Health & Disease

- Hospitals & Clinics -

1998 - 1999

Cash incentive for hospitals

JENNY VIALL ARG 2/11/98
HEALTH REPORTER

Academic hospitals in the Western Cape will soon be able to keep some of the money they make from paying patients, says Health MEC Peter Marais.

This would be an incentive for cash-strapped hospitals to collect revenue, he said at a function to celebrate 10 years of liver transplants at Groote Schuur Hospital.

Mr Marais said the provincial cabinet had recently agreed that hospitals could retain a proportion of their revenue, but details of how much had yet to be decided.

At present money generated by hospitals is offset against their budgets.

Mr Marais said academic hospitals with their excellent services had the potential to be major foreign exchange earners. "We cannot afford to destroy academic health. We need liver and kidney transplants, he said.

"My health department is proud of this unit and regards it as a national asset."

Delawir Khan, head of the transplant unit at Groote Schuur, paid tribute to the courage of Groote Schuur's first liver transplant recipient Lena Martin, who had her operation in 1988 and died last year of heart failure.

Dr Khan said 87 transplants had been carried out on 81 patients in the past decade, 36 of whom were children.

Of these 70% to 80% had survived long-term, a rate which compares favourably with other units in the world. (98)

Liver transplants, while expensive, are cost-effective as it is cheaper to do a transplant than to treat the complications of liver disease.

Only a few health posts to be filled

Superintendents informed that only 50 critical positions in Gauteng will be filled in the coming year

(98) Star 4/11/98

By Anso Thom
Health Reporter

Gauteng's already overburdened hospital services have been dealt another blow with restrictions that only 50 vacant posts will be filled on January 1.

A circular sent by the Department of Health to superintendents at its 27 hospitals disclosed that "provincial services will be allocated 50 posts".

This referred to about 1 200 posts of all types but excludes doctors allocated for community service.

According to a source, the latest move would impact severely on hospitals such as Edenvale Hospital and Helen Joseph. At Edenvale, there is no anaesthetist or theatre services operating after 4pm, while at Helen Joseph, the intensive care unit and theatre services are struggling to cope.

"Paediatric sections at a few hospitals will also be forced to close," the source said.

The circular said the move would have far-reaching consequences for services rendered now and more particularly for those rendered from January 1.

The circular ordered the superintendent and his team of doctors and management structures to provide the department with a "rational assessment of what services would have to be rationalised, and an operational plan to introduce the rationalisation process at your institution over the next 8 to 10 weeks".

Dr Martin Smith, chairperson of the medical advisory committee at Helen Joseph, said it had been left up to doctors and administrative staff to determine how the cuts should be implemented.

He said that for two years, doctors had been involved in talks with the department about staffing.

"It was a consultative process and good work was done from which recommendations flowed, but all this has been ignored. We are sick and tired of taking responsibility for service cuts. We have to look the patients in the eye," he said.

Dr Dieter van den Berg, chief director of provincial health services at the Gauteng Health Department, said that although doctors had done splendid work in the clinical forums, which addressed workloads, the reality was that the budget could not afford more posts.

"The budget is overspent at the moment, but despite this we are filling 50 critical posts."

Van den Berg agreed that the restrictions would lead to the rationalisation of services. "We will support the doctors in terms of expecting them to put up with reasonable workloads," he added.

Dr Dave Morrell, chairperson of the full-time practice committee at the SA Medical Association, said the decision was purely financially driven.

"There is a lot of resentment among doctors because they feel this is not of their doing. They are trying to cover the best they can, but they are trying to do more with less," he said.

DP calls for outsourcing as theft costs Gauteng hospital laundries millions

Star 9/11/98 (98)

By Anso Thom
Health Reporter

Gauteng Health MEC Mondli Gungubele has revealed that hospital linen worth R16,5-million was stolen from five of the province's state hospitals in 1996 and last year.

This revelation comes after the department admitted last week that only 50 posts, across all levels, could be filled in the province's 27 hospitals from January 1 because of lack of money.

Gungubele was responding to questions submitted by Democratic Party Gauteng MPL Jack Bloom.

Linen worth R5,3-million went missing from the Dunswart laundry's stock, R4,8-million from the Masakhane laundry and R4,3-million from the Chris Hani Baragwanath laundry during the two-year period.

Johannesburg Hospital lost linen worth R969 874 in 1996 and Edenvale lost linen worth R951 329 during the same period.

Gungubele said that without resorting to body searches, it was difficult to stop "this kind of petty theft.

> **"Items small and can be concealed on the body"**

Most linen is used in areas easily accessible to staff, patients and the public. Items are generally small and can be concealed in personal belongings or on the body," he said.

Gungubele admitted that the control of linen was poor in some institutions, but that this was complicated by the extensive chain along which theft could occur.

The MEC said the thefts resulted in the department wasting money, in hospitals delaying certain procedures, and in patients being embarrassed.

Bloom said linen shortages even caused some operations to be cancelled.

He said a tender for a study into the possible commercialisation or outsourcing of these laundries had yet to be awarded – a year after it was initially proposed by the department.

"There is vast room for improvement in the management of laundry services, and private sector involvement is needed to cut down on the shocking current high level of theft," Bloom added.

Tight controls to combat linen thefts

(98)

Star 11/11/98

30 hospitals, clinics reviewed

By Anso Thom
Health Reporter

A number of steps have been put in place to curb the theft of linen from Gauteng's 30 hospitals and network of clinics, according to Health MEC Mondli Gungubele.

Responding to revelations that hospital linen worth R16,5-million has been stolen from five of the province's state hospitals between 1996 and last year, Gungubele said the department was not sitting back while goods disappeared.

Measures put in place included:

- Marking linen to make it less attractive for private use;
- A system of exchanging clean linen for soiled linen on the wards has been instituted. This one-for-one supply implied that if the soiled linen was short, the replacement would be insufficient to meet normal needs;
- Bags of linen transported to and from the laundry are carefully counted;
- Loaded laundry trucks are kept locked and the keys retained, not by the driver, but at either end by the laundry manager and the hospital linen supervisor;
- Hospitals encouraged to keep linen rooms locked;
- Random counts and checks instituted where serious and unexplained shortages occur.

Gungubele said the privatisation of laundries would not solve the problem of linen theft on its own.

"Blankets, sheets and pillows often disappear directly from the hospitals, not from the laundries.

"Clearly the problem is complex – ranging from petty theft to organised crime, and its elimination requires multiple strategies," the MEC said.

He claimed hospitals were stepping up security, controlling exit points more tightly and introducing systems suited to their individual circumstances.

Questions posed to the MEC by Democratic Party MPL Jack Bloom revealed that linen worth R5,3-million had gone missing from the Dunswart laundry's stock, R4,8-million from the Masakhane laundry and R4,3-million from the Chris Hani Baragwanath laundry in this two-year period.

Cutbacks another blow for battling hospitals

(98) Star 14/11/98

By CHARLENE SMITH

Doctors have warned that patients will die if present staff and budget cutbacks at hospitals are not halted.

Gauteng hospital superintendents are on the warpath after the provincial department issued a directive to all 27 hospitals on November 2 saying that, between them, a maximum of 50 posts would be allotted in the new year for doctors, nurses and other hospital staff.

On Thursday this week, superintendents and senior hospital staff from 18 hospitals in Gauteng, including Chris Hani Baragwanath, Sebokeng, Johannesburg, Yusuf Dadoo, Leratong, Thembisa, South Rand, Heidelberg, Pholosong and Kopanong, met in Johannesburg to discuss a strategy to deal with the crisis.

In a letter issued at the meeting, superintendents and doctors said the Gauteng directive "will result in the irreversible collapse of vital services. We as clinicians and managers reject this process."

They said service provision was being pushed "far below minimum requirements. We cannot in good conscience accept that financial constraints will mandate the collapse of health services in Gauteng ... Those who decide the budget ... must stand before the community and inform them of what will happen ... We are tired of being held responsible by patients and their families for dirty wards, long queues, no beds, and unfriendly and inadequate services. It is time for those in power to stand up and be accountable for this crisis in public hospitals."

Superintendents will meet Gauteng MEC for Health Mondli Gungubele on Tuesday to protest against the directive and present data on how health services are in a process of "irreversible collapse".

Gauteng is not alone; sources in the national Department of Health said every province in the country was drawing up similar directives. A senior official in the Department of Finance said: "The problem is not that budgets are inadequate, it is how they are managed."

Gungubele said: "I am not ready to make any comment regarding the mechanisms around that directive. I am assessing the whole thing; we do not have a definite view."

After the *Saturday Star* spoke to Gungubele, Gauteng's deputy director of health, Eric Buch, issued a fax to all hospitals, and the *Saturday Star*, saying an additional 30 posts would be made available for clinics.

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Another blow for battling hospitals

(98)

■ From Page 1

He invited hospitals to suggest priority appointments.

Doctors and superintendents say many services have already collapsed or are close to collapse. They say the freezing of posts has led to a chronic shortage of nurses and doctors – which community service will not be sufficient to address.

At the same time, the national Health Department has issued a directive for the work permits of 1 300 foreign doctors to be withdrawn.

And the chaos is already having an effect: Jo'burg Hospital this week told five hospitals that, because of its staffing problems, it could no longer supply radiologists as part of its outreach programme. The hospitals it can no longer serve include Yusuf Dadoo (Krugersdorp), Germiston, Far East Rand (Springs), Pholosong and South Rand.

One hospital administrator said: "Without radiologists we are unable to do sonar. This, for example, endangers the lives of women who come for free abortions. In all emergency situations, lives could be endangered. We have x-ray equipment at the hospitals, but without radiologists, assessments will be as good as the guess of the doctor on call."

> *'Lives could be endangered in emergency medical cases'*

Dr Warrick Sive, one of only two superintendents left at Johannesburg Hospital – six have left – said the hospital scheduled a three-hour meeting late yesterday to assess the situation.

The 850-bed hospital is battling to survive. Sive said they had "desperate queues. We have too many patients. They come here because of cutbacks at other hospitals, which means we overspend."

Dr Claude Monzanga, deputy superintendent of Chris Hani Baragwanath, said the new directive would mean doctors could not see "the number of patients we are seeing now, and we may have to close some units; those in danger include paediatrics, neurosurgery, urology and orthopaedic. Nursing is a major problem. Without an adequate number of nurses, patients do not get adequate care, but we are not allowed to replace those who leave or retire."

From Monday, Leratong Hospital becomes the only hospital on the West Rand to offer after-hours casualty services. Those at Yusuf Dadoo in Krugersdorp are being closed.

Dr M S Cabado, acting superintendent at Leratong, said: "It will be a hell of a job to cope. We have 700 beds and the hospital is always 90% full. There are only 37 full-time doctors, 18 interns and one part-time doctor. According to Pretoria's organogram, two years ago we should have 102."

Other Gauteng hospitals are experiencing similar problems.

Star 14/11/98

Penniless hospitals about to collapse

Patients in the northern Eastern Cape could soon be dying

(98)

C/15/11/98

EMBATTLED... Eastern Cape health MEC Trudi Thomas is facing a serious problem as several rural hospitals face financial collapse.

EMERGENCY patients could die this week if they reach the doorstep of at least one remote Eastern Cape town hospital because Bisho has run out of cash.

"You cannot describe it, I don't know what we're going to do! Very sick people are going to end up on the street," said Lady Grey Hospital's medical superintendent, Dr Erik Engelbrecht.

Five small town hospitals in the northern Eastern Cape were tottering on the brink of a financial precipice this week.

The provincial health department had promised to dredge up the cash on Tuesday, but by Wednesday hospitals reported no change.

Engelbrecht said his hospital was in a dire situation because of a shortfall in provincial subsidies.

If they did not get money urgently, the hospital would have to refuse to treat injured and sick people.

He said that the hospital had "very, very sick" patients, some of whom had already left other hospitals because conditions there were "so poor".

The five hospitals would run out of food for patients and money to pay staff at the end of this month.

Those affected are the hospitals in Indwe, Dordrecht, Molteno and Tarkastad, and St Francis Hospital in Aliwal North. All are 90 percent subsidised by the provincial health department.

Engelbrecht warned: "People brought in for emergencies will end up dying because there just won't be services."

He said he had sent the hospital's secretary to buy food supplies on Thursday this week for the last time.

His staff would probably not be paid in November and December.

"If we can't pay salaries, we'll eventually have no choice but to close," said Engelbrecht.

He said the department was supposed to cover 90 percent of the hospital's expenditure, but the quarterly subsidies did not even cover 90 percent of salaries, let alone the hospital's running costs.

"We'll eventually have to transfer our patients to State hospitals, but at this stage we are having difficulties transferring patients needing Caesarean sections because State hospitals are full and understaffed."

He said doctors would eventually be forced to leave the district if their salaries were not paid.

"It is extremely satisfying working in such a needy area because you can see results.

"It will be terribly sad if we have to leave because we have no option," said Engelbrecht.

Indwe Hospital secretary Kitty Labuschagne said her hospital would be able to survive for a bit longer because they had an overdraft facility and the hospital buildings belonged to the community.

"At the end of October we were already in the red by about R150 000."

Their overdraft limit was about R200 000, Labuschagne said.

She said they would not be able to pay hospital staff their salaries this month unless they received more money from the provincial health department.

"I'm very worried. I've got 44 staff members and we render a very good service to the community. What will happen to the staff if we can't pay salaries?"

The provincial health department's deputy permanent secretary of district health services, Dr Peter Milligan, this week vowed that the department would not allow the hospitals to collapse. He promised they would be paid before the end of the month.

"We are at the moment procuring payments and will ensure that no hospital collapses."

Milligan said the department would provide the money it had available to keep the hospitals going.

He said the hospitals had a "chronic problem" in that their budgets had not kept pace with their expenditure.

However, the prognosis for provincial health services in general is far from rosy.

Last month health MEC Trudy Thomas told the Eastern Cape legislature that health services would collapse by February or March 1999 unless the department received money from the provincial reserve fund.

Thomas said her department had calculated it would need R3,5 billion for health services for the 1998-99 financial year just to keep its services going.

The national Department of Finance initially agreed the department's figures were credible, but later said it would only be able to give it R3,1bn.

The next blow came when the province said it could only give the health department R2,9bn, due to statutory and personnel obligations.

The final blow came with the crisis in education which resulted in R115 million being suspended from the health budget for use in the provincial reserve fund.

The fund is aimed at slashing the estimated R1,8bn provincial debt from last year.

Thomas said her department would need to get back the R115 million suspended from its first allocation, plus another R33 million to keep going.

This amount of R148 million did not include some of the debts that had surfaced and whose exact amount had not yet been determined.

Thomas said if they only got R2,8 billion, a halt would be declared on the building of clinics, hospital restoration, buying and replacing equipment, and buying ambulances for rural hospitals.

There would be no money for critical posts such as new clinic staff, security staff, pharmacists, financial managers and a media officer.

And there would be a cutback in supplies of medicines, food for patients, water, electricity and laboratory services, said Thomas. – ECN Weekend Service.

Gauteng halts capital spending at hospitals

Star 20/11/98 (98)

By Anso Thom
Health Reporter

Budget cuts have forced Gauteng's health department to halt all capital projects at hospitals and clinics for which a tender has not yet been awarded.

Jo-Anne Collinge, spokesperson for the department, said it had stopped certain capital and maintenance projects in order to channel additional funds towards covering the operational cost of health services.

"Cabinet has given its approval for the reallocation of some R76-million in this way, out of a total capital and maintenance budget of R382-million."

Democratic Party MPL Jack Bloom said all repairs had been drastically curtailed at hospitals, including electrical standby generators and sterilising equipment.

Collinge denied this, saying that only Sizwe Hospital's standby generator needed repair.

"The projects that have been halted were carefully examined, and patients' lives and safety will certainly not be put at risk as a result of this change in spending," Collinge said.

Among the projects "proposed to be stopped" by the department were the construction of the J D Allen theatre at Chris Hani Baragwanath Hospital, the building of new clinics, upgrading of lifts, upgrading of the sewerage system at Coronationville, upgrading of casualty at Mamelodi, and general renovations.

The announcement comes shortly after revelations that all appointments at Gauteng's hospitals had been frozen.

Clinics to fall under local govt

By Anso Thom

Gauteng's department of health is expected to delegate primary healthcare services at its 340 clinics to local government, after a two-day summit which ends today.

Gauteng Health MEC Mondli Gungubele said this week they were planning to integrate the preventive and promotive health services offered by local clinics with the curative services offered by provincial clinics and community health centres.

"We are trying to integrate the services, making it more easily accessible to all communities," he said.

Development Planning and Local Government MEC Sicelo Shiceka said the move was aimed at utilising resources optimally and saving costs wasted through duplication.

Gungubele said the delegation of primary healthcare services would allow the government to concentrate more on strained and overutilised hospitals.

Chain of clinics brings healthcare to millions

(98) Star 24/11/98

By Anso Thom
Health Reporter

South Africans will soon have access to more than 70 private healthcare clinics where they can receive primary healthcare for a fee of R50.

The service would include a consultation, medication, x-rays and ultrasound examinations.

Already eight Carewell clinics have opened in Soweto, Vosloorus, the Vaal Triangle, the Eastern Cape, Middelburg and Germiston.

"We felt we needed to help the Government in the daunting task facing them with a scenario where R20-billion is spent on private healthcare which reaches 20% of the population, and R20-billion on serving 80% of the people," Dr Thabo Lehlokoe, managing director of Carewell, said yesterday.

"There are a lot of people out there who are at least able to pay something. Between 12 million and 16 million people are working but can't afford to visit a general practitioner," he said.

Lehlokoe added that Carewell clinics would play an active part in providing not only preventive services, but also curative services.

Carewell would provide immunisation and adequate contraception, and would also offer the Government access to its data.

Dr Claudine Mtshali, chief director of national programmes at the Department of Health, welcomed the initiative on behalf of Health Minister Dr Nkosazana Zuma.

"Primary healthcare clinics is the most effective way of rendering a broad healthcare service. If we have 100 patients arriving at a clinic, we are able to treat 85, thus alleviating the load on the tertiary hospitals," she said.

Mtshali added that one of the Health Department's biggest challenges had been to make healthcare affordable and accessible to most people.

Baragwanath medics in protest over crime

(98) ARG 25/11/98

Johannesburg – Doctors at Africa's biggest hospital, the Chris Hani-Baragwanath, have embarked on protest action to highlight the high incidence of crime at the hospital.

A spokeswoman for the doctors, Beverly Traub, said all the hospital's doctors would gather at its main entrance to present a memorandum of protest to Soweto Mayor Nandi Mayathula-Khoza.

"Car theft has become so common as to pass unremarked.

"Of late, there have been many incidents where staff members have been physically threatened and their lives put in danger.

"Our possessions have been forcibly snatched from us in hospital corridors and we have been accosted at bedsides while attending to patients," says the memorandum.

The hospital employs 600 full-time doctors and several others on a part-time basis.

Dr Traub said the onus rested on the Government, the hospital's security department, the South African Police Service and the community to ensure that crime was rooted out at the hospital.

– Sapa

Audit reveals hospital crisis

(98) ARG 27/11/98

Bisho – Eastern Cape auditor-general Chris Oosthuisen has told the provincial legislature that years of neglect have contributed to an estimated backlog of R1,2-billion in repairs and renovations at hospitals in the province, 60% of them in the Umtata region.

In a report tabled in the legislature this week, Mr Oosthuisen said he had also found several discrepancies in service provision and management at the province's hospitals.

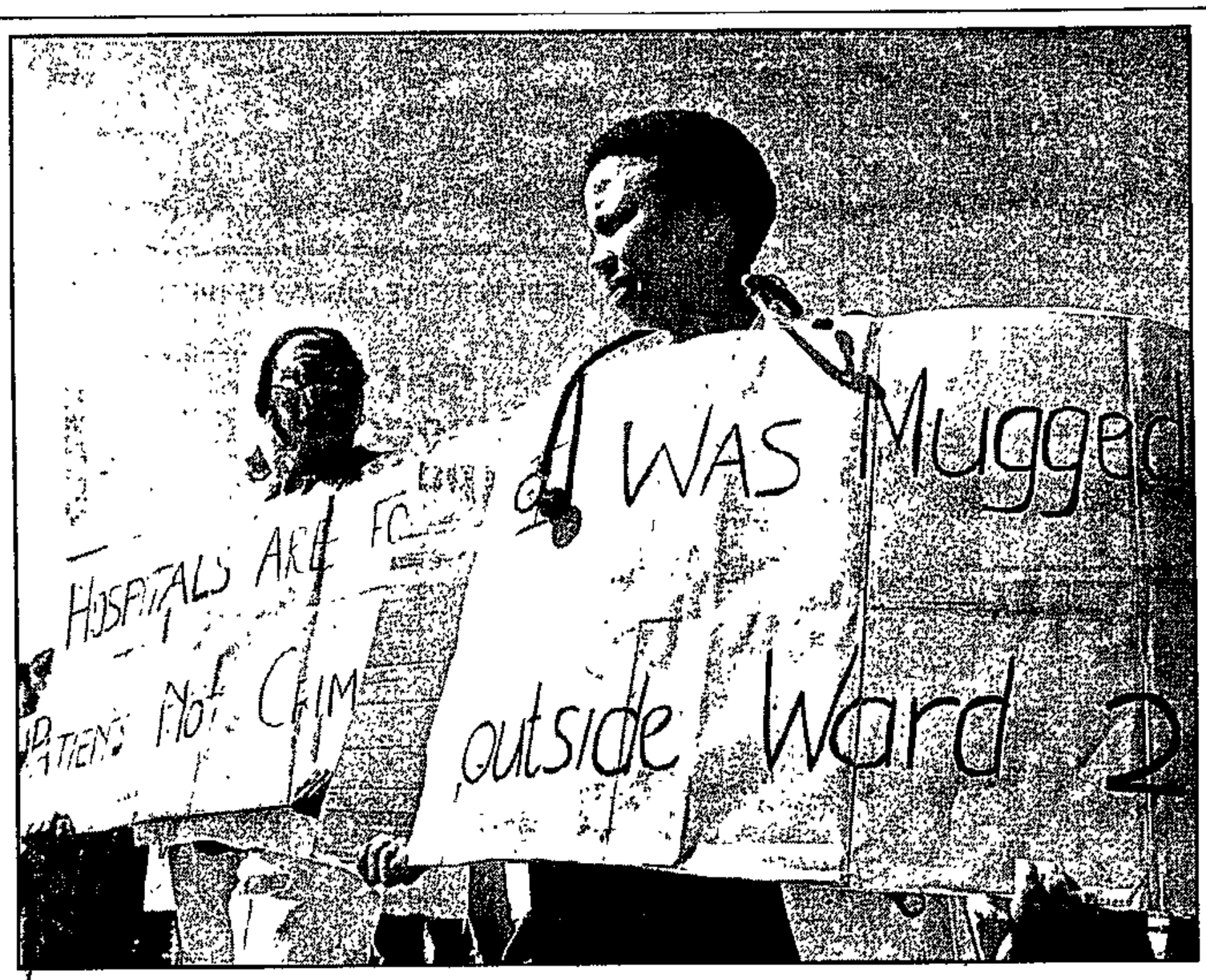
The performance audit focused mainly on planning, control and management of information and human resources, and was carried out by a steering committee consisting of senior health department officials and an audit team from the AG's office.

