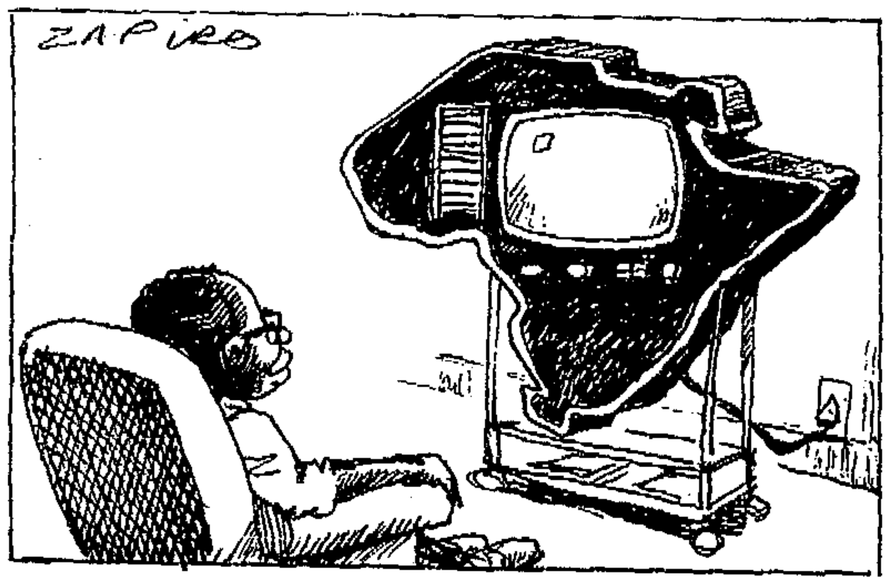
The lifestyle that is propagated by these dramas is unreal and destroys African values. They teach violence, drug addiction and prostitution. The morals and values that are disseminated through such programmes destroy African family life. Its characters are self-centred and lack the bond that goes into extended families.

Report success

The other problem with the SABC is what they regard as news. African life is only shown when there is war or disaster. The SABC fails to cover the developments and successes that take place in other African countries.

There are hardly any reports when the Organisation of African Union is in session. We do not receive reports on the resolutions that are passed from conferences on African matters. They broadcast what is happening in America and other imperialist countries.

Africans are shown as hostile and violent. They are shown as porters and servants in the corridors of the imperialists power. Africa is shown as a land of poverty and death.



It is from this perspective that I sympathise with all those Africans crying foul about the SABC.

The medium plays a central role in the education of a nation. The SABC must recognise that its audience is African and it must broadcast what will help in African development.

It must re-educate Africans about their culture and decolonise Africans. The prosecution of people who do not pay their TV licences will not help solve the problem of imperialism.

We want to be Africans and only African knowledge of our culture and tradition will help us become real Africans. We cannot finance imperialism. Imperialists and white capitalists must pay to maintain television.

LEHLOMELA PHAKISI,
Witsieshoek

To the point

EITHER nudist Beau Brummell does not understand the Bible or he just wants to mislead Christians of little faith. To say Christianity must be destroyed is wrong because nowhere in the Bible does it say true Christians should destroy, enslave or mistreat blacks.

Most people today who claim to be Christians are so far from the truth as West is from East. They are fakes. Christianity as taught by Jesus and his apostles is not what you see these days. Preachers are out to make a quick buck. Your reasons for wanting to destroy Christianity are invalid, Mr Brummell. You should rather destroy "fake Christians".

MARTIN,
Excom

I WAS shocked by the death of four boys at a circumcision school in the Eastern Cape. Not only that, scores were admitted to hospital with wounds that had turned septic. The people in charge of these schools do not know what they are doing. I think it is high time the Government took over all circumcision schools. If not, young men will die in their hundreds.

DAVID MKHOBO,
Virginia

THERE are far too many accidents resulting in people dying on the DF Malan Drive which runs through Honeydew. Many people are hit by cars on their way to work or coming home in the afternoon. The Honeydew authorities have to erect robots on DF Malan Drive to avoid these nasty accidents.

REUBEN M MAHLAELA,
Honeydew

I AM deeply touched by the violent death of singer Peta Teanet. I was also shocked to learn that the guy has left eight wives, 13 children and two unborn babies with no income. He also had not paid his telephone bill and the big mansion he lived in had no furniture. It looks as if many musicians in South Africa cannot take care of their hard-earned money and end up broke. What a pity.

ANDREW KUTAMA,
Louis Trichard

I READ with interest the letter written by Beau Brummell about the failure of Christianity to help blacks. To a large extent I agree with him. Of all religions pushed down the throats of blacks, Christianity is the most confusing. It has been the belief of Africans to worship one God but the Bible tells us to worship the Holy Trinity.

ANDREW MAHLANGU,
Mhluzi

SABC-TV is not being fair to us. The dramas screened lately are very old . They promote white international music instead of playing our kind.

KWAME ka ZWANE,
Thembisa

Words of Faith

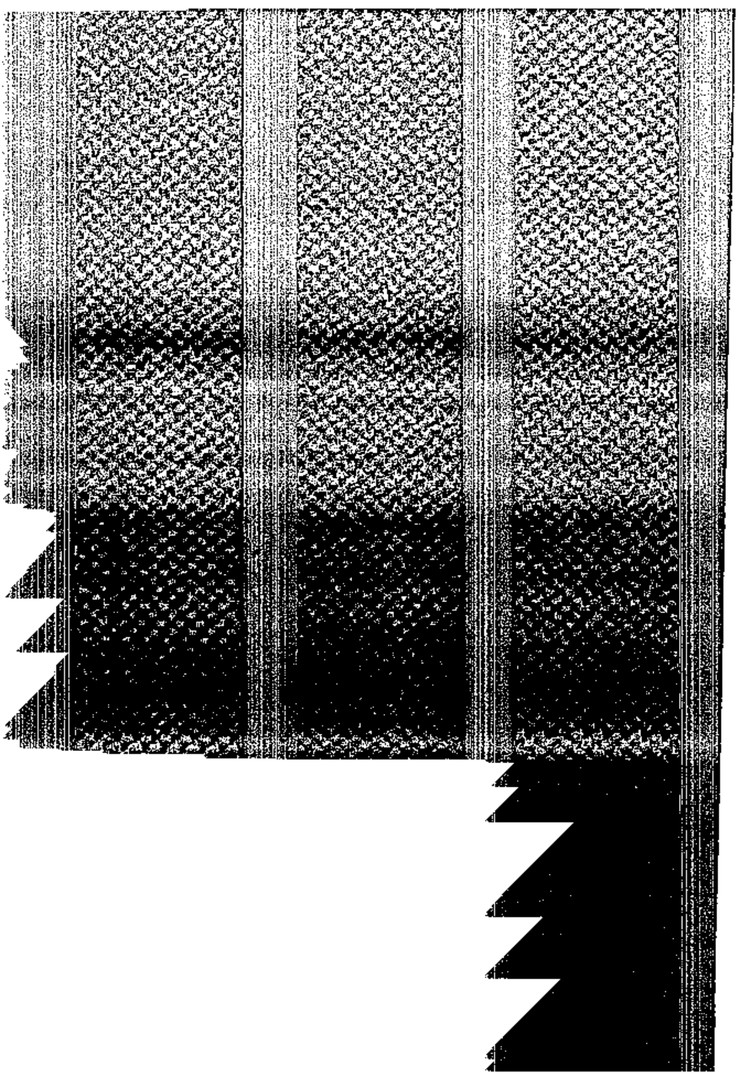
A wise man is hungry for the truth, while the mocker feeds on trash. When a man is gloomy everything seems to go wrong; when he is cheerful, everything seems right. Better a little reverence for God, than great treasure and trouble with it.

A quick-tempered man starts fights; a cool tempered man tries to stop them. A lazy fellow has trouble all through life; a good man's path is easy! A sensible son gladdens his father. A rebellious son saddens his mother. If a man enjoys folly, something is wrong! The sensible stay on the pathways of right.

Proverbs 15:14-21

They live on borrowed time

(85) Sowetan 25/7/96



SOUTH AFRICA'S organ transplant programmes are in crisis with thousands of patients urgently needing organs being more likely to die than to find a donor in time.

Patients on waiting lists for vital organs such as hearts, livers, lungs and kidneys are struggling to find donors because organs are being buried rather than used to save other lives.

At least one institution, Ga-Rankuwa Hospital near Pretoria – which serves people from Gauteng, Northern Province and North West – is considering suspending its kidney transplant programme due to the low number of transplants.

The crisis is so severe that transplant coordinators say it is only the "few lucky ones" who are put on waiting lists for organ transplants. Thousands more are simply sent home to die.

Doctors and transplant coordinators say the crisis is due to a great reluctance, particularly in the black community, to give consent for organs from a brain-dead relative to be taken out for transplant.

Ga-Rankuwa Hospital kidney patient Mr Padwell Nyukane (26) has been waiting for six years for a donor

Currently organs being used in transplants come almost entirely from white people.

"The sad part is the majority of people waiting for organs are black," says coordinator Mrs Belinda Rossi.

Doctors say there is a greater demand for kidneys among black people because of the higher incidence of high blood pressure in blacks than whites. High blood pressure can lead to strokes and kidney failure.

Professor Anthony Meyers of the renal unit at Johannesburg Hospital says out of 10 new patients with kidney failure every week, nine ultimately die because they cannot be accommodated at the hospital.

"In Gauteng alone we should be doing 3 000 (transplants) but we do only 300 for the whole country...we are way behind," says Meyer.

Rossi says every year between 100 and 200 people are on the waiting list for heart transplants and about half of them die before a donor is found. On average, there are about 70 people at any given time waiting for liver transplants, who will die if there are no donors found.

There is also a need for 20 heart and lung donors at any one time.

Rossi explains that patients needing hearts, livers and lungs were already critical and did not live long.

Rossi said while black families in cities were willing sometimes to give permission for organs to be used for transplants, family elders, often living in the rural areas, would often refuse because of the belief that a body has to be buried whole or ancestors would be upset.

See Page 17

New call to fight VAT on the sick

(BL6)(85) sowetan 25/7/96

By Mokgadi Pela

THE fight against the imposition of Value Added Tax on health care has been rekindled following a fresh call by the South African Medical and Dental Practitioners.

The call came after a two-day strategic planning workshop held at Broederstroom near Pretoria.

The workshop resolved that members of medical and dental associations throughout the country should "rekindle" the debate about VAT on illnesses and demand that it be zero-rated.

The anti-VAT lobby on health care was in the limelight before the April 1994 general elections during which activists felt it was immoral to tax the sick.

On the deregulation of medical aid schemes, SAMDP said the move should be reversed. Deregulation enabled medical aids not to guarantee a minimum insured package to the members and to discriminate against the chronically ill and the old.

The workshop also came out strongly against moves by Government to limit medical practitioners from dispensing medicines. SAMDP believes dispensing by private practitioners can only be limited when:

- Non-exploitative community dispensaries and pharmacies are situated in every neighbourhood;
- Payment to practitioners for patient examination and counselling is reasonable and in line with rates set up by the Medical Association of South Africa;
- Medical and dental graduates automatically qualify to receive the licence to dispense; and
- Restrictive measures apply equally to both private sector health facilities and Government clinics.

The SAMDP further resolved to contact all dispensing practitioners in order to forge a joint programme of action and "reverse all apartheid laws".

Central registry of donor organs must be set up

(85) CT 31/7/96

DR JOHAN BRINK analyses the factors that need to be taken into account when formulating a national policy on organ transplantation.

AN ARTICLE in the Cape Times of June 18 titled "Donor scramble not in the interests of patients", inferring inappropriate allocation of donor organs in South Africa, is prejudicial to the interests of organ donation.

A national policy on organ transplantation is being formulated by the Department of Health. Draft guidelines for this policy have been widely circulated to all interested parties for input.

A main advisory committee on organ transplantation and various expert sub-committees will be set-up to deal with specific organ transplants. The equitable distribution of organs will be an important task of these committees.

There will always be "competition" for donor organs worldwide as the demand always exceeds the supply.

The local "competition" for donor organs between units, implied in your article, was created by the starting of heart transplantation in the private sector in Cape Town without the sanction of the Department of Health, without consultation with the established heart transplant unit and without fulfilling a demonstrable public need.

What is needed is the establishment of a second heart transplant unit in Gauteng to serve both public and private sector patients there. (At present only private sector heart transplants are performed in Gauteng.)

There is no doubt that the ideal for heart transplantation in South Africa would be to have two or three well-funded, well staffed units each serving a different region of the country and each serving the interests of both private and public sector patients.

Each unit would apply both internationally accepted and locally relevant criteria for the equitable allocation of organs, a scarce national resource, in the best interests of all South Africans.

These criteria are followed at Groote Schuur Hospital. That they serve our patients well is shown in the low mortality on our waiting list (around 15%) compared to the international experience of around 30-40%.

We are, however, strongly in agreement with a central registry of all donor organs since many organs (particularly hearts and livers) are being "wasted" by not being referred to the relevant transplant centres. This is being addressed by the Department of Health.

In the formulation of a national policy, lessons can be learnt from the international transplant community. The best situation exists in commonwealth countries (United Kingdom, Australia, Canada and New Zealand) where a nationally regulated approach exists.

Only one heart transplant unit per major region has been allowed (all linked to an academic centre) and each has been adequately funded to serve the transplant needs of the whole population of that region (a region usually comprising a population of 10 million patients or more) without "competition" for organs from other units in the region.

If available organs cannot be used in that region then they are referred to other regions. The staff of the regional unit has current and detailed knowledge of each patient on their waiting list and therefore donor organs can be allocated to the most appropriate patients.

The alternative, which exists in continental Europe and the United States where many heart transplant units co-exist in the same region, is that these units (often performing less than nine transplants a year with significantly worse results) "compete" for organs. Despite regulations on the allocation of organs there is alleged abuse of the system and undesirable incidents occur to the detriment of organ donation.

Should not organs be equitably distributed by academic institutions that can appropriately allocate them to the most deserving?

THE PERFECT THING: "Organ donation is the ultimate and greatest gift of life," says Dr Johan Brink.

It has also been shown that units which perform more transplants have better results and that it is more cost effective for a unit to perform more than 25 heart transplants a year, ideally up to 50, because the cost per patient managed can be reduced.

It also allows sufficient numbers of patients for ongoing research to improve the long-term results of transplantation and for the training of personnel. These are further reasons to limit the number of units in a region to academic centres.

Eighty percent of all donor hearts in South Africa come from the state hospital sector, mostly from indigent patients.

Should not these organs be equitably distributed among the whole population by academic institutions that serve both private and public sector patients, that have in place a system of peer review and transparency and that can appropriately allocate organs to the most deserving patients irrespective of their financial status or ability to pay?

Should our scarce resource of donor organs be provided to foreigners, who are on long waiting lists in Western countries and who have the resources to pay highly for their transplants? (The present private sector cost for a heart transplant in South Africa is about R160 000 compared to about R600 000 in the US.

There is, therefore, much money to be made out of transplanting hearts into foreign patients. Transplants have recently been performed on foreigners in the private sector.

For this reason, among others, the private sector has been resistant to the concept of regulation and licensing of organ transplantation in South Africa. Should we be seen as a country where organs can be "bought" and where no controls are in place?

Therefore many factors need to be taken into account when formulating a national policy on organ transplantation. Hence your allegation of inappropriate allocation of organs is untimely, based only on the opinion of one member of the private sector and on an article which is detrimental to the interests of organ donation by presenting undesirable aspects of organ transplantation.

Organ donation will always be the ultimate and greatest gift of life for many desperate patients on long waiting lists for organ transplants. Any adverse publicity will decrease this precious resource.

We therefore ask that before publishing emotive articles with potential negative public consequences, first to consult other role players such as the Department of Health and members of well-established transplant units for more relevant information and alternative opinions.

❑ *Dr Johan Brink is a member of the Groote Schuur Hospital/University of Cape Town Heart Transplant Unit.*

from Saturday night, covering a wide area east of Witbank.

Manning dispute leaves centre idle

(85) BD 9/7/96

KHAYELITSHA — A new community health centre in Khayelitsha, Cape Town, has been standing empty for almost two years since it was completed.

The Michael Maphongwana Health Centre, named after a Sanco leader who died during the 1993 Khayelitsha taxi feud, has been standing empty because of a dispute over who should be employed there.

Initially Khayelitsha residents, including Sanco members, were adamant that only township residents be employed, delaying the health centre's official opening.

After recent government intervention in the matter, which resulted in an agreement that a significant number of Sanco members who had guarded the centre since its completion would be given jobs, the centre was officially opened by Deputy President Thabo Mbeki last month.

The centre, which now serves more than 800 000 township residents, has more than 200 nurses and three doctors in its employ.

Doctor in charge of the centre Theo Dahms said about 250 outpatients were treated daily and maternity patients were also admitted.

He said that the centre expected a huge influx of patients from areas such as the former Transkei and Ciskei.

The centre, which cost more than R10m, was completed in March 1994.

Authorities held numerous talks with Sanco and Sanco-aligned health committees but without consensus until government intervened. However, discussions are still under way. — SaFrica News.

HEALTH AND DISEASE — GENERAL

1996

AUG. — DEC.

Trust to research reproductive health

BD 11/8/96 (85)

Kathryn Strachan

IN RESPONSE to the alarmingly high rate of maternal deaths in SA, the Durban-based Health Systems Trust has launched a R6,5m fund to research reproductive health.

Aside from the maternal deaths, health services also battle with the high number of children born with congenital syphilis and HIV, many unwanted teenage pregnancies and an increasing incidence of sexually transmitted diseases in adults.

Many of these problems were preventable. However, as reproductive health services were poorly developed and inaccessible to those most in need, people did not have the opportunity to make informed decisions about their reproductive health, the fund said.

The fund would be sponsored by the US-based Henry J Kaiser Family Foundation, the SA health department and Britain's Overseas Development Administration.

President Nelson Mandela with one of the babies at the polio campaign launch in Johannesburg on Friday. Picture: AP

'Africa to conduct mass immunisation projects'

(85) (BDS 18/96)

Kathryn Strachan

PRESIDENT Nelson Mandela called on all African nations to conduct mass immunisation campaigns against polio at the weekend launch of the "Kick polio out of Africa" campaign.

Polio remains a major problem in Africa, crippling more than 12 000 children every year, although due to weak surveillance systems, less than a tenth of these cases are reported.

The disease is most prominent in West Africa and the four biggest African countries — Angola, Ethiopia, Nigeria and Zaire — UN World Health Organisation (WHO) regional director Ebrahim Samba said.

With more than 150 countries having been declared free of polio since eradication efforts began two decades ago, the focus has fallen on Africa which is furthest from this goal.

In 1994 only half of all African children under one year were immunised with the polio vaccine. Serious outbreaks of polio occurred last year in Namibia, Central African Republic and Zaire.

The new initiative aims to immunise all children under five on two national polio immunisation days each year for the next three years.

While the last case of polio in SA was reported in 1989, Mandela said it was essential to increase present immunisation efforts to ensure the disease was eradicated completely.

Health Minister Nkosazana Zuma said 76% of one-year-old babies in SA were reached through routine immunisation at clinics, leaving more than 20% unprotected. However, last year's campaign reached 89% of those below the age of five years.

This year's mass immunisation campaign in SA will be held next week with army medical services helping the health department to reach children in the most remote corners of the country. The polio campaign will be linked with measles immunisation.

On the rest of the continent, nations have heeded the WHO call for mass immunisation, and 29 countries in sub-Saharan Africa will be conducting polio campaigns this year.

As there would still be children who would not be reached, governments needed to focus on educating women, particularly in rural areas, to look out for signs of polio in their children, such as weakness of the limbs.

With the high-profile political support given to the campaign, it was hoped that polio would soon be eradicated altogether — as smallpox was in the 1970s. The efforts made so far in Africa as a whole have been encouraging with incidents of polio in children decreasing from more than 4 000 in 1990 to less than 1 000 in 1993.

"But our aim is not merely to reduce the numbers afflicted," said Mandela. "It is to eliminate the disease completely. No country can be safe from this disease until the whole world is rid of it, for it can cross borders with ease."

Zuma said that as well as eradicating polio from SA completely by 1998, other goals of the health department were to reduce measles to less than 4 000 cases a year over five consecutive years, and to increase immunisation coverage to 90% for all the vaccines in the primary childhood series.

Spreading good health

(ST)(85)

ARG 6/8/96

How do you spread health messages that will give people information and, more importantly, get people to change their behaviour? Entertain them, of course. That's the thinking behind the television series *Soul City*, a drama with a health message. Health Reporter JENNY VIALL takes a closer look.

THE finger-wagging educational style of the past didn't – and doesn't – work. It's no use scaring people to get them to change their behaviour.

Especially young people. Telling people they may get lung cancer if they smoke, or Aids if they have unprotected sex, is not going to stop them.

Yet health educators in South Africa face the daunting challenge of spreading awareness of major problems, which include:

- Two-million people who are infected with HIV (human immuno-deficiency virus), a figure that will double in two years.
- About 140 000 people who will get active TB this year, a figure that is rising with the HIV epidemic. Of them, 85 000 will be identified and 50 000 cured. The 55 000 not found will continue to spread infection and stay ill.
- Young people who start smoking today will be among the 10-million people who will die from tobacco use in the year 2025.

Recent evidence is that advertising cigarettes has a major effect on young people, with a 10 percent increase in tobacco advertising resulting in an increase of smoking in three percent of adults and nine percent of children.

Knowledge about these health issues is one thing.

Changing behaviour is another.

Enter Soul City, a television series set in a township dealing with the lives and concerns of the majority of South Africans.

Soul City is the brainchild of Garth Japhet, a young doctor who decided that harnessing the power of the media to spread health messages was the best way to save lives.

His idea was to use television, radio and the print media simultaneously to reach as many people as possible. *Soul City* was born, a unique project in its scope and research process, and one that captured the imaginations of many South Africans.

The first television series *Soul City 1* focused on pregnancy and birth, reaching a total black population of 4,35-million people, 36 percent from rural areas.

An assessment of the series showed that 19 percent of people said they had changed their behaviour in some way, and this ranged from using a condom to storing paraffin safely.

The series has also appeared on television in Namibia and Zambia, and Kenya and Zimbabwe will also screen it.

Soul City 2 focuses on Aids, TB, smoking and land issues. It's the result of an 18-month extensive research and development process, which included consultation to prioritise topics, target audience research, consultation with relevant groups, and workshops with scriptwriters.

The series was pre-tested for appeal, personal relevance and credibility, mesage recall and understanding, and unintended consequences.

The result is a drama that most South Africans can relate to.

Says Sue Goldstein, a doctor working on the project:

"*Soul City* is not fairytale stuff – we wanted it to be real. We wanted to create a powerful, credible, effective and continuing vehicle as a national and international resource."

● *Soul City 2* starts tonight on SABC1 at 8pm.

The series will be supported by a radio drama on nine radio stations, excerpts from the booklet printed in major newspapers, and a competition.

The first 13 serialised excerpts on "Aids in the Community" start this week in the Classified section of The Argus. Look for them every Monday, Wednesday and Friday.

Readers can win R100 000 worth of cash prizes in the competition. The entry form will be published on Thursday, August 8.

HOW TO GET A HOUSE: Left, Nonceba (Nomonde Gongxeka) and Thandi (Clementine Mosimane) discuss various issues at the community housing meeting in a scene from *Soul City 2*.

HIV DRAMA: Mandla (Arthur Molep the results of his HIV test in the *Soul*

SMOKED OUT: Right, Ali (Aubrey Moalusi) tries to sneak a smoke break in the store room at a clinic – the setting for much of the drama of *Soul City 2* – but activates the smoke detector.

More thar

JENNY VIALL
Health Reporter

UNINTENDED consequences can be deadly in a health drama.

Picture this scene: Your character has tested HIV-positive and is so devastated by the news that he wants to kill himself. A good place to end the week's episode?

Yes, maybe, if you're making good drama. But if your viewer doesn't see the follow up episode, the message he or she takes away is that if you have HIV there is no hope and you should kill yourself.

These are the kinds of conflicts the scriptwriters, directors, actors and health professionals involved in making Soul City 2 grappled with as they reconciled the conflicting agendas of drama and health promotion.

The bottom line is that if you don't entertain, you won't edu-

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(92)(85) ARG 6/8/96

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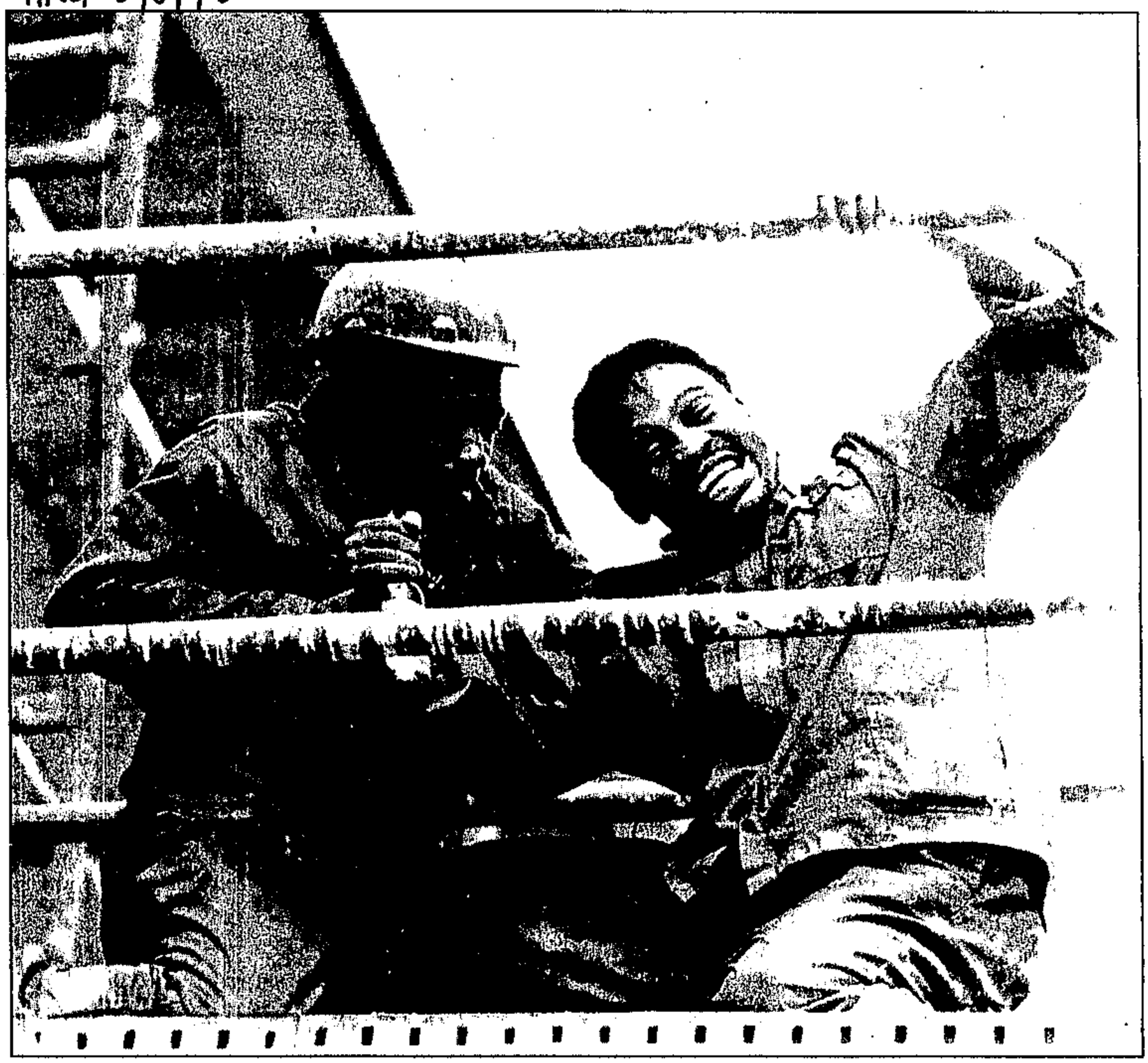

HOW TO GET A HOUSE: Left, Nonceba (Nomonde Gongxeka) and Thandi (Clementine Mosimane) liscuss various issues at the ommunity housing meeting in a scene from *Soul City 2*.

HIV DRAMA: Mandla (Arthur Molepo) tries to stop George (David Mohloki) from committing suicide after he hears the results of his HIV test in the *Soul City 2* series.

More than a soap … it's got soul

JENNY VIALL
Health Reporter

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Picture this scene: Your character has tested HIV-positive and is so devastated by the news that he wants to kill himself. A good place to end the week's episode?

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These are the kinds of conflicts the scriptwriters, directors, actors and health professionals involved in making Soul City 2 grappled with as they reconciled the conflicting agendas of drama and health promotion.

The bottom line is that if you don't entertain, you won't educate, says Harry Dugmore, who along with Steve Francis (both of Madam and Eve fame) scripted the series.

"We had some intriguing conflicts: – drama is sexist, racist and homophobic and gives many bad messages.

"Many subliminal messages are deeply disempowering. We needed to take the entertainment aspect of the Bold and the Beautiful and change it into a subtle progressive, pro-social message," says Dugmore.

Sue Goldstein, a doctor on the Soul City team, said for health promotion to work people had to identify with the issues.

At the same time it was important to challenge issues without making the series unreal.

"For example we had a lot of difficulty with language around Aids and sexuality.

"We had to make sure people knew exactly what the message was, and talking about 'sleeping' with people when we meant having sex was not good enough."

She said the production team was aware violence was not acceptable.

"We see gratuitous violence in many dramas and soaps, without any consequences. Most people don't just fall down and die, it takes time, and its horrible."

Once scripted, Neo Matsunyane, assistant director, had the job of checking the script.

"I had to ask: does it relate to me?" he says.

"I had to sort out what was too Hollywood, what was too white. I checked for cultural differences in the way we do so that nobody is offended.

"For instance humour cannot be translated from one culture to another."

Bobby Heaney, director of Soul City, says that making the series was a learning process for him as he grappled with resolving the conflict between sound messages and good drama.

"My business is drama, and drama comes from conflict. I wanted to shoot rape, violence and mayhem. In the end, I managed to show conflict, but with a message of hope. Soul City is completely different from what I have seen produced in South Africa and 90 percent of imports."

Scriptwriter Steven Francis agrees: "It's not just a soap: it's about characters we care about. It's not about people receiving education: the trick was to weave the message through drama and comedy.

"We needed to get across that you can do something about your life.

"We hope that people will see themselves and identify with the characters."

Minister: gifts received

503. Mr J A JORDAAN asked the Minister for the Public Service and Administration:

Whether he and/or his wife received any gifts in an official capacity during the period 1 January 1995 up to the latest specified date for which information is available; of so, in each case, (a) from whom were the gifts received, (b) what was the (i) nature and (ii) value of these gifts and (c) why were these gifts given?

N865E

The MINISTER FOR THE PUBLIC SERVICE AND ADMINISTRATION:

Yes, but no information in respect of Mrs Skweyiya is available.

(a)	(b)(i)	(b)(ii)	(c)
South African Breweries	5 cases of SAB beer	± R220	Christmas gift
Monitoring Management (Thebe Investment Group)	Vanity Bag	± R60	In view of the official launch of the JHB Stadium on Thursday, 23 November 1995
Sanlam	Ball pen set	± R250	
Prime Minister of Lower-Saxony, Germany	Ball pen set	± R300	
Airports Company Limited	Ball pen set and wallet	± R250	
Chinese Centre	Pillow cover		
M-Net	Two tickets to Pavarotti	± R900	
M-Net	Decoder	± R900	Offered to all Cabinet Ministers
M-Net	Satellite dish	± R3 500	Offered to all Cabinet Ministers

Source: Department of Welfare and Population Development, Chief Directorate: Population Development.

Infant mortality rate

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

What was the infant mortality rate amongst (a) Blacks, (b) Whites, (c) Coloureds and (d) Indians in (i) urban and (ii) rural areas in the Republic in 1995?

N870E

The MINISTER OF HEALTH:

The 1995 infant mortality rate is not available.

In 1994, the infant mortality rate (per 1 000 live births) was as follows:

(a) Blacks 49

(b) Whites 8

(c) Coloureds 23

(d) Asians 9

(i) and (ii) The infant mortality rate by urban and rural areas are not available.

SA's African Cup of Nations victory

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

(1) Whether any coins have been minted to celebrate South Africa's African Cup of Nations victory; if so, what was the cost of producing the coins;

(2) whether any of the coins are to be (a) sold and/or (b) given away; if so, (i) how many and (ii) to whom;

(3) whether all the production costs are to be recovered; if not, (a) what will be the shortfall and (b) from what budget will the funds be derived to make up for the shortfall?

N873E

The MINISTER OF FINANCE:

(1) Yes. In 1996 Cabinet approved a silver R2 coin to commemorate the African Cup of Nations tournament. It is a unique coin as the words "South Africa" appear in all official languages on the obverse.

(2) (a) (i) The mintage of the coin is 7500.

(ii) Every effort is being made to sell this number both in South Africa and overseas. The selling price is R99 each.

(b) (i) 15

(ii) These coins were given to the members of the team and officials at two public relations events to which the press was invited. The subsequent publicity has helped to sell the coins.

(3) Yes.

(a) and (b) Fall away.

Homes for the aged: subsidies

518. Mrs T J MALAN asked the Minister for Welfare and Population Development:†

(a) What was the total amount in subsidies paid out by his Department to homes for the aged in the past financial year and (b) what amount was paid in respect of each province?

N881E

The MINISTER FOR WELFARE AND POPULATION DEVELOPMENT:

(a) The National Department of Welfare is not involved in the financing of homes for the aged. Each Provincial Welfare Department is responsible for old aged homes in their provinces.

(b) Gauteng R100,2 million

Northern Province R5,4 million

Northern Cape R10,2 million

Eastern Cape R82,5 million

KwaZulu-Natal R39,6 million

Mpumalanga R18,7 million

The Department could not get any information from the remaining three provinces.

Welfare and Population Development: subsidies to institutions

519. Mrs T J MALAN asked the Minister for Welfare and Population Development:†

What was the total amount in subsidies paid out by his Department to every specified institution in the past financial year?

N882E

The MINISTER FOR WELFARE AND POPULATION DEVELOPMENT:

The National Department of Welfare is not responsible for the financing of social welfare services on grassroots level. Particulars regarding the financing of homes for the aged are supplied in the reply to question 518(b).

Illegal immigrants

522. Mr I J PRETORIUS asked the Minister of Home Affairs:†

(a) How many illegal immigrants were there in the Republic at the latest specified date for which information is available and (b) how many of these immigrants came from (i) Lesotho, (ii) Botswana, (iii) Swaziland, (iv) Mozambique, (v) Zimbabwe, (vi) Zambia, (vii) Malawi, (viii) Zaïre and (ix) other African countries?

N885E

The MINISTER OF HOME AFFAIRS:

(a) As the majority of illegal aliens enter the country clandestinely, it is not possible to quantify their numbers accurately. In a study, initiated by the Department, and carried out by the Human Sciences Research Council during 1995, it was found that there may be as many as 2,5 to 4,1 million illegal aliens in the country.

(b) No such statistics are available.

Ratification of conventions

524. Dr F J VAN HEERDEN asked the Minister of Foreign Affairs:

Whether South Africa has ratified or acceded to the (a) Convention on the International Right of Correction (1959), (b) Convention relating to the Status of Stateless Persons (1954), (c) Convention on the Reduction of Statelessness (1961), (d) African Charter on Human and

Smoking in any toilet is strictly prohibited and the toilets are monitored by smoke detectors.

Introduction of Senior Cabin Controller

(English) Ladies and Gentlemen, on your flight today, I am the Senior Cabin Controller. My name is . . . Should you wish to bring anything to my attention, kindly ask one of the Cabin Attendants to call me.

(Additional)

The front of the cabin: . . .
In the aft section we have as the team leader . . . assisting him/her are . . .

(Add to the above the following)

The cabin crew are here for your safety and comfort.

We invite you to make yourself at home on our B737/A320/A300 aircraft, the . . . (name).

Your complimentary copy of our inflight magazine "The Flying Springbok" is in the magazine pocket in front of you.

On this flight today, the crew are conversant in:
. . ., . . ., and . . . (Establish at briefing which languages).

Please inform us should you wish to be addressed in any of the mentioned languages.

We wish you a pleasant flight.

Before meal/snack services

(English) Ladies and Gentlemen, as a courtesy to the passenger behind you, kindly put your seat in the upright position for the duration of the meal/snack service.

Ultra short beverage service

* Ladies and Gentlemen, due to the very short flying time, we will serve only a fruit juice between . . . and . . .
* Ladies and Gentlemen, breakfast will be served shortly.
* Ladies and Gentlemen, lunch/dinner with a bar will be served shortly.

(If applicable)

We offer a choice of the main course on this flight. The meals are supplied on a percentage basis and we may, unfortunately, not have your original choice by the time we serve you.

(Meals served on same flight—separate sectors)

Ladies and Gentlemen, we would like to inform you that a (cold/hot) . . . (breakfast/lunch/dinner) will be served from . . . to . . . On the sector . . . to . . . we will serve a (cold/hot) . . . (breakfast/lunch/dinner).

(Ultra short sectors)

Ladies and Gentlemen, the flying time on this flight does not allow us to do a bar service within the economy class of the cabin. A (cold) meal with a fruit juice only will be served to our customers seated in that section of the aircraft.

Top of descent

(English) Ladies and Gentlemen, we have commenced our descent. The cabin crew will now prepare the cabin for landing.

Seat belt lights on

(English) Ladies and Gentlemen, we are about to land at . . . (City/Town).

Please fasten your seat belts, ensure that your seat backs are in the upright position, that the armrests are down, that tray tables and foot rests are folded away and all hand baggage are safetly stored.

(On flights longer than three hours add the following)

As an additional safety precaution, please review the information on your safety pamphlet.

(At all transit stations add the following)

Passengers who have changed seats must please return to their original seats.

End of flight

(English) Ladies and Gentlemen, welcome to . . . (City/Town). For your own safety remain seated, with your seat belt fastened until the aircraft has come to a standstill and the seat belt lights have been switched off. When opening the overhead stowages be careful of articles that may fall out and cause injury. Please ensure that you are in possession of all your personal belongings before leaving the aircraft.

Do not smoke until you are in designated smoking areas of the airport building. Once all the other passengers have disembarked we will attend to the passengers who require assistance.

Goodbye

(English) (One of the following):
- Thank you for flying South African Airways, we look forward to seeing you on board again.
- We trust that you have enjoyed your flight with us. Thank you and goodbye.
- On behalf of the Captain . . . And the rest of the crew, I trust that you have enjoyed this flight with us. Thank you and goodbye.

(Afrikaans) Ons vertrou dat u hierdie vlug met Suid-Afrikaanse Lugdiens geniet het.

(Zulu) Siyabonga, nihambe kahle.

(Sotho) Re a leboha. Tsamayang ka kgotso.

(ii) (English) To convey a welcome or bid the passengers goodbye and to inform passengers of safety instructions and regulations.

(Afrikaans), (Zulu) and (Sotho). To convey a welcome or bid the passengers goodbye.

(c) As indicated, an announcement is made to inform passengers of the language proficiency of the crew on the flight. Whilst it will obviously be impossible to have crew proficient in all official languages on each flight, most new appointees to the position of Cabin Attendant are proficient in at least one Black language which will continuously improve services to passengers.

(2) The most effective use of National languages on aircraft is being investigated as part of the new Corporate Identity for SAA which will be phased in towards the middle of 1997 after broad consultation.

Hospital wings for free medical care

*31. Inkosi B P BIYELA asked the Minister for Health:

(1) Whether her Department will consider the establishment of wings for free medical care in hospitals in areas where there are no health clinics where patients can receive such free health care; if not, why not; if so, what are the relevant details;

(2) whether she will make a statement on the matter? N1118E

The MINISTER FOR HEALTH:

(1) No; many primary health care services are currently being rendered at hospitals

where there are no clinics available, including services such as free health care. For that reason the Department has embarked on the clinic upgrading and building programme to provide the necessary clinics at which these services can be made available. The primary concern of the Department is the large number of people being seen at hospitals who should actually be attending clinics, and for that reason there are no plans to open wings at hospitals to provide free health care.

(2) No.

Madlala people of Emzumbe district: chief appointed

*32. Ms N C ROUTLEDGE asked the Minister for Provincial Affairs and Constitutional Development:

(1) Whether a certain person, whose name has been furnished to his Department for the purposes of his reply, has been appointed as chief of the Madlala people of the Emzumbe district near Port Shepstone; if so, in terms of what statutory and/or other provisions;

(2) whether it has been established whether such appointment and the manner in which the said person was appointed is consistent with tradition and the Constitution; if not, why not; if so, what are the relevant details;

(3) whether he will consider taking steps to review (a) the relevant laws and provisions pertaining to such appointments and (b) all appointments based on such laws and provisions; if not, why not; if so, what steps?

N1119E

The MINISTER FOR PROVINCIAL AFFAIRS AND CONSTITUTIONAL DEVELOPMENT:

The information is not readily available in the Department. In an attempt to be of assistance to the hon member, the following information was obtained from the KwaZulu-Natal Province:

(1) Yes. Ngamzizwe Moses Madlala has been appointed as Inkosi of the Madlala tribe in terms of a resolution of the Provincial Executive Council of KwaZulu-Natal, No 130 of 1994, and in terms of section 12 of the Amakhosi and Iziphakanyiswa Act, 1990 (Act No 9 of 1990).

(2) and (3) The appointment was made in terms of the Amakhosi and Iziphakanyiswa Act, 1990, which is now being adminstered by the KwaZulu-Natal Provincial Government. It is not within my jurisdiction to review this Act or appointments made under the Act.

Privatisation of Armscor/Denel

*33. Mr M T MAFOLO asked the Minister of Defence:

(1) Whether it is the intention to privatise Armscor and/or Denel; if not, what is the position in this regard; if so, what are the relevant details in respect of (a) timeframes and (b) guidelines that will be followed in this regard;

(2) whether the interests and security of the country have been considered in this regard; if not, why not; if so, what are the relevant details;

(3) whether there are any contingency plans to deal with any adverse effects on the security of the country; if not, what is the position in this regard; if so, what are the relevant details?

N1120E

The MINISTER OF DEFENCE:

(1) When discussing Armscor and Denel it is necessary to draw a clear distinction between them. Denel used to be part of Armscor. The Armscor Act requires Armscor to concentrate on meeting the Defence needs of the RSA. With the decline in the defence budget, it was felt that Armscor's subsidiaries should be allowed to expand into the commercial sector. They could not do this while under Armscor. As a consequence Denel was established in 1992 consisting of the various Armscor subsidiaries and reporting to the Minister of Public Enterprises.

Whether Denel should be privatised or not is a decision for the Minister of Public Enterprises.

As far as Armscor is concerned I would like to make the following points:

Firstly, Armscor's main function is to be the acquisition agency for the SA National Defence Force. In other countries this function is carried out by different institutions. For example the UK has the Procurement Executive which is part of the Department of Defence. The Swedes have a structure called the FMV, which is an independent government owned structure. In some cases the services carry out their own procurement. Armscor has an almost five decades history. It has certain features which the acquisition organisations of many democratic countries are beginning to develop now. These include being small, but having a high-powered technical capability. It is independent of both the supplier (the defence industry) as well as the end-user (the National Defence Force).

The second point to be made is that the Armscor Board of Directors act as the independent state tender board. They are appointed by the Minister of Defence and are required to adjudicate on the awarding of defence contracts. It is clear, therefore, that Armscor is not a commercial undertaking and there is no value in privatising it.

In 1994 I appointed a work-group called the Ministry of Defence Acquisition (MODAC) work-group. The MODAC work-group consists of representatives from the Defence Industry, Defence Secretariat, Defence Force and Armscor. In its most recent report presented to me on 31 May 1996 it recommended the maintenance of Armscor as a statutory state corporation responsible for acquisition. I have accepted the report and its recommendations and have asked the Armscor Chairman, Mr Ron Haywood, to investigate Armscor's other function, namely the international marketing of South Africa's defence industry.

The marketing of South Africa's defence industrial capabilities has been very successfully conducted by Armscor. Big corporations like Denel are quite capable of doing this themselves. However, the hundreds of other firms which have a place in South Africa's Defence Industry need assistance. Whilst not discriminating against the larger corporations, Armscor facilitates the marketing of our goods and services overseas.

That is the status quo as it prevails today. I have asked Mr Haywood to head a team to recommend how best the international marketing function can be executed.

(2) On the second part of this question, we believe that the security needs of our country can best be met by Armscor under the Ministry of Defence.

(3) Falls away.

Local authorities in Republic

*34. Mr M T MAFOLO asked the Minister for Provincial Affairs and Constitutional Development:

(a) How many local authorities are there currently in the Republic, (b) how many of these authorities are financially viable, (c) which of these local authorities have the capacity to undertake (i) service delivery and (ii) housebuilding programmes and (d) in respect of what date is this information furnished?

N1121E

The MINISTER FOR PROVINCIAL AFFAIRS AND CONSTITUTIONAL DEVELOPMENT:

(a) There are 811 municipalities (local authorities) in the Republic, consisting of metropolitan councils, metropolitan local councils, local councils, rural councils, representative councils and district councils.

(b) My Department, in conjunction with the Institute for Municipal Treasurers and Accountants, measures the financial viability of local authorities through a project, called the Project Liquidity, on a monthly and quarterly basis.

In general, most of the local authorities are financially viable. There are however a number of local authorities currently experiencing serious financial problems which have resulted in defaults on loan payments as well as bulk accounts such as water and electricity. My Department is attending to these problems in conjunction with the various provincial governments.

(c) (i) The newly established rural and representative councils do not have the

Rural masses key to sick economy

BD 19/8/96 (85)

Herbert Vilakazi

A CRIPPLING weakness of our established economics is the invisibility in it of the masses of black people. The health of any market economy depends directly on the buying power of the majority members of the society. An axiom in the US is that consumer demand and buying power are the engine of the country's economy.

A fundamental cause of the sickness of our economy is the low buying power, and level of demand, of most of the masses, most of whom are in rural and semi-rural areas. The basic flaw is that the masses are not properly integrated into the industrial sector, a sector which influential economists wrongly take to be the growth engine of the entire economy.

Our society, in fact, contains two separate economies, which are tied together by some sort of umbilical chord.

The first is the white-controlled economy of industry, commerce and market agriculture, narrowly based and within which a tiny fraction of society lives.

The masses of blacks are not well linked to this sector — as managers, owners or skilled workers. They have served merely as cheap labour for it. More importantly, they are not fully integrated into this economy as consumers.

Racism, by legislation and tradition, restricted blacks' buying power and consumer demand via very low wages, and deprived their communities of modern infrastructure like electricity, telephones, roads railways, modern housing, education and health services. Until very recently, this sector was purely a plundering, exploiting economy in relation to blacks.

Established SA economics is about the white economic experience. Focusing almost totally on the ups and downs of the white-controlled sector of the society, it fails to realise that the African masses are the massive engine for the economy.

As a result, this economic analysis fails to prescribe the correct medicine for curing the sickness of the economy.

The other economy within the same society is the underdeveloped one in rural and semi-rural black communities. The greater bulk of blacks live within this sector.

It is primarily agricultural, now largely defective, with decayed manufacture which was once integrated with agriculture in the traditional black economy. In all indices of underdevelopment, SA's Africans are in the same league as the least developed countries of the world.

This sector, containing the great majority of society, is not industrialised. Yet this underdeveloped, black world is the product of the developed, white world of our country. Thus the two economies are linked. One gave rise to, and now poisons, the other.

Underdevelopment

The key point is that the low buying power, and low consumer demand, of the masses of Africans within the underdeveloped sector is now the heavy drag pulling down economic performance in the entire society.

The economy of the country cannot move forward without the elimination of the state of underdevelopment of the masses. There can only be forward movement if there is stimulation and impulse coming from development of these masses.

That is, the modernisation and industrialisation of underdeveloped communities in rural and semi-rural areas. Established economists simply tell us this sector's contribution to GNP is negative. I have another conception of GNP — gross national poor.

What contributes 2% to the GNP contributes 90% to the gross national poor — to the housing, health, and unemployment crises, to crime, to family and sexual violence, and to other disorders in our society.

Therefore, the first cure for our sick economy is the elimination of the under-development of the masses of black people in rural and semi-rural areas.

We must then follow the same development economics strategy initially followed by the now developing Asian nations.

There, initially, the focus was on the modernisation of family farms, rural development and education.

This creates a large rural market for urban products, also stimulating rural manufacture, and creating a properly educated workforce — all giving a large boost to modern, urban-based industry.

Our economists and planners must open both eyes, so that they can see the black masses as the massive engine of our economy and adopt a suitable cure for our sick economy.

□ **Vilakazi is the executive director of the Council for African Thought and professor of sociology at Zululand University.**

Parties divided on crime and health during Budget debate

(A 84) (85) Star 20/8/96

By Patrick Bulger
Parliamentary Correspondent

Cape Town – Political parties yesterday began a three-day debate on the 1996-97 Budget with sharp divisions emerging over crime and health.

The Freedom Front, Democratic Party and National Party said they would oppose the health budget in the light of the *Sarafina* 2 debacle.

The parties are voting on the allocations to each of the government departments before a final vote on the budget as a whole tomorrow.

NP health spokesman Willem Odendaal said the NP would oppose the health vote because of the *Sarafina* 2 issue. He alleged that any money voted to the Department of Health would be squandered by Health Minister Dr Nkosazana Zuma. He was supported by DP health spokesman Mike Ellis who said he was waiting for Zuma to disclose who had provided the R14,27-million for the ill-fated Aids play.

The DP also gave notice that it would oppose the justice vote.

The NP's Sheila Camerer said the NP supported the justice vote but was concerned at the rate of crime. She questioned where Justice Minister Dullah Omar would find the money for the extra 100 prosecutors he wanted to employ.

Province to build and save on rent

BD 27/8/96 (25B)

Kevin O'Grady

THE Northern Province government yesterday hit back at criticism of its handling of the building of a new government complex in Pietersburg by property owners and business, who say they stand to lose R15m a year government is paying in rent.

The SA Property Owners' Association and chamber of commerce in the province said on Sunday the cost of the complex had ballooned from R160m at inception to R400m on its completion in two years time, Sapa reported.

Government spokesman Jack Mokobi said yesterday he did not have the figures available to comment on the cost of the project.

"Business has an interest in these matters which sometimes clouds their judgment. At the moment government is occupying and renting offices which belong to members of the SA Property Owners' Association," he said.

"They're making a very big killing — about R15m a year — at the moment and it will be more beneficial to the taxpayer to build our own buildings," he said.

The new government complex would include offices, meeting halls and a legislative chamber "so we don't have to go and squat in the city council building any more", Mokobi said.

R400m burden on Gauteng's budget

BD 27/8/96 (85) (25B)

Ingrid Salgado

THE Gauteng health department could face a R400m shortfall at the end of the 1996/7 financial year if three neighbouring provinces fail to transfer this amount for health services arising from interprovincial patient flows.

Gauteng finance and economic affairs MEC Jabu Moleketi said Mpumalanga, Northwest and Northern Province had not yet paid up despite an agreement at the end of last year.

In terms of the agreement, the provinces were to have paid Gauteng about R200m in both 1995/6 and 1996/7 to compensate for health services rendered. This was because provincial health budgets were based on provincial population figures.

A study last year found that Mpumalanga cost Gauteng R58m in referrals in the last fiscal year, Northwest R80m and Northern Province R46m.

Gauteng health deputy director-general Eric Buch said yesterday that provincial and national health officials agreed at a recent meeting that Gauteng would be compensated for patients who were formally referred to Gauteng hospitals for secondary level care. The national department would facilitate resolution of the matter.

The delay in transferring the funds had not held up Gauteng spending on provincial programmes since expenditure was based on the assumption that the money would be forthcoming.

Mpumalanga government officials said yesterday the province would not transfer the funds. Gauteng should budget for patients across its borders because SA was one country, Premier Mathews Phosa's spokesman Oupa Pilane said. Mpumalanga, which treated many illegal immigrants from Mozambique, did not request funds from the Mozambican government.

Northern Province said it would pay only if Gauteng could produce accounts for patients using Gauteng hospitals. "We can't just transfer an arbitrary amount," Premier Ngoako Ramatlhodi's spokesman Jack Mokobi said.

Gauteng finance head Roland Hunter disputed the Mpumalanga government's argument. Provincial health budgets were based largely on the population base of provinces and not on the number of patients, he said.

Gauteng was effectively paying for health services that exceeded its population base. Ga Rankuwa Hospital — where 80% of patients were non-Gauteng residents — presented a R300m burden on Gauteng's health budget.

HOSPITAL TARIFFS UP 37,5% ON AVERAGE

Health-care hikes won't affect poor or pregnant

(85) (98) CT 28/8/96

WHILE THE INCREASES in the price of health care appear to be high in some cases, a balance seems to have been reached between the actual cost of health and the needs of the disadvantaged, Health Writer **ANEEZ SALIE** reports.

FREE or inexpensive health care for the poor, for children under six and for pregnant women will remain untouched by an average 37,5% increase in hospital tariffs, says Western Cape Health and Welfare MEC Mr Ebrahim Rasool.

From Sunday the cost of in-patient care (for those requiring beds) will increase on average by 43%. At hospitals such as Groote Schuur and Tygerberg, patients will pay between R37 (for poorer patients) and R373 a day for private patients. The same care will cost between R29 and R285 at a district hospital.

Outpatients face an average increase of 32%. Poorer patients will pay about R17 at an academic hospital and private patients R68, whereas at a district hospital the rates will be between R11 and R43.

Rasool said the hike was necessary because tariffs had not been increased for three years, although inflation was at nine percent and the cost of imports and services had risen sharply.

"As a result of keeping fees artificially low, we have lost R17,5m in revenue (over four years) and a fall in collection of 37%," he said.

The province expects an additional R14m in increased fees by the end of the financial year (March 1997). Thereafter there should be R24m extra a year.

Rasool said the higher fees would help to take the pressure off tertiary and secondary hospitals by ensuring that patients first sought help at the primary level.

He believed this was a more effective deterrent than a R50 fine for bypassing the primary stage that the national health department had recommended.

But in formulating the increases they had not abandoned the poor.

"As a public health system, we remain responsive to the needs of the most vulnerable people in our community," said Rasool.

● Primary health-care services remain free for the poor and for low-earners at clinics, day hospitals, community health centres and at district hospitals where there are no clinics.

● To ensure that almost everybody is close to a primary health-care facility, the health department has in the past two years built or upgraded 31 centres in townships, squatter communities and rural areas across the province.

● Patients who qualify for free primary health care but are referred upwards for further treatment will not have to pay.

Rasool said that after the increases had been added — even the 131% hike for high care and 93% increase for intensive care required by less than two percent of patients — the public service tariffs were less than the fees prescribed for the private sector by the Representative Association of Medical Schemes.

Rasool said a balance had been reached in the competing demands between the actual cost of health and the needs of the disadvantaged.

Excluded from free health care

● Members of medical aid schemes.

● People treated in provincial and province-aided hospitals or institutions by their private doctors.

● People with an annual family income exceeding R39 000 (R3 250 a month) or who have assets exceeding R192 000.

● Single people with an annual income exceeding R23 000 (R1 916 a month) or assets exceeding R115 000.

● Foreign patients, except immigrants residing permanently in the country who have not yet obtained South African citizenship, and those with permits for study, temporary work or visits.

Services requiring payment by everyone, even at primary health-care level, include:

● Ambulance services.

● Some oral health services, such as dentures and bridgework.

● Disability aids such as prostheses and wheelchairs.

● Injuries covered by the Workmen's Compensation Act.

● Accident injuries provided for by the MVA fund.

Ills hide minister's healthy progress

(85) (-) ST 1/9/96

By PAT SIDLEY

PRESIDENT Nelson Mandela this week defended the Minister of Health, Dr Nkosazana Zuma, saying she was a good minister who needed to be allowed to get on with her work. But what has Zuma actually done to give him this impression?

In two years of office, she has:

- Introduced free primary health care for all;
- Introduced free health care at all levels for children under six, their mothers and pregnant women;
- Re-allocated the health budgets to give health care to areas which previously had none;
- Built or refurbished hundreds of primary health care clinics;
- Administered feeding schemes for children. Where these work, they draw children to school;
- Introduced a national drugs policy;
- Pulled in foreign doctors to plug massive staffing gaps;
- Squeezed the cabinet into drastically raising doctors' salaries, and paying them overtime; and
- Paved the way for the introduction of fluoride to water, which will improve oral health.

Even some of Zuma's constant detractors in the medical profession say she is the country's first health minister who has had the will and resources to bring health care to those who need it most.

Although free health care has strained the system, initial evaluations show it has been beneficial.

The National Drug Policy will end many abuses in the market place and put a stop to doctors dispensing where pharmacists can do the job. A stipulated fee will end profiteering on dispensing and the Essential Drugs List has been introduced to cut down the government's unnecessary spending on drugs.

While controversial, many people in health care have welcomed the Cuban doctors brought to South Africa by Zuma. Their selection and placement has been accompanied by massive salary hikes for public sector doctors in a bid to draw back those lost to the private sector.

But Zuma's terrible public relations and her dogged determination to shoot herself in the foot over the controversial AIDS play, *Sarafina 2*, have obscured any accurate appraisal of her department's achievements.

The scandal has also ensured that priority projects such as the AIDS programme and the Hospital Strategies Plan, have been slowed drastically and in some cases derailed.

Zuma and her department have displayed some glaring errors of judgment, a desire to rush ahead with ill-thought-out intentions and a consequent need to apply brakes and start all over again

All of this has slowed her progress considerably — and unnecessarily.

State auditor probes Health's R600m tender

By RAY HARTLEY
Political Correspondent

(85)
ST 1/9/96

THE fate of a controversial Health Department tender worth hundreds of millions of rands will be decided this week after the office of the Auditor General, Henri Kleuver, queried the tender process.

The project — said to be worth up to R600-million over five years — is for a new computer information system which would link hospitals and clinics countrywide.

Tender Board official Jan Breytenbach said that the board would hear a confidential report on the tender on Thursday, but would say nothing further on the matter.

The Deputy Auditor General, Bertie Loots, confirmed that his office had written to Dr Olive Shisana, the director general of health, to raise "pertinent questions" about the tender. However, Loots would not elaborate on the problems.

But the Sunday Times has learnt that some of the questions raised about the tender were:

- Why an Indian computer company with no South African infrastructure had been identified as most likely to win the contract;
- Why the company's offer, which was "way out of proportion" with all the other tenders, had been deemed acceptable by health officials; and
- Whether the company had the capacity to fulfil the requirements of the tender.

The letter is also said to query other health department contracts.

The Financial Mail reported in July that Loots had written to Shisana about the problems. This weekend Loots said that he had yet to receive a reply from her.

The auditor general began his investigation in March, following allegations, by both the Democratic Party and the National Party, of irregularities.

Drug industry slams Zuma's anti-theft plan

(85) ST 1/9/96

THE Minister of Health, Dr Nkosazana Zuma, has been caught up in another row — this time over plans to "ram" through an anti-drug theft system which could cost the pharmaceutical industry about R1-billion and cause the price of medicine to rocket.

And the top drug-squad policeman punting the system has a son working for a company linked to the new plan.

Leading players in the drug industry sent an urgent submission to Zuma this week, calling on her to scrap her proposed "non-validated, non-tried, cost-driving plan . . . which promises very definite and indeterminate cost escalations".

If the plan is adopted, manufacturers will have to mark all drug packaging with a digital stamp which will act as an identity tag. The identities will be stored in a computer system managed by the Department of Health.

All drugs would thus be traceable. The ministry hopes this will stop medicine theft, which costs more than R1-billion a year.

Captain Daan Davis, the national co-ordinator for pharmaceutical investigations, is punting a tracking system called Vericode. His son Willem

By CRAIG DOONAN

works at Verimed, the company that presented Vericode to Zuma.

Davis said this week he had suggested only that a system such as Vericode be considered: "We never said go for Vericode. It's just an example of what we can do. We said to the industry: 'If you can come with something better, let's take it'."

He said that although his son worked for the company, his job had nothing to do with the tracking system.

But the drug-manufacturing industry says the system has never been tested in a pharmaceutical environment, will cost millions to introduce, will push up the price of medicine, and is being hurried through.

Paul Glover, a member of the Pharmaceutical Manufacturers Association's science and technology committee, said Zuma's plan would be a "nightmare" to implement.

"The state is asking the industry to finance the solution to theft for them. We're telling them it's not going to work. It's impractical and cannot be implemented," he said.

The manufacturers' submission this week said the special mark alone could cost the industry R500-million a year — "a disproportionately high cost given that the total annual worth of the industry does not exceed R7-billion".

"If one takes other elements into consideration, such as the modifications required for packaging equipment, investment in scanners, computer hardware and software, the total bill could easily reach R1-billion in the first year of implementation," Glover said.

"The man in the street will eventually have to pay for it."

The Registrar of Medicines in the Department of Health, Professor Johann Schlebusch, who has been working on the new system, said that while there might be start-up costs, "these should perhaps be balanced against the losses taking place".

He said: "When stolen medicines are rechannelled into illicit routes, they are competition for pharmaceutical agencies; so what one loses on the corners, one may be making up on the straights.

"There is a huge theft problem. When medicines are diverted to illicit channels you don't know how they are stored, how they are transported, at what temperature they're being kept or whether safety is being compromised.

"At the end of the process, the public may be taking ineffective medicine so there's a real obligation on the powers that be to bring the system under control."

Barney Sachs, the executive director of the National Association of Pharmaceutical Manufacturers, said about 80 percent of thefts took place at state hospitals and warehouses, and "they have to tighten up their own control".

Immunisation campaign exceeds expectations

A mass immùnisation campaign to eradicate polio and measles in Gauteng has exceeded all expectations, with more than 750 000 children being immunised in the first stage. The province is now gearing up for a second round in the coming week.

This is a follow-up to the "Kick Polio out of Africa" continental mass campaign launched in Gauteng last month, in which 755 000 children were immunised for polio. A further 660 000 were immunised in the first major anti-measles campaign. The results far exceeded the target of 620 000 children.

The Gauteng health department says the response from the informal settlements was "particularly impressive", while it was good in most townships.

"The 1996 campaign is not over. For the polio immunisation to be effective, children must be brought back for another dose of drops next week," it said.

"I'm sure people who have missed out on the first round won't be turned away, and perhaps some arrangement will be made for them to get their second dose," said Jo-Anne Collinge of the Gauteng premier's office as she emphasised the importance of immunisation.

(84) (85) Star 7/9/96

A REAL REDUCTION IN SERVICES

The Western Cape is considering axing at least 2 000 medical personnel and closing up to 30 specialist health facilities — including transplant units and one of its two medical and dental schools.

The discovery that the Western Cape's 1997-1998 budget is to be slashed by R780m (a real decrease of 9,6%) has dealt a crushing blow to its health department, which is already heading for a R100m-R200m deficit this year.

The province is also reeling from the news that one in four school principals — 374 of its best educators — have accepted severance packages as part of a plan to rationalise 6 000 teaching posts.

The Western Cape is also the hardest hit by national Budget cuts. Provincial budgets have been cut by an average of 6,8% in order to meet government's ambitious 4% deficit target.

Gauteng will also suffer. Its 1997-1998 budget will take a R500m cut (a real decrease of 4,28%). Departmental funding requests exceed the allocation by R3bn.

Gauteng head of finance Roland Hunter says that it may have to bring forward plans to close certain high-cost hospitals and may sell Garankua Hospital to Northern Province or the North-West.

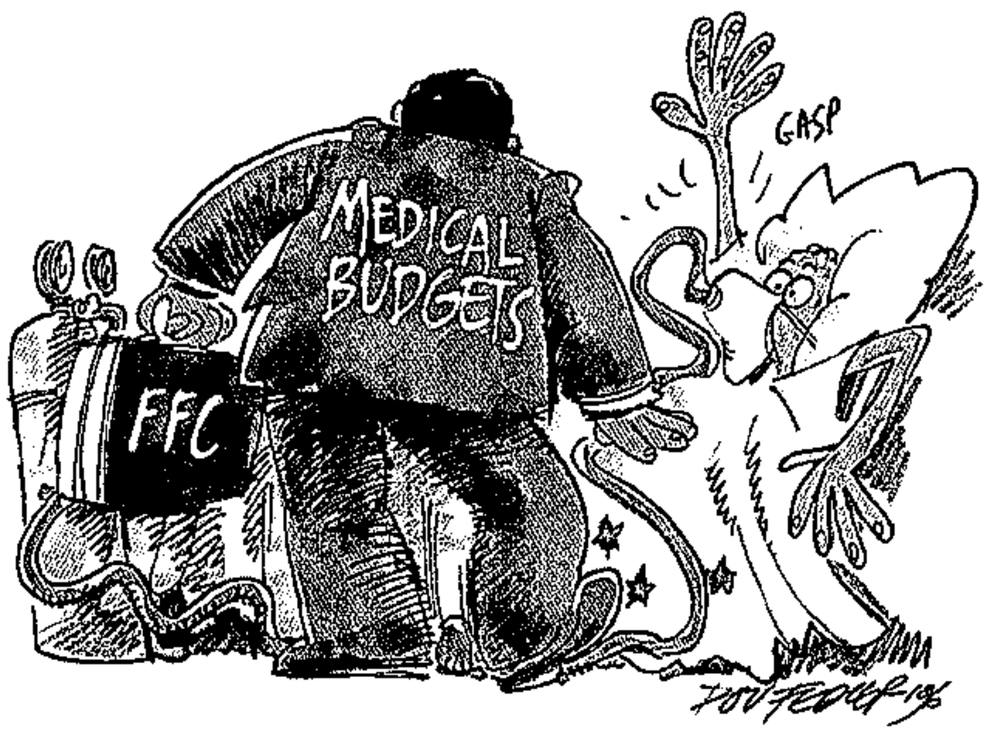
"We're finding out the consequences for government service delivery of the national policy decision to reduce the Budget deficit to 4%. We can't accommodate the cuts this fast by trimming fat. It means a real reduction in services."

On October 1, the Western Cape will try to convince its budget council to finance certain specialist health facilities — such as the cardio, thoracic and immunology units — from the national Budget. "If central government is unable to finance them, they must instruct us to close them down," says province health department chief director Faried Abdullah. But it's hard to see how the Western Cape can be accommodated when national Budgets are being cut by an average 17%.

Intergovernmental financial relations chief director Ismail Momoniat says that harsher Budget figures will emerge later in the financial year and allocations will be "interrogated" to ensure no province is discriminated against.

To save R780m, the Western Cape will have to be ruthless in slashing expenditure in health, education and social services, which make up 80% of its budget.

It's clear that costly academic health services will bear the brunt of the cuts. Though the creation of primary and secondary health facilities is also in jeopardy, it would be counterproductive to drastically reduce expenditure on them, says Abdullah, as this would cause the whole cost spiral to escalate.



"In academic complexes we will probably have to reduce all levels of staff by a minimum of 2 000 people. About 300 hospital beds will have to go just for starters. It also raises questions about whether this province can continue to afford two medical and dental schools. These are important institutions, producing a third of SA's health professionals. If central government doesn't fund them, it could lead to severe rationalisation and the possible collapse of certain institutions."

The Western Cape has spent two years painstakingly negotiating the rationalisation of its three academic hospitals and two medical schools into a composite service in line with the Financial & Fiscal Commission's provincial budget projections. The lowering of the deficit target by 0,5% means the cuts will be more severe than anticipated.

Stellenbosch has resisted amalgamating its medical school into a common faculty, saying it wants to retain its identity. This may no longer be possible.

UCT medical school dean Prof J P van Niekerk fears that, if the two medical schools combine and student numbers drop accordingly, it will have "enormous implications" for the university's budgets as government subsidies are linked to the size of the student population.

This is the nightmare which the Western Cape has feared with successive budget cuts, but until now has managed to stave off. ■

PRIVATE SCHOOL SUBSIDY CUTS

GAUTENG SPITES ITS FACE

Behind the 30% subsidy cut for independent schools announced by Gauteng's Education Department lies an aversion to such schools. A media release it issued last week makes this quite clear. Though it recognises that "private schools have very different histories and starting points," it observes that "they are all a product of our apartheid history."

It then takes a swipe at "schools for rich children whose parents simply have no confidence in a public school system. As a matter of fact, they have little confidence even in this democratic government or its future. There is primarily a rejection of the ability of this new democracy to meet with the extremely individualistic and private expectations of parents who cannot see this government doing so."

Senior ANC figures, many of whom send their children to SA's most expensive schools, will be bemused by that observation. Far less affluent parents,

Continued on page 48

Health writer David Robbins looks beyond the controversy to assess the st

Sarafina aside: Is SA health care on track?

(85)

Star 16/9/96

Is the controversy surrounding the play *Sarafina* 2 obscuring the achievements of our minister of health and her national department? Or are some of the ingredients of the controversy indicative of the general performance of our health authorities?

Such questions are being increasingly asked as the seemingly endless twists in the *Sarafina* affair continue. The affair itself is no laughing matter in a country struggling to achieve a model of democracy that works.

Even more sinister is the impact on the work of many thousands of health planners and administrators throughout the country. In the public imagination, *Sarafina* and health care have become synonymous. Talk of one and the other inevitably crops up.

In consequence, the knives are definitely out for minister Nkosazana Zuma and her director-general, Dr Olive Shisana. Are they any good at their jobs? There can be little doubt that the *Sarafina* affair has been inexpertly handled by ministry and department alike. The cost of the damage to the public image of health reform is proving to be extremely high.

But perhaps the time has come to separate the affair from the task of transforming health care in post-apartheid South Africa. Once *Sarafina* is removed from the health arena – and inevitably it will be removed – what's the state of play in the offices of the minister and her director-general? In other words, how is the implementation of our new health policy getting on?

Let's first define the policy. Confronted with an apartheid-dominated health system which laid emphasis on racial disparities of spending in an urban and curative-based system, the major thrust of new policy has been to establish accessible health for all on an equitable and nonracial basis. This has entailed the development of mechanisms which would shift resources from the centre to the periphery, new emphases on primary health care (PHC) and devolution of governing power to local communities via the establishment of district health models.

These general directions were worked out by the ANC's health desk in the early 1990s, and few convincing arguments have been raised against them. But what about implementation?

Certainly, free PHC for all, the importation of Cuban doctors, the diverting of financial resources from hospitals to peripheral services, the clinic building programme, the issue of vocational training for graduating doctors, the essential drugs list, and recent attempts to improve service conditions in state health – all these initiatives make sense in terms of the overall thrust of our new health policy.

But doubts remain. "My strongest criticism of the Department of Health does not concern the content of health policy itself," says Professor Dave Morrell, head of the Wits Medical School's department of anaesthesia and chairman of the Medical Association of SA's committee dealing with public sector doctors.

"The content is excellent. My criticism concerns the department's ability to communicate. Even though there's been a fair amount of consultation, the implementation of policy invariably has a negative impact.

"My belief is that this is a manifestation of departmental inexperience. The political and administrative leaders of health since 1994 were thrust into positions of enormous responsibility without much preparation. Nevertheless, the shift from idealism to pragmatism has been tangible."

But when one looks more closely at the basic framework into which the various elements of health care reform are intended to fit, the temptation is to say that the shift has been insufficiently fundamental. Health care in South Africa is an enormously complex and unruly animal. For this reason, any reform process must clearly be supported by a realistic financial plan contained within well-designed enabling legislation.

Yet it is in these twin fields of finance and legislation that the performance of our health ministry and department over the past two years looks weakest.

Take finance. Stress was laid on the reallocation of resources from well-provided provinces (for example, Western Cape and Gauteng) to under-provided provinces (example, Northern Province). But the process was undertaken too rapidly.

Gauteng was faced with a 20% budget cut, subsequently reduced to 10% by bridging finance from the RDP.

The major thrust is accessibility to everyone

The result was that the province was forced into fire-fighting mode, and into a situation where overspending was inevitable if services were not to collapse.

The Northern Province, on the other hand, received a massive 30% increase which it simply did not have the capacity to spend effectively. Far better, say some health economists, for the nation-

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e of play in the offices of the minister and her director-general

THYS DULLAART

Basic care ... Bangladeshi doctor Abu Meher at the Natalspruit Hospital. Initiatives like the importation of doctors make sense in the light of the new policy. The areas of weakness in the national approach seem to be finance and legislation.

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Dr David Harrison, director of the Health Systems Trust, an organisation which funds many research projects dealing with the delivery of health the national depart-first not clear about

to do something ge the old order of duced new policies without quite sepa-t was properly its what should have provinces."

grees that the two ess in the national approach have been finance and legislation.

"Apart from the generally unsuccessful reallocation attempt, there was a lot of talk about alternative sources of income and legislation to regulate the relationship between the private and public health sectors. Nothing has emerged yet in either of these directions."

Does this mean that the process of health care reform is floundering? Harrison believes that the contrary is true. "Think of 1993 and think of now.

"There's no comparison. For the first time ever, local people all over the country are excited and engaged in health reform.

"The stagnation of the past exists only in isolated pockets. The national department's constant focus on PHC and district health must take credit for what is happening."

There have also been considerable successes in the areas of essential drugs (a policy which has been introduced with the support of the powerful drugs industry); and in the training and retraining of medical personnel: doctors in managerial skills, nurses in PHC.

"We're seeing a fundamental shift in thinking towards real PHC via district health as a strategy for improving the health of millions of people," Harrison says. "There's also considerable progress in the integration of previously fragmented services."

But he described a changing role for the national department. "Over the past six to 12 months, the provincial health departments have dragged away considerable amounts of power from the centre. And as a result some of the provinces are really beginning to get the show on the road."

The hope is that the national department will now emerge with a clearer understanding of what it should be doing – not implementing change on the ground, but looking at the truly national issues such as setting standards and co-ordinating support.

Says Harrison: "It's true that the national department is weaker than it ought to be for the tasks ahead, and *Sarafina* has probably had a hand in this. But the impetus for reform has moved from the top to the bottom, and the national department will now have to follow. This in itself is a measure of the success of the reform initiative.

"Real health systems reform is difficult, piecemeal, and confusing. A lot of people inevitably get upset. But all this is part of the chaos and confusion of things happening. Far better to have this chaos and confusion than the stagnation of the past. If we can get *Sarafina* behind us, and get the national department moving forward more coherently, the optimism I feel now will be greatly enhanced."

There is an emerging sense that the ministry and the department have, to an extent and not only through the *Sarafina* affair, been cut down to size. For the ultimate shape of health care in a democratic SA, the result of this will be good rather than ill.

Row over health budget cut

Farouk Chothia

BD 17/9/96

DURBAN — KwaZulu-Natal health MEC Zweli Mkhize (ANC) said yesterday he would lobby against a possible cut of 8,1% in the province's health budget as it was contrary to an earlier agreement with Health Minister Nkosazana Zuma to address the under-funding of KwaZulu-Natal.

There were strong protests from IFP and NP MPs at a meeting of the provincial legislature's health portfolio committee when they were told what the estimated cut was.

Mkhize said the figure was not yet official and he would argue against the cut at a meeting with Zuma later this week.

Compared with a province like Gauteng, KwaZulu-Natal had been underfunded during the apartheid era. There had been agreement with Zuma in 1994 that equity in funding would be achieved by 1999.

Health department director-general Ronald Green-Thompson said an urgent meeting should be sought with Finance Minister Trevor Manuel, "otherwise the equity process is going to be killed".

Health management support services chief director Herman Conradie said R268m was needed annually for the next eight years "just to bring up to standard" existing health facilities in the province.

Mkhize said it was difficult to justify severance packages in KwaZulu-Natal as there was a shortage of about 4 000 nurses and 500 doctors.

Western Cape health leaders challenge

BD. 23/9/96 (85)

Linda Ensor

CAPE TOWN — Leaders of the Western Cape health establishment have challenged government to rethink its macroeconomic strategy because they say it pays no attention to its social costs and is applied with little finesse to the health sector.

The appeal was made following a high-level meeting of health leaders on Friday to discuss the financial crisis in health care in the Western Cape which would require a cutback of 2 000 medical staff and the closure of 500 beds at the three academic hospitals before the end of March next year.

The summit, initiated by health MEC Ebrahim Rasool, was attended by the deans of medical and dental faculties at the universities of Cape Town, Western Cape and Stellenbosch, superintendents of three academic hospitals and health administrators.

Academic health centres chief director Dr Gilbert Lawrence told a news briefing that the bed closures would result in a 15% reduction in inpatient facilities in teaching hospitals in the province.

"The implications of these closures is that services will be curtailed and it will be even more difficult for patients to gain access to hospital care. This is ... regretted."

It emerged that people had already died in Western Cape hospitals because of inadequate medical attention.

The academic hospitals — Groote Schuur, Tygerberg and Red Cross, which trained about one third of SA's medical staff — were threatened with collapse because of major staff and financial cutbacks. Patient care was being compromised and fewer students would be able to be taken on.

From an annual expenditure of about R998m, the academic hospitals budget was targeted under the "rightsizing" programme to fall to R690m by the year 2001.

Health department head Dr Tom Sutcliffe said to reach the staff target of 29 800 by 2000, 3 500 staff would have to be retrenched, 2 000 in this financial year and 800 each year thereafter. This would mean closing about 500 beds this year.

Sutcliffe said the department would begin the 1997/98 financial year with a R300m deficit and would be faced with a further budget cut because the Western Cape provincial allocation from central government was expected to be slashed by about R780m.

"The bottom line of all these cuts is that there will be fewer services in health in the Western Cape," Rasool said.

"We have resolved one very important thing. We need to fundamentally challenge the intellectual basis on which decision-making in this country is occurring. Our universities have signalled to us that they are willing to take on that intellectual challenge," he said.

University of the Western Cape dental faculty dean Martin Hobdale believed the policy had been applied with "little finesse".

Groote Schuur and University of Cape Town head of surgery Prof John Terblanche said deaths had occurred because treatment of patients was delayed. It could take four to five days to treat a fracture as staff were deployed on emergency cases.

"Because of the cutbacks both the tertiary and routine emergency services are being delayed and it is going to become increasingly difficult to have health care delivered to you as a member of the population," Terblanche warned.

The situation was even worse with the emergency cases which were overloading academic hospitals.

"Therefore there are delays in the management, complications and there are deaths that are directly related to the diminished financial resources and therefore the diminished number of staff," Terblanche said.

"My advice to you is this weekend don't get sick, don't get injured ... as you are likely to end up in one of our academic institutions. Despite the best will in the world, we are going to treat you badly."

The health department is to have a conference with university vice-rectors in a bid to find solutions to the crisis and decide which services will be cut.

Comment: Page 11

Tensions between staff delay integrated health system plan

(85) Star 30/9/96

Plans to set up an integrated district health system in Gauteng are being held up by tensions between provincial and local authority health staff.

Employees are concerned about their future promotion prospects and are also unhappy about the disparity in salaries between provincial and local bodies.

This was confirmed by health deputy director-general Dr Eric Buch, who told a meeting of interim district management teams (IDMTs) on Friday that provincial and local government staff were "uneasy" and did not trust the process of change. "Provincial staff feel sold out by this conceptual framework, and local government staff worry about things like career paths once province and local authority structures merge."

There were formal negotiated agreements in place about the transfer of provincial staff to local authority structures, as well as a policy understanding at ministerial level.

But Gauteng health management specialists were concerned about "stirring divisiveness" and said the IDMTs had to face the challenge of creating a single service from a fragmented system. – Medical Correspondent.

MONDAY
SEPTEMBER 30, 1996 ★

'HOSPITALS CAN'T COPE'

CT 30/9/96

Public urged to adopt 'defensive' lifestyles

(85)

A MEETING of health authorities and academics has decided to establish a joint committee to devise ways to deal with severe budget cuts and the accompanying crises in health services in the least disruptive way.

A MASSIVE increase in the number of trauma cases and crippling budget cuts have led to patients in overcrowded hospital casualty wards having to wait up to 20 hours for attention for injuries like a broken leg or jaw.

Saying this yesterday, Western Cape director of Hospital Services Dr Tom Sutcliffe warned the public to adopt a more defensive lifestyle to avoid the need to use emergency and specialist services.

He also appealed to people to use hospitals closest to their homes.

"Obviously we can't turn people away, but people must realise that we have very limited capacity.

"There has been a dramatic increase in the use of firearms in the Western Cape — well over 100% in the past two years. The number of serious gunshot wounds has increased tremendously. Our dwindling resources are being swallowed up by trauma incidents, many related to violence and reckless driving. By tradition, these injuries are taken to Tygerberg or Groote Schuur and staff there have huge loads. They just can't cope.

"We're appealing to people to adopt a more defensive lifestyle — particularly to avoid alcohol-related injuries, reckless driving and violence."

Details of the effects of budget cuts were discussed at a weekend meeting of the provincial Department of Health and health professionals from the universities of Cape Town, Western Cape and Stellenbosch.

The cuts mean the number of health care posts will have to be slashed by 1 600 by March. At least 500 beds at Groote Schuur, Tygerberg and Red Cross will be closed.

In a joint statement last night, the representatives said: "It is unavoidable that these drastic reductions will cause irreparable damage to essential and specialist health service across the province and seriously reduce the ability of hospitals to cope with the demand.

"It will not be possible to sustain training of health professionals and research at the same levels. These cuts will also delay and significantly jeopardise the implementation of the provincial health plan."

The meeting agreed to:

- Establish a joint management committee to bring together senior officials of the Department of Health, the heads of major clinical services at the academic hospitals and technical and management experts. The committee is to develop plans to deal with the cuts in the least disruptive way.
- To pool the clinical resources of the dental faculties of UWC and the University of Stellenbosch.

The statement emphasised the the "grave danger of the possible collapse of services". — Staff Writer

R12,9-m EU boost for Soul City

(85) Star 1/10/96

The European Union announced yesterday it is to grant R12,9-million for a period of three years to Soul City, the multimedia health promotion project involving television, radio and newspapers.

The grant, to be made today, brings the total EU contribution to Soul City to R14,37-million.

The latest grant forms part of the European programme for reconstruction and development under which the EU will grant South Africa about R600-million a year until 1999 to support the RDP.

The EU said in a statement that the funds would be used to contribute to a further two series of *Soul City*, which would focus on Aids, tuberculosis, smoking, healthy living conditions, alcohol and drug abuse, hypertension, crime, violence and mental health.

It was expected that half-hour TV dramas would be produced for each series and that at least 8 million South Africans and 15 million people in other African countries would benefit from *Soul City*.

Forty-five 15-minute radio dramas would be developed as well as three 36-page colour booklets for each series.

About 750 000 copies of each book would be printed and distributed in a serialised form through a number of newspapers. Distribution to other African countries was expected to begin in December.

"The EU recognises that health issues are among the most pressing problems facing South Africa and has been supporting health projects since 1986," the statement said.

"Up until 1994 all assistance was through partnerships with non-governmental organisations. This assistance has now been extended to include direct co-operation with the Government, and the EU has provided approximately R100-million to the Department of Health and the nine provincial departments of health." – Sapa.

exposed

ET 11/10/96 (85)

Money-for-blood plan

MINISTER TO INVESTIGATE ALLEGATIONS

AN ALLEGED scheme to pass the supply of blood and blood products further into private hands "behind the government's back", is to be investigated by the Minister of Health Dr Nkosazana Zuma, reports Health Writer **ANEEZ SALIE**.

WESTERN Province Blood Transfusion directors may have tried to bypass the government to create a profitable, private monopoly from blood donated by the public, a Cape Times investigation has found.

The "Coastal Services" in the Western Cape, Eastern Cape, Border and Natal had planned to merge with or sell lucrative fractionation (processing) plants to a pharmaceutical company, Natal Bioproducts Institute (NBI), according to a letter in the possession of the Cape Times.

Donated blood is split into cells and liquid plasma. The plasma is processed into different products, or can be frozen and "exported" for lucrative processing into pharmaceutical products elsewhere.

Health Minister Dr Nkosazana Zuma is to investigate the scheme.

Health director-general Dr Olive Shisana said if the allegation was true, strong action would be taken.

"It is unthinkable that the essential supply of blood and blood products pass further into private hands, behind our backs."

About 500 000 South Africans donate blood to provincial blood transfusion services, which supply fresh blood and blood products to private and state health facilities.

Documentary and other evidence uncovered by the Cape Times suggests that local blood chiefs may have tried to ward off government intervention ahead of the sale or merger.

The directors stood to profit from the move as they have, according to the letter, asked for seats on the board of the new company.

Senior health department officials described the attempts to bypass them as a bombshell, especially in view of recent joint attempts by the industry and government to negotiate the rationalisation of the industry.

To this end a National Blood Committee was inaugurated in August last year, on which the Department of Health and the various provincial blood transfusion services were represented.

Two of three Western Province Blood Transfusion Service directors, Dr Arthur Bird and Mr Malcolm Khan, were invited to serve on this committee.

However, less than a month later, on September 6, 1995, Khan wrote to Mr Harry Dwyer, his counterpart in KwaZulu-Natal, to offer an urgent merger or sale of the Western Cape plant to the Natal Bioproducts Institute.

"Naturally, WPBTS would require representation on the NBI board," wrote Khan.

Top of a list of seven advantages of the sale or merger, according to Khan's letter, was that the number of independent plants would be reduced to two, "and this proactive move will ward off any future possible approaches from government or whatever source, for rationalisation of the industry".

Khan was not available when

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FRIDAY OCTOBER 10, 1996 ★

City blood money revealed

scandal revealed (84) Cnd 10/10/96

From Page 1

contacted, but Bird said the service felt it could function "as an efficient, non-governmental organisation, but in close co-operation with the Department of Health".

Bird now denies the urgency of the sale/merger, yet Khan's letter, on behalf of the WPBTS, refers twice to the urgency of the deal.

Bird also wrote in a response to Cape Times queries that the directorate had no hidden agendas. But National Education Health and Allied Workers Union spokesman, Mr Thabo Mveta, accused Bird of trying to get the Workers Forum to "rubber stamp" plans they had been hatching for some time. He said Bird had tried to discuss the issue at a forum meeting, but was rebuffed by Nehawu.

Mveta said they refused to entertain the issue because it was the first they had heard of it.

The management and the workers are due to meet next week.

● Bird and Khan, together with fellow-director Dr Jane Khan, are earning almost double what senior specialists at large hospitals earn.

Last year, while senior specialists were earning an annual salary of R148 599, the transfusion service directors — nowhere near as qualified — were taking home almost double at R275 832 each.

The service, which is dependant on blood given free by the public, currently pays each director R22 986 a month, plus a free, luxury car, medical aid, pension and a 13th cheque.

Health Department to improve services

(86) Sowetan 11/10/96

By Mokgadi Pela

THE Department of Health has reiterated its commitment to make services user-friendly and to train health workers in order to achieve optimal care of patients.

The statement coincided with October 10 – World Mental Health Day. The day has been set aside to achieve greater understanding of the complexity of the management of mental health problems.

Emotional health

The day is also aimed at encouraging society to accept those who need treatment.

"By promoting optimal mental and emotional health among all people, the stigma associated with mental health will diminish.

"We also wish to focus on the issue of women and mental health. People with mental illnesses have rights and neither they nor their families should be discriminated against.

Care of the community is the aim of treatment which should not happen in isolation from society.

"Only some patients need prolonged hospital care and this should not be a criteria by which they are judged. We are presently designing policies to enable people to be treated in their communities," the department said in its message.

The department has also committed itself to integrating mental health services with the Primary Health Care system.

"This will be done to increase accessibility and affordability, thus providing more effective and equitable services for all South African citizens."

Observe the day

Meanwhile, the Soweto Life Skills Centre and the Soweto Mental Health Clinics are to observe the day tomorrow at the Tswelopele offices of the Witwatersrand Mental Health Society at 11am.

The offices are situated in Mofolo South, opposite Nicro offices.

Shisana strikes back

Star 14/10/96

(85)

D-G lists achievements but admits communication is a major problem

By David Robbins
Health Writer

A recurring theme in the currently turbulent waters of health reform is the complaint that the Health Ministry is "high-handed and uncommunicative" in its dealings with major role players. At the moment these players are doctors and pharmaceutical companies.

The Director-General of Health, Dr Olive Shisana, is typically forthright in her response. "If people are saying we're high-handed, then let's unpack that accusation. Let's judge our performance by the facts."

Shisana says that the current turbulence is for the most part caused by two major struts in the overall process of health reform: the first the introduction of universal free access to primary health care (PHC)and the second the drugs policy.

"Clearly, the introduction of free PHC has affected the earnings of numerous doctors, some of the old-style district surgeons in particular.

"Some of these people were earning from R750 000 to R1,4-million a year, incomes based on the inefficiencies of the old state health system.

"Now that clinics are beginning to function properly, naturally these incomes are disappearing. But is it fair to say that the department has behaved in a high-handed way?"

Shisana points out that the introduction in April of free PHC for all was the culmination of a process which began in January 1995, and which included full consultation with all role players. "But it seems many people find it easier to accept new policy than to accept the implementation of that new policy. Then all sorts of accusations and misrepresentations start to fly."

Shisana ... 'accusa

The new drugs policy, designed to increase access to affordable quality medicines, is an excellent case in point, Shisana says.

"Our stress on generic prescribing is being represented as a disregard for patient safety. This isn't true.

"What we are saying is that generic medicines, rather than specific brand names, should be prescribed by doctors and that pharmacists should then explain to individual patients the pros and cons of selecting either brand name or generic. It would be criminal to impose generics on everyone, regardless of individual need. But this is how the policy is being represented."

Shisana applies the same criticism to some of the arguments raised by dispensing doctors.

"My department frequently receives calls from dispensing doctors' wives saying that our policy is taking away their livelihood.

"I reply that doctors should consider charging more realistic consulting fees than depending on trading in drugs to earn their living.

"There's also a widespread belief that we are banning dispensing by doctors. This is patently untrue. In the interests of quality control, however, doctors must have the necessary qualifications, and medicine storage facilities at doctors' rooms must be of an adequate standard."

But has the department been high-handed in its handling of the controversial elements of the essential drugs policy? Shisana doesn't think so.

"The broad policy was first enshrined in the ANC's health document published in 1994. Our own consultative process culminated in a public launch of the policy document early in February this year.

"Dispensing doctors and pharmaceutical companies were well-represented at the launch and did not object to this policy. But now, as implementation time approaches, accusations of high-handed attitudes are flying."

Two accusations in particular concern Shisana.

The first is that the Department of Health does not want doctors to earn a reasonable living. The recent salary increases for state doctors contradict this, she points out. The second is that the department wants to destroy the profitability of South Africa's pharmaceutical industry.

"It's internationally acknowledged that tough drugs policies incur the wrath of pharmaceutical companies. There is inevitably a tension between the state's aim of affordable medicine and the industry's imperative to maximise profits. "Of course our policy is designed to bring down prices, but that needn't deprive pharmaceutical companies of a living."

Shisana readily agrees that South Africa's pharmaceutical industry is a valuable national asset. "It's now a matter of realignment," she says. "We have to continue to negotiate to get a proper balance between our priorities and theirs."

Taking an overview of health care reform, Shisana stresses that all policy change introduced via the ministry has had one overriding aim: to improve access to quality health care.

And improvements are everywhere in the making. She provides this list, for example, from the Northern Province alone: 100 new ambulances; a new training school for emergency staff; 73 new clinics built; 88 clinic upgrades; R10 000 per clinic for the upgrading of staff accommodation; 780 clinic posts currently being filled; an improved medicines distribution programme; improved security in the form of guards and fences at scores of clinics and increased doctor sessions at most service points throughout the province.

"This is real access to health care," Shisana comments.

In the light of this and similar lists, are the accusations of high-handedness the result of genuine problems, or are they manifestations of annoyance – and even outrage – from the many areas of vested interest within the skewed models of health-care provision of the past?

Shisana leaves others to answer. On the issue of communication skills, on the other hand, she is more forthcoming.

"I think it is fair to say that we have not done as well at communicating our ideas and intentions as we would have liked. All of us in the department acknowledge this. The frequent criticisms directed against us in this regard are valid. For this reason we've now set aside a substantial amount of money to beef up our communications division."

Shisana comments finally: "We're as serious about improving our communications skills as we are about continuing to improve the heath care on offer to all South Africans."

Senate's report on Natal criticised

BD 18/10/96 (2nd)

Wyndham Hartley

CAPE TOWN — A multiparty delegation from KwaZulu-Natal yesterday slammed the Senate for a superficial and inaccurate report on the province which sounded like a "tourist" report.

The Senate, in terms of its programme of provincial visits, was debating the report of its two-week visit to KwaZulu-Natal.

A delegation of provincial legislature members led by IFP provincial premier Frank Mdlalose participated in the debate.

DP provincial leader Roger Burrows began the onslaught when he said the report of the Senate visit to KwaZulu-Natal sounded like a tourist trip report. It failed, he said, to address any of the province's fundamental issues.

Burrows said elements of the report were "anecdotal, inaccurate, and in some cases simply untrue". He asked the Senate how it could visit KwaZulu-Natal and not include a single word in its report about Durban which was the largest port in Africa.

He also challenged the report's section about the border dispute in East Griqualand which failed to note "the ANC is fighting the ANC" over whether the region should be in KwaZulu-Natal or the Eastern Cape.

The fact that a national ANC MP from the Eastern Cape, who was resident in Kokstad and was "fomenting some of the conflict" was not mentioned was strange, Burrows said.

KwaZulu-Natal legislature ANC chief whip Ina Cronje echoed Burrows, saying the Senate visit had been able to allocate only 90 minutes to provincial legislature members, and in that time the visitors could not have come to terms with the problems in the region.

"At best your report was unscientific," Cronje said. She said the report was "ad hoc" and a good example of what co-operative governance between central government and the provinces should not be.

NP KwaZulu-Natal MP Tino Volker also voiced his displeasure about the report, saying it was inadequate.

Earlier in the debate Mdlalose criticised diversion of water from the Tugela River to other provinces. He said it was unfair that KwaZulu-Natal should be impoverished while other provinces grew rich on its resources.

He said control of water was a national function, not a regional one, and his government thus had no control on this issue. Control over land, water and forestry should, Mdlalose said, become provincial functions and not remain in the hands of national government.

Gauteng bills other provinces

(85) BD 18/10/96

Ingrid Salgado

GAUTENG had charged its neighbours Mpumalanga, Northwest and Northern Province more than R400m for health services rendered to residents of those provinces last year and this year, provincial health department head Ralph Mgijima said yesterday.

Northern Province confirmed yesterday it would pay its portion, Mgijima said at Gauteng public accounts standing committee hearings on the province's 1994/95 financial year. Mpumalanga and Northwest had expressed doubt that provisions existed for them to make the transfers, he said.

National health director-general Olive Shisana had referred the matter to the state expenditure department.

Interprovincial transfers for 1994/95 would not be forthcoming because no agreement on transfers had been reached at that date. A total of R200m was charged for last year and R220m for this year.

Mgijima said the Gauteng health department had managed to reduce a projected R173m shortfall during 1994/95 to R76m. The province was examining various cost-cutting measures.

Most of Gauteng's R81m unauthorised expenditure arose from overspending in the health sector (R76m).

Members of the executive council and the premier's office incurred R1,2m of unauthorised spending while unauthorised leasing of office accommodation cost the provincial government more than R3m.

Mgijima said the focus on primary health care and extending health services had contributed to the department's shortfall. He also blamed the former system of provincial allocations, which were determined largely by central government through functions committees.

Standing committee member Brian Goodall (DP) said the system in some instances compelled provinces to incur unauthorised spending.

UPBEAT . . . Health Minister Nkosazana Zuma at the opening of the Michael Mapongwana Community Health Centre in Khayelitsha, yesterday PICTURE: TERRY SHEAN

Health service is ailing, but there are signs of recovery

(85) ST (TRCM) 20/10/96

By YVETTE VAN BREDA

THE health crisis in the Western Cape deepened this week following draconian budget cuts at hospitals — but the health department says there is light at the end of the tunnel.

Local Health Minister Ebrahim Rasool predicted that cuts to the province's health budget will mean more trauma patients will die and thousands will be turned away from the two largest tertiary hospitals.

But according to the chief director of health care, Dr Faried Abdullah, all is not "doom and gloom" and the province's health plan — to upgrade primary and secondary levels of care and down-grade tertiary institutions — was beginning to work.

Abdullah said that although tertiary institutions would be losing nearly 500 beds, 386 beds had been opened at secondary level.

Rasool warned that severe budget cuts could cause irreparable damage to essential and specialist health services and reduce the ability of tertiary hospitals to cope with the demand for health care.

Future health services in the Western Cape will be drastically and progressively cut back over the next five years, and Groote Schuur and Tygerberg hospitals will loose nearly 500 beds and 1 600 hospital personnel.

Abdullah agreed there had been a decline in the quality of services at hospitals, but he was optimistic that the five-year provincial health plan would work.

"As expected, we are starting to see results in the third year of the five-year plan," he said.

He added that they had used national Health Minister Dr Nkosasana Zuma's "free health care plan as a shaping tool".

And yesterday Rasool and Zuma were at the official opening of the Michael Mapongwana Community Health Centre in Khayelitsha.

The clinic, which opened its doors to the public in June, offers a "one-stop" health facility with oral health, psychiatric, obstetric, radiology, nutrition, curative and contagious disease services.

It is one of 36 primary health care facilities which have been completed over two years and a further 16 are under construction.

Abdullah said patients had to learn to enter the health system at the correct level so that the tertiary institutions were not overloaded.

Six district hospitals have been substantially renovated and in Manenberg on the Cape Flats, G F Jooste hospital opened on September 4 with 186 new beds and 29 doctors. This would reduce emergency patients at Groote Schuur by 60 percent, said Abdullah.

"Last week 100 beds became vacant at Groote Schuur as a direct result of the first specialist hospital on the Cape Flats."

At Karl Bremmer in Bellville, 200 extra beds had been provided and the building had been revamped.

The George hospital, which was suffering from staff shortages, was being upgraded to accommodate 80 more beds.

Similar upgrading was planned for Paarl and Worcester where more specialists are now available.

"At Paarl they now have a full-time surgeon and they're doing a lot more operations there which means they are not as dependent on Tygerberg as they used to be," Abdullah said.

Red Cross Children's Hospital, the only one of its kind in Africa, is unlikely to lose any beds at this stage.

"Over the next four years the province's entire budget would be slashed by R780 million, and every year 800 hospital posts could become redundant"

Their out-patient facility would be scaled down in February, but staff would be absorbed elsewhere.

Abdullah said it cost R550 a day to treat a patient at Groote Schuur and Tygerberg, but it would cost only R300 a day at secondary centres.

"That's where the health plan shows savings," he explained.

The three large academic centres in the province, which trained about a third of the country's doctors and two-thirds of its specialists, would be merging services to cope with the cuts and fees at tertiary hospitals would be increased.

"Even with the cuts the Western Cape still has the highest per capita cost of all the provinces," Abdullah said, adding that this showed local commitment to funding health care.

But the budget cuts should "not be perceived as a punishment to the province", he said.

The department's budget for the 95/96 tax year was R2,345-billion and next year it would get R2,364-billion, which, when inflation was taken into account, translated into an effective seven percent decrease.

In the year from September 1994 to August 1995 Western Cape hospitals treated 319 foreign patients at a cost of over R2,2-million of which they recouped only 45 percent. The hospitals also saw 158 patients from other African countries and treated 6 772 in-patients and 44 335 out-patients from other provinces at a cost of over R37-million. The department was claiming from other provinces for this cost, a policy which had been agreed to nationally.

They had also put in a claim to the Department of Finance of R131-million for the 96/97 tax year for training, research and unique health services.

Rasool said that over the next four years the province's total budget would be slashed by R780-million, and each year 800 hospital posts could become redundant.

Rasool stressed the importance of adopting healthier lifestyles to take the burden off hospitals and he added that the department would embark on a health education and awareness campaign.

A health care *bosberaad* was held in Stellenbosch recently and the consequences of budget cuts were discussed by representatives of the provincial health department officials and health professionals from the three Western Cape universities.

They agreed that the cuts would prove destructive to the standard of health services, training and research and would reduce the ability of the tertiary hospitals to cope.

The cuts called for the reduction of the workforce by 1 600 health care posts before March 1997, along with the loss of 492 beds at the three academic hospitals by the end of the financial year.

Head of the Western Cape health department, Dr Tom Sutcliffe, said the department had reluctantly agreed to down-scaling.

"We had an important role to play in planning and handling the cuts in the best way possible.

"It is not going to be business as usual and we accept that the budget cuts mean that things cannot go on as before," he said.

Dr Ralph Kirsch, a professor of medicine at UCT, said teaching hospitals saw about two million out-patients and 275 000 in-patients a year and performed 75 000 operations. And 80 percent of those treated were indigent, added Kirsch.

Drastic restructuring of Gauteng health services

(89) (89) Star 23/10/96

Hospitals and academic institutions face shake-up as closures, cutbacks and shifting of resources proposed

By Janine Simon
Medical Correspondent

The Gauteng cabinet will today consider a far-reaching plan to restructure the province's health services which, if approved, will mean historic changes to Gauteng's 40 hospitals, and particularly to its eight academic institutions.

Among the proposals are the closure of a limited number of small hospitals, dramatic cutbacks at almost a dozen others, and the shifting of resources to, among others, large but under-equipped regional hospitals.

The aim is to build up primary health care, achieve an equitable spread of services and still manage budget cuts of at least R250-million.

A full announcement is expected tomorrow, but Health Department officials are tight-lipped about the details. "As soon as there is any clarity this will be communicated to the players directly and to the public through the media," said media spokesman Joanne Collinge.

Insiders expect heated reaction to the plan, particularly from academics. The plans have been drawn up by a full-time task team seconded from academic and regional hospitals since January.

They are an attempt to both expand and rejig the province's entire tertiary-based health care system in the face of a real budget cut of 20% over the past two years, and a further cut of up to 10% for the 1997-98 financial year.

The province's silence thus far on the budgeting and restructuring process is in marked contrast to the Western Cape, where health department officials, university principals and hospital superintendents have declared an intellectual challenge to the principles underlying the drastic cut in funding.

Gauteng and the Western Cape health departments were forced to absorb about a 20% real cut in budgets in the first two years in office, as the national department, in the name of equity, swung its budget to favour underserved outlying areas like Northern Province and Northern Cape.

Gauteng has been left to convince Northern Province, North West and Mpumalanga to pay for the R400-million worth of treatment this province provided for their patients during those two years.

Budgeting systems for the 1997-98 financial year have been changed, and all provincial health departments are to be funded by the provincial parliaments, which are under pressure to control government spending in line with the macro-economic policy.

BD 25/10/96 (85)

Rationalisation of Gauteng health services will see 2 418 retrenched

Kathryn Strachan

A FAR-REACHING plan aimed at revitalising Gauteng health services will begin today, but rationalisation will go hand in hand with the retrenchment of 118 doctors and 2 300 cleaners.

By redeploying staff and resources in hospitals and health centres to where they are most needed, the plan, announced by Gauteng health MEC Amos Masondo yesterday, aims to improve the quality of services and achieve budget cuts.

It involves closing three smaller hospitals and downgrading another seven to health centres. Nurses will not be retrenched but there is a surplus of doctors in the province. A further 88 medical specialist posts will be lost over the next five years as posts are frozen when specialists resign.

Some regional and township hospitals will be strengthened, while hospitals which are underutilised or duplicate services will be closed.

The hospitals to be closed are Pretoria's Andrew McColm and Kempton Park, both of which are less than 40% full, and Westfort psychiatric hospital, which was recently condemned for its "inhumane" conditions.

Hillbrow, Lenasia, Nigel, Willem Cruywagen, Hendrick van der Bijl, Laudium and Ontdekkers hospitals will all be downgraded to health centres, bringing about a 40% saving on their running costs.

While the plan was initiated to stop the accumulated overspend (which is heading for R400m this year) getting out of hand, the province hopes to also bring equity and improve services for patients across the province.

This will be done by redeploying 6 000 health workers to create a more equitable spread of personnel and by strengthening primary health care.

Unions would be consulted in the retrenchment process, the province said, but the fundamental redesign of hospital services had enabled the retrenchment figure to be limited to 2 600 — far less than the 8 500 retrenchments that would have occurred without the new rationalisation plan.

The plan brings about substantial savings from 1997/98, but it does not immediately close the gap between spending and budget provision. However, it keeps the overspend to manageable proportions, reducing it to an estimated R242m next year, R209m the year after and R73m in 1999/2000. The expectation is that Gauteng will endure another two lean budget years, until the new census figures kick in and gambling tax becomes available. It should be possible for the health department to break even in 2000/01.

SA and Cuba to co-operate on health issues

(85)

South Africa and Cuba are to widen the scope of co-operation in health to the field of vaccine and pharmaceutical production and exchanging personnel other than doctors, Health Minister Dr Nkosazana Zuma said in Johannesburg yesterday.

She was speaking at a press conference after the arrival of Cuba's Minister of Health, Dr Carlos Dotres, for a week-long visit.

Dotres will be signing a declaration of intent on health co-operation with Zuma in Cape Town tomorrow, and will meet the president and deputy president, tour Gauteng hospitals, and visit Cuban doctors in Northern Province, Western Cape and Mpumalanga.

The two ministers hotly defended the work and qualifications of the Cuban doctors in South Africa.

Cuba was an underdeveloped country but had an avant-garde health system, where health indicators were on a par with the developed countries, Dotres said.

■ Two German doctors arrived in Northern Province last week on a two-year contract initiated by an agreement between the Ministry of Health and the German Centre for International Migration and Development.

"With the assistance of the European Union, it is envisaged to second up to 50 physicians from Germany and the EU," according to a statement from the embassy of the Federal Republic of Germany. – Medical Correspondent.

A turning point for health care

ef 5/11/96

(85)

KAKAMAS in the Northern Cape Province is an arid, hot town in a region of vast distances and widespread poverty.

One exception is the provision of health facilities, which are fairly good, according to Dr David Harrison, newly-appointed national director of the Initiative for Sub-District Support.

The group is funded by the Kaiser Family Foundation, the European Union and the British Overseas Development Administration to the tune of R20 million, and supported by the Health Systems Trust with R3m.

Despite Kakamas' health facilities, however, it has South Africa's highest incidence of tuberculosis and malnutrition.

It was apparent, said Harrison, that its health facilities were not functioning well, nor were its health workers effective. The community did not participate or have control.

The key to turning around the situation was to develop the health worker by making information resources available by providing technical support, developing management systems and providing research and evaluation.

The Initiative for Sub-District Support would facilitate this, he said yesterday at a funding function in Johannesburg.

The aim is to improve standards of primary health care by providing sustained and comprehensive support to selected sub-districts across the country. Besides Kakamas, about 25 other districts have been identified. — Health Writer.

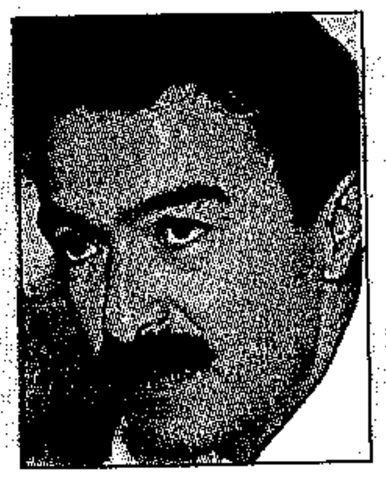
TUESDAY
NOVEMBER 5, 1996 ★

BOOST FOR RESEARCH, PRIMARY CARE

US foundation gives R25m in health aid

CT 5/11/96 (85)

THE HEALTH SYSTEMS TRUST has been given R25 million by a US foundation to improve the standard of primary health care. Health Writer **ANEEZ SALIE** reports.



THE largest private American grant made to a South African organisation — R25m to the Health Systems Trust in support of health reform — was announced by the Henry J Kaiser Family Foundation yesterday.

The amount brings to R250m the foundation's local contributions in the past nine years.

At a function in Johannesburg yesterday, its vice-president, Dr Michael R Sinclair, said the foundation's mission was to improve the health and health care of all South Africans, particularly women, children, the rural poor and urban squatter communities.

The foundation, based in California, is a private philanthropic trust dedicated to improving the health and life chances of the disadvantaged. With an endowment of $480m (about R2 250m), it annually makes grants of about $30m (R140m) and is one of the largest private foundations in the US dedicated to health.

It was established in 1948 by industrialist Mr Henry J Kaiser and his wife, Bess. South Africa is the only country outside the US in which the foundation makes grants.

The Health Systems Trust (HST) was established in 1992 as a three-way partnership between the foundation, the Department of Health and the European Union.

Through appropriate health systems research and planning, the trust's role had been pivotal, Sinclair said. The trust was a model of public-private collaboration.

"I would like to pay particular tribute to the senior leadership of the Health Department for their far-sightedness in actively developing partnerships with the non-governmental sector," Sinclair said.

He acknowledged the contribution of other funders, notably the European Union and the British Overseas Development Agency.

He said R10m of the R25m would support the HST's research and development of health systems.

The balance would help to launch a three-to-five-year national programme to devolve to communities and districts the administration of health, as well as provide services and overall control.

This should improve the standard of primary care services across the country, particularly in the poorer and more remote areas.

"Our goal is to help ensure that reform in health administration quickly translates into tangible improvements in the availability and quality of services for the bulk of this country's population, for whom health services remain inadequate," Sinclair said.

He challenged other funders and the private sector "to recognise what is increasingly evident the world over — investment in improving health is good politics and it is good business".

"If the moral and ethical arguments do not sway you, then consider the impact of health on social stability and productivity."

SA Health Review paints bleak picture of rural health services

(85) BD 5/11/96

Kathryn Strachan

THIS year's SA Health Review, released yesterday, shows that nearly half the clinics in the Eastern Cape do not have adequate water supply, 52% have no electricity and 38% have no phone.

The situation is hardly better in the Northern Province, the Northwest and KwaZulu-Natal.

In Northern Province, 30% of the 333 clinics have no adequate water supply and 23% have no telephone and no electricity. In the Northwest 30% have no adequate water supply, 43% have no telephone and 42% no electricity. In KwaZulu-Natal 20% have no adequate water supply.

The review paints a bleak picture of health facilities in rural areas but finds progress has been made in other areas. In the end it gives a mixed scoreboard in its assessment of progress over the past year.

An authoritative account of health in SA, the review documents the degree to which policy formulation and structural reform has translated into real improvements in health service and quality of life.

The review, published by Durban-based Health Systems Trust and US-based Henry J Kaiser Family Foundation, shows that in the critical areas of financing and health legislation, progress has been slow.

Discussion about some form of national social health insurance has so far borne little fruit. The financial sustainability of such a system continues to be questioned, in particular what effect the proposed special tax on employers, needed to cover the costs of a national health insurance, would have on jobs.

In response to questions at the launch of the publication, health department research and information director Mohamed Jeenah confirmed that the National Health Insurance proposal was "on the back burner". It was contained within the department's five-year medium-term expenditure plan before Cabinet, Jeenah said.

The other area of concern in the review is the new Health Act, in its seventh draft, but still unavailable for public comment.

Presenting the review, Health Systems Trust research director Peter Barron said the health department's lack of openness over legislation was disconcerting.

On the other hand, he said, the health ministry had achieved overriding success in restructuring towards primary health care.

This included the extension of free primary care to all, the reallocation of financial resources from richer to poorer provinces and from curative to primary services.

□ In another development, the Henry J Kaiser Family Foundation yesterday announced a grant of R25m to SA's Health Systems Trust for programmes aimed at uplifting the quality of rural health care.

The donation was the largest private sector contribution to be made in support of health development in SA, said foundation vice-president Michael Sinclair.

Of this contribution, R10m would fund the trust's health systems and planning activities. The rest would go to a new initiative supporting the establishment of management systems at district level.

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Several factors inhibited delivery of better service, says annual review

MEDICAL CORRESPONDENT

The health sector has received a "mixed scorecard" for its reforms and plans to improve the quality of people's lives in South Africa, according to the 1996 South African Health Review.

The review, considered the most authoritative and comprehensive annual review of health care in the country, said there were a number of questionable factors relating to the delivery of a better service.

Stumbling blocks in the past year included the lack of reliable information, the *Sarafina 2* issue which diverted attention from developing a comprehensive programme on HIV/Aids and the controversies over Cuban doctors and vocational training for doctors, both of which obscured the need to address the maldistribution of medical professionals and training institutions.

The review, which was released in Johannesburg yesterday, is published jointly by the Durban-based Health Systems Trust and the Henry J Kaiser Family Foundation (USA).

Peter Barron of the Health Systems Trust said professionals were still badly distributed with, for example, five of the country's eight medical schools in two provinces and only 953 of 15 794 pharmacists in state service, 733 of them in just three provinces.

The country still lacked a legislative framework and there was a "disconcerting" lack of openness about the framing of the draft Health Act, he said.

The recommendation that a compulsory hospital insurance be instituted had not been implemented. Staff morale was poor and an uncaring ethos prevailed, Barron said.

However, excellent first steps in health reform towards primary health care had been boldly tackled. Health resources had been redirected and the district management system had developed substantial momentum.

R20-m boost for rural health care

MEDICAL CORRESPONDENT

International aid organisations have poured R20-million into a new three-year programme to improve district health care in various parts of the country.

The funds will be used to tackle problems such as drug shortages, lack of water and electricity, and staff morale.

The bulk of the funds are from the USA-based Henry J Kaiser Family Foundation, as part of its R25-million commitment to health reform in SA.

Other funding is from the British Overseas Development Administration and the Independent Development Trust.

The Kaiser grant is believed to be the largest by a private US foundation to a single South African organisation, the Health Systems Trust said.

The trust is to launch the new programme, called the Initiative for Sub District Support (ISDS), and aims to tackle hands-on the assumption that simply putting new district structures into place will automatically improve the standard of primary health care.

"Unless there is a deliberate effort at delivery, all parts of health reform could be arrested at the administrative level," Dr David Harrison, national director of the ISDS said at its launch in Johannesburg yesterday.

"We need to identify the factors impacting on service and find innovative ways to address these," Harrison added.

The programme will target 30 to 40 sites over the next three years, largely in the poorer, most remote and under-served areas of the country, where the standards of primary health care are notoriously inadequate.

Sites that have already been identified include Kakamas, in the Northern Cape, which has the highest TB rate in the country despite fairly good health facilities, and Mount Frere in KwaZulu Natal where there are ten clinics but no water, electricity and medicines.

"Research has proved that when drug supplies run dry, clinic attendance drops off," said Harrison.

"People will not go to clinics if they know they would not get medicine."

The ISDS will be developed as a partnership between national and provincial government and NGOs.

Work will start in a limited number of sites and support at each is expected to be sustained for up to two years.

It is the accumulation of little changes which will ultimately improve service delivery as a whole, says chairman of the board of Health Systems Trust Professor Jairam Reddy.

"The objective is to improve people's health status in the selected subdistricts, and people's satisfaction with their health service so that they voluntarily choose to first seek care at a clinic, instead of the established pattern of by-passing the local clinics to go straight to hospital."

Teenagers may receive sweeping health rights

(85)

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By PAT SIDLEY

TEENAGERS of 14 and older will be able to keep medical information from their parents if the National Health Bill passes in its present form.

Dr Olive Shishana, health department director general, says the Bill may have to be changed to fit in with the abortion and sterilisation Act — and that may mean dropping the age limit again.

A clause already proving controversial in the abortion arena would allow "health care providers" to object to performing a procedure on grounds of conscience — but they would have to refer the patient to someone who will carry it out.

The draft bill envisages the setting up of an authority which will effectively license all forms of health establishments whether public or private.

Without the required permission, it will be impossible to open up, or enlarge, or even close "health establishments" without the consent of the authority.

It will also have the power to monitor what goes on in the establishments — and if the health care provided is inadequate, or if the hospital (for instance) is not safe, the establishment can be closed.

From tomorrow, the Department of Health begins a round of consultation with a two-day workshop including all the major "stakeholders" in a body called the National Consultative Forum.

Project launched to improve health services

(85) BD 11/11/96

Kathryn Strachan

AN INNOVATIVE R20m project to improve health services at district level has been launched by the Durban-based Health Systems Trust.

The trust's programme director, Dr David Harrison, says the new project will target 30 to 40 sites during the next three years in an effort to ensure that health policy reform translates into tangible improvements in the availability and quality of primary health care services.

The project will give priority to poor rural areas and squatter settlements, and at the same time will disseminate lessons learnt from these underserviced pilot sites to various other areas.

The project is funded by the US-based Kaiser Family Foundation, the EU and the Overseas Development Agency. The foundation has donated R15m to the project and a further R10m to the trust's planning and research activities. This brings its grant to R25m — the largest private sector contribution yet made in support of health development in SA, says foundation vice-president Michael Sinclair.

Harrison says that unless there are deliberate efforts to assess exactly what is happening at the point of health service delivery, attempts to improve health care will be arrested at the administrative level.

The project will explore all the factors affecting care at clinics or health centres, and from that point work back through the health system to assess what is needed to change the situation.

He cites as an example Kakamas in Northern Cape which, despite having good health facilities, still has the highest tuberculosis rate in SA and high rates of malnutrition. The project will look at where the health service has gone wrong in Kakamas: why its health indicators are poor, where the break in the health service chain occurs and how health workers can change their approach to enable them to reach out to communities.

Another illustration is 10 clinics in the Mount Frere distrivt of KwaZulu-Natal which have no medicine, water or electricity.

The project will look at why these essential amenities are missing and how the health system needs to change in order to ensure that basic items are provided.

The project will support management systems at district level and look at ways of involving communities and at lifting the poor morale of nurses.

Health staff protest over planned cuts

By JANINE SIMON
Medical Correspondent
Star 15/11/96

About 3 000 members of the National Education, Health and Allied Workers' Union (Nehawu) marched on the Gauteng health department offices in central Johannesburg yesterday, demanding it suspend its plan to restructure and rationalise health services.

The controversial plan – which includes the closure of three hospitals, the conversion of seven others to community health centres, the transfer of 6 000 staff and retrenchment of about 2 500 others – has already been strongly criticised by academics and hospital staff, and is now being punted instead as a proposal document for discussion.

The march coincided with the day on which it was tabled before the technical committee of the province's bargaining chamber.

Nehawu regional chairman Sheila Sikiti said yesterday the union was concerned that the plan had been developed in secrecy.

"We note with alarm and dismay that this so-called plan will result in the reduction of the health service staff complement by 5 010 workers and the retrenchment of 2 594. This plan flies in face of the country's constitution on transparency and accountability and does not even pretend to address the human resource problem in the hospitals," she said.

The union called for bilateral discussions with the MEC and for the department to honour the agreement, reached in the Public Service Bargaining Chamber in April, that there would be no employer-initiated retrenchments.

Accepting the marchers' memorandum, MEC for health Amos Masondo said the province would not "go around" central bargaining chamber agreements, and would consult on redeployment of staff in the provincial bargaining chamber.

CHRIS COLLINGRIDGE

Angry marchers ... about 6 000 National Education, Health and Allied Workers' Union members marched through Johannesburg city centre yesterday in protest again the proposed closure of a number of hospitals in Gauteng.

Health rationalisation held up

(85) (98) BD 15/11/96

Linda Ensor

CAPE TOWN — Vested interests within Western Cape academic hospitals had held up the process of rationalisation and international consultants would be brought in to devise a strategy for the transformation of the sector, provincial health and social services MEC Ebrahim Rasool said yesterday.

He said negotiations were under way to bring the consultants, preferably from London where the hospital system was overhauled and rationalised and where hospitals such as centuries-old St Bartholomews were closed.

"The impetus seen in rationalising the academic health centres is faltering under the weight of complex structures, committees and sensitivities."

Rasool said interest groups at Stellenbosch and Cape Town universities were using issues such as language differences as barriers to change.

But the province had no time to waste as it had to have plans in place by the start of the new financial year. Rasool believed the use of international experts on a short-term basis would give impetus to the rationalisation process.

Their brief would be to find ways of trimming expenditure while maintaining existing infrastructure. Rasool said expenditure of academic hospitals had been cut from R1,1bn in 1994 to the present R980m and would have to be cut further to R830m in the next few years.

Approaches had been made to foreign ambassadors to cover the cost of the consulting exercise.

Despite the budget cutbacks Rasool found cause for greater optimism about the health service which had made notable achievements since the ANC took over central government. The department's budget deficit had been cut from R400m at the end of 1994 to R150m.

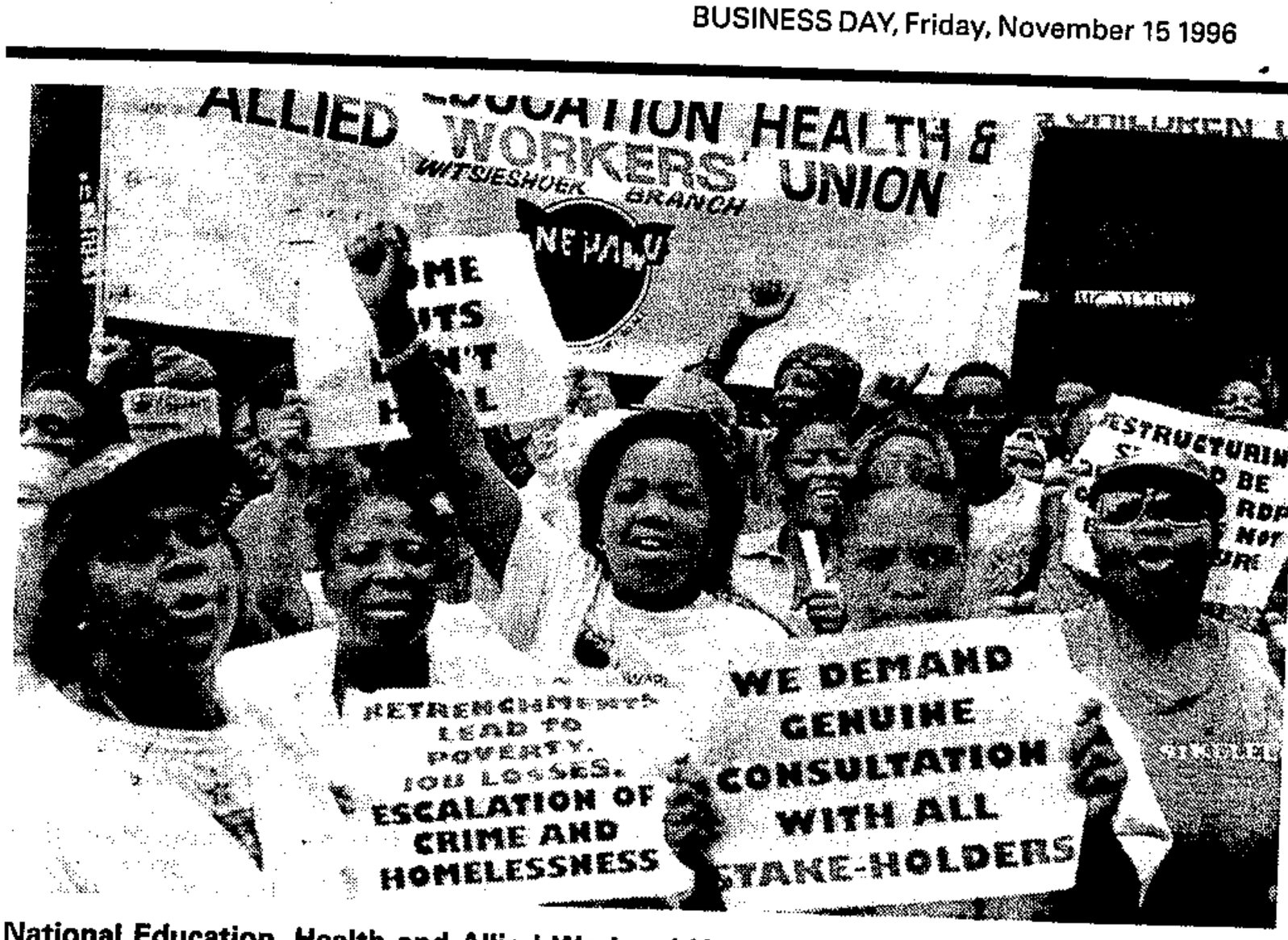
A mid-term ANC health session concluded that people were beginning to feel the difference.