Mr Oosthuisen said hospital fees of R46,4-million were outstanding by March 31, 1997, and in at least three hospitals about R5-million in fees was written off during the 1996/97 fiscal year.

The audit found that health services were fragmented in the former Transkei, Ciskei and the former Cape Provincial Administration and that services were not distributed equitably.

Equipment in hospitals was not always in working condition, and there was not enough accommodation for the growing number of patients.

Umtata General Hospital's tumble-driers had not worked for 10 years and new driers delivered in May last year had not been installed. – Sapa



Doctors at Chris Hani Baragwanath Hospital in Soweto display placards in protest against the high incidence of criminal activity in and around the hospital.
PIC·VELI NHLAPO

Local medics fed up with lawlessness

(98)

Sowetan 27/11/98

By Mokgadi Pela

HUNDREDS of doctors staged an early morning demonstration outside Chris Hani Baragwanath Hospital in Soweto yesterday to protest against the recent spate of criminal attacks they have suffered.

They used the occasion to call on the police, hospital security personnel and the community to help stamp out these acts.

Some of them said that unless something was done urgently, an exodus of doctors, including top specialists, would be inevitable.

In a memorandum handed to Soweto mayor Mrs Nandi Mayathula-Khoza, the doctors said: "We have had to become accustomed to our belongings being stolen. Car theft has become so common as to pass almost unremarked.

"There have been many incidents where staff members have been physically threatened and possessions forcibly taken in the hospital corridors. We have been accosted at the bedside while attending to our patients. We have also had guns pointed at our heads and knives held to our throats."

In her response, Mayathula-Khoza said: "It's up to us and the Ministry of Safety and Security to ensure that mechanisms are put in place to address this problem before it's too late. We are committed to see to it that this evil of crime is brought to an immediate halt."

Also in attendance were police commander Andries Vercuiel, Soweto police spokesman Govindsamy Mariemuthoo and councillor Mr Danny Kekana.

All pledged to work with the community to "fight this scourge tooth and nail".

Kekana said he had already alerted the Diepkloof Community Police Forum and local civic bodies to "be on the lookout for suspicious elements who want to cause chaos at the hospital".

Drs Ismail Ganchi and Marike du Plooy said even more worrying was that patient care was being compromised in the process.

"How can we give patients optimum medical care when we are worried about our own safety and the fact that our goods may be stolen at any time?"

Du Plooy and Ganchi said their demonstration was aimed at raising public awareness about their plight.

They also carried placards to convey their message

One of the posters read: "No guns at Bara" while another said: "Dead nurses don't save lives".

The duo said as an indication of doctors' commitment to the welfare of patients, emergency staff remained on duty during the protest.

"We are also on standby should the need arise for us to help in emergency rooms," Ganchi and Du Plooy said.

Meanwhile, Dr Anne Stratling of the Department of Medicine at Bara said she was particularly concerned that "many patients did not want to make use of local clinics in Soweto and instead resorted to the hospital. This results in unnecessary patient overload"

Thugs prey on doctors

By Noxolo Nxusani

SEVEN cars belonging to doctors at Chris Hani Baragwanath Hospital had been stolen since January this year, hospital spokeswomen Mrs Hester Vorster said yesterday.

Vorster said all the vehicles were stolen while parked inside the hospital premises.

About 30 incidents of theft out of motor vehicles were also reported to the hospital's security personnel.

"Radios, cellular phones and other personal belongings were stolen during these break-ins," Vorster said.

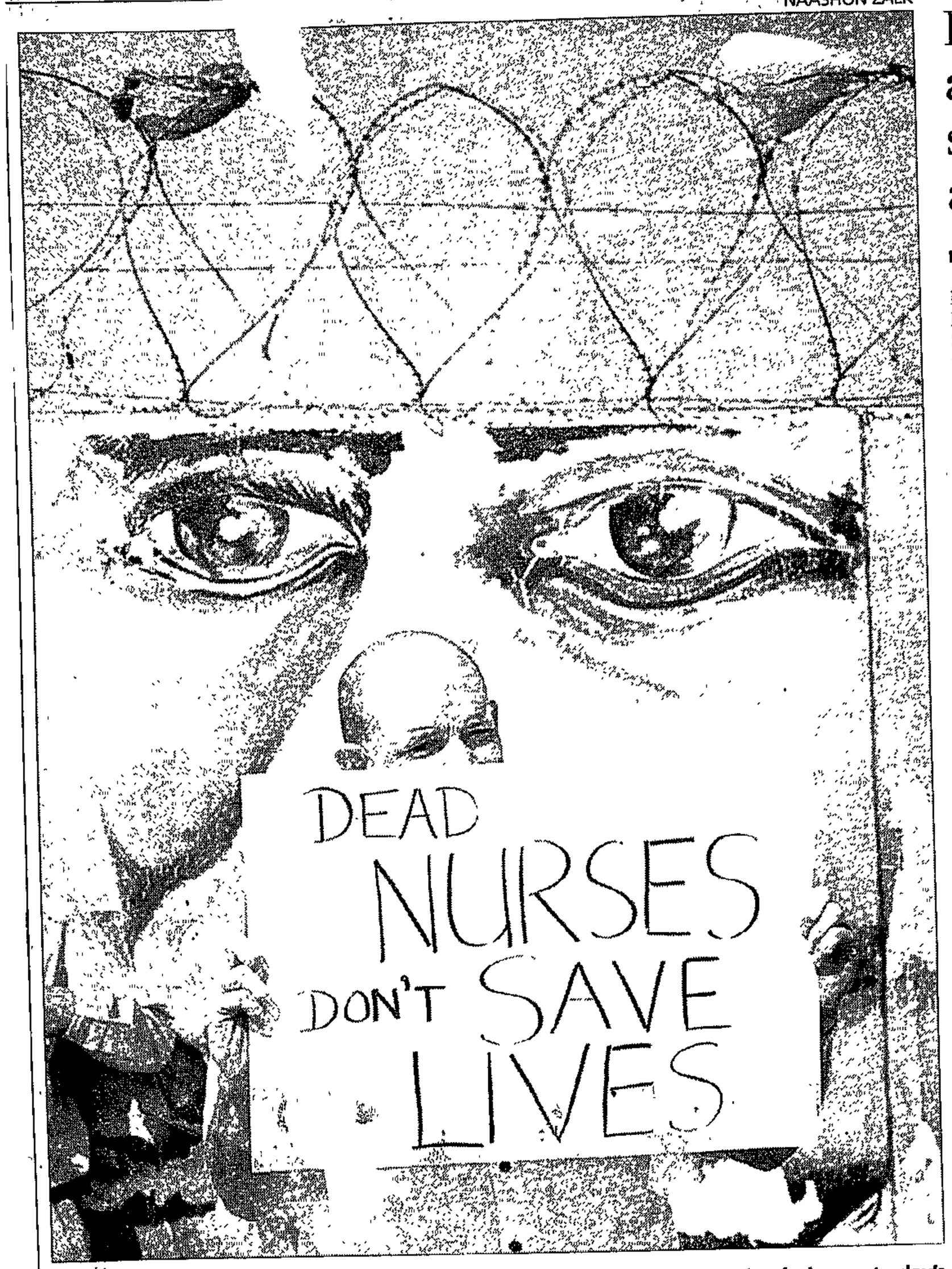
At least 12 theft cases were also reported to security guards while seven hospital staff members were threatened with firearms while working inside the hospital.

Mrs Vorster said the hospital needed more security guards to be able to patrol inside the premises night and day.

"Our security personnel are unarmed and unable to deal with criminals who are in possession of guns. We need to send them for firearm training," she said.

Some recent victims of crime include :

- Soweto pharmacist Dennis Khoza (52), who was shot and killed inside his pharmacy in White City Jabavu, Soweto, in March this year;
- Dr Ronnie Bethlehem, a top Johannesburg economics consultant who was murdered outside his Bramley home during a hijack in May last year. Two armed men shot him twice in the chest before fleeing in his German luxury car;
- Dr Stephen Pon was also slain by hijackers as he was leaving the Johannesburg General Hospital in October 1995. His attackers were sentenced to life imprisonment in 1996. Pon was a specialist at the then JG Strijdom Hospital at the time of his death.



NAASHON ZALK

They've got the needle ... a doctor at Chris Hani Baragwanath makes his point during yesterday's protest by medical workers against escalating crime at the hospital.

Bara's nurses and doctors stage protest against crime

(98)

BY LUMKA OLIPHANT

Star 27/11/98

Doctors and nurses at Chris Hani Baragwanath Hospital in Soweto demonstrated outside the hospital's main entrance yesterday to protest against increasing criminal attacks on staff inside the hospital.

In the past two months, 10 doctors have been held up in the hospital and five staff members have had their cars stolen from the car park.

An angry Dr Gabriel Vorobiof, whose car was stolen in February, said he was disgusted by the hospital superintendent's response to his complaint.

"The superintendent refused to take any action unless there was a written statement from the police."

Another doctor, who did not wish to be identified, said: "The security problem at the hospital is just symptomatic of the intolerable conditions we work under here."

The doctors waited patiently, some carrying placards saying "Criminals rule the country – not the Government".

They handed a memorandum to a representative for Safety and Security MEC Paul Mashatile and the mayor of Soweto, Nandi Mayathula-Khoza.

Mayathula-Khoza promised to address the problem with the relevant authorities.

Beverly Traub, spokesperson for the hospital staff, said that if there was no positive response to the memorandum within a month, another protest would be held.

Baragwanath doctors sick of crime

There have been 10 separate attacks in two months

By MAX MARX

PLACARDS bearing slogans such as "Dead doctors don't save lives", "Hospitals are for patients, not criminals", "I was mugged outside Ward 20", and "No Crime vs No Smoke" were held up high when 300 doctors demonstrated outside Chris Hani Baragwanath Hospital on Thursday morning.

They were protesting against the inadequate security on the hospital premises. Doctors have been held up at gun- and knifepoint inside hospital wards and in the corridors in 10 separate incidents in the past two months.

The protest culminated with doctors handing over a memorandum to the mayors of Soweto, the area commissioner, and representatives from the offices of the Gauteng MEC for Safety and Security, Paul Mashatile, and the MEC for Health, Monde Gungubele.

Here is an abridged version of the memorandum. "There is an intolerably high level of crime on the hospital premises and we have come to fear for our personal safety. Staff have been physically threatened and their lives have been in danger. Our possessions have been forcibly snatched from us in the hospital corridors. We have been accosted while attending to our patients, have had guns pointed at our heads and knives held to our throats. Under these circumstances we are hard pressed to give our patients our undivided attention and to provide them with the care they expect of us and must have. Our patients could begin to suffer the consequences of our fear. Our security personnel, the police and the government must take their share of the responsibility for ensuring our safety at the hospital. The general public too have a very important role to play in curbing the activities of criminals. We appeal to the people and communities we serve to do everything in their power to help us put an end to this scourge."

On Wednesday last week Dr Mark Hopley, a physician in the department of medicine, was held up by three armed men at the Lilian Ngoyi Community Health Centre. They held a gun to his head and robbed him of his cellphone and money. Later the same day, security guards at the centre were held up and tied up. They were not injured. Hopley said if something was not done soon to stop crime in the hospital, someone could be killed by these criminals in the future. He said the hospital administration was very defensive when asked what they were going to do about the situation.

"They have been claiming they are going to institute changes for some time but nothing has been implemented. I don't believe the adminstration is really serious about doing anything. Staff at the hospital have been victims of crime for a long time but the adminstration has done nothing about it," he said.

Dr Beverley Traub, senior consultant in Baragwanath's Department of Medicine said doctors in the hospital were tired of being attacked while on duty in the wards. "This protest is to create a public awareness of what is going on in the hospital. We are appealing to the community to assist with putting an end to crime," she said.

The appeal follows a recent incident in which a doctor was held at gunpoint in front of patients for 30 minutes. According to one doctor, no-one who witnessed the incident called the police or the Baragwanath security to come to the doctor's aid.

"I would like security to make sure no guns are brought into the hospital," she said."

Dr Helen Ford, who works in the medical department was mugged outside the medical admissions ward in August. "I was walking to the emergency laboratory when someone jumped in front of me, pointed a gun at me and demanded my cellphone."

Ford said she was still feeling the psychological effects of the mugging. "I still feel afraid three months later. If somebody comes running towards me from behind, I get very scared. I'm afraid to carry a cellphone in the corridors of Baragwanath."

She said she'd like to see more vigilant security in the hospital because criminal elements could start targeting patients and put them at risk.

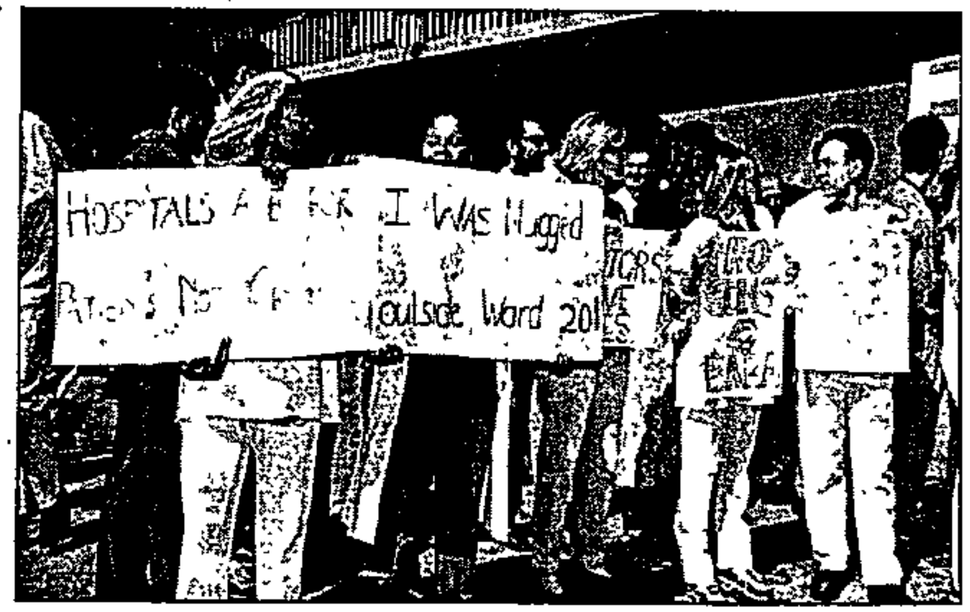
Dr Tshepo Maaka who works in the anaesthetics department and is studying to be a specialist said it was hard to study effectively and give patients the necessary attention when she kept wondering if she would be the next victim.

The Mayor of the Southern Metropolitan Local Council (SMLC), Nandi Mayathula-Khoza, who accepted the memorandum from the doctors, said she would bring the seriousness of the situation to the attention of MECs Gungubele and Mashatile and ask them to address the matter immediately.

"We have to work together with the doctors, the community and the government to stamp out crime in this hospital where doctors and patients are at risk."

The mayor of the Northern Metropolitan Local Council, Danny Kekana, was booed by the crowd after confessing that he had not been aware of the crimes taking place at Baragwanath until he received notice about the protest. He undertook to work with the Community Policing Forum, Civic Association and the ANC in Zone 6 to seek solutions.

Representatives from Mashatile and Gungubele's offices accepted the memorandum on their behalf and said they would be meeting with all the role players involved with security at the hospital to find ways of improving it.



ENOUGH IS ENOUGH... **(Above)** *Dr Beverley Traub read out a memorandum highlighting the plight of doctors at Baragwanath Hospital during a protest held outside the hospital on Thursday. The memorandum was handed to Soweto's mayors and to representatives from the offices of the MECs of Safety and Security and Health* **Top right:** *The mayor of the Southern Metropolitan Local Council, Nandi Mayathula-Khoza said doctors, the community and the government need to work together to stamp out crime at Baragwanath Hospital.* **Right:** *These doctors were among 300 who protested outside Baragwanath Hospital on Thursday. Many of them have been victims of crime on the premises.*

CRIPPLED: Elizabeth Tymbios's infected leg caused her agony Picture: ELIZABETH SEJAKE

High-risk hospitals

'We are applying First World medicine in Third World conditions'

ST 29/11/98 (98)

LAURICE TAITZ

ELIZABETH Tymbios was admitted to Johannesburg Hospital in April for surgery on an open compound fracture on her left ankle. Today, as a result of the wound being infected by a "vicious bacteria" during her 11-day stay there, she is still on crutches.

Tymbios now faces medical bills of more than R70 000 from the private hospital where she sought treatment for the infection. She is in constant pain, unable to work and will not be able to walk without crutches for at least another year.

Mark Cotton, a specialist in paediatric infectious diseases at Tygerberg Hospital in Cape Town, says hospital-acquired infections are a reflection of poor infrastructure — "they are our hidden national disgrace".

Cotton and four colleagues completed a landmark study at Soweto's Chris Hani Baragwanath Hospital in 1989 on fungal and bacterial infections whose development is favoured by a hospital environment — and where patients are at risk because of their reduced resistance to infection.

Among the most common bugs are klebsiella, which inhabits the gut and is implicated in urinary tract and respiratory infections among others, and MRSA, a virulent bacteria which is highly resistant to antibiotics.

Tymbios was infected with MRSA, which she probably contracted in theatre from contaminated surgical instruments.

"The hospital was filthy," says Tymbios. "My sheets weren't changed in 11 days and there was urine on the bathroom floor.

"So far, the filth of the Johannesburg Hospital has cost me R70 000-plus, a shorter leg, severe depression and total loss of confidence and income.

"I intend to fight the hospital for the money."

Dr Adrian Duse, the head of hospital epidemiology and infection control at the South African Institute for Medical Research, says only 30 to 50 percent of hospital-acquired infections are preventable. The balance need early detection and treatment.

Duse says even in the most sophisticated private hospitals there is a minimum rate of infection of three to five percent.

Infections are spread through nursing staff not washing their hands and can be transmitted directly into the bloodstream through intravenous lines. A small number of infections occur because of contaminated blood or saline in drips.

'So far, the filth of the Johannesburg Hospital has cost me R70 000-plus, a shorter leg, severe depression and total loss of confidence and income'

Cotton's research showed almost 15 percent of children in paediatric wards were infected. The causes are attributed to overcrowding, understaffing and a high proportion of patients being admitted with infectious diseases and not being isolated. Another contributing factor is the shortage of wash basins.

Hospital-acquired infections include pneumonia, upper respiratory tract infections, croup, gastro-enteritis, chickenpox, mumps, measles and meningitis.

"Infections are hidden at our hospitals, but they are there and they are real," says Cotton.

In 1996 an outbreak of deaths in the neonatal ward at Tygerberg Hospital was found to be caused by the ward being overrun by swarms of cockroaches.

"We are applying First World medicine — using expensive antibiotics, sophisticated surgery and equipment — in Third World conditions," says Cotton. "The bottom line is we need more nurses. It is a vicious circle. Nurses get blamed for this when there are actually too few to do the job properly."

He says the profile of infection control is not high enough at public hospitals. "We don't have money and infrastructure but that is not really an excuse."

Cotton says that at some private hospitals there is one qualified nurse for every child patient. "At Tygerberg we have one nursing assistant for three to four patients. We have two infection-control sisters when we should have six.

"In 1996 Tygerberg spent R780 000 on antibiotics to treat hospital-acquired infections. We need to be spending that on preventing infection.

"A lot of lives are saved at our hospitals but for every 10 we save, we lose one because they caught something in hospital."

CRIPPLED: Elizabeth Tymbios's infected leg caused her agony Picture: ELIZABETH SEJAKE

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Two shot in hospital

PATIENTS, STAFF THREATENED

(98) CT 30/11/98

THE CALL for hospitals to be declared gun-free zones has intensified after another senseless shooting at a Khayelitsha hospital over the weekend. **JO-ANNE SMETHERHAM** reports.

THREE armed men stormed into Khayelitsha Day Hospital and shot two security guards early yesterday, prompting frightened staff to condemn the lack of safety measures in what one official described as a "war zone".

The men entered the hospital at 4.30am and demanded assistance. Security guard Restitution Katase said they then produced firearms and began threatening staff and patients.