However, issues of governance were a source of unease within the ANC.

"The ANC is concerned that no direction exists between local and provincial governments about who has responsibility for health at the district level," Rasool said. A team had been elected to report in one month to prepare the ANC's position so negotiations could commence.

Rasool said the ANC was also concerned the "potentially devastating" use of voluntary severance packages was not the best tool for rationalising the health service as it would lead to the loss of vital expertise. Discussions were to take place within the ANC alliance about what other methods could be adopted.

The goal in the transformation of social services was to overcome the past political patronage, financial irregularities and corruption by past officials. Negotiations were under way to use the Post Office for pension payouts to replace Nisec, whose contract was being evaluated by the Tender Board.



National Education, Health and Allied Workers' Union members protesting in central Johannesburg yesterday against rationalisation of health services in Gauteng. Heath MEC Amos Masondo later addressed the crowd.

Picture: TYRONE ARTHUR

Ambulance service crisis

(80) (96)
NOV. '96

BY PENNY SWIFT

EIGHT large Western Cape ambulances, including two new advanced life-support paramedic vehicles worth more than R500 000, have been withdrawn from service because there are no qualified drivers to man them.

This has affected not only the provincial ambulance service, but also two voluntary emergency medical service groups based in Hout Bay and False Bay which are having to use smaller vehicles.

As the Christmas season, with its inevitable increase in accidents, approaches, this could lead to unnecessary loss of life, ambulance sources have warned.

The Hout Bay emergency service cannot carry vital "jaws of life" — essential for extricating accident victims from mangled vehicles — and other life-support equipment in the substitute vehicle it has been given.

Last weekend, False Bay's emergency service had to get outside help because its smaller ambulance could not carry all the victims of a motor smash.

Most ambulance drivers have only basic Code 8 licences, but it is understood the Traffic Department has told the Western Cape Ambulance Services that it is now compulsory to have a Code 10 licence, which qualifies people to drive vehicles of more than 3 500 kg.

According to Dr B A Brand, provincial director of the Western Cape Ambulance Services, "somebody" realised that two new Iveco paramedic vehicles were over the limit for Code 8 drivers.

"Then they discovered we had other heavier vehicles. The ambulances have been pulled off the road and we are rectifying the situation."

According to another spokesman, who has asked not to be named, only about 20 of 290 ambulance service personnel have Code 10 licences.

"Now our chaps have to get learners' licences and then do Code 10 tests. The first eight go for their learners tomorrow," he said.

Even though four of the 30 volunteers from False Bay EMS have Code 10 licences, they cannot use the larger ambulance. According to David Burr, a full-time paramedic who heads the False Bay service, the repercussions could be serious.

Bruce Bodmer, head of Hout Bay EMS, said the service's main problem was that not all the emergency and rescue equipment could fit into its smaller ambulance.

"If there are serious accidents we will now have to wait for Metro Rescue to assist us and time becomes a critical factor. The only solution is to get our Code 10 drivers licences. I am confident we will overcome the problem, but I doubt if we will be able to do so this year."

Voluntary EMS units were introduced largely because of the poor response time of ambulances called to areas like Hout Bay and False Bay.

Although no one at the Traffic Department was available to confirm that a fax, insisting on Code 10 licences, had been sent to the ambulance services about 10 days ago, a spokesman said the only relevant factor seemed to be the gross vehicle mass of 3 500 kg.

HEALTH CARE

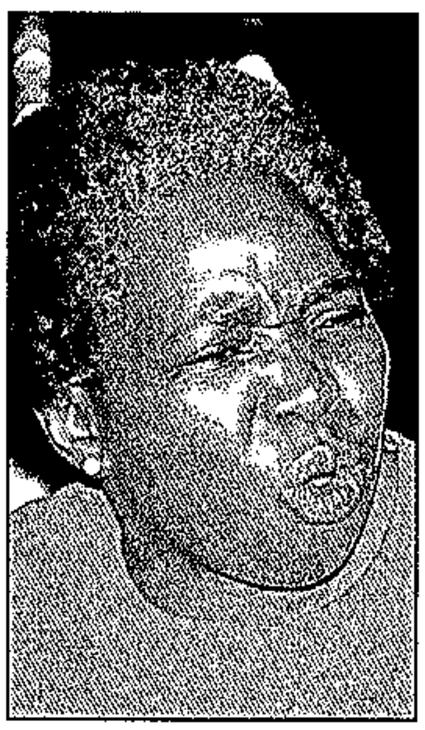
UTOPIAN QUEST FLOUNDERS IN MIRE OF BAD PLANNING

(85) FM 22/11/96

Long queues and staff shortages

Health Minister Nkosazana Zuma's unquestioning pursuit of the ANC's socialist health-care vision has earned her President Nelson Mandela's loyalty and praise. Free primary health care (PHC) is one of the few election promises the ANC government has managed to deliver. But, in Zuma's hands, it has become a blunt instrument for reforming the health system.

Zuma is credited with the provision from May 1994 of free PHC for pregnant women and children under six, followed in April 1996 by the introduction of free PHC for all; the expansion of immunisation, nutrition and disease prevention programmes; substantial salary increases for doctors and nurses; an infrastructural programme and an essential drugs list.



Nkosazana Zuma

The overriding success of the Health Ministry, according to the independent *SA Health Care Review 1996*, has been the reallocation of resources to PHC, resulting in 700 new PHC posts in under-served provinces and 60 new clinics. It notes that a lack of detailed planning and inadequate consultation preceded the implementation of both free health-care policies. The decision to extend free PHC was made before the effects of free PHC for pregnant women and children under six had been evaluated.

The Health Systems Trust commissioned such a study in which 70% of health-care workers interviewed felt that the policy had helped prevent serious illness or death. But it had also increased waiting times, resulted in irregular drug supplies and lower staff morale.

These problems were exacerbated by the premature extension of free PHC to all. When introduced at the 45 public health centres run by the Community Health Services Organisation in Cape Town, attendance among black communities increased by 27%-35%. But with a quarter of posts vacant, these centres were swamped, medicines have had to be rationed and up to 200 patients a day are being turned away.

Senior superintendent Dr Edmund Michaels says: "In the past, the service was, in effect, free because nobody who could not afford to pay was turned away. Now people come for the smallest complaint with the whole family in tow and demand more medicine than before."

In the Eastern Cape, Northern Province, the North-West and KwaZulu-Natal, the service may be free but a significant portion of clinics do not have an adequate water supply, electricity or telephones.

CUTTING IT FINE

% of clinics & healthcentres without basic amenities

	Northern Province	KwaZulu-Natal	North-West	Eastern Cape	Free State	Northern Cape
Total No (Clinics, clinic satellites & health centres)	333	407	300	645	281	134
% no adequate water supply	30	20	30	46	7	7
% no telephone	23	15	43	38	10	13
% no grid electricity	23	11	42	52	9	12

SOURCE: HEALTH SYSTEMS TRUST, DEPARTMENT OF HEALTH, RCHMS ANALYSIS 1996

In the Western Cape, which has the best PHC infrastructure, 30 clinics have opened since April 1994, mostly in the outlying areas.

Along with Cape Town's other academic hospitals, the Red Cross Children's Hospital was forced to slash its general outpatient department this year so that these resources could be re-routed to PHC centres. However, Red Cross senior medical superintendent Dr Rod Marshall believes it will take 18 months to two years for other facilities to become fully operational.

He says: "The PHC services must not only be available, they must be acceptable to the community because the path to the Red Cross is well worn. Unless there is a huge publicity campaign so that the staff reduction is accompanied by a decrease in patient load, the situation will be untenable."

It is premature for Zuma to declare — as she has done in parliament — that when it comes to health care, "South Africans can say with pride: 'We know we have a safety net.' "

Zuma is blamed for pushing academic hospitals to the verge of collapse by forcing provinces, through budget cuts, to shift resources away from costly tertiary care to kick-start her PHC programme. That SA should shift resources towards the creation of a decentralised PHC network, where the emphasis is on preventive medicine, is not disputed. The problem is that, during the transition, academic hospitals have had to cater for an increasing patient load within a budget that is being squeezed from all sides.

The situation — bleak because of Zuma's budget reprioritisation drive and inter-provincial resource shifts — looks set to deteriorate further next year as government tightens the fiscal screws to achieve a deficit target of 4%.

Preliminary 1997-1998 estimates indicate that provincial budgets are to be cut by an average of about 7%. For the Western Cape to effect a R780m saving (a real decrease of 9,6%), the academic health sector must contract by 15% in the next six months.

UCT-Groote Schuur head of surgery Prof John Terblanche says: "We would,

in time, be able to scale down but we can't do it overnight. Many of the secondary-level services don't exist elsewhere. If ours are closed, there is nowhere else to go if you get injured.

"My advice is: don't get sick, injured or run over because you are likely to end up at one of our academic institutions. Despite the best will in the world, we will treat you badly. You could sit slobbering for five days with a broken jaw because we don't have the staff to see to it."

Earlier this year, 16 babies died at Tygerberg Hospital in three months from a bacterial outbreak caused by cockroach-infested wards. The province says it lacks the staff to maintain adequate medical and hygiene standards because of the freezing of posts occasioned by the redistribution of funds among provinces and the need to shift posts to PHC.

Gauteng is also suffering. Three hospitals are to be closed or scaled down in January. Gauteng finance head Roland Hunter says: "Next year is a crunch year for government departments. We can't accommodate cuts this fast by trimming fat. It means a reduction in services."

Zuma's job is to ensure that health reform is feasible given the prevailing fiscal constraints. Her policy is contributing to a reduction in the quality and availability of health care in parts of SA. While it is encouraging that her medium-term expenditure framework recommends an annual real increase for academic hospitals — 1,3% against a 9% increase for PHC services — it is improbable that such increases will be attainable.

An additional R6bn-R8bn will be needed over the next eight years to repair and replace the 27% of hospitals that are in an advanced state of disrepair. The *SA Health Review* considers it unlikely that such funds will be forthcoming from conventional budgets.

When invited to a snap debate in the Senate last month on the state of health services, Zuma told the NP she had nothing to say as health delivery was the responsibility of provinces.

When Zuma — whose disregard for public opinion over *Sarafina 2* shook many a South African's faith in her health reform plan — finally did agree to participate, she told the House that health services were becoming more accessible to those deprived in the past but that the situation had deteriorated for whites who "suddenly had to queue with Africans and everyone else."

Her suggestion that hospitals be allowed to retain a portion of fees will never yield substantial resources while the few with medical aid cover prefer to be treated at private hospitals. She has stopped short of permitting public hospitals to enter into joint ventures with the private sector.

In creating a national PHC infrastructure from scratch, Zuma has ignored the network of doctors that provides PHC, including medication, for as little as R45 a consultation in remote areas.

Cape Independent Practitioners' Association chairman Dr Steve Jooste says: "There is a willingness among doctors and medical aid schemes to act together to contract for PHC work from the State at a relatively low cost for the 7m people who have jobs but aren't on medical aid, but Zuma has overlooked this option. The result is lengthening queues and disastrous levels of service."

Instead of devising a comprehensive plan to redress the maldistribution of health personnel, Zuma has imported Cuban doctors and attempted to conscript medical graduates to serve in outlying areas. Poorly prepared plans to curtail dispensing doctors and introduce mandatory generic substitution have also had to be relegated to the backburner. None of these proposals have addressed the lack of confidence among medical personnel and have probably added to the exodus of doctors.

Zuma may have saved herself the time and embarrassment of these blind alleys had she published a White Paper on transformation setting out a broad, enabling framework. Instead, she produced six policy documents in 30 months.

A draft National Health Bill was sprung on a consultative forum last week. Members seeing the document in its ninth draft for the first time have been given six weeks to comment. The Bill is to be tabled in parliament in early 1997 but the ANC-dominated portfolio committee on health has indicated that it will insist on commenting on a White Paper prior to the presentation of the Bill.

In its 1996-1997 budget report, the committee says it has not been kept sufficiently informed regarding the drafting of the Bill. It also raises concerns about the Health Department's alleged lack of transparency, accountability, adherence to public administration rules and regulations, sound preparation of new policies, consultation in policy development and proper reporting to parliament.

Zuma believes her department "shall not be judged by how many green and white papers we produce or how many policy declarations but by whether there is health for all."

In terms of Zuma's plan, conditionally approved by Cabinet, total public health expenditure is expected to increase from R16,8bn in 1995-1996 to R19,98bn in 2000-2001, an annual average real increase of 3,4%. It relies on foreign aid to reduce the State's requirement to a more feasible 0,6% real annual increase. Her projections assume that each person will visit a free PHC facility 1,8 times a year, increasing to 2,8 visits by 2000-2001, an assumption many consider unrealistic (*Leading Articles* March 22).

Zuma deserves credit for being the first Health Minister to tackle the fragmented, inequitable and top-heavy health system head-on, but, without significant off-budget financing, her vision of a widespread and effective PHC network will fail.

Considering government will never go back on its promise of free health care, if Zuma's costing principles flounder, the State could well face a financial crisis that would require the taxpayer to bail it out. ■

SHIFTING RESOURCES

Allocation of 1995/96 health budget according to service category (R000)

Service category	Current	Capital	Total	% of total
Nursing training	165 047	5 412	170 459	10,6
Academic hospitals	4 240 098	19 785	4 437 883	27,52
Regional hospitals	1 856 481	113 532	1 970 013	12,22
Community hospitals	3 403 445	194 637	3 598 082	22,32
PHC (Personnel)	2 261 503	167 056	2 428 559	15,06
PHC (Non personnel)	586 847	12 897	599 744	3,72
Psychiatric hospitals	575 184	23 233	598 417	3,71
TB hospitals	403 318	14 378	417 696	2,59
Emergency services	422 149	53 540	475 689	2,95
Administration	1 221 795	205 527	1 427 322	8,85
Total	15 135 867	987 997	16 123 864	100,00

SOURCE: PORTFOLIO COMMITTEE ON HEALTH. REPORT ON THE 1996/97 HEALTH BUDGET VOTE

Govt, medical rescue airlines to step up cross-border health controls

BD 26/11/96 (85)

Kathryn Strachan

THE SA health department is to meet medical rescue airlines and private clinics today to find ways of preventing a recurrence of tragedies such as the death on Sunday of nursing sister Marilyn Lahana from the Ebola virus.

Flying patients into SA from the rest of Africa has become a business, prompting the authorities to search for ways to improve health controls.

Health department director of communicable diseases, Dr Neil Cameron, said the first step towards tighter control was to introduce an early warning system. It would be proposed that medical airline carriers should be compelled to notify the port health official in severe cases. The port official would inform provincial health authorities and the hospital that received the patient would be obliged to inform the provincial control officer. An expert in infectious diseases would then be sent to assess the patient.

This would ensure that patients entering the country were tracked constantly. Nurses would take precautions when handling these patients until the test results were known.

Gauteng health deputy director Eric Buch said flying patients into SA from all over Africa had become a business and, in the light of this SA had to set up regulations and take steps over and above the international controls set by the World Health Organisation.

Cameron said greater care needed to be taken with patients being flown in with fever of an unknown origin. Doctors at any public or private hospital could refer these patients to Rietfontein Hospital on the West Rand where they could be isolated.

He said nurses treating Gabonese doctor Clement Mambana, who passed on the Ebola virus to Lahana during an operation, used barrier nursing procedures even though they did not know he had the Ebola virus. Nurses needed to be more aware of the risks and of the need to take universal precautions at all times with any patient, he said.

Sapa reports more cases of the deadly Ebola virus have not been ruled out by the Gauteng health department, but officials are confident that monitoring procedures will prevent the disease spreading further.

Gauteng health department director for AIDS and communicable diseases Dr Liz Floyd said yesterday further cases could develop among about 300 health workers being monitored after possible exposure to the fever while caring for Lahana.

The virus could be spread only by contact with a person exhibiting symptoms of the disease, Floyd said.

PRIVATE SECTOR FACES PAIN

(85) FM 29/11/96

The draft National Health Bill, due to be tabled in parliament in the New Year, grants excessive powers to the Health Minister and a new central health authority to regulate the private sector.

Of key concern is the process of awarding authorisation or "certificates of need" to enable the "rational and equitable distribution of health services, technology, establishments and human resources by the use of objectively verifiable criteria."

A national health authority — made up of the Health Minister, provincial health MECs and three local government representatives — has the power to grant and withdraw certificates of need. In deciding whether to authorise the creation, enlargement or modification of a health facility, the authority must consider such criteria as its compliance with government plans, relationships between existing and proposed establishments, demographic and geographic features, the availability of personnel and alternative establishments in the vicinity and funding conditions.

The Pharmaceutical Manufacturers' Association (PMA) warns that these requirements could be open to abuse and assume that the authorities are a better judge of the demand for health care than the investor.

It also paves the way for vested interests to capture favours. If this is at the expense of more effective candidates, it could stifle innovation and increase the total operating costs of the system. Not only could innovative types of health care provision be discouraged, but also innovative financing methods.

"If regulation is indeed required by certification in health care, it would be more appropriate to use licensing fees than bureaucratic discretion to sift out less socially attractive proposals," says the PMA.

Wits Prof Duncan Reekie feels that government's role should be limited to certifying hygiene and quality standards, not assessing whether there's a market need or whether developers have sufficient capital. "The provisions would deter investment in the private health sector and limit its expansion," says Reekie. "They run counter to the official policy of wanting a healthy private sector so that government can devote resources to the public sector."

Health Minister Nkosazana Zuma's moratorium on the licensing of private hospitals — in effect for more than two years — is already imposing unnecessary delays on the expansion of facilities.

Reekie says that, if government believes there's surplus capacity in the private sector, the solution is not to reregulate. Prior to the 1994 amendments to the Medical Schemes Act, there was an incentive to overinvest in private health care, as the law guaranteed fee for service payments. That guarantee no longer exists and normal market forces should now be allowed to prevail.

The Hospital Association of SA is also concerned that the certification process may hamper private sector development and that, if used irresponsibly, "the sweeping powers granted to the Health Minister could lead to overregulation of the private sector."

The Minister is empowered to issue regulations that:

- Determine the price and charges associated with the dispensing, administering, retail sale or supply of any drug;
- Integrate private care providers and private health establishments into the national health system; and
- Relate to the purchase, distribution and access to technologically advanced medical equipment.

These provisions smack of price control and nationalisation and are probably unconstitutional if applied to the private sector. They should be scrapped from the draft Bill. But it's encouraging that the Bill allows district, provincial and national health authorities to contract with private practitioners and establishments for products and services.

The Bill proposes a federal concept, whereby each provincial health authority addresses policy and the delivery of services within national guidelines. Within each province, responsibility is further devolved down to a district (municipal) health authority. The PMA warns that the national health authority's extensive powers may well undercut the desirable decentralisation of decision-making.

While the Hospital Association welcomes the joint role envisaged for private and public providers in ensuring emergency medical care for all, it's concerned that the private sector is not represented on the proposed national health advisory council, which will guide the health authority in policy formulation.

The Health Department has convened a consultative forum — consisting of the key role-players in the health sector — who have been given six weeks to comment on the draft Bill. The Medical Association of SA declined to comment, as "it cannot pre-empt the outcome (of the consultative process) by highlighting specific issues." ■

FIGHTING CRIME

KEEP YOUR FINGERS CROSSED

FM 29/11/96

It would be comforting to believe the police's claim that most serious crimes declined or stabilised this year compared with 1995 and 1994.

New system will put health care in the hands of the people

turning to finer detail,

Broad brushstrokes of new national and provincial health structures have been painted in and attention is now turning to finer detail, such as setting up systems at district level. **Kathryn Strachan** reports

4/12/96 (85) MD

DISTRICT health is a new concept in SA and many obstacles still need to be overcome for it to be implemented successfully over the next few years.

District-based health systems have been used successfully in many parts of the world from developing countries in Africa to Canada. The principle is one of devolving control of health down to districts to ensure that local people, who are most attuned to the needs of the community, have greater say over health care and can help improve health care delivery. The focus is moved closer to prevention and health promotion.

A number of difficult issues have followed the district debate, not least of all the relationship of district health structures to local government, the form of representation of communities and discrepancies between the salaries of nurses employed by the state and those employed by local authorities.

While these obstacles are being resolved, a lot of energy is going into putting district health systems into place. Borders are being drawn up, managers are being appointed, and finances are being reprioritised.

National health systems director Yogan Pillay hopes to have districts in place in about three years' time. But, he says, "this could be too optimistic, and five years would perhaps be a better mark to aim for. If we have one or two health districts per health region up and running by the end of this year, we will have done well.

"However, to devolve functions we have to change many regulations, in terms of treasury rules especially, and that is one of the major constraints."

The new district model is fundamentally different to the present system. Primary health care services are at present provided in a fragmented and inefficient way. There have been a multitude of different and overlapping authorities responsible for service. In many areas the pieces of the jigsaw do not fit together and there are areas that receive very little attention.

There is no single body to take responsibility for a geographical area, and this means peri-urban areas, which are catered for by the province, receive far less attention than urban areas which are catered for by metropolitan councils.

In the new system each province will be broken down into about 20 districts, and the health services in each district will cater for all the people in their catchment area. This changes the present focus of providing care only to those who come to the clinic, towards an outreach approach where health programmes are aimed at all. In rural areas there are many people who do not use the health services and the new approach ensures that these people, who are most at risk, fall into the net.

These preventative programmes are best carried out through creating district-based management units.These units will provide the framework for the new system, so that a district health authority can take responsibility for the health of the population in its catchment area.

Devolving control down to districts also makes it far easier for all the sectors that affect health to co-ordinate their efforts.

Co-ordination of all the health services and health workers in the district will take place at district level. So it becomes a self-contained unit which includes all health care workers and facilities up to and including the hospital at the first referral level, the district hospital. Cases which need more specialised treatment are then referred on to the secondary regional hospital, or the tertiary academic hospital.

This also means a change in the status of district hospitals. Because the district health authority will be an amalgamation of the clinics and the district hospital, a new balance will be created between them. Putting the system in place will be complex and many issues still need to be resolved, particularly the question of governance. In many rural areas each suggested health district includes several local authorities.

On the thorny issue of the relationship between districts and local government Pillay says local government should ideally be responsible for district health services.

However, not all local authorities have the capacity or the desire to provide health services. Provinces therefore need to put in place mechanisms that would bring local governments into the planning process.

The department has set out three options for governing district level health systems: first, that the province can appoint a district health manager who will manage the district health services on behalf of the province; second, that where local government has capacity it will provide these services; and third that an autonomous statutory District Health Authority be charged with delivering services in each district.

Each model has its own mechanism for ensuring strong community participation. Each district structure is decided on will be responsible for the financial control of the district health services. The budget will come out of existing funds allocated.

In defining district boundaries, it is important that they relate to local government boundaries. Ideally, boundaries should also be the same as other service sector boundaries, such as welfare and education.

"But we have not been able to secure that yet," says Pillay. "Other players have called for different boundaries. Bureaucrats want boundaries based on technical criteria and politicians want boundaries based on political grounds. Some provinces have got it right. The Eastern and Western Cape, for example, have been able to convince their premiers that these boundaries should be the boundaries that everyone uses. It is ultimately a political decision."

In the districts that have been demarcated, interim regional and district management teams have been set up. In many cases these teams are composed of all stakeholders in health, and at the district level local government, communities and non-governmental organisations are involved.

To Pillay, decentralisation is not an event, but a process which took 20 years to achieve in the UK. "There are many things we need to get right," he says. "We need to get the governance issues right, and we need to get the legislative framework right. We have a draft National Health Bill which we are hoping will go to Parliament in the second session next year.

"We also cannot devolve responsibility without putting in place accountability mechanisms, and a financial system is being developed for districts. Finally, it is critical to monitor the effect this has on health and on equity, and to do this we need a health information system at district level."

Patients in the outdoor waiting area at a rural clininc near Tzaneen. Picture: KATHRYN STRACHAN

Villages pioneer district health

(85) BD 4/12/96

In the rarefied health policy world, it is the down-to-earth minibus taxi that is making things happen, writes Kathryn Strachan

LOCAL taxis carrying blood specimens between clinics on their daily route in Bushbuckridge, on the border of Kruger Park, give meaning to the new system of district health which will soon be implemented countrywide.

The system is aimed at making health services more responsive to community needs. Central to the plan is ensuring communities are involved in making decisions and running health facilities.

Bushbuckridge, the subject of a border dispute between Mpumalanga and Northern Province, is one of the few rural areas to have a functioning interim district health authority and it is showing a way through the myriad problems facing districts.

But it is limited by the fact that it still has no resources and it lacks the authority needed to carry out decisions.

In fact, while Bushbuckridge is the subject of a border dispute, it does not even have a province to grant it that authority. Getting the district formula right is the most critical element in determining the quality of care.

The difference between the way the health system operates now and the new approach is that at present, the catchment area is defined by patients who come to the clinic door. In a district system it is those who do not come to the door who are most at risk and in need of care.

The Bushbuckridge example shows how communities can influence the health service.

Precious Mnisi, a field worker with the unit, illustrates how teenagers and women got together to decide what the health services should focus on. "I started by going to soccer teams and netball teams in villages to find out their health problems and they came up with sexual health. From this we started working together and they have now set up drama groups, using songs and plays to convey sex education to other youth."

The women expressed the need for information on agriculture. They had a vegetable garden but no water. Through this initiative, they have contacted a donor and got their borehole.

One subdistrict, Agincourt, organised voluntary committees around local clinics and sent representatives to district health committee meetings. This process meant the needs of people in the villages were relayed to district meetings. With its encouraging results, the pattern was replicated in another 20 villages.

Jane Mawela, a worker at the community based rehabilitation centre, said initiatives based in the district were able to play a far more supportive role in rehabilitation programmes. Families are closely involved in the centre and most of Mawela's work is in the home, helping people to be self-sufficient in their everyday lives and educating families about caring for their mentally ill.

The district system also means the old lines of referral between clinics and hospitals will be unravelled and a logical new network will be set up.

"When we referred a patient to a hospital, we never heard what happened to him," said Clara Chiloane, who runs the Agincourt health centre. "But now there will be better communication between the hospital and health centre."

"There is enthusiasm," said community nurse Elizabeth Malomane, "but we don't have enough authority, we are not well informed and the problems we have to address are overwhelming."

Shadrack Mkhonto, a teacher, said the committees served as a link between communities and health services: "Now there is someone to go to if you have a problem. There is a feeling of ownership on the part of the community. The committee can also play a promotional role by encouraging people to take others to the clinic, especially the mentally ill."

But simply setting up a health committee was not enough, said Mkhonto. The health centres were beset by a lack of funds and basic amenities such as phones, doctors and medicines. "People are asking us: 'You say you are a health committee, but there is no ambulance. What are you doing?' "

Health-care a victim of party politics

(87)

CT 5/12/96

ERIC NTABAZALILA

PARTY politics is bedevilling the delivery of primary health-care to the residents of Heinz Park squatter camp near Philippi.

The clinic, originally run from four dilapidated containers without windows or doors, was moved to the home of NP member Mrs Joana Adams a year ago.

Recently, however,Heinz Park/Philippi councillor Mr David Ntlanganiso ordered the clinic to be moved from Adams' house to a shack on an open field. He said last night: "I took this decision after a group from the community I work with came to me with complaints about the presence of the clinic in Adams' house. I was under pressure from this group and we took the decision to remove it.

"I was aware of the condition of the containers but it was the duty of the Cape Metropolitan Council to renovate them. The 'supershack' is in a better condition and only leaks when it is raining," he said.

The "supershack" is a two-room shack made of hardboard. Most of its windows are broken.

An irate Adams said she had not been consulted about the decision.

Adams, who also runs a daily feeding scheme for more than 200 children, said conditions in the original containers had been "appalling".

"I felt that since I had no children and my house was big, I could accommodate them (patients and nurses) in my lounge when the mobile clinic comes around on Mondays. I did this out of grace, not because I wanted to be paid," Adams said.

Heinz Park health committee chairman Mr Leon Brown said his committee had welcomed her suggestion as conditions in the containers were very bad for sick people.

"We only asked her to report to us (the health committee) on the problems she had in accommodating the clinic in her house. We were surprised to hear about the removal of the clinic from her house, which was announced in a general meeting last week.

Ntlanganiso denied the claims by Adams and the health committee and claimed the clinic had never been held in the containers.

"This clinic was hijacked by Adams even before it went to the containers. All along I was not aware that the clinic was in her house. They never contacted me when it arrived in the area and I was not worried about that as long as people were treated."

Adams and Brown claimed Ntlanganiso liked to use the "National Party thing" when residents complained about the removal of the clinic.

Ntlanganiso agreed he had used the name of the National Party.

"When Adams wrote me a letter telling me that she and her organisation struggled to get the clinic in the area I assumed that she was talking about the NP as she was a member of it," he said.He had not been aware that Adams was working with another organisation called "New Life ACA Feeding Scheme".

New medical plan 'not panacea for system's ills'

Many doctors believe managed health care is structurally flawed

(85) Star 10/12/96

By Janine Simon
Medical Correspondent

Local doctors are voicing concern over whether managed health care is as good a solution to rising medical costs as is being punted.

Several major medical aid administrators have already switched to managed health care systems, including Eskom, Sanlam, and Anglo American, and elements of managed care are expected to be included in every major fund over the next 12 months.

But, said Dr David Presbury, chairman of the Medical Association of South Africa's southern Transvaal branch, many doctors are concerned that managed health – which uses a third party to manage costs – is structurally flawed.

As a business it necessitates the making of profit and demanding of fees for management. Individuals are not allowed freedom of choice, and schemes usually assign a physician or nurse to evaluate a patient's complaint with the least expensive tests, and to treat it with the least expensive medicines and methods.

Doctors function as an agent for management rather than an advocate for the patient, he says.

> **Insurance with savings packages a better option**

"Health care insurance, coupled with savings packages, is a better option," Presbury said.

Like a motor car insurance, when there is a breakdown the vehicle is repaired at the owner's cost (from the savings account), but when a major accident occurs, owners claim from insurance. This keeps expenditure in the hands of the individual and doctor.

"It is significant that managed care in the US does not enjoy the popularity it once had," Presbury said. The US spends 14% of gross domestic product on medical care and has two doctors and nurses for every one medical care administrative employee.

Singapore, by contrast, has had a mandatory medical savings programme operating for more than 10 years. It spends only 3,1% of gross domestic product on medical care and has five doctors and nurses for every medical care administrative employee, he said.

"It has taken us a long time to recognise the shortcomings of medical aids. We should benefit by their demise by not repeating our mistakes in a new third party direction," he said.

Doctors take heart surgery to rural areas

(85) BD 31/12/96

Kathryn Strachan

MEDICAL specialists from the Medical University of SA have initiated a pioneering surgery programme performing open heart operations in Northern Province hospitals.

Loading all the hi-tech equipment needed onto the back of a truck, the team — made up of a thoracic surgeon, an anaesthesiologist, registrars and specialised nurses — has demonstrated that sophisticated care can be provided in rural areas.

The two hospitals, Tintswalo in Acornhoek and Menkweng in Pietersburg, are staffed by nonspecialised nurses and doctors and offer no more than basic pre- and post-operative care without intensive-care facilities.

A report in the SA Medical Journal said the programme had cared for 35 patients who underwent major heart operations such as aortic and valve replacement and cardiopulmonary bypasses. Many of these procedures are regarded as being more difficult than heart transplants.

One patient died in the post-operative phase after a double valve replacement. The others recovered.

The report said the project was necessary because health professionals in rural hospitals were isolated and had to deal with a variety of clinical conditions for which they had inadequate training. The large turnover of medical staff, many of whom were foreigners and might be unfamiliar with local conditions and languages, further complicated conditions.

As a result of the low level of skill, patients who were referred to bigger hospitals for heart surgery had often not been selected properly. Patients had to travel long distances and were treated in unfamiliar environments. Their language might not be spoken in the hospital they had been referred to, making communication difficult, thus compromising patient care.

The report said benefits from the two-year pilot exercise included bringing tertiary care to the communities, boosting the morale of rural nurses and doctors by making them part of the "A team", raising standards of care in the hospitals and passing on skills. The programme also lowered the costs of transport, medicines and operations.

HEALTH AND DISEASE — GENERAL

~~1996~~ — 1997

Health research focus shifts to public issues

BD 3/1/97

Kathryn Strachan

AS the country's health system changes its focus from hi-tech medical care to strengthening primary-level care in communities, research is required to keep pace with and support the changes.

At present most research initiatives are still focused on narrow medical issues. Now a new movement is emerging aimed at strengthening research into public health issues and finding new ways of extending the limited capacity for research.

Peter Barron, research manager at the Durban-based Health Systems Trust, says the challenge facing research in SA is to create links between decision makers and researchers.

The trust is taking a new approach, initiating research and linking researchers, decision makers and the trust as funder. The ideal is for decision makers to identify key questions, and for the trust to be the broker, finding the researchers who can find the answer to those questions.

The problem remains however, that the health department's research agenda has not been clearly worked out. While the national level has sorted out its priorities, provincial and local levels still have a long way to go.

Initiatives planned for this year include TB. Biomedical, clinical and health systems researchers will collaborate on the project, and together will work towards changing the complete picture of the TB epidemic.

This will be a gradual process, says Barron, but in the end researchers will see that it is more satisfying and that they have a far better chance of having their recommendations implemented.

As there has been little training in research, and as health systems research in particular is in its infancy, the trust is also seeking to develop research capacity. This is being done by encouraging formerly white universities to work in partnership with disadvantaged institutions, thus transferring skills and resources.

Another route is to train a key person in an institution who can pass on skills to others in the field. Technikon Northern Transvaal's environmental health department head Stanley Mukhola is passing on research skills to environmental health officers working in government structures and in industry in the Pretoria area.

"This is about training people in senior roles who can mobilise others to explore research," says Mukhola. "Practitioners now see research as a tool they can apply... . Before, they had the information, but they would file it away and forget about it. Now they have the skills to pull it together in a research report, with clear objectives and methodologies."

Mpumalanga's district health care moves ahead

BD 6/1/97 (85)

Kathryn Strachan

AS NEW legislation strengthening the district health system initiative is being debated, Mpumalanga is showing how the creation of partnerships with SA's nongovernmental organisations (NGOs) can spur the initiative on.

"When it comes to health at primary care level, this can be done only in partnership with NGOs," says Dr Colin Mupombwa, community medical officer working in outreach teams in Eerstehoek, Mpumalanga. "As most NGOs are based in the community, they are accepted by people, and that experience and that position places them way ahead of government," he says. "If government can fund NGOs in an appropriate way and recognise the huge role they play, it will go a long way to improving the lives of people."

When it comes to realising the district health system goal of making a clinic more than just a place for treating people who come to the clinic, and extending it to include promoting health in all people in its area, NGOs are best placed to achieve this change.

In Mpumalanga the plan is for NGOs to be an integral part of planning and delivering services in districts. At the level of clinic, health centre and district hospital, the idea is that each facility will have a governing body and a management team. In each case the governing body will be made up of community and NGO representatives as well as clinical staff. While the governing body will have a lot of influence over the workings of each facility, the daily running of the facility will be managed by clinical staff.

In drawing up the plan for primary health care in Mpumalanga, and in setting up district health teams, NGOs have been instrumental in bringing the needs of the community to the fore. While in theory, this all appears simple, Mupombwa says it is a radical departure from past ways for working. This means the process is complicated by people's resistance to change, particularly those who have held control in the past and who are now required to share that power. Other obstacles are the lack of training and the fact that communities are not always equipped with the skills they need to participate.

"We have an opportunity now. There has been a lot of funding directed towards establishing district health teams, and we now have a political will behind all the changes that are happening," he says.

The partnership between NGOs and government in Mpumalanga has received further impetus with the success of a home-based nutrition programme in Eerstehoek. This programme, run by several NGOs together with the health department, has gone a long way to improving the nutritional status of children under five.

ANALYSIS

Proposed legislation will present future's full health picture

(85)

BD 8/1/97

This will be the "year of legislation" for the health sector in SA, writes **Kathryn Strachan**

WHILE many new plans and policies for health care have been introduced over the past few years, the void in health legislation has limited their effect. Once these policies are converted into legislation the full health picture for the future will emerge.

The void has left major health policies vulnerable to legal challenges and severely limited the authority of the health department to implement them.

And, without a comprehensive framework and vision, which would be provided by national legislation in the absence of a white paper, policies have often conflicted with each other and caused confusion among health workers.

"(The legislation) will mean that everyone will be clear about the rules of the game and how they will affect them," says health department deputy director-general Ayanda Ntsaluba.

The health department intends bringing 10 pieces of legislation before Parliament this year. First up at the end of March will be the Nursing Amendment Bill, which will look at the composition of the Nursing Council and how it should operate. This will involve public hearings with nurses, and particularly with community health workers who have tended to be left behind.

Next will be the Medical Dental and Supplementary Health Services Professions Amendment Bill, which will look at the structures and operations of the four councils governing these professions. Other proposed legislation, which is still to be scheduled, includes:

- ☐ The Tobacco Products Control Amendment Bill;
- ☐ The Occupational Diseases in Mines and Works Amendment Bill;
- ☐ The Pharmacy Amendment Bill;
- ☐ The Prohibition of Pre-Employment HIV/AIDS Testing Bill;
- ☐ The Medicines and Related Substances Control Amendment Bill;
- ☐ The National Health Bill;
- ☐ The Sterilisation Bill; and
- ☐ Dental Technicians Amendment Bill.

While very little health legislation has been processed by Parliament since 1994, a number of key lessons have been learnt from the experience of the Choice on Termination of Pregnancy Bill, says parliamentary health portfolio committee researcher Lynette Sait. One of these is the value of close collaboration with the health department to ensure that public health imperatives and not political technicalities determine the shape of legislation. Such collaboration, however, does not lessen the committee's role as an independent oversight agency, Sait says.

The most important of the proposed legislation for this year is the National Health Bill. This bill is a comprehensive overview, covering most aspects of the department's work including district health development, national health system restructuring, transformation of hospital services and management, medicines and essential drug programmes, health information systems and the department's regulatory functions.

National Progressive Primary Healthcare Network director Ivan Toms is supportive of the progressive nature of the bill. "It has a comprehensive framework for transformation of the health services, particularly the development of a district health system."

Speaking on behalf of all non-governmental organisations in health who put forward their ideas at a recent workshop, he says the bill is a progressive move that will decentralise authority to the local level, thereby making real community involvement far more possible.

Its major thrust is in the direction of the district health system, and by allowing for intersectoral collaboration it broadens the view of health to cover all socioeconomic factors leading to ill health.

Aspects of the bill still need to be refined, however, such as creating a balance between a document that will stand for the next 20 years and flexibility.

The health department intends bringing 10 pieces of legislation before Parliament this year. Once these laws are passed the full picture for the future of health will emerge. Picture: CHRISTINE NESBITT

The most exciting development in the new bill is chapter 2, which is devoted to patient's rights. For the first time, the rights and duties of users and providers of health care are outlined.

"It is very progressive for an act of Parliament to state that every user is entitled to respect, and has the right to full knowledge of their health status. This really empowers people to make decisions about their health," says Toms. The act is strong on the issue of confidentiality, and on the right to complain. Further, it compels every health facility (even a private clinic) to treat a person in an emergency.

However, while it reinforces patients' rights, it places on them obligations — to protect their own health, to co-operate with health providers, and to treat them with dignity and respect. Health providers too are given rights, and through a process of conscientious objection they may refuse to perform certain procedures.

Ntsaluba says a major obstacle has been homeland legislation, and a lot of work has had to be done on streamlining that.

The bill currently being circulated is the ninth draft and has still to be gazetted. "What we want to do now is enrich it and get it closer to what it should be before it is put out for comment at the end of January," he says. "We are anxious that it should accommodate as wide a view as possible."

While the department is not deaf to allegations that, in fact, it has not consulted widely enough, Ntsaluba says he believes the criticism is misplaced.

To take this consultation further, the department will hold public meetings around the country in addition to receiving written submissions, as meetings are simpler, particularly for rural and illiterate communities.

On the issue of consultation, portfolio committee chairman Dr Abe Nkomo says simply, "I am aware that there has been consultation, but I do not know with whom. I am, therefore, not competent to comment."

But sources close to the portfolio committee say his simple answer belies a far more serious situation.

There has not been nearly enough consultation, they say, and the portfolio committee did not know that the bill was out for consultation until the week after it was released. This, say the sources, shows further disregard for the committee. When the committee asked to see the bill, five copies were sent for 40 members.

While attempts are now being made to consult people, the sources say the committee should have been brought on board when the process started two years ago as there is a limit to how far a bill can be altered once it is already drafted.

The director-general's office has arranged workshops with the provincial portfolio committees, but the national portfolio committee will be following these up with its own workshops, where criticism and discussion of the document can be more open.

This lack of consultation from the department is a flaw that runs through all legislation, say the sources.

People are never allowed enough time to give feedback, and that feedback appears not to be used.

This situation is not eased by the health ministry making statements that the submissions of the portfolio committee on the issue of dispensing doctors "will be treated in the same way as any other submission". This is in spite of the committee drawing together a wide group of stakeholders, from dispensing doctors, pharmaceutical companies and NGOs, to discuss the issue.

In the end there appears to be a total disregard for the portfolio committee, which makes it difficult for it to fulfil its role of supporting the work of the department, the sources say.

The portfolio committee now has a new chairman, but the problems remain exactly the same.

NP says Zuma's health bill could destroy present services

Star 8/1/97

85

By Jovial Rantao
Political Correspondent

The National Party has launched a scathing attack on some parts of the proposed new National Health Bill, saying the sections in the bill which it found objectionable would have a disastrous effect on the quality of existing health services in South Africa.

NP spokesman on health Dr Willie Odendaal said his party would do everything to convince Health Minister Dr Nkosazana Zuma to abandon the provisions in the bill that did not place the interests of the patient and the rendering of health services of an acceptable quality first.

"The suppliers of private health services, like entrepreneurs who run private hospitals or their own private practices, as well as manufacturers of pharmaceutical products and other health care services that were established through private initiative, are in terms of the provisions of the bill forced to render only those medical services to patients that are prescribed by the central Government and for which such health institutions are accredited.

"Patients and medical provident funds will be prohibited from deciding what health services they require from the suppliers of their choice, and what they are prepared to pay for this. The proposed bill empowers the minister to merely promulgate regulations without consulting Parliament in order to determine and control the scope and quality of each health service rendered in South Africa.

> **"Patients and suppliers will be prohibited from deciding"**

"The comprehensive and extreme powers that are allocated to the proposed National Health Authority in terms of the provisions of the bill effectively mean that the provincial and district health authorities have virtually no decision-making capacity to speak on health matters of provincial and local interest," Odendaal said.

He said that in the proposed bill, Zuma protects herself against accountability and responsibility through the introduction of a "Gestapo-like" network of command bodies to which the minister could delegate all responsibility.

He said proposals in the bill for correcting historical inequalities between the different communities was praiseworthy. "Unfortunately (it) focuses on introducing measures that will first ensure drastic government control over the provision of health services, with a subsequent drop in the quality of such services to the level that can be afforded by the exchequer. Why the minister does not rather try and allow people who can partially or wholly pay for their own health services, or private initiative that renders health services to the public at a fee, to do so, is inexplicable," he said.

Odendaal said savings accomplished through privatisation, together with money that could be saved through the rationalisation and the elimination of unnecessary duplication and expensive services, would be well spent on the establishment of the necessary health services in disadvantaged communities.

"The bill contains a large number of praiseworthy provisions, like the proposed structure for the implementation of a health policy. With the necessary adjustments ... the bill can be transformed into an acceptable and affordable health system," Odendaal said.

Ministry of Health spokesman Vincent Hlongwane said the proposed bill was a discussion document and invited the NP to make a constructive contribution to it.

SA health care seriously ill

(85) Soweton 9/1/97

The latest plan is so elaborate that there is little prospect of success

By June Laing

IF IT has been necessary for you to go to a hospital lately, and you are on a medical aid and can be treated in a private one, thank your lucky stars.

Most of the provincial hospitals in South Africa are seriously, if not mortally, ill and will need intensive resuscitation if any of them are to be returned to some semblance of health.

Much of the blame for the decline of public-sector health services in South Africa, in both hospitals and clinics, has been laid at the door of the National Party government and was caused largely by inefficient organisation, inadequate financing and corruption.

In spite of this, however, the bare bones of a reasonable health service did, in fact, exist.

The Health Act of 1977 was a good one on paper and made provision for a wide and comprehensive health service for the whole population.

Increased spending

It recognised the need for increased spending on primary health care and for an extension of services, especially in the rural areas.

However, it seems that successive health ministers were never able to persuade their colleagues in the cabinet to make the necessary funds available.

Instead, the expansion of private health care was encouraged and this, with the help of medical aid societies, flourished and expanded at the expense of the public sector.

When previously white hospitals were opened to all races, these were inundated with patients.

A further influx followed on the announcement by the new Department of Health that children under the age of five and pregnant women would be treated free of charge, and this stretched facilities beyond their capacity to cope adequately.

Most of South Africa's hospitals are in a state that can only be described as disgraceful.

Dr Erich Buch, deputy director of Gauteng's health department, admits that the province's hospitals alone face a R1,5 billion maintenance backlog.

Health Minister Dr Nkosazana Zuma has stated that at least one-third of the hospital stock needs repair or upgrading, at an estimated cost of between R6 billion and R8 billion, yet her department has set aside a mere R241 million for this purpose in the current financial year.

In the light of this, it would have been sensible to have dealt with the existing problems before embarking on a romantic grand plan. Not so, however.

An official policy document issued last year by the Health Department – *Restructuring the National Health System for Universal Primary Health Care* – ignores the reality of the present situation almost completely.

Solutions to some of the deficiencies that the authors identified – such as shortages and maldistribution of trained medical staff – are either not mentioned or are glossed over.

The plan notes that more clinics, health centres and hospitals will have to be built or upgraded but goes on to plan a free primary health care system so far-reaching that it looks like a blueprint for a health service in Utopia.

It is so elaborate that one wonders how those trying to implement it could ever decipher their responsibilities.

The management system that is contemplated is hugely complicated and top-heavy: it has numerous committees, forums, councils and boards to advise, coordinate, monitor and audit.

The importance of good primary health care should not be underestimated. And it is an excellent principle that patients should, where possible, always be treated at the lowest level, thus freeing hospitals to deal with more serious cases.

But tertiary care does not only mean heart and kidney transplants; it is necessary for the proper treatment of many other common diseases.

Precious assets

Even where there is an improvement in primary health care, our hospitals will have to cater for large numbers of patients who are not the affluent, as Zuma would apparently have us believe.

Yet these hospitals, many of which are overcrowded, ill-equipped and understaffed, are now told they will have to make do with even less money.

Our hospitals, particularly the academic ones, are precious assets, where our doctors, nurses and other health professionals are trained.

If we compromise them, we will destroy any hopes we may have of a good health care system in this country.

As it is, we have no prospect of being able to train, in the foreseeable future, the huge number of personnel necessary for the implementation of the proposed National Health System.

The problem of professional staffing is an area of huge concern. The recent salary increases are so minimal they will probably make little impact on the steady drift to the private sector.

Those who remain in the public service are disgruntled and demotivated, having to work long hours in unsatisfactory conditions, while the patient-loads increase.

Governments sometimes make unpopular decisions but it is generally unwise to antagonise the people whose cooperation is essential.

Zuma is managing, however, to do exactly that in her relationship with the medical profession and her manner is confrontational and abrasive.

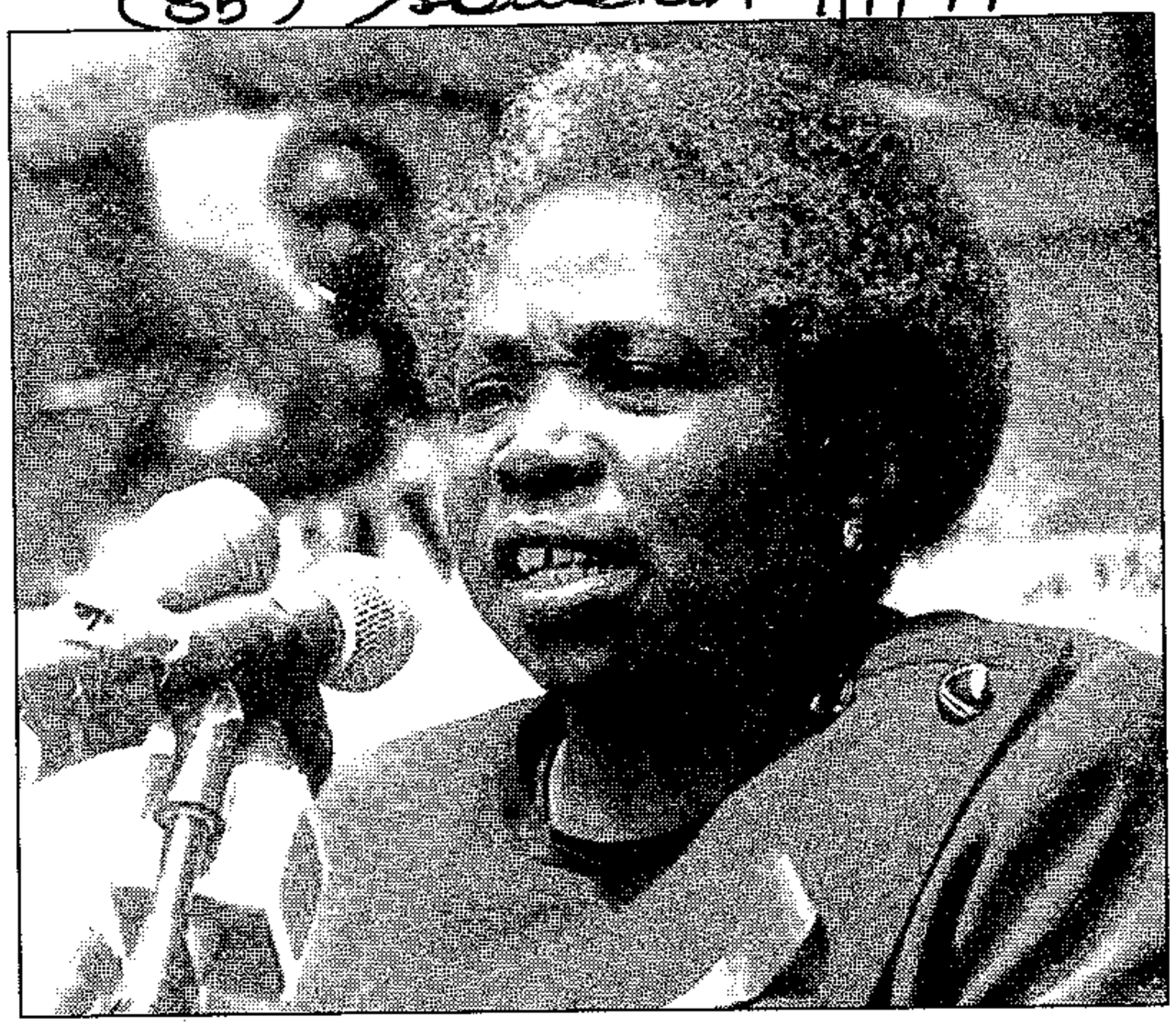
One of the major problems is that health departments seem to make plans without thinking them through. The closing of certain hospitals in Gauteng is a good example.

Other examples are the generic medicine debate, attempts to limit dispensing doctors and plans for community service for newly qualified doctors.

An overview of the proposed health legislation shows that, while it contains a few good concepts, it is fatally flawed in most areas.

It is suggested that Zuma and her advisers first sort out the present problems, face reality and go back to their drawing boards – and make plans that have some prospect of success.

(The writer is an occupational therapist. This article was first published in the latest issue of the SA Institute of Race Relations publication Frontiers of Freedom.*)*



Health Minister Nkosazana Zuma ... her critics feel that the proposed health legislation needs to be taken back to the drawing board.

FRIDAY
JANUARY 10, 1997

PUBLIC COMMENT SOUGHT

Health bill circulated

(85) CT 10/1/97

THE PRESENT Health Act is said to have many flaws and does not address issues the government must tackle head-on. Health Writer **ANEEZ SALIE** reports.

THE long-awaited draft National Health Bill is now being circulated by the Department of Health for comment before it is submitted to Parliament later this year.

Many health workers and activists have criticised the department's delay in involving interest groups in formulating and finalising legislation.

Mr Nogolide Nojozi, of the department's health promotion and communication section, said the present Health Act had many flaws and did not address the pertinent issues the government had to tackle head-on.

"It therefore becomes critically important that the department should start developing the Health Bill aimed at creating a legal framework for the implementation of the policies that define the roles and functions of various spheres of government," he said.

The National Party has slammed the proposed legislation as not being in the interests of patients, and predicted it will destroy the health service.

Its health spokesman, Dr Willie Odendaal, has said his party will try everything to get Health Minister Dr Nkosazana Zuma to abandon the provisions in the bill.

In response, Nojoli said: "We fully appreciate that any discussion document should be the subject of vigorous debates and discussions. We would like to commend the National Party for stimulating a debate around certain aspects of the draft bill.

"We, however, urge the National Party and other stakeholders to make a meaningful contribution in developing a National Health Bill."

National Education, Health and Allied Workers Union (Nehawu) spokesman Mr Jeremiah Sithole has hit out at the NP for its criticism of the bill.

He feared it could be the start of a prolonged attack not only on the bill but on the restructuring of apartheid health services.

The Department of Health has produced a number of policy documents over the past two years, including Towards a National Health System in South Africa, the National Drug Policy, the Restructuring of the National Health System for Universal Primary Health Care, and the District Health System.

Rethink urged on Gauteng health plan

Implementation of Gauteng's health plan has been delayed for a further three months. Medical experts hope aspects will be reviewed, writes Kathryn Strachan

(85) BD 14/1/97

WHILE Gauteng is planning to close hospitals and make massive staff cuts because of a slashed budget, the question has to be asked as to whether all the best options for restructuring health services have been considered.

Implementation of the province's health plan was last week delayed for three months, and many are hoping that this period of grace could see new ideas coming to the fore.

Wits Centre for Health Policy researcher Alex van den Heever says the Gauteng health department should cut its budget for hospital services only if the savings are to be used to expand health services elsewhere, either within the province, or in provinces with poor health services.

Yet, with the introduction of fiscal federalism in the 1997/98 financial year, provinces will get a lump sum for all sectors within their borders. Consequently, cutting a health department budget in one province will not be linked to an increase elsewhere, and therefore will result in a net reduction in overall public health expenditure, he says.

A decision to cut services in one province should be made only within the context of a national plan, says Van den Heever. And there is no national plan.

This means Gauteng is following a senseless order to cut health spending which is totally unconnected to national health priorities. The public sector provides services primarily to the most marginalised communities in the country. Net reductions in the service as a whole marginalise these groups further, he says.

"I would definitely question the validity of any claim that the public health system is unaffordable at current levels of expenditure," he says.

What is needed for health is a national plan which ensures that when spending on health services in one province goes down, it goes up somewhere else. When the new financing system is introduced next year, each province will make its own decision as to how much of its annual allocation from the central national budget it will allocate to health.

Provinces do not have to make any commitment to safeguard a set minimum amount for health, and Van den Heever's prediction is that when provinces are faced with budget pressures, health services will be the first to be affected.

Education is a national priority so it cannot be cut, welfare expenditure is based on entitlements, and budgets for other sectors are too small to make a difference.

The crudeness of current budgeting procedures, says Van den Heever, means health will inevitably be the first to feel the pinch.

"No one in Gauteng appears to be questioning whether the proposed financial cuts are feasible, fair or realistic," he says.

This view is echoed by Wits medical school dean Max Price. Gauteng should not, he says, be making drastic spending cuts when they may turn out to be unnecessary once a new provincial allocation, based on the results of the national census, is set out.

Where the medical school deans and the Gauteng health department go different ways is over the approach to coming in line with the budget.

While the health department looks towards reducing spending as the way to balance the budget, the deans of Gauteng's three medical schools say that there are more innovative and creative ways of meeting budget requirements through raising revenue.

Price suggests that instead of cutting spending, hospitals should be allowed to generate their own funds by allowing limited private practice, and by attracting and billing private patients on medical aid. As an incentive to cost-consciousness, each hospital should be allowed to keep what it has saved, rather than being forced to return savings to central coffers.

However, these proposals depend on giving hospital superintendents greater autonomy. While such suggestions have been put forward countless times over the past few years, government has not appeared to have moved any closer to giving superintendents managerial autonomy.

This autonomy would allow greater efficiency through simple interventions, such as allowing hospitals to contract out laundry and maintenance services, which would in the end generate substantial savings, says Price.

Running a hospital with a R100m annual budget requires a manager with considerable expertise, and the R125 000 a year annual salary currently offered to hospital superintendents is hardly the kind of salary that attracts top-level managers, he says.

"There are alternatives to budget cuts, but these require restructuring management systems," he says.

The plan will also have an effect on academic training. GaRankuwa teaching hospital attached to Medunsa will have a third of its specialist posts cut — thereby taking the hospital below the critical level needed for teaching.

The deans believe that as Gauteng's medical schools train half the doctors in SA, they should be treated as a national resource and not fall victim to the decisions of a single provincial legislature.

Constitutionally, provinces are not meant to be responsible for tertiary education, so they have no obligation to protect academic complexes. Thus, when cuts have to be made, academic complexes will be the first target.

The Gauteng health department responds to the criticism of its strategy by saying that its plan is less about meeting a budget than it is about changing the direction of its health services.

It says that, regardless of the need to cut spending, the department needs to create a more efficient, streamlined health service that places greater emphasis on providing services in previously neglected areas and on strengthening primary health care.

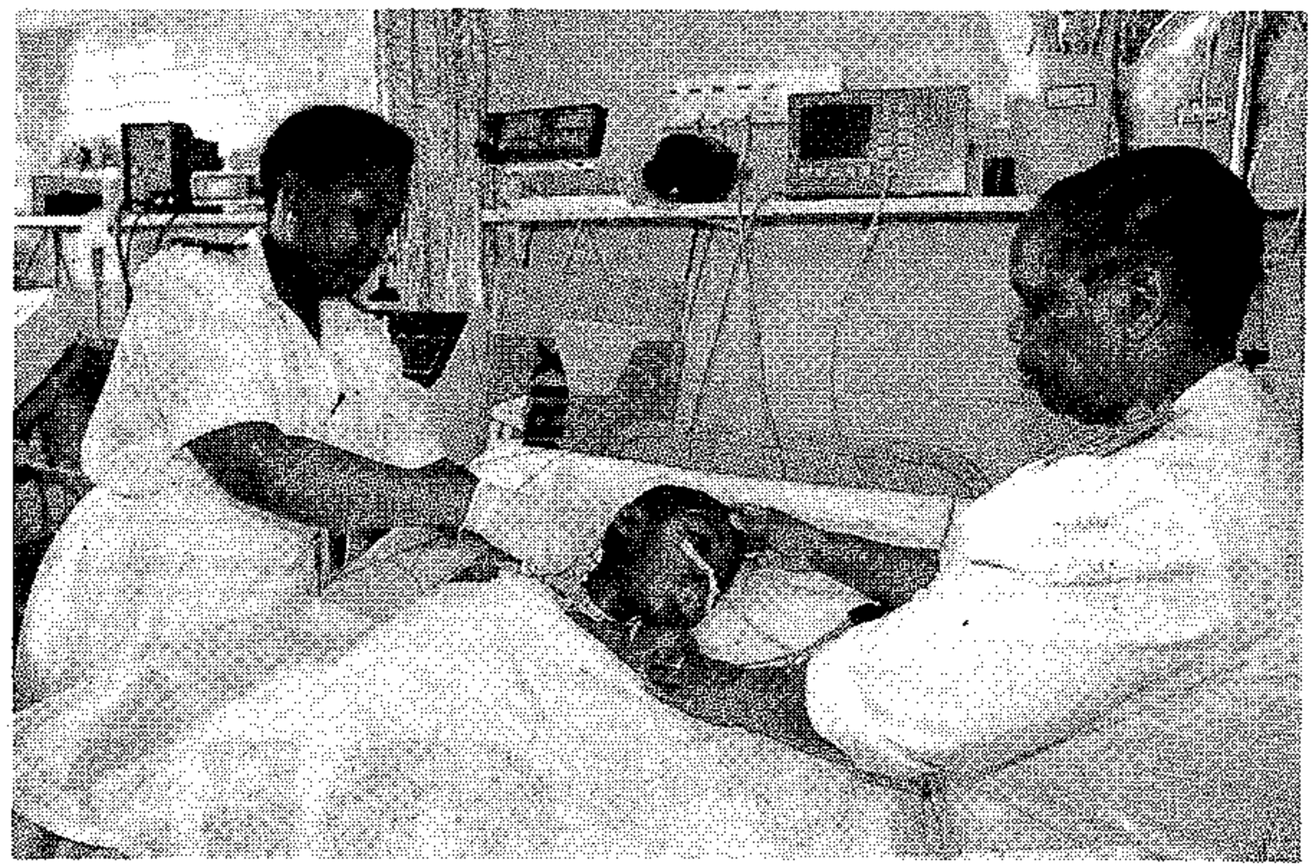
The deans say the plan is nevertheless a threat to services, and point to the case of the 700-bed Hillbrow Hospital which, while it sees 10 000 patients a month, is due to be downscaled to a community clinic.

Again, the department responds that the debate over Hillbrow Hospital has been going on for many years. Having two major hospitals side by side was an impossible situation, it says, and the proposed transformation was not only precipitated by budget cuts.

On the issue of whether the department put up enough of a fight, the department responds: how do the critics know what was said in provincial cabinet meetings?

Gauteng health MEC Amos Masondo defends the provincial health plan, saying that by redeploying staff and resources in hospitals and health centres where they are most needed, the plan aims to improve the quality of services and achieve budget cuts.

While the department aims to streamline facilities and to distribute provincial health services more equitably, this efficiency comes at a high cost: the retrenchment of 118 doctors, and 2 300 cleaners, the closure of three hospitals, and downgrading of seven hospitals into health centres.