Katase was shot in his leg while another guard, Christopher Ndandani, was shot in the foot.

The assailants fled after the shooting and no arrests have been made.

Ndandani has been discharged from hospital while Katase is in a satisfactory condition.

According to social worker Thelma Sidinana, "Everything was disrupted. People were screaming and running around frantically and nobody knew what to do."

She said such incidents were not new to the hospital. Its staff worked in fear because they "did not know what would happen next" and were at the mercy of those who walked in and demanded attention.

This weekend's violence follows acting premier Peter Marais' plea to President Nelson Mandela for hospitals to be declared gun-free zones.

Johan Smit, spokesperson for Marais, said yesterday: "We are in a state of siege. Patients and medical personnel are caught within a war zone. It infuriates everybody."

The solution, says Smit, is to outlaw guns in certain zones such as hospitals and places of worship.

"We will soon hear Mandela's response. We need strict penalties. We have not only to give medical care but also ensure people's safety.

"Violence is no longer only a crime problem but now a health problem too," he said.

A senior staff member who declined to be named described the security situation at the hospital as a "can of worms".

"Staff feel very frightened," he said. "We are very unsafe in this place."

Earlier this year a security guard shot and killed a patient at point-blank range, while bullet holes on walls bear witness to a gun battle last Christmas. About six weeks ago someone fired a shot through a window before fleeing.

Staff complain that holes in the fences enable attackers to enter and exit the premises unchallenged.

Edmund Michaels, medical superintendent of the province's day hospitals, yesterday acknowledged a security problem.

"However, we would need machine guns to keep armed assailants away," he said.

4

Patients hit out at long Bara queues (98)

By Saint P Molakeng

PATIENTS at Chris Hani-Baragwanath Hospital in Soweto have been made to wait in long queues, with some elderly ones even fainting, because the dispensary has been understaffed in the first week of the year.

It is feared that the crisis could continue for the next four to six weeks because a moratorium has been placed on the employment of more pharmacists, Bara's chief pharmacist Ms Zulcika Rhemtula told *Sowetan* at the weekend.

She said that there were 19 vacant posts that, if occupied, would have alleviated the crisis. At the moment there are only 18 pharmacists; a 37-strong workforce would have made the situation manageable.

As a result patients have been forced to wait in long qucues, as *Sowetan* found during a visit to the hospital last week. All benches were occupied, forcing other patients to stand for hours.

A patient had earlier phoned *Sowetan* to complain about the queues and fatigue. "Exhaustion and hunger cause elderly people to collapse in the queucs," the patient claimed.

Responding to the claims, Rhemtula admitted that patients had complained to the dispensary, but there was nothing that could be done unless the complaints were directed to authorities who could redress the situation.

"It does not help to complain to the dispensary.

"People should instead complain to the public rclations office who would see what to do," Rhemtula said.

She added that if the crisis continued for more than a month, an appeal would be lodged to have the moratorium on posts for pharmacists lifted.

Besides the moratorium caused by lack of finance, the resignations of eight pharmacists last year had also exacerbated the crisis, Rhemtula said.

Since the dispensary employed eight interns on a yearly contract, problems cropped up at the beginning of the year.

Medicine was allegedly in short supply, according to a pharmacist who spoke anonymously.

"Yes, there is limited medicine," the pharmacist said.

Asked as to the when it had started and what had caused it, the pharmacist referred *Sowctan* to Rhemtula.

"We have enough medicine," Rhemtula countered. But patients complained that, indeed, medicine was limited as they have had headache tablets dispensed in the absence of morc effective medication.

Hospital restricts night visitors

(98)

CT 13/11/99

ERIC NTABAZALILA

KHAYELITSHA Day Hospital has decided to allow only one friend or relative of each patient into the hospital grounds at night after a spate of shootings on its premises.

On Saturday night people accompanying ill and wounded relatives and friends were asked to wait outside the hospital yard — despite the darkness and the possibility that they would be robbed or assaulted.

The doctor in charge, David Noah, said the hospital had had a spate of security problems over the past year.

"There were a number of shootings last year.

"One security guard was shot dead inside the hospital and (in another incident) a security guard shot and killed a patient at point-blank range after an argument.

"In the latest incident, two security guards were shot after three men entered the hospital and demanded assistance.

"The problem is so big that we had a staff meeting where we demanded that one of the authorities from the provincial health department should come to address us about security at our hospital."

The health department told them that the security company would be replaced and that the construction of a concrete perimeter fence had begun, Noah said.

However, because of the security company's "inefficiency", various interim measures, such as refusing access to non-patients, were being implemented.

"If it was up to me I would have changed the security company long ago as its employees were not doing their job," said Noah.

"According to the contract between the provincial department of health and the security company, the security guards are supposed to have handcuffs, batons and scanners to avoid people getting into the hospital with guns.

"This is supposed to be a gun-free centre, but when some of the patients undressed they had more than one gun with them.

"At times some of the criminals come here to finish off the people with whom they had fights in the township.

"A recent example is of a woman who came here to be treated, only to find the man who assaulted her in the hospital.

"He had a parcel with him in which a bottle-neck was found only after the woman reported the man's presence in the hospital to the security guard.

'When some of the patients undressed they had more than one gun with them.'

"So all these incidents have led us to this corner.

"Look, it's not that we have any grudges against the community. We are trying to reduce the number of violent incidents which usually happen, especially when people are drunk," said Noah.

"We know that relatives would love to be next to their sick family members, but we are appealing to our people to understand the problem we are facing.

"We are here to deliver a service to them and we also want to feel safe."

Edmund Michaels, senior superintendent of the province's day hospitals, said he was aware of the security problem at the hospital.

There was nothing he could do except forward complaints to the tender board that had granted the tender to Real Security, the security company concerned.

He said only the tender board had the authority to relieve the company of its services.

"I have forwarded all the complaints from the hospital staff to the tender board. But obviously they won't fire the company before giving it a chance to improve its services," Michaels said.

Stan Fisher, managing director of Real Security, declined to comment yesterday.

Hospital reeling as chaos sets in

Bhungani ka Mzolo
Health Reporter

SOUTH Africa's biggest hospital, Chris Hani Baragwanath Hospital, is in a critical state with staff shortages reaching new highs, and no end in sight to the problem.

Senior nursing staff at the hospital said the strain of overwork – because of staff shortages – was overwhelming.

A sister in a surgical ward said there were forty patients in her ward with only two nurses to look after them.

"If one of them has to escort a patient to another department, it means she has to stop dressing another patient's wounds."

At a women's' ward, a male nurse said there was no linen for patients to change their bedding.

He said this was due to budget cuts at the hospital.

"The department of health will tell you that we are coping in the wards, but this is not true," a sister in charge of a ward of forty patients said.

"As the person in-charge, I have to administer the ward, attend to patient care and do ward rounds, but how do I do that with a staff of only two?"

At a psychiatric ward where there were only two staff nurses, a patient held the keys to open and close the gate in the ward.

There were also reports that once hospital staff get paid, some of them do not return to work after lunch, even when they are supposed to be on duty.

Spokesman for the Gauteng health department, Mr Popo Maja confirmed the staff-shortage problem at the hospital, but said the department was attending to it.

He said the MEC, Mr Mondli Gugubele, had spent four days with the hospital management just before Christmas to see what could be done.

Maja said the department of health faced the problem of trying to deliver effective health care on a reduced budget. As a result the department could not fill some posts.

"Staff at the hospital are, however, able to deal with life-threatening emergency operations," he said.

Maja said it was not acceptable that patients were allowed to handle ward keys.

"We appeal to the staff that while we are aware that they are short-staffed, they should not be found wanting in health-care delivery."

He said the department had received a number of complaints from the public that some of the nurses go on long tea and lunch breaks. "We do not doubt the commitment of the staff, but they have to demonstrate this commitment."

To help relieve the problem, Maja said they were moving excess staff from certain hospitals and sending them to Baragwanath.

Saturday UPDATE

Patients 'cannot be turned away'

(98) Star 23/1/99

Hospitals that turn away patients because they come from other provinces must be reported to the central government's health department, Mpumalanga chief director of health Dr Gulam Karim said in Nelspruit yesterday.

This follows a *Saturday Star* exposé last week that Mpumalanga hospitals turned away patients from Bushbuckridge in the Northern Province.

Bushbuckridge residents are closer to hospitals in White River and Nelspruit in Mpumalanga than they are to hospitals in Northern Province.

The Bill of Rights enshrines the right of access to healthcare, and turning away any patients from other provinces violates this right.

Northern Province health spokesperson Tsepo Moshima said it was difficult for the two provinces to quantify how much they owed each other for treating patients from the neighbouring province.

An interprovincial committee whose purpose is to attempt to break down the bureaucratic barriers in the Bushbuckridge area will begin functioning at the end of February. – Sapa

THYS DULLAART

In support ... ambulance personnel from Krugersdorp, Westonaria, Randfontein and Carletonville stand together in defiance against the Western Gauteng Services Council's decision to remove ambulances from the Krugersdorp fire and ambulance station.

Council's decision sparks ambulance staff furore

98

Star 27/11/99

By Bunty West

Emergency service personnel from three West Rand councils dumped ambulances and rescue vehicles at Krugersdorp's town hall yesterday morning in a show of solidarity with their Krugersdorp counterparts.

This followed an early morning raid on Krugersdorp's fire and ambulance station – at 1am on Monday – by officials of the Western Gauteng Services Council, which runs the ambulance service for the province. The WGSC confiscated ambulances from the station after receiving complaints that personnel were not responding to some calls.

The WGSC says the protest action will not affect emergency services in the region, as contingency plans have been made for replacement vehicles and personnel.

To support their Krugersdorp colleagues, more than 100 ambulance department staff – in more than 20 emergency vehicles – from Carletonville, Westonaria and Randfontein arrived at the town hall with sirens wailing.

Led by fire engines from the Krugersdorp station, the procession drove into the adjoining car park, stopping traffic in the town.

They parked their vehicles at the Krugersdorp offices of the WGSC and crowded around to sing and toyi-toyi, but were dispersed by police ordered to remove the "illegal gathering".

A representative group from the four municipalities handed a memorandum to Jorrie Jordaan, director of emergency and disaster management at the WGSC, asking for ambulances to be restored to the Krugersdorp department immediately, or else none of the ambulances would be operated within the WGSC area.

The WGSC made contingency plans to place ambulances at key points throughout the West Rand.

All the vehicles will be manned by volunteers and are on standby at Carletonville Hospital, Magaliesburg, Krugersdorp Private Hospital, the Randfontein Ambulance Training Academy, the Libanon mine and the Bekkersdal informal settlement.

In addition, the WGSC can call on the help of Medicair, Netcare, MRI and off-duty staff at Carletonville Hospital for backup.

Krugersdorp's assistant fire-department chief, Luke Hartog, said the allegation that the ambulance department had failed to respond to a call for help was untrue.

"We did refuse to do a transfer from the Krugersdorp Private Hospital to Carletonville on Sunday but all three of our working ambulances were on the road. The call from the Private Hospital – which refused to treat the patient unless R4 000 was paid upfront – was not deemed an emergency as the injured person was taken to hospital by car.

"We work a 72-hour shift at weekends and this is all the thanks we get," Hartog said.

MEDICAL INFLATION

fm 29/1/99

PRIVATE HOSPITAL COST HIKES UNDER THE MICROSCOPE (98)

Rises questioned in view of headline earnings last year

Increases in private hospital costs of 13%-15% for the coming year are not justifiable given the healthy financial results achieved by many listed hospital groups.

This is the contention of the administrators of several large medical aids and managed care companies who are having a tough time explaining to member schemes why they have increased their contributions by up to 20% despite their promises that managed care would bring costs under control.

But they do have a point Private hospitals are receiving an increasing portion of medical aid expenditure, rising from 18,7% in 1993 to 21,4% in 1994, 23,5% in 1995 and 27% in December 1997.

Last year, more people were admitted to hospital and they stayed longer than in 1997, according to Medscheme's quarterly bulletin, *Healthcare Indicators* (see table)

Some administrators feel the industry association, the Representative Association of Medical Schemes (Rams) has let them down in negotiations with the hospital industry on the 1999 hospital tariff.

Rams agreed to award hospitals a 20% increase in ward, theatre and consumable charges in exchange for the elimination of the 10% hospital mark-up on pharmaceuticals. Rams spokesman Aslam Dasoo says this averages out at an 8% increase, which is the same as last year's

But Southern Healthcare CEO Graham Anderson says the impact of the tariff increase will be to push up Southern's hospital costs by 15,5% on average.

"I find the increases iniquitous when every one of the private hospital groups achieved headline earnings last year. There is absolutely no justification for it," he says.

Healthcare Management Holdings CEO Tommy Edmond says the tariff increase will raise Northern Medical Society's hospital costs by 13%, excluding any increases in hospital utilisation and assuming an 8% increase in drug prices.

Medscheme's Managed Care MD Reg Magennis expects the tariff to raise Medscheme's hospital bill by 13%-15% because the weaker rand will probably push up the price of medicines and consumables 15%-20% this year.

"This will have a severe impact on our schemes," says Magennis, adding that Medscheme has voiced strong objections to Rams but to no avail.

Anderson is bemused by the hospital industry's undertaking to do away with the 10% drug mark-up He points out that hospital groups get rebates from drug suppliers because they buy in bulk, resulting in gross profits on drugs of 28%-35%, including rebates and the 10% mark-up

"They'll just approach the suppliers looking for a larger rebate," he scoffs. "The suppliers will say it's impossible unless they raise their cost price, which is what they'll do. It's exactly what happened in the early Nineties. The hospitals will probably still make a 25% mark-up while higher drug prices are passed on to the consumer."

Edmond feels any increase above inflation is unjustifiable and that it is wrong for hospitals to take an increasing portion of the cake while the GP's share is shrinking. But Dasoo says administrators misunderstand the written agreement reached between Rams and the Hospital Association of SA (Hasa) in December.

He explains that the two bodies will for the first time co-operate to control rising medicine expenditure by forming a committee to monitor drug manufacturers' prices Rams says that by the end of January, drug price increases caused by the fall in the rand will have been effected and, for the remainder of the year, should not increase by more than inflation.

He says if manufacturers' price increases (as reflected in the Blue Book net acquisition or wholesale price) exceed the new Rams scale of benefits for medicine after January 31, and if manufacturers refuse to temper their increases on the request of the monitoring committee, then the amount will not be reimbursed in full.

This means that after January 31, the medical aid industry will refuse to reimburse hospitals in full for drugs at wholesale prices if it feels future increases are excessive.

This will put the squeeze on hospitals because if the scheme refuses to pay the drug portion of a hospital bill in full, the hospital will either have to reclaim the outstanding amount from the patient or get payment from the patient upfront — a fraught task.

Dasoo stresses the aim is not to hurt the hospital industry, which is seen as a partner in the process He says the hospital industry is amenable to the plan because of the healthy increases posted and because it has a built-in buffer since it currently obtains medicine at 40%-100% below the Blue Book wholesale price. This means that under the new system it will still make a profit on medicine

Hasa chairman Norman Weltman stresses the aim of the agreement is not to peg the price of medicine but to proactively monitor it in order to restrain huge price hikes.

"Hospitals will be under tremendous pressure this year," he says "Any attempt to transfer risk to hospitals, without adjustments elsewhere, is just not a viable option."

Since the *FM* began investigating the issue, Hasa has reportedly taken a softer stance in continuing negotiations with Rams members on how the new system will work in practice.

Claire Bisseker

THE RISING COST OF PRIVATE HEALTH CARE

Private hospital costs	
1997 vs 1998	**Increase**
Admissions per family	7,2%
Average cost per case	18,2%
Average length of stay	6,1%
Medicines	
1997 vs 1998	
No of prescriptions per family	4,2%
Average cost per script	11,0%
No of Chronic scripts per family	21,6%
No of Acute scripts per family	3,0%
Average cost per Chronic script	10,3%
Average cost per Acute script	12,7%

SOURCE MEDSCHEME DATA WAREHOUSE

"Some managed care administrators feel the industry association, Rams, has let them down in negotiations over this year's hospital tariff"

Medical staff unpaid

Delayed hospital subsidies mean no wages

EASTERN Cape hospitals are suffering from the centralisation of finance, according to ECN Weekend Service.

Former trade union stalwart, now Finance MEC Enoch Godongwana is involved in a petty battle that has sorely affected health employees.

A PETTY battle between the Eastern Cape's Finance MEC Enoch Godongwana and other provincial departments has been sorely felt by state employees.

Medical workers from at least four state subsidised hospitals in small and remote Eastern Cape towns went without any pay this week.

Reliable sources claimed that state departments, especially education and health, were deliberately stalling payments to employees while blaming "centralisation of finances".

The row blew up when the Eastern Cape Health Department failed to pay certain hospitals their quarterly subsidies for the January to March period on time. In November many provincially-aided hospitals faced the danger of closure because of a shortfall in subsidies.

The monies were supposed to be paid in in the first two weeks of January, but by Monday, the Stutterheim, Lady Grey, Indwe, Molteno and Jamestown hospitals still had not received a cent.

Stutterheim Hospital medical superintendent Dr Adrian Cole said he was unable to pay his staff on Monday as planned.

Cole said he experienced severe difficulties every three months because either the payments of the subsidies were late or there were some administrative problems.

He said that in previous years the hospital had not gone into overdraft, but in the past two to three years this had become a constant reality.

"The feeling one gets is that Bisho is bankrupt and is stalling for time."

This was strongly disputed by Godongwana in interviews with ECN this week.

He said the province's finances had never looked better.

Godongwana said provincial debt had been reduced and that payments submitted with the correct bank account numbers and other details from departments were being met within days.

He said his department could not be held responsible for the administrative management of different departments.

He also said there were "early warning systems" in place to inform the national finance department if the province was in danger of running out of money.

Meanwhile, the Lady Grey, Molteno, Jamestown and Indwe Hospitals also did not receive the subsidies on time.

Indwe Hospital Secretary Kitty Labuschagne said: "I don't know what to say. There is such a mess.

"If you ask the Department of Health what's going on, they blame the Department of Finance."

She added that none of the Eastern Cape's provincially aided hospitals had received their money on time.

However, Health permanent secretary Siphiwo Stamper said the "money was in" on Monday.

But the hospitals informed ECN that they would only be able to access the money on Monday because the electronic transfer of money resulted in a four day delay.

Health MEC Dr Trudy Thomas told ECN that the problems with the subsidy payments to provincially-aided hospitals were due to the developing systems under the new centralised financial management system of the province.

She said her department had the necessary money to meet their needs, but did not have direct control of the payment of accounts and the subsidies.

She said her department had sent the subsidy documentation to the provincial department of finance on time.

But she claimed that Finance's computer systems were still being put in place and were not running smoothly.

Thomas said the Finance department came back to her department and said they wanted the documentation in a different form. This caused the delay in payment.

Thomas said that a task team – consisting of provincially aided hospital staff and department officials – was formed about six to eight months ago and was looking at ways of structuring the finances of the hospitals.

She said the task team was also looking at ways of improving the flow of money to the hospitals.

Actonville Hospital breaks new ground

By SOLLY MOELA (98)

ACTONVILLE Hospital prides itself on being the first in Benoni to serve all sections of the previously disadvantaged community on the East Rand town.

"We are receiving messages from people who applaud the establishment of our hospital," said operations manager Ms Hafisa Ally.

"It has become a shining example to them and they would like to emulate us."

She said the hospital was preparing for expansion and "to enter the competitive world by offering the best services to our patients".

Actonville Hospital was liquidated in 1997, but this did not deter staff from putting together the resources to make the hospital survive.

Ally is emphatic that the liquidation was a great challenge and an eye opener to her staff.

Throughout the liquidation process they remained committed to providing essential services to patients and to restoring normality to the hospital.

"We feel that we have a lot of potential to grow.

"We want the community to back us all the way.

"I believe the success of any private hospital lies in sound patient-care.

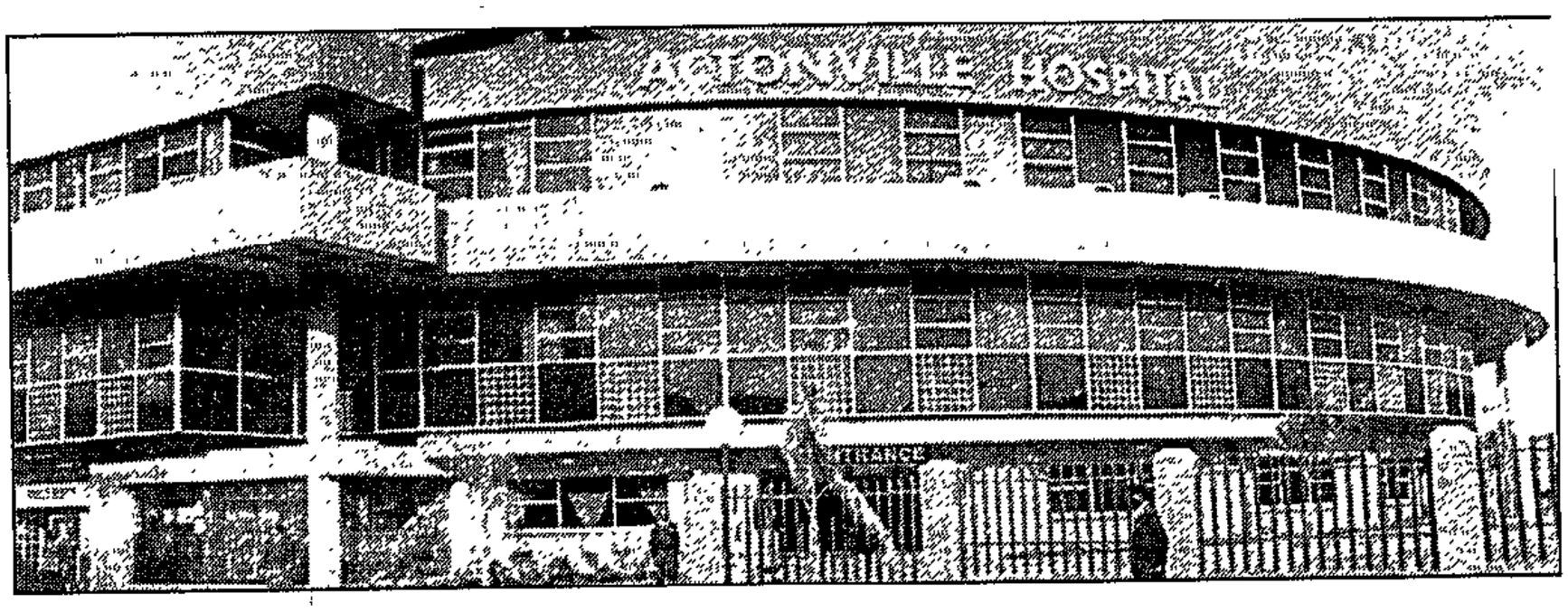
Whatever we do, it must be impressive from the onset," she said.

The hospital is open to anyone, including patients without medical aid schemes.

The hospital employs highly qualified and experienced professional staff.

It has a maternity unit, five operating theatres, a casualty ward, a children's ward and an intensive care unit with seven beds.

CP 31/1/99



BENONI'S PRIDE . . . *Actonville Hospital is fast improving its facilities.*

Another Bara doctor attacked and robbed

(98) Star 2/2/99

SELBY BOKABA
ne Reporter

other doctor has been at-
ked inside the Chris Hani
agwanath Hospital grounds,
pite pleas by medical staff
better security.
Dr Wendy Friedlander was
acked by an assailant who
bed her of cash and a cell-
one inside the hospital
mises on Friday.

Hester Vorster, spokesperson for the hospital, said Friedlander was driving out of the hospital at about 3pm on Friday when she was stopped by a man inside the gates who asked her for money.

Vorster said that as Friedlander was searching her purse for money, the man took out a hammer and hit her on the head, before pushing her to the passenger's seat.

The assailant drove off with her out of the hospital to an unidentified area in Soweto, Vorster said.

"She jumped out of the car and begged the man for her life. He robbed her of R70 and a cellphone before giving her back the car.

"Dr Friedlander managed to drive back to the hospital although she was bleeding profusely from the wound in her head," Vorster said.

Vorster questioned how security personnel at the hospital had opened the gates for an unknown person travelling with a woman with her face covered in blood.

She said that, despite last year's march by doctors and nurses protesting against attacks on staff inside the hospital's premises, staff still fell victim to criminals.

Vorster said the hospital was trying to improve security, but lack of personnel was hampering its efforts.

Police spokesperson Superintendent Govindsamy Mariemuthoo said Friedlander had laid a charge of assault against her assailant.

Police are investigating.

Not our fault, says Bara security boss

Star #19 4/2/99 (98)

Requests to management and government for more staff and better safety measures ignored

By Mike Masipa, Prince Hamnca and Cathy Powers

The private security company at Soweto's Chris Hani Baragwanath Hospital has blamed the Gauteng government and hospital authorities for deteriorating security, while the health department is reviewing the company's contract.

Security at the hospital came under the spotlight this week after Dr Wendy Friedlander was assaulted and hijacked on the premises. The attack came only three months after medical personnel protested at the unsafe working conditions, claiming that 10 doctors had been attacked on hospital premises and five cars stolen in the preceding 10 months.

The Gauteng health department instructed its attorneys to review the security company's contract following Friday's hijacking.

Health department spokesperson Popo Maja said talks would be held with the department of safety and security with a view to installing metal detectors at all entrances.

Carolus Security's managing director, Claude Carolus, said he had made numerous requests to hospital management and the Gauteng government to beef up security, but to no avail. The company was contracted to handle security at three main entry points, while government security staff were supposed to secure the inside, he said.

"Since we started out here, lots of government security guards have taken early retirement and they have not been replaced. We have told them that

> **Once a place of sanctuary, now place of desperation**

the security inside was understaffed, which was placing an extra burden on us. Now some of our men guard the inside as well," said Carolus.

The request for the installation of closed-circuit cameras had also gone unheeded.

The supervisor on duty is the only guard allowed to carry a gun, Carolus said. He added that his men were not contracted to man a pedestrian gate that had no metal detectors, making it easy "for anybody to smuggle weapons into the wards".

Despite increased security concerns at Chris Hani Baragwanath following Friday's hijacking, cars entering the main gates were not searched on Tuesday.

A *Star* journalist who visited the hospital was not searched at any of the hospital's entrances. However, cars are searched when they leave.

Professor Ken Huddle commented: "Ironically, in the days of political upheaval, this hospital was seen by the community as a safe sanctuary for the sick and the staff. Soweto would be up in flames and yet the hospital was regarded by the community as their hospital.

"The staff feel they are making a difference, but how far can you push it if the place is insecure? It's unacceptable."

Staff resignations have not increased since the crime wave engulfed the hospital, but Huddle expects them to. "I am concerned that (the resignations) might start, and that people thinking of working here may be put off."

The hospital superintendent was unavailable for comment.

Hostage drama after money fails to arrive

(98) CP 7/2/99

Hospital staff in the Bisho area this week took the law into their own hands in the wake of another set of failed financial promises. ECN WEEKEND SERVICE takes a look at the problems in the region.

BISHO'S botching of salary payments ended in a hostage drama this week. Singing, chanting hospital workers locked up their superiors for six hours.

In what is regarded as a wake-up call for the province's Health Department – Bisho's Finance MEC Enoch Godongwana has the cash but says the departments can't get it together to make proper payments – Jansenville Hospital's superintendent and matron spent six frightening hours as hostages in their own hospital on Tuesday.

This was a result of the Eastern Cape Health Department's failure to pay the hospital its quarterly subsidy, despite numerous promises to do so.

The staffers were meant to be paid on January 25, but had to wait for more than a week for the money.

This was just one of the hospitals which had not seen a cent of the quarterly subsidies owed to them by the Health Department.

Staff at Jansenville also went on strike on Wednesday and toyi-toyed in protest, until the department finally deposited the money directly in the hospital's account.

Meanwhile, the Stutterheim Hospital this week faced bankruptcy, after their overdraft rocketed from R45 000 to R176 000 in one week. They were obliged to pay salaries in the absence of the subsidies.

Hospital medical superintendent Dr Adrian Cole told ECN: "Unless the subsidy comes immediately, we are technically bankrupt. It will mean we will have to close."

The Lady Grey Hospital faced closure, after it could not buy adequate food for patients.

Hospital medical superintendent Dr Erik Engelbrecht said that the hospital was only able to buy basic food and it was "just enough to keep the patients alive".

He also said that he could not buy food on credit because suppliers were wary of Bisho's track record.

The Tarkastad Hospital and the St Francis Hospital in Aliwal North were also leading a hand-to-mouth existence.

These hospitals were all told last week by Health Department officials that the "money was in".

However, they were also told that there was a four-day delay because the money was electronically transferred. Many had never heard of such a delay in electronic transfers.

By Tuesday the Stutterheim, Jansenville and Lady Grey Hospitals had still not received any money.

Health Department's permanent deputy secretary of district health services, Dr Peter Milligan, told ECN that the money was never transferred electronically to the Stutterheim and Jansenville Hospitals, because the provincial treasury did not have the hospitals' banking details.

As a result the treasury was "forced" to issue cheques.

The department had to collect them from the post office before they were posted and deposit the money directly into the two hospitals' accounts.

Milligan said that money had been transferred electronically to the Lady Grey Hospital and they could expect to receive their money in a couple of days.

Bara sickens as crime grows

(98) Sowetan 8/2/199

By Saint P Molakeng

POOR security at Soweto's Chris Hani Baragwanath hospital, which resulted in the hijacking of a doctor inside the hospital premises two weeks ago, will only improve if the budget granted to the security company guarding the hospital increases substantially.

Staff at the hospital, particularly doctors, have experienced criminal assaults that led to a protest against the situation in November last year.

Since then the situation has worsened, according to Baragwanath employee Dr Beverly Traub.

Following the incident where a doctor was forced to drive out of the hospital into Soweto, a meeting was held last Monday between doctors, hospital management and Carolus security company.

Large number

"We told hospital Superintendent Dr Claude Monzanga that unless the situation improved dramatically within the next two months, a large number of resignations could be expected," Traub said.

He also said that during the years of apartheid and political turbulence that had Soweto in flames, Baragwanath had been a haven for the besieged community.

But today members of the community were attacking hospital staff and even vandalising the institution.

Mr Claude Carolus, managing director of the firm that has guarded the hospital for the past four years, told *Sowetan* at the weekend that the company had insufficient manpower to guard the hospital effectively.

"We have only 56 security personnel, and we need at least 10 more people to beef up the security," Carolus said.

He claimed that approaches had been made to the provincial health department to increase the Carolus budget, but these had not been heeded.

Early retirement

However, Carolus declined to reveal what amount had been allocated for the operation of his company.

He complained that some government security staff, who were charged with guarding the hospital inside, had taken early retirement and had not yet been replaced.

Carolus personnel, who man the three entry points, are now guarding the hospital inside as well.

That means that the guards cannot cope with their duties. This allows cars to enter the hospital premises without being searched properly.

Carolus claims that calls for a closed circuit television camera system to be installed have also gone unheeded. The same was true for metal detector equipment needed for detecting weapons.

Sangster gets top post in jacked-up city emergency service

ARG 8/2/99 (98)

Streamlined operations in wake of bomb blasts

SHARKEY ISAACS
SPECIAL CORRESPONDENT

Cape Town's beleaguered emergency and protection services are being jacked-up to streamline operations and increase community safety after a spate of bomb blasts in the city.

On February 1 traffic chief Mark Sangster became director of the City of Cape Town Protection Services, with responsibility for the Cape Town division of the national Safer Cities Project (crime prevention), ambulance and fire brigade rescue services, disaster management, the traffic department and the civic patrol – which now encompasses beach law enforcement staff and parks and forests personnel, including foresters and firefighters.

Last year Mr Sangster, 38, a former traffic officer, made history when he became Cape Town's first traffic chief of colour.

He will remain caretaker traffic chief for the next four to six months, learning the ropes of his new portfolio and waiting for a new traffic chief to be appointed.

He is already already out of uniform, and until he moves from his office at the traffic department at Gallows Hill to the Cape Town Civic Centre he will confer daily with Alan Dolby, who is running the protection services at present on a contract basis.

Mr Sangster said: "This will be a very challenging post. The step is designed to transform Cape Town into a better place – and I am looking forward to the challenge. Each department and service has an excellent chief. I have always had good co-operation from them and expect to continue getting this in the future."

Mike Marsden, executive director of the City of Cape Town's Municipal Services, said: "We believed we needed to do something pivotal to make the city safer and to boost the flagging morale of the city's emergency services."

Mr Sangster's brief is also to forge close links with the police, the justice department and the office of the Director of Prosecutions.

Mr Marsden said Mr Dolby, who had "served the city extremely well", had been appointed special project manager for community safety.

Bara waits for security improvements

Star - 11/2/99

By Mike Masipa

The management of the Chris Hani-Baragwanath Hospital has started negotiations with the Gauteng department of health to get extra funding for improved security at the crime-ravaged Soweto hospital.

Security at Chris Hani-Baragwanath was in the news last week following the hijacking of a doctor on the premises. The incident outraged medical staff, who said they found themselves running a daily gauntlet of criminals on the premises.

In the face of mounting protests, the health department said it was reconsidering the security tender granted to a private company, Carolus Security.

According to departmental spokesperson Popo Maja, a meeting where the fate of the Carolus contract was to be discussed had to be postponed on two occasions.

The meeting would have been attended by Gauteng Premier Mathole Motshekga and health MEC Mondli Gungubele.

The hospital's security improvement plans, which included putting up metal detectors and installing closed-circuit surveillance cameras, will be put on hold a while longer until a new date for the meeting with Motshekga and Gungubele is secured.

Budget deficit takes toll on upgrading and capital expenditure in Gauteng hospitals

(98)

By Anso Thom and Cecilia Russell

Gauteng's ailing hospitals will have to wait for a cash injection from the province's new budget before they can begin the upgrading and maintenance backlog totalling millions of rands.

Gauteng finance and economic affairs MEC Jabu Moleketi said this week that capital expenditure had been cut back because the health department had overspent its budget by R240-million.

He said the only possible cut that could be made in Gauteng's budget was in capital expenditure, because most of the budget was taken up by the payment of salaries and the province's statutory obligations.

The backlog of upgrading and maintenance in the health department alone was estimated at about R2-billion, Moleketi said. This backlog was to be addressed over a seven-year period, but according to a health department list, most of the projects planned for the 1998/9 financial year, estimated at R26,5-million, were delayed or put on hold.

Health department spokesperson Jo-Anne Collinge confirmed that in principle most of the cost-cutting measures proposed in the list had been implemented.

Meanwhile, a much-lauded private sector rescue package for health services in the province is still in its infancy.

Premier Mathole Motshekga and the health department have fielded several approaches from the private sector, among them a proposal to privatise Chris Hani Baragwanath Hospital's administrative systems.

The health department said none of the public-private partnerships had been given final approval, although the department was investigating the feasibility of several proposals.

According to a senior source in the department, three public-private partnerships were likely to become pilot projects in the near future. This included an agreement where the public hospital gained access to private facilities or vice versa.

This would be similar to the care and treatment of people with tuberculosis – a service currently rendered on behalf of the state by the SA National Tuberculosis Association.

Two other pilot projects included taking on patients of certain medical aids, especially those in the lower range of contribution, and the leasing of equipment.

Details on the implementation of the projects were apparently approaching finality, with the final go-ahead expected soon.

Province defies Zuma on private hospital licences

(98) BD 15/2/99

Linda Ensor

CAPE TOWN — The Western Cape provincial government is defying central government's moratorium on issuing private sector hospital licences.

Western Cape health and welfare MEC Peter Marais said he was ignoring the moratorium — to achieve what was best for the province. He refused to say how many licences had been granted, but said it was fewer than 100. These included specialist and general hospitals.

Marais said he doubted whether Health Minister Nkosazana Zuma, who imposed the moratorium, had any legal grounds to challenge his policy.

His health department had reached an advanced stage of negotiation on public-private sector partnerships, underpinned by a philosophy of "one health service, two suppliers". The public sector had buildings and specialist staff, and the private sector had more money, better equipment and excellent financial management skills.

Private-public co-operation would work best at academic hospitals, where sophisticated and expensive equipment and beds were not fully utilised. These could be shared on a "pay-as-you-use" basis, he said.

Contracting specialist units in a public hospital to the private sector would be considered, provided affordable fees were charged. Unutilised space could be made available for private use.

Private hospitals would be encouraged to supply services to local people under contract to the state. Marais envisaged private hospitals using about 90% of their capacity for private patients and 10% for local people.

"Obviously the private sector can't just scoop off the cream of fee paying patients and leave public hospitals with the rest. It has to give a hand in addressing the health needs of the poor," he said.

HOSPITALS TO DECENTRALISE

Twinning up for change

CT 16/2/99 (98)

RED CROSS Children's Hospital has a new twin: Sheffield Children's Hospital in the UK. The head of Sheffield visited Red Cross last week to help prepare for the big decentralisation. Health Writer **JUDITH SOAL** reports.

AFTER a few grim years, South Africa's academic hospitals again have something to look forward to: It's called decentralisation and it's part of the national Health Department's plan to improve state services.

"Imagine trying to run a hospital properly when you don't have the power to hire or fire your staff, or order equipment when you need it. We can't even decide to give up one superintendent's post and hire 10 nurses, for example," said Red Cross Children's Hospital spokesperson Diana Ross.

This is about to change. The Health Department has received R20 million from the European Union to help kick-start its decentralisation programme and part of this money will be used to form partnerships between each of the country's academic hospitals and a hospital in England.

Red Cross was the first to meet its "twin" last week: Sheffield Children's Hospital in the UK.

The differences between the two hospitals are glaring: Sheffield is run by a qualified health manager known as a chief executive officer. Red Cross Children's Hospital is run by a doctor known as a medical superintendent. Sheffield has control over its staff complement, Red Cross has to work through the provincial Health Department. Sheffield runs its own financial systems; the finances of Red Cross are handled by the province.

"Eight years ago in England we ran under roughly the same centralised system," said John Adler, the chief executive officer of Sheffield Children's Hospital Trust who is in Cape Town to visit Red Cross. "Since then things have changed dramatically. We think it's been a change for the better and we hope we can pass on what we have learnt."

One of the benefits of decentralisation is that it gives individual hospitals the flexibility to respond to problems as they arise and to cater for the special needs of its patients.

"It's easier for a manager who works in an office miles away to ignore problems; if you walk through the outpatients department every day you will soon notice if things aren't working and try to get them right," Adler said.

One of the disadvantages is the increased managerial costs.

"There is no doubt that you need to spend more on managerial functions because you are having to do things that you didn't before, but this is more than made up for by the increase in efficiency. At the end of the day what we focus on is improving the quality of service."

Adler's hospital is given a fixed amount of money from the National Health Service and contracted to provide a certain amount of care. "After that it is up to us," he said.

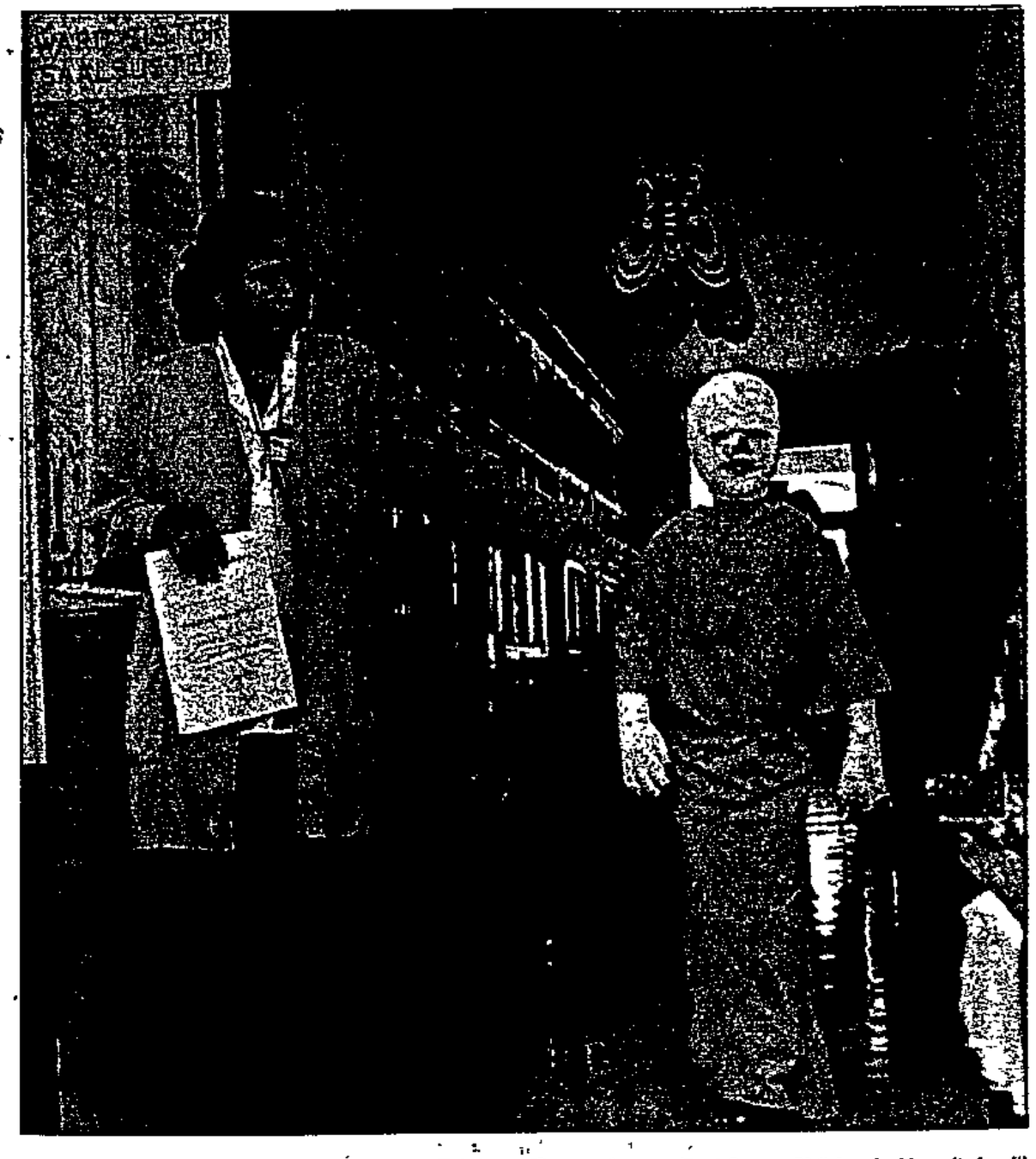
Western Cape deputy director-general for health Gilbert Lawrence said that a similar system was being envisaged here. "Obviously there have to be controls so that hospitals can't decide, say, they will only see private patients. We have to make sure we meet our obligations to the population, but both the provincial and national departments are committed to decentralising and the EU money will help accelerate that."

The unions are more cautious.

"Certainly we don't reject (decentralisation) out of hand," said Andrew Madella of the National Education, Health and Allied Workers' Union (Nehawu). "We support anything that will improve service delivery, but if it will lead to the loss of jobs then we will not take it lying down."