Gauteng's health department says spending cuts will balance the budget but medical school deans say there are more innovative ways to meet budget requirements.

Call for input on crucial health bill

(85)

Star 15/1/97

National Party say legislation would have disastrous effect on quality of services

By Janine Simon
Medical Correspondent

The Department of Health has called on "stakeholders" to help develop the new National Health Bill, after vigorous National Party criticism of the draft bill, which was circulated for comment in November.

The bill is seen as crucial enabling legislation for the department's new health system, but was delayed by nine internal revisions before it was released for comment.

"The draft is a discussion paper on the legal framework needed to implement the White Paper on Health," health promotion and communication director Dr Gonda Perez said yesterday.

The white paper, which is now before the Cabinet, was based on discussion around the document "Towards a National Health System" which was released in 1995, she said.

National Party spokesman on health Dr Willem Odendaal said last week the proposed bill would have a disastrous effect on the quality of existing health services.

Health Minister Dr Nkosazana Zuma had the "bizarre distinction" of being the only ANC minister who had tried to launch a fundamental piece of legislation without having produced an official policy document, he said.

The proposed bill focused on introducing measures that would ensure drastic government control over the provision of health services, with a subsequent drop in quality to the level which the exchequer could afford, Odendaal said.

The draft bill allows for the establishment of a national health authority (NHA), comprising the minister, MECs and local government representatives, to determine policy for the promotion of health.

Along with tasks such as co-ordinating health services and human-resource management, the draft allows the NHA to design programmes to integrate public and private health establishments, and set norms to implement a distribution programme for health-care providers.

The NHA is supported by a national health advisory council, comprising national directors-general and provincial heads, whose task is to investigate health matters and co-ordinate policy implementation.

The council also forms part of a national health consultative forum, to review and report to the NHA on any matter relating to health.

Odendaal labelled these bodies "a Gestapo-like network" to which the minister could delegate responsibility, and which would allow her to remain inaccessible to role-players such as the medical and nursing professions.

Dr Anette van der Merwe, executive director of the National Hospital Association, also expressed reservation about the sweeping powers granted to the minister, but said: "There are also some very good things in the bill."

The return date for comment is January 31.

Medical association rejects new health care contracts

(85) BD 22/1/97

Kathryn Strachan

THE SA Medical and Dental Practitioners' Association, which represents 3 000 doctors, has rejected contracts offered by Sanlam Health and Southern Healthcare to participate in their new managed health care initiatives.

The association said yesterday that while it supported the principle of managed health care, it was opposed to the way in which the two companies were attempting to impose the contracts on doctors, rather than negotiating them.

The larger Medical Association of SA has left the decision of whether to accept the contracts up to its individual members.

The new concept of managed health care aims to contain spiralling medical costs in the private sector by contracting private clinics and doctors directly to a medical aid scheme. Members of the scheme would be able to go only to those facilities which have been contracted. This would give the medical aid administrator control over health spending and allocate to doctors a set group of patients.

Association spokesman Dr Norman Mabasa said the main objection was against a clause stating that doctors had to have authorisation from the managing company before they could admit a patient to hospital, and that patients had to pay an up-front fee to the doctor as a disincentive to going to a doctor unnecessarily.

Talks begin on budgeting for specialised health care

(85) Star 23/1/97

By Janine Simon

The Department of Health has started "early and exploratory" talks with provinces on central budgeting for unique specialised medical services such as transplant and heart surgery.

Although this could improve the finances of hard-pressed academic hospitals, there is no time-frame on the talks and they are unlikely to yield benefits in the 1997-8 financial year, according to Dr Tim Wilson, chief director academic health centres and hospital development.

Under discussion are hospitals which deal with many patients from other provinces. The difficulty, said Wilson, is working out how to budget rationally for patients who, for example, move provinces to be near a unique service, or who are treated while on holiday, or who travel for their treatment.

"It's a question of from where the funding should come," said Wilson, adding that top-slice funding from the national budget was just one option.

"It's more rational to fund specialised services than to have a tertiary hospital competing with primary-care clinics for funds," he said.

Gauteng head of health Dr Ralph Mgijima said a list of proposals had been circulated for discussion. One of the problems was that there was no consensus on which services were tertiary, and which qualified as unique "national asset" services, he said.

The proposal did not do away with the principle that provinces such as Gauteng had the right to charge other provinces for patients who came here to seek any level of treatment, Mgijima said.

Although the department has previously taken a stand on specialised services – Minister Nkosazana Zuma ruled in 1995 that Groote Schuur would be the country's only state heart transplant facility – this appears to be the first sign that the call for unique centres of excellence to be funded from a national pot is being heeded.

It comes just weeks before the introduction of the 1997-8 budgeting system for health, whereby provincial health departments will be allocated funds from the provincial budget rather than receiving a slice of the national department's budget.

Provinces to draft health laws

BD 27/1/97 (85)

Kathryn Strachan

NEARLY three years after the new provinces came into existence, they have only now been given the go-ahead to draw up health legislation, and it is expected to take another year before the previous health laws governing the provinces are harmonised.

Without clarity from national level, provinces have been reluctant to amend and rewrite provincial health legislation. Thus, the health services of all the provinces continue to be governed by the previous laws of the former four provinces and homelands. In some provinces conflicting statutes exist, making the situation unworkable.

But with the process of setting up an overall legislative framework for health finally under way at national level, provinces can now begin their own initiatives to draw up enabling legislation.

Enabling national legislation is due in the course of the year. Although it will probably be early next year before provincial health legislation is passed to harmonise previous health laws, some provinces have already begun taking steps towards creating new legislation.

The Free State health department has drafted a bill to restructure its hospital services and rationalise hospital management and staff. It sets out policies governing the admission and discharge of patients and the establishment of hospital boards. Finally, it establishes the province's authority to oversee private hospitals. This draft bill draws many of its recommendations from the findings of a national hospital strategy project that is advising the health department on the transformation of hospital services and management.

The North West has drafted a bill which will establish community governance structures for the health and welfare system at the district level. The draft bill gives MECs wide-ranging powers to establish community and district health committees and hospital boards.

Analysts also believe that the legislative process and health care reform will be significantly strengthened by the constitution.

Rights pertaining to health and development contained in the interim constitution were expanded considerably in the final constitution. The limited right to an environment that is not harmful to a person's health and well-being was retained. In addition, the state is required to take reasonable legislative and other measures to protect the environment.

This change from a negative right to a positive right should greatly alter its scope. Rather than the burden of proof resting solely with an individual to prove that the environment is detrimental to their health, the state must now show that it is taking "reasonable legislative and other measures" to protect the environment.

Beyond broadening the scope of environmental rights, specific health care rights have also been included. Again this places the burden on government to take measures to provide health care services, food, water and social security. Finally, no one may be refused emergency treatment.

Beyond health rights, a whole series of related rights should provide an enabling framework for improving the health of the population.

Finding the right medicine for SA

(85) Star 31/1/97

The much-criticised draft health bill has had a long evolution and more input is still being awaited

Making a good start ... current draft legislation is designed to serve all peop

By David Robbins
Health Writer

The draft National Health Bill (in fact, it's the 9th draft) seems to be causing a bit of consternation. Certain people are voicing indignant objections. Some of the criticism is aimed at the content of the bill, other criticisms appear to be more bound up with the way in which the bill has been developed.

But how valid are these criticisms?

Does the bill discriminate against the private sector, as is claimed? Does it threaten the quality of health care? Does it concentrate too much power at the centre when it comes to the governance of health? Or does it allow this governance to depend on too complicated a network of governing bodies? And has the delivery of the bill on an unsuspecting public been high-handed, unsupported by an official policy document?

Of course, such questions are impossible to answer unless some basic facts are known about the bill itself, and also about the context within which it has evolved.

I asked Dr Yogan Pillay of the Department of Health to describe the new National Health Bill. Pillay is the director of "systems development, legislation and policy co-ordination", which means he's been overseeing the development of the bill by representatives of the national department and all nine provincial health departments.

"It's designed to put the legislative framework for our national health policy in place. The detail will be supplied either via sets of regulations promulgated by the minister or via area-specific provincial legislation," he said.

To get an inkling of the intent of the bill, therefore, it's necessary to take a look once again at "our national health policy" and how this has evolved.

Remember the bad old days of apartheid health, when our curative-based system was not only racially fragmented but concentrated in hospitals in town? During the early years of the 1990s, a new policy was developed via meetings and conferences throughout the country. This was finally published in 1993 as the ANC health policy document.

Here was the blueprint for the policy changes which were deemed necessary. The principle of primary health care, with its emphasis on preventive and promotive care and of greater community participation in health care governance (via district models) were established. The idea of a single national health service (NHS) which integrated public and private sector resources was also outlined.

This blueprint found its way into national policy when minister Nkosazana Zuma established the first post-apartheid health ministry after April 1994.

Zuma established 12 ministerial committees to report on various aspects of the total health-care package. The brief for each committee was to establish ways of making services more efficient and effective, and also more equitable and accessible for all users, black or white, urban or rural.

The following year (1995) was devoted to combining the recommendations of the 12 committees into a composite policy document. There was a bit of a fuss early in 1995 over some of the recommendations (or reported recommendations) relating to the financing of an NHS.

Remember the Deeble controversy, and the subsequent establishment of the Shisana-Broomberg committee to further examine the various financing options?

When the dust had settled, a composite document was finally put together and a protracted period of consultation followed. Senior health officials toured the country, holding meetings. Written submissions were also invited. After this, the document was completely revised and published under the title *Towards the National Health System.*

Comments were again invited, the document was once more revised, and finally, towards the end of 1996, prepared for submission to the Cabinet in the form of a white paper on health policy.

At the same time, draft legislation (the new National Health Bill) was prepared and released in November 1996 at the National Health Consultative Forum. Present at the meeting were the professional associations (for doctors, nurses, etc), statutory bodies concerned with regulating various aspects of health (for example, the SA Medical and Dental Council), and non-governmental organisations involved in health care.

"The bill is very much in draft form," says Pillay. "Naturally, the process is dependent on the Cabinet response to the white paper. But once this response has been received, the bill will be revised and gazetted (hopefully by the end of March) when it'll once again be open to public scrutiny and comment, and to normal parliamentary procedures."

All this sounds reasonable enough, but what does the National Health Bill contain? To gain an overall picture, one needs to go back to the policy intentions originally outlined in the ANC health

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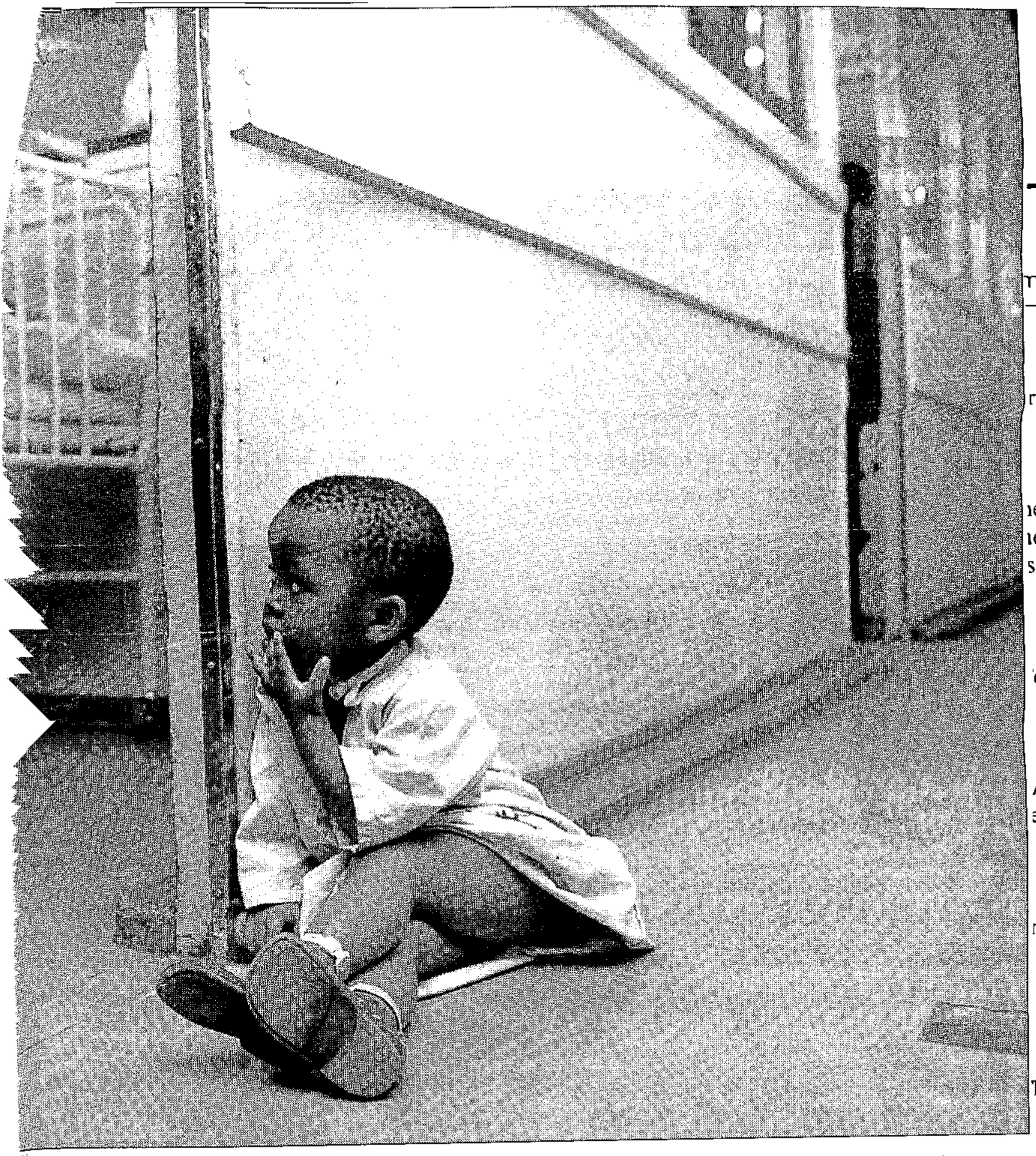

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14 chapters tell whole story

What the draft National Health Bill contains:

Chapter 1: Fundamental provision. This chapter deals with the intent of establishing a single NHS with inputs from the public and private sectors, and NGOs.

Chapter 2: The rights and duties of service users and providers.

Chapter 3: National and provincial structures. This chapter outlines a structure comprising a National Health Authority of elected politicians supported by another advisory council of civil servants and health experts. And beneath the national level, there are a further nine provincial authorities and councils.

Chapter 4: District health. Demarcation of districts and establishing District Health Authorities is outlined in this chapter.

Chapter 5: Health establishments. Hospitals, clinics and other medical institutions. Criteria for their classification and registration are laid down, as are the rules for starting new facilities through a "certificate of need".

Chapter 6: Human resources. The training, accreditation and distribution of the various categories of health workers

Chapter 7: Public health programmes and services. This chapter lists and outlines the functions of all major programmes and services which need to be enshrined in law rather than left to the discretion of health authorities. They include: health promotion, emergency services, mental health, maternal and child health and nutrition, rehabilitative services, care for the elderly, substance abuse, communicable diseases.

Chapter 8: Control and use of tissue and organs in humans.

Chapter 9: National centre for occupational health.

Chapter 10: Research and epidemiological surveillance.

Chapter 11: Laboratory services.

Chapter 12: Health officers, offences and penalties.

Chapter 13: Regulations. The procedures to be followed for the promulgation of ministerial regulations in areas such as: fees for health services, codes of conduct for service providers, job descriptions, norms and standards, essential drugs lists and procedures for buying hi-tech equipment.

Chapter 14: General provisions.

What is not found in the bill is any mention of the financing of the NHS. This is outside the scope of the proposed legislation, and is currently under discussion with the finance department. It's no secret, however, that health officials still favour some form of compulsory hospital insurance for formally employed people not currently covered by the medical schemes. This insurance would make it possible for state hospitals to charge far more realistic fees than at present.

State to recognise role of traditional medicine

Research unit to help bridge gap

ARG 8/2/97 (@) # (85)

ADELE BALETA
STAFF REPORTER

Government recognition for traditional healers as legitimate health practitioners in South Africa will be the subject of public hearings countrywide early this year.

And in another move towards greater acceptance of the role of traditional healers, a research unit to investigate traditional medicines and to help bridge the gap between traditional healers and Western medical practitioners has been established in collaboration with the universities of Cape Town and the Western Cape and the Medical Research Council.

According to the Department of Health, at least 80 percent of black South Africans consult traditional healers.

At a recent meeting convened by the National Assembly and the former Senate portfolio committees on health it was decided that recognition, registration, medical certification and insurance for traditional healers would be top of the agenda at the hearings to be held by the Provincial Legislature's Standing Committee on Health.

National Assembly Health Committee chairman Abe Nkomo said it would be important to have hearings at a provincial level to make sure all interested parties were included.

There are 350 000 traditional practitioners compared with 300 000 Western trained health professionals in the country, according to the Health Department. But until now traditional healers, who have been campaigning for recognition for years, have largely been dismissed as 'witchdoctors', a label many shun, and their practice regarded as 'witchcraft'.

'Traditional healers have been largely dismissed as witchdoctors'

Among key issues expected to be ironed out for future policy on traditional healers are the definitions of a traditional practitioner, how he or she practices and what benefits can be expected.

There is growing acknowledgment that traditional healers are not an homogeneous group, and the provincial committees appointed to hold hearings would be required to consult with healers so as to avoid misrepresentation.

The research unit to investigate traditional medicines will be overseen by UCT pharmacology professor Peter Folb and UWC School of pharmacy professor Peter Eagles.

The group plans to create a database of traditional medicines for east and southern African traditional healers, primary health care workers, the pharmaceutical industry and the public.

Laboratory screening systems would be devised to test medicines used to combat malaria and tuberculosis in particular. Medicinal plant extracts would be investigated.

The researchers have already produced a health care handbook dealing with diseases often seen by traditional healers.

Professor Folb said that the research unit did not pretend to offer political solutions involving the role of traditional healers, but would hopefully "stimulate and inform" policy making on their future role in South Africa.

But he said this did not mean that all traditional healers were ethical practitioners. "It is well nigh impossible to separate the genuine traditional practitioner from the charlatan and consequently, to separate genuine traditional remedies from fake ones."

ROY WIGLEY

A second opinion: Medical Research Council president Dr Walter Prozesky collaborates with sangomas Jim Nbira, sitting, from the Transkei, Western Cape Traditional Doctors and Herbalists Association president Philip Kubukeli and Constance Zwane from Ladysmith

Medical aids can help legitimate healers gain recognition

(~~249~~) (85) AR 8/2/97

ADELE BALETA
STAFF REPORTER

Eskom Medical Aid recognises traditional healers and with moves by the Government to accredit traditional healers, more medical aids may be faced with demands by members to pay their sangoma's or inyanga's bills.

Manager of Eskom Medical Aid Wilma Jankowitz said she believed Eskom was the first parastatal which had an arrangement with members whereby each employee would be given a R50 voucher a month which could also be used by members of the family to consult traditional healers.

The scheme was in place from the beginning of the year in response to members' requests.

The size of trade in herbal remedies is estimated at more than a R1-billion a year with about 350 000 practicing traditional healers in South Africa.

Representative Association of Medical Schemes (Rams) policy director Aslam Dasoo said they were likely to recommend to their members that they pay for traditional healers' bills.

"We are formulating policy in consultation with stakeholders, including the Government, on the question of traditional healers which will be circulated as a recommendation to our 180 member schemes," said Dr Dasoo.

At present, individual medical aids applied their own rules in terms of remuneration.

He said: "Schemes take their queue from various professions. If the Interim Medical and Dental Council recognised a profession as a bona fide health discipline, then medical aid schemes were likely to follow suit."

The scheme would then negotiate with the discipline – traditional healer – a scale of benefits for remuneration. "It is up to the scheme to decide if it will go into negotiations."

Remuneration is dependent on the ability of the profession to organise itself and to engage Rams or the medical aid schemes directly in negotiations around a scale of benefits.

This can proceed only if the requisite registration has been obtained from the registering body which is likely to be the Interim Medical and Dental Council.

A spokesman for the Chamber of Mines Medical Aid Society (Comass), Sister K Bekker, said: "At this point, our rules for belonging to the medical aid depend on whether a traditional healer is registered with the Registrar of Medical Aids".

She confirmed Comass would honour any claim for service rendered by a service provider who was registered with RAMS and who had a practice number.

Quality health care framework mooted

(85) BD 26/2/97

Pearl Sebolao

TO IMPROVE the quality of health care in SA, the capacity of the health department needed to be strengthened and an official quality framework established to guide the department and care providers, the UK's King's Fund fellow Fitzroy Ambursely said.

At the International Federation of Health Funds conference in Johannesburg yesterday, Ambursely said a study commissioned by the health department last year to assess quality care found that quality was not a priority for provinces. "The provinces were snowed under and had no time to look at quality properly," he said. The health department should "drive the process" of providing quality health care.

There were also mixed views on who should be responsible for ensuring that patients received quality care, he said.

The national department had an important role. It had to facilitate the process of delivering quality care by providing support to the provinces and working with relevant stakeholders to achieve a workable solution to problems.

There was also a need to develop the patient and consumer voice, through supporting non-governmental organisations and improving patient satisfaction techniques and methodology.

A successful health system depended on knowing what the customers or patients wanted from it.

This was echoed by the UK's PPP Health Care Group CE Peter Owen who argued that everybody needed to be involved in the "virtual cycle of quality".

"To drive down costs and improve quality you need to start from the perspective of the customer and know how they define quality and success," Owen said. There was also a need for standards which would facilitate a partnership between the public and the private sector.

Big role for SA's private health sector

(85)

Star 27/2/97

Conference warns that new system needs careful regulation

By Janine Simon
Medical Correspondent

This week's international conference on private sector health-care reform warned that managed care may not prove the universal panacea it has been labelled, and that managed care needs regulation.

But it also made clear that the private sector had the opportunity to help mould the country's future health system.

Now on the cusp of regulatory change – in the form of proposed changes to the Medical Schemes Act – SA's R20-billion private medical industry used the conference to learn from the experiences of private funders in the US, UK, Canada, Australia, New Zealand and the Netherlands.

The industry had a unique opportunity to carve out a significant new role in health care because of its experience of the local milieu and use of international expertise, Representative Association of Medical Schemes chairman Keith Hollis said.

The sector was being called on to provide lifelong affordable cover to members and to relieve the state from the burden of caring for people who are employed but have no medical cover. Managed care (MC) is seen as being a key tool for savings, and the industry has invested about R2-billion in MC systems, infrastructure and expertise over the past three years, he said.

But implementation appears to have met with patchy success.

First-generation MC interventions tried to contain spiralling drug costs but had limited success because the fee-for-service structure remained intact.

Medical professionals had also resisted the trend to discount prices by drawing up contracts between buyers and suppliers of health, in the form of preferred provider networks of hospitals, general practitioners and pharmacists.

This had forced organisations to review their stances, at least on

Industry can learn from other experiences

pharmacies and hospitals, and "the battle lines between suppliers and buyers had been drawn", Hollis said.

Attempts to introduce advanced MC concepts had also been resisted.

In addition, said Council of Medical Schemes chairman Mr Justice D A Melamet, this growth of MC within medical aids had not had adequate supervision.

This aggravated the difficulties of the registrar of medical schemes, who had a staff of seven to regulate 172 schemes and was already hindered by the shortcomings of the act and the advent of insurance-based health packages, he said.

Discussions were needed to determine, for example, access to emergency treatment and specialist care, standards by which decisions to approve and deny care were made, access and quality of case information, and grievance and complaints procedures for enrollees, Judge Melamet said.

In the US – from where much of the local expertise is imported – MC had made enormous inroads and disruptions, and caused a profound consumer backlash, a deep suspicion of medical services and a flurry of legislation to address the problems of under- and non-coverage, according to Dr David Lawrence, chairman of Kaiser Permanent, the US's largest non-profit health care funder.

Full benefits would be felt only if there were totally integrated care and productive partnerships between all parties, he said.

But SA's private sector had a one-off opportunity to help manage the public thrust in terms of primary health care, said Dr Clive Ashenden, MD of the Medical Benefits Fund of Australia.

What stood in the path was – as in Australia, – in-fighting between doctors, funders and hospitals, and the fact that it was difficult to get the public and private sectors to recognise that managing the interface between the two systems was critical to management of the total system.

ANALYSIS

Sound health care is possible only with sound financing

(85) BD 24/2/97

The fundamental flaws in proposed legislation on health insurance will set SA back many decades, writes **Adrian Gore**

GOVERNMENT's proposed legislation on health insurance, unveiled in December and now open for public discussion, is fundamentally flawed. If implemented, it will take SA back many decades.

It contains elements of the worst-run health care systems in the world, ignores the large body of evidence from the best-run systems and is in conflict with the most elementary economic principles.

One cannot but totally support what government is trying to achieve — affordable health care for all South Africans. However, one has to disagree with the way in which government is going about it. The proposed legislation will, in fact, achieve exactly the opposite of what it intends.

Proposed legislation is based largely on social solidarity. Key features include:

- Members would pay a contribution to medical schemes dependent only on income and number of dependants — a return to a pure community rating system;
- Medical schemes may not exclude any individual on the basis of their health risk — there must be guaranteed acceptance;
- The belief that individuals have no real role to play in containing health care costs, and that the responsibility should lie with third parties;
- No competition from medical schemes run along different lines; and
- An emphasis on pay-as-you-go rather than pre-funding.

The proposed legislation is flawed because it is based on a number of common misconceptions:

Community rating and guaranteed acceptance maximise accessibility and affordability:

Reality: In a community-rated environment, the combination of a flat contribution irrespective of one's health risk and the fact that one cannot be turned away encourages the young and healthy not to join, or simply to opt out. Therefore, on average, the people covered tend to be the old and sick.

To compensate for this, medical schemes must increase the community rates they charge, putting pressure on the young and healthy still in the scheme to opt out. Contributions for those who remain therefore go up again, causing an upward price spiral. In other words, a small contribution paid by a large group of people degenerates into an ever larger contribution paid by an ever smaller group of people. Accessibility and affordability are therefore minimised. An extensive body of evidence from the US and other countries proves this conclusively.

Community rating and guaranteed acceptance will ensure cradle-to-grave cover for all.

Reality: Because a community rating environment is inherently unstable (the young and healthy opt out), it can achieve cradle-to-grave cover only through a number of artificial devices.

These might include compulsory participation (to keep people in the system), a legislatively enforced monopoly situation (to keep people from migrating to "better" competitor medical schemes) and some form of equalisation fund (to address the imbalance in the quality of different risk pools).

These devices are clearly untenable in a private health care environment like that in SA.

The principles of insurance are inherently prejudicial to the old and sick because they imply basing contributions on age and sex.

Reality: Quite the opposite: the fundamental premise of insurance — pooling risks to guard against unpredictable occurrences — provides value for money for the young and healthy. It therefore attracts them into the system and, more importantly, keeps them there — an important requirement of a sustainable health care environment. It provides also predictable costs for the old and so enables prefunding mechanisms to be put in place to ensure that health care is kept affordable in advanced age.

People are not capable of taking care of their health care financing and should not be empowered to do so — for example, through the use of medical savings accounts.

Reality: A large body of evidence — from Singapore and SA to the US — proves conclusively that people who have direct control over health care funding spend about 30% less with no adverse effect on their health.

Recognising this, the US finally passed legislation last year to allow medical savings accounts.

Health insurance run on a not-for-profit basis minimises costs and maximises quality.

Reality: The best way to minimise costs is to reward health care financiers for achieving it, and that means a for-profit system.

No profit means no shareholders, and no shareholders means no capital. The results are an inability to fund major projects, such as managed care, and a lack of capital to provide financial security. As for quality, the market always acts as an arbiter of those plans that provide superior or inferior care.

Health care should be about social solidarity.

Reality: Health care should be about sound financial principles. Ignoring them reduces the availability of health care treatment (through waiting lists), raises the costs (through higher taxes and/or higher contributions) and, consequently, compromises quality.

Worldwide, health care systems based on social solidarity, be they private or state-run, are deep in debt and unable to meet their customers' needs timeously and cost-effectively.

Adrian Gore is the CEO of Momentum Health.

Health care should be about sound financial principles, not social solidarity.

Cape Town needs huge bed boost for Olympics

CT 13/3/97 (85)

DAN SIMON
TOURISM WRITER

CAPE TOWN will need about 235 000 beds for the huge influx of visitors if the city hosts the 2004 Summer Olympic Games.

This figure excludes the needs of an estimated 10 000 athletes, 5 000 officials and 15 000 members of the media, who will be accommodated in special villages.

Because of the limited number of beds in hotels, guest houses and bed and breakfast establishments, additional accommodation will be provided on cruise ships, at the residences of educational institutions and in private homes.

A report compiled for the 2004 Olympic Bid Company by consultants Kessel Feinstein Consulting, in collaboration with the Cape Town City Council, estimates that if tourism to Cape Town continues to grow at its current pace, the city will have to provide accommodation for about 3,4 million visitors by the year 2000 and a possible 9,3m visitors in 2010.

The report, Cape Town Accommodation Requirements for the 2004 Olympic Games, notes that the city has a significant supply of tourist accommodation and that this supply was "growing at an unprecedented rate".

However, this phenomenon was "unrelated" to the prospect of hosting the Olympics.

It notes that there are currently 188 graded hotels in Greater Cape Town with a total of 9 200 rooms and that this number is to increase by 14 or 15 more hotels over the next two years.

But in keeping with trends in the hospitality industry elsewhere in the world, various forms of tourist accommodation, such as bed and breakfast establishments, guesthouses, cottages, bungalows, holiday flats and youth hostels have proliferated recently.

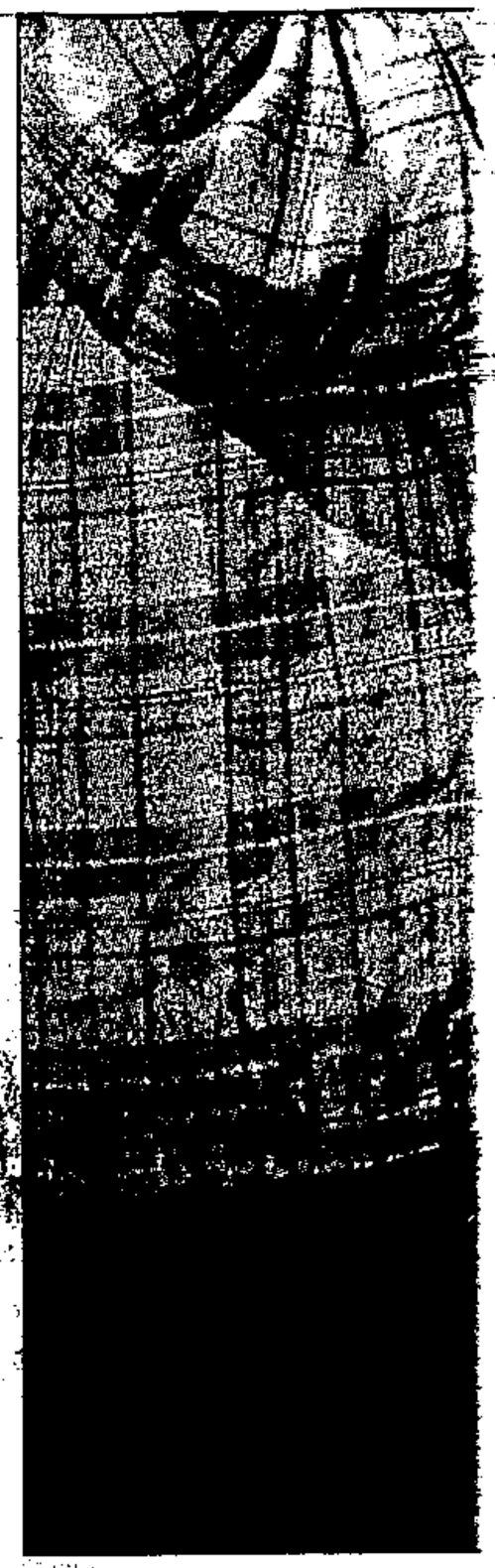
There are 1 182 such establishments in the Greater Cape Town area.

The consultants say there will be 26 000-34 000 rooms available in Greater Cape Town in 2004, and that other forms of accommodation could be made available for the influx of visitors.

This includes chartering luxury cruise liners to be berthed in Cape Town and Simon's Town harbours.

Educational institutions, such as the city's three universities, its technikons and schools have about 20 000 beds between them. This number is expected to increase to at least 25 000 by the year 2004.

There are also plans for foreign visitors to stay with local residents by way of a home-stay programme, a host programme and a friends and relatives programme.



DISPLAYING PAYING: Inform motorists appreciate the help

Medics argue merits of 'racial' data

PETER DENNEHY

DEBATE is raging in the medical fraternity over whether or not South African health statistics should be racially desegregated.

Arguments for and against are featured in the letter pages of the latest SA Medical Journal.

Five doctors — A R P Walker of Wits, F Sitas of the SA Institute for Medical Research, P E Cleaton-Jones of the Medical Research Council, H H Vorster of Potchestroom University and D E Whittaker of UCT — argue jointly for retaining racial categories for research purposes, which they say is internationally acceptable.

They say desegregated data in South Africa is often meaningless when compared with earlier work, which was reported in terms of racial categories.

For example, from 1978 to 1989, the mortality rate from coronary heart disease in the white population fell by 56%, while the rates for the Indian and coloured populations each fell by 36%. Doctors wanted to update the information, but this is no longer possible.

Both the Central Statistical Services and the public health departments in large cities have excluded ethnic sub-divisions from their mortality statistics.

Their information is therefore "no longer meaningfully citable in research publications".

Abandoning race-based statistics will stultify research and "diffuse the identity of ... (those) who are in most need of help".

The doctors who argue against them are G T H Ellison, T De Wet, C B Ijsselmuiden, and L M Richter. They say racial categories are just proxy measures of other phenomena, such as differences in levels of wealth.

"Studies that use racial categories to describe the distribution of different diseases provide little insight into the underlying causes of such disease," they say.

Removing race classification would give us a far better chance of confronting the causes of supposedly racial inequalities in health, the anti-classificationists argue.

CT 13/3/97 (85)

Health has 'little space for expansion'

Kathryn Strachan

HEALTH received a 9,5% increase over its previous budgetary allocation, which left very little space for expanding projects, health economists said yesterday.

Wits centre for health policy researcher Alex van den Heever said the R22,2bn allocation for health was "reasonable". After covering inflation and improvements in public service conditions, the increase would essentially be able only to keep health developments at current levels. The increase would not cover the added pressure of population growth on the public health sector.

The small increase was not necessarily such a problem as provinces needed time to restructure their administrations. However, a strategy which looked at increasing the health sector budget in the long term was critical, he said.

The public sector continued to lose highly qualified and experienced staff, and this issue had to be dealt with urgently.

The National Progressive Primary Healthcare Network, the umbrella body for all nongovernmental organisations in health, criticised many elements of the budget. Director Irwin Friedman described it as "a confidence-building tool for the private sector aimed at rallying support for the free market-orientated growth, employment and redistribution strategy".

While the budget in the short term purported to be supporting redistribution in favour of the poor, the scale of redistribution through community-based public works and other social security mechanisms were insignificant compared to need.

High unemployment and persistent severe poverty were the trade-offs that government was accepting at the cost of laying foundations for an economy that it believed would be sustainable in the long term.

"Inadequate social spending imposes severe social costs in the form of insecurity, crime and illness which arise from conditions of abject poverty. In the longer term, we believe these will erode any gains made by postponing current expenditure on social welfare in favour of private sector investment. A measure of this can be seen in the degree to which commitments to funding the reconstruction and development programme are falling behind schedule," the organisation said.

BD 13/3/97 (85)

Tobacco tax

Finance Minister Trevor Manuel's announcement that tobacco excise taxes would be significantly increased met with resounding approval from the antismoking lobby. The Council Against Smoking said that the increase of 27c for 10 cigarettes would result in about 400 000 fewer smokers and, over time, about 130 000 fewer premature deaths from cancer, heart attacks and lung disease. It would also yield about R620m in new revenue.

"The new tax will make a significant contribution to improving the health of South Africans by discouraging smoking," the council said.

The Cancer Association said price was the single most important determinant of the demand for tobacco products. The experience of other countries showed that raising taxes on tobacco and hence the price, was a very effective means of reducing tobacco consumption, particularly among the youth. Research in Canada and the UK indicated that with a 10% price increase, teenagers cut their spending by between 10% and 14%.

The council said that despite the latest increases the SA smoker still paid less tax on cigarettes than did smokers in other countries. Taxes now made up 50% of the retail price of cigarettes in SA, compared to 86% in Denmark, 76% in the UK, 74% in Brazil and 52% in Kenya.

The Cancer Association said that while the tax proportion of tobacco retail price remained low by international standards, it was a significant increase relative to previous years and represented a commitment on the part of government to use tobacco taxation as part of a sound health policy.

What remained, said the association, was to persuade government to use the additional revenue to fund key health programmes — a measure which has been implemented in several other countries, including Australia, Canada, New Zealand, Peru and Portugal. A recent survey showed substantial support for this proposal in SA.

Health rights charter mooted to give consumers muscle

(98) (87) Star 17/3/97

By Janine Simon
Medical Correspondent

South Africa has no effective, accessible mechanism to address complaints about health services, says Judy Fortuin, spokesman on advocacy for the National Progressive Primary Health Care Network (NPPHCN).

Fortuin said there was a broad perception that medicine was a "closed shop" and there was no redress for consumers.

"Everyone needs to be accountable, from medical aids to traditional healers," she said.

Consumers had several options: they could go to the people in charge of a facility, to the professional bodies, the Public Protectorate, Human Rights Commission, Consumer Court, the ombudsman of the Medical Association of South Africa, or the Constitutional Court.

But, said Fortuin, "we have to make sure the public knows that these mechanisms exist, pressurise the mechanisms for action and evaluate whether they are appropriate".

It was imperative that South Africa's new district health system constructed strong community health committees to protect consumers, she added.

Health commissions in countries like Canada and Australia used field officers to investigate all complaints, and even provided counselling.

The NPPHCN would put forward the concept of a health rights charter in an attempt to create awareness of the need to support consumers of health services, she added

Meanwhile, the Interim Medical and Dental Council of South Africa confirmed that its role was not widely advertised, and that only a fraction of complaints received had qualified for hearings on the grounds of professional misconduct.

An average of 1 400 to 1 500 written complaints were received a year, mostly against private practitioners, said assistant registrar Ronnie Filmalter.

Only 10% of those resulted in the doctors being charged, because investigations showed that the complaints did not warrant disciplinary action.

"This does not mean that the complaint is not valid, but that it does not warrant hauling the doctor up on charges of improper conduct," he said.

The decision to lay charges rests with a six-member committee appointed by the council, and is based on whether there is evidence of disgraceful or improper conduct. Inquiries take 12 to 18 months to finalise.

Govt health care plans 'could make costs soar'

(85) BD 19/3/97

Edward West

GOVERNMENT's draft proposals on private health care financing were likely to result in spiralling costs in the sector rather than maximising medical aid coverage, a group consisting of some of SA's largest private medical schemes said yesterday.

The group — called the Concerned Medical Schemes Group — includes schemes from Chamber of Mines, Anglovaal, Edgars, Gencor, the Rembrandt Group, Wooltru and includes schemes such as Sanlam Health, Old Mutual Staff, Fedsure Health, Momentum Health, Compcare and Caremed.

They were commenting on government's ninth draft proposal on private health care financing. A representative spokesman Adrian Gore, from Momentum Health, said yesterday the group supported governments' aim of extending health care to all.

However, he said key proposals in the draft policy would result in the cost of cover increasing dramatically, a decrease in the number of persons covered and a drop in the number of insurers in the market.

Government's proposals included a requirement that medical aid schemes enrol any person applying to be a member provided the person pays a contribution, and that contributions can be differentiated only on the basis of income and number of dependants.

Gore said the result of creating a voluntary flat community rating system was that healthy, young people would simply withdraw from the system. This damaged the viability of the medical scheme, resulting in higher premiums and reduced benefits.

Government had proposed a flat community premium rating based on scheme plan type, number of dependants, geographic area and income. However, the group had proposed the inclusion of age and sex as criteria as well, to ensure the long-term financial viability of the industry, Gore said.

The group had also suggested creation of a tax incentive to encourage prefunding. Medical schemes were currently drawing tax benefits by the use of provident and pension fund benefits.

Also, imposition of prescribed minimum benefits needed to be defined and debated with the industry, as historically this type of proposal had only resulted in increased costs, said Gore.

The group's proposals would result in a "leakage" of some uninsurable people. Yet these medical costs would represent less than 3% of government's total yearly spending on health care. Artificial devices, managed and funded by the private sector, could be created to cover these costs, said Gore.

Health department paid R30m in unauthorised consulting fes

BD 27/3/97 (85)

CAPE TOWN — The health department paid R30m in unauthorised fees to consultants for a "fast-track" clinic building plan in 1995/96, the auditor-general's report for the fiscal year said.

It noted that the final figure could be even higher and that the department, which came under the spotlight for its R10,5m funding of the AIDS play, Sarafina 2, had not replied to a request for further details.

In addition the health department had paid R13,2m to 1 779 consultants to audit the health facilities funded from RDP monies without complying with the correct tender procedures. Total unauthorised expenditure by the department amounted to R58m.

It was noted in the report that government departments had paid R51m in unauthorised expenditure to consultants in the 1995/96 fiscal year, with the health department claiming R43m of this amount.

Total unauthorised expenditure by all departments for the year was R151,5m, most of it relating to the non-compliance with tendering procedures.

Correctional services incurred unauthorised expenditure of R35m for the operation of shops, mess and club services.

Other departments such as education and environmental affairs also failed to comply with tender procedures, while the R47,9m tagged against finance related mainly to interest paid into the Closed Pension Fund.

The R112 960 in unauthorised expenditure outstanding from former arts, culture, science and technology deputy minister Winnie Madikezela-Mandela was still in the hands of the public accounts committee.

Kluever explained that unauthorised expenditure did not necessarily mean the money was lost or stolen, but noted that persistent unauthorised expenditures were indicative of bad financial management.

Meanwhile, the SA Police Services suffered thefts, losses and other write-offs amounting to R87,9m.

Vehicles valued at R1,3m and other state property valued at R3,4m were stolen and compensation of R20,5m was paid to policemen injured or killed on duty.

Repair costs and write-offs relating to police vehicle collisions amounted to R27,7m and compensation payments R8,8m.

It was noted in the report there were 11 504 collisions of SAPS vehicles during the year, a 5,5% decline over the previous year. Total losses were 12,6% higher.

Democratic Party health spokesman Mike Ellis slammed the health department's large unauthorised expenditure saying it was a "damning indictment of the arrogance and incompetence" of both Health Minister Nkosazana Zuma and her director-general Olive Shishana.

The auditor-general's report showed that the millions wasted on Sarafina 2 was "just the tip of the iceberg". Clinics built were sometimes not accessible to the community because of the lack of procedures to prioritise community needs, it said in the report.

VAT to be imposed on personal tax to fund national health service

(85) BD 11/4/97

Gilbert St Caithness and Germinal Douze

GOVERNMENT's previously shelved plans for an all-embracing national health service have been dusted off and will be implemented shortly after the present parliamentary recess. This follows official agreement on new financing proposals in confidential codicils to the Katz commission's recently released fourth report.

According to confidential exchanges between the finance and health ministries and the relevant finance committees, government is planning to increase health funding beyond the R711m national estimate contained in the budget and the R17,3bn budgeted for provincial health spending by levying about R10bn worth of VAT charges on personal income taxes. The VAT levy was decided upon after some Katz commission members proposed a shift in the tax base away from direct taxes towards consumption taxes.

The plan was apparently taken to President Nelson Mandela some weeks ago and received his enthusiastic support. Deputy President Thabo Mbeki suggested some refinements and will officially announce the new health service's launch soon.

The initiative, according to normally reliable cabinet sources, came from Health Minister Nkosazana Zuma. Her arguments, endorsed by Finance Minister Trevor Manuel, were that health provision was essentially a consumer item and should therefore be funded by a consumption tax.

Zuma had also become increasingly, though privately, concerned at the possibility of a deterioration in the quality of SA's medical research as health spending was directed towards rural clinics and away from large teaching hospitals. The proposed VAT levy will help obviate this and is expected to go a long way towards providing funds needed to deliver first world medical services to the entire population.

Corporate taxpayers will, for the present, be exempt from the levy following intervention by Labour Minister Tito Mboweni. He and his advisers fear that it would effectively become a payroll levy with the attendant danger that it might result in job cuts in labour-intensive industries. Nevertheless, a finance ministry insider says the option of levying VAT on corporate tax rates could be revisited in next year's budget depending on how successful the new levy on personal income taxes proves to be.

In round figures, a 14% levy on personal income taxes and estate duties is

Continued on Page 2

Health

(85) BD 11/4/97

Continued from Page 1

expected to enhance government revenues by more than R10bn. This is equivalent to about 6% of government's tax collection estimate in the budget and represents about 40% of the estimated deficit before borrowing.

Originally, government had planned to establish a pay-as-you-go national health service by direct levies of R56 a month on families. This proposal was shelved as being unaffordable by many indigent families who might, therefore, have been bureaucratically excluded from access to state health facilities.

It is estimated that an average middle class family with a single total annual income of R150 000 will face an additional tax levy of less than R700, against which would be offset the earlier proposed direct levy.

Further voluntary savings would also be possible, health and finance ministry planners believe, if families turn to the new national health service and away from private medicine.

Health industry analysts believe the new system will be welcomed as its effectiveness will be directly measurable in an extension of the state's health provision services.

Curate's egg of health care

Star 2/4/97 (85)

Early in 1993, the US-based Henry J Kaiser Family Foundation entered into an agreement with The Star which allowed for the appointment of David Robbins as a specialist health writer. His task was to chart the transformation of South Africa's health policies as the country itself turned towards democracy for the first time. Last week, the special arrangement with the Kaiser Foundation came to an end. In this article, Robbins looks back over a remarkable four years .

It's difficult now to recapture the stagnation which characterised health care as the long apartheid era came to an end. But the files provide an inkling.

On Wednesday, April 7 1993, our first health-policy article appeared. Listen to the picture which was then described: "With preventable diseases on the increase, immunisation programmes collapsing, and millions living in poverty and unsanitary conditions, South Africa has little to celebrate as World Health Day is observed today."

The point of the article was to stress the necessity of finding a new health policy. The racially divided health system needed to be replaced with one which provided equal access for all. The statistics demanded it. Infant mortality rates ranged between 13/1 000 for whites and 124/1 000 for Africans. Doctor/population ratios told a similar story: the national average stood at a healthy-looking 1/1 340, even though the average for the 10 so-called homelands was an appalling 1/15 000.

By the end of 1993 we were beginning to form a clearer idea of what this new health policy would look like. The ANC had already published guidelines, and health experts helped to fill the picture.

What was needed was a system which moved away from the hospital-based and urban-centred one of the past. The preventive and promotive elements of good primary health care (PHC) should be rapidly developed where the people lived, while at the same time protecting the referral system by improving the efficiency and rationalising the functions of hospitals at every level.

How to fund these radical changes became a national preoccupation which is still with us.

The health care system was (and remains) split between the private and the public sectors, with the private sector using 60% of resources to service less than 20% of the population. In addition, while the public sector staggered under major inefficiencies and a maldistribution of resources between the cities and the homelands, the private sector was dominated by the medical schemes, an industry which itself was threatening to fall apart under rapid health care price increases and the endemic overprovision of services.

Into this depressing and highly complex situation came (in January 1994) the ANC's health plan, and then (in May 1994) a new health ministry under Nkosazana Zuma. The process of transformation was poised to get under way.

By the end of that momentous year, certain distinct trends had begun to emerge. The free health care programme for under-sixes and mothers had placed significant strain on hospital outpatient departments, a situation which added to the woes of hospitals already feeling the pinch as resources started to flow away towards the periphery. At the same time, the problem of funding was looming large in the minds of the planners at the new ministry.

"Governments often see health budgets as spending with not much in return," Zuma said at the time. "We have to try to get our government to believe that health spending is an investment. In what? In human beings."

But the 1995 budget allocations did not indicate any major increases in health spending, although large increases in other development areas such as housing and water and sanitation would clearly impact positively on the overall health of the nation.

Meanwhile, clinic building and refurbishing continued apace, a programme facilitated at least in part by carving about R150-million from the budgets of the tertiary hospitals. Most of 1995 was dominated by the cries of distress from the country's major hospitals as budgets were trimmed and out-patient numbers increased. This situation was inevitable as the new system of strengthened PHC at the periphery struggled to be born.

The funding debate also continued as the Health Ministry tried to find ways of financing the equalisation of health care access and quality. Naturally enough, attention focused on the relatively wealthy private sector.

Should private sector doctors be compelled to do community service in under-served areas as part of their training? Should doctors be imported from other countries (Cuba)? Should the medical schemes continue to enjoy tax breaks? How could community-rated schemes be protected from inroads by an insurance industry making good profits on risk-rated packages?

Could the medical schemes be used to provide basic health cover for all those employed in the formal sector? Should private doctors be allowed to dispense medicines? Could the pharmaceutical sector, plagued by lawlessness and bad practice, be brought to heel in the ministry's pursuit of more affordable medicines?

As the questions multiplied, two realities became abundantly clear: the enormous vested interest in all aspects of health care; and the complex interdependence of the private and public sectors.

It has sometimes been difficult to tell whether these realities, especially the vested interests, have lent more credence than was actually deserved to the frequent claims of high-handed arrogance levelled against Zuma and her director-general Olive Shisana, claims which of course reached a crescendo over the Sarafina 2 affair last year. Political naivete´ and administrative inexperience would probably be fairer charges.

Behind the dust of the controversies and arguments, however, the transformation of South Africa's health care system has continued. By the end of 1995, for example, 63% of people included in a national survey said they were enjoying easier access to health care than before. And by the end of 1996, some of the stagnation and despair so evident in many parts of the country in 1993 has been replaced by actual optimism.

The introduction of the district health care system (which includes expanded care and community governance) is in part responsible for this. Also to be taken into account is the continuing shift of financial and human resources to areas of previous under-provision.

But this is not to say that all, or even most, of the problems have been solved. A visit to public health care facilities nearly anywhere in the country will confirm this.

The transformation process is only just beginning. But change and controversy are in the air, and are certain to remain there well into the 21st century.

R1bn down the brain drain

Government admits civil service programme backfired

ST 6/4/97

RAY HARTLEY
Political Correspondent

THE government has wasted R1-billion on a programme to trim the civil service that has robbed the service of its best brains and further damaged the government's financial management capacity.

The Minister of Public Service and Administration, Zola Skweyiya, admitted this week that the voluntary severance offer had failed. "It is the best people who are leaving the public service and you are left with the people you would like to have retrenched."

The government had spent R999-million on severance packages by December — and the figure is set to rise when 58 731 top civil servants' applications for severance are processed.

Skweyiya's admission came a week after Auditor General Henri Kluever suggested that the public service was being crippled by a skills crisis. In a damning report on government finances, Kluever said: "It is clear that quality of financial management and administration in many institutions has deteriorated."

Skweyiya said the crisis was worse than Kluever claimed because his report covered only the 1995 financial year — before the voluntary severance package deal had accelerated the flight of skilled officials from the service.

A report being prepared by his director general, Paseko Ncholo, for presentation to President Nelson Mandela next month would show "it is very bad".

"The basic issue is the lack of clear financial management systems in almost all the provinces. The human resources development systems are bad, especially in those which have inherited bantustans," he said.

Skweyiya also said that the government had decided on its target of cutting 300 000 jobs in three years "unscientifically". "We have to see whether we are capable of getting the 300 000 target. It should be scientifically proved that 300 000 is the right number. We are going from department to department to find the best size for each," he said.

If the figure is revised, the government's pay deal with public sector unions could collapse. In terms of the deal, pay increases are supposed to be financed by the savings made through job cuts.

A revision of the job-cutting target is unlikely to affect the government's growth, employment and redistribution plan because it was calculated on the basis of only 20 000 job cuts in the first year.

Faced with rapidly deteriorating management in the service, Skweyiya called on universities, technikons and the private sector to assist him in a massive training programme.

Skweyiya said his officials had been "driven out" of some provinces that wanted to cover up the poor state of their administrations.

Premiers had supported the investigations but, he added: "I don't think the majority of directors general are very helpful."

Skweyiya said the public sector was having difficulty competing with salaries paid in the private sector.

"The employees in the public service cannot expect the government, at the moment, to offer better. They cannot expect to get what the private sector is offering if they don't provide a service of the same quality," he said.

Uncertainty over jobs had contributed to morale problems, he said.

All will pay for health scheme

(8h)

PAT SIDLEY

ST 6/4/97

ALL employees in the country will be forced to contribute to a new national health insurance fund by 1999 — if the Department of Health gets its way.

According to the department's director general, Dr Olive Shisana, the new scheme would ensure that all employees, including lower-paid workers in "formal" employment, contribute towards their health care.

According to Shisana, the contributions would not be a payroll tax. However, these contributions would be paid by employers who are likely, in turn, to deduct the amounts from individual employees' pay packets.

This money will flow into a new state-controlled fund, perhaps in the form of a parastatal, she said.

The package of benefits for employees would cover basic health care needs including hospital stays.

Asked if the department believed the scheme would find favour among lower-paid workers and their unions, Shisana said the department had already canvassed opinion within Cosatu, who viewed the plan favourably.

One of the reasons for the new plan is the fact that millions of workers in formal employment rely solely on the state for their health care needs, without any contributions. Also, many employees' existing medical aid packages run out by mid-year, and they then use state facilities for free.

COMMENT & ANALYSIS

Trauma, disease exacting a toll on SA

How healthy are South Africans? Medical writer **Kathryn Strachan** looks at the state of the nation's health and how changes in society are affecting it

09/4/97 (85)

THE shifting patterns of SA as it makes its way through its transition are being reflected in its disease profile, with the high rate of rural children dying of easily preventable illnesses existing side by side with an increase in ailments of affluence, such as heart disease.

Diseases of poverty, such as infectious diseases, and maternal and infant illness and mortality remain high. All these conditions could have been virtually eliminated if proper health services were provided.

At the same time, as the pace of urbanisation quickens and newly urbanised people with increased incomes are exposed to new, unhealthy lifestyles, a host of new risk factors are emerging. When people move to cities, their lifestyles often incline towards more processed foods, tobacco and stress — which leads to a different set of diseases.

Statistics show that 24,5% of all deaths are due to chronic diseases such as cancer, strokes, heart disease, diabetes and hypertension. A Medical Research Council survey found that 25% of adults aged between 15 and 64, and 70% of those past 65 years, are suffering from one of these chronic diseases.

Cancer is on the increase with the rate per 100 000 population being 146 for women and 163 for men. The most common fatal cancers are lung, oesophagus and breast cancer.

The latest SA National Cancer Registry report says the incidence of cancers caused by unhealthy lifestyles, rather than genetics, in SA ranks among the highest in the world. The report, which registered 152 new cases a day, shows that one in four South Africans will develop cancer.

However, while urbanisation and new dietary patterns generally lead to heightened cholesterol, cholesterol levels are still lowest among African men when the population as a whole is measured. The reason for this is that they have a high ratio of the protective variety of high density lipoprotein cholesterol, which has the effect of decreasing overall cholesterol levels.

Overall, mortality rates have been steadily declining over the past few decades, but the increase in HIV and tobacco-related diseases is threatening this trend, say medical researchers Debbie Bradshaw and Gcinile Buthelezi in the Health Systems Trust annual review.

Most recent HIV statistics show that the epidemic has increased tenfold in the past five years. With a doubling rate of between 13 and 15 months, the results of the latest survey show that 10,44% of women attending antenatal clinics across the country are infected with HIV. It is estimated that 10 500 babies were born with HIV in 1994, and the trend which is the cause of most concern is the rapid increase in the number of teenage girls contracting the virus.

The trauma of SA life has left many scars, and mental illness is emerging as a major concern. A study in Khayelitsha found that 19% of children and adolescents in informal settlements had diagnosable psychiatric disorders, predominantly anxiety-related.

For the most part, severe psychiatric illnesses are dealt with through long-term treatment of patients in institutions, far removed from family support. Less severe problems are not dealt with at all. Recent initiatives are making an attempt to integrate mental health as part of primary health care and to involve communities in mental health care.

A recent survey found almost one-quarter of the adult population had experienced one or more traumatic events in their lives — the most common being physical attack and having witnessed an attack, a life-threatening event or a home burning.

The incidence of disability is high, with the Household Survey of Health Inequalities indicating that 17% of adults between 16 and 64, and 55% of those older than 65, have a disability of some kind.

While the "new" diseases spread, there is no fall-off in the traditional diseases of poverty.

Of all notifiable diseases, tuberculosis accounts for more than 80% of cases. SA's TB rate is among the highest in the world and its distribution is along clear racial and geographical lines. Driven by the HIV epidemic and the emergence of new drug-resistant strains, the TB rate is climbing all the time.

Measles is the second most important notifiable disease, despite the fact that it can be prevented through effective immunisation programmes.

Despite SA being at the tip of Africa's malaria zone, the number of malaria cases has been rising streadily over the past decade, driven mainly by the emergence of drug-resistant strains and the development of irrigation systens in malarial areas. Last year more than 20 000 cases and 124 deaths were recorded in SA.

Typhoid still ranks among the five most notified diseases in the country, although rates have dropped considerably over the past few years. With the link between typhoid and unclean water supply, Africans living in underserviced areas are worst affected. The rates in Northern Province soar above those in other regions.

Maternal mortality provides the best picture of the health of women, and SA rates draw a bleak picture. The maternal mortality rate per 100 000 births is three for white women, 15 for Indians, 30 for coloureds and 23 for African women.

Malnutrition and stunted growth are a major problem. One in four children is stunted, and one in 10 is underweight.

This means that 660 000 preschool children are malnourished and more than 1,5-million stunted as a result of long-term malnutrition. One child in three suffers from Vitamin A deficiency; one in five is anaemic.

While the health services are battling to cope with the new demands presented by the country's shifting disease pattern, a large proportion of their scarce resources is being consumed by the exceedingly high level of injury.

A recent survey found that in Cape Town 30% of deaths were due to injuries, and in many cases there were high levels of blood alcohol present.

The Cape Town homicide rate was an average 44 homocides per 100 000 people, six times the the US rate. The traffic injury rate, of 24 traffic deaths per 100 000 population, was double the US rate.

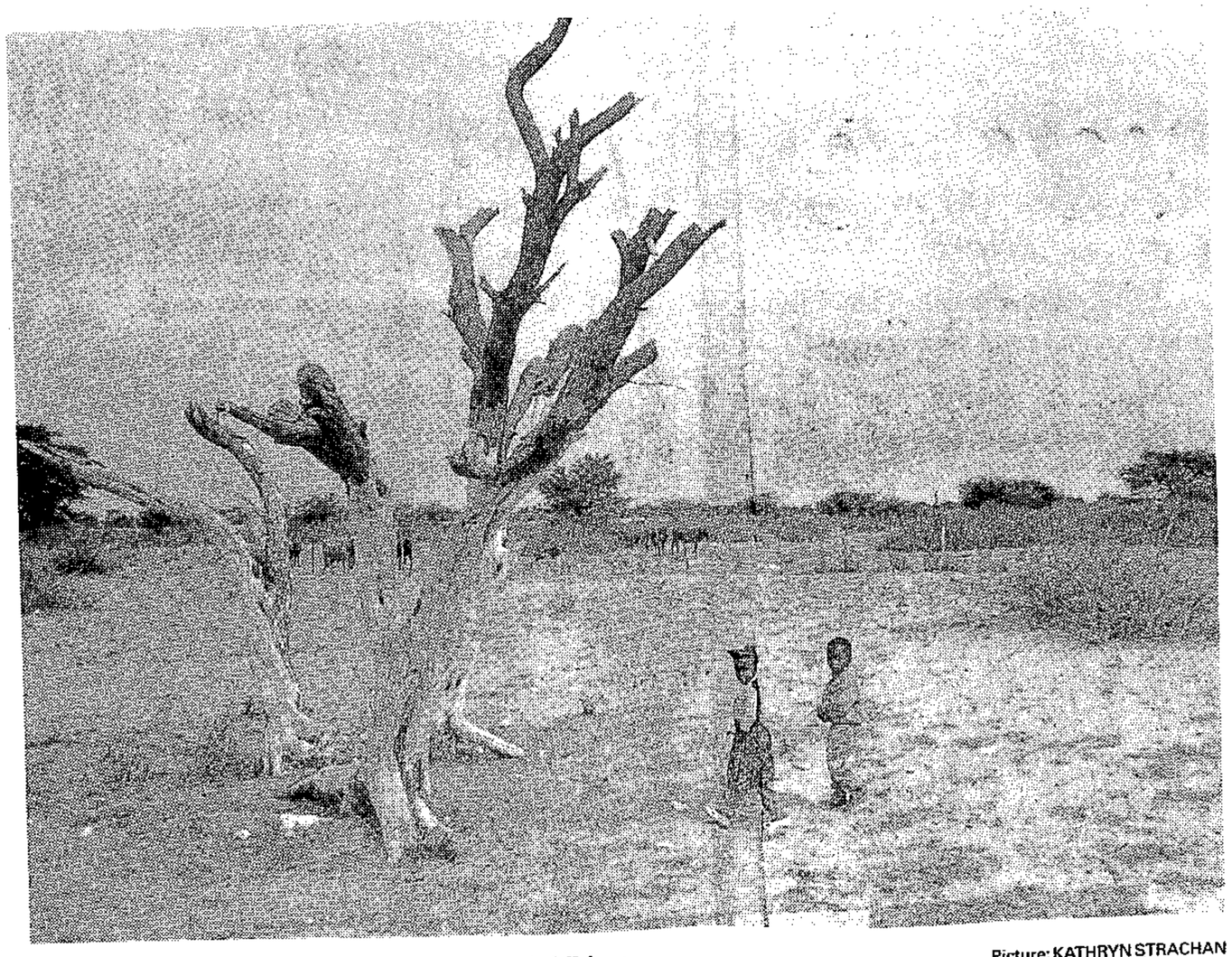
About R300m is spent by Cape metropole public hospitals on people with traffic injuries. This amount represents 80% of Groote Schuur Hospital's annual budget.

A study undertaken by the Medical Research Council and Natal University shows that in the decade up to 1992 there had been a more than eightfold increase in gunshot wounds in the country.

Overall, the pattern of disease shows that the pace of SA's transition varies significantly for its different populations.

"A mixed profile displaying pre- and post-transitional extremes is evident," say Buthelezi and Bradshaw. The disease and death profile of whites and Indians is characteristic of more developed societies with degenerative diseases gaining prominence.

On the other hand, researchers say, the profile for Africans and coloureds reflects the situation of less developed societies, where poverty-related diseases are prominent.



There is a high mortality rate in SA among rural children. Picture: KATHRYN STRACHAN

Government rumblings have insurers running for cover

ST(BT) 13/4/97 (85)

Health is one of the most important issues in our new democracy. Changes in policy have important implications for all South Africans and the government is devoting a great deal of its energy and resources to health issues. In a new weekly column, PAT SIDLEY will be looking at policy changes, their pros and cons and how they will affect you. She will also look at many other aspects of the industry such as insurance, medical aids, hospitals and pharmaceuticals.

THERE isn't a sector of the health-care industry which will be left untouched by the policy changes planned by the Department of Health.

The majority of the changes are intended to improve the quality of care — but most of us are likely to pay more. The plans will also ruffle the feathers of doctors, hospitals and many other providers whose activities will be closely monitored.

Many of the legislative changes will be introduced over the next eight months. Among these will be a National Health Bill, implementation of the department's drug policy and a White Paper on health.

The department is close to completing its final draft regulations for financing in the private sector — the regulation of medical aids and insurance companies offering health-care products. The regulations will be aimed, says Health Department director-general Dr Olive Shisana, at minimising the continuing escalation of costs in medical schemes.

Certain insurance products, which provide financing for health care for the younger and healthier members of society while not providing for older people, will be targeted. Older and sicker people are often either not insured by these companies, or premiums are so high that they will probably not be able to afford the cover.

Medical schemes will have to obtain a "community rating" to be registered and this will, if the team drafting the regulations gets its way, ensure continued tax breaks worth R4-billion a year on the contributions to such medical schemes.

The department would like to see schemes provide medical cover "from the cradle to the grave". The schemes will have to provide a basic minimum package to members. The package has not been determined in detail, but it will most likely take the form of a "negative" list with items excluded for basic cover, such as cosmetic surgery. Members who opt to join late in life or when they become sick will face some form of penalty.

"There is a tendency for insurers to skim the younger and healthier off the top," says Shisana. "It removes from other medical schemes the very people who would be subsidising the elderly and the sick."

The likely vehicle to encourage compliance will be the tax incentive. Those schemes not registered will not benefit from the tax incentive. The registrar for medical schemes will also have its status and functions beefed up, so that the behaviour of schemes can be monitored and the law enforced.

The Department of Health intends to reduce the amount of fraud in the system. Included in the proposed regulations are ways of regulating the administration of medical aid schemes. At present the industry is dominated by administrators who run the schemes. While the schemes may not make a profit, administrators may. The department would like to see fewer adminstrators and more medical scheme members represented on boards, with measures in place to minimise the potential for conflict of interest. Administrators have no financial incentive to keep premiums and costs to members down, she says.

These proposals have been welcomed by some medical aid schemes within the Representative Association for Medical Schemes, but have caused disquiet among others, mainly those which use risk- rating criteria which will not survive the community rating process.

These companies claim the proposed regulations will drive costs up and push consumers out of the system altogether. These consumers will then use the state's facilities, without paying enough for treatment.

The department intends ensuring that all South Africans in formal employment, whether they are covered by medical aid schemes or not, pay their way for health care and do not burden the state with these costs. To this end, says Shisana, all people in formal employment will be forced to take out a mandatory package of basic health care — a National Health Insurance plan — which will cover things like the use of hospitals when necessary. This will be in addition to any medical aid the employee already has. Although Shisana referred to this plan as the department's view, a task team is working on the issue and has four different options on the table. Not all of these will see all South Africans covered by the NHI. Other options may see those covered by medical aids not having to contribute to the NHI.

DETERMINED . . . Olive Shisana wants the government's new policies to make a difference

The department intends ensuring that all South Africans in formal employment pay their way for health care

Picture: BRETT ELOFF

BITTER PILL . . . Jenny Ramsden and Marlene Heymans have been presenting their revealing report to institutions

Treatment for the galling cost of being ill

(85) ST(BT) 13/4/97

Medical inflation has run at 30% a year for the past five years, making managed health care essential, writes JULIE WALKER

LIKE it or not, managed health care presents the only viable solution to South Africa's health-care problems. There are four serious players and several new entrants in the pipeline.

Stockbroking firm First National Equities has compiled an overview of the managed health-care scene and makes recommendations where participants are quoted companies. For long-term growth, SA Druggists is preferred whereas Adcock Ingram is favoured in the short term for operational improvements following the merger between Adcock and Prempharm. Presmed and Afrox are the best-positioned hospital groups in terms of offering and benefiting from managed care.

The authors, Jenny Ramsden and Marlene Heymans, presented their findings last month on a roadshow that was well received by institutions. They calculate that health-care spending of more than R40-billion is about 8.5% of gross domestic product, but that 20% of the population accounts for 60% of this expenditure.

Medical inflation has averaged more than 30% a year for the past five years but salaries (on which medical-aid contributions are based) have climbed by only 10%. Consequently, the number of registered medical aid schemes is down by 100 to 170, many of which are technically insolvent.

Unfunded post-retirement liabilities also loom as cross-subsidisation opportunities diminish, and many companies face having to make up shortfalls from current profits. Accounting standard AC305, to be introduced this year, requires these shortfalls to be recognised on the balance sheet and will bring the problem under closer scrutiny.

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Most controversial are two proposals: an equalisation fund to which all schemes must contribute, and the disallowing of claims limits.

"As nationalisation is likely to be second prize from everybody's perspective, there is great pressure on the private health-care industry to get its house in order. The only viable means of gaining control of the costs of private health care is to introduce the concept of managed health-care," say the authors.

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Managed health-care has as its initial target market the 6.5-million people currently covered by traditional medical aid schemes.

The average monthly medical aid premium is conservatively estimated at R250 a person. Legislation obliging employers to provide a basic health-care plan for all employees opens the market for another 14-million people, albeit at lower premium levels.

Ramsden and Heymans have identified the major market players, summarised them and projected where they might be going. The players include: Health Management Services, which is owned by SA Druggists — itself one of two arms in the Sanlam stable as there is also Sanlam Health; Southern Healthcare JV; Fedhealth; Momentum Health; the Forbes Group's Medmanage; Norwich Life's Davidson & Ewing; Afrox Health; and Mediclinic's joint venture Medimo. Two potential new entrants are Medhold's Pharma Clinic and Dr Walter Ward's Universal Healthcare. Ward was the originator of Medicross Clinics, now part of HMS. Many attribute SAD's entry into managed health-care to him.

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Whether or not the company assumes risk, such as do the insurance companies, there are four critical success factors: a funding mechanism, membership base to provide a large risk pool, access to a network of service providers and risk-management technology for managed health care.

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Graphic: FIONA KRISCH
Source: FIRST NATIONAL EQUITIES

Weighing up hospital costs

ALL private hospitals charge the RAMS tariff and two of the better-located Medi-Clinic hospitals make a small surcharge, says Dr Edwin Hertzog, chairman of Medi-Clinic.

On average, hospitalisation costs R1 200 a day and the average patient's bill is about R3 500, excluding doctors' fees. Day clinics charge about 90% of 24-hour hospitals.

Managed-care companies seeking preferred-provider agreements with hospital groups need to take everything into consideration, such as geographic spread, quality and range of services and availability and reliability of information. Cost is only one factor.

"It is very difficult to measure value for money," says Hertzog, "because it has to be gauged against the future quality of life enjoyed by the patient."

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Hertzog says the state licenses new private hospitals. There are now 150 in South Africa and he does not expect many more to be granted.

Picture: BRETT ELOFF

BITTER PILL . . . Jenny Ramsden and Marlene Heymans have been presenting their revealing report to institutions

Treatment for the galling cost of being ill

(85) ST(BT) 13/4/97

Medical inflation has run at 30% a year for the past five years, making managed health care essential, writes JULIE WALKER

LIKE it or not, managed health care presents the only viable solution to South Africa's health-care problems. There are four serious players and several new entrants in the pipeline.

Stockbroking firm First National Equities has compiled an overview of the managed health-care scene and makes recommendations where participants are quoted companies. For long-term growth, SA Druggists is preferred whereas Adcock Ingram is favoured in the short term for operational improvements following the merger between Adcock and Prempharm. Presmed and Afrox are the best-positioned hospital groups in terms of offering and benefiting from managed care.

The authors, Jenny Ramsden and Marlene Heymans, presented their findings last month on a roadshow that was well received by institutions. They calculate that health-care spending of more than R40-billion is about 8.5% of gross domestic product, but that 20% of the population accounts for 60% of this expenditure.

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Health Department posts slashed in two years

Cape Town – The Health Department's right-sizing exercise, started two years ago, has led to a massive reduction of staff and a saving of about R4,3-million, departmental director-general Dr Olive Shisana said yesterday.

Shisana told Parliament's health committee that in 1994 the department had 7 086 posts.

"In January 1995 we had 6 906 posts. By January 1 1997 the department had 1 694 posts. Nearly half the posts went to the Department of Welfare and the majority of the remainder of the posts were devolved to the provinces.

"(A total of) 132 posts were abolished as part of the right-sizing exercise, with a resultant saving of approximately R4,3-million," Shisana said. – Political Correspondent

Star 16/4/97

(85)

Zuma outlines wide-ranging health revamp

District teams the key

(85) ARG 17/4/97

CLIVE SAWYER
POLITICAL CORRESPONDENT

Health Minister Nkosazana Zuma today unveiled a vast array of proposals to reform the national health system, including a campaign against eating too much sugar.

In a white paper tabled in Parliament, plans for the new system include:

■ Decentralised management of health services, with a strong emphasis on a district health system.

■ Making primary health care available to all citizens.

■ Ensuring the availability of safe, good-quality essential drugs in health facilities.

■ Rationalising health financing by reprioritising budgets.

The white paper proposes a national health information system to boost health planning and the prevention of such diseases as AIDS and other sexually transmitted diseases, as well as promoting maternity, women's and child health care.

An integrated nutrition programme should focus on food security for the needy, it suggests.

Proposals for better oral health include the extension of water fluoridation, a minimum package of oral health care and a campaign against too much sugar.

The white paper proposes dividing the country into health districts, each led by a team responsible for primary health care, in line with national policy.

Steps should be taken to draw in private health practitioners to the public sector to supplement provision of health services.

In a significant reform of the district surgeon system, it suggests primary health-care nurses should refer patients to accredited private practitioners in areas where these are in short supply.

It says a national audit of the numbers and distribution of trained health staff and training institutions should be done before decisions are made on future training of personnel.

Recommendations are for the eight existing medical schools to be retained, while ensuring that they reflect the demographic mix of the population.

Among proposals for a more equitable distribution of health staff, the white paper says all health professionals should spent at least two years in a public sector non-tertiary institution before entering health practice.

It calls on the Government to review the salary packages of all health personnel and calls for a realistic affirmative action policy and gender sensitivity in training, recruitment and promotions.

Huge task ahead for district health system

A White Paper on transforming SA's health system was tabled in Parliament yesterday. Kathryn Strachan visited the Eastern Cape to assess the challenges ahead

BD 17/4/97 (85)

SIX-year-old Mawethu Sijendu has his broken arm tied up in a home-made sling. He has been waiting in the queue at the hospital in Mount Frere, Transkei for nearly two days and he has yet to see a doctor.

His grandparents brought him to the hospital at 8am the previous day. They were still far back in the queue when the outpatients section closed at 4,30pm. It is now 2,30pm on the following day and he has still not been attended to.

"Every night about 10 patients sleep over on the benches in the waiting room because we did not get to the end of the queue and it is too far for them to walk home and then come back again the next day," says Sister Florence Gogo.

Nothobile Makele is one of the women who has spent the night on the hard benches with her sick baby. At 2,30pm the following day she is still waiting to see a doctor. "It is exhausting," she says simply.

In the dilapidated hospital with its peeling plaster and broken windows, beds line the corridors as patients spill out of the cramped, overcrowded wards. Desks positioned in a row of disused showers serve as makeshift consulting rooms.

To enter the family planning clinic, women have to crouch down to get through the one metre high opening that leads into the cellar. It is a far cry from the welcoming atmosphere family planning services are supposed to project.

The hospital often runs out of medicine supplies, and has only one resuscitation machine for the entire establishment. In the casualty section, there are no cardiac or ECG machines. Because women have lost faith in services at the hospital, up to 80% of women in the district choose to deliver at home.

Until last month, there was only one doctor at the hospital, but he has now been joined by two Cuban doctors.

When surrounding clinics run out of medicines, they refer patients to the hospital. But patients often find that it does not have the medicine they need. For patients who need drugs to keep a stable condition, this can be a serious problem.

Poorly maintained and treacherous roads in the area also play their part in stalling health services, and when it rains the hospital vehicles (there is no ambulance) can reach only two of the 20 clinics it services.

The situation in the clinics is hardly better. In nearby Rode village, the clinic does not have a single medicine, bandage or vaccine.

It is only the first week of the month, and already all its supplies have run out — as they do every month.

The broken-down wattle and daub clinic is almost deserted as prospective patients know it will not have any medical supplies.

The trickle of patients that do arrive are turned away, or told to try the next clinic at Mount Ayliff, which is half an hour away.

The clinic also does not have running water, and nurses have to carry buckets of water from the river over the hill.

"Last week a schoolboy was stabbed in his neck. We sent him in a taxi to Umtata Hospital, where he died soon after he arrived. If we only had bandages we could have saved him," says nurse Nomfundo Sandla.

The clinic never sees a doctor. But it does have a radiophone. However, in emergencies it has to rely on local taxis as Mount Frere hospital's vehicles are never available.

While some women do still come to the clinic to give birth, the clinic does not have the intravenous equipment or resuscitation machines needed in emergencies.

In the Mount Frere clinics, which are open 24 hours, there is no electricity and when complications arise during childbirth, nurses have to deal with the emergency with only candlelight.

Yet health services in Mount Frere are no worse that in other parts of the former Transkei. Because it displays the typical difficulties that beset the devastated former homeland, Mount Frere has been selected by the Durban-based Health Systems Trust as one of the four subdistricts countrywide to be set up as model health districts.

While health services around the country are being organised along a new structure, called the district health system, there is still a lot to be learnt in terms of what these districts require to function.

The idea of the district system is that all health services provided in a demarcated zone fall under one umbrella. This allows services to be provided in a far more rational and comprehensive way than they were in the previous fragmented system.

Health Systems Trust has chosen one subdistrict in four provinces to serve as models.

It was found that providing piecemeal support to these districts did not work, and the solution now being tried is to provide an integrated package of support to these subdistricts.

The trust provides support in all the functions a district needs to perform. These include research and evaluation, training health workers and developing skills, and providing technical support.

As soon as lessons are learnt from the experimental zones, the new ideas will be introduced to the surrounding districts immediately, thus creating a "knock-on effect", says programme director Dr David Harrison.

Yet at the centre of this support package is the principle that the district health system can only work if people regard themselves as key resources in the battle to uplift health in marginalised regions.

White paper on transforming health tabled

BD 17/4/97 (85)

Kathryn Strachan

A WHITE paper on the transformation of the SA health system was tabled by Health Minister Nkosazana Zuma in Parliament yesterday.

The document sets out a plan for decentralising health care delivery as well as reorientating services to focus on primary health care.

According to the white paper, the new national health system would be based on the concept of the district health system, which means services in each district would be based on local conditions and health problems.

Health department deputy director Ayanda Ntsaluba said the objectives of restructuring were to unify the fragmented health services at all levels into a comprehensive and integrated national health system.

The advent of the white paper was welcomed by the nongovernmental sector.

National Progressive Primary Healthcare Network advocacy director Judi Fortuin said the existence of an official document which clearly set out the official policy would inform public debate on health.

"For too long there was much confusion, and at least now we will know what we are dealing with," she said.

While the white paper was not preceded by a green paper, Ntsaluba said the document was collated from the findings of 13 committees which were set up early in 1995.

The 13 committees, which were set up to investigate all areas of health policy, all held public hearings and the stakeholders' views were incorporated into the final reports, Ntsaluba said.

These 13 reports made up a draft policy document entitled "Towards a national health system", which was circulated for public comment.

More than 200 stakeholders had made contributions on the draft document.

Ntsaluba said the entire consultation process took two years which meant the public consultation was a lot deeper than the two months usually set aside for comment on a green paper.

Of the 13 committees, the one that received most attention was the committee investigating a national health insurance system.

However, the white paper provides no further clarity on the status of this proposal.

The document simply sets out the core principles of financing the health system, but does not elaborate on mechanisms for financing the health system.

Ntsaluba said there were many areas of the proposed national health insurance system which still needed to be investigated.

The health department was working on these areas.

Compulsory health plan unveiled

CLIVE SAWYER
POLITICAL CORRESPONDENT

The Government today unveiled plans to boost funds for cash-strapped public hospitals by forcing all employed people to join a new national health insurance scheme.

The compulsory scheme for all those in formal employment will aim to cover the costs of treatment for them and their dependants at public hospitals.

Contributions will be shared between employers and employees, and will be related to income and family size.

The proposal is contained in the white paper on transformation of the health system, tabled in Parliament today by Health Minister Nkosazana Zuma.

The document suggests even those who are already members of medical aid schemes should be compelled to join the new health insurance scheme for treatment in public hospitals.

The white paper said that large numbers of employed people who were not members of medical schemes used public hospitals without paying the prescribed fees, even though they could afford to.

Medical scheme members and their families could attend public hospitals when their scheme cover was exhausted without paying the prescribed fees.

The white paper, in its proposals on physical and financial resources for a transformed health system, also contains a bold plan for public hospitals to be allowed to keep some of their revenue. At present fees paid to public hospitals are passed on to provincial revenue funds. This meant hospital managers had little incentive to collect fees, the white paper said.

Cash plan: Nkosazana Zuma

The problem was worsened by the low quality of care in most public hospitals, which had prompted most paying patients to go to private hospitals.

Allowing hospitals to keep some fees would provide an incentive for managers to increase the efficiency of fee collection, and provide them with funds which could be used flexibly. The policy would be phased in.

ARG 17/4/97

See page 2

Basic health care for all 'within 10 years'

(85)

ARG 18/4/97

JENNY VIALL
HEALTH REPORTER

The new national health system will focus on primary health care at community level and aims to provide basic health care for all South Africans within 10 years.

Health Minister Nkosazana Zuma unveiled the proposals yesterday in a white paper policy document tabled in Parliament.

They include a compulsory national health insurance scheme for formally employed people to finance public hospitals. Even those on medical aid will have to join the scheme.

The plans make provision for a fundamental transformation of the health care system which includes decentralised management of services, emphasis on the district health system and increased access to primary health care.

Although South Africa spends about 8,5 percent of its budget on health services, distribution is inequitable and wasteful, according to the white paper.

Spending had been weighted heavily in favour of certain provinces, urban areas and curative hospital-based care while two-thirds of the population had deficient health care. Because of this imbalance, resources would in future be redistributed from high technology hospitals to district health services.

"This policy will require continuous defence in the political arena," says the white paper.

"There is a major disjunction between established policy and popular demand. Health policy worldwide prioritises prevention and primary health care. But everywhere demand is mainly for curative and hospital services.

"Popular demand for high technology hospitals tends to be translated into political decisions to use funds for hospital provision, hence the relative over-provision of hospitals all over the world."

The emphasis on primary health care would include integrated preventive, promotive and curative services for children and women.

South Africa would be able to afford the new system only through a redistribution of public health resources and finding new sources of finance, according to the white paper.

These were a national health insurance plan and a system whereby health services could keep the fees collected by public hospitals.

Vital role seen for traditional healers

ARCT 18/4/1997 (97 85)

Traditional healers and birth attendants should not at this stage form part of the public health service but be recognised as an important component of the broader primary health care team, according to the White Paper.

Regulation and control of healers should be investigated and criteria outlining standards of practice and an ethical code be developed to facilitate registration.

The department proposes that foreign doctors working in South Africa be monitored. Clinical competence and the ability to communicate in at least one South African language will be a prerequisite for registration. They should be recruited to serve in neglected areas.

District system the key

ARG 18/4/97

HEALTH REPORTER

South Africa is to be divided into districts to implement the new national health policy, according to the government white paper on health.

The district system is central to the provision of health care and rapid implementation is the highest priority in a new transformed health system, according to the paper. The country will be divided into districts, each with a team responsible for planning and managing all local health services.

If the public sector is to continue providing for the majority of South Africans a number of interventions are necessary, according to the paper. These include:

■ Greater payment for hospital care by those who can afford it..

■ Medical schemes as a private source of funding will continue but in a more regulated environment.

■ Regulatory mechanisms are required to reverse the deregulation of the private health insurance market.

■ Medical schemes will not be allowed to exclude an individual on the basis of health risk.

■ No new licences will be granted for private hospitals whose shareholders are doctors and specialists.

Curing the costs can hurt the patient

(87)

Managed care has become a reality in South Africa and consumers need to be aware of the advantages and pitfalls, writes PAT SIDLEY

ST 20/4/97

A WOMAN in Washington DC needing an operation to her knee, failed to convince her health plan — a managed care organisation — of the need for a particular specialist in a specialist hospital.

Neither the doctor nor the hospital were contracted to the plan, and it would have cost the plan more money than it wanted to pay. Not only did the plan refuse her pleas for the specialised care, but failed to recognise that she had had an addiction problem in the past and needed specialised care in the use of pain-killers to avoid a recurrence. Several operations later — and now having to use the specialist and his hospital the plan first rejected — the woman may lose her leg altogether, and is addicted to a wide range of painkillers, all prescribed by doctors. Now she requires her plan to take care of that problem too.

This is a worst-case scenario for managed-care disasters — but completely true.

Another scenario illustrates how managed health care could reduce costs. Southern Health Care reports that among its members who had babies in January at private hospitals, 68% had Caesarian sections for the birth. By contrast, in Holland 70% of women give birth at home with midwives in attendance. At the Johannesburg Hospital, of a group of "high-risk" women only 20% had Caesarian sections. Managed health care could reduce the number of "convenient", but costly and often unnecessary Caesarians.

On the other hand, managed care in the US has led to what are coined "drive-by" deliveries. Managed-care plans believe they can save millions by sending mothers and infants home within 24 hours of delivery. But the US public rebelled against this, and several states have now legislated against the phenomenon, enforcing a minimum two-day stay in hospital after delivery.

Schemes believe they can save millions by sending mothers and infants home within 24 hours — 'drive-by deliveries'

In South Africa, managed care is a growing reality. It was only a matter of time before it would have arrived with our spiralling private sector health-care costs, constantly being pushed up by, among other things, "fee-for-service" medical-aid packages.

But what is managed care? What are its benefits and drawbacks and how should consumers deal with it?

Sanlam's Altus van der Merwe says it is a "mechanism whereby the quality and cost efficiency of health care delivery can be improved". United Health Care, a huge US managed care organisation which owns 20% of Southern Health Care in SA (a managed health-care company) defines it as a "system of health-care delivery that influences utilisation and cost of services and measures performance. The goal is a system that delivers value by giving people access to quality, cost-effective health care."

Either way, using collected information from doctors, hospitals, drug companies and other providers, managed care companies seek to place limitations on unnecessary spending while trying to deliver quality care to patients. By pulling the administration of all patient health-care needs under one umbrella, the managed-care organisations can co-ordinate all levels of care to reduce costs in several ways. Most of them exist for profit and make money out of the scheme. Typically, the managed-care company will sign up doctors, hospitals, and other health-care providers in some form of contractual relationship which will ensure that the company has a deciding vote (by way of pre-authorisation procedures) on what services they deliver to patients.

Using the "drive-by" delivery row as a model, managed care companies in the US say that little actual medical care is delivered on the second day, causing much unnecessary expenditure in hospitals. A few high-profile deaths after 24-hour discharges, however, charged the debate with emotion and anger from patients.

In the US, the early history of managed care showed concern mainly with prices. Employers, in particular, faced with the mounting health-care costs of their employees, focused almost entirely on cutting those costs. Managed care has cut costs in the US — but the agenda has changed too. The public and medical profession now focus on the quality of care as the most important issue — and both employers and the managed-care companies have been forced to look at issues other than costs.

This has spawned several agencies which purport to rate and compare the managed-care companies. They are not independent, nor do they have any backing from regulatory authorities, but consumer organisations believe some of them provide a useful guide.

The managed-care organisations in South Africa have already inspired the wrath of doctors, particularly specialists. The contracts bother many doctors and several believe the pre-authorisation system is a problem.

Sanlam runs a vast room of nurses and computers with software designed to take calls and answer questions. To a doctor, it must look like a vision from hell: "Computers diagnosing and assessing treatment," as one says.

Managed care does, however, offer to help cash-strapped patients, provided the local managed-care organisations and legislators protect consumer interests.

Health, housing departments slated

Star 22/4/97 (Eds) (Sat)

Incompetence costing millions, report by Gauteng auditor-general reveals

By Priscilla Singh
Health Reporter

Gauteng's departments of health and housing have come under scathing attack following the release of an auditor-general's report yesterday which revealed gross incompetence and mismanagement.

The performance audit report by Gauteng Auditor-General Shauket Fakie was tabled in the provincial legislature yesterday. It showed that millions were lost as a result of bad management.

DP leader in the legislature Peter Leon called the report "quite a condemnation" of how the departments were being run.

Fakie's report showed that half the health-care vehicles provided for Soweto were stolen, that gardeners were doing the work of pharmacists at one clinic, that dentists were doing work usually performed by therapists, and that there was no maintenance policy for primary health-care clinics.

The report revealed that no financial provision was made for the replacement of ambulances, and a lack of staff management resulted in the ratio of nurses to patients varying from 1:55 to 1:8.

"What next, hospital cleaners doing heart bypasses?" asked Leon last night.

On the provincial Housing Department, Leon said Fakie reported that R400 000 in subsidies had been paid to developers in Phola Park, but no houses were built.

The report said that despite a housing backlog of 500 000, the department received only 643 applications for subsidies by September last year because of poor marketing of the subsidy programme.

Health Department spokesman Jo-Anne Collinge said last night the department would comment today.

HEALTH WHITE PAPER

Zuma to squeeze medicine from stone

The Health Minister's new national health plan could hit the pockets of high- and middle-income earners

FM 25/4/97

At first, Health Minister Nkosazana Zuma proposed free primary health care for all within five years. Now the goal is to provide basic health care within 10 years — and it is no longer free for those who can afford to pay.

This is the key feature of the White Paper on the transformation of the health system, published last week.

It aims to unify the fragmented health service into a comprehensive and integrated National Health System. Central to the strategy is the devolution of managerial control from provincial to district health authorities, which must ensure the delivery of basic health services in each district.

The plan provides for an average of 2,8 primary health-care consultations per person per year by the end of the century, rising to 3,5 consultants' visits by 2005-2006.

Many in the medical fraternity consider this a gross underestimation of likely demand, especially in a country where the rate of HIV infection is rising exponentially.

The scheme will cost about R11,9bn in 2002-2003. No figures are provided for the final two years — a criticism also levelled at earlier policy proposals.

What's more, the figures rely on Financial and Fiscal Commission recommendations made in May 1996, which do not take into account the fiscal constraints imposed by government's Growth, Employment and Redistribution strategy.

The plan is undercosted by an average of 4%-5% per year, says SA Managed Care Coalition secretary-general Dr Steve Jooste.

But the White Paper says it is "broadly affordable" as long as public health resources are redistributed (geographically and with an emphasis on district and primary health care) and new sources of revenue are found.

The main sources it proposes are social health insurance and allowing public hospitals to retain a portion of user fees.

The former would require introduction of a mandatory medical aid package for all in formal employment and their dependants to cover their treatment in public hospitals.

It plans to stop large numbers of employed workers and their families from using public hospitals without paying fees even though they can afford to, and stop people who have exhausted their medical aid cover from using public hospitals without paying.

It implies that those with existing medical cover will not be exempt from taking out the additional package. It says contributions will be shared between employers and employees and related to income and family size.

A crucial omission in the White Paper, says Ginsburg Malan & Carsons director Gavin Watkins, is clarity on whether contributions will be calculated on a fixed monthly rand amount, or on a percentage of income. The latter would have severe consequences for top income earners.

Dan Pienaar, chairman of the Life Offices Association (LOA)'s health-care standing committee, sees the proposal as a form of dedicated tax that those in formal employment — who prefer to be treated in private hospitals — will pay to cross-subsidise basic health care for the majority. The proposal, he says, will substantially increase the cost of employment and have a dramatically negative impact on the economy.

NP health spokesman and MP Willem Odendaal says the White Paper contains several ideas from the Cuban socialist health-care model. But at least Zuma has abandoned some radical proposals, he adds, such as plans to allocate patients to certain doctors and institutions according to a register. The patient's right to choose is now recognised.

Claire Bisseker

Top team to study traditional medicine

BD 30/4/97 (85)

Kathryn Strachan

A HIGH-level research team, made up of SA's leading pharmacologists, has been set up to focus on traditional medicines, and for the first time to bridge the gap between western medicine and traditional medicine.

The Medical Research Council, the University of Cape Town (UCT) and the University of the Western Cape (UWC) have created the research group, which will be led by UCT pharmacology department head Prof Peter Folb and UWC pharmacy school head Prof Peter Eagles.

Working with traditional healers, the researchers aim to collect medical and botanical information on southern African medicinal plants and to use this knowledge to set safety standards regarding herbal remedies. The research will focus particularly on promoting valuable traditional medicines used for malaria and tuberculosis (TB).

Modern scientific and biomedical knowledge will be used to investigate medicinal plant extracts and to isolate bioactive compounds for developing safer and more effective drugs. An integral part of the operation will be to develop strategies that will support the preservation of African flora with medicinal importance.

The group will also form part of the World Health Organisation Collaborating Centre for Drug Policy, which serves as a reference centre for Africa and other developing countries.

An important objective will be to create a comprehensive traditional medicines database for eastern and southern Africa for use by traditional healers, health workers at primary care facilities, policy makers, drug regulatory authorities and the pharmaceutical industry.

The group also intends to collaborate with traditional healers regarding primary health care as they have enormous potential for participating in immunisation programmes, supervising treatment of TB, controlling the use of alcohol and curbing domestic violence.

NEWS

Bitter pill for Cape health care

Sick face fewer services and hospital beds

ARG 2/5/97 (48) (85)

JENNY VIALL
HEALTH REPORTER

Western Cape Health Minister Ebrahim Rasool has spelt out how the province's severe spending cuts will result in fewer health services.

Managing a R234-million provincial budget deficit over the next year would be a formidable task, he said.

Mr Rasool said in his budget speech this week that projects to cut spending included cutting back psychiatric services, further bed closures at Groote Schuur, Red Cross and Tygerberg academic hospitals, reducing staff numbers and rationalising nursing colleges and laundries.

The 1997/98 health budget was R2,474-billion, which included almost R341-million for improvements in conditions of service. This in effect meant that the health department's budget was R2,133-billion.

"The fact that we have been reduced beyond the point of R2,423-billion requested from the treasury represents a lack of understanding of the pace and scale of change that is possible in one financial year," said Mr Rasool.

"More importantly, it prevents my management team from being systematic in the achievement of realistic targets."

Primary health care, the cornerstone of the new national health plan, was to get a marginal increase on last year's allocation from 29 percent to 33 percent.

"While we have tried to protect primary health services in this budget, a larger increase was not possible in the current financial environment," said Mr Rasool.

Outpatient visits to primary health care clinics in the Western Cape had increased by 29 percent and admissions to hospitals had fallen by 8,7 percent in the past year. Forty five new clinics had been built, 38 were to be upgraded and a further 16 extensions and upgrades were planned.

The academic, or tertiary, hospitals (Groote Schuur, Tygerberg and Red Cross Children's hospitals) were hardest hit by budget cuts and would get R78-million less than last year.

Almost R830-million had been allocated to the hospitals, with R189-million for salary increases, putting pressure on non-staff spending and replacing staff.

Funding for these hospitals was the "most complex and challenging task of this year's budget" said Mr Rasool.

"Already 1 000 voluntary severance applications have been approved at these hospitals. As a result of this, 375 beds will be closed at Tygerberg and Groote Schuur."

These patients would be absorbed by G F Jooste, Karl Bremmer and other regional hospitals. Negotiations were being held with Health Minister Nkosazana Zuma and Finance Minister Trevor Manuel for funding health services at the academic hospitals and training health professionals.

Savings from voluntary severance packages last year were estimated at R50-million. There would also be a saving of R80-million from staff losses in the previous financial year. Hospitals would also try to generate revenue, said Mr Rasool.

Health tax plan triggers outcry

Zuma in for more flak

ARG 3/5/97 (85)

ADELE BALETA
STAFF REPORTER

A proposal to introduce a controversial new compulsory health tax is expected to cause a huge outcry from overburdened South African taxpayers, especially those who already contribute to medical aid schemes.

And Health Minister Nkosazana Zuma, under fire for the lack of an HIV/AIDS policy, the importation of Cuban doctors and the introduction of extended compulsory training for junior doctors, is likely to draw more flak if the levy is introduced.

Judging by early reaction to the proposed Social Health Insurance, the issue will be the subject of heated debate with some welcoming it as a move toward greater access to health care and equity and others slamming it as double taxation and setting a precedent for the imposition of blanket taxes by other ministries.

According to the Health Department's white paper, the Social Health Insurance scheme will require all formally employed people to be insured for the cost of treatment of themselves and their dependents in public hospitals.

Contributions will be shared between employers and employees, and will be related to income and family size. Those already paying medical aid will not be exempt from the tax.

The Health Department says its medium-term expenditure framework for the public health sector indicates that it is broadly affordable to provide basic care for all South Africans within a 10-year period, with two provisos. The first, that there is redistribution of public health resources and the other that there are new sources of public health finance over and above general government revenue.

The proposed health tax and retention in the health service of fees collected by public hospitals are seen as the main new financial sources.

In the white paper, the department says many people are abusing the public health system, resulting in large losses.

Commenting on the proposed tax, Momentum Health chief executive officer Adrian Gore says ensuring coverage for everyone is good, but there are "too many red flags".

"We believe that any dedicated tax is bad because it is likely to set a precedent for a tax on housing, water and so on. Government should levy tax in the appropriate way. Funding for public hospitals should be through the general tax system. If not, there could be serious economic ramifications."

Judy Fortuin, advocacy manager of the National Progressive Primary Health Care Network, supports a social health insurance.

She says that at present, most of Cosatu's membership can't afford medical aid.

She says a government health insurance plan will introduce long overdue competition in the medical scheme marketplace which will lead to targeted packages.

Decklin Brennan, executive director of the Representative Association of Medical Schemes (RAMS) says the organisation is opposed to the "financial burden" of the proposed levy which it views as double taxation on its members.

Medical scheme members represent the major share of individual taxpayers ... "Consequently they already pay for the public sector hospitals through their tax. They will now be paying twice."

Mass fluoridation of South Africa's water supply expected to be up and running by end of the year

Cape Town – A draft of the regulations which will make mass fluoridation of drinking water possible in South Africa is to be published soon, national fluoridation committee chairman Dr Peter Owen said yesterday.

The Department of Health had been ready to gazette the draft a year ago, but technical issues raised by the Department of Water Affairs and Forestry had delayed publication, he said in an interview.

The rules would enable providers such as water boards to adjust fluoride levels to what was best for a particular area. Fluoridation would be mandatory, and any provider wanting exemption would have to put up a good case.

The regulations would be published for public comment, then go back to the minister of health, as well as to Parliament, before being finalised, hopefully before the end of this year.

Implementation could be "fairly rapid" for large water suppliers such as Rand Water, the Umgeni Water Board, Cape Town and Port Elizabeth, which were very keen to implement the new scheme.

The Health Department would also have to look at defluoridation in some areas, such as the Northern Cape and the Northern and North West provinces, where natural fluoride levels in drinking water were too high.

Mass fluoridation would cost between 60c and 66c a person a year, Owen said.

Earlier yesterday, former chief dental officer for the Irish Republic Dr Seamus O'Hickey told the National Assembly health committee that fluoridation of water in Ireland, which began in 1964, had reduced dental decay by about 40% in the entire population.

O'Hickey, an adviser to the SA fluoridation committee, said fluoridation in Ireland cost a sixth of fluoride rinses and a ninth of plastic anti-decay barriers.

Fluoride was a clear, colourless and odourless crystal or liquid. The optimal dose in South African water would be about 0,05 parts per million.

IFP health spokesman Dr Ruth Rabinowitz said there was research which showed that fluoridation made no difference to dental health and that fluoride could affect the body's immune system, cause cancer and lead to bone deformities.

She had also been told that fluoride taken internally was effective only for children up to the age of 11, and that it had to be applied locally through a toothpaste or rinses after that.

O'Hickey said critics should make sure the data they were quoting came from reputable medical journal articles that had been properly reviewed by other researchers. The last thing MPs should do was disbelieve the figures provided by their own health department.

"I don't doubt the sincerity of the anti-fluoridation people but I think they are being misled by a few people who gain financially from it," he said. – Sapa

(85) Star 31/5/97

Health-tax plan set to draw flak

By ADELE BALETA (85)

Cape Town – Proposals to introduce a controversial new compulsory health tax is expected to cause a huge outcry from already hard-pressed South African taxpayers, especially those who are contributing to medical aid schemes. Star 3/5/97

And Minister Nkosazana Zuma, under fire for the lack of an HIV/Aids policy, the importation of Cuban doctors and the introduction of extended compulsory training for junior doctors, is likely to draw more flak if the health levy is introduced.

The proposed social health insurance will be debated heatedly, with some welcoming it as a move towards greater access and equity, and others slamming it as triple taxation and setting a precedent for the imposition of blanket taxes by other ministries.

The scheme, according to the Health Department's white paper, will require all formally employed people to be insured to cover the costs of treatment of themselves and dependants in public hospitals.

Contributions will be shared between employers and employees, and will be related to income and family size. Those already on medical aids will not be exempt from the tax.

The Health Department says its medium-term expenditure framework for the public health sector indicates that it is broadly affordable to provide basic care for all South Africans, with two provisos.

The first is that there is redistribution of public health resources and the other that there are new sources of public health finance over and above general government revenue.

Abusing the system

The new health tax and retention in the health service of fees collected by public hospitals are visualised as the main new financial sources. In the white paper, the department says many people are abusing the health system, resulting in large losses.

It says there are many employed workers who are not medical aid scheme members who, in addition to their families, often attend public hospitals without paying the prescribed fees, even though they can afford to do so. "Also, medical scheme members and their families may attend public hospitals when their scheme cover is exhausted and again may not pay the prescribed fees."

Momentum Health chief executive officer Adrian Gore says ensuring coverage for everyone is good but there are "too many red flags".

"We believe that any dedicated tax is bad because it is likely to set a precedent for a tax on housing, water and so on. The Government should levy tax in the appropriate way. Funding for public hospitals should be through the general tax system. If not, there could be serious economic ramifications."

Gore is concerned about the rising cost of employment. "Can we afford another issue that increases the cost of labour which, of course, in turn increases the propensity for unemployment?" he asks.

He estimates there are 2,5 million principal medical aid members – that includes their families – and a further 7 million employees who are not covered.

Introducing this tax would remove their freedom of choice. Many of the 7 million are in the low-income group and they have chosen not to join medical aids. There needs to be a proper means test, Gore says.

US model of managed health care is taking root in SA

BD 6/5/97 (86)

Kathryn Strachan

THE new US model of managed health care is gradually making its mark on SA's private health care with more than 80% of private hospital beds countrywide contracted to the scheme, Southern Healthcare managers said yesterday.

Southern Healthcare, the leading company in the new managed health care environment, said yesterday that it had broken through its implementation phase with an expanded network of health care providers and an elaborate set of tools designed to co-ordinate and influence medical costs.

The model was still in its early phases, however, and would take another six months to collate all the data needed to plan the new medical protocols required to control costs and increase quality of care.

Southern Healthcare GM John Wardle said the recent contract with the National Hospital Network brings to 181 the number of hospitals and clinics on the provider network. This represented more than 80% of the private hospital beds countrywide.

To date more than 1 200 doctors and specialists have been accepted into the network and members now had access to 1 800 Interpharm-linked pharmacies. Its system of shared information would assist doctors, he said.

Wardle said the growing network gave Southern Healthcare the opportunity to obtain the information it needed from the medical profession to make its sophisticated case management software work effectively. This would enable the organisation to measure the quality of health care and reduce the cost.

The information technology now used also had the ability to detect fraud and abuse — a cause of concern for most medical aids.

Southern Healthcare is a joint venture between Anglo American, Southern Life and the US's United Healthcare Corporation.

It currently has a base of 110 000 patients on its managed care plan and an additional 150 000 members on its indemnity portfolio.

Gauteng health, housing in a sick state – report

Star 6/6/97 (86)

The money pours out, but there's no way of checking how it's being spent

By Janine Simon

Management shortcomings in Gauteng's health and housing departments have hobbled service delivery and cost millions in lost revenue, according to an auditor-general's report tabled in the provincial legislature yesterday.

The performance audit, the first of its kind presented to the province's public accounts committee, covered the 1994/5 and 1995/6 financial years and was completed in the last six months of 1996.

Performance audits do not only outline the amount of money used by departments, but provide details on management efficiency and administration of the funds.

The report tabled yesterday identified weak staff management, inadequate information systems and lack of budget controls as some of the deficiencies underlying the poor utilisation of resources.

This saw departments unable to plan, finance, monitor or retain control of key projects.

The report also contained a point-by-point breakdown of corrective steps taken by the relevant heads of department.

Although it highlighted management shortcomings, it "did not mean that poor or no value for money was received throughout the departments", said the auditor-general's corporate executive manager Louis van Rooyen.

According to the report, the department of housing and land affairs paid out 1 283 subsidies to the value of R385 788 under a project-linked housing subsidy scheme in Phola Park, but by October 1995 no houses had been built because the department had no control to ensure a return on its investment once the subsidy had been paid out.

The housing department lost R1,5-million because there was no administration process to recover rent for provincially owned hostel rooms, and R212 581 a month for failing to charge interest on R16,5-million of arrears rental, the report said.

Also, the contract amounts of five provincial hostels overran by R4,6-million when the recommended completion time stretched to two years because the department failed to keep close contact with role-players.

Another R8,1-million was lost when the contractor due to renovate the Wattville hostel cancelled after hostel residents refused to vacate their rooms.

Controls on funds allocated for hostel upgrades were inadequate, with the approved allocation exceeded by almost 300% in one case, the report said.

The department also delayed completion of planned projects by failing to make available R24,3-million of the R170-million RDP funds allocated for the provision of infrastructure during the first three years of the administration; the funds had to be rolled over to the 1996/7 financial year.

There was no means to correctly calculate the cost of free health care because the estimated budget deficit of R383 309 621 for free care for the 1995/96 financial year was based on inaccurate information, the report said.

Health insurance will not help haemorrhaging system

(85) (~~200~~) BD 7/5/97

Does the planned national health insurance get to the heart of health reform, asks **David Harrison**

IF THE SA health system is moribund then revenue from the proposed compulsory national health insurance scheme is an infusion that could give it new life.

However, any first-year medical student, or plumber for that matter, will tell you that fluids in one orifice are fluids out another, unless the seepage can be halted and the problem addressed.

So what is the central problem of the health service? Is it a shortage of money?

Not if international comparisons are anything to go by. Middle-income countries like Botswana, Malaysia, Hungary and Chile spend less money on health care than we do, yet have healthier populations. Poorer countries like Tanzania spend the equivalent of a fifth of our per capita expenditure on health services and have a better primary health-care system than we have.

The essential problem is how we use that money.

The debate about hospital services versus primary level care is old hat and will not be regurgitated here. Let us accept that SA's hospital infrastructure is good and needs to be protected (albeit with some degree of rationalisation). Compulsory contributions to provide public hospital cover for employees is a sound way to maintain and upgrade these institutions. But the real site of health reform, the place where change will have the most impact on the quality of people's lives, is far away from the big hospitals.

It is the people who live in the small towns and rural areas who need to be the central target of health reform. And, if the truth be told, the national health insurance is unlikely to affect Mrs Nxumalo and her children living in rural Maputaland or old Japhta on his smallholding beyond Bochum in Northern Province.

So what will affect their lives? What is the crux of health reform?

The crux lies in taking a distorted and clumsy primary health service and making it make sense. My point is best illustrated by a few examples.

Medicines account for one-eighth of recurrent public health expenditure. There are clinics in this country without medicines. So, health personnel (who account for five-eighths of that public spending) sit idle in these facilities because they have no means to treat patients.

Or take the example of a man diagnosed and treated for tuberculosis in a small town in which he works. There needs to be follow-up of his family and other contacts who live just out of town. Unfortunately, services outside of town fall under another health authority, so follow-up is not assured.

These situations highlight the absurdities in many parts of the country where primary health-care provision makes little sense.

Creating a rational, efficient and effective primary health service is the crux of health reform. If this is not achieved, the system will be in a state of perpetual haemorrhage and more money in will mean more money out.

The health ministry knows this and has set about establishing a district-based system, which is the most logical framework for managing health services.

The system is based on the premise that the health system must serve the interests of every person in the district and that these interests are best served by a local management team responsible for delivering quality care in an efficient and effective manner.

But interpretation of a single clause in the new constitution threatens to jeopardise the logic of the district health system and perpetuate the confusion that exists.

This clause delegates "municipal health services" to local authorities. What is meant by "municipal health services" is not clear. Certainly, if it means that strange amalgam of services rendered by many local authorities, it will annul all efforts to establish an organised health system.

At the end of the day, it probably does not matter whether primary health care is rendered by a local authority for each district so that there can be integrated, cost-effective care.

This is a fundamental element of SA health reform that needs to be entrenched now; an element that risks being ignored as hospital insurance assumes centre stage over the next few months.

There is a story told to students at the University of Cape Town medical school (or is it every medical school?). It describes a nurse instructed to ensure that a post-operative patient drank 500ml of fluid plus the equivalent of the previous day's urinary output. The following day the nurse dutifully reported that the patient tolerated the 500ml of fluid well, but fiercely resisted drinking his previous day's urinary output!

Revenue from the proposed insurance scheme will be a valuable top-up of public sector funds, but the benefit from a new source such as this risks being piddled away by illogical management of primary health care. And unlike the surgical patient, there will be no chance of getting it back.

□ *David Harrison is director of the Initiative for Sub-District Support of the Health Systems Trust. He writes in his personal capacity.*

HEALTH-CARE CONFERENCE

Can Zuma's health tax be justified?

FM 9/5/97 (85)

In her inimitable fashion, Health Minister Nkosazana Zuma has stirred up yet another outcry with her proposal to introduce a compulsory new health tax. Business is already smarting at Labour Department plans for a payroll levy to fund training and skills upgrading. Now it is told it must also pay towards a national health insurance scheme for all South Africans in formal employment.

According to a Health Department White Paper, the social health insurance scheme will require both employer and employee to contribute towards insurance cover for treatment in public hospitals. This includes those already paying medical aid contributions.

Nkosazana Zuma

The department says it needs the money to meet overall health policy spending needs. And while there is some support for the concept, some businessmen have expressed opposition to what, in conjunction with medical aid, they consider to be "double" taxation.

Zuma has been invited to explain government's thinking at the fourth *FM* Corporate Health-Care Conference at Gallagher Estate, Midrand, on May 22.

Opposition speakers have already agreed to give their views. In particular, they will argue the need for health-care rands to be spent wisely.

One of several important conference topics, the discussion will explain the potential impact of the scheme on companies' bottom lines.

To book, or for more information, telephone Odette at Global Conferences, on (021) 762-8600, or fax (021) 762-8606. ■

Medicine plans leave a bad taste

By Janine Simon
Medical Correspondent

Health sources fear that Health Minister Nkosazana Zuma's proposed new medicines legislation will emasculate the Medicines Control Council.

This is the authoritative body charged with ensuring the safety and efficacy of medicines registered for local use.

The MCC also sets standards for ethical and scientific research. Its intervention in the Virodene Aids-drug controversy, clarifying where researchers had erred, and what clinical and scientific principles should be met to continue the work, is considered masterly.

The Medicines and Related Substances Control Amendment Bill is aimed at giving a legal framework to the National Drug Policy, which was released in January 1996 and aimed at securing a safe, cost-effective and accessible medicine supply.

MCC chairman Professor Peter Folb and vice-chairman Professor Peter Eagle met parliamentary portfolio committee on health chairman Dr Abe Nkomo yesterday, and the MCC will be making a full submission at the public committee hearings on the bill next week.

Folb declined to comment, saying the MCC was in discussion with the minister and the committee and that he did not want to jeopardise the talks.

Nkomo confirmed the meeting, but refused to disclose the details of the consultations.

However, it is understood the MCC's deep concerns centre on the fact that the draft bill gives the minister the power to overrule the council, the general lack of consultation and insight, loopholes on proposals for parallel importing (finding cheaper sources of drugs already registered and available in South Africa), and the fast-tracking of drugs on the essential drugs list.

Worry that minister could overrule council

The draft bill has also enraged the Pharmaceutical Manufacturers' Association, which says it infringes intellectual property rights.

PMA chief executive Mirryena Deeb said the PMA would take legal action and petition President Mandela for a ruling on whether that principle would be respected in South Africa; getting governments to accept intellectual property rights was regarded as the international pharmaceutical manufacturer's biggest single challenge.

Deeb said the legislation contained severe restraints on intellectual property rights. It would not allow firms to use brand names for government tender and, by legalising parallel imports, would violate the intellectual property rights of the firms which registered the drug in South Africa.

A source in a generic-drug company, which has recently entered the local market, said multinationals were fighting to protect profit margins which were significantly higher than elsewhere in the world.

In SA, drugs which had come off patent were sold at up to 40% above the cost of generics, the source said.

The bill is one of three to be heard by the committee next week, as the Health Department progresses with the 10 pieces of legislation it is expecting to pass this year to give legal framework to the shift in health policy over the past three years.

Also up for portfolio committee hearings next week are the Pharmacy Amendment Act, which allows for ownership of pharmacies to be opened to all, and the Medical, Dental and Supplementary Health Service Professions Amendment Bill.

This bill contains enabling legislation for the controversial two years' vocational training for doctors, continuing medical education, as well as community representation on the Medical and Dental Council and the registration of foreign doctors.

Parties reject Zuma's rush to pass bills

By Jovial Rantao
Political Correspondent

Cape Town – Five opposition parties have objected to attempts by Health Minister Dr Nkosazana Zuma to push through three pieces of legislation before the end of the current parliamentary session.

In a joint statement, the NP, the DP, the IFP, the FF and the PAC objected to an attempt to push the Medicines and Related Substances Control Bill, the Medical, Dental and Supplementary Health Service Professions Amendment Bill, and the Pharmacy Council Bill through Parliament.

The parties said that if adequate time was not provided, the bills would represent a mockery of the parliamentary process.

"These are major bills, with far-reaching implications for the sale of pharmaceuticals and the roles of the Medical and Dental Council and the Pharmaceutical Council. Aspects of the white paper have a bearing on them, and discussion of the white paper should be completed before they are entertained," the parties said in a joint statement.

Zuma's spokesman Vincent Hlongwane said the ministry did not think there was any conflict in introducing the bills while the Health White Paper was being introduced.

Top health officials slam Olympic bid

HENRY LUDSKI

ST (CM) 11/6/97

CAPE TOWN'S controversial 2004 Olympic bid has come under fire from leading medical officials, who have criticised provincial authorities for pumping R104-million into the Games while cutting back drastically on health services.

A group of Cape Town's top health administrators and the angry medical superintendent of a small hospital lashed out at the national and provincial governments for placing the bid above the health care needs of the poor.

"It's immoral and almost criminal that the government can make money available for softball fields when basic health of the very poorest is being completely neglected," said Dr Norman Maharaj, superintendent of the G F Jooste hospital in Manenberg.

The Western Cape's health budget has been slashed by R230-million this year, and health officials have expressed fears that the health care crisis could worsen if Cape Town were to win the bid when the International Olympic Committee makes its final decision in five months' time.

"If this is what we have to deal with now, God help us if we get the Olympics," said one of Cape Town's highest ranking health administrators, who asked not to be named.

IOC officials, here to see how Cape Town's bid plans are progressing, were taken on a tour by Olympic Bid Company planning director Peter de Tolly yesterday.

He said everyone "was obviously concerned that the city had the best possible health care", but he did not believe the Games would take funds away from health.

Maharaj expressed alarm that while provincial authorities had suspended all new health capital projects, they were prepared to spend at least R100-million to keep alive the city's chances of hosting the Games.

Opposition bid to halt push on health bills

Parties united

CLIVE SAWYER
POLITICAL CORRESPONDENT

(86)

ARG 13/5/97

Five opposition parties are trying to block government attempts to push a series of major and controversial health bills through Parliament before the winter recess in July.

Spokesmen for the Democratic Party, the Inkatha Freedom Party, the National Party, the Freedom Front and the Pan Africanist Congress said in a joint statement that the bills had far-reaching implications for the sale of pharmaceuticals.

At issue are the Medicines and Related Substances Control Bill, the Medicine, Dental and Supplementary Health Service Profession Amendment Bill and the Pharmacy Council Bill.

The bills would also have a serious impact on the roles of the Medical and Dental Council and the Pharmaceutical Council. Discussion of the white paper on reforming the health-care system should be completed before the bills were processed, the party officials said.

"If adequate time for public debate and wide consultation on these bills is not provided for, the passage will represent a mockery of the so-called transparent and consultative parliamentary process."

Mike Ellis, DP health spokesman, said the Health Ministry was trying to push through the bills "in unprecedented haste".

All three bills deserved full and open public hearings before extensive debate in the health committee, he said.

"Yet each bill has been allocated only one morning's hearing, and then on consecutive days. It is obvious that no committee can do justice to three important bills at the same time, and that normal procedure, of dealing with one bill at a time through to finality, should be employed."

'Fears are obstacles to managed health care'

BD 15/5/97 (85)

Bonile Ngqiyaza

FEAR of disempowerment by the medical profession and the misconception that managed health care is a cheaper, low-quality alternative, are two major obstacles to managed health care, said Norwich Health Care senior manager Cliff Altree yesterday.

Doctors felt threatened that the schemes would prescribe treatment of patients and that, if they disagreed with the scheme's analysis, they would withhold payment or prevent members from consulting them, he said.

"There needs to be a clear understanding that we are working towards containing health costs while promoting the health of our mutual clients. Our only interest is quality health care that is cost effective," he said.

The conception that the quality of health care would drop because cheaper choices were being prescribed, was misplaced.

"The major task facing advocates of managed health schemes is to break down the adversarial relationship between medical schemes and practitioners, and gain credibility with the medical fraternity."

This could be done only if the correct methodologies and technologies were in place to support such partnerships.

"We believe it is best to work through provider organisations such as Independent Practitioner Associations, so that we can develop relationships which acknowledge shared risks and devise mutually acceptable guidelines for diagnosis and treatment."

Managed health care should be able to demonstrate to doctors that they would not lose out financially by contracting their services, he said.

"The success of managed health care is based on maintaining costs while boosting patient volumes through good health care practices."

Altree also spoke out in favour of the development of national guidelines governing diagnosis and treatment.

Actuaries call on Government to rethink proposed health system

ARG 15/5/97

THABO MABASO
BUSINESS REPORTER

Old Mutual Actuaries and Consultants (OMAC) has called on the Government to rethink its proposed Social Health Insurance system, which it says will have serious implications for medical aid schemes as the AIDS epidemic increases.

OMAC director Erich Potgieter said yesterday that although it was difficult to quantify the impact of AIDS on health care costs, he estimated that providing treatment to sufferers could increase medical costs by 25 percent or more.

"Moreover, medical costs are only a part of the overall socio-economic impact of AIDS. Other costs, like those of group life assurance to provide for the families of employees who die of AIDS, will be more dramatically effected," Dr Potgieter said.

In terms of the Social Health Insurance system everyone who is treated in a public hospital and is in formal employment must have insurance.

Medical schemes would be unable to refuse membership to someone in poor health or charge them higher premiums. They would also be obliged to guarantee continuation of membership to the families of deceased AIDS sufferers.

(85)

Last month the seventh national HIV survey estimated that 20 percent of the working population would be infected by the turn of the century.

Dr Potgieter said the Government ought to convene a consultative forum of stakeholders as a means of trying to minimise costs on medical aid schemes.

Wrestling to pin managed care down

No one in the health industry has quite the same idea in mind when managed health care comes up, writes PAT SIDLEY

ST(BT) 18/5/97

(85)

IF THERE was one thing everybody agreed on at the Department of Health's managed care conference in Pretoria this week, it was that nobody quite knew exactly what managed care was.

Anglo American's Brian Brink referred to people's perceptions of it as some kind of "monster" about to descend on people, doctors saw it (almost uniformly) as a foe to be fought off at all costs, while hospitals and suppliers to the health care market viewed it as a looming opportunity to carve the market up. Everybody noted that no one had a definition for managed care.

Managed care companies offer reduced costs and quality care (so they maintain). This is often done by limiting the way in which doctors and other providers are reimbursed (fee for service usually comes under critical scrutiny), and care frequently has to be authorised before it is given to patients.

Managed care companies will say they trade in information, not health care, and their business happens to be information about health care.

The Department of Health had called on all parties interested in managed care to begin a process of consultation which may lead to legislation aimed at regulating the field.

The department has set a first-round target of two months hence. This is probably unrealistic given its track record, but task teams have already begun drawing up proposals which may or may not be affected by what the stakeholders say.

The meeting was an attempt to set off a process of consultation. Several political parties claimed in parliament this week that insufficient consultation had taken place on several health bills before parliament at the moment. Almost all the health-care stakeholders affected by the bills are saying the same thing — although the issues have been hotly debated in public for the past two years at least, and the African National Congress's views on many of the issues are widely known.

Several themes were presented to the conference, including provider protection (how to ensure that doctors are not abused in the managed care process), consumer protection (ironically presented by doctors and not by consumers), possible financial regulations (which would seek to regulate the financial environment in which managed care operates), competition, vertical integration, oligopolies and others. The feeling was that if problems were isolated in the areas which could usefully be addressed by legislation, proposals to this effect would be discussed. Not everyone agreed that there should be regulations. In fact, broadly speaking, those in favour of regulation were government representatives, doctors, consumers (if they had been adequately represented) and parts of the reimbursement industry. The medical aid industry argument was that if they were to be regulated, then all others in the reimbursement game should be regulated in the same way.

'Doctors have no choice but to band together to assert their rights and needs while trying to get acceptable contracts from managed care companies'

Against regulation were those who are used to the cut-and-thrust of the business environment and who naturally shy away from regulation: medical supply companies, pharmaceutical companies, hospital groups and the like.

Doctors had some serious concerns, some of which emerged in the group concerned with competition. Doctors have been forced to band together to compete in an environment of too many resources chasing too few health-care rands. They are now negotiating for drugs, equipment, hospital beds and prices in groups organised along strictly business lines.

The old-fashioned form of medical ethics seldom intrude on this process. While some of these business practices are deemed anti-competitive in law if they are carried out by other business groups, when doctors form associations and haggle for fees, the same rules do not apply.

In private-sector health care in this country, there are too many hospital beds and too many doctors concentrated in urban areas with pharmaceutical companies and equipment companies all vying for a slice of a diminishing cake. This became apparent in the discussion on whether ownerships and cross-shareholdings, vertical integration in companies and control of companies ought to be regulated. It was the Hospital Association's Dr Annette van der Merwe who brought some sanity to the debate while each group argued for other sectors to be regulated to stop competition.

She suggested that doctors in the present environment had no choice but to band together to assert their rights and needs — all the other health-care sectors were doing it — while trying to get acceptable remuneration contracts from managed care companies.

The meeting looked quite spontaneous — to the point that much of the debate and contributions were marked by a lack of sophisticated information.

Behind the scenes, however, several groups have made suggestions for regulations which were not presented at the indaba. These are presumably being looked at by the department's fundis, who are investigating the possibility of regulation, although most people on Monday may have been forgiven for thinking their own input was initiating the process.

Health boss pleased with first 1 000 days

86

By Mokgadi Pela

THE Ministry of Health says the first 1 000 days of the new health system have successfully brought medical care closer to the people.

This is the view of deputy director-general of policy and planning Dr A Ntsaluba in his review of the first 1 000 days of the restructuring and developing of the health system.

He said achievements over the same period demonstrated the ministry's resolve to bring quality health care to the people.

Among the achievements Ntsaluba cited were the:

● Rationalising of 14 departments of health that existed prior to the April 1994 general elections – this task involved integrating and rationalising functions and resources;

● Equity and access to primary health care – as part of this goal, the ministry has given free health care to children under six and pregnant mothers since June 1994;

● Decentralisation of services – this system is designed to bring decision-making closer to the people so that community-participation can be maximised;

● Drug policy – the mission is not only to improve access but to better the quality and affordability of services;

● Nutrition – the importance of proper and adequate nutrition for primary school children was identified by government as one of the major programmes of the presidential lead projects;

● Right to reproductive health care – the ministry has responded to this provision by expanding reproductive health services, including family planning counselling and free access to contraceptive measures;

● HIV-Aids – the ministry increased the budget for HIV-Aids and other sexually transmitted diseases from R70 million to R80 million; and

● Importing doctors – these doctors have been deployed in all nine provinces, particularly in rural and under-served areas of the country.

"Their assistance has helped to increase access to appropriate health care to many who did not previously have access to the skills and expertise of doctors," Ntsaluba said.