Nehawu is on record as criticising the high managerial costs in the health sector and won't be pleased to hear about increases. Madella said they were also not prepared to give up centralised bargaining on labour issues.

"The point is they haven't spoken to us about decentralisation so it's hard to comment. If they are serious about this they will have to start talking soon," he said.



ROAD TO RECOVERY: Burn victim Zukile Folokwe, 7, a patient at Red Cross Children's Hospital, will be one of those to gain when hospitals are given the power to run like businesses, health authorities say. With Zukile is nurse and confidant Soraya Fredericks. *PICTURE: DENZIL MAREGELE*

Star 20/2/99

Theft crippling healthcare

(98)

Syndicates steal prescription drugs from under the noses of security staff at hospitals

By HAZEL FRIEDMAN

A powerful nationwide crime syndicate is behind large-scale thefts of medicines from government hospitals throughout South Africa, according to the police.

With annual revenues exceeding the R1-billion mark, this illicit trade is crippling the state's ailing healthcare sector.

"We are dealing with a highly sophisticated organisation that has been operating for several years and there is clearly collusion among people employed in pharmaceutical companies and people working in the public sector," said Captain Tiaan de Klerk of the Pretoria police.

About R2-billion, or 10% of the annual health budget, is spent on medicines. The pharmaceuticals industry estimates that the lucrative trade in stolen medicines amounts to more than R1,5-billion a year.

"The entire health sector has been affected by the thefts," said a spokesperson for the police's Narcotics Bureau in the Western Cape. "It is clear that these are not isolated incidents but part of a well-co-ordinated crime syndicate."

Fifteen suspects have been arrested and charged with theft of medicines in North West province. They have appeared in court and their case was postponed. They were apprehended by a special team of investigators while removing large medicine stocks from Taung Hospital.

Earmarked

The stock was stolen in broad daylight from the hospital's dispensary in the presence of security guards. The prescription drugs, earmarked for Gauteng, were to be sold to senior members of the syndicate.

Police believe the problem of large-scale pharmaceutical theft will not be solved until effective stock controls are implemented.

But one of the obstacles facing the police is that medicines are not identifiable when they leave the manufacturers. If they are stolen, nobody can tell their origin or destination.

And if someone is found in possession of bulk medicines, which are clearly unaccounted for, the onus is on the government to prove who stole them, not on the person to show where they came from. Without a tracking system it is extremely difficult to secure convictions.

OUTCRY: Dr Zuma's efforts to stop stealing were blocked

"We are dealing with the tip of the iceberg," said Professor Caroline Ntoane, deputy director of health and welfare services in North West, which has an estimated R40-million shortfall in its healthcare sector. Of the province's annual health budget of R1,8-billion, 8% is spent on medicines.

The ease with which the syndicate operates can be attributed to the extraordinary lack of control in government hospitals.

If stock is missing or unaccounted for, additional supplies are simply ordered.

In 1996, Minister of Health Nkosazana Zuma tried to get the National Drug Policy off the ground and to pass related regulations through Parliament. But it caused an outcry from pharmaceutical companies.

Their complaint centred on proposals to adopt "Vericode", a multi-dimensional digital marking system that would track, from manufacturer to dispenser, the 18 billion packets and bottles of medicine made annually.

At a cost of 2c a unit, the system, used by the National Aeronautics and Space Administration in the United States to track space shuttle parts, would cost manufacturers R36-million a year. They complained this would be too expensive.

In response the Department of Health established a task team with the heads of the pharmaceutical industry to investigate less costly systems. In December 1996 they released a preliminary report suggesting other options, such as bar-coding.

Outsourcing the supply of medicines to private companies was mooted as another possible option.

In the Northern Province and Mpumalanga, security at state depots is being tightened up and outsourcing has succeeded in slightly reducing the problem.

Shortcomings

But the other provinces have been slow to implement privatisation.

"We acknowledge that our shortcomings include not identifying the areas in healthcare which can be controlled by the private sector," said Ntoane. "We're trying to rectify this."

She added that tender boards were in place to oversee the process of privatising the distribution of medicines in North West.

Take your bed to hospital

MPUMALANGA'S third largest hospital, Rob Ferreira Hospital, warned residents on Thursday that patients would have to bring their own bedding and food for the next six weeks because the hospital has run out of money.

The warning follows shortly after Eskom threatened to cut electricity to the Nelspruit hospital because it failed to pay an outstanding bill of R500 000.

Hospital superintendent, Dr Joos Scheepers said on Friday that the hospital had spent every cent and would only get a top up on April 1, when it received its budget for the next financial year.

"Services such as kitchens and laundries may have to be shut down until we get the new budget, so that we can continue offering basic medical services. We're in a real crisis unless some Good Samaritan comes and helps us out," he said.

Scheepers said he did not expect government to bail the hospital out, because of its own budget constraints, but said farmers in the Eastern Cape had enabled cash-strapped hospitals there to continue functioning by providing food free of charge.

"All we can do is hope that there are similar good-hearted people here. If no money is forthcoming, we may have to ask families to support patients in the hospital," Dr Scheepers explained.

He said the 257-bed hospital had run out of money because its budget only catered for patient loads from Greater Nelspruit, when the hospital actually catered for residents from towns as far away as Bushbuckridge in Northern Province.

"The hospital uses lots of money to buy medicine because many people, including people from Bushbuckridge, come to the hospital to receive medical services," he said.

The hospital's financial status is so poor that on Wednesday, the provincial health department was forced to pay its R500 000 electricity bill before the lights were cut.

"We paid the account to the council because we were afraid that patients might be left in the dark," explained council spokesperson, Dina Pule.

She said the department was unaware of the hospital's financial woes as hospitals were responsible for their own budgets.

This is not the first time the hospital's ability to provide decent medical services has been threatened.

In October last year it was forced to cancel all surgical operations after it ran out of intravenous fluid drips and other basics after suppliers failed to deliver on time. An emergency delivery of medicines, by the department, was able to delay the threatened closure of the hospital.

– African Eye News Service

(98) CP 21/2/99

Ailing hospital takes a turn for the worse (98)

Nelspruit – Mpumalanga's third largest hospital, Rob Ferreira, warned yesterday that patients would have to bring their own bedding and food for the next six weeks because the hospital has run out of money.

The warning follows shortly after Eskom threatened to cut electricity to the Nelspruit hospital because it had failed to pay a bill of R500 000. Hospital superintendent Dr Joos Scheepers said the hospital would get additional funding only on April 1.

"Services such as kitchens and laundries may have to be shut down until we get the new budget just so that we continue offering basic medical services."

Scheepers said he did not expect the Government to bail the hospital out because of its own budget constraints, but said farmers in the Eastern Cape had helped cash-strapped hospitals by providing food.

"All we can do is hope that there are similar, good-hearted people here. If there's no money forthcoming, we may well have to ask families to support patients in the hospital," he explained.

He said the 257-bed hospital had run out of money because its budget catered only for expected patient loads from Greater Nelspruit, whereas the hospital also catered for residents from towns as far away as Northern Province.

"The hospital uses lots of money to buy medicine because many people, including people from Bushbuckridge, come to the hospital to receive medical services," he said.

The hospital's financial status is so bad that the provincial health department was forced to pay its R500 000 electricity bill before the lights were due to be cut last week. – African Eye News Service

R10m security boost for Gauteng hospitals

ES 24/2/99 (98)

Fighting crime in hospitals is a war, writes **Nomavenda Mathiane**

THE recent spate of car thefts and highjackings, as well as wide-scale pilfering, at the Chris Hani Baragwanath hospital in Soweto has prompted the Gauteng government to take drastic measures to improve security at hospitals in the province.

Gauteng premier Mathole Motshekga made no bones about the fact that fighting crime in hospitals was a "war" and said the provincial government would spend up to R10m initially on its efforts to curb crime.

"The gains made by government in providing free health care will be wiped out unless we make a concerted effort to defend our facilities against criminals," Motshekga said.

The reality of the situation was brought home at a meeting of health professionals and the health department last week.

"Managers confronted the fact that access to health care could be seriously undermined if skilled workers became too afraid to work in provincial facilities and patients no longer felt safe to use our clinics and hospitals," Motshekga said.

Accompanied by Gauteng health MEC Mondli Gungubele and Ralph Mgijima, provincial health superintendent-general, Motshekga yesterday viewed the security around the pedestrian gate, the casualty and surgical departments and the admission ward of the hospital.

Unveiling the security strategy plans for Gauteng hospitals, Gungubele said the immediate plan was to tighten the access control areas, issue security cards to all visitors and not allow anyone to carry a firearm into the hospital.

Controls

Medium and long-term plans included implementing bar-coding systems for stock control and improving lighting, burglar proofing and security doors.

For years, Baragwanath hospital has been dogged by pilfering of items ranging from drugs and medicines, bed linen and foodstuffs such as milk and meat.

This has happened under the nose of two security operations — Gauteng provincial security, which patrols within the hospital, and the Carolus Security company which mans the exit points.

Walls in the hospital, which in the past were immaculately clean, are now stained with dirt.

Vendors with trolleys of fruit and cooldrinks have access to most corridors and verandas.

Audrey Petaut said she had been sitting in casualty waiting to be admitted for a liver operation for three days. Nurses had told her there was no bed for her and she should come back the following day.

She said she returned to Baragwanath because she was told it was the only hospital equipped to perform the operation.

The story was no different at the filing department where the clerks said they were overburdened with documents that should be discarded, but cannot be destroyed for lack of staff to go through them.

Morale at the hospital is low.

Past visits of politicians have been greeted with enthusiasm by both patients and staff. Motshekga's visit was received with less interest.

Gauteng premier Mathole Motshekga, right, declared war on crime in provincial hospitals when he and health MEC Mondli Gungubele, centre, inspected the security systems at Soweto's Chris Hani Baragwanath Hospital yesterday. Picture: TREVOR SAMSON

Security measures stepped up at crime-ridden Bara

By Selby Bokaba
Crime Reporter

Security at the crime-ravaged Chris Hani Baragwanath Hospital, hit by a spate of robberies recently, has been tightened as part of a Gauteng government drive to improve safety at hospitals and clinics.

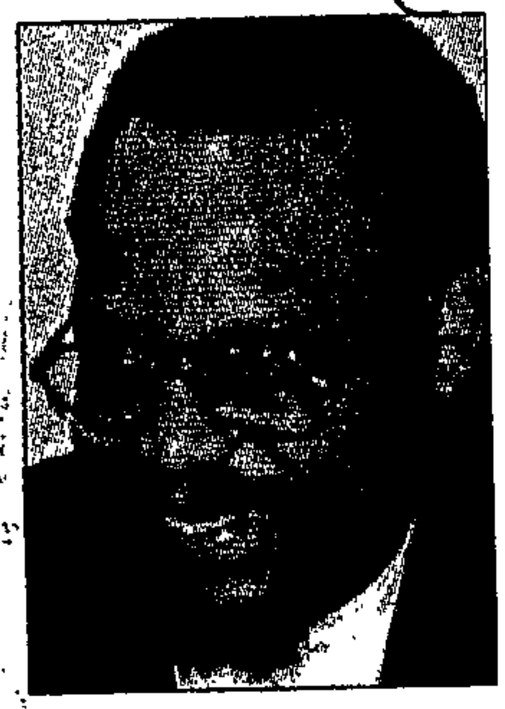
Gauteng Premier Mathole Motshekga and health MEC Mondli Gungubele yesterday announced immediate and medium and long-term measures to curb crime at health institutions.

Measures already implemented at Chris Hani Baragwanath include the tightening of access control, the issuing of access cards to all visitors' vehicles, the searching of vehicles on exit, and the evaluation of security systems in "hotspots".

Motshekga said they were working towards implementation of the gun-free policy adopted by the Health Department in respect of all healthcare institutions.

He said where gun safes had been installed at the entrance to hospitals, no armed person – whether a staff member, patient or visitor – may enter the premises.

Motshekga said improvements to security provisions would be planned and budgeted for during the 1999/2000 financial year.



Premier Mathole Motshekga

"They would include measures such as securing parking areas by means of fencing and local access control, installing surveillance equipment in key areas, implanting electronic tracers in equipment, and upgrading the training of security personnel.

"I believe that the crucial first steps have been taken to reverse the tide of criminality sweeping our hospitals and clinics," he said.

Dr Claude Mondzanga, the hospital's acting chief superintendent, said he was happy with the proposed safety measures.

Boesak's advocate lashes out at media and witnesses

Cape Town – As Allan Boesak celebrated his 53rd birthday in the Cape High Court yesterday, his lawyer lashed out at the media, saying it had fanned the public perception that Boesak was guilty of fraud and theft.

Mike Maritz was arguing in the trial of Boesak, who has pleaded not guilty to fraud and theft charges involving R1,1-million in foreign donor funds from the Foundation of Peace and Justice, which he headed.

Maritz said Boesak's only safeguard was the objectivity of the court. Without that he would be at the mercy of the media. "The court has to be on guard not to be influenced by this prevalent climate. In 1997 Dr Boesak's picture was placed in a newspaper with South Africa's 10 most notorious criminals.

"The media reported extensively on the Office for Serious Economic Offences' investigation and Freddie Steenkamp's trial, and there was a public outcry, fanned by the media, about his post as an ambassador to Geneva," Maritz said.

Boesak was out of work and in public disgrace. His trial was the topic of discussion at dinner parties and social events.

"The media reported on allegations and rumours of Boesak's misappropriation of funds by people such as former foundation employee Thelma Sacco, who was fired by Boesak."

Allan Boesak

Maritz said Sacco was a gossip monger who over the years had waged a campaign against Boesak, and her evidence during the trial was irrelevant.

The perception of Boesak's guilt was also prevalent in legal circles. Maritz said: "These are the people who should know that a person is presumed innocent until proved guilty."

Maritz called the State's forensic evidence a shambles, and auditors Dawn King and Johan van der Walt biased. "The State's forensic evidence was lacking in logic and at time cavalier," he said. – Own Correspondent

Closure of hospitals saved costs

98
Sowetan 25/2/99

By Bhungani ka Mzolo
Health Reporter

THE Department of Health has been able to cut costs through the closure of certain hospitals and the redeploying of staff to newly opened clinics, says Dr Ralph Mgijima, the superintendent-general of the Health Department.

The saving from closing hospitals such as Hillbrow had paid dividends in that patients did not have to spend money on transport and hospitals did not have to use expensive equipment to treat minor ailments.

"In this way both patients and hospitals save money which is then used elsewhere," he said.

In addition, Mgijima said there was an essential drug programme which listed essential cheap drugs which helped to cut costs.

However, the closure of certain hospitals has been criticised by hospital workers, including doctors, as impractical while patients have complained that there were no medication at some of the clinics.

One doctor at Edenvale Hospital said Hillbrow has a population of about a million people and the closure of that hospital has meant that many other smaller hospitals nearby have been flooded with too many patients to handle. "It was the most disastrous decision to have been taken," the doctor said.

Mgijima said the department was presently in a position to monitor and arrest people with stolen property before they left the hospital premises and so prevent loss of money.

He said they hoped to strengthen the billing system of hospitals by introducing a computer system to be able to recoup some of the money from patients.

The department was negotiating with certain medical aid schemes to encourage them to use government hospitals for their patients to help bring revenue to hospitals.

Mums-to-be still flock to Bara

(98)

Sowetan 2/3/99

By Charity Bhengu

THE maternity section at Chris Hani Baragwanath Hospital is full of pregnant women waiting for the birth of their babies.

They pace up and down, concerned only about the safe arrival of the child they have been carrying for months.

The *Sowetan* team was back at Baragwanath, checking on the allegedly callous treatment to which pregnant women are subjected at the institution.

Sowetan has responded to numerous complaints from women who claim to have either been ill-treated by Bara nurses or to have had miscarriages because of staff negligence.

Last Thursday *Sowetan* reported that Miss Matsiesti Mohaka allegedly lost her baby after nurses ignored her pleas for help.

During our visit to the maternity section on Friday, pregnant women were talking excitedly among themselves about the pending arrival of their babies and appeared oblivious of the recent allegations about the institution.

When the clock struck 3pm – visiting hour – they streamed out of their wards to greet friends and relatives. Some then paced the floor, wearing worried expressions.

Centre of attention

Bara, the largest hospital in the world, became the centre of attention last week after the loss of Mohaka's baby, the trauma she suffered at the institution and the subsequent publicity.

After initially refusing to comment the hospital has now had a change of heart and is inviting all women who have experienced similar treatment to come forward, so that an end can be put to this "inhumane, insensitive treatment of patients".

Spokeswoman for Chris Hani Bara Hospital Mrs Hester Vorster said that Mohaka's allegations were being investigated and, if possible, those responsible "will be identified and reprimanded".

She said: "We are trying to create an environment of service excellence at our health services and would very much like to identify staff members who are guilty of inhumane, insensitive or fraudulent treatment of patients."

Vorster said the hospital required the community's cooperation in this regard, "as we need their views of the staff's attitude towards them.

"Our appeal to the public is therefore: help us to help you".

When the allegations were first revealed by *Sowetan*, readers who called said Mohaka's experience was "typical" and the hospital was overcrowded and understaffed. The members of staff, they said, were stressed.

"What's happening at the hospital is symptomatic of problems throughout the public health service," said *Sowetan* reader Mr Edward Molefe.

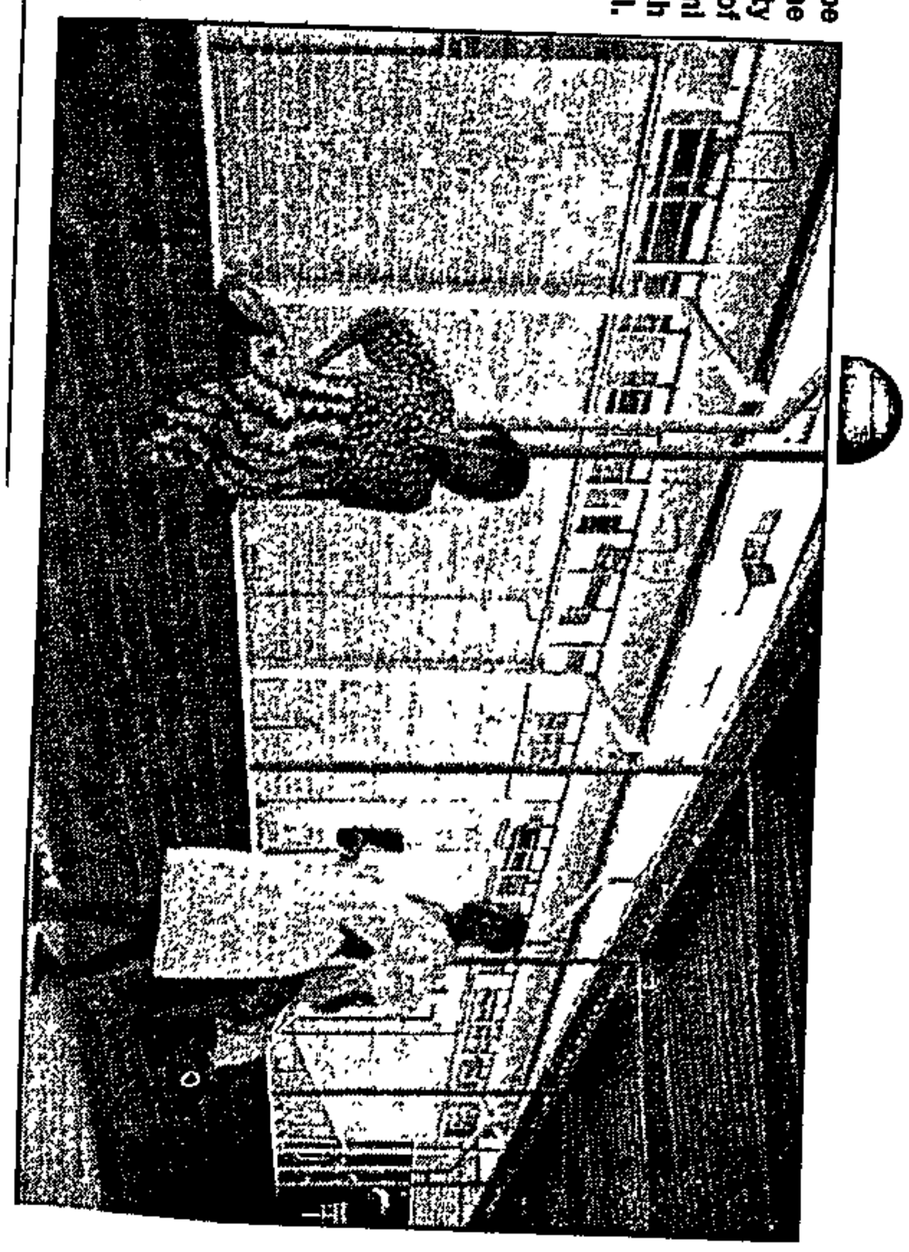
Bara has the reputation of being the largest hospital in the world and since 1997 it has been recorded as such in the *Guinness Book of Records*.

Built during World War II to treat soldiers, Bara later became a hospital catering exclusively for blacks.

The hospital serves the four million residents of Soweto. It has more than 3 000 nurses and 600 doctors and treats 2 000 outpatients daily. It has 3 297 beds.