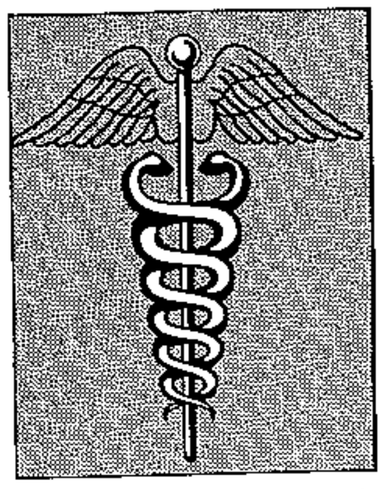
Sowetan 20/5/97

Health white paper seeking an impossible dream

(85)

A well-meaning effort to deliver too much will end in failure, warns Ruth Rabinowitz

Star 21/5/97



The RDP lives on in the health white paper, not as a reconstruction and development programme, but as rhetoric, dreams and promises which will provide a fatal injection of misguided intentions into an already ailing health system.

Not that the Government inherited a flourishing health system from the old order. Funding for health was skewered towards the wealthy and the urban and towards hi-tech medicine; costs of private health care were spiralling beyond the reach of the average wage earner.

The motives articulated in the white paper are laudable, but fail to take account of the realities of South Africa.

Proposed policy fosters entitlement, inefficiency and perverse incentives. It shows distrust of the private sector, no faith in market competition and little respect for freedom of choice.

To assist the Department of Health in its mission to perfectly balance health services countrywide, the entire population will be listed on a database. According to needs analyses, public and private distribution of care will be engineered.

The ratio of public/private care will be maintained at 80/20, and all private institutions will be licensed to practise only where there is a demonstrable need.

A Father Christmas package of primary health care will be provided free to all. Existing finances can cater for 1,8 visits per person per year, escalating to 3,5 by the year 2007. For more than that 1,8 visits, primary care is a chimera.

Owing to the funds absorbed by the generous primary care package, funding must be found for secondary care (hospitals). One way of doing this will be to provide an incentive for hospitals to collect fees by granting them management autonomy and the permission to keep a percentage of profits.

A second will be to increase the number of fee-paying private patients in state hospitals, by stifling the growth of private hospitals and day clinics so that they don't steal patients away from the state; and a third will be to impose a national health insurance on all working people even if they contribute to private medical schemes.

The combined effect of the latter two initiatives will be to shrink the number of people with private health insurance, reduce private provision of hospital care and place an even greater burden on the inefficient state.

Cultivating entitlement, fostering unrealistic dreams and curtailing the private sector are not solutions to the country's health problems. For those who can afford it, private care should be encouraged, relieving the burden on the state.

This would require competitive private health insurance offering a variety of schemes which attract young and healthy members, pre-funding for retirement, pay as you go or managed health-care cover.

All employed persons should pay towards health insurance of their choice and the uninsured fall into a special pool insured by the insurance industry and state. State hospitals should attract private patients by offering differing facilities and private hospitals should treat state patients for less. Government should focus funds and philanthropy on those who need them and deserve better than a utopian dream.

Let us have moderate care of varying standards rather than promise uniform excellence and provide poorly for all.

■ *Dr Rabinowitz is an IFP MP.*

Health service hiccups

Sowetan 21/5/97 (85)

Free health care for certain sections of the community has corrected many of the wrongs of the past, but has created problems of its own, says **Janine Simon.**

ASK NURSE ALLETA KHANYE about free health care services and her first reaction is to point to the crowded wooden benches of the Katlehong North Clinic's waiting room. "Aah," she says, "there are a lot of patients."

Like many others in the health care sector in South Africa – Khanye – a tuberculosis control nurse – knows that when user fees are scrapped more patients turn up for care.

She learned that in 1994, when free primary health care was introduced as part of the Government's ambitious attempt to make accessible and equitable a health system which, by the early 1990s, was noted only for its ability to widen the gap between black and white patients.

When the Government came to power, seven times as many black infants were dying as white, with the classic preventable conditions of poverty, like malnutrition and diarrhoea, and diseases like measles, taking a heavy toll.

Nationally, each doctor had to care for 1 340 patients. But in the 10 black homelands, some 15 000 people had to share one doctor.

Moreover, two-thirds of the country's total spending on health, and nearly two-thirds of the country's doctors, were devoted to a tiny one-sixth of the population – almost entirely white – who could afford private care.

State services were concentrated in cities, leaving rural areas unserviced.

Plans to overhaul the system had been brewing for two years in Mandela's African National Congress party. And the first action came within a month of Mandela taking office in 1994.

In his state of the nation speech, Mandela declared that health services for children under six and pregnant women would be free at state facilities and district surgeries.

Later the health policy was extended to everyone at the primary care level – and became law.

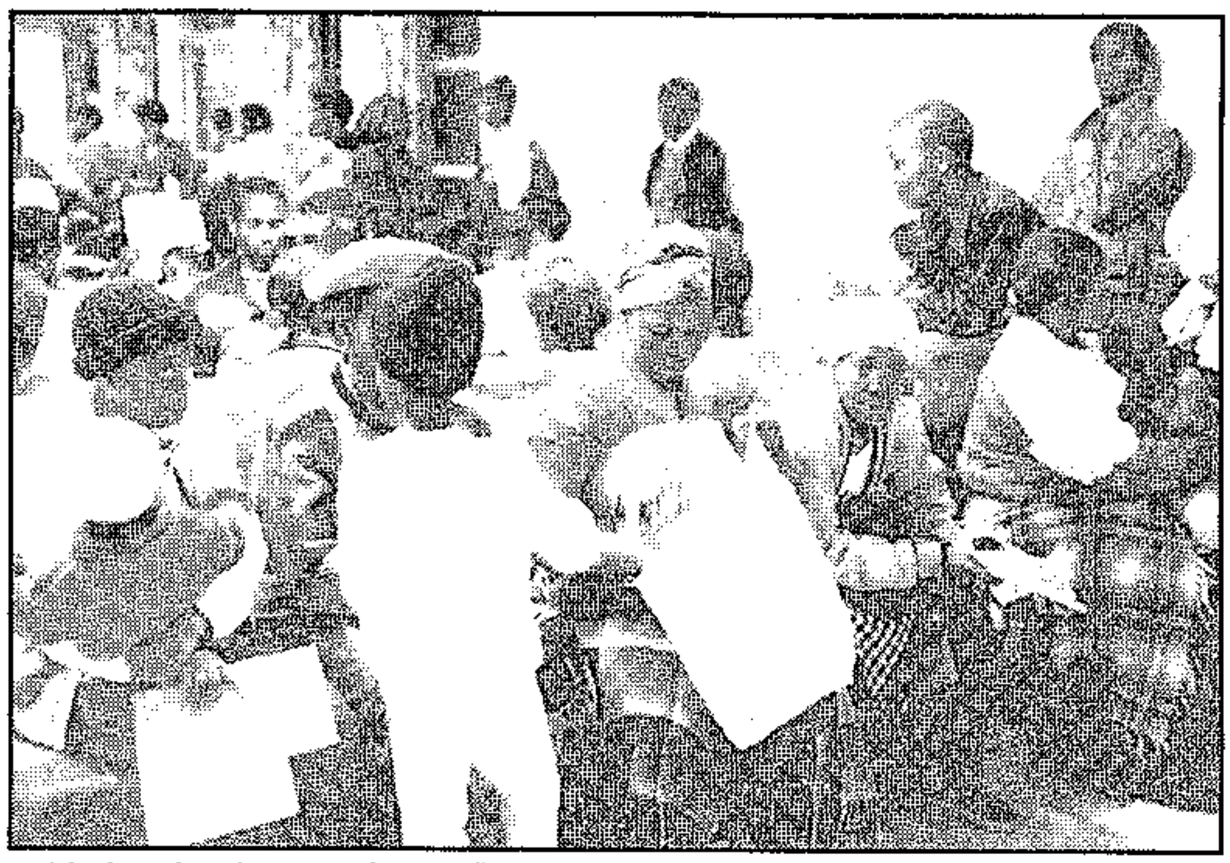
Previously fees were small – diagnosis and treatment at Soweto clinics cost R8, and income-based fees were as low as R20 for surgery and hospitalisation. But for the poorest, even these sums were prohibitive.

The policy promoted a rush of patients – especially children – to hospitals and clinics across the country.

In the densely-populated Gauteng, for instance, free care saw child outpatient attendance at some clinics almost double overnight before levelling off between 30 000 and 40 000 patients a month.

By the end of 1995, two out of three people in a national survey said they enjoyed easier access to health care, with patients in rural and informal settlements the happiest.

The South African Health Review of 1996 said the rise in attendance figures confirmed that user fees in the state sector had been a barrier to health.



South Africa's new health policy produced a rush of patients, especially children, to hospitals and clinics. In Gauteng child outpatient attendance at some clinics doubled overnight in the scramble to benefit from free health care.

Two new midwife obstetric units rendering free services at the western edges of Gauteng have drastically cut infant mortality and morbidity in the area and vindicated the accessible free primary health care approach, according to provincial health authorities.

Nurses at another clinic, the newly-expanded Hikensile Clinic in northeast Johannesburg, provides services to the 5 000 under-fives in the area with pride.

"We've had stillbirths, but we have not heard of any deaths from preventable diseases among children last year," chief community nurse Nellie Shongwe said.

But some serious problems have been uncovered following the policy changes.

Medical Research Council staff tracking the impact of the free health care policies in the Hlabisa district of northern KwaZulu-Natal say the population there seems to be so sick that the demand for cures is rocketing and overextending the health service.

As a result; its crucial preventive work such as childhood immunisation, care for pregnant women and HIV-Aids education is suffering.

"The fine balance between important preventive services and demand for curative services is in danger of being lost unless more resources are made available," said researcher David Wilkinson.

There are also complaints from the country's renowned academic hospitals which train medical staff.

Teaching hospitals, which represent half of all the tertiary-level care in South Africa, grumble that they may end up footing the bill for Mandela's free primary health care scheme.

The fact remains that free primary health care will cost the Government only about R680 million in the coming year – a tiny proportion of the total health budget.

But teaching hospitals claim that they provide a considerable amount of primary health care in urban areas and they used to be able to charge for that care.

In the first two years of the new policy, the teaching hospitals, which are clustered mainly in Gauteng and the Western Cape, took a seven percent budget cut to fund the building of more than 100 primary health clinics.

In addition, the health budgets of Gauteng and the Western Cape were slashed as the Government shifted money to poor provinces like North West and Eastern Cape.

With the little that was left, the Western Cape and Gauteng governments had to fund both academic hospitals and the shift within their own provinces to create new primary health care facilities.

There is another issue at play here – a legacy of apartheid. Teaching hospitals in Western Cape and Gauteng provinces mostly trained white students and catered to white patients.

Mandela, it appears, is trying to undo some of that wrong by shifting resources from urban teaching hospitals to health services in poor provinces. – *Panos (London).*

Problems, but the cure is there

ARLG 24/5/97 (85)

The last two weeks have seen an enormous amount of attention focused on the problems in our health services.

The spotlight has highlighted the very tragic circumstances in which Thobeka Madayi died in Khayelitsha, the state of the ambulance services and conditions at community health centres. The citizens of the Western Cape can be forgiven for thinking the health system has all but collapsed.

I do not want to make light of the problems we have, but I do want to say that, despite many stresses and strains, we still have 32 000 of the finest health care professionals working in this province, some of the world's finest institutions, and the best health indicators in the country and on the continent.

It may be tempting to think that the difficulties experienced in health care in the Western Cape are unique. The fact is that the Western Cape is now reaching the same limitations in health that some countries, like Britain, have already reached.

This means that the money available for health is decreasing.

We cannot have limitless growth of super-specialist care, and unless we have accessible, prevention-orientated primary health care, the poor will have few health benefits.

The challenge to us in the Western Cape is how we move from a dependence on three tertiary hospitals to a more appropriate health care system reaching into every community.

I would argue that substantial progress has been made in changing the health system, but we are now in that very uncomfortable period of change, described by Antonio Gramsci when he said: "... the old has not yet died, and the new has not yet been born".

So, while we try to give birth to the new, and try to preserve the best of the old, there is a lot of pain.

It is with great regret that we acknowledge that some of that pain has affected some of our citizens. This was never our intention.

We also acknowledge the sacrifices of our staff who suddenly find themselves having to cope with a patient load which in the "old" South Africa was 1,5 million patients per year at primary health level and in the "new" South Africa now stands at 4,5 million patients per year in the Western Cape. However, the improving mortality figures suggest the system is saving more lives.

I think the citizens of this province, who may, understandably, have been horrified about the future of the health system, deserve an idea of both the progress and the problems in the health system.

BUILDING A NEW HEALTH SYSTEM

Our efforts in this regard remain absolutely logical and intelligent. The key is to find the best balance between the three levels of health care. This means that super-specialist care at Tygerberg and Groote Schuur must be appropriate.

They must pool their resources and expertise, and ordinary citizens must only go there when they are referred. The days of the big academic hospitals which saw half the population and used 60 percent of the resources are over.

This means that good specialist and other hospital health care must be improved in places where people live – in rural areas, on the Cape Flats, in squatter communities.

That is why we have spent time and money in our efforts to upgrade the hospitals in George and Ceres, as well as the GF Jooste in Manenberg.

That is why plans exist to upgrade the hospitals in Worcester and Paarl, and why we hope to build a hospital in Phillipi.

Nothing illustrates our commitment to remain logical more than the fact that we now have a trauma facility for the first time in Beaufort West to deal with accidents on the N1.

However, what stands out has been our ability, in only two years, to build or upgrade 45 primary level facilities. Of these, six are already open 24 hours a day. The idea is that every district must have access to a 24 hour facility. From July, Delft will play this role for the northern suburbs.

All in all, we are quite advanced in building a health structure that will have a small super-specialist component at the top of the pyramid, a medium-sized network of specialist and district hospitals, and a broad base of primary, community facilities.

EBRAHIM RASOOL

MEC FOR HEALTH & SOCIAL SERVICES

MAKING THIS SYSTEM WORK

A health system can be logical, well-planned, and internationally acclaimed, but it relies on some important factors to make it work to the satisfaction of the citizens it serves. These include:

■ An Effective Prevention Programme

Based on the wisdom that "prevention is better than cure" we are implementing programmes to fight TB, to prevent the occurrence of measles, polio and other diseases, to minimise health risks and generally to promote a healthy lifestyle.

In time, we hope that the effect of such programmes will decrease the number of people needing our clinics and hospitals.

■. Patients Knowing How To Use The System

One of our major weaknesses is that we have not communicated with citizens sufficiently about how to use the health system. This is especially crucial following the complete change the health system has undergone.

I am committed to correcting this through a campaign to explain why everyone must enter the system at the primary level, why ambulances can only transport the critically ill, and why hospitals and clinics are zoned in the way they are.

Knowing these things will empower ordinary citizens to use the system with more confidence.

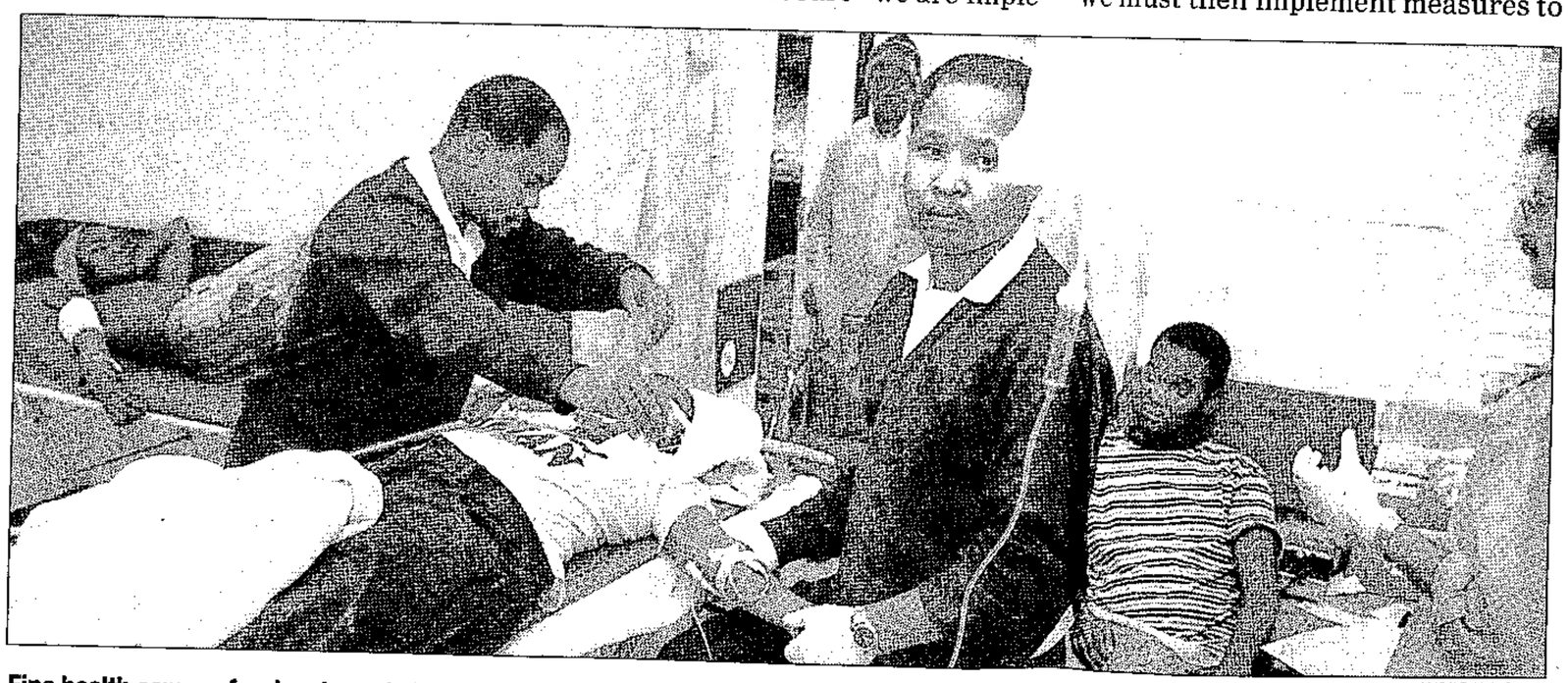
■ Creating a Caring Health System

The common factor that binds the entire health family is a love for, and a desire to serve. In times of stress and pressure, such devotion often takes a back seat.

In addition, there are aberrations, such as the quota system, which sees many patients turned away, or leaving without medication, and the clinics or day hospital being empty after lunch. This must end.

We need, firstly, to find a balance between the needs of the staff and the rights of the patients.

This relationship must be governed by a sense of commitment and discipline. We must then implement measures to relieve the work pressure on staff through, for example, using community volunteers. Simultaneously, the compulsory use of name tags by staff members coupled with a toll-free complaints phone line may enable citizens to exercise their rights.



Fine health care professionals: ambulancemen prepare to transfer a patient from the Khayelitsha day hospital

ANDREW INGRAM

THE HEALTH BUDGET

There is great public awareness about the cuts to the health budget which does open us up to potential abuse. I am dismayed when, for example, a hospital blames budget cuts for the discomfort of its patients when, in fact, their budget has increased.

The danger is that "budget cuts" becomes a catch-all excuse and lets everybody off the hook when, in fact, both management and staff must take responsibility to improve the situation.

However, there is a budget problem which leads to other problems such as a shortage of staff to fulfil all the health functions required of us.

However, we are in the process of fulfilling our vision of rationalising the academic hospitals (although we would like to do so at a slower pace) and protecting the rest of the health system. In reality, this means that posts are being cut at academic hospitals, but not at primary and secondary level.

The difficulty lies in the unwillingness of some health personnel to take up vacant posts in rural, squatter and poor communities.

The other major problem is that we have lost about 3 500 health workers through voluntary severance packages.

Unfortunately, many were nurses (who are critical to the system) and health workers. This has made the uncomfortable period between the old and the new even more painful.

I have suggested to the health management that we only approve those packages which accord with our overall vision for the new health system, and that we accelerate the filling of posts which will bring direct relief to the many poor communities of the Western Cape.

THERE IS HOPE

I want to urge the public and health workers to hold faith.

We are committed to create a health system that is fair to all. The press has put us under pressure to get our house in order. That is their role and we appreciate it. But we must not panic. We must hold on to our vision for a new health service and the signs of hope are already there.

Against enormous odds our staff are pushing the TB figures down, getting food to hungry children, curbing complications at child birth, immunising our children, giving burn victims a second chance in life, doing the most complicated surgical procedures, and caring for patients. Such achievements are often forgotten in moments of crisis.

The road ahead is going to be tough, but the new is almost born. In this lies our optimism.

■ *Ebrahim Rasool is the MEC for health and social services in the Western Cape, and leader of the ANC in the provincial government.*

Call for traditional healers to join health system

Star 29/5/97

Gauteng's standing committee on health has invited traditional healers and interested parties to make submissions on how herbalists and healers could be incorporated into the provincial health system.

Addressing the committee's meeting at the legislature yesterday, chairman Mondli Gungubele said the province was seeking practical solutions towards formally recognising and registering the various traditional healing practices.

Gungubele said the committee was finding it difficult to identify the stakeholders because the sector was not organised.

He urged individuals and organisations with an interest in the matter to forward their written submissions to the secretary or indicate their wish to attend the hearings to be held at the legislature on June 5 and 6.

Gungubele said the hearings would be publicised this week to attract the relevant people in the field.

However, the committee would appreciate "credible submissions".

He said research showed that traditional healers of all descriptions were used by more than 60% of Africans, 40% of Indians and more than 30% of whites.

The committee defined traditional healing practitioners as all healers not in the medical mainstream, including homeopathy and faith healers. – Provincial Reporter and Sapa.

MANAGED HEALTH CARE

(86)

Diagnostic dilemma

High price to pay for the perfect bedside manner

FM 30/5/97

Statistics are dangerous, particularly when selectively quoted and then used to advance an agenda. Some members of the medical profession are disputing the 24% medical inflation figure commonly thrown around by medical fund managers and employers eager to shift the burden of health cost increases to employees. Research by the Hospital Association of SA (Hasa) puts medical inflation consistently below 10%.

"Medical aids quote this figure of 24%, but what they are referring to is the increase in their expenditure," says Hasa CEO Dr Annette van der Merwe. "This figure includes an increase in the volume utilisation of the fund, the shift from public to private sector and changing technology.

"When employers talk about health-care inflation, they are referring to the increase in medical aid contributions. This is partly the result of cross-subsidisation."

Van der Merwe says the actual increase in the costs of medical services has never risen by more than 10% over the past decade, putting medical inflation in line with economic inflation.

This is not to say that all is well with the health-care industry, she adds. Less than a quarter of the population is covered by formal, private-sector medical schemes. The question is how to extend this and maintain a high level of care without bankrupting the system.

The medical profession is sharply divided on the subject of managed health care, which seeks to reduce costs by controlling doctors' remuneration for services rendered, often to the point where authorisation for certain medical treatments must be obtained in advance.

The traditional fee for service system is reputed to have made many doctors extremely wealthy by giving them free rein to decide the nature and frequency of treatment. Kickbacks from drug companies added to an already murky ethical picture. The problem is, what should replace the fee for service system?

Capitation agreements, or predetermined fees for each category of treatment, could lead to underservicing of patients by doctors in order to save costs. There is understandable concern that the chaos which attended the birth of managed health care in the US — where barely conscious patients admitted to hospital emergency wings were asked to produce proof of medical insurance before treatment would be administered — will be repeated here.

Various studies have found that the fee for service system encourages medical aid members to camp out in GPs' consulting rooms, largely because they bear little or no cost risk. Often, these visits are unnecessary. Sanlam Health introduced a medical hotline for its members and of the 1 500 calls received in the first month, 67% of those planning to visit their doctors decided against it after receiving telephonic medical advice.

"The cornerstone of managed health care is denial of care," says practising doctor Douglas Gurnell. "Managed care bureaucrats believe that medicine should be organised as a mechanised industry, which means the product, sick human beings, can be treated on an assembly line as inanimate objects. The flaw, however, is that the raw materials entering the production line do not come in standardised form."

The alternative, says Gurnell, is a system of medical savings accounts linked to calamity insurance, similar to that operating in Singapore. This system is not unlike motor insurance, where the cost of "breakdowns" is borne by the individual, but where major expenses are incurred, such as after an accident, the insurance pays. Research by Rand Corporation among 5 809 people found that individuals responsible for 50% of their medical payments spent 25% less than those who bore no responsibility for payment.

Ciaran Ryan

Rasool gets tough

Barrow death sparks probe into system

Flashback: the Cape Argus breaks the story

ARG 3/6/97 (85)

JENNY VIALL
HEALTH REPORTER

The entire primary health system in the Western Cape, complaints about uncaring health workers and the ambulance service are to be probed by the team investigating the wheelbarrow death in Khayelitsha.

This was announced today by Western Cape Health Minister Ebrahim Rasool, who said he was extending the brief of the team appointed to look into the death of Thobeka Madayi.

Last month, the Cape Argus reported the death of Mrs Madayi in a wheelbarrow after she was turned away from the Nolungile community health centre in Khayelitsha.

Her desperate husband, Vuyani Magazi, took his terminally ill wife to the clinic after being told no ambulance was available. When he arrived, staff told him they were closing and it might be quicker to get an ambulance from another clinic.

Mrs Madayi died in the street on the way to the second clinic. The report prompted a huge response from readers, who made further allegations about the uncaring attitude of health workers.

The report also highlighted the crisis at clinics and in the ambulance service.

Mr Rasool said he was giving the team more time to look into broader problems in primary health care in the Western Cape. Its report would have "a profound influence" on the provincial health system.

He had given the team until June 13 to report back and had broadened its terms of reference to enable it to identify other factors affecting primary health care delivery. The team would also investigate complaints directed at the Health Department.

The Deputy Speaker of the provincial parliament, Mampe Ramotsamai, heads the team and the members are John Frankish, Lynne Brown and Gabrielle Urgoiti.

Mr Rasool has briefed the team to investigate the circumstances surrounding the

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health

Rasool gets tough on health system

ARG 3/6/97 (85)

From page 1

death of Mrs Madayi, and the reasons for the poor quality of care at community health centres in the metropole.

The brief includes questions of negligence, the lack of a caring attitude and possible disciplinary measures.

The team has also been asked to make recommendations on corrective measures, ways to improve the quality of care and staff morale at community health centres, and methods of improving the management and motivation of staff.

The team will also investigate the ambulance service, especially in relation to community health centres.

In his brief to the team, Mr Rasool said there appeared to have been a gross violation of the ethics of health professionals in the case of Mrs Madayi and that he had been greatly perturbed by her tragic death.

"That a person in the last stages of a long struggle against illness has to endure the indignity of dying in a wheelbarrow in the middle of a street is a poor reflection on our society and the health service," he said.

"Still, judgment cannot be served on all staff at Nolungile community health centre and an investigation needs to be carried out to establish the facts."

Music students join health care scheme

Kathryn Strachan (85) BD 6/6/97

IN TWO impoverished KwaZulu-Natal communities, music students are the latest recruits to the new-look primary health care teams.

A project based in Durban is emerging as a model of the new trend of finding more community-orientated approach to health care. The Natal Institute for Community Health Education — a partnership of universities, health services and the community — runs the project, which takes a holistic strategy of giving health workers the wide range of skills they need for primary health care.

The music students from the University of Durban Westville got involved after they looked at the role of music in recreation and education, and in their project they emphasise how people with musical ability can generate an income through their talent.

"The programme looks right back to the basic needs, and the key is developing communities by allowing them to participate at every level, and giving them the skills they need to be able to stand up and change things," project co-ordinator Glen Jager said.

It takes students into disadvantaged areas to give them an understanding of conditions in those communities and of how to find solutions within the constraints of poverty.

This year about 550 final year students are being taken from Natal University, University of Durban Westville, Natal Technikon and Mangosuthu Technikon to work with communities in the Valley of a Thousand Hills and in Mgababa on the south coast.

The programme has spread to almost all categories of health science students — medical, nursing, environmental science, pharmacy, optometry, occupational health and chiropractic. At times the focus falls more on research, at others it is on service.

Out of the initiative have come seven different programmes. There is early stimulation in creches, training creche teachers to identify early signs of disability or developmental lags, and support groups for disabled children.

A community mental health project tackles the high rate of teen pregnancy through life skills education, while other programmes look at substance abuse and provide support for mentally ill patients living in the community.

Medical students are looking at how TB services in the valley can be changed.

"There are so many barriers to break down," Jager said. "We need to develop students so that they look beyond the individual patient and see people in the context of their family and community, and understand all the aspects that affect their well being."

Opposition parties walk out of health hearings

(85) ARG 7/6/97

JENNY VIALL
HEALTH REPORTER

Opposition political parties have walked out of a hearing of the portfolio committee on health in a united protest over "undemocratic" procedures.

The parties walked out yesterday after appeals to increase the amount of time allowed to people making submissions on the Medical, Dental and Supplementary Health Services Professions Bill were refused.

The bill deals with, among other things, the composition of the new council and the two-year vocational training programme for newly-qualified doctors.

The parties had appealed to committee chairman Abe Nkomo to allow more time for questions and discussions. But this was refused and each person was given only 10 minutes in which to make their submissions.

In a statement, the parties expressed concern at the procedures followed at the hearing.

President Nelson Mandela is to be approached to investigate the "undemocratic procedure", which "flies in the face of openess and transparency, which were to have been the hallmark of all parliamentary committee work, especially legislation", the statement said.

Six die as blast

Walkout at health hearings

By JENNY VIALL

Opposition political parties walked out of the portfolio committee on health hearings yesterday in a united protest against the "undemocratic" procedures followed at the hearings.

The IFP, the National Party, the Democratic Party and African Christian Democratic Party, with the Freedom Front and the PAC, want the Medical, Dental and Supplementary Health Service Professions Amendment Bill withdrawn, and the life of the Interim National Medical and Dental Council to be extended by six months.

This would allow the bill to be given appropriate consideration and do away with the need to pass it urgently before the council's legal life expired, the parties said. The bill establishes the council's successor.

The parties left after repeatedly objecting to the short time given for people to make submissions on the bill. They appealed to committee chairman Abe Nkomo to allow more time for questions and discussions on the bill. This was refused.

Each person was given 10 minutes to make submissions, and all the parties objected to the way the hearings were being rushed through.

The bill deals with, among other things, the controversial two-year vocational training programme for newly qualified doctors.

"We've been told the urgency is because the council's term of office expires in August," said Democratic Party spokesman on health Mike Ellis. "If we can extend the IMDC's life, we can deal with the bill properly and with the sensitivity it deserves."

President Mandela is to be approached to investigate the undemocratic procedure which "flies in the face of openness and transparency which were to have been the hallmark of all parliamentary committee work, especially legislation", reads the statement.

"This bill is highly technical in nature and contains complex matters which have the potential to significantly alter the provision of health care in this country.

"As such it will impact on the lives of both providers and users of services."

Opposition parties say they are not necessarily opposed to the content of the bill, but rather the procedures followed.

Other portfolio committees, said Ellis, discussed the process to be followed as to who would make the submissions and for how long. "We have simply not been consulted."

Pensioners feel the squeeze as costs soar

THE provision of health care cover is the most significant element of a pensioner's budget — and the least provided for.

Fedsure Health MD Rod Harpur says three issues have affected pensioners:

- Massive increases in medical aid or health insurance premiums in recent years have left premiums taking up 10% to 15% of the employee's monthly salary;
- As a direct result of the weight of these premiums, companies are not able to continue contributing towards their pensioners' medical costs, leaving these members to carry 100% of costs, which could add up to 40% of their post-retirement income;
- Claims pressure on older-style schemes is forcing them to remove pensioner subsidies. The trend towards more progressive schemes that introduce age-related rates that are more closely geared to the cost of risk, is also adding to the cost for pensioners.

Liability

The first step in recognising the problem has been taken in terms of the SA Institute of Chartered Accountants' AC305 draft accounting proposal requiring company disclosure of pensioner health-care liability, and some companies are starting to consider taking action, says Harpur.

However, more often than not they are still ignoring their responsibilities, he says.

Sometimes the sheer weight of this previously unrecognised obligation is enough to scare companies off. Product flexibility and a phased strategy are therefore often required to help employer groups to a fully funded position over a number of years.

Employers, however, can no longer claim that the exercise requires months of investigation, says Harpur.

Some health-care companies – such as Fedsure Health – are able to provide assistance.

The company provides a choice of plans that allow firms to quantify the problem with actuarially projected valuations of how much a person will need to have accumulated at retirement age to be able to budget for medical aid premiums during retirement.

BD 12/6/97

The bottom-line benefits of health management

(85)

EMPLOYERS who can find ways of improving the health of their employees will derive major benefits that include long-term cost containment, better productivity and the freeing of financial resources for investment in other projects. BD 12/6/97

Janina Slawski, Southern Life risk management consultancy manager, says measures that companies can take include:

- ☐ Improving safety conditions in the workplace;
- ☐ Introducing employee wellness programmes to educate them towards healthier lifestyles;
- ☐ Providing health education and;
- ☐ Providing better access to preventative care.

Southern believes employers need to view employee health in terms of a health continuum.

"The combined effect of actions like these would bring about significant reductions in the incidence of new illnesses and disabilities among employees," says Slawski.

She says that in terms of employee benefit schemes, reducing the incidence of illness and disability will cut the cost of providing group disability benefits and the costs associated with early retirement through ill health.

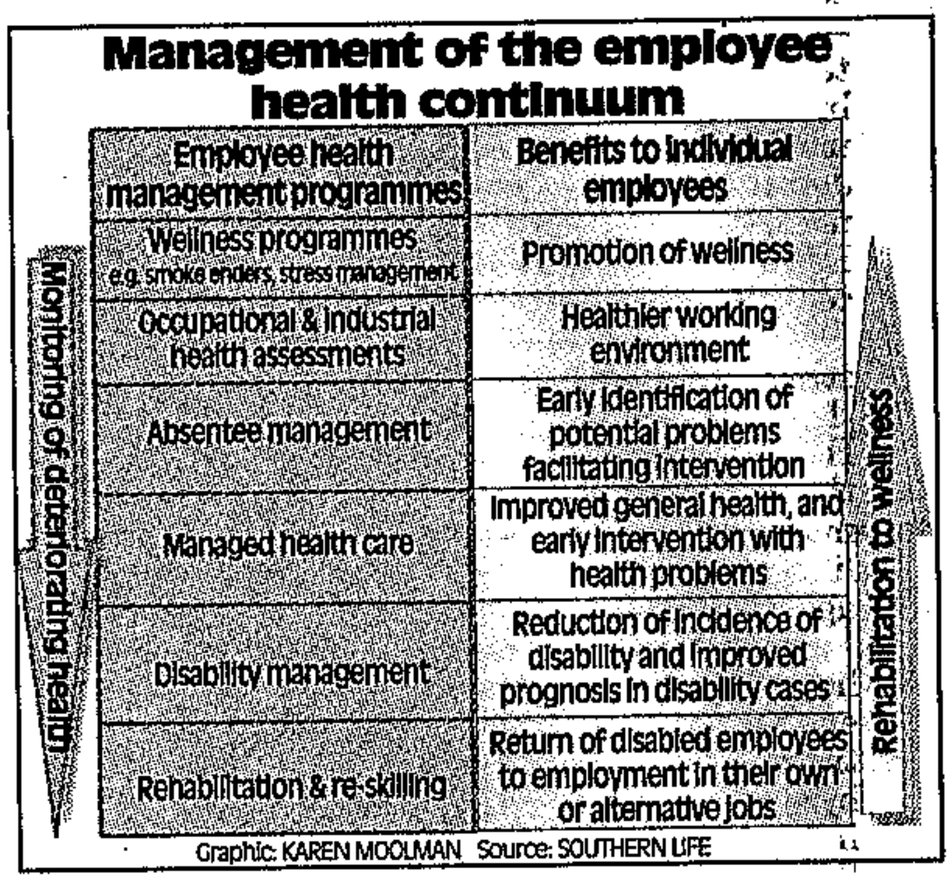
"The aim should be to balance paying the benefits that are genuinely needed by employees who are ill or disabled, and cutting off benefits that are not needed because the employee can earn an alternative income.

"This approach will reduce the cost of providing benefits they receive during the duration of their illness," says Slawski.

The implementation of managed health care principles aimed at providing efficient, cost-effective health services to members is the most effective way of getting a company medical aid scheme to support initiatives to improve employee health. The mechanisms used include analysis of the outcomes of medical treatment, development of practice guidelines for optimal care, encouragement of preventative care and early intervention.

While there may be costs involved in the short term in converting existing schemes to managed care, over time the health of employees will improve.

"Employees will generally be healthier and will share in the cost savings achieved, while employers will benefit from increased productivity and long-term cost-containment," say Slawski.



BUSINESS DAY survey

The health department's plans for a community rated pay-as-you-go system in which there is universal access to health cover are being met with sharp criticism by leading players in the industry. ***Lynn Carlisle*** *reports.*

Industry players slam 'outmoded' thinking

(85)

BD 12/6/97

LEADING health care industry players say proposed legislation is based on outmoded socialistic thinking and cannot support an economically viable health delivery system.

This is the most controversial issue in health financing at the moment, says Peter Nieuwoudt, Institute of Life Pension Advisors (Ilpa) vice-president and spokesman on health benefits.

These department of health proposals for financing the private health industry have reached an advanced stage, but have little support from the industry.

"Unfortunately, they ignore virtually all suggestions made in response to the department's initial discussion documents," he says.

"The recommendations of the Melamet Commission of Inquiry have been disregarded and many of the proposals pre-empt the findings of the Katz Commission," says Nieuwoudt.

In essence, the the department is proposing a return to a community rated "pay-as-you-go" system in which there is universal access to health cover, irrespective of risk.

"All this defies conventional insurance and actuarial logic. It is regressive and will have far reaching implications for the industry," says Nieuwoudt.

A series of proposed disincentives could also result in further manipulation of the tax system.

For example, medical scheme contributions are limited to people who conform to prescribed benefit structures, although these may be unsuited to the demographics or needs of their membership.

Benefits which are "excessive", including those funded via personal savings, would not qualify for tax concessions.

"The existence of a stabilisation fund along the lines of the MVA, the proposal that we all pay, whether or not we use the system, and the differentiation of contributions on the basis of income, all reflect a political agenda," says Nieuwoudt.

The idea of an umbrella Health Finance Act and the creation of level playing fields are nothing new. Melamet recommended that overall regulatory authority be vested in the Financial Services Board (FSB) where the necessary technical skills and resources reside.

The department of health has neither the infrastructure nor expertise to regulate a sophisticated national health financing system.

Nevertheless it proposes that all health financing should fall under its control.

Further proposals recommend that all health financiers should fall under the department's control within a regime bent on doing things the old-fashioned way, says Nieuwoudt.

Experience has already shown that old systems which include the pay-as-you-go approach are untenable, leading to the defection of younger, healthier and more responsible members.

The 1994 amendments to the Medical Schemes Act paved the way for "new generation" products which employ sound risk management and underwriting principles and engage competent accounting and actuarial skills, he says.

John Gardner, CEO of Northern Medical Society, says that if some of the proposals should be implemented, everything learnt during the years would be compromised.

"And in the process the real health care dilemma and the needs of the public would not have been solved," says Gardner.

Nieuwoudt says medical schemes have undergone a metamorphosis and are generally far healthier and better managed than at any time in the past.

"Members participate actively in the management of costs and are encouraged to pre-fund for post retirement cover," he says.

"The key to cost containment is the empowerment of members, not prescriptiveness or paternalism," he says.

Employers must keep their fingers on health-care pulse

(85) BO 12/6/97

THE days of employers not taking an active role in the provision of health care are numbered.

The arrival of managed health care in SA and the growing need to contain costs and provide adequate post-retirement benefits is forcing employers to play a more decisive role.

Managed health care calls for employers to think in broad terms as health care companies introduce a wide range of tools in an effort to contain spiralling costs and increases in medical aid contributions.

Jaco van der Walt, Ernst & Young partner (medical financial services), says while employers and employees will welcome a reduction in contribution levels, some of the new arrangements need to be carefully considered.

He says certain of these schemes may affect the accessibility of care, and freedom of choice, of patients in relation to facilities and service providers they would like to use.

For example, it will make sense for the funder to enter into an agreement with a preferred provider network in the area in cases where the employee base is restricted to a specific area.

Van der Walt says this could include specific hospitals, pharmacies, medical specialists and general practitioners in the area.

Employers who have employees spread around the country will, however, have to consider the implications for staff in areas not covered by the various provider networks.

"Additional costs may have to be met to travel to network facilities, and may exceed the benefits achieved by managed health care for these employees," says Van der Walt.

He says families of travelling patients, who have no facility close to home, will also incur higher expenses in order to be close to the patient.

Employers should also ensure that their managed-care companies measure the quality of care patients receive, as quality can easily deteriorate in cost containment exercises.

The doctor networks that are contracted should also have their own peer review programmes to ensure quality while reducing overservicing.

Van der Walt says many employers have moral and legal duties to provide health care for retired staff and should put mechanisms in place to ensure that both the company and the pensioners can afford post-retirement cover.

In the near future, companies will have to disclose their liability in this regard in their financial statements.

(85) BD 12/6/97

Health insurance proposal faces hurdles

THE white paper on the transformation of SA's health system, including the proposed introduction of a mandatory social health insurance scheme, is expected to have a major financial impact on the private sector.

The proposal is seen more as a mechanism to raise additional public health finance, says Richard Bryant, principal consultant for Old Mutual Actuaries & Consultants.

What social health insurance implies is mandatory cover for all formal sector employees and their dependants, for treatment in public hospitals.

"This is an effort by government to deal with people who currently receive free treatment at public hospitals despite their ability to pay.

"It also includes the problem of members who have exhausted their medical aid benefits and who seek further treatment at public hospitals.

"Our view, however, is that the proposal cannot be realistically considered for implementation before crossing two major hurdles: acceptance by Nedlac and the department of finance."

He says contributions to health insurance will be shared by employers and employees.

"This could affect even marginally profitable businesses as a result of higher labour costs, making it possible that business and labour could both oppose the proposal.

"Labour representatives have tended to resist participating in medschemes and other arrangements since treatment at public hospitals has traditionally been free, and the cost of participation in medschemes has become prohibitive."

What is more, says Bryant, is the health insurance proposal is a direct attempt by the department of health to institute a new tax."

Since it is policy to divert national tax funding away from hospitals to primary health care, health insurance paid in the form of a payroll levy provides the department of health with a new way of funding these institutions outside of the national fiscus.

However, under the proposed scheme hospitals would retain only a portion of their fees with the balance paid to provincial health departments "in order to distribute some of the income to needy facilities which are unable to generate significant fee revenue".

Still, he says a system of social health insurance may be regarded as desirable, particularly with buy-in from stakeholders on measures such as employer and employee contributions being paid directly to public hospitals for a core package of services.

Health department apologises for complicity with security apparatus

Dianna Games

CAPE TOWN — The department of health yesterday delivered a damning submission to the truth commission in which it admitted serious ethical and professional violations and complicity with the security apparatus of the past government.

The submission, delivered by deputy director-general Dr Harm Pretorius, who also served under the old dispensation, was read to the special truth commission sitting on the health sector.

"In terms of human suffering, this department has much to answer for and much to apologise for. Rather than allowing health to be the driving force of its policies, it concentrated most of its efforts and resources on only part of the population in line with the political objectives of the apartheid state.

It apologised:

- To those discriminated against by the lack of health services which resulted from inequitable, racist allocations of resources;
- To detainees and their families who received inadequate health care or who were abused by department officials;
- To activists who were not protected by the department and who might have died or been permanently injured as a result;
- To patients "violated" in psychiatric institutions;
- To people who suffered as a result of emergency services operated on racial lines;
- To practitioners who were discriminated against in terms of training, salaries, facilities and for acting against apartheid; and
- For not supporting those who objected to torture and other abuses of medical ethics, and for not taking actions to ensure such abuses did not occur.

It said as the employer of district surgeons, the department had to bear some responsibility for the fact that many of them became accomplices to actions leading to unnecessary illness and even death.

While it had no evidence that doctors were actively involved in torture, they did not expose torture when it was clear it had occurred. The department had also not ensured that detainees' health was protected.

In some cases, the health department, by not acting, had collaborated with police against the interests of patients and had allowed the professional integrity of its employees to be violated.

It also admitted to using its "so called family planning services" to control the size of the black population and to manipulating information to give distorted or inaccurate perceptions of health care in SA.

Meanwhile, the Medical Association of SA (Masa) said its complacency during the apartheid era had allowed blacks and whites to be treated differently, a form of human rights violation for which it stood disgraced.

In its submission to the truth commission, hearing Masa said it had also tended to close ranks to protect other doctors, choosing professional self-interest over support for human rights development.

"In trying to remain 'neutral' we recognise that Masa actually served to maintain the status quo," it said.

"While we have not yet heard of doctors who actually committed acts of killing, torture or abduction, we have long heard of doctors who helped the perpetrators get away with it by remaining silent or even assisting them," it said.

The organisation printed an unconditional apology for its past wrongs in the SA Medical Journal in 1995.

However, commissioner Dr Wendy Orr said it was too easy to issue a general apology. "Masa should make individual and personal apologies to those who it vilified and failed to support during those years," she said.

Masa federal council member Dr Edoo Barker told the commission: "Masa was always without doubt a part of the white establishment in SA, and for the most part shared with world view and political beliefs of that establishment. Inescapably it also shared the misdeeds and sins for which the white establishment was responsible."

Barker said Steve Biko's death and the circumstances surrounding it, "in which members of the medical profession were so clearly and shockingly involved", rocked its complacency about human rights and forced it to begin examining the ethics and morality of its actions.

Masa had supported the initial finding of the SA Medical and Dental Council that no action be taken against the doctors implicated in Biko's death, mounting a nationwide propaganda campaign to ensure the membership followed its lead in the matter.

Masa had also failed to take a stand against segregated medical facilities, its submission said. and it only ruled in 1994 that it was unethical to segregate waiting rooms on a racial basis. Sapa reports that this was five years after the Separate Amenities Act was scrapped.

Meanwhile, the now defunct SA Nursing Council — the regulatory body for the nursing profession under apartheid — apologised unreservedly for undermining human rights "from time to time", saying it had been influenced by the then government's apartheid policies.

Review of govt employees is needed, says truth body doctor

(85) BD 26/6/97

Nomavenda Mathiane

A FUNDAMENTAL review of government and its health services was needed to see if employees were fit for their jobs, truth commission health sector head Dr Wendy Orr said yesterday.

She was reacting to reports that Dr Ivor Lang — one of the doctors found guilty of improper conduct after examining late black consciousness leader Steve Biko — is still a state employee.

Lang, who is employed as a "sessional" district surgeon in Port Elizabeth, was cautioned at a disciplinary hearing in 1985 for his part in Biko's 1977 death

Last year Dr Mangaliso Maqina, the Western Cape region district council health director, gave evidence at commission hearings and accused Lang of "gross human rights violations".

Former detainee Mzukisi Mapela also told the commission last year Lang had touched political detainees with his stethoscope and pronounced them healthy even though they had been tortured repeatedly.

Eastern Cape health department spokesman Khululekile Bata said his government had inherited structures and resources from the apartheid health department, which was in line with the policies of the government of national unity.

He said Lang continued being employed by the department as district surgeon in the belief that there should be a spirit of reconciliation.

He said the department had no right to dismiss Lang because there were previous processes which dealt with the matter.

Meanwhile, Ecna reports that Steve Biko's grave may soon become a national monument.

Biko, then banned to King William's Town's Ginsberg township, died in Pretoria from injuries sustained through torture by security police.

Biko's body was brought back from Pretoria and buried in a cemetery near King William's Town.

On Tuesday, the town council controlling Bisho and King William's Town agreed to apply to the National Monuments Council to have the grave recognised as a national monument.

'Managed care the answer'

BD 27/6/97

Lucia Mutikani

THE successful implementation of managed health care could provide the cost efficiency desperately needed in SA heath care delivery, Sanlam Health MD Altus van der Merwe said.

Managed health care was not a "quick fix", but the only sustainable solution for medical hyperinflation and the elimination of waste. It could also lead to lower premium increases and provide access to quality health for all South Africans, he said.

Van der Merwe said Sanlam Health had been instrumental in bringing down the average number of bed-days per 1 000 members to 675 in the last five months of last year, from 858 per 1 000 during the first seven months.

"The real net saving of 22% in direct costs can be attributed to the elimination of inefficiencies. This success was achieved without undue medico-legal risks and with proper measuring and monitoring of the quality care that patients receive," he said.

"Of particular importance is the fact that the saving was effected within the requirement of the registrar of medical schemes that administration costs should not exceed 10% of contributions received by the administrator of the medical fund."

Van der Merwe said overuse was eliminated in a managed care environment, while clinical quality standards could be monitored and maintained.

He urged concerned parties to focus on patient needs and co-operate to make quality health care more affordable and accessible. This would prove that the private sector was willing, prepared and able to contribute towards attaining the government's national objectives for health care, he said.

Cutting Caesarean arrogance down to manageable size

SA doctors who do Caesars for money and their own convenience are in for a shock, writes PAT SIDLEY

MANAGED care has become infamous in the United States for practices such as "drive-by deliveries" — trying to get women who have given birth out of their expensive hospital beds as soon as possible.

Obstetricians in this country, who are paid for delivering babies on a fee-for-service basis, are notorious for an alarmingly high rate of Caesarean deliveries. Depending on who is collecting the data, anything up to 68% of babies born in private hospitals are delivered in this manner.

Momentum Health's figures for Caesarean sections are no exception to the rule — but MD Adrian Gore says its solution to the problems spawned by fee-for-service payments will reflect wisdom gained from managed care experience in the US.

The US managed care experience has produced a consumer backlash joined by physicians and more recently by employers backing their employees' rights to better health care.

Momentum Health spends 12% of its total hospital bills on maternity. If the babies are born the natural way, the bill for each birth would be about R4 550. A Caesarean section pushes up that bill to R6 400.

Gore says about 60% of the births his company finances are Caesarean sections, now falling rapidly towards 40%. The decline is thanks to the introduction of a managed maternity programme which arms mothers-to-be with the information to make better choices.

The mother is guided by in-house maternity counsellors and a range of incentives which help her make choices likely to suit both her body and her insurer's purse.

Among the incentives are ante-natal classes paid for by the company.

These classes typically will tell the pregnant women about their pregnancies and about alternative methods of delivery — including information on when Caesars are necessary, and when they are not necessary.

The incentive to avoid lengthy hospital stays is Momentum's provision of a nurse to take home. This happens if the new mother is discharged from hospital within two days of an uncomplicated birth — or three days after a Caesarean section. The nurse will help at home for another two days. It is naturally much cheaper for the insurer to pay a nurse than to pay the hospital for additional days.

Momentum has been collecting data on Caesarean deliveries. The sample is too small for firm conclusions yet, but it suggests that some doctors perform Caesarean sections almost to the exclusion of natural births.

For anyone contemplating parenthood, however, a word of warning. The maternity counsellor can be hard to find — and it takes a while for the telephone to be answered. I called looking for a maternity counsellor to test the level of information provided. After a frustrating wait (and questions I did not want to answer to a nameless telephonist), I was told all the counsellors were at a meeting.

Gore has recently returned from the US where he noted that the move in managed care and health maintenance organisations is towards satisfying consumers' demands.

The system whereby the general practitioner becomes the gatekeeper to all other medical services is largely being abandoned, he says, in favour of allowing patients the choice.

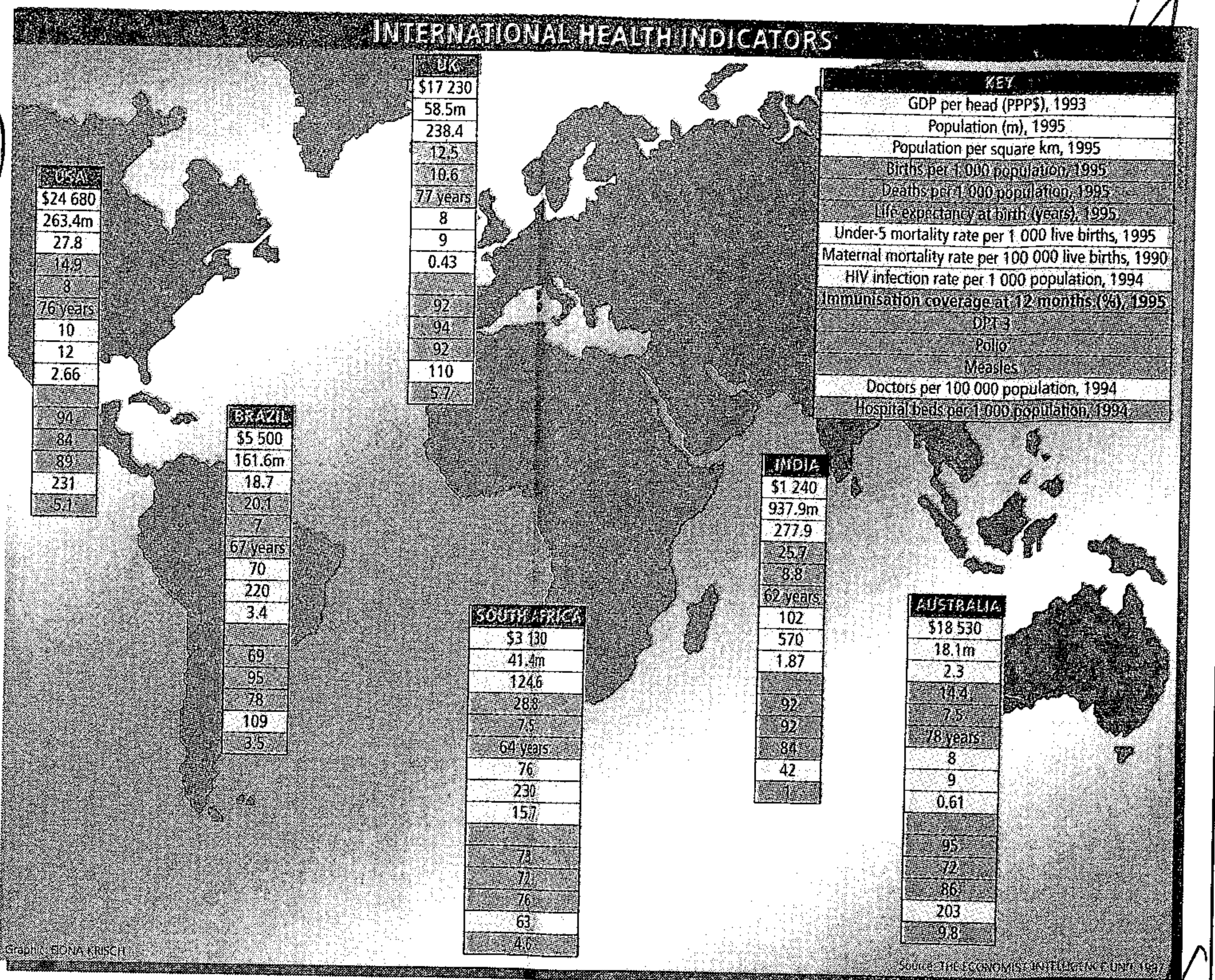
The patients, however, are increasingly being armed with information on which to base their medical choices.

He has returned, too, with another US buzzword, "demand management". To ordinary mortals this entails giving people better information.

It is done by using nurses or other health professionals on the other end of a telephone line as the first port of call for a patient.

A key area of Momentum's insurance products is its medical savings accounts. This is an area surrounded by controversy at the moment as government health planners are casting a slightly disapproving eye at this method of providing for health care financing.

The savings account allows the member the flexibility to make the health care choices herself and manage many of her own costs, as opposed to the top-down approach of many managed care groups and health maintenance organisations, according to Gore. He says it is an increasing trend in the US.



Nationalise SA health system – hospital chief

'Only way to aid poor'

ARG 30/6/97

JERMAINE CRAIG
STAFF REPORTER

There are enough facilities to provide proper health care for all Capetonians, but poor people are being discriminated against in the allocation of resources, says the head of a Cape Flats hospital.

Norman Maharaj, medical superintendent of the G F Jooste trauma-emergency hospital in Manenberg, the smallest secondary hospital in the Peninsula, said only a fifth of the country's health resources was spent on public hospitals.

Chief: Norman Maharaj

Most money spent on health came from private sources and was pumped into private hospitals, resulting in poor people having to make do with Government-funded hospitals which could not cope with the tremendous workload.

Dr Maharaj said there were enough health facilities in the Western Cape, but many of them catered for the well-off rather than the poor. "The difference is so vast it is unreal," he said.

"Eighty percent of all money spent on health in this country goes to 20 percent of the people. Poor people are the ones who suffer because they make use of public hospitals."

He felt the answer was to nationalise the health system and scrap private hospitals.

"We cannot afford the luxury of private health care while the poor are suffering. We need to use all the resources in this town so that poor people can be helped," said Dr Maharaj.

His hospital serves an estimated million people from areas such as Khayelitsha, Mitchell's Plain, Strandfontein, Guguletu, Heideveld, Nyanga, Manenberg, Philippi, Crossroads and Surrey Estate.

Dr Maharaj said his hospital did not have the capacity to cope with the thousands of patients who streamed through its doors every month. People sometimes waited up to 12 hours for treatment.

Crisis as patients left to die

ARG 30/6/97

From page 1

"This place is chaos today. There are people who have been waiting for 12 hours. We have had about four emergencies today," said Dr Maharaj.

In a tiny room used as a "makeshift clinic", at the entrance to the hospital, incoming patients are "sorted" according to how serious their injuries are.

Dr Maharaj said doctors normally did the screening of patients in this room, but when called to an emergency, they had to leave this to the nurses.

Senior nurses were normally required to assist with emergencies and inexperienced juniors left to screen patients.

Two people at the centre of the siege are Julie Moses and Hawa Abbas, who manage the nursing staff.

They say staff are committed to serving people in the most impoverished communities, but usually all they get in return is verbal abuse.

"People do not know what we have to deal with. The workload we must handle is tremendous. We are doing it for the community and they do not appreciate us. People abuse us every day. Staff morale is very low," said Sister Abbas.

Sister Moses blames the lack of back-up facilities at primary health care institutions for the chaos G F Jooste Hospital finds itself in.

Dr Zuma: grey from maturity or the strain of office?

Star 22/7/97 (85)

By Jovial Rantao

Grey hair is universally accepted as a sign of maturity, an indication that an individual has begun to mellow like vintage wine.

But in some communities or social circles, grey hair is seen as a symptom of the strain that an individual is subjected to – and our Health Minister Dr Nkosazana Zuma has a touch of grey hair. Could this be a sign of maturity or strain? Both, it would seem.

Since the ANC came to power Zuma has, more than any other cabinet minister, been in the media spotlight: her name has become familiar in headlines and posters. It sells newspapers. It makes certain people angry.

The bulk of the attacks on Zuma have largely been on the way certain sensitive issues have been handled.

Perhaps the most notorious was the millions spent without the proper controls on *Sarafina II*, the Aids awareness play.

Zuma was also at the receiving end after expressing support for some inconclusive local research on a cure for Aids.

Zuma could not be faulted for embarking on a educational programme to highlight the danger of HIV infection: her intentions were undisputably good.

But she was rightly cited for not ensuring sufficient consultation and correct procedures were followed before Sarafina received R14-million of taxpayers' money.

Through Zuma's policy on primary health care, communities in the rural areas, most of whom had not had a doctor or a clinic for years, can now enjoy this basic right. Her focus and emphasis on preventative health care remains undisputed and follows a trend in developing countries worldwide.

TJ LEMON

Nkosazana Zuma ... many achievements amid errors

She brought Cuban doctors who were prepared to practise where most of our white doctors, who still make up the majority of medical interns, are not prepared to go.

She has gone to all lengths to ensure that primary health care reaches the indigent – something, as the ANC likes to remind us – that the former government did not.

After the Sarafina debacle, the biggest problem Zuma had to face was when she introduced three bills in Parliament which would help increase access to health care, reduce the price of drugs drastically and make it possible for Joe Citizen to afford medicine. Pharmaceutical companies have been angered by Zuma's plan to import parallel medicine.

They, however, still have not given an indication on whether they would take up Zuma's challenge that she would not import drugs if they provided them at cheaper prices.

Health care has always been limited to those who have financial means, and Zuma's mission is to change that scenario. She intends to make sure that all will receive quality health care at affordable and sustainable prices, both in the private and public sector, regardless of a patient's economic circumstances.

While it was undisputably important that the Medicines and Related Control Amendment Bill, the Pharmacy Bill and the Medical, Dental and Supplementary Health Services Bill should be introduced at the same time because they were inter-linked, it was also clear that she committed a technical error as the time allowed for the bills to go through Parliament's health committee and public hearing was not nearly enough.

The three pieces of draft legislation were withdrawn from Parliament and will be resubmitted at the start of the next session, amended here and there but containing the same basic tenets.

Political parties such as the Democratic Party, the National Party, the Inkatha Freedom Party and to a lesser extent the Pan Africanist Congress and the African Christian Democratic Party vociferously attacked the three bills but did not, like most stakeholders, table any alternatives and hence lost a golden opportunity of contributing constructively to the debate.

Zuma may have made some procedural and technical errors since she became health minister but no one can dispute her success in ensuring that access to primary health care should not be a privilege of the rich.

Even some opposition parties agree that Zuma's policies rank among the best in the world, but also concur that the way she goes about handling them is not ideal.

In ANC and Government circles, she is known as a head-strong woman who, sometimes, hesitates to listen to advice.

She has to become a better manager of her affairs so focus should remain on her good work as a minister and not on the mistakes made.

And maybe the touch of grey on her hair will be a sign of political maturity and nothing else.

Managed care nurses medical aid to health

ARGUS 2/8/97 (05)

In the third article on the future financing of health care, Esann de Kock investigates whether managed care is a quick fix or a viable solution to medical scheme problems

You can get value for money spent on health care, despite the gloomy scenario of rising medical inflation and confusion about the direction in which medical schemes should move.

One of the most important options available to you today is managed care.

Available from life assurers as well as other companies, medical schemes based on managed-care principles aim to give you quality health care while reducing your long-term healthcare costs.

Johan Human, senior manager of actuarial services at D&E Health Benefits, a wholly owned subsidiary of Norwich Holdings, says schemes similar to managed care started taking off in South Africa about three or four years ago. As managed care grew more popular overseas – particularly in the United States – South African life assurers caught on.

A managed care scheme is usually instituted by your employer and in many cases you as a member are assigned a physician or nurse.

With the problems experienced by medical aid schemes and the government's plans to restructure healthcare financing, you can be forgiven for wondering whether managed care is a quick fix.

It is not, say those at the forefront of managed-care companies.

Despite strong criticism from some sectors, especially service providers, medical schemes that offer managed care are gaining ground and are influencing opinion that running a medical aid scheme on managed-care principles eliminates abuse and is the answer to rising medical inflation.

Big players in managed care, including Sanlam, Momentum Life and Southern Life, agree that the successful implementation of managed care will provide greater cost efficiency, will lower premium increases and create quality health care for more South Africans.

The principles of managed care

Most medical schemes try to give you the best quality care for the best price. They don't all succeed.

Human says the effectiveness of a managed-care scheme lies in the strong relationship between the scheme itself, hospitals that form part of the network, your doctors and you.

It relies heavily on you to be a wise medical consumer and keeping your costs down, while getting the best care from the system.

The ways in which managed care encourages you to do this include:

◆ Looking after your health so that you can avoid getting sick in the first place;

◆ Working in partnership with your doctor and pharmacist so that you get the treatment you need at the best price; and

◆ Taking part in decisions on your health and medical care.

Many medical schemes that offer managed care also try to give you a good advice and support service.

Early successes

In South Africa, managed care in its current form only took off about two years ago.

Human believes it is the only way to bring affordable, quality medical care within reach of a greater number of people – the main challenge facing the South African healthcare industry today.

"It's easy to reduce costs. The difficulty comes with maintaining quality and accessibility."

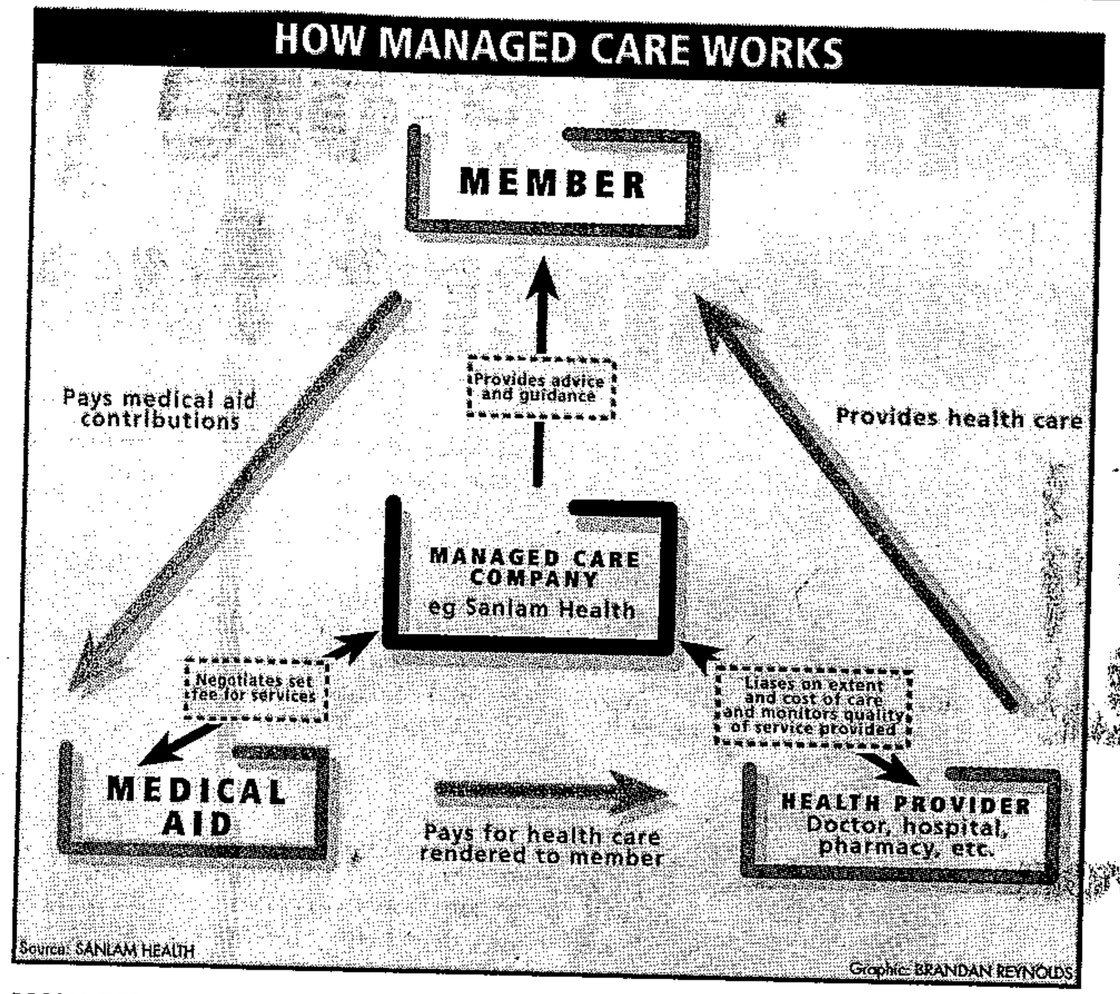
Human says that in the experience of D&E Health Benefits, white collar high-income earners are not as attracted to managed care solutions as lower paid employees.

"The reason is that people perceive a system as restrictive when they can't just go to any doctor or any hospital they choose.

"Managed care does restrict your access and for mobile, high-income earners it sometimes isn't appealing to concentrate on a specific service provider (doctor or hospital) in a specific area."

Human says it is a challenge to make managed care work. The rate at which managed-care schemes are coming onto the market shows that many believe in it.

Sanlam Health – a leading managed care company – has shown how managed care principles can successfully lead to quality health care in a cost effective environment.



MANAGED HEALTH CARE: The graphic illustrates the link between you, the member, your medical aid, health providers and the managed care company.

From August to December last year, Sanlam Health was instrumental in bringing the average number of bed days per 1 000 members down to 675 from 858 the previous year.

At the time, Sanlam Health MD Altus van der Merwe attributed the real net saving of 22 percent in direct costs to the elimination of inefficiencies and said the scheme had succeeded without undue medical and legal risks and with proper measuring and regular monitoring of the quality care that patients received.

In the case of Norwich Health Care, Human says managed care has proven particularly effective in areas where there is a high concentration of members and where the medical scheme can contract with service providers.

Managed care and government

The government has welcomed the introduction of managed care in South Africa.

Olive Shisana, director-general of health, says the government firmly supports a system whereby patients, doctors, hospitals and medical schemes take joint responsibility for quality health care at affordable prices.

Momentum Health, an early advocate of managed care and the first company to launch a managed-care service, recently welcomed the government's interest in managed care. It will participate in future meetings with the Department of Health to explore issues surrounding managed care.

Chief executive officer of Momentum Health, Adrian Gore, said initial discussions with the department had centred around four issues:

◆ Protecting the rights of patients;

◆ Protecting medical professionals from pressures which might undermine the standard or appropriateness of care;

◆ Financial regulation of managed care on an ethical basis; and

◆ The long-term assurance of fair competition and the avoidance of monopolistic practices when strong groups emerge.

Doctors' fears spark lively debate

The merits and demerits of managed care has sparked a lively debate especially among service providers, such as pharmacists and doctors, who say it restricts their professional practice and limits individuals' freedom of choice.

The main criticisms are:

◆ Many doctors fear managed health-care schemes will prescribe how they should treat patients;

◆ Healthcare service providers fear they will be pressurised into contracts favouring the managed-care companies;

◆ Doctors fear that under managed care they will be agents for the schemes instead of at their patients' service;

◆ Doctors have criticised managed care schemes' cost-cutting measures, such as limiting expensive hospital stays and arranging home nursing. Doctors say they should be taking these decisions and not the organisations which profit from reduced costs;

◆ Doctors have also questioned successes claimed in the United States. Some say medical professionals in the US have been receiving shoddy treatment at the hands of managed care operators who are more concerned with profit and loss than health care. They say doctors are forced to carry out the bidding of the accountant or face being kicked out of the scheme.

The critics say assurance companies offering managed care see it as a means of making up for life cover and endowment policy income lost to unit trust companies.

Cliff Altree, senior manager of Norwich Health Care, says the medical profession's fear of disempowerment and the misconception that managed care is a lower-quality alternative to medical aid schemes are two major obstacles to managed care realising its full potential.

Pieter Coetzer, Sanlam chief medical adviser, says often doctors who oppose managed care change their minds once the partnership concept has been properly explained to them.

NEWS

Better basic health care one step closer

ARG 7/8/97 (85)

New system in place next year

JENNY VIALL
HEALTH REPORTER

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

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

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

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

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

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

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

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

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

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

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

BRENTON GEACH

Health team: Pieter Marais and Ebrahim Rasool yesterday

QUESTIONS

†Indicates translated version.

For written reply:

Health Donations Fund (85)

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

(a) (i) What total accumulated funds were held by the Health Donations Fund as at 31 March 1997, (ii) what income was generated by the Fund in the 1996-97 financial year and (iii) what was the source of this income, (b) what specified costs were incurred in connection with the management and auditing of this Fund in respect of the 1996-97 financial year and (c) what is the purpose of the Fund? N819E

The MINISTER OF HEALTH

The following supplied information is as at 31 March 1997:

(a) (i) R15 276,25

(ii) R2 129,04

(iii) Monthly interest accumulated on a daily balance

(b) R1 514,60 – audit costs

(c) The moneys in the fund shall be used –

(i) to undertake or promote studies, surveys and applied research with regard to any matter which, in the opinion of the Minister, is related to the functions of the Department;

(ii) to make grants to any person engaged, in the Republic or elsewhere, in co-operation with the Department, in any studies, surveys and applied research referred to in paragraph (i);

(iii) to foster, whether by the granting of study loans or bursaries or otherwise, the training of persons required to undertake any such studies, surveys and applied research, or of persons receiving education in connection with any science which in the opinion of the Minister, is of material importance in connection with any matter relating to health;

(iv) to establish and control facilities for the collection and dissemination of information of a technical nature in connection with any matter relating to health;

(v) generally, to provide any service which the Minister considers necessary in connection with any matter referred to in paragraph (i), (ii) or (iii).

Bomvini Location: public servants absent from meetings

572. Mr G Q M DOIDGE asked the Minister for Welfare and Population Development:

(1) Whether, with reference to a certain letter, a copy of which has been furnished to her Department for the purpose of her reply, any officials of her Department failed to show up for two successive meetings convened on 11 January 1997 and 4 February 1997 in the Bomvini Location for the purpose of obtaining advice and assistance for the aged and disabled in that community from such officials; if not, what is the position in this regard; if so, why;

(2) whether the said officials failed to advise the community of their inability to attend these meetings; if not, what is the position in this regard; if so, why;

(3) whether the said officials have taken or intend taking any action to address the problems experienced by the said community; if not, why not; if so, what action;

(4) whether she or her Department has undertaken an investigation so as to determine what issues the said community intended to bring to the attention of these officials; if not, what is the position in this regard if so, what are the relevant details? N957E

The MINISTER FOR WELFARE AND POPULATION DEVELOPMENT:

(1) Yes, the main reason for the non attendance of two meetings by officials of the Department of Welfare in the Eastern Cape Province was basically a problem of transport. There is a severe lack of transport at all levels in this province for use by all categories of staff. Government vehicles are centrally controlled by the Department of Transport at the moment;

(2) yes, the social worker concerned did communicate with the organisers of the meeting and explained why she did not honour the appointment. Furthermore, when this matter was brought to the attention of the Regional Director in charge of that region, he formally wrote a letter of apology to the community and particularly explained the, reason of non attendance of his staff;

(3) yes, arrangements were made between the social workers and the organisers for a meeting to take place; and such a meeting took place on 24 April 1997; and

(4) no, the Regional Director of the Department of Welfare in the Eastern Cape has instructed the region director in that region to investigate the issues experienced by the community and thereafter to Report to the Regional Director. It can be reported that during this Region's campaign of the Care of the Aged in the Community in October 1996, the Umzimkulu District chose the Bomvini Locality as their target community.

Information obtained from the Department of Welfare: Eastern Cape

Justice: advisers employed

617. Mr J H VAN DER MERWE asked the Minister of Justice:

Whether, in respect of each adviser employed by his Department, he will furnish a schedule for the period 1 July 1994 to 1 March 1997, (a) indicating for each month, the number of business days on which such adviser was (i) present in and (ii) absent from the office in which he or she was based, (b) indicating for each business day whether or not such adviser was in the office in which he or she was based and (c) indicating for each business day on which such adviser was not in his or her office, (i) where he or she was, (ii) the reasons for his or her absence, (iii) whether such adviser was absent on official business or not, (iv) whether he or she had prior permission to be absent, (v) the cost of his or her absence and (vi) the steps that were taken in cases of unauthorised absence to (aa) discipline him or her and (bb) recover the appropriate amounts from his or her salary; if not, why not; if so, what are the relevant details in each case? N1057E

The MINISTER OF JUSTICE:

During the period 1 July 1994 to 1 March 1997 Messrs E Daniels and V P Pikoli were employed as advisers to the Minister of Justice. Both of them were based in either Cape Town or Pretoria depending on where the Minister required their services. Both of them were for longer or shorter periods absent from either Cape Town or Pretoria in the course of their official duties as directed by the Minister. Unauthorised absences did not occur. It is, not possible to indicate for each month, the number of business days on which each of the advisers were either absent from or present at the office where they were based. In reality they performed services not only during normal office hours but after hours as well. They were also often required to render services over weekends

Ludidi Administration area: paying out of pensions

678. Mr G Q M DOIDGE asked the Minister for Welfare and Population Development:

(1) What facilities are being employed to facilitate the paying out of pensions in the Ludidi Administration area;

(2) whether such facilities have been found to be adequate and suitable for this purpose; if not, what is the position in this regard; if so, what are the relevant details;

(3) whether any problems are being experienced with the paying out of pensions in the said area; if so, what problems;

(4) on what dates were pensions paid out during the latest specified period of six months for which information is available? N1168E

The MINISTER FOR WELFARE AND POPULATION DEVELOPMENT:

(1) The Department makes use of mobile units to facilitate the payment of grants;

Blessings and problems of new health-care policy

Star 24/9/97 (85)

By Janine Simon
Medical Correspondent

The policy shift to primary care has brought uneven changes to Gauteng's health system, and now the improvements rub shoulders with systems and situations which have yet to be resolved.

In Bekkersdal on Monday, for example, Thengiswa Joya (17) had two midwives in attendance when she gave birth to her first son in the delivery room of the province's new maternal obstetric unit.

Yet, in the adjoining Bekkersdal Clinic, Xoliswa Mhlekwa and Eunice Memani had been waiting since 6am with their children Peter (7) and Nellie (six months); by 11am they were still among more than 100 patients queuing to see one of the two nurses available that day.

After the birth, Joya, a Transkei teenager who had come to live with her parents in the Randfontein township's Tambo section, rested for six hours in a new two-bed ward, with burgundy and fern linen, a bathroom en-suite and frilly curtains blocking the view of litter clinging to the perimeter wall.

Since April, when the Gauteng health department officially opened the R1,75-million midwife obstetric unit (MOU), 390 babies have found this spacious 14-bed facility their welcome to the world. The clinic is one of 14 new and 12 upgraded by the province since 1995.

Previously mothers would have travelled to Leratong Hospital, 20km away, or given birth unattended.

The 24-hour centre is staffed by 10 professional nurses, eight assistant nurses, and eight general assistants, two clerks, five security people, says sister Basinki Molipa. It appears to be providing a good service, but whether more of the 211 000-plus people in the area should be making use of it, remains a question: Alexandra Health Centre, which services a slightly bigger population outside Johannesburg, delivered more than 230 babies a month last year.

West Rand regional assistant director mother and child services, Julia Molebo says some patients still choose to go to hospital because they are not used to midwives doing deliveries on their doorstep.

Dr Refik Bismilla, Gauteng's chief director district health is more direct: "We're a hospi-centric country. We have to market primary care as something we are proud of," he says.

Just metres from the MOU, is the Bekkersdal Clinic, a primary care facility run by the Westonaria local authority. It has different problems.

Local authority clinics used to offer well-baby, immunisation and family planning services, but the new health policy dictates that they should also offer free comprehensive primary care. That means sisters should also diagnose and treat common ailments.

The queues have lengthened since free care was introduced but, as yet, none of Bekkersdal's five nurses has the full comprehensive primary care qualifications.

There have been no problems with supplies of antibiotic and painkiller drugs, but she has neither the drugs nor skills to deal with chronic conditions like asthma, high blood pressure, diabetes and epilepsy, so she takes a case history and refers patients to Leratong.

Clinics benefiting tens of thousands

The Department of Health says that in the two years since August 1995:

- More than 8,5 million South Africans have benefited from the initiative to build new clinics and upgrade existing ones. An average of 125 000 people per week can now rely on essential services.
- More than 19 000 temporary and 8 000 permanent jobs have been created.
- About five new or upgraded clinics are handed over to communities every week; since August 1995, R225-million was spent on clinic building from RDP funds; contributions from provinces brings the total money available to R710-million.
- The Clinic Upgrading and Building Programme (CUBP) was launched in August 1995 – and is the only public sector project to be honoured by the National Productivity Institute this year.

In Gauteng, the CUBP has meant:

- Increasing the PHC budget from R550-million to R739-million over the past three years, by diverting funds from academic hospitals
- 14 clinics opened and 12 upgraded since 1995; another five clinics have been completed in the current financial year and eight are in various stages.
- The number of patients seeking free care has increased from 128 213 in April 1996, to 284 133 in April 1997, and by between 36% (Vaal) and 84% (East Rand) in specific areas. Most patients (66%) are women aged between 15 and 59.
- A tender has gone out for a provincial health information system, and work has started to both set the minimum database and standardise the PHC form to collect this data.

Jo'burg's disease time bomb

(85)

Star 27/9/97

Eight sewerage works allow raw waste into our rivers

By JACKIE CAMERON

Contaminated sewage is flowing into Johannesburg rivers – and health experts have warned that a deadly-disease time bomb is ticking in the city.

At least eight sewerage works have allowed huge batches of raw human waste into rivers; one because it "ran out" of chlorine, another after a "power failure"; and the others because they "misjudged" the amount of chlorine needed or time taken for bacteria to be killed.

Sewage is a fertile conductor for diseases such as cholera, typhoid, hepatitis and dysentery, which all start off with acute diarrhoea and, if left untreated, can kill the sufferer.

The Department of Water Affairs has warned Erwat, a non-profit organisation responsible for treating most of the sewage on the East Rand, to clean up its act or face prosecution.

Results of government-commissioned spot tests on rivers in the East Rand reveal that at least seven sewerage facilities have allowed bacteria-infested waste into rivers. The water is considered highly hazardous to drink and is also unfit to swim in or even touch.

Spillage from broken sewers on the Klip River is also believed to be responsible for the death of hundreds of fish in the Klip River, one government source said.

Greater Johannesburg's Transitional Metropolitan Council is struggling to consistently comply with health standards at four large sewerage works around the city.

Russel Rimmer, of the council's Cydna Laboratories, told the *Saturday Star* this week that Northern Works, which treats water that goes to Hartbeespoort Dam, released sewage recently despite "running out of chlorine".

"I tried to find out why. To my mind it was a lack of delivery, and it was probably only one delivery of chlorine," Rimmer, who had been asked to speak on behalf of the council, said.

The Olifantsvlei works, in the south, was "not getting the results we should be getting" because the "right environment" for bacteria to die off was not being created at the plant.

"Not a lot is being done about this because it is believed that the water going into the rivers is pretty much okay. The Government is expecting us to make sure we'll get the levels (of bacteria) down as soon as possible.

"We cannot compare our situation to other countries. Our rivers are small, and what we discharge has a more exaggerated effect. Rivers are under greater pressure, particularly from informal settlements."

However, Rimmer said he did not believe the contaminated sewage posed a serious health risk. "You can get the cholera virus in rivers, but you need an awful lot of these things before you get infected."

But national director of communicable diseases Dr Neil Cameron warned that these test results should be regarded as "very serious".

"If these figures are true and water is going into rivers used for drinking water, it is cause for concern. The message is that this is serious, but I don't believe it affects tapped drinking water.

"Diseases which spread through water include cholera, typhoid and hepatitis A. We're expecting cholera ... it has to do with the sanitary conditions in many rural areas.

"Typhoid is also endemic in such areas. It's often spread by dirty toilets but you can get it through water and food. It's tied to the environment."

And a senior Department of Health official said: "If something is not done now, it will get worse. This may be the start of the whole service being in jeopardy. There seems to be a serious management problem at local government level."

Dr Quentin Espey, director of the Group of Environmental Monitoring, said: "Waterborne diseases are among the biggest killers in South Africa. About 50 000 people die each year from diarrhoea alone, and the contamination of rivers is a contributory factor."

Wits University microbiology department lecturer John Dewar said South Africa was sitting on a health time-bomb.

TO PAGE 2

P.T.O

Delta G Scientific was taken over by Sentrachem in August 1993. Sentrachem was in no way involved in Delta G's manufacture of ecstasy. Indeed, Koekemoer says the chemical giant "told us to clean up any materials and documents relating to our work prior to the takeover."

While remanded on R12 000 bail, Koekemoer appeared before a company disciplinary hearing, and on March 12 was told he had been found guilty of being in possession of a drug and failing to obey an order to destroy such compounds. He was summarily dismissed.

The criminal possession charge was withdrawn on May 5, after the Witwatersrand Attorney-General's office accepted his explanation that the ecstasy found in his office was part of a number of capsules he had come across four years previously, on an inspection of Delta G's plant 3.

Koekemoer ascribes his arrest to the fact that in 1994 he had been asked to do a financial costing on two possible approaches to the manufacture of ecstasy. He believes the costing document, with an accompanying note signed by himself, was discovered recently during a police raid.

"I feel very bad about this," says Koekemoer. "I'm completely against drugs. Ecstasy is a nondesirable, potentially habit-forming drug. I've studied the effect it has on humans and it's bad stuff. If the ecstasy that I made has been misused I would like the perpetrators to come to book."

Despite the withdrawal of criminal charges against him, Koekemoer's appeal against dismissal has been rejected by Sentrachem. His lawyers are considering seeking reinstatement or compensation through arbitration or the Labour Court.

Continuing investigations into the now dismantled Project Coast are described by the Office for Serious Economic Offences as at a "very sensitive stage."

OSEO advocate Dawie Fouché says: "We're investigating mainly the financial aspects. The Attorney-General's investigation team is looking at other aspects, which may or may not include dealing in prohibited substances." **Jack Lundin**

HEALTH MINISTRY

Zuma hires private PRs for R2,8m

FM 12/9/97

Health Minister Nkosazana Zuma's public image has never been good. But her decision to spend R2,8m of taxpayers' money to improve it is hardly likely to endear her to the public.

The Health Ministry and Department of Health have hired a consortium to beef up their public relations unit and to market health policy directly.

The consortium is made up of public relations company Lowe, Bell & Mann, research consultants Africa Now and SA's leading black advertising agency, HerdBuoys McCann. The contract took effect in mid-August and runs for a year.

"Our communications ability is poor," says Health director-general Olive Shisana. "We felt we needed a plan to communicate more effectively. If we are going to change our image and get our message across, we'll need people who can help us."

A departmental spokesman says 15 companies responded to the tender advertisement placed in all national newspapers. The contract was awarded to the bidder that "best satisfied the tender requirements."

The brief asked those tendering to "outline the multimedia strategies which will be undertaken to change the perceptions of target audiences."

Assistance in media liaison, training liaison staff and the production of publications was also part of the contract.

The R2,8m cost will be met out of the existing budgets of the ministry and the department's directorate of health promotion & communication.

HerdBuoys McCann senior account manager Mohale Ralebitso says: "The ministry, especially the Minister, has had unhappy dealings with the media. The controversy surrounding things like *Sarafina 2* has overshadowed her good works."

He says Zuma's image should improve if the public receives her health messages directly and not through the media.

"All too often the line between reporting and interpreting the news is blurred by the media," he says.

But Zuma's move has provoked an outcry.

"It's unforgivable that money which should be spent on health care is going to improve the Minister's image," says DP health spokesman Mike Ellis.

"This is another serious error on the part of the Minister. If she has shortcomings as big as R2,8m she should not be in the job."

Nkosazana Zuma

Provincial governments use private communications companies to liaise with the press and government does occasionally make use of them to market specific events, but the *FM* is not aware of any other department or ministry that has hired a private communications team in this way.

Wilmot James, executive director of the Institute for Democracy in SA (Idasa), agrees that the contract is "highly unusual," though he doesn't think R2,8m is excessive if it includes training and the placing of ads.

While acknowledging that Zuma's positive achievements should be made known, he warns that attempts to replace "a credible and independent assessment of government's performance will be a waste of money.

"One thing people in government don't understand is that ordinary people will not find their policies more palatable by being bombarded with propaganda."

Ralebitso says the consortium will also assist the ministry in selecting and training media liaison officers in an effort to shorten the time it takes to respond to media inquiries.

Journalists regularly complain that Zuma's spokesman, Vincent Hlongwane, rarely returns calls.

The first press releases issued by the consortium have been on the controversial health Bills Zuma is piloting through parliament. Her handling of the three Bills has further damaged her image and outraged interns and pharmaceutical companies.

NP health spokesman Willem Odendaal says: "She is trying to sugar the pill we have to swallow on the three health Bills. She is blatantly misusing taxpayers' money. It's the best reason I've heard to ask President Mandela to relieve her of her duties." **Claire Bisseker**

Tax for convict's health bill

7/9/97 (85)

By PERCY MAKHARAMEDZHA

TAXPAYERS are paying out over R160 000 per year in hospital bills for a 65-year-old Zonderwater Prison inmate who has been suffering from a chronic illness for the past seven years.

Prisoner William "Baby" Koen is serving a life sentence for murder, robbery, house breaking and theft.

He has been in and out of private hospitals since being struck by a heart attack seven years ago.

Koen, who has already spent 11 years for his sentence, has now been permanently moved from his cell to the prison hospital bed.

Koen's condition represent the dilemma faced by the Department of Correctional Services which is now finding itself spending over R150-million for inmates' health care.

The rising health care cost of the prisoners has further been increased by referrals to private hospitals that normally charge twice - even thrice - what public and government hospitals charge.

There are 750 convicts over the age 60 currently in SA prisons.

Several medical experts, including former district surgeon Dr Deon Lombard, had recommended - as early as in 1995 - to the department that Koen be granted early parole on medical grounds, according to documents in City Press' possession.

Dr Lombard had asked the Department of Correctional Services to consider Koen for early release because he is "seriously sick and is suffering from heart failure, stroke, hypertension and had prostate and heart operations".

Over R160 000 has already been spent on Koen's medical expenses in the past two years.

Gauteng Correctional Services spokesman Rudi Potgieter dismissed the allegations that the Department of Correctional Services had refused to give Koen a parole.

Potgieter said the correctional services had recommended that he be released because "he is a sick man".

He said Koen had not been released after medical expert's recommendations because "the Advisory Board sits only once a year".

The next time the board sits will be next month.

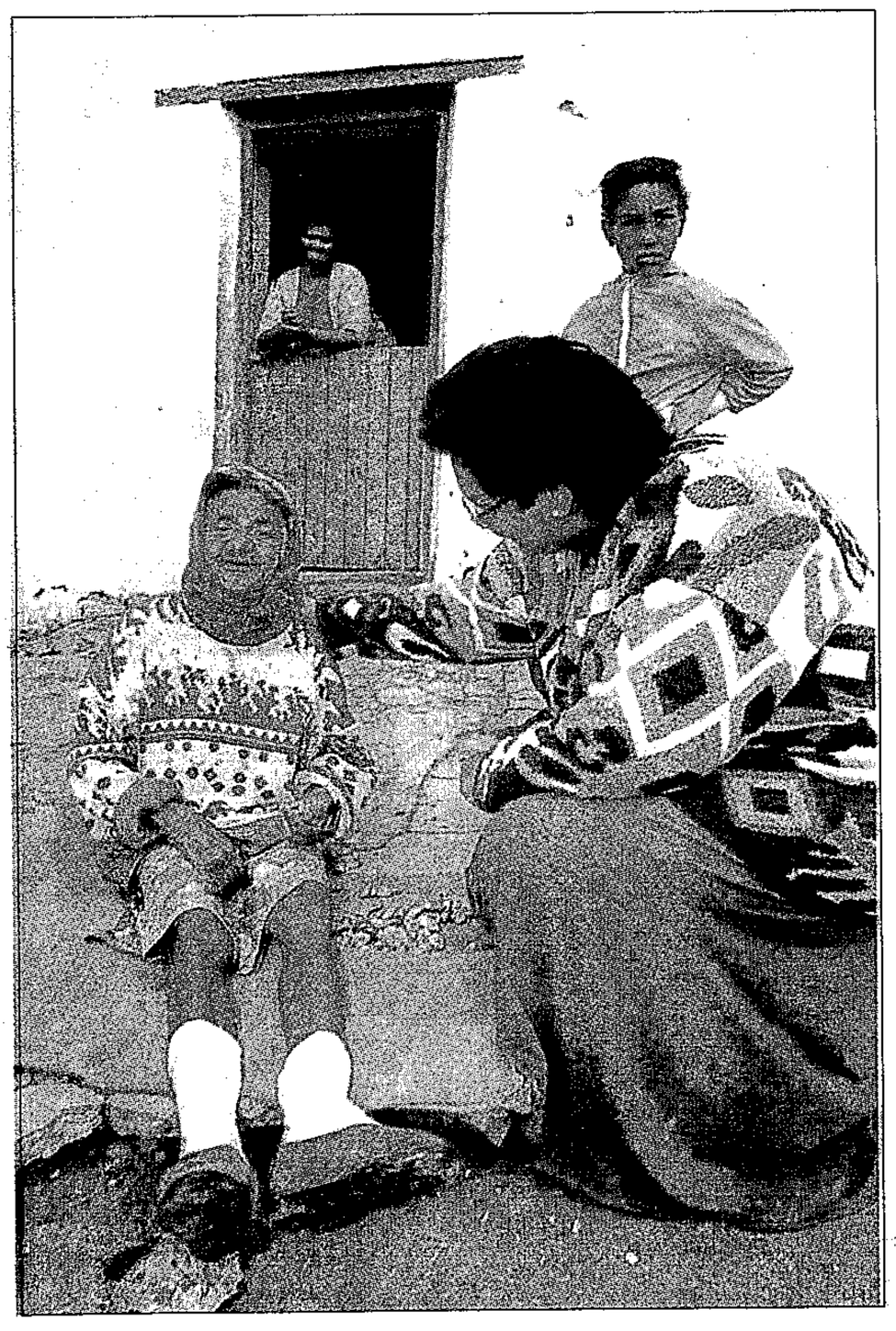
Potgieter said he could not comment on the issue of Koen's medical bills because the correctional services did not keep separate medical accounts for prisoners.

"Koen received good treatment at the hospitals like any prisoner," he said.

Sleepy Paternoster a hypertensive town

Argus 10/9/97 (85)

Strokes are a high risk



Passing time: Petronella Blanco, "Aunty Poppy" to the people of Paternoster, counts stones to pass the time. With her is Ethelwynn Stellenberg

JENNY VIALL
HEALTH REPORTER

The sleepy veneer of the village of Paternoster on the west coast hides the fact that it is a hypertensive town. Forty percent of its 1 000 residents have high blood pressure.
Few people know they have high blood pressure, however, and they don't seek help which puts them at high risk of strokes.

The University of Stellenbosch's Nursing department plans to change that. Last year it started an outreach project with the aim of developing and "waking up" the community to take responsibility for its own health.

"The only way to have a healthy country is for people to take charge of their lives and their health," says Ethelwynn Stellenberg, nursing sciences lecturer at the university.

The project's philosophy is to educate people: It's no use just handing out pills if people don't know how to take them. And unless you teach people what to do to prevent further problems, their health will not improve.

Under the guidance of Mrs Stellenberg, students have screened 321 people by means of house-to-house visits to identify the areas needing intervention.

High blood pressure, sometimes dangerously high, emerged as the major health problem. Unchecked it can lead to strokes which are debilitating and have devastating consequences for people and their families as they can cause paralysis and incontinence.

The students also found diabetes, skin problems and a range of ailments with which people have simply learned to live.

Health is about more than just not being sick, and the community, through a workshop, soon identified the need for better recreation facilities for people and support groups.

There is a clinic, built two years ago, which used to operate for four hours a week. Because this was clearly inadequate, local authorities increased it to twice a week and a third day every second week.

However, villagers can only see a nurse there. To see a doctor means a trip to Vredenburg 20km away on a sandy road.

Marie Clark is 57 and has lived in Paternoster all her life in a house with no electricity or water.

She's just one of those screened by the project. When we visit her she tells us she has a headache (one of the symptoms of high blood pressure) and student Annette Van Niekerk takes her blood pressure. It's very high. Mrs Clark looks sheepish as she tells us she didn't take her pills this morning. Asked why she says they make her very thirsty.

JACK LESTRADE

High pressure: Marie Clark has her blood pressure checked by Annette Van Niekerk

But she hastens to add that the day before she took a taxi to Vredenburg to get a repeat prescription from the doctor at the day hospital. The local clinic cannot give her the pills until her file is transferred from Vredenburg.

"I don't like to run out of pills," she says, showing us the three she has left. But her trip was in vain. She waited all day at the day hospital without being seen and had to catch the last taxi home at 5pm.

Low tide: fishing boats on the beach

This is the complaint most often heard about health services in Paternoster: The only way to see a doctor is to take a taxi, which costs R10, a big expense to those whose income is limited. And there's no guarantee you'll be successful. "We need a doctor to come here," says Mrs Clark. "Even if it's only once a week."

Has the university's project made any difference? "It's done me a lot of good," she says. For one thing she's cut her smoking from a packet a day to four or five cigarettes.

Mrs Stellenberg's students found some people only took pills when they had a headache and stopped when they felt better. To be effective blood pressure medication must be taken constantly. Others were sharing ointments for sexually transmitted diseases, spreading infection rather than curing it.

Although the students will not be coming back, the Paternoster Community Forum has taken over and a workshop in May identified areas that need attention. The university's role is now to facilitate the forum.

High blood pressure is linked to alcohol abuse, high salt intake, smoking and lack of exercise. The forum knows that simply handing out pills will not solve the problem and so has set up groups to look at lifestyle changes.

Groups to tackle alcoholism and drug addiction, diabetes, healthy lifestyle and literacy have been set up and First Aid identified as a priority, as there is no one in Paternoster who can cope with accidents.

A walking group has started and 15 women have been trained to take blood pressure and to support each other. Louisa Sampson was one of these women. "We were shocked to find two women whose blood pressure was very high," she says.

The community has no blood pressure equipment. That's one area where the community needs a donor. Student Annette Van Niekerk knows that changing lifestyle is not easy.

Says councillor for Paternoster, Paul Sampson: "This is the first time someone has taken an interest in Paternoster. It's been an inspiration to the community."

Parallel importing of drugs aims to lower prices — Zuma

Jacob Dlamini BD 10/9/97

CAPE TOWN — Government would not introduce the parallel importing of drugs if pharmaceutical companies agreed to sell the state patented drugs at competitive prices, Health Minister Nkosazana Zuma said yesterday.

Plans to introduce parallel importing had been prompted by government's aim to lower the price of medicines by encouraging the use of generic medicines.

She denied that her plans would violate World Trade Organisation regulations, saying the parallel importing clause had been examined and pronounced satisfactory by the trade and industry department.

Zuma rejected suggestions that her relations with the pharmaceutical industry had deteriorated. She said only those companies dealing with patented drugs were unhappy with her plans while those responsible for producing generic drugs had welcomed them.

Zuma also dismissed suggestions that the government wanted to impose community service on newly qualified doctors. She said medical students had asked for community service to be included in health reforms currently before Parliament.

Zuma said the introduction of vocational training was a responsibility of the interim national medical and dental council. While the council had temporarily shelved its plans to introduce the system next year, it remained its domain and she would be guided by it on the matter, she said.

Josey Ballenger reports the National Interns Alliance has objected to Zuma's bill on compulsory community service due for discussion by Parliament's health portfolio committee tomorrow and Friday.

The alliance, which said interns supported "the concept" of community service and restructuring the health service, objected to the lack of infrastructure at medical facilities, the "authoritarian powers" it claimed the bill would give the minister and the "late notification" of compulsory service from January.

"The lack of infrastructure in the facilities where compulsory community service is meant to take place will result not only in the failure of delivery of health services to the community, but also destroy the medical delivery in the major centres such as Soweto and Atteridgeville," the alliance said.

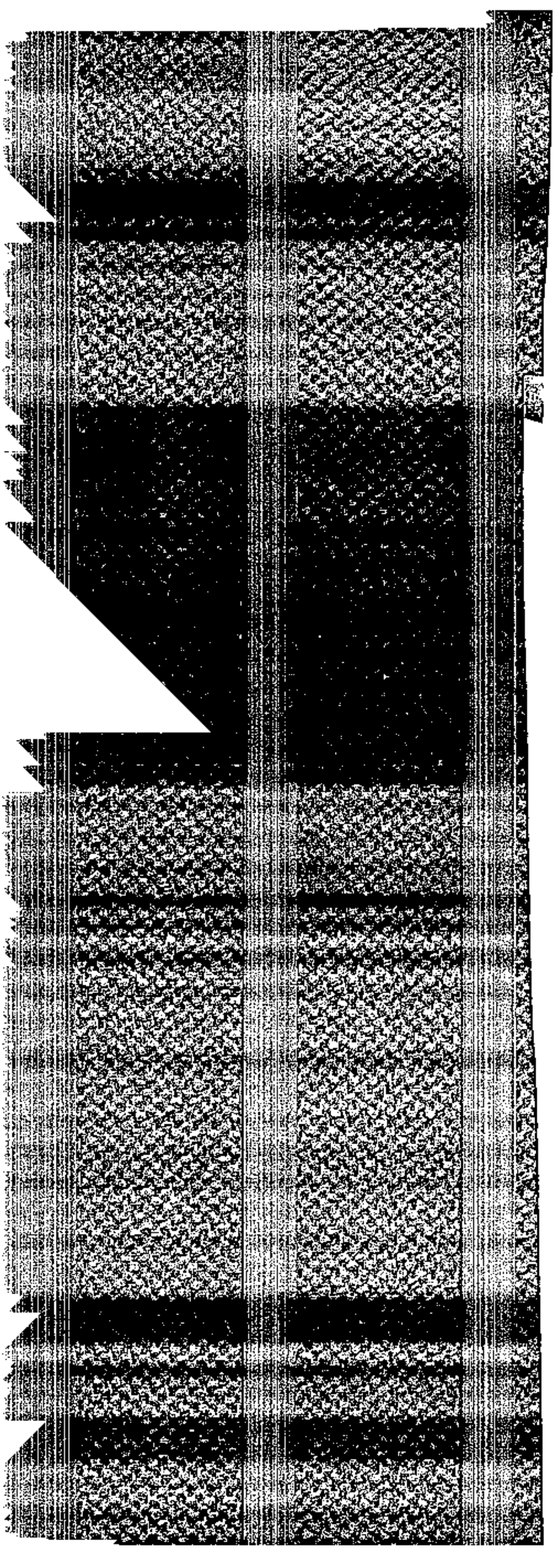
Press officer Dr Yair Safriel said: "The minister has created the perception that if you put a doctor in a room, you will solve health problems. But that is naive. Medicine today is very infrastructure-based, even with something basic like laboratory tests and chest x-rays."

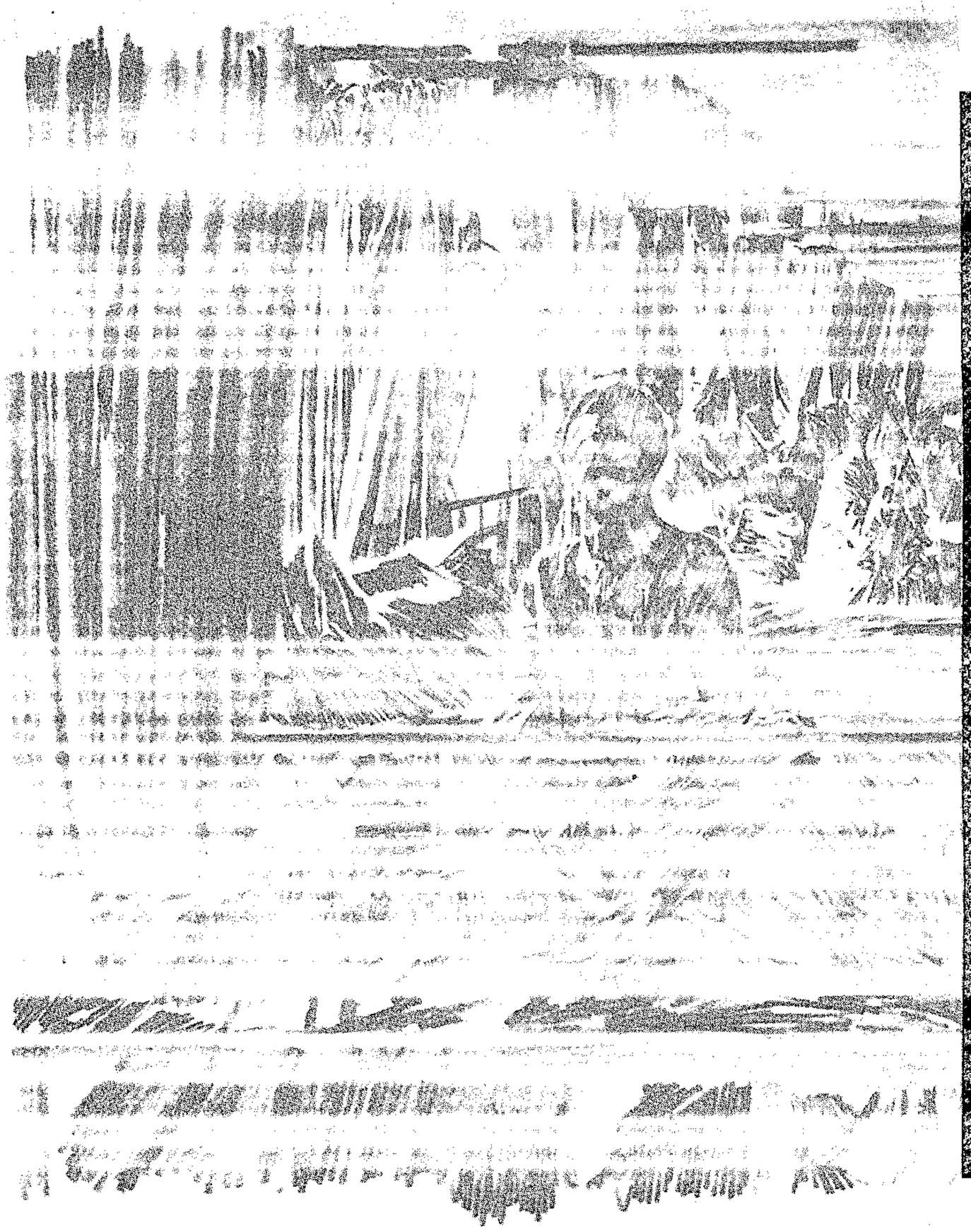
Safriel said the bill gave the minister powers to bypass the Medical and Dental Council and Parliament, which "sets a very dangerous precedent in a democracy". The alliance contended the bill will allow the minister to send practitioners "army-style to an area she chooses, irrespective of their wishes" and to lengthen their service indefinitely.

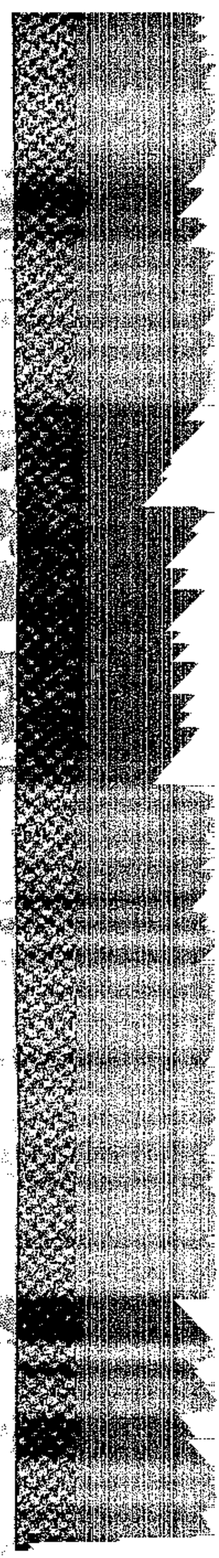
Demands of change pa

In theory, provinces have the power to take decisions on all sorts of issues but in practice

By Janine Simon
Medical Correspondent







It is common cause that patients in the public health

Health is at a crossroads, he says.

Failing to recognise the realities will condemn public health to being an expensive but marginal service for the destitute.

The Ministry of Health has grabbed the headlines because of its clash with the pharmaceutical industry over patent law, the moratorium on building new hospitals and attempts to [illegible] state services.

But [illegible] battles against vested interests [illegible]

securing any benefits in the shift away from hospital based care.

Observers believe the national department's poor performance of the subtle role it should be playing in [illegible] standards for health service delivery within the provincial system scripted by the constitution.

One key example is that, three years after switching to a new policy, South Africa's health system is still being held together by a national health bill passed in 1977.

As a result, the local authorities responsible for delivering primary care do not have the power to do so, stalling in turn the shift from policy to implementation.

Signals around private sector involvement remain mixed, and, says health economist Dr Di McIntyre, there's an urgent need for a coherent approach.

The department's medium-term expenditure assumes hospitals will generate and retain additional income, but never spells out how they are expected to go about doing so.

The ideas of contracting GPs to provide services, and setting up private wards in public hospitals have been around for at least three years, but no service has been delivered, and there's no clue whether the national authorities would support a state ward with pretty "hotel" facilities to lure paying patients.

The Gauteng administration has had almost 20 approaches from the private sector providers. It wants to experiment, but is hesitant to enter uncharted territory. But they are not alone, says McIntyre, director of the UCT's health economics unit – all provinces are unsure how to tackle this issue.

The only line taken so far has been a regulatory one: the amendment to the Medicines Control Act, which has invoked all the sophisticated lobbying power of the pharmaceutical industry for its perceived attacks on intellectual and property rights, and the blanket moratorium on the construction of private hospitals.

Local authorities do not have power to deliver care

Both show that the health department sees itself as the central regulator and provider of health services. This, of course, is fundamentally at odds with the Department of Finance's liberal macro-economic policy, which sees the public sector only as a regulator.

But in state clinics and hospitals it is the details of decentralisation of public health into a provincial system – and not that of central control – which is fouling the waters.

Provincial health departments battle with administration systems designed for national government. They are responsible, for example, for building maintenance, but have no control over when or how it is done, says Robb. Only a provincial director-general can set up a disciplinary investigation, even if a hospital or district manager sees a staffer committing a crime.

Hospital managers must still be backed by a paper system of authorisation that reduces them to the level of clerks, and in some provinces it takes 20 days to get authorisation for a standard 10 000km vehicle service.

The ambitious national health information system never materialised, and provinces are embarking on nine different information systems, with no minimum standards.

The national department has done little so far to train managers to resolve this mess, provide provinces with tools to help calculate adequate service provisions, or endorse norms for hospital care or doctor patient ratios.

Neither is it helping weak provincial administrations take up their constitutional roles. Only four of the nine provinces had a c[illegible] the role [illegible] provide[illegible] sorb th[illegible] homelan[illegible]

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ıralyse health care

Star 11/9/97 (85)

ney are hampered by fear and inexperience

GRAPHICS: JASON ASKEW

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budgeting system was changed to allow provinces to allocate the funds, taking no account of the fact that services here, and in the Western Cape, are used by patients from other provinces.

The national department has effectively lost control of financing patients going outside their province for care. It

National dept has lost control of financing patients

should be playing lobbyist, monitoring provincial budgets and making submissions around a formula, says McIntyre.

The national department should also be taking the lead in negotiating the downscaling of the public sector with the Public Service Commission, so that provincial departments facing budget cuts can retrench staff, who currently make up an estimated 75% of costs, she said.

District services are the nub of the new health system. But, says Bupendra Makan, senior researcher at the UCT unit, the issue of governance – whether provinces absorb local authority health services and staff, or vice versa – hasn't been resolved.

In the 1995/96 financial year, local authority's 12 800 health workers had substantially better salaries and benefits than the province's 228 000 – a difference which it will take an estimated R1-billion to equalise. The national department still has to develop a strategy to deal with the discrepancies.

Crucially, it also has no national strategy for training and retaining doctors, nurses and paramedical professionals.

Instead, it has drafted legislation to coerce students, the most vulnerable, and some say, useless, members of the profession into extended state service. Cuban doctors were a stopgap to fill the service needs in rural areas, but there is still no talk of incentives to entice local doctors to replace them.

"We need to revisit rural allowances offered by the previous government for doctors and key nurses in the former homelands," says Makan.

Trying to make care accessible, affordable

By Janine Simon

The Health Department is not fighting the pharmaceutical industry or private sector, and has no intention of exhausting its energy in disputes, said director-general of health Dr Olive Shisana.

It is the industry that has taken out adverts and obtained court interdicts against departmental policy, and taken the minister to the public protector's office on pharmaceutical issues, she says.

"All we are trying to do is make health care accessible and affordable to all."

The question of the deterioration of health services depends on whether users previously have all the resources to themselves, or whether they are used to sharing inadequate resources, she says.

The delay with the health bill is regrettable, but "due to the democratic process".

She says a period of almost 18 months is spent developing policy, which is then tabled in the Cabinet and submitted as a white paper. The white paper will be discussed in Parliament next month.

There have been nine drafts of the bill, based on the white paper, and it will be tabled once discussion is complete, she says.

The Government has led most of the plans for provision of services through districts, but faces obstacles because local government development is incomplete and health personnel will have to be transferred from province to municipality, or vice versa, Shisana adds.

Policy on the public/private mix in South Africa is contained in the white paper.

A number of public hospitals have agreed to share facilities with private doctors, specifically in the Eastern Cape where a group of doctors have financed ward improvements in a provincially run building.

She says the department will also be evaluating a new British pilot project where private finance funded capital investment in a hospital, in a similar vein to private financing of new prisons. This could be a sound way of rehabilitating poorly maintained public hospitals.

Most major public hospitals have accepted the idea of retaining revenue, but face delays because provinces need to have appropriate legislation passed, and to develop better hospital billing systems and the capacity to run these systems.

Some provinces are exploring having accredited providers supply a package of primary health care, but have met with legal challenges by district surgeons with lucrative practices, Shisana says.

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Zuma adds portfolio: 'Minister of Unanswered Questions'

Star 13/9/97

Cape Town – Controversial Health Minister Nkosazana Zuma now has another unofficial portfolio – she has been dubbed the "Minister of Unanswered Questions".

A count of questions early this month for written reply put to her by fellow MPs shows that Dr Zuma holds the dubious record as the minister with the largest number of unanswered questions against her name.

According to the rules of Parliament, any parliamentarian has the right to put written or oral questions to any minister – one of the most important ways ministers can be brought to account for what is happening in their ministries.

If a question for written reply is not answered within 10 parliamentary working days, the question can be transferred to the list for oral reply, a procedure that forces the minister to stand up in Parliament to answer the question.

But commentators have warned of an alarming trend of some ministers becoming less responsive to the critical scrutiny of Parliament.

This trend, they say, is particularly evident in the number of questions for written reply that remain unanswered at the end of the parliamentary session. In 1995, 10% of written questions remained unanswered, a figure that grew to 39% last year.

A count of unanswered questions on this week's order paper shows that a total of 156 questions have been on the order paper for more than 10 working days. Zuma tops the list of ministers lax to answer questions, with 27 of them unanswered.

Other culprits include Safety and Security Minister Sydney Mufamadi (15), Education Minister Sibisuso Bengu (13), and Welfare and Population Development Minister Geraldine Fraser-Moleketi (11).

Zuma's spokesman Vincent Hlongwane shrugged off the issue as unimportant. He accused the *Saturday Star's* sister paper, the *Argus* of focusing on "peripheral" issues. – Own Correspondent

The minister of unanswered questions

Zuma keeps MPs waiting most often ... and for longest

(85) (~~xxxx~~) ARG 13/9/97

Culprit No 1: Health Minister Nkosazana Zuma tops the list of ministers yet to answer questions with 27 awaiting her reply

PIETER MALAN

Controversial Health Minister Nkosazana Zuma now has another unofficial portfolio – she has been dubbed the "Minister of Unanswered Questions".

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A count of unanswered questions on last week's order paper shows that a total of 156 questions have been on the order paper for more than 10 working days. Dr Zuma tops the list of ministers slow to respond with 27 unanswered questions. Other culprits include Safety and Security Minister Sydney Mufamadi (15), Education Minister Sibusiso Bengu (13) and Welfare and Population Development Minister Geraldine Fraser-Moleketi (11).

The NP's Jacko Maree described the situation as 'pathetic'

While most of these ministries could give an exact breakdown of what the status of each unanswered question was and why there were problems in getting the information, Dr Zuma's spokesman, Vincent Hlongwane, shrugged off the issue as unimportant.

He told Saturday Argus that it was "not the first time the issue was brought up", accusing the paper of focusing on issues on the "periphery".

He then referred all questions to ANC chief whip Max Sisulu who he said had been dealing with the issue together with his National Party counterpart.

But Mr Sisulu's spokesman Mike Elrinck denied knowledge of any such discussions and said Mr Sisulu could not respond on behalf of Dr Zuma.

Dr Zuma's spokesman shrugged off the issue as unimportant

Dr Zuma also holds the record for the unanswered question that has waited the longest without reply – a question put to her by the Democratic Party's health spokesman Mike Ellis on March 14 this year.

He wanted to know from Dr Zuma how many doctors, including foreigners, were appointed at state hospitals since January last year.

National Party MP Jacko Maree described the situation as "pathetic".

One of his questions had to be put on the order paper again this year after Dr Zuma failed to come back to him by the end of last year.

Dr Zuma has been the centre of several controversies including the *Sarafina 2* AIDS awareness play debacle, her backing of the now discredited Virodene anti-AIDS drug, and her support for the import of Cuban doctors.

Party researchers in recent months have started transferring up to 100 questions a time from the list of questions for written reply to that for oral reply to force various ministers to answer them.

Maxwell Mulaudzi, spokesman for Mr Mufamadi, said all questions appearing on last week's order list had been answered during the week.

This was confirmed by parliamentary workers who said the Safety and Security ministry was usually very diligent in answering questions.

Lincoln Mali, speaking on behalf of Professor Bengu said the ministry was still waiting for reply from provinces on many of the questions put to the ministers.

"The process of getting answers from provinces usually takes a bit of time, which explains the delay," he said.

Mr Mali suggested a system should be put in place whereby MPs could be officially notified if answers to their questions took longer than expected and the reasons for the delay.

Ms Fraser-Moleketi's spokesman could not be reached for comment.

Culprit No 2: Sydney Mufamadi

Culprit No 3: Sibusiso Bengu

Culprit No 4: Geraldine Fraser-Moleketi

Deal signed to create national health-care provider network

BDS/11/97 (85)

Josey Ballenger

MEDICAL fund-administrator Sanlam Health and independent medical-practitioner association SA Managed Care Co-operative (SAMCC) have signed a deal outlined in September to create an independent, self-regulated, national health-care provider network.

The private company African Health Synergies (AHS) aims to provide the means to develop independent practitioners associations or doctor groups and enable them to provide cost-effective, quality health care "to as much of the population as possible", CEO Martyn Schickerling said.

It promises to invest in community programmes focusing on quality of life and well-being, to support initiatives of government's national health plan and to assist in developing community-oriented health care delivery systems.

At the same time, "we must sustain and expand private practice ... and be adequately rewarded for quality value-added services," SAMCC chairman Dennis Dyer said.

The private sector initiative was "bigger than any individual company or political group" and aimed to "make a contribution towards bringing solutions to our country's health care dilemmas" and to "unlock the synergies between funders and providers", Sanlam Health medical director Herc Hoffman said.

Sanlam Health had provided the initial R2m capital plus a further R1,5m loan, while the SAMCC was contributing resources to the 50-50 joint venture, said Schickerling, who is also MD of Clinic Cross. The full board of directors would be appointed by February, at which time 30-million shares would be offered to "all legally established" funders at R1 each and on a proportional basis to provider groups at 1c a share.

Schickerling said AHS would be a for-profit company only to the extent that it would financially support its member practitioners associations. The SAMCC had 4 300 members, while the SA Medical and Dental Practitioners had 2 000 members.

Schickerling said a court case hanging over Sanlam's head regarding another managed care company, SA Health Alliance, would have no bearing on AHS as the two companies would not be competitors.

IDS

Time will prove to be the great healer

Policy shake-ups haven't produced a clear plan on traditional medicine. Janine Simon reports

Star 11/11/97 (85)

More than 80% of the South African population consult a traditional medical practitioner before, after or in place of going to a clinic or Western medical doctor. And they also use indigenous plants for home medication.

Pietermaritzburg's Institute of Natural Resources has shown traditional healers are used between 90- and 100-million times a year. At an estimated R100 a visit, it would cost the state R10-billion (or about half the health budget) to replace this service.

The practice is less stigmatised than in the past, when it was dismissed as close to sorcery. Yet the area is fraught with problems.

Healers say, despite a shake-up in health policy over the past three years, that the Government has no clear plan on how to fit traditional medicine into the formal health system.

Attempts to register the basic ingredients used by inyangas, and to set up a national reference centre for traditional medicines, are top-down approaches, they say.

The real needs of traditional healers (education, organisation, business skills and a way to secure the rapidly diminishing supply of wild medicinal plants) are not being addressed.

For the patient, the experience with an inyanga can be intense. One nurse tutor, who asked not to be named, says her faith in traditional healing remains because of childhood and adult experiences.

When she was 16, in rural KwaZulu Natal, her legs were suddenly and completely paralysed. A relative, and an inyanga, burnt herbs for her to smell, made small cuts on her joints and rubbed in a herbal paste, and made her drink an infusion and eat herbs. This was repeated every half hour, and the next morning she could walk, the nurse says.

What was in those mixtures, or any other dispensed by a traditional healer, is a hotly debated issue of intellectual property rights about who, if anyone, owns the information on the healing properties of plants.

Many indigenous plants have been scientifically identified and the findings published. But the healers who gave the information have yet to see any reward, says Dr Solomon Mahlaba, who is on the technical committee for traditional African medicines, set up under the Complementary Medicines Committee (CMC) of the Medicines Control Council (MCC), and Dr Seth Seroka, director of the African National Healers' Association.

Mahlaba acknowledges that the properties of plants like wild ginger and the pepper bark tree are now public and could be placed in a registry. But, he says, the MCC is backpedalling. Its listing system for complementary medicines has focused on imported folk medicines and plants, like homeopathic preparations, used by only 7% of the population.

Groups working on nutritional supplements, for example, are to submit lists of substances for approval this month. The traditional medicines technical committee was set up in September, but has yet to meet because members have no funds to travel. The CMC also promised three months ago to allow a broad meeting of healers, says Mahlaba, but this has not happened. "It's all endless meetings and no proper discussions."

Registrar of Medicines Professor Johann Schlebusch says the MCC is waiting for guidance from Mahlaba's committee. "It is problematic if there is no input from them. We can help collate information, but would prefer it to come from them."

The real problem is traditional healers are one-man businesses, whose stock-in-trade, plants, are expensive and harder to source.

Organising a representative professional body is hard. It is commonly said there are 300 000 healers in the country, but membership of the numerous associations is a closely guarded secret, and some say a figure of 30 000 to 40 000 is more realistic.

Government so far has been of little use: "We are always invited to discuss issues, but our discussions are not completed and we never get time for our own issues, " says KwaZulu Natal healer Simon Mhlaba.

Traditional healers are dealt with under the National Drug Policy, which says they are to be encouraged to work more closely with the formal sector, but are not necessarily to be made part of it.

This is vastly different from other approaches. In India, folk medicine has a formal place in the system. In Zimbabwe the health minister co-operates very closely with the traditional healers' association.

Precious Matsoso, director of Medical Schemes, Supplies and Pharmaceutical Services, admits SA has not yet thought through exactly what role healers could play in the health system.

ANDREAS VLACHAKIS

Mixing medicines ... traditional healers, like Dr Solomon Mahlaba, are one-man businesses, whose stock-in-trade, plants, are expensive and hard to source.

The full potential as a parallel health service

Traditional healers provide a huge parallel health-care service, says the Institute of Natural Resources. It's research shows:

- In the Durban area, 84% of clinic patients use traditional medicine more than three times a year, excluding self-medication.
- In Durban there are 1 500 healers who create jobs for 3 750 assistants and 7 500 gatherers. In total between 20 000 and 30 000 jobs are created in the province by the industry.
- About 4 300 tons of plant material valued at R61-million are traded in KwaZulu Natal annually. Not one plant is cultivated, but the trade is worth a third of the provincial maize harvest. Nationally the figure could be as high as 19 500 tons worth R270-million.
- More than 700 plants are traded and many are on the specially protected species list, which theoretically need permits to trade.
- About 40 tons of plant material is brought in from Mozambique annually, and plants are also brought from Namibia, Botswana even Malaysia.

Western Cape takes lead in health plan

Josey Ballenger

BD 11/11/97 (86)

THE Western Cape has taken the lead in starting up a World Health Organisation (WHO) designed education programme in schools, the health department said yesterday.

Health promotion and communication director Gonda Perez said the Western Cape had established its programme more than a year ago. It was government's goal to have every province establish one within the next 12 months. Private schools were "welcome to join" the programme.

Perez said provincial health departments, which funded their own health-promoting programmes, tailored the WHO programme to their own needs.

Perez said she could not quantify how much provinces were spending on health promotion, under which the schools' programme fell, as the national department did not dictate how the provinces allocated their budgets. However, she said the department saw the schools programme as a "priority", and that most provincial health departments had started talks with their education counterparts.