Over the years, the hospital has been plagued by incidents of theft and attacks on hospital staff, a shortage of nursing staff, allegations of deaths due to malpractice, shocking health hazards and theft of medicines

- Two weeks ago, incidents of theft and attacks on hospital staff, inside and outside wards, were reported. A demonstration by doctors resulted in the hospital tightening its security Surveillance cameras have been installed and stricter access for visitors implemented.
- A shortage of nursing staff was reported at the beginning of the year, with nurses complaining of strain and overwork. In response, the Gauteng Department of Health deployed staff from other hospitals.
- In July 1998 senior superintendent, Dr Bokkie Rabinowitz, alleged that 40 patients died during surgery as a result of malpractice at Bara. A commission of inquiry was instituted to investigate the patient deaths. The Gauteng MEC for Health, Mr Mondli Gungubele said: "The outcome of the investigation reveals that the hospital's management system leaves much to be desired".
- In November 1996, a man allegedly died in filth at the hospital. Following an outcry from the public, conditions have since improved.
- In July 1996, two babies in intensive care allegedly died after the hospital's emergency generator system failed. Following this, the emergency power generation plant underwent a major revamp.
- In June 1996, Bara was plagued by theft with at least R500 000 worth of medical and other goods stolen from the hospital each month by staff and patients. About 25 hospital employees were arrested.



Mums-to-be at the maternity section of Chris Hani Baragwanath Hospital.

PIC: CLEMENT LEKANYANE

SOWETAN Friday March 5 1999

'Race' strife rips hospital union apart

(98) Sowetan 5/3/99

By Mzwakhe Hlangani
Labour Reporter

THE FORMER whites-only Hospital Personnel Trade Union of South Africa (Hospersa) is reportedly purging itself of senior black executives.

Disillusioned former trade union leaders said yesterday that six more black provincial executive members were expelled from the union as internal racial tensions and suspensions reached a peak this week.

There are charges that the white leadership is resisting transforming Hospersa from "a lily-white bastion" to a workers' trade union.

Former Mpumalanga Hospersa provincial chairman, Mmupi Mogoboya, who was expelled after being found guilty of participating in the disruption of a union congress, claimed that the white union leadership exercised naked racism.

Mogoboya said he was instructed to attend a disciplinary hearing in Bloemfontein without transport arrangements being made for him. When he protested, he was notified that the case would be finalised even if he failed to appear.

Gauteng chairman Moses Ntlhane and his regional executives Gabriel Kguduge and David Mwale were expelled this week, also for allegedly taking part in the disruption of congress last December.

Others include Mpumalanga treasurer Zodwa Nyalunga, North West vice-president Mackson Ranku and Northern Province executive member Laura Kgaka.

A spokesman for the union denied that the conflict was racial, saying that those dismissed had been found guilty by the disciplinary hearing.

He declined to comment further since union president Gavin Moultrie and secretary general Johan Steyn were on leave.

For some time the union has been embroiled in racial conflict and court interdicts. The entire provincial committee in Northern Province was suspended after its chairman, David Tsheola, was dismissed.

Sowetan 5/3/99

'No more drastic Western Cape hospital staff cuts'

(98) BD 9/3/99

Linda Ensor

CAPE TOWN — There would be no more drastic staff reductions in the Western Cape's public health sector, provincial health MEC Peter Marais said in his budget speech in the legislature yesterday.

With staff numbers already slashed by 8 020 since 1996, any further cuts would jeopardise the standard of service delivery, he warned. About 2 150 posts were abolished last year, which would result in R110m less being spent on staff in the coming year compared with the previous year's estimate. However, the cost of 317 excess staff (supernumeraries) would amount to R27,4m in the year ahead.

Marais said he believed that after last year's rationalisation the sector had bottomed out. The objective this year was to consolidate service delivery and address the backlog in equipment, pruned by R20m in 1998/99. The amount allocated to equipment in this year's R3bn health budget is R35m, up from R15m last year.

Of concern was the decline in revenue from private patients using public hospitals, which fell R10,5m last year from R75m the year before. Attempts would be made to attract them back.

Marais outlined the business plan to deal with last year's R151m budget deficit. Academic hospitals were brought under one authority and a new framework agreement was thrashed out with universities so the province did not have to bear the cost of training and research.

In rationalising academic hospitals, 126 beds were closed, 1 292 staff were shed (bringing the job cuts total since 1996 to 5 025) and 596 people were declared supernumerary. Academic hospitals' share of total budget fell from 42% in 1994/95 to 37% in 1999/2000 as emphasis shifted to primary health care and budgets shrank. Universities had taken over a greater role in funding dental hospitals.

Marais highlighted the growing role of public-private partnerships. Talks were being held with the universities of Cape Town and Stellenbosch for them to lease 125 beds at Groote Schuur and 135 beds at Tygerberg Hospital for private patients. The private sector was involved in the development of the Westlake and DP Marais hospitals, which were closed.

Western Cape health MEC Peter Marais prepares to present his budget speech yesterday. Marais announced that further staff reductions could be expected in the public health sector this year. Picture: TYRONE ARTHUR

No more health cuts — Marais

CT 10/3/99

JUDITH SOAL
HEALTH WRITER

THERE will no more job losses or service cuts in the health sector, Health MEC Peter Marais said this week.

Marais told the provincial legislature during the health budget vote that his department had made up a R151 million shortfall from April 1998. Most of this money was saved through losing staff.

"In 3½ years the filled posts in the Health Department were reduced by 8 020," Marais said. "The impact of our staff losses bordered on devastation."

Marais said he believed the department had "bottomed out", although it would still overspend by R29m on its personnel budget this year.

"I am not prepared to make any more cuts to our academic hospitals," he said.

Among the cuts in the health services during the 1998/9 financial year were:

- 126 beds lost at academic hospitals.
- 1 292 staff left academic hospitals.
- 269 staff left psychiatric hospitals, most of them nurses.
- The Princess Alice Orthopaedic Hospital was closed and 60 posts lost.
- The northern block of Somerset Hospital was closed and 57 beds lost.
- The capital and maintenance budgets for health facilities were reduced by R22m to keep within budget.
- The equipment budget was cut by R20m.

Marais said one of the most important developments while restructuring academic hospitals was a new "framework of agreement" between universities and the provincial department, which recognised that the province was primarily responsible for financing health services, not research.

He also spoke about:

- The recent decision to "rationalise" the four nursing colleges by locating the main campus at Nico Malan, with a satellite campus at Otto Du Plessis.
- The appointment of an outside contractor, from the beginning of March, to collect fees due to public hospitals after a R10,46m decline from the previous year in the amount of money collected in 1998/1999.
- A 250-bed hospital to be built in Philippi East.
- An "onslaught" on the equipment backlog in state health facilities.
- "Advanced discussions" with UCT and Stellenbosch University to lease out 125 beds at Groote Schuur and Tygerberg Hospitals respectively, to be used as beds for private patients.

The Western Cape chief director of health care, Fareed Abdullah, said the health department could begin building itself again.

"This is a good-news budget," he said, adding that he believed the total number of staff employed in the health services was appropriate, although the staff mix needed to be adjusted.

"I think we have got too few nurses," Abdullah said, "but at least now we are operating in a rational climate. There will be no more drastic cuts."

State hospitals fleeced by rich and foreigners

(98)

Thousands take advantage of free services

ARG 13/3/99

PETA KROST
Johannesburg

Wealthy South Africans and foreigners are jeopardising the lives of scores of poor people by abusing state hospital services.

South African government hospitals have lost over R200-million, which could have been used to treat those desperately in need.

Many medical aid members who can easily afford private medical rates are paying a pittance or not paying at all for government medical services. The abuse is believed to have caused a deficit of almost R200-million in the government hospitals' annual income.

Tens of millions of rands are also owed by citizens of Southern African Development Community (SADC) countries who come to South Africa for medical treatment but don't pay for it.

The deficit is partly because of the government hospitals' billing systems, which Ayanda Ntsaluba, the director-general of the Department of Health, described as "chaotic".

"The billing system does not operate properly partly because there is no incentive for the provincial hospitals to ensure accurate billing – the money goes to the provincial treasury anyway – and they get none of it."

Dr Ntsaluba told the Saturday Argus that the Government was already tackling the abuse of the state hospital system.

"The seriousness of the foreign issue is linked to the fact that hospitals are not able to provide foreigners with costly medical treatment without this somehow limiting medical help for our own citizens," Dr Ntsaluba said.

He said it was often the case that foreigners went to a private hospitals for treatment first. But when they ran out of money, they were dumped in a government hospital.

"When a person is really ill or once he has already had an operation and is desperate for follow-up treatment, a hospital can hardly refuse to treat him," Dr Ntsaluba said.

Ralph Ngijima, Gauteng's superintendent of general health, estimated that the province had lost R4,5-million because on non-payment by SADC citizens.

But Dr Ntsaluba said Dr Ngijima's estimate was based only on the number of people the province had been able to trace. Many more patients – from Botswana, Angola, Zimbabwe, Congo, Malawi, Swaziland, Zambia, Mozambique, Lesotho, Mauritius and the Comores – were untraceable.

South Africa had put the problem at the top of the agenda for the SADC health-sector negotiations as it was a "burning issue", he said.

South Africa had offered to provide specialised training to doctors from other SADC countries in the fields in which South African doctors excel. "We will only do this as long as they only stay for training and then return to their own countries," he said.

Dr Ntsaluba said that, in the short term, South Africa would continue to help a limited number of foreigners as long as their governments were prepared to give formal referrals, which would legally bind them to pay for outstanding medical costs.

In South Africa, outstanding medical costs are often not even billed.

"The State is losing a great deal of money because provincial hospitals are not billing people properly," Dr Ntsaluba said.

"If we want to ensure billing is done properly, we need to give staff an incentive. Right now the money goes to the provincial treasury – so the health sector gets none of it. But the (Gauteng) health minister said in his budget that this would change.

"The money over and above the minimal budget the hospitals get would be ploughed back into its system."

At present, the inadequate billing system allows patients to vastly understate their income. They get away with paying very little, if anything, for the medical services.

"If you declare that you are unemployed, you can almost get medical treatment free," Dr Ntsaluba said.

Eric Buch, Gauteng's director-general for hospitals, said there was very little time to check people's details when they were admitted to hospital. He also said it was virtually impossible to check whether patients had medical aid.

Although it was difficult to tell exactly how much government hospitals were losing to fraud, it was clear from hospital records that there were proportionately far too many poverty-stricken patients, Dr Buch said.

"In the absence of very draconian measures that might jeopardise the health system, it is difficult to get precise information about patients in government hospitals," Dr Buch said.

(98) CP 14/3/99

Corpses rotting in hospital mortuary

Staff complain of unbearable stench and health hazard

By MALOSE MONAMA

EIGHT unidentified corpses retrieved by Northern Province police from crime and accident scenes are beginning to rot after lying at a government mortuary for more than two years.

Staff at the Mankweng Hospital mortuary who have to bear with the suffocating stench are perplexed as to why the corpses have been kept for so long.

The bodies have been stored since January 1997 and are in an advanced stage of decomposition.

City Press visited the mortuary this week after a tip-off from an undertaker, who said complaints to the authorities about the repulsive smell had fallen on deaf ears.

The undertaker did not want to be named.

An employee at the mortuary, who also did not want to be named for fear of reprisal, said he no longer looked forward to going to work.

"Just the thought of coming to work saps my energy.

"I have to drag myself out of bed each morning and my health has deteriorated," he said.

The employee said all the corpses had been brought in by the Mankweng police, who had retrieved them from accident scenes or found them in bushes. He felt that not enough had been done to establish the identities of the bodies.

"There have not been appeals to members of the public missing their next-of-kin to visit the hospital to identify these people," he explained.

One of the rotting bodies is dated January 2, 1997.

City Press asked the hospital authorities and the police why the dead had not been declared paupers and buried.

Sergeant Mosena, who is in charge of the mortuary, said the delay in burying the unidentified bodies was due to budget constraints.

He said he had been told there was no more money for pauper burials.

Senior magistrate Collen Nkoenyane said he was not aware of the matter.

"I am the head of this office and I know nothing of the sort.

"I will, however, expedite the disposal of those bodies once I have received the necessary documentation from the police and welfare officers," he said.

Mankweng Hospital superintendent Dr Amara Anozie said he was concerned about the bad odour from the mortuary

"We have been urging the police for a long time to do something about the bodies. I can't wait to see them disposed of," he said.

□ Meanwhile, **Matthews Mpete** reports that the indiscriminate killing of people in the Ga-Rankuwa and Mabopane areas is causing concern among residents about bodies left decaying in the mountains.

Their concern comes in the wake of a mass funeral that was held last Wednesday at Odi stadium for 18 unidentified bodies that had been lying at the government mortuary in Medunsa for nine months.

Social worker Ruth Pooe, who together with the North West health department organised the funeral, said the decomposing and smelling corpses were becoming a health hazard.

"It is unhealthy for workers at the government mortuary to work in that kind of environment.

"The bodies were smelling and could lead to diseases," she said.

Pooe praised the communities for burying people they did not even know, at a time when most people were pre-occupied with themselves and ubuntu (humanness) was in decline. Equally heartening was the offer by Se ra Poo funeral services to bury the unidentified corpses.

North West health MEC Paul Sefularo said he was shocked to learn that more than 18 bodies had been in the government mortuary for more than nine months.

Sefularo said unidentified people deserved a proper burial, adding that it was a challenge to the community to do something about crime as most of the unidentified bodies were victims of crime.

Inspector Thomas Makwela of the Mabopane police said there were 28 unidentified bodies at the government mortuary.

Foreign patients costing Gauteng hospitals dearly

Pearl Sebolao BD 16/7/99

98

THE Gauteng health department should undertake a study to assess the degree of cross-border patient flow and its effect on service delivery, the legislature's standing health committee recommended yesterday.

In its draft report on health's 1999/2000 budget vote, the committee said the conditional grant allocation for the province's central hospitals was insufficient and the mechanism of recouping amounts owed by other provinces had to be looked at.

Gauteng's equitable share of the allocation for four central hospitals — Garankuwa, Pretoria Academic, Chris Hani Baragwanath and Johannesburg — amounts to R1,481bn.

It does not, however, cater for regional hospitals which also handle referrals from other provinces.

The committee recommended that the study look at ways to calculate the costs involved and what mechanism could be used to recoup what was owed to Gauteng.

The study should cover other provinces as well and not only Gauteng as the problem affected everyone.

The home affairs department had to be brought in as well, as referrals also came from neighbouring nations.

Last year it was reported that the governments of Botswana, Zimbabwe, Zaire, Swaziland, Angola and Malawi were among Gauteng's biggest debtors and allegedly refused to pay hospital bills incurred by their nationals.

Some sums had been outstanding for more than two years despite the fact that arrangements, including written requests and payment guarantees, were made with the governments before the patients were admitted.

Committee chairman Gwen Ramakgopa said it would not be possible to recover the costs incurred in treating patients from other provinces this year as there were no proper monitoring mechanisms.

The committee also recommended that an assessment of rank and leg promotions, which cost the department R269m in the 1998/99 financial year, be done as soon as possible.

It said these negatively affected department resources and also had implications on its organisational structure, roles and responsibilities.

'Hospitals too broke to save victims'

(98)

Many dying who could be saved, as health budget plummets and number of gunshot injuries soars

Star 19/3/99

By Gill Gifford and Sapa

Gunshot injuries, the fastest-growing cause of violent death in South Africa, are claiming ever more fatalities because cash-strapped hospitals do not have the resources to cope with the mounting number of cases.

Professor Ken Boffard, principal surgeon and head of the trauma unit at Johannesburg Hospital, yesterday said people who could have been saved were dying every day because cost-cutting by provincial administrations had left state hospitals with depleted resources.

He was speaking hours before police commissioner George Fivaz said the top priority this year would be to cut down on the number of illegal firearms. Fivaz said illegal firearms were the common denominator in almost all violent crimes committed in the country.

Speaking at a Gun Free South Africa seminar, Boffard said the number of gunshot victims admitted to Johannesburg Hospital had more than doubled in the past five years: "We have less money, fewer doctors, fewer beds and more patients than ever before," he said.

The number of gunshot victims brought in to Johannesburg Hospital had increased from 241 in 1993 to 651 in 1998.

"The cost of a trauma case was about R10 000 per day to the taxpayer in 1998. The cost at our unit is about R63 000 per patient – this amounts to a huge, unaffordable bill at the end of the day," Boffard said.

He said gunshot injuries sustained by hijack victims were a growing problem, and the single biggest cause of quadriplegia in South Africa.

"Unfortunately, the nature of a hijacking involves the perpetrator shooting the victim from the side. Because of this, when the bullet enters, it tends to go through the spinal cord," said Boffard.

He said 40 to 50 hijack victims in Johannesburg last year had been left permanently paralysed.

South Africa and Rwanda were the only countries in the world where death caused by interpersonal conflict in a non-war situation exceeded car accident-related deaths, he said.

Speaking at Fivaz's media briefing in Cape Town, divisional commissioner André Pruis said police confiscated between 20 000 and 25 000 illegal firearms each year, and had set a target of between 25 000 and 27 000 for this year.

However, there were no reliable statistics on exactly how many illegal weapons were currently in circulation.

The public could expect an increase in roadblocks aimed at finding illegal weapons, especially in known "hotspot" areas, he said.

A total of 29 694 firearms were reported stolen last year, of which 1 775 were either lost or stolen from the police, Safety and Security Minister Sydney Mufamadi told Parliament yesterday. Only 1 764 of these firearms were recovered during the same period, he said in written reply to Democratic Party justice spokesperson Douglas Gibson.

Policemen had lost 778 firearms during visits to discos, shebeens or when drunk. Eighteen were lost in bathrooms or toilets, while 264 weapons had disappeared from charge offices. Police had also lost two firearms during riot action and 21 more during other duties.

A total of 708 firearms were taken from police members' possession during robberies, with a further 378 weapons stolen during thefts at their private homes or official quarters.

Forty-one firearms were stolen from state vehicles and 30 from private vehicles, he said.

A total of 42 firearms disappeared during car accidents in which police officers were killed or injured.

At least 168 policemen were found guilty of negligence in the loss of a firearm. Of these, eight had admitted guilt, while in five cases the attorney-general's office had declined to prosecute, Mufamadi said.

Six charges were withdrawn. Eighty-six cases were still outstanding, with disciplinary steps outstanding in 51 cases, he said.

Outcry as rich push poor out of state hospitals

By PETA KROST

Wealthy South Africans and foreigners are jeopardising the lives of many poor people by abusing state hospitals, which have been losing more than R200-million a year.

Many South Africans on medical aids and who can afford private medical rates are vastly underpaying, or not paying at all, for government medical services.

And tens of millions of rands are owed to South Africa by Southern African Development Community countries' citizens who come here for treatment and don't pay for it.

No incentive

The shocking deficit is partly due to government hospitals' billing systems, which Department of Health director-general Dr Ayanda Ntsaluba described as chaotic.

"The billing system doesn't operate properly, partly because there is no incentive for provincial hospitals to ensure accurate billing as the money goes to the provincial treasury and they get none of it."

Ntsaluba this week told the *Saturday Star* that while both these abuses were huge problems, the government was well on its way to dealing with the abuse.

"The seriousness of the foreign issue is linked to the fact that hospitals are not able to provide foreigners with costly medical treatment without this somehow limiting medical help for our own citizens."

He explained that the typical scenario was when a foreigner comes to the country for medical help. Foreigners go to a private hospital, and when out of money, are dumped at a government hospital.

To Page 2

Rich push poor out of state hospitals

From Page 1

"When a person is really ill or after an operation and desperate for follow-up treatment, a hospital can hardly refuse to treat them," Ntsaluba said.

Gauteng's superintendent-general for health Dr Ralph Mgijima estimates that R4,5-million has been lost to the province because of non-payment by SADC citizens. But Ntsaluba said this estimate was based solely on the number of people Gauteng was able to trace. Many more, from Botswana, Angola, Zimbabwe, the DRC, Malawi, Swaziland, Zambia, Mozambique, Lesotho, Mauritius and the Comores, were untraceable.

South Africa had put this problem on top of the agenda for SADC health sector negotiations and offered to give specialised training to doctors from other SADC countries. "We will only do this as long as they only stay for training and then return to their own countries."

Ntsaluba explained that in the short term South Africa would continue to help a limited number of foreigners if their governments were prepared to give formal referrals legally binding them to pay for any outstanding medical costs.

Currently, the inadequate billing system allows patients to vastly underestimate their income. "If you declare that you are unemployed, you can almost get medical treatment for free," he said.

Gauteng director-general for hospitals Dr Eric Buch said: "The public needs to find an inner integrity which will make them realise that, by falsifying information, some really poor person is not going to get the proper treatment because there are insufficient funds to cover it."

According to Dr Kamy Chetty, deputy director-general of health administration, it is estimated there is an annual loss of about R200-million because, four or five years ago, government hospitals collected about R300-million a year and were now making little more than R100-million. "This has a huge impact on patient care," she said.

Bara changes its hours

Sowetan 23/3/99 (98)

By Bhungani Mzolo
Health Reporter

CHRIS Hani-Baragwanath Hospital has changed its visiting hours in a continuing effort to tighten security.

The hospital's public relations officer Mrs Hester Vorster told *Sowetan* that from Mondays to Sundays patients could only be visited between 2pm and 4pm. No visitors would be allowed into the hospital after 4pm without a valid reason or a special permit, she said.

Vorster said the move had become necessary because of a spate of crimes committed on hospital premises.

These included attacks on doctors and the nursing staff, as well as attempts to steal hospital property.

"The hospital management would like to apologise for any inconvenience this may cause the public. However, we would like to once again emphasise that we will do everything in our power to ensure the safety of both patients and staff," she said.

Last month, Gauteng Premier Mathole Motshekga, accompanied by the MEC for health Mr Mondli Gungubele visited the hospital to assess the security situation.

Future security measures include the introduction of a barcoding system for stock control; secured parking for staff and the public; the installation of a high-technology surveillance system; and the searching of vehicles and personal possessions of people leaving the premises.

Gungubele said yesterday the number of new tuberculosis infections in Gauteng was growing at an alarming rate, with more than 14 000 cases diagnosed in 1998 alone, reports Sapa.

"The disturbing increase suggests two things. One, that we have lots of undiagnosed, untreated and therefore infectious tuberculosis among us in our province.

"Secondly, that HIV is weakening the immunity of many people who are now more likely to get TB," Gungubele said.

He said as the country celebrated World Tuberculosis Day tomorrow, the people in the province should re-examine the social responsibilities placed on them by the disease.

Pàtients terrorise city clinic

Staff tell of violence

(98)

EMELITA MINKO
SPECIAL CORRESPONDENT

Working under siege conditions, staff at the Mitchell's Plain community health clinic are close to breaking point over violent abuse by patients and people accompanying them.

Recently, the clinic was forced to close for three hours when a man who had brought his mother for treatment became violent and started attacking patients and a security guard. He also tried to break down the door to the surgery.

Police had to be called and teargas was used to subdue the man.

Staff say they work under extremely dangerous conditions, with security guards employed to protect them.

But guards and nurses are intimidated and threatened with violence – "We'll get you in Town Centre", they are told, or "We know where you live."

Staff doctor Annette Pautz said patients brought dangerous weapons to the clinic. "I have found patients carrying guns, knives and even a screwdriver," she said.

Chief professional nurse Louise Appolis has endured enough abuse and has decided to speak out about the plight of staff.

"Since the clinic started a 24-hour medical emergency service about six years ago, things have been getting worse," she said. "We were dedicated when we started working here, but there is no job satisfaction for us now."

In once incident, a woman hit a security guard in the face after he refused her entry to the surgery where her daughter was being treated, she said.

But the woman claimed afterwards that the security guard had closed a safety gate on her arm. According to Ms Appolis, the woman is "hounding" medical superintendent Rob Martell for an apology.

An administrative clerk was cut on the wrist when a man smashed the window of her cubicle, accusing her of taking too long to retrieve his medical folder.

Staff nurse Lynn Groenewald was attacked while working in the storeroom, and was hit in the face by a patient. She later got a letter of apology.

Another patient spat in a nurse's face, and a radiologist was attacked after working with a patient.

Clinical pharmacist Chantal Dayaram – one of four pharmacists assigned to process

ARG 29/3/99

To page 4

P.T.O.

Demoralised staff tell of abuse and violence as patients and families terrorise Mitchell's Plain clinic

(98) ARG 29/3/99

From page 1

about 700 prescriptions daily – said she had been sworn at by patients.

"Patients don't seem to understand it takes time to process all the dockets that seem to get there at the same time," she said.

Patients have thrown medicine back at doctors after treatment.

Day staff and night workers have to endure similar abuse. Although the 24-hour service handles only emergencies, people demanded treatment for common ailments, Ms Appolis said.

Dr Martell has seen some of the abuse endured by his staff.

"I think the patients' demands are unreasonable. It is extremely demoralising to work under such conditions," he said.

Senior staff nurse Esme Andrews said she felt angry at the way she was treated and has applied for a severance package.

"I started nursing because I wanted a career. I have been robbed of my personality because I am not the person I used to be," said Mrs Andrews.

Some nursing staff feel they do not get support from some of their superiors.

The Community Health Services Organisation superintendent, Edmund Michaels, said as demand for health services increased dramatically, staff were put under considerable stress.

"The lack of staff prolongs waiting time and causes tempers to fray and rudeness among patients."

Community clinic shuts after doctor is threatened at gunpoint

(98)

ARG 10/4/99

DI CAELERS

The Mitchell's Plain community clinic closed its doors for about two hours yesterday when angry and frightened staff stopped work after hearing that a doctor had been threatened at gunpoint the night before.

"The staff are at the end of their tether," said Edmund Michaels, the senior medical superintendent of the Community Health Services Organisation, which oversees more than 40 community clinics in greater Cape Town.

Dr Michaels said Robert Martell, the chief medical officer for the Mitchell's Plain area, met clinic staff and managed "to put some assurances in place". But staff were still "very jumpy".

The Cape Argus reported this week that state hospitals and clinics were being forced to spend hundreds of thousands of rands on security to protect staff from escalating verbal and physical abuse by patients, their families and friends.

Dr Michaels said about R1-million a month was already being spent on security for the clinics. Six guards worked at night and four during the day at the 24-hour clinics. But still a patient ignored the guards at the Mitchell's Plain clinic: he walked in with a gun and threatened a doctor.

The health department was considering installing walk-through metal detectors – security guards use handheld ones – but they cost about R9 000 each.

Dr Michaels said a major problem at the clinics was that many patients were coming for treatment after hours because they said queues were shorter. That placed enormous strain on the skeleton staff who worked night shifts.

You no longer have to be patient with bad hospitals

YOUR RIGHTS AS A HOSPITAL PATIENT

- STAFF WHO ARE CLINICALLY PROFICIENT, ACCESSIBLE, ATTENTIVE AND HELPFUL
- PROMPT, PROFESSIONAL AND COMPASSIONATE TREATMENT
- ASSISTANCE IN HAVING THE DIAGNOSIS, TREATMENT PLAN AND THE EFFECT OF THE TREATMENT EXPLAINED
- TO WITHOLD YOUR CONSENT
- THE FACILITATION OF A SECOND OPINION
- A CLEAN, SAFE AND HYGIENIC HOSPITAL
- EFFICIENT, FRIENDLY SERVICE FROM ALL MEMBERS OF STAFF AND MEDICAL PERSONNEL THROUGHOUT YOUR HOSPITAL STAY
- YOUR PRIVACY , DIGNITY AND RESPECT FOR YOUR CULTURAL BELIEFS
- NUTRITIOUS FOOD
- A QUIET ENVIRONMENT
- FACILITIES THAT ARE IN GOOD WORKING ORDER
- REASONABLE ACCESS FOR YOUR FAMILY AND FRIENDS

Graphic RUBY GAY CAETANO Source DISCOVERY HEALTH

DINA SEEGER

Looks at how a discovery in a taxi can ease the pain of illness

(98) ST (BT) 11/4/99

POWER to the patients! Private hospital patients may finally have the upper hand in demanding quality care and professional service.

Thanks to medical insurer Discovery Health, we now have a Patient Bill of Rights which has been agreed to and signed by 95% of SA's private hospitals.

The bill's guarantees include a clean, safe and quiet hospital environment, attentive and helpful staff, nutritious food, and facilities in good working order (see graphic).

Discovery Health has nominated itself as a medical industry watchdog: it promises to enforce the bill by following up any complaints, but will only resolve problems reported by its own clients.

While other patients can insist that these rights are protected, as a non-member you'll have to approach the hospital yourself if you have a complaint. If you have no luck in resolving the problem, you can contact the medical ombudsman, Professor Oliver Ransome, at 0800 119 820.

Johan van Rooyen, Discovery Health's head of provider networks, says it's likely that other health insurers may soon follow with their own patient rights programmes.

Discovery clients are advised of the bill when they notify the insurer of a planned hospital visit (many medical funds require you to phone before you check into a private hospital, except in emergencies). Discovery Health also sends clients a "get well" card — which lists patient rights and gives a hotline number to call for complaints.

With the card is a form for you to fill in and fax back to Discovery. It enables you to rate service quality, cleanliness, competence of staff and standard of food.

"It's important the hospitals know they are being watched," says Van Rooyen. He adds that because private hospitals have no regulatory body, patients often feel disempowered. Many do not know they have the right to complain.

Since the bill was signed by private hospitals in October, Discovery has received more than 40 complaints, and extracted several apologies from hospitals.

"We sensed a bit of reluctance from the hospitals when we asked them to sign the bill last year," says Van Rooyen. A few hospital groups argued that they already had a patient bill of rights.

"But their bills hardly have the same standing — first, because patients are never told what their rights are, and second, because there's no objective body to enforce protection of these rights."

Van Rooyen says they had to negotiate with the hospitals before they would agree to the bill, and several rights had to be altered.

"For example, we wanted patients to have the right to nutritious and good food, but the hospitals argued that patients would say their rights were being abused because they didn't like the food." This right has since been changed simply to "nutritious food".

One hospital manager made the point that patients could easily abuse their rights, and hospitals should also have rights. "He wanted us to create a hospital bill of rights," says Van Rooyen.

Discovery Health says its idea originated in the US. However, it wasn't taken from the medical industry, but from New York's taxi service.

The city's famous yellow taxi cabs each have a "passenger" bill of rights pasted in full view of passengers. And this got Discovery Health's chief executive, Adrian Gore, thinking about a patient bill of rights.

"It was in Minneapolis that I realised the importance of the patient's rights," he says.

"I was in a taxi and the cab driver was smoking and playing loud music; he certainly would not have been able to do that in New York because passengers are empowered by their bill of rights."

Hospitals that really care

Health Services Charter intended to stop the rot and improve services

By DOMINIC MAHLANGU

PATIENTS at government hospitals and clinics in Gauteng may soon get better service and treatment, if implementation of the Gauteng Health Services Charter has the desired effect.

The charter is part of an effort by the Gauteng health department to improve the standard of service at these institutions.

The health department has also promised to make R1 million available, through the Khanyisa Awards for Service Excellence, as an incentive for health workers to provide a better service.

East Rand Health Services, which recently held a workshop on how to stop the decline in standards at State health institutions, has already drafted a document on how services can be improved.

It will be circulated to hospitals and clinics in the area.

Jabu Rakosa, acting district director of healthcare services in the area, said the action plan would go a long way to addressing the neglect of patients and sub-standard treatment at hospitals and clinics.

She said the Gauteng Health Services Charter would be implemented by each region according to its problems and needs.

The charter would create an environment of "accessibility and accountability" in State hospitals.

"Patients will have the right to either accept or decline treatment if they feel that the service being offered to them is poor.

"Health workers will, on the other hand, be held accountable for poor service or patient neglect," said Rakosa.

The charter is being introduced after news reports highlighted cases of patients left unattended in hospitals, in some cases leading to their deaths. In other cases, reports claimed, patients were being refused treatment because they were unable to pay.

The charter is divided into two sections, one dealing with patients (The Patients Charter) and the other dealing with standards of service.

Gauteng health MEC Mondli Gungubele described the charter as "a step in the right direction".

The "Patients Charter" stipulates that every individual will have access to healthcare and that information about the kinds of service available at the hospital or clinic will be made available to the patient.

It also states that health professionals will be responsible for explaining to patients their health condition, what treatment they should receive, and what the results of this treatment might be.

In the charter the patient is given a choice to refuse treatment, including tests or an operation.

SAVE US ... *Some of the patients at Chris Hani Baragwanath Hospital in Soweto.*

"If the patient refuses a particular treatment, our doctors and nurses are still responsible for helping you in the best way possible through offering other kinds of treatment," the document says.

Patients will have a right to privacy and the hospital will only be able to share information with a family member of the patient or a friend if there has been a request from the patient.

The health department said strict policies would be put into place to ensure the charter on service standards is implemented

Support will be provided to hospital management and further training given to staff.

Performance contracts will be introduced to enable hospitals to focus on problems affecting staff members. Capacity building will focus on the training and retraining of staff.

The Gauteng health department will make the "Patients Charter" available to all visiting patients in State hospitals and clinics around the province.

The document will also be distributed in communities.

The department said the eventual objective was to improve standards and provide better care for patients.

Y2K bug to cripple SA hospitals?

MHG9-15/4/99 (98)

Aaron Nicodemus

A leading Y2K expert says South Africa's public hospitals are woefully unprepared for the January 1 2000 computer glitches that may disrupt the flow of medical supplies and cause life-support systems to malfunction. Private hospitals are only doing slightly better, says Mohammed Madhi, CEO of Cyberknowledge Systems and a national expert on Y2K.

In a worst-case scenario, electricity and water supplies would terminate on January 1 2000, crippling hospitals. Once the electricity returns, hospitals would find many of their life-support machines malfunctioning or shutting down as their internal clocks would believe it to be January 1 1900.

"I'm very sceptical about the level of energy being put into the problem," says Madhi. "It's only recently that hospitals have begun attacking the problem. They don't have a feel for what the total cost is going to be, and what exactly has to be done."

Madhi says that since South African hospitals are so far behind, the health care industry should refocus its efforts on contingency planning.

Veli Mahlangu, risk and scenario manager at the government-funded Y2K Centre in Pretoria, agrees with Madhi's assessment. He is creating a national contingency plan for Y2K.

Mahlangu says that a discussion with a top official at the National Disaster Service confirmed that nothing has been done there to address Y2K.

There are other impediments to creating a Y2K contingency plan, he says. "Hospital administrators fear heading up such a plan because, if it fails, they fear they'll be blamed and then fired." There is also the issue of funding and resources, both of which are issues for a public health care system that has enough budget trouble.

Madhi says Netcare is one of the few hospital chains that has adequately prepared for Y2K. Dr Ian Kadish, Netcare executive director, says his hospitals have created disaster plans in preparation for the possible shutdown of services. "We've put diesel generators in place," he says.

Even more at risk of disastrous failure are small private hospitals and rural hospitals, which might not have the resources to combat Y2K.

● The United States Food and Drug Administration has set up a repository of information for the health care industry on the Internet. The address is <www.fda.gov/cdhr/yr2000/y2kguide.html>.

For more information, contact Desré Hilson at (0331) 95-3246, or Lebona Moshayana at (012) 312-0605

Call for rights of patients to be formalised

Star 19/4/99 (98)

Consumer Institute says a charter would improve relations between receivers and providers of healthcare

HEALTH REPORTER

The Consumer Institute of South Africa (CISA) has called for the formal establishment of a charter of patient rights to improve relations between patients and healthcare providers, and has urged consumers to inform themselves of their rights.

CISA said in its latest edition of *Consumer Focus* that a charter was needed because medical treatment was becoming more proactive rather than reactive, and because consumers were being asked to assume more responsibility for their health.

The institute said a charter of patient rights would serve as a guideline for strengthening professional codes of ethics and conduct and would serve as a measuring instrument for the quality of service, participation and other patient rights.

"The charter should include social rights that cover quality and accessibility of healthcare and individual rights as they relate to basic human and consumer rights," the institute said.

CISA said there were seven basic patient rights that consumers needed to be aware of:

1. The right to healthcare – the right to reasonable and acceptable standards of health;
2. Access to information – thus enabling patients to play an active role in health management;
3. Choice – which depends on having sufficient information with which to make an informed decision;
4. Participation – the right to take part in decision-making about the healthcare system through consumer representation;
5. Dignity and human care – each patient has the right to be treated with care, consideration, respect and dignity without discrimination of any kind;
6. Confidentiality – CISA believes privacy legislation is necessary to provide and protect confidentiality;
7. Complaints and redress – direct complaints can be made to the medical ombudsman on 0800-119820 or the dental ombudsman on 0800-113334.

Valkenberg hospital will stay open – but some changes

(98) ARG 20/4/99

DI CAELERS
HEALTH WRITER

Valkenberg hospital, which has faced closure for nearly two years, is now gearing up for a major restructuring initiative in the bid to reduce its number of beds to 224.

Changes at the psychiatric hospital are in line with the provincial government decision to create a single management structure for all the city's psychiatric hospitals.

It was agreed that patients with acute psychiatric conditions be treated at Valkenberg, ending nearly two years of speculation that the hospital would be forced to close.

The restructuring of psychiatric services means patients with particular conditions will be sent to the specific hospital dealing with that condition. No patients will be forced to leave Valkenberg with nowhere to go.

Fran Robertson, convener of Friends of Valkenberg, said the hospital was now enthusiastically going ahead with its plan to raise about R6 million to upgrade its eight riverside wards, promising acute patients top-notch facilities.

Francois van der Merwe, Valkenberg's medical superintendent, said the hospital had 600 beds, many of them in appalling conditions that they had been unable to do anything about while the hospital's future was in question.

"And if anyone thinks the state of Valkenberg is not particularly their problem, they should think again. One in every 80 people in greater Cape Town spend some time here in their lifetimes," Dr Van der Merwe said.

Most patients are schizophrenics – one in 150 people are affected, and the second largest group of manic depressives.

Valkenberg will continue to care for 224 acute patients who need temporary care for between three and about 12 weeks.

Its forensic service, which accounts for roughly 200 patients who go to Valkenberg through the court or penal system, including 65 maximum security patients, will be relocated to Lentegeur and to Fort England in Grahamstown.

Dr Van der Merwe said Valkenberg would still get patients for observation and that they hoped to run a 15-bed assessment unit where patients would stay for short periods before being relocated.

Valkenberg's 160 to 180 chronic patients, who need long-term care and cannot care for themselves, will be relocated to Lentegeur and Stikland hospitals, to old age homes or into the care of families if possible.

Ms Robertson said no one would be discharged until social workers were happy with the alternative arrangement.

are in the pipeline

Anger over dispensary service at hospital (98)

Sowetan 21/4/99

By McKeed Kotlolo

HUNDREDS of outpatients at the Kalafong Hospital near Atteridgeville in Pretoria are daily subjected to long hours of waiting at the dispensary before they receive medicines.

Some patients from outside Atteridgeville arrive at the hospital before 6am and are attended to by doctors before 11am – after which they have to queue at the dispensary for more than five hours.

"After we have been seen by doctors we come to the dispensary, place our files in the pigeon hole and take our seats in the hall to wait for our names to be called before we can get our medicines," a 67-year-old diabetic said.

When *Sowetan* visited the hospital on two successive days last week, the dispensary hall was always full. From about 10am to 4pm, the hall was crowded with patients.

The hospital's chief superintendent, Dr Hanlie Dafel, confirmed yesterday that the dispensary was experiencing problems because of a shortage of pharmacists.

"At times we have only one pharmacist working and this causes a huge backlog in the section".

She said the hospital employed nine pharmacists to work in two dispensaries. They were having to contend with a shortage of five pharmacists as the institution found it difficult to recruit experienced ones.

She said most young pharmacists joined the private sector soon after serving their internship.

Patients told *Sowetan* that they had left their homes very early. They wanted to be there before the office where they collected quota stickers opened at 6am so that they could be among the first to be seen by doctors.

"Sometimes we leave the consultation rooms at 11am and "due to the slow dispensary, we leave the hospital after 4pm. Others are told to return the following day for their medicines", said a group of elderly patients.

Some hospital staff said that at times they had to collect medicines for patients who were either too weak, hungry or tired to wait at the dispensary.

On both occasion that *Sowetan* visited the dispensary, patients grew impatient, left their seats and crowded the dispensary cubicle to urge workers to speed up medicine delivery.

Hospital hits back at abusive patients

We've had enough, say traumatised staff

(98)

ART 23/4/99

DI CAELERS
HEALTH WRITER

Mitchell's Plain community health centre staff have declared "enough is enough" as, trembling and tearful, they told of guns pointed at them and having their lives threatened.

"No more abuse will be tolerated at this hospital," said Dr Rolene Wagner, a member of a new hospital task team set up last week to ensure a safer environment for staff and patients.

"Our after-hours service is being badly abused and we have decided that we will deal only with emergencies after hours to cut down on the number of patients at night.

"We have also instituted temporary security measures to control access to the hospital. The community has volunteered two porters, so now no one else is allowed to accompany a patient into the trauma unit," said Dr Wagner.

They had also requested a walk-through metal detector as a priority.

At a press conference yesterday, staff spoke of how they could not sleep at night after being threatened and abused and told things like "Ek gaan vir jou vrek maak" (I'm going to kill you).

The situation has deteriorated to such an extent that they are starting to feel unsafe even in off-duty hours.

Nursing assistant Juwaya Muller was sworn and shouted at and threatened by a patient last Thursday when she told him he was in the wrong section.

The next day, she bumped into the man in the Mitchell's Plain Town Centre. He walked next to her, shouting and threatening her, then asked his friend for a gun so he could "shoot me in the knees".

In another incident two weeks ago, nurse Gladys Adriaanse recounted how, when she asked a patient to collect his folder before she could help him, he threatened her and started to argue violently.

Being afraid, she walked away but heard a noise, which another patient told her was the man cocking his gun.

On Easter Monday, after a fight between two patients, one of them slapped the security guard out of the way and closed the gate. Patients could get into the hospital only two hours later, when the police arrived.

Dr Wagner said that on April 9 staff at the hospital went on a go-slow which resulted in a meeting last Monday with the community police forum, the security monitoring company, the police and unions.

"From that meeting we decided to set up a task team to address the problems.

The task team has sent a list of recommendations to Edmund Michaels, senior medical superintendent responsible for Mitchell's Plain community health centre. They expect to get a report-back by Wednesday.

Something rotten in Garankuwa Hospital

(98) CP 25/4/99

MAPULA SIBANDA

GARANKUWA Hospital in Pretoria has covered up major financial irregularities running into millions of rands dating back to a finding by a commission of inquiry in 1995 which was not made public.

The probe was conducted by the Independent Mediation Service of South Africa (IMSSA).

City Press has documents detailing the web of corruption dating back to 1992.

The hospital authorities denied there was a cover-up.

The damning findings were:

☐ Alleged irregularities in overtime payments.

Certain individuals including hospital secretary MJ Prinsloo, AM Brits, and PJ Jacobs were found responsible for submitting exorbitant overtime claims, resulting in large payments they were not entitled to. These four also claimed transport for overtime ranging from R6 000 to R15 000.

Prinsloo was found to have been paid R14 782,08 for a three-month period in 1992 after claiming 342 ordinary overtime hours and 369 Sunday overtime hours.

In 1993, M Cronje claimed R25 000 in overtime for a period during which his name never appeared on the overtime register. Some of the other people who claimed overtime were seen gambling at the Morula Sun at the time they were supposed to have been at work.

☐ Corruption in the awarding of tenders and the supply of equipment.

IMSSA found the pattern to be that the most expensive tender was awarded. An Auditor General's report for the period of 1995 indicated that the collective difference between the most expensive and the cheapest tenders was R436 760,20.

ADMINISTRATIVE CHAOS . . . At the X-ray department City Press found patients' files lying on the floor ■ *PIC: MPHO MPHOTHO*

☐ Irregularities concerning certain firms were also noted by the Auditor General.

From April 1993 to March 1994, amounts of R215 069 and R469 410 were paid to JO Elma Enterprises.

No quotations or invoices specifying work done were found. The wife of a Mr LeGrange, JO Elma's sole director, was working at the hospital's payments section and had authorised the payments.

A computer firm, Genchem, was found to be charging up to 500 to 600 percent more than all the other firms. It was found that the company had done work without any quotations and that equipment which did not need repairs was often sent to the company.

Hospital sources this week revealed more cases of corruption:

☐ A senior official paid more than R250 000 for a hospital order of gowns which were never delivered.

No disciplinary action was taken against him and the money has not yet been recovered.

☐ A radiographer was caught stealing used X-ray films and loading them in a truck for silver processing. Although senior management officials were called to witness the incident, no action has been taken against her.

☐ A financial audit of the stores department had to be halted after a computer was stolen from a locked office.

☐ A garage card belonging to a hospital truck was stolen recently and, while the truck was undergoing repairs, R4 000 worth of diesel was fraudulently bought on the card.

☐ An official who used a car without authorisation on a weekend has had no disciplinary action taken against him, although he crashed the car and wrote it off.

☐ A nephew of a radiographer drew a salary for several months although he was not employed by the hospital.

Chief Medical Superintendent Broekmann said as far as he was aware, most of the cases had been referred to the head offices of Gauteng Health MEC in Johannesburg.

Broekmann said cases of a serious nature were referred to both the police and the head office's fraud unit in Johannesburg.

Community leaders to sit on hospital boards

(98) Star 30/4/99

r VIVIAN WARBY

Gauteng health MEC takes steps to strengthen management and delivery

Gauteng community leaders who have been appointed to hospital oards will now have a "real y" in the running of their lo- l state hospitals, provincial ealth MEC Mondli Gungubele id yesterday.

Gungubele has finalised the ppointment of about 120 com- unity leaders to the boards of public hospitals.

This is one of the four steps e has taken to strengthen the anagement of Gauteng's state hospitals, in an attempt to make them deliver quality patient care more effectively.

The province's state hospitals, many understaffed and overburdened, have been racked by controversy surrounding, among other things, lack of adequate patient care, theft of stock and the resulting crippling financial losses, and bad management.

Chris Hani Baragwanath Hospital, in particular, hit the headlines this year when a baby died in his mother's arms while they waited for urgent medical treatment.

The incident highlighted the plight of communities using state hospitals.

Two main functions of the hospital boards will be to advise hospital management on a wide range of management issues, and to represent the community's interests in relation to the hospital.

"They keep an eye on the quality of service, the utilisation of public funds and our adherence to the goals of transformation. They have the potential to make public hospitals accountable to communities in a real way," said Gungubele.

The department has also passed legislation to enable it to appoint people other than medical practitioners to the post of chief executive officers previously superintendents of state hospitals.

The amendment would have the effect of widening the pool of talent from which CEO appointments can be made.

This was an attempt to get hospitals to be run on a more businesslike manner, he said.

A pilot project on participative management at the troubled Chris Hani Baragwanath Hospital has also been launched. It aims to develop and test the effectiveness of a specific management style and private sector principles used in hospital settings.

Certain preconditions which allow participative management to be in place ensure that the CEO will have more autonomy.

A number of powers, such as hiring and firing, vested at present with the provincial department, will be devolved to the hospitals.

Futuristic deal for medics

(98)

Sowetan 5/6/99

By McKeed Kotlolo

HEALTH Minister Dr Nkosazana Zuma has signed an agreement with British Aerospace to enable electronic connections between rural clinics and properly equipped hospitals.

The signing of the memorandum of understanding between Zuma and Professor Steven Grigg, the chairman of Innovation Partnership Worldwide, a British Aerospace and Loughborough University joint venture, took place in Pretoria yesterday.

The Health Department yesterday described the medical system as Telemedicine which "involves linking patients with doctors and other health care providers and facilities through a fixed telecommunications network".

The system enables patients in remote areas to consult doctors over the network and allows doctors to perform "on-line" examinations, diagnose the ailments and prescribe the necessary treatment and medicine.

According to the department, Telemedicine "will be used in South Africa specifically to provide primary health care treatment and information. It also enables the creation of hub-and-spoke medical services by electronically linking rural clinics to well-equipped tertiary hospitals".

The system is already widely used in Norway, the United States, the United Kingdom, Australia, Malaysia and Ireland where it is used by health care services to "provide continuous medical education and preventative health awareness programmes, such as Aids awareness".

Telemedicine also allows the transmission of digital X-rays and other types of scans between doctors and consultants through satellite or landline. "It is able to facilitate the identification and monitoring of epidemics as well as the analysis of data "so that other trends can be detected".

In terms of the agreement, a telemidicine manufacturing platform will be established in South Africa with technology transferred from British Aerospace and the institution of telemedicine and telecare at Queen University in Belfast.

Probe puts Gauteng hospitals under microscope

Doctor's complaints about Chris Hani Baragwanath stir up a hornet's nest

(98) Star 6/5/99

By Raphael Banda

A commission of inquiry began probing patient-care practices in Gauteng's provincial hospitals yesterday as the provincial government conceded that the apparent rot extended beyond Soweto's Chris Hani Baragwanath Hospital.

Premier Mathole Motshekga announced that, following two external investigations into alleged substandard care at Baragwanath, and a subsequent visit he paid to the hospital, it had emerged that the allegations "were more widespread than we had initially anticipated".

Gauteng Health MEC Mondli Gungubele said yesterday that the appointment of the commission was an indication that the situation was very serious in the 20 provincial hospitals.

The appointment of the eight-person commission, headed by Maria Mamodupi Rantho of the Public Service Commission, means investigators can now subpoena anybody to testify before the inquiry and seize documents, among other wider powers.

Dr Bernard Rabinowitz, who blew the whistle on the alleged substandard care at Baragwanath, where he had worked, said yesterday that the wider probe was "long overdue".

He hoped that "something good will come up, that there will be no ongoing coverups, so that this whole mess can be laid open for scrutiny".

Rabinowitz claimed that since exposing the alleged rot at Bara, "a number of people who were totally culpable are still in their positions in Gauteng health".

Claiming that he knew what was going on, he questioned why he had not been included on the panel of commissioners to investigate the matter.

The commission has to report back its findings and present its recommendations on July 9.

It includes attorney Rekgama Andries Manoko; Professor Soromini Kallichurum, chairperson of the Interim Medical and Dental Council; Jerry Vilakazi, of the Public Service Commission; Dr Mohammed Fazel Randera, one of the truth and reconciliation commissioners; Catherine Makwakwa, ex-Nursing Council staff member; Leone Fourie, of the Department of Health; and Advocate Daniel Petrus de Villiers.

The commission will investigate whether any official or employee of the provincial department of health contravened the provisions of any act, regulation or relevant policy in the performance of their duties, and whether patients are treated with the required standard of service.

It will also investigate the causes and extent of the poor treatment of patients and customers at provincial hospitals, among other terms of reference.

The health department in March suspended a doctor and two nurses at three provincial hospitals following allegations of negligence.

Emergencies chief calls for urgent R10-m control room

(98) ARG 7/7/99

upgrade

HANTEL ERFORT
TAFF REPORTER

An urgent upgrade of Cape Town's outdated ambulance control room will cost between R6-million and R10-million, says a senior emergency doctor.

The emergency medical services control room is non-electronic, and all dispatching is done on paper.

Emergency services operations manager Cleeve Robertson said: "It is critical that Cape Town gets an efficient emergency control centre."

His remarks follow the death last week of TB sufferer Benson Mankayi, who lay on the station deck for nine hours despite repeated calls to the ambulance service.

Dr Robertson said emergency services personnel were unable to operate at their full potential due to outdated equipment and a lack of support from local authorities.

"Our control-room technology is just not up to date," he said.

"It is impossible for us to handle properly the large number of calls coming in every day."

Dr Robertson is negotiating with local authorities to fund a new emergency control centre for the city, which would cost between R6-million and R10-million.

"We know what we need to make our emergency services work, but it's just a matter of getting the funding," said Dr Robertson.

He said that ideally all emergency services should be under one roof and share resources.

"If we can share technology and premises, we can cut costs and the money being used to run all the other little control rooms can be put to better use."

Dr Robertson said if they got funding soon, a new control room could be up and running by the beginning of next year.

The new system proposed by Dr Robertson would bring South Africa up to the same standard as other countries already using computerised control rooms.

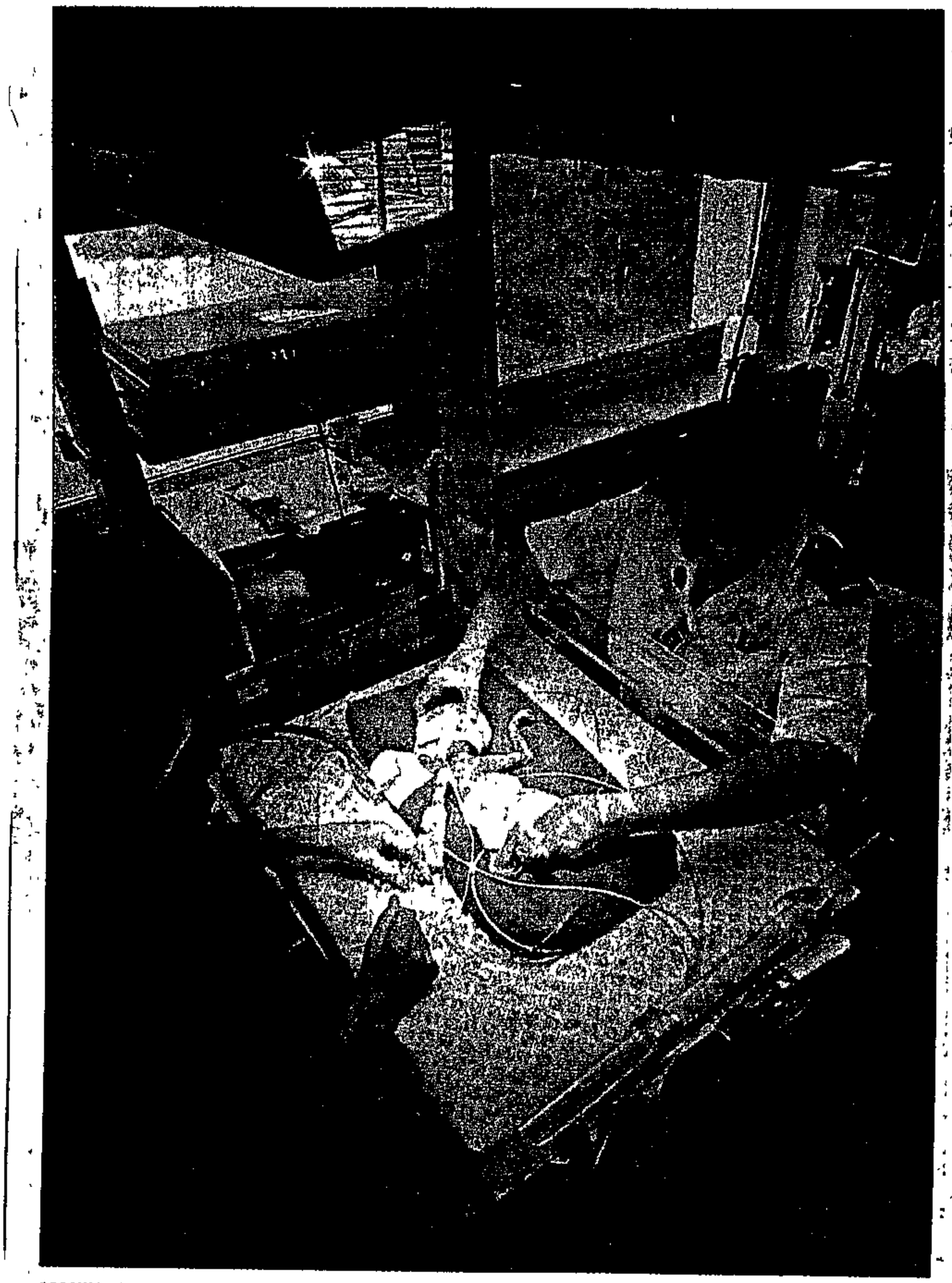
The software includes features that automatically display the location and telephone number of the caller once a call has been answered.

Among other advantages, the system would help emergency personnel distinguish between prank calls and genuine emergency calls.

"The dispatching of emergency vehicles needs to be looked at, but we just don't have the money in our budget," said Dr Robertson.

"We realise we're just one department in a huge system which consumes large amounts of money, but something needs to be done."

CAPE TIMES
★ WEDNESDAY, MAY 12, 1999



MAKING IT: Two-week-old Chad Williams in one of Groote Schuur Hospital's incubators. Sister Laurian Hendry (right) helps out as mother Renata looks on. *PICTURE: MUJAHID SAFODIEN*

Generosity of readers saves 10 infants a month

CT 12/5/99 (98.)

KATHLEEN CHAPMAN

CHAD Williams was born 10 weeks premature in Groote Schuur Hospital. Weighing only 900g, he was so small they could have fitted him in a shoe box — too tiny to save when larger babies already occupied the hospital's precious few incubators.

But doctors expect the two-week-old infant to go home healthy, thanks to donations from *Cape Times* readers that Neonatal Unit Head Dave Woods said will save the lives of about 10 premature infants each month.

In the hospital's Newborn Medicine Unit, where babies are dwarfed by the costly machines they depend on for breath and warmth, doctors and nurses are forced to sacrifice the tiniest babies to make room for those with a better chance of survival. Two infants often share an incubator and doctors can rarely afford space for newborns under 1kg, because "there is basically no room in the inn", Woods said.

Thanks to the generosity of contributors, however, doctors have had to make fewer painful decisions about which babies are to be saved by the neonatal ward's electronic mothers.

Since last October, when the *Cape Times* reported on the ward's funding crisis, hundreds of individuals have donated money, ranging from R5 to R500. Safmarine, a shipping company, gave R30 000 to bring the total to R110 000, twice the neonatal ward's equipment budget for last year.

This money allowed the hospital to purchase three incubators, five breathing monitors as well as five light units to treat jaundice.

Groote Schuur also received four ventilators, worth R93 000 each, from a hospital in Seattle which replaced its still-functional machines with newer models.

"I've been amazed at the response from people," said neonatal specialist Mary Hann. "They just opened their hearts when they heard about the shortage of equipment."

The increased flexibility has saved several babies like Chad Williams, who is now thriving in one of the nursery's new incubators. Chad's grandmother Elizabeth Williams said: "Without this machine, Chad would not have made it. It's doing wonders. I'd like to say from the bottom of my heart, that I thank the people out there. Money cannot pay for what they've done."

The unit still needs to replace four of its monitors — which check infants' vital signs — and many of its incubators, some of which are 20 years old — equipment totalling R160 000. Hann found many babies who were too hot or cold because the nurses rely on antiquated equipment.

To pledge donations, call Z Stanley on (021) 404-6025.

Three arrested for theft at Bara

(98) Soweton 18/5/99

By Charity Bhengu

SECURITY staff at the Chris Hani-Baragwanath Hospital made a breakthrough last night when they arrested three men who allegedly broke into a doctor's car and stole his possessions.

Carolus security head Mr Walter Sefiri said the doctor's car was broken into and medical equipment and other items stolen while parked at a reserved area last night.

Three men were found in possession of the stolen items after being searched by security guards at the gate.

Sefiri said a case of theft and trespassing was been opened against the three. They were taken into police custody by members of the Soweto Flying Squad.

The arrest was as a result of tight security measures which were introduced in February to curb theft and attacks on staff within the hospital grounds.

In the past few months doctors and other staff members have been reportedly assaulted and robbed of cellphones and cars.

Following protests and complaints from staff, metal detectors were installed at the hospital's entrance to stop guns from being smuggled in.

There has also been stricter control of the use of hospital IDs and visitors' cards when entering and leaving the hospital. Cars leaving the hospital are now searched and patrols have been stepped up.

The owner of the security company, Mr Claude Carolus, said last night: "We have made quiet a few arrests and crime at the hospital has declined since the tightening up of security."

Clinic amalgamation a boon for community

By Bhungani Mzolo
Health Reporter

COMMUNITIES falling under the South Metropolitan Local Council (SMLC) will no longer be shunted between clinics following the integration of Mofolo South Clinic and Mofolo Community Health Centre in Soweto.

The integration of the two clinics follows a series of meetings and workshops between health personnel from both clinics, community representatives and ward councillors.

Mofolo South Clinic, which offered treatment for babies, immunisation, treatment for TB and for sexually transmitted diseases (STDs) will now as a result of the integration, also treat pneumonia and fungal infections.

Mofolo Community Health Centre, which previously offered dental and mental health services and the delivery of babies, will now add immunisations, STDs, family planning and TB.

The SMLC's executive officer for community health, Dr Natalie Mayet, said Mofolo South Clinic would now attend to people in that area, as well as White City Jabavu, Moroka, Dlamini Extension 5, Kliptown Extension 2, Fred Clarke, Chris Hani and Nancefield hostels.

People from Mshenguville, Mofolo Central and White City Jabavu will receive treatment from the Mofolo Community Health Centre, Mayet said.

"The main aim of the zoning of areas is to prevent people from being shunted from one clinic to another," she said.

(98) Sowetan 20/5/99

'DEPARTMENT NEEDS CONTROL OF WAITING LISTS'

Home dishing up inequality, claim workers

(98) CT 21/5/99

THE Western Cape pays R700 to R1 000 a month for each of the roughly 150 mentally handicapped residents of the Alta du Toit After-Care Centre in Bellville. All the residents are white. Special Assignments Team **ROGER FRIEDMAN** and **BENNY GOOL** report.

NOT only are all those cared for of pale complexion, but those who take care of them eat from different coloured plates, depending on their race — and occupy vastly inferior accommodation if they are black.

These were some of the issues which confronted Western Cape ANC leader Ebrahim Rasool when he dropped in to visit members of staff yesterday. Later, when Rasool confronted the centre's director, Rian Basson about the claims, Basson said he wanted Rasool's questions in writing so that they could be put to the management committee.

Asked about the paucity of black residents, Basson responded that the centre recently received an application from a handicapped black person, but he did not venture whether the application would be successful. He suggested that one reason the centre has no black residents is that no blacks live in the area, and most blacks do not have access to transport.

About 150 people live at the centre, while day-residents are transported from their homes in the centre's minibus, said driver and Nehawu shop steward Edward Doctor.

According to Basson, the only reason that black staff members eat off blue plates and whites eat off white ones is because the centre has run short of white crockery.

But the workers said that when they used to eat off white plates, they had to write their names on their plates and eat off their own plates exclusively. The black staff also complained that white staff are allowed to live with their children while they are not.

Rasool reminded Basson that to qualify for welfare subsidies from the government, institutions are required to be equitably run and maintained. Basson requested Rassol to make an appointment the next time he intends visiting.

MAKING HIS POINT: The centre's director, Rian Basson, asked the ANC's Ebrahim Rasool to put his questions in writing.

BITTER TASTE: Western Cape ANC leader Ebrahim Rasool yesterday heard how Christene Jonas and other black workers employed at the Alta du Toit Centre in Bellville are required to eat off plates of a different colour to those used by whites at the centre.

After the visit, the *Cape Times* contacted Virginia Petersen, deputy director-general of the Western Cape's Department of Health and Social Services, to inquire whether the state does in fact subsidise such institutions as the Alta Du Toit After-Care Centre.

She confirmed a provincial government subsidy of R700 to R1 000 per capita.

"The official policy of the department is one of integration but we have had problems with the pace of it, not only at homes for the handicapped but also at old-age homes and other facilities."

The department is under a moral obligation to fund facilities for people with disabilities, she said. But many of these facilities are "semi-autonomous" in the sense that they also receive funding from elsewhere, which makes it difficult for the department to exert any control.

"Some things are out of our control. For example, they produce waiting lists — whether real or fabricated — whenever we query the situation. To speed up integration we should find a way to be able to manage the waiting lists for the whole province.

"It's not constitutional (to run a single-race facility) but if they have no space to accommodate any extra people, what must we do? That's why we need control over the waiting lists," Petersen said.

She said an old-age home in Mossel Bay "got around the integration issue" by turning its back on government subsidies and going it alone. An investigation into these practices is under way, she said.

Petition to reopen section of hospital

By Anso Thom

Members of the Democratic Party and the Unemployed Masses of South Africa will march to Hillbrow Hospital tomorrow in support of a petition to reopen a section of the institution.

DP MPL Jack Bloom announced that they would launch a petition to reopen the 102-year-old hospital, which was converted into a community health centre in December 1997.

Bloom said it had become clear that the closure of the hospital was a major mistake, placing unbearable pressure on the Johannesburg and Helen Joseph hospitals.

The march will leave the Library Gardens in central Johannesburg at noon and will culminate at 12.30pm on the corner of Hospital and Kotze streets in Hillbrow, where speakers will address the marchers and supporters will sign the petition.

Gauteng's health department said in response that it was considering reopening an annexe at the hospital as a facility to care for people in the final stages of Aids and other chronic diseases.

Bloom said the department should consider public-private partnerships for:

- An emergency internal-medicine centre