At a workshop in Cape Town last week, health director-general Dr Olive Shisana said government had identified schools as one of the settings in which health could be improved, as learning in that environment happened at a "critical time in the development of a human being".

"Health promotion encompasses much more than health education through the mass media. The needs of children must be paramount throughout all programmes and (in) meeting basic needs and socio-economic upliftment." She said programmes in basic education, primary health care, nutrition, water, sanitation and housing were all "crucial" to meet SA's socioeconomic needs in the next century.

Rehabilitation centre boasts globally linked assessment system

Josey Ballenger

THE FIRST specialised physical rehabilitation unit in SA using an "internationally accepted" assessment system which allows domestic cases to be compared to a database of more than 3-million patient records worldwide was opened formally last night at Johannesburg's Brenthurst Clinic.

The unit is affiliated to 1 200 rehabilitation hospitals in 18 countries. The assessment system, licensed in SA to the Physical Rehab Group, aims to quantify financial and legal implications for employers and insurers and medical aid and lifestyle changes for patients and their families.

The unit assesses a patient's functional ability before treatment using 18 different measurements and predicts the optimum degree of improvement in areas such as self-care, mobility and mental abilities, as well as the cost and duration of treatment.

The service was "invaluable to insurers and medical aid schemes," said Prof Stephen Louw, head of the group's SA academic base at the University of Cape Town.

Louw said although physical medicine and rehabilitation was relatively undeveloped in SA, it was well established overseas. Physical rehabilitation patients are those disabled by strokes, sports, motor or work-related accidents, crime attacks or any activity that brings injury to the brain or spinal cord.

Dr Nilesh Patel, director of clinical services, said the group planned to open more units in Gauteng, Cape Town and Durban, but that it was not financially viable to operate in areas where patients did not have medical aid. The Brenthurst unit, which has been operating for about a month, has treated some 20 patients so far.

Physical Rehab Group is a joint venture between hospitals group Afrox Healthcare and medical aid and clinics group Specialised Healthcare Services.

Traditional medicine fights for recognition

ARG 12/11/97

'Government has no clear plan'

ARGUS CORRESPONDENT

Johannesburg – No complementary medicine is more avidly supported in South Africa than traditional healers and the plant-based treatments they prescribe for illnesses.

More than 80% of the population consult a traditional medical practitioner before, after or in place of a clinic sister or conventional medical doctor. They also use indigenous plants for home medication.

Pietermaritzburg's Institute of Natural Resources has shown that traditional healers are used between 90 million and 100 million times a year. At an estimated R100 per visit, it would cost the state R10 billion – or around half the total health budget – to replace this health service.

The practice is less stigmatised than in the past, when it was dismissed as close to sorcery. Yet the area is fraught with problems.

Angry healers say that despite a total shake up in health policy over the last three years, the Government still has no clear plan of how to fit traditional medicine into the formal health system.

Attempts to formalise the registration of basic ingredients used by inyangas, and of setting up a national reference centre for traditional medicines, are top-down approaches, they say.

The real needs of traditional healers – education, organisation, business skills and a way to secure the rapidly diminishing supply of wild medicinal plants – are not being addressed.

The experience of the consultation is quite different from a medical doctor taking a case history.

Diagnosis can be from something as simple as touching your hand.

"For the diagnosis I look into his eyes, or conduct a palmist reading or bone throwing, " says traditional medical practitioner Nhlavana Maseko, international president of the Traditional Healers Organisation.

"If they are mentally disturbed, or hungry, or have a stomach problem, I can tell you. It could be food, or liver, even that the person is taking liquor."

Maseko is a trained homeopath who learnt the skills of traditional healing at his grandfather's feet.

For the patient, the experience can be intense. One nurse tutor, who asked not to be named for professional reasons, says her faith in traditional healing remains because of personal experience.

Medicine man: Solomon Mahlaba sits on the committee for traditional African medicines

When she was 16, home from boarding school and out picking cabbages for her mother in rural KwaZulu Natal, she felt a burning pain in her back, and sat down to recover only to find her legs were completely paralysed.

A family relative who was an inyanga burnt herbs in her room for her to smell, made small cuts on her joints and rubbed in a paste of other herbs, and made her drink an infusion and eat herbs in a little water hot from a frying pan.

The process was repeated every half hour, and the next morning she could walk, the nurse says.

Many indigenous plants have been scientifically identified and published. But the healers who have given the researchers the information have yet to see any reward, say Solomon Mahlaba, who sits on the technical committee for traditional African medicines, set up under the Complementary Medicines Committee of the Medicines' Control Council.

Mahlaba says that the properties of individual plants like wild ginger and the pepper bark tree, are now in the public domain and could be formalised into a registry.

But, he says, the MCC is back pedalling. Its new listing system for complementary medicines has focused on the imported folk medicines and plants, like homeopathic preparations, used by only seven percent of the population.

Registrar of Medicines Professor Johann Schlebusch says the MCC can help but is waiting for guidance from Mahlaba's committee. "It is problematic if there is no input from them, we can help collate information, but would prefer it to come from them."

Traditional healers are one-man businesses, whose stock-in-trade – plants – are becoming expensive and harder to source.

Organising a representative body is hard. It is said there are about 300 000 healers in the country, but some say a figure of 30 000 to 40 000 is more realistic.

Statistics on healers

Traditional healers provide a huge, parallel health care service, says Miles Manders of the Institute of Natural Resources.

Institute research shows:

■ In the Durban area, 84% of clinic patients use traditional medicine more than three times a year – excluding self medication. It would cost R2-billion – more than half the province's health budget of R3,7-billion – to replace this service.

■ In Durban, there are 1 500 healers who create jobs for 3 750 assistants and 7 500 gatherers. In total, between 20 000 and 30 000 jobs are created in the province by the indigenous medicine industry.

■ About 4 300 tons of plant material valued at R61-million are traded in KwaZulu Natal annually. Not one plant is cultivated, but the trade is worth a third of the provincial maize harvest.

■ Over 700 plants are traded and many are on the specially protected species list, which theoretically need permits to trade.

■ About 40 tons of plant material is brought in from Mozambique annually, and plants are also brought from Namibia, Botswana and even Malaysia.

Health's deficit may lead to job losses

(85) (87)

BD 14/11/97

Linda Ensor and Farouk Chothia

THOUSANDS of employees in provincial health departments are set to lose their jobs because of the national health budget deficit of R1,5bn.

The National Education, Health and Allied Workers' Union said it understood the provincial health department was considering retrenching 11 000 employees in the catering, cleaning, laundry and security sectors. These tasks would be outsourced.

In the Western Cape it is understood an additional 4 000 personnel will lose their jobs by April 1 if provincial treasury instructions are followed.

Health MECs met the national and finance ministries this week to examine ways of clawing back the deficit.

The initial target for staff reductions in the Western Cape this year was 27 500, and about 4 000 had already been removed from the system. However, expenditure overruns required further cuts, the treasury said.

Health MEC Ebrahim Rasool said he believed such a radical pruning of staff numbers would be "impossible" as there was no administrative mechanism such as a retrenchment procedure to achieve it.

The Western Cape's share of the national health deficit was R422,3m, even though it had instituted far-reaching cost-cutting measures and reduced staff numbers. Already the province had had to make inroads into the "protected" primary health care sector, Rasool said. This had inevitably meant poorer services, longer queues and bottlenecks.

Rasool said the deficit had to be broken down into traditional inflationary factors, cash flow problems and the structural deficit, or underfunding. In the Western Cape, this structural deficit amounted to about R300m, which represented the money paid on indispensable salaries and services.

The meeting between the health ministry and MECs had hotly debated the tradeoffs required between the national programme for social transformation and the achievement of fiscal goals. The two programmes were running at odds with each other, Rasool said, with fiscal goals the driving force.

A final decision on extra funding for provinces would be made at the December 3 cabinet meeting.

The Western Cape has lobbied hard for "top slice" funding of about R300m for its academic hospitals on grounds that they provide a national service.

However, Rasool said that caution was required as it appeared the finance allocated for this would be at the expense of the national primary health care budget.

In KwaZulu-Natal, Nehawu secretary Sithembizo Shezi said the provincial health department had informed labour of the budget crisis last month, but had not indicated that it planned to retrench staff. However, it believed 11 000 jobs were on the line.

Department spokesman Desre Hilson said retrenchments would be an "absolute last resort" to avoid a deficit of about R800m.

The Northern Province did not have any plans in the "foreseeable future" to retrench staff, a spokesman for the premier's office said. Cost-cutting measures already in place would wipe out the figure by the financial year-end.

Northern Cape health director-general Barry Kistanasamy said the province had a shortfall of only R8m on its health budget.

Gauteng cost-cutting centres on health, teachers

Farouk Chothia

THE Gauteng government had introduced wide-ranging cost-cutting measures in a bid to avert overexpenditure on its R14,5bn budget this financial year, Gauteng treasury chief director Pradeep Maharaj said yesterday.

Maharaj said current estimates of overexpenditure this financial year were about R1,1bn. However, the figure would be reduced to between R150m and R200m once the national treasury transferred funds for public service salary increases which came into effect on July 1.

The transfers should take place next month, Maharaj said.

He said overexpenditure was largely confined to the education and health departments, with the figures standing at about R600m and R580m respectively.

The provincial government wanted teachers who went on lengthy leave next year not to be replaced with "substitute" teachers, as was the case in the past. An exception would be teachers who took maternity leave, Maharaj said.

SA Democratic Teachers' Union (Sadtu) Gauteng deputy chairman Jabu Ngwenya said the education department tabled the issue in the provincial bargaining chamber last week, but the discussion was shelved because the department failed to give the required 17-days notice that it planned to raise the matter.

The Mass Democratic Movement's provincial consultative forum would discuss the plan later this week, before it was again raised in the chamber, he said.

The department wanted school governing bodies to take responsibility for employing substitute teachers, but Sadtu was opposed to this as only historically privileged schools would be able to afford payment.

This would perpetuate inequities and result in higher teacher-pupil ratios in disadvantaged schools, Ngwenya said.

Maharaj said this plan was separate from negotiations under way on the non-renewal of contracts of temporary teachers in various provinces. Contract terminations were also likely in Gauteng.

Maharaj said the health department was also looking into the issue of cutting costs by reducing stock levels at hospitals, without compromising health care.

"If there is, for example, a four-week buffer of stock, we are seeing whether we can bring it down to two or three weeks."

Maharaj said other decisions aimed at cost-cutting included a ban on new projects without the approval of the provincial cabinet and treasury and the requirement of treasury approval for any tender worth more than R2m. Only "absolutely critical" posts in the public service would be filled after treasury approval.

Maharaj said he expected the legislature to pass an adjustment appropriation bill before the end of the financial year that would shift funds from departments which had made savings to those that were overspending.

The measures would help ensure government broke even this financial year, he said. National treasury officials would meet their Gauteng counterparts today as part of the continuing evaluation of provincial expenditure patterns.

Provinces look set to approve health bills

(85)
BD 17/11/97

Jacob Dlamini

CAPE TOWN — The national council of provinces select social services committee looks set to approve three controversial health bills this week, despite claims by opposition parties that Health Minister Nkosazana Zuma had withheld crucial information on the legislation from the National Assembly.

The support of at least five provinces is needed for the bills to go through and, with the Western Cape being the only province to have totally opposed the legislation, it is likely the committee will approve it when it meets to vote on Thursday.

Chairman Sipho Cwele said it was "most likely" the Medicines and Related Substances Control amendment Bill, the Pharmacy Amendment Bill and the Health Professions Amendment Bill would be accepted without any changes.

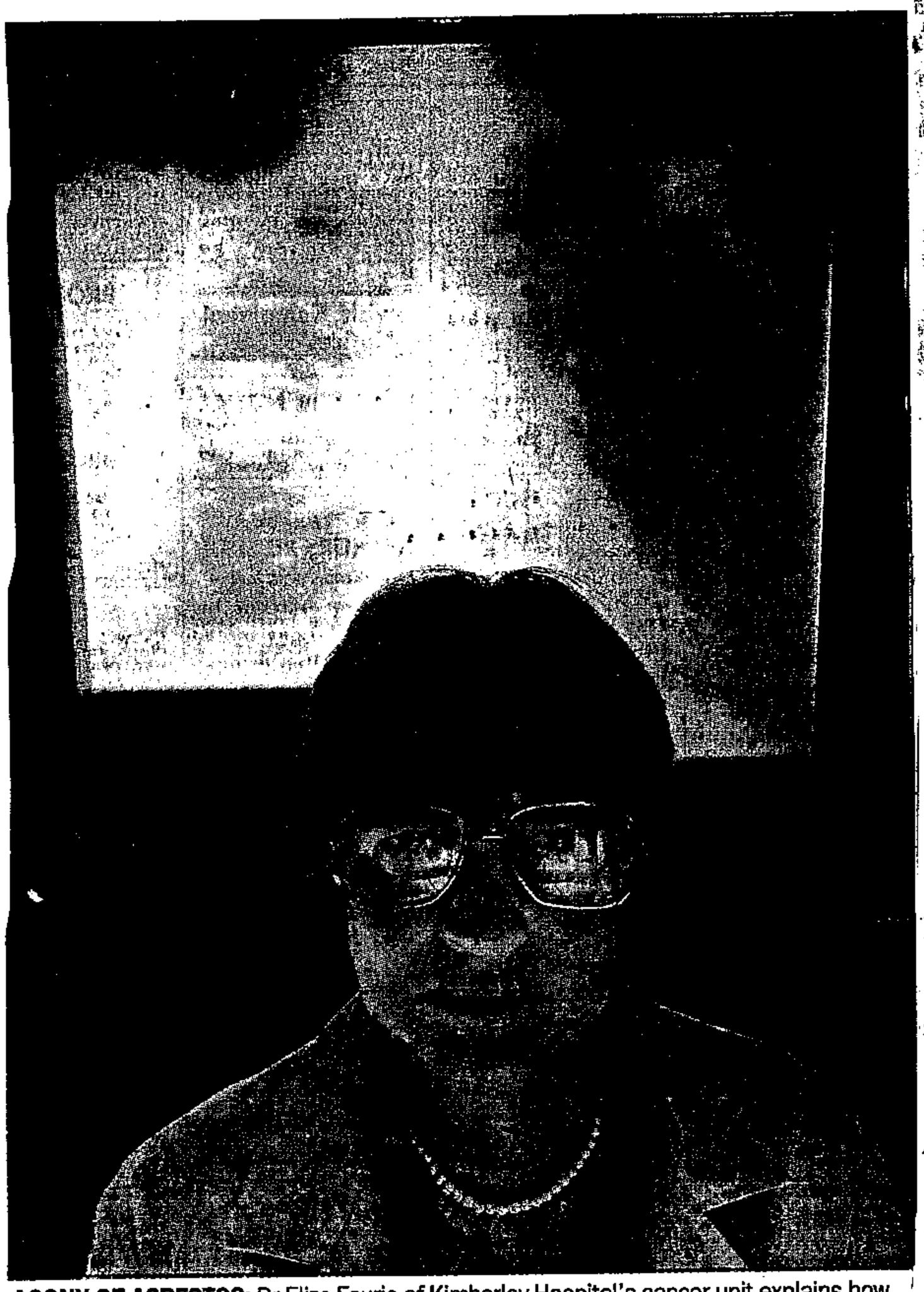
Last week the National Party and the Democratic Party (DP) called for the medicines bill, which seeks to lower the price of drugs through parallel importation and generic substitution, to be withdrawn and accused Zuma of misleading Parliament and the National Assembly's portfolio committee on health.

DP spokesman Mike Ellis claimed Zuma had failed to share with the portfolio committee advice that she had been given by the trade and industry department's advisory committee on patents, trademarks, copyrights and designs warning her the bill would violate international trade agreements.

Cwele said the advisory committee's opinion had been based on the original draft of the bill and that significant amendments had been made to deal with its concerns. The amended version had not been referred to the advisory committee.

Advisory committee vice-chairman Esme Du Plessis confirmed the committee had been consulted only on the original bill. Du Plessis, a partner at a Pretoria law firm, said the bill had contained a number of "objectionable" clauses. Du Plessis said while these were toned down, the amended version still contained clauses which would violate patent rights.

Health director-general Olive Shisana challenged opposition parties and the pharmaceutical industry to take objections to the World Trade Organisation (WTO) for it to adjudicate on the dispute. "We have no intention of busting patents and are confident our interpretation of WTO regulations is correct."



AGONY OF ASBESTOS: Dr Elize Fourie of Kimberley Hospital's cancer unit explains how the x-ray of a mesothelioma patient shows the effect of asbestos fibres. The tumour is visible in the lung on the left, as is the thickening of the membrane. *PICTURE: GARTH STEAD*

Death mines shut, but toll still rising

(85)

CT 17/11/97

(282)

LISA TEMPLETON

"WE cannot cure you: you can go home to die, or you can stay here and die."

So a patient with advanced mesothelioma was told.

He did not see his home again. He died in Kimberley Hospital's cancer unit the night before the Cape Times visited the unit.

His suffocating death was the price he paid for his years of working and living in the asbestos mining towns of the Northern Cape.

Dr Elize Fourie, of the oncology unit, has not cured anyone in the 14 years she has worked in the unit.

When she joined it, she saw up to 20 cases of mesothelioma a week, most of them from the asbestos mining towns of Kuruman, Prieska, Koegas and Whitebank. The mines have long since closed, but the exposed dumps of asbestos waste remain.

She is still seeing new patients with mesothelioma and thinks there are many more in the Northern Cape who do not reach the unit because they cannot afford the trip to Kimberley. An ambulance trip from Kuruman costs the patient R48.

Fourie estimates that 60% of her patients have not been miners but have been exposed to asbestos fibre as they live and work in areas where there is asbestos pollution.

"I have had patients who simply went into the mining towns to play tennis," she said.

Mesothelioma is a cancer directly linked to asbestos exposure and takes 20 to 40 years to develop. Fibres needle their way into the soft lining of the lung, where they become irritants, causing a fluid reaction and a tumour to develop.

Ultimately the tumour can grow into the ribs, heart and abdomen or bulge painfully from a patient's side.

A nursing sister at the hospital, who had watched a post mortem on a mesothelioma patient, said: "The lung was hard as rock, white like cement and had solidified on to the ribs."

Fourie said some patients she had seen were in such pain they were unable to speak.

"If you catch the cancer early you can treat it by removing the tumour and treating the patient with chemotherapy, but it keeps growing," Fourie said.

Patients are treated for pain and sedated where necessary, but Fourie is not happy with the way patients are nursed at the hospital.

"These patients need special care and they don't get it here — they are neglected and their comfort is not seen to. Sometimes it is better for them to return to their home town, where they can be cared for by hospitals there or their families."

Health care languishing in sick bay, says top doc

(85)

JENNY VIALL
HEALTH REPORTER

Top physician Solly Benatar today paints an alarming picture of a collapsing public health service.

In a letter to the Cape Argus, published as today's Inside Story, Professor Benatar warns **of a reduction in health care for the poor, the growth of private medical care at increasing cost and the erosion of capacity to educate future generations of health care professionals.**

Professor Benatar, who is head of medicine at the University of Cape Town and Chief Physician at Groote Schuur Hospital, says funding cuts in the Western Cape and the shift in emphasis to primary care are having radical short-term effects.

Specifically, he says:

■ In spite of having cut 6 000 jobs in three years, the Western Cape still has 6 000 more health workers – a total of 27 500 is projected by next March – than it has budgeted for in 1998.

■ More hospital beds are to go, on top of the 100-plus average axed every month since March 1995.

■ The "totally random ... attrition of staff" has hit vulnerable areas of health care hardest. ARG 18/11/97

■ Reduced efficiency in the public sector has "severely undermined" support services such as maintenance, catering, cleaning and transport.

■ Theft, and union demands for higher pay, have further reduced productivity.

Professor Benatar hits out most strongly at the way "much-needed change" in medical academia is being handled.

"Such poorly planned changes will adversely affect medical practice – initially in the public sector but inevitably and very soon in the private sector as well," he says.

And he speculates that behind the reforms could be an ideological plan to restructure medical schools so that they train only primary care practitioners to meet the needs of neglected rural people.

'Quick-fixes' damning medical care, page 10

Health department in talks to take over Institute for Medical Research

BD 20/11/97 (35)

Josey Ballenger

THE health department was in talks to become the sole owner of the SA Institute for Medical Research and merge it with other state-owned laboratory services into one public enterprise, the department said yesterday.

The department, which currently owns half the institute — a nonprofit research, training and laboratory services organisation founded in 1912 — would have to buy the Chamber of Mines' 50% stake.

National health systems chief director Ray Mabope confirmed that the department had been approached earlier this year by private parties — a multinational pharmaceutical company and a group of SA pathologists — to buy into the institute, but said the department was not interested in a joint venture. He declined to disclose the names of the parties.

However, he said there had been just "preliminary discussions".

The institute's chairman, Anglovaal CEO Jurie Geldenhuys, said there had been a number of "expressions of interest" from pharmaceutical companies in the past few years, but that they had made "no real offers because it (the ownership structure) is such a complicated setup".

Mabope said that the department viewed the institute as a "strategic national asset" and sought to "overcome fragmentation and duplication" in the provision of pathology laboratory services. After rejecting the options of privatisation and nationalisation, the department aimed to establish a public enterprise "run on sound business principles". He said the enterprise would enjoy better management autonomy and should yield better cost efficiency and effectiveness in delivery of lab services to support the national health system. The state would "exert its influence" through a board of directors in which the national and provincial health departments would be represented.

Institute director Prof Keith Klugman said "substantive negotiations" had not yet started, and that the institute had only this week informed its staff union and the National Education, Health and Allied Workers' Union that talks were under way.

Klugman said he would support a national health laboratory service similar to the UK's: "Obviously, there are economies of scale in bringing all the laboratories together." Surveillance of infectious diseases, for example, would be pooled into one central data system.

However, Klugman said, there were "concerns (about how well) the institute and other laboratories would answer to the same parastatal". Klugman said institute turnover was R3m.

Health care is still facing sick future

(85) Star 26/11/97

Compromises and budget-juggling are not closing the gaps in inequalities

By Janine Simon

The Government had made great strides in health policy, but its slow introduction had ensured there were still inequalities in health care.

This is according to the South African Health Review, recognised as a leading barometer of change in the health sector, and which is funded to a small extent by the Health Department.

The review is conducted by an independent body.

Both national health director-general Dr Olive Shisana and the chief director of Mpumalanga's health department, where the health review was launched, cancelled their attendance late on Monday.

This prompted speculation that they might be unhappy with certain aspects of the report. The two were supposed to make inputs about the document.

The report – the third major independent review of progress in reforming the health system – recommends that the Health Department step up the implementation of policy.

Dr Peter Barron, research manager for Health Systems Trust, which produces the review, said that despite commitment to primary health care, disparities continued and rural and poorer people were losing out.

The public/private divide remained the largest source of inequality, with the private sector absorbing up to 94% of certain health professionals and serving only 25% of the population.

The new system of block grants to provinces could also compromise equity in health because it left health financing to the discretion of provincial cabinets.

A survey of 160 clinics conducted by the review found that more than 20% of rural clinics did not meet basic indicators for service provision.

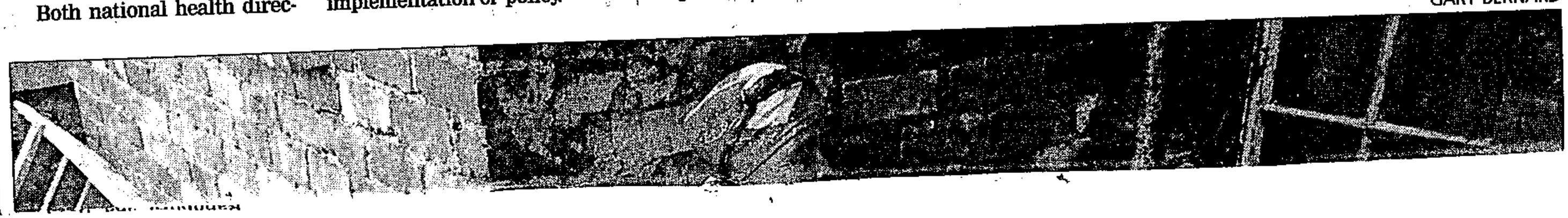
Nonhlanhla Makhanya, research manager for reproductive health, said more than 20% of rural clinics did not have functioning taps, and more than 10% had no functioning fridges, which were used to maintain the cold chain for drugs used for immunisation.

A total of 20% of rural clinics surveyed had no response to ambulance calls in the month before the survey, she said. Only 41% have an ambulance within an hour of an emergency call, compared with 74% of urban clinics.

Treatment of priority problems of sexually transmitted diseases and tuberculosis were far from the standards set for their management.

Encouraging findings included a relatively acceptable level of child-care services and the fact that 72% of clinics offered daily family-planning services.

GARY BERNARD



R1,8-m foundation unveiled

By Shadrack Mashalaba

NEDBANK Professional Banking and Medical Association of South Africa (Masa) officially unveiled a R1,8-million foundation yesterday which is aimed at upgrading the skills of workers in the health industry.

The new Masa-Nedbank Foundation for Professional Development (FPD), which was launched in Johannesburg, will be spent over the next three years.

The foundation will offer healthcare professionals a series of customised educational programmes ranging from business management and finances tc continuing medical education.

Speaking at the launch, FPD executive director Dr Gustaff Wolvaardt said the launch of the organisation represented an era of change.

Wolvaardt said healthcare professionals needed empowerment in business and management skills in line with changing international trends.

Second best health care for rural areas

JENNY VIALL
HEALTH REPORTER

ARG 26/11/97

Rural areas and poorer provinces get second best in terms of health care and the move towards more equitable services is becoming increasingly uncertain now that funding is at the discretion of provincial cabinets.

So says the Health Systems Trust in its latest South African Health Review, a recognised barometer of the progress of reform in the health service, which assesses health successes and failures. It includes a survey of the realities in clinics in every province.

Past reviews have focused on the development of new policies as part of restructuring in the health sector.

This one concentrates on trying to assess the extent to which new policies have been translated into real improvements in the quality of life of South Africans.

The review found that in spite of the commitment to providing primary health care for everyone, there was continuing disparity between service provision in rural and urban areas with rural people and poorer provinces still losing out.

The survey showed only 41% of rural clinics had ambulances on their doorsteps within an hour of emergency calls compared with 74% in urban clinics.

The move towards more equitable provision had become even more uncertain now that provincial cabinets got block grants from the national treasury and made allocations to health at their discretion.

The review found that in spite of legislation allowing for termination of pregnancy which came into effect in February, service provision had been "patchy at best" with a number of provinces doing far less than their proportional share of terminations.

The clinic survey revealed that only just more than 60% of rural clinics and about 85% of urban clinics offered family planning services on a daily basis. The review found it was difficult to measure what had really changed for a poor person in need of health care.

More reliable up-to-date information was needed to assess, evaluate, plan, prioritise and improve in every part of the health system.

The review is funded by the Department for International Development in the United Kingdom and the Kaiser Family Foundation in the United States.

DP wants 'R3m adviser' probed

Linda Ensor
BD 26/11/97

CAPE TOWN — The Democratic Party (DP) has called on President Nelson Mandela to appoint a judicial commission of inquiry to probe the appointment of Emanuel Shaw as a R3m-a-year adviser to Central Energy Fund chairman Don Mkhwanazi.

DP minerals and energy spokesman Kobus Jordaan moved a motion in the House of Assembly yesterday calling for an investigation into Shaw's background and his involvement in oil deals including those concluded during the pre-1990 sanctions period.

Shaw allegedly participated in a series of shady business deals with Liberia's minister of finance.

Jordaan proposed the commission also inquire into the circumstances surrounding Shaw's appointment; any possible role he might have played in the suspension of CEF GM Kobus van Zyl; and the role, if any, of Deputy President Thabo Mbeki, Minerals and Energy Minister Penuell Maduna and deputy director-general Gordon Sibiya in his appointment.

Such a judicial commission would be in addition to the departmental commission of inquiry appointed by Maduna about two weeks ago.

Jordaan said it appeared Mkhwanazi had misled Parliament at a meeting on November 3 about Shaw's appointment.

ANC rejects call for debate on health bill

BD 26/11/97 (85)

Jacob Dlamini

CAPE TOWN — The African National Congress (ANC) yesterday rejected a National Party (NP) motion calling for a parliamentary debate on the public protector's findings that Health Minister Nkosazana Zuma had made grossly exaggerated and misleading claims about the price of medicines in SA.

In a report released on Friday, Public Protector Selby Baqwa found Zuma had failed to prove the claim that SA's drug prices placed it among the five most expensive countries in the world.

The claim that some medicines in SA sold for up to 4 000% above the world average was found to have been based on a wrong calculation and a statement by a health department official that SA paid 2 500% more for anti-tapeworm medicines was found to be misleading but not improper.

Baqwa found claims that medicine costs had increased at double the inflation rate in the past decade had been made by the media, and not the department.

He found Zuma had given misleading but not improper information about the use of generics in the UK, the US and Germany.

His findings followed a Pharmaceutical Manufacturers' Association investigation into the conduct of health department officials regarding the above allegations.

Baqwa said that while he had found no evidence to suggest Zuma and her officials had acted improperly, he called on the department to try to use correct information in public statements.

Baqwa did find that pharmaceutical profits in SA were substantial. The average amount spent on health care was nearly triple that of other countries.

Zuma's spokesman Vincent Hlongwane welcomed Baqwa's findings and said the minister would take his advice about using accurate information in future.

Pharmaceutical association CEO Mirryena Deeb welcomed the findings and called for a review of the legislation allowing for the parallel importation of drugs, as Zuma's arguments had been based on incorrect data.

The association had asked President Nelson Mandela not to sign the legislation into law and would possibly launch a Constitutional Court challenge if he ignored their request, Deeb said.

NP spokesman Kobus Gous, whose motion for a debate on the report was rejected as "cheap politicking" by the ANC, called for Zuma's resignation and for Mandela not to sign the bill into law.

'Cost containment measures will save millions'

Pule Molebeledi

BD 26/11/97

RUSTENBURG — North West had introduced strong measures to manage its finances in a manner which would not allow for runaway expenditure to occur, the province's premier Popo Molefe said this week.

Molefe said North West was regarded as one of the provinces which was handling its expenses relatively better than others. The province had projected over-expenditure of about R700m, but through cost containment measures, "we will be able to reduce it to R170m".

The entire country was experiencing fiscal constraints, with the result being insufficient money allocated to the provinces for their budgets. Provinces had found themselves overspending due to backlogs in social services like education, health and social welfare, as well as government's commitment to cash containment.

Molefe said he had introduced a string of measures to fight corruption within his government.

This included the appointment of a unit to fight corruption which had already been instrumental in 56 people appearing in the regional court on corruption charges.

The special unit was investigating 118 cases of corruption, a number of which had been reported by members of the public through an anticorruption hotline in Molefe's office.

Payouts to traditional healers to end

BD 27/11/97 (85) (249)

THE Registrar of Medical Schemes would early next year stop medical aid schemes which had been paying out benefits to traditional healers, the registrar announced at a benefits conference in Johannesburg on Tuesday.

Medscheme Groups spokesman Gary Taylor said yesterday the move was in response to the Medical Scheme Act which stated that medical aid schemes should not pay unregistered health care providers. Taylor said those medical schemes which had been doing so were contravening the law.

While traditional healers had been proposing that their treatment be included in medical aid benefits, it was only recently that support for the proposal was received from union sources and certain academic and political circles, said Taylor.

"The onus is now on traditional healers to lobby government to give them legal status." He said there were strong arguments for and against traditional healers being brought into the medical aid system because "many inappropriate treatments have had serious consequences for the patient". Western preparations also had harmful effects, Taylor said.

"We administer 57 schemes, serving 2-million patients.

"Half of these patients are black and for many years we have had discussions with various associations representing traditional healers." There were 200 000 healers in SA.

He said there was a way of bringing healers into the formal medical aid system if all parties involved were prepared to adopt a sensible approach. The body, mind and soul approach adopted by traditional healers was increasingly being followed by Western doctors, as well as the use of herbs and other organic substances, said Taylor. — Sapa.

'Transforming' medical research

(85)

The Medical Research Council, now ending its first three-year term under Professor Makgoba, has redressed inequalities and implemented fast-tracking

Star 28/11/97

By Jovial Rantao
Political Correspondent

The success story of South Africa's first fully representative Medical Research Council (MRC) is the story of the new South Africa.

It's a story about hope, achievement and more importantly, a demonstration that where there is a will, a clear uncompromising programme and a buy-in by stakeholders, real progress and transformation can be achieved.

Appointed by Health Minister Dr Nkosazana Zuma in December 1994, the 17-member MRC board took over a statutory council that mirrored the old South Africa. The board was all white and its programmes were not geared towards benefiting the majority.

As it comes to the end of its three-year term, the MRC board, led by Professor Malegapuru Makgoba – he of University of the Witwatersrand fame – has reported on its successes to Parliament, via the Health Ministry.

Despite being a small underfunded national council – the budget of the MRC is currently R75-million, compared with R50-billion for the National Institutes of Health in the USA – the council has scored some major achievements.

For instance, before the new board was installed, the MRC supported a portfolio of two centres and 13 research units at universities, with one at a historically disadvantaged institution.

Figures released by the MRC to Parliament show that transformation in the grants offered by the council has been dramatic.

In 1993 57% of MRC scholarships went to white students and 43% to black students. In 1996, 27% went to white students and 73% to black students.

The MRC's achievements were underpinned by organisational transformation and development, which included:

- A planning process which resulted in a corporate plan for 1995-1997 with the focus on strategy implementation, regular assessment of milestones reached and cyclical revision.
- Redressing the inequities of the past in a progressive employment policy, with 75% of all vacancies to be filled by black candidates. The race profile of the MRC has changed over the past three years from 41% black and 59% white to 47,1% black and 52,9% white, "although more blacks are needed in senior positions".
- Career fast-tracking of black employees, with individuals receiving assistance for formal postgraduate training.
- A system of internships within MRC programmes which further allowed for involving young black scientists in active research, while pursuing their formal studies at academic institutions.
- A process to align MRC salaries with market trends within the constraints of its budget.
- The GEAR objective of democratising state and society, influencing the pace of greater involvement by researchers and other MRC staff members in shaping a new MRC. A scientific strategy committee was formed to assist the board in planning detailed research strategy.
- New financial systems to enable the MRC to recover from financial difficulties.
- A recent analysis of the five most cited science papers, which showed that three out of these were from MRC researchers, confirming the competitive edge of the council's medical research.

Satisfactory health care 'impossible' after cuts

CT 2/12/97

85

DIANE CASSERE

THE Western Cape Department of Health believes it would be "irresponsible and virtually impossible" to deliver satisfactory health services on the reduced budget for 1998/99.

Dr Faried Abdullah, chief director of health services, said the department would meet this morning to discuss a strategy to appeal for more funds. The meeting would also seek ways to protect the already hard-hit health services from further "catastrophic" cuts.

The provisional budget allocation is R2 083 million — R800m short of the R2,9 billion needed to sustain health services in 1998/99. This represents a 27,5% cut in all services, which, if implemented, will lead to the collapse of all three academic hospitals (Groote Schuur, Red Cross Children's and Tygerberg).

It will also mean the closure of many community health centres and regional and district hospitals, the loss of 6 000 staff members and the closure of 2 500 hospital beds.

"It is significant that the accepted international maximum for the downscaling of health services over one year is 2,5%," says Abdullah.

The department will make a presentation to the Western Cape Standing Committee on Health. The committee will also receive submissions from many other sectors, such as trade unions, NGOs, academics and health service officials. Interested members of the health sector and the public are also urged to attend the meeting.

"The Department of Health is confident that the standing committee will make substantive recommendations to have the allocation reviewed," said Abdullah.

'The planned budget cut of R800m cannot be implemented.'

"We believe it would be irresponsible and indeed virtually impossible to deliver satisfactory health services on such a reduced budget and will be making an urgent pleas for review by the National and Provincial Treasuries."

The budget cuts have been made despite the fact that:

- 5 000 staff have been lost since 1995.
- 2 500 beds have already been lost.
- There were 400 000 more outpatient visits in the past year.
- Free primary health care has been implemented.
- Termination of pregnancies has been implemented.

The crisis in health care has been caused by the need to bring equity between provinces and the scale of existing inequities, as well as reduced social spending; insufficient recognition for services and training rendered to other provinces; and the failure to prioritise health care.

The cuts mean there will be longer queues at health services and some patients may be turned away. There will also be closures of casualty services, ward closures at some hospitals, longer waiting times for ambulances, some non-emergency operations will be curtailed and there will be increased stress and demoralisation among staff.

"The Department of Health's management position is that the budget cut of R800m cannot be implemented," says Abdullah.

"The department asks the public from all sectors to attend this hearing and take whatever action they think necessary to lobby for a realistic budget.

"It is imperative that the health sector and all other affected persons unite to sustain a workable health system in the Western Cape."

- The meeting takes place this morning at 9 in the auditorium, Western Cape Legislature Building, Wale Street.

Budget cuts will cost lives, experts tell health crisis meeting

85

CT 3/12/97

DIANE CASSERE

THE auditorium at the provincial administration buildings in Wale Street had never been so crowded. Members of the public, academics, politicians, unionists, health care workers and others poured in to voice their opinion at the crisis meeting on health budget cuts.

Some 50 health care workers from Tygerberg Hospital arrived together: they had organised a bus so that they could be at the meeting. There were nurses, doctors, ambulance personnel, administration staff, professors and teachers, some in uniform, some not.

They were there to hear submissions to the Western Cape Standing Committee on Health from all the key role players and other sectors such as trade unions, NGOs, academics and health service officials. Members of the public were also given time to ask questions.

What they heard from more than one health department head was that lives could be lost — perhaps were already being lost — if additional money was not found for essential health services.

They also heard that if Groote Schuur and its complex was closed for a year, a saving of R500 million could be achieved — but with disastrous results to health care.

The Western Cape Department of Health believes it would be "irresponsible and virtually impossible" to deliver satisfactory health services on the reduced budget for 1998/99. Yesterday's meeting was to call for a review by the national and provincial treasuries.

The provisional budget allocation stands at R2,083 billion, R800 million short of the R2,9 billion required to sustain health services in 1998/99. This represents a massive 27,5% downscaling of all services, which, if implemented, will lead to the collapse of all three academic hospitals in the province (Groote Schuur, Red Cross and Tygerberg).

It will also mean the closure of a large number of community health centres and regional and district hospitals, the loss of 6 000 staff members and the closure of 2 500 hospital beds.

The budget cuts have been made despite the fact that 5 000 staff have been lost since 1995, 2 500 beds have been closed to date, there were 400 000 more outpatient visits in the past year, free primary health care has been implemented and the termination of pregnancy policy has been implemented.

In his presentation, Dr Tom Sutcliffe, head of the provincial department of health, said while he backed the government policy of equity, health and training were non-negotiable.

There had been cuts in the health budgets in all provinces, from 8% (Mpumalanga) to 27% in the Western Cape.

Sutcliffe said that to survive, the public health sector would have to make itself more marketable and introduce a private/public mix. However any money generated by the province would go to the national budget.

Professor Solly Benatar of UCT said he did not believe proposed ways to counteract the budget cuts would make a difference in time to prevent the collapse of the system: "If we closed Groote Schuur Hospital complex for a whole year, we could save R500 million, but we would have to fire everyone with no provision for a severance package to achieve this."

'Maybe we should have a lottery for the health services and call it Zuma Zuma.' — Delegate

Benatar said the "short-term approach" of budget cuts discounted the ability to train people for the future.

Dr Edmond Michaels, head of primary health services for the Western Cape, said it was "false economy" to focus only on reducing the budget deficit: "With the Aids epidemic and the reduction in health care, there may be nobody left to worry about our debt."

At present, patients faced a four to six-hour waiting period in casualty, three days on a trolley or chair waiting for a bed, five days for surgery for a broken jaw and six to ten weeks for an appointment with a doctor.

"There will be many more deaths of young children — and from violence. I want to say cynically to the politicians, those people are voters and the children are children of voters," said Michaels.

Professor A G van Wyk, rector and vice-chancellor of the University of Stellenbosch, pointed out that the three training hospitals in the Western Cape produced one-third of South Africa's medical graduates: "I deplore the insufficient allocation of funds by national government for the academic hospitals. Groote Schuur, Tygerberg and Red Cross are pillars far beyond the borders of the Western Cape."

A statement from Nehawu (National Education Health and Allied Workers' Union) and Pawusa (Public and Allied Workers' Union of SA), which represent 80% of health department employees, denounced working conditions for health care workers and said the unions would not condone unfair labour practice, excess overtime and poor pay. The unions called on the department to address the present staffing and related crisis.

At tea time, members of the audience voiced their own opinions on strategy to increase funding for provincial health care: "We should have a lottery to benefit Western Cape health," suggested one woman.

"Great idea, we could call it Zuma Zuma," quipped her companion.

Health dept thrown R600m lifeline

ET 4/12/97 (85)

LISA TEMPLETON

THE cash-strapped Western Cape Health Department has been granted a R600-million lifeline by the provincial treasury.

This was announced yesterday by the provincial Health MEC Mr Ebrahim Rasool.

He also said the government had agreed to spread the health department's R400m deficit this year over three years, instead of recalling the debt by March next year, which would cripple the health system.

But last night a spokesperson for Finance Minister Mr Trevor Manuel denied this.

Until yesterday the Western Cape Health Department was faced with a massive 27% budget cut, which would have led to the loss of 6 000 staff, 2 500 hospital beds and the collapse of all three of the province's academic hospitals (Groote Schuur Hospital, Red Cross Children's Hospital and Tygerberg Hospital).

But, faced with a provisional budget of R2,083 billion, Rasool said yesterday's R2,686bn budget allocation made up for the R600m shortfall and "pulled us from the abyss".

However, it was still short of the R2,9bn needed to fully sustain health services in the province.

An additional R264m conditional grant by the government was under debate to save the three academic hospitals and a decision would be made before the national budget is put to bed in March next year.

At the standing committee on health hearing — when more than 250 health providers, trade unionists, non-government organisations and health department members crowded into the provincial administration buildings to discuss the crisis facing the health service — the common call was that budget cuts would lead to unnecessary loss of lives and something needed to be done.

Since Rasool took office in 1994 the provincial health system has already been slimmed down by more than 1 000 staff.

Rasool said he would continue to fight the national treasury for the conditional grant of R264m. Failing this, cuts would be made over the next three years, including:

- The closure of nearly 1 500 beds (including 800 at a psychiatric level).
- The cutting of some 2 500 staff in the health department.
- The closure of four to six hospitals in the province.

In terms of this the deficit would be factored out by 200.

Dr Tom Sutcliffe, head of Health, said the R600m boost was "important because it came at a time when the situation was becoming unmanageable," but so much more rested on the grant by central government.

CAPE TIMES
FRIDAY, DECEMBER 5, 1997

'PUBLIC HAS RIGHT TO KNOW'

Budget cuts forcing doctors to 'play God'

IF HEALTH care cuts are implemented, the Western Cape's academic hospitals could face collapse, warns a Groote Schuur doctor. **MELANIE GOSLING** reports.

CT 5/12/97

THE head of Groote Schuur's cardiac unit has called on the government to explain to the public how doctors are going to be forced to play God in choosing who gets medical treatment at academic hospitals.

Professor Ulrich von Oppell, head of UCT's Department of Cardiacthoracic Surgery, said the government's drastic budget cuts to academic hospitals meant that secondary and tertiary medical treatment to poor people would soon have to be rationed.

"The question is how? The public has a right to know," he said.

Speaking at Groote Schuur's 30th anniversary celebrations on Wednesday of the world's first heart transplant, Von Oppell referred to the case of Mr Thiagraj Soobramoney, who died last week after being denied dialysis treatment at a public hospital.

Von Oppell said that press headlines — such as "Too poor to live!" — raised the question of how medical care for 80% of the South African population would in future be rationed.

Doctors were being expected to select "the most deserving patient", yet their medical ethics demanded that they seek the best medical care for each patient. They were being forced, through budget cuts, to play the dual role of rationing medical care and being the patients' advocate.

"With reduced funding to Groote Schuur and Red Cross, it is inevitable that secondary and tertiary health care to patients who cannot afford private health care, will have to be rationed.

"Will it be rationed by default, by the non-existence of certain services like heart transplantation in the public sector?

"Will it be rationed by ever increasing queues for services, or by forcing the majority of the population to pay for medical care in the expensive private sector?

Von Oppell said Groote Schuur's heart transplant unit, famous throughout the world for its excellence and for its pioneering work, was likely to shut next year because of lack of money.

Once it closed, it was extremely unlikely that a heart transplant unit would ever again function in the public sector.

"Whether Groote Schuur will continue with an active heart and lung transplant programme must now be decided by the public through their elected politicians.

"The collapse of Western Cape academic hospitals is something South Africa cannot afford to risk."

About 83% of South Africans are dependent on academic hospitals for high-tech tertiary medical care, and it was this group who would be affected by the government's drastic cut-backs, he said. His department had been forced to decrease their clinical service at Groote Schuur and Red Cross by 30%, despite an increase in patient referrals.

While the unit was considered to be a international leader in some fields, this excellence was being seriously eroded. Budget cuts, retrenchments and the freezing of posts had already driven many doctors, nurses and technologists into the private sector or overseas.

"Transplantation has been singled out as a costly intervention and yet, in terms of life-years saved, heart transplantation is more cost-effective than the pharmacological treatment of mild-to-moderate high blood pressure," he said.

The trauma units were overloaded with drunk patients who repeatedly expected free medical treatment, although their condition was often the result of their irresponsible behaviour.

Von Oppell said academic hospitals needed to become autonomous and retain generated income, provided a management system based on business principles was established.

"The government should allocate the national health budget by defining what level of primary health care can be provided free, and the amount of subsidisation it can afford for higher levels of care.

"Common business sense needs to be applied to the allocation of scarce funds. The current structure of fee tariffs, where a patient will pay R37 irrespective of whether he is admitted for an enema or a heart transplant, is clearly ludicrous." Von Oppell said.

WHEN THEY FIRST CUT OUT A LIVE PERSON'S HEART

– Page 28

Communities warned not to drink unpurified water

By Priscilla Singh
Health Reporter

Star 8/12/97

Communities as far afield as Bronkhorspruit, Magaliesberg, Nigel, Heidelberg and the Vaal have been warned not to use unpiped, unpurified river water because of the risk of getting cholera.

The health department has embarked on a widescale education campaign to inform residents in rural areas of the hazards of drinking contaminated water. These regions have been identified as communities "at risk".

Gauteng has been on a cholera alert since the massive outbreak in Mozambique two months ago.

Johan van den Heever, deputy director of Aids and communicable diseases in the Gauteng health department, said the department expected less than 5% of Gauteng's population to be at risk.

Informal settlements in which water supplies periodically broke down were especially in danger.

So far, only one cholera patient – a Mozambican – has been treated in Gauteng, but an initial assessment that the province would experience a limited number of cases from people outside the province seeking treatment had been confirmed.

The department has focused its efforts on the use of safe water in communities at risk in each of the province's 25 health districts, and is educating them to use piped water and to purify river water with bleach.

Small, recently established informal settlements which do not have piped water, and small groups of people living along rivers outside these settlements, will also be targeted.

Van den Heever said the department is emphasising public education on oral dehydration therapy for diarrhoea and our strategy is to prepare clinic and hospital workers for treating cholera.

Patients' rights incorporated into health bill

Josey Ballenger BD 11/12/97

A CHARTER of rights and responsibilities regarding health care would be incorporated into the national health amendment bill to be tabled early next year, the charter's developer said last night.

The charter outlines 24 patient "rights", including access to care, confidentiality, treatment, choice and information; 18 "responsibilities", such as being constructive in complaints and providing accurate information to health providers; and ways in which the charter could be implemented.

The charter was developed by one of SA's largest nongovernmental health care organisations, the National Progressive Primary Health Care Network, following two years of consultation with community groups nationwide.

Network advocacy manager Judi Fortuin said at the charter's Johannesburg launch that the constitution and the National Health Act were the charter's legal framework and that health director-general Olive Shisana had committed the department to adopting at least some of the charter's recommendations into the national health amendment bill to be tabled in Parliament's first session next year.

"Access to these basic rights is still beyond the reach of a large proportion of the population and ignorance of their health rights has left many people at the mercy of health workers who do not always have their welfare at heart," Fortuin said.

"In fact, those most vulnerable to ill health have the greatest difficulty in accessing health services and are treated shabbily when they do go for care.

"An example of this is waiting for the whole day at a health centre without being seen and then being told to come back the next day."

Fortuin said the network would also lobby government to implement mechanisms to address health rights "violations", as the present avenues — the courts, the Interim Medical and Dental Council, provincial health officials and facility administrators — were "inadequate, cumbersome, not user friendly and not accessible to everyone".

She said there was an urgent need for such a mechanisms, as evidenced by the network's toll-free number for health-rights inquiries and complaints, which had so far received 1 850 calls.

Fortuin also said the organisation needed funding to print and distribute more charters in at least three other languages. At present, they were available only in English.

The present copies had been funded by the Kaiser Family Foundation in the US.

Poor still don't get care

(89) Sowetan 11/12/97

By Sello Seripe

DESPITE the Bill of Rights' guaranteeing every individual access to health services, communities most vulnerable to illnesses still have the greatest difficulty in accessing these services.

This assertion was made by Judi Fortuin, advocacy manager of the National Progressive Primary Health Care Network (NPPHCN), on Tuesday in Johannesburg at the launch of the Health Rights Charter (HRC).

The launch of the HRC was the culmination of two years' work spearheaded by the NPPHCN throughout South Africa and involving thousands of individuals, organisations and projects advocating equity in the provision of health services. It outlines the rights and obligations of the communities with regard to health provision.

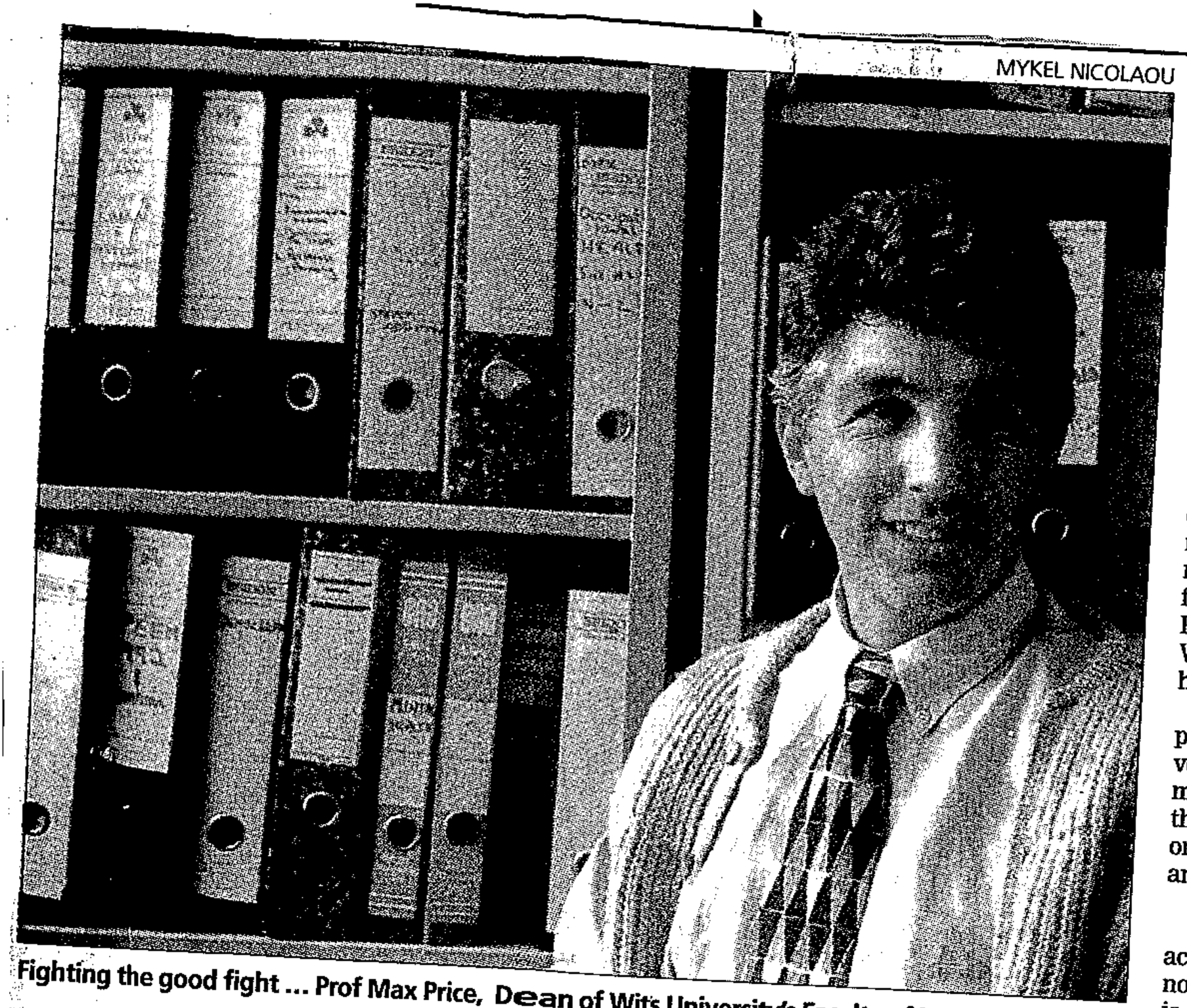
The NPPHCN hopes that the HRC will be adopted by the Ministry of Health in its transformation of the healthcare system.

Referring to the hurdles preventing some communities from accessing healthcare providers, Fortuin said they "are treated shabbily when they do go for care".

"An example of this is waiting the whole day at a health centre without being seen and then being told to come back the next day," she said.

Fortuin said: "Access to this basic right is still beyond the reach of a large proportion of the population and ignorance of their health rights has left many people at the mercy of health workers who do not always have their welfare at heart."

Guest speaker Murphy Morobe, who is chairman of the finance and fiscal commission, said the struggle for equity in the provision of health began long before the dawn of the new democratic government.



MYKEL NICOLAOU

Fighting the good fight ... Prof Max Price, Dean of Wits University's Faculty of Health Sciences.

Medical education in SA 'has hopeful future'

Morale is low and cash short, but student standards are being maintained, says Wits' dean

Star 12/12/97 (93)

By Janine Simon

Medical staff have suffered body blows to their morale, and medicine is no longer the glamorous profession of the white middle class, but nevertheless medical education has a hopeful future in South Africa, says Professor Max Price, dean of Wits University's faculty of health sciences.

Morale has been flattened by protracted wrangling over both vocational training and community service and the fact that heads of department had only a 3% increase in salaries, among other things, he said.

But not all is gloomy.

This year's graduates achieved a 95% pass rate with no drop in standards and Wits is intent on making sure its graduates are well equipped to practise in the next century.

At the moment they leave university with nine weeks' practical experience of primary health care. From 1998, there will be a mandatory six-week block in a community-based medical practice.

Wits also sees an enormous opportunity to set up an academic primary care site when Hillbrow Hospital is converted to a community health centre.

In future, the stress will be on getting undergraduates competent in the primary scientific foundations of medicine. Clinical skills will be strengthened with vocational training for medical students – whose intern year has not changed in more than 40 years – and an intern year for the allied health professionals.

Future medical studies should include interpersonal skills. Health promotion is also increasingly important as most major public health problems are at least partially preventable. In recognition of this Wits has created a new chair in community psychiatry and a new department of infectious diseases.

But all students must also be computer literate, said Price. Technology will revolutionise the way physicians practise, allowing them to access medical and patient data in palm-top computers at the bedside.

The emphasis on building up services outside of hospitals and metropolitan areas means Wits will no longer be a complex of five academic hospitals.

Instead it will be affiliated to hospitals of different levels in and out of Gauteng, Price says.

Already, restructuring in Gauteng will give the university control over services in peripheral hospitals which, in turn, should improve quality of care and make posts there more attractive.

But health authorities have not done their job properly, and patients who should have been directed elsewhere were flooding the Johannesburg Hospital.

"The province can look forward to a year of terrible overcrowding and costly litigation," he warned.

Wits was critical of the process as the university was a traditionally liberal one and was not at all willing to give up the principles of academic freedom and university autonomy just because it supported the Government.

Government funding was likely to decrease further and Wits had developed the Wits Health Consortium to seek additional revenue by, for example, seeking out contract clinical trials and externally funded research, and marketing the university as a source for the now mandatory continuing medical education.

Price added that many of the areas of policy changes in health had moved too swiftly: the introduction of free health care, the changes to provincial health budgets and the voluntary retrenchment process.

But, in contrast, there was still no action on the Hospital Strategy Project, which had recommended hospitals become autonomous cost centres.

"The department agreed to this, but the whole thing has died," he said.

SA health system had good year

(85)

sowetan 16/12/97

WHO helps ministry to adopt a primary health care approach

By Mokgadi Pela

THE Ministry of Health has declared that the country is well on its way towards achieving the goal of a national health system.

In a statement released yesterday, department spokesperson Dr G Perez said: "From a fragmented health system that served the needs of a few, 1997 will be remembered as a year the department put in place mechanisms that will make health accessible and affordable to all South African citizens."

As early as April, the white paper on Health set out the ministry's vision across the whole spectrum of health-related issues to 2000.

The ministry's mission statement reads: "To provide leadership and guidance to the national health system in its efforts to promote and monitor the health of all people in South Africa and to provide caring and effective services through a primary health care (PHC) approach."

As part of attaining this goal, the ministry embarked on a bold mission and established key pillars of health care which include:

- Achieving equity in resource allocation;
- Shifting resources from tertiary care to PHC, in line with recommendations of international bodies like the World Health Organisation and the World Bank; and
- Improving accessibility to PHC and improved quality and affordability of services.

Perez said: "This focus on improved access and quality and affordability of services underlies the National Drug Policy, of which the Standard Treatment Guidelines and the Essential Drug list for PHC are critical guidelines.

"The drug policy is aimed at controlling costs and improving distribution management of drug supplies to ensure rational drug use by both health providers and patients.

"In addition, recently passed legislation is aimed at reducing the price of drugs through parallel importation and the use of generic substances."

'Health services are deteriorating fast'

BD 23/12/97 (85)

Pearl Sebolao

THE United Democratic Movement called on Health Minister Nkosazana Zuma yesterday to appoint an inquiry to investigate the theft of equipment and supplies worth more than R12m from Johannesburg General Hospital.

Party spokesman Paulo Andrade said the theft underlined an unhealthy state of affairs in the department, especially in Gauteng, where health services seemed to be deteriorating fast. He urged Zuma to put in place measures to ensure state assets were not abused.

Johannesburg Hospital's medical resources could barely cope with the increasing patient load over the festive season and the conversion of Hillbrow Hospital into a community health centre had led to a massive overflow of patients.

The party's call followed the announcement by Soweto's Chris Hani Baragwanath Hospital of strict spending constraints in an effort to cut its projected R152m overspending this financial year.

Andrade said Zuma "must be held accountable personally for this state of affairs. Failure to deal with the problem expeditiously will once again reflect on the total inefficiency of a health department."

Andrade said it was evident that medical services in government-controlled hospitals were in a state of crisis.

"We are asking her if she is capable of controlling the situation. If she can't then she must reconsider her position" and allow a capable person to take over, he said.

The National Party (NP) blamed what it called the tripartite alliance's dogma-driven policies and administrative bungling for the chaos in the Gauteng health system.

With Johannesburg Hospital buckling under pressure, Chris Hani Baragwanath delivering only emergency treatment, the conversion of Hillbrow, and Helen Joseph and Coronation paralysed by labour disruptions, "it can justly be stated that public health services in Gauteng have become nonexistent", the NP said.

Blaming the situation on apartheid would no longer disguise incompetence.

It said it would demand that Gauteng premier-elect Mathole Motshekga took urgent steps to restore acceptable health services to the people of Gauteng.

Meanwhile, the provincial health department denied there were disruptions at the Helen Joseph and Coronation hospitals. A conflict which had affected services in November had been resolved by an independent investigation, spokesman Jo-Anne Collinge said.

She said it was untrue that Chris Hani Baragwanath was delivering only "emergency treatment". It would perform only urgent and emergency surgery for the next few months to reduce its overspending.

Steps were being taken to strengthen Johannesburg's capacity to cope with the large trauma load, Collinge said.

New regulations allow providers to add fluoride to public water

BD 29/2/1997 (85)

Pat Sidley

THE health department has drafted regulations that will allow for the fluoridation of water next year.

Fluoridated water has been supplied in many countries for decades to help reduce the incidence of tooth decay, and it has proved to be successful.

However, there has been controversy over the use of fluoride in water in several countries, and the lobby in SA which opposes its use has blocked its introduction into the country until now.

According to the regulations, all "water providers" must fluoridate water unless they are granted an exemption by the director-general of health.

Water providers — an example would be Rand Water — will have to register within a year of the regulations coming into force.

The providers must tell the local authorities to whom they supply the water that it will be fluoridated. The authorities will then inform the public and allow representations to be made on the issue.

Several criteria will be examined by the director-general when she is making a decision to fluoridate the water.

These include the levels of tooth decay in the area, the size of the population, the estimated costs of fluoridating the water for each person in the area and the feasibility of using substitutes where necessary.

Provisions are in place to carefully protect the health and safety of those using the fluoridated water.

The regulations stipulate the levels of fluoridation, how they will be monitored and how the chemicals will be stored. There should be regular inspections, workers must be trained and the effects on the community must be checked.

Providers can apply for exemption from fluoridating the water. For successful fluoridation, three elements are necessary — the water, the community and specific resources. If any of these elements make it impossible to fluoridate water, alternative methods will be considered.

In considering exemptions, the director-general will look at how much fluoride is already in the water, how well regulated the flow of water is and whether fluoridation will have an adverse effect on the water resources after consultation with the department of water affairs.

For exemption purposes, a community can also refer to the dental health of the residents — there may be no need for fluoridation in areas where the population has little or no tooth decay.

The conditions for exemption also stipulate that well-maintained and accurate equipment must be used and that chemicals must be continually available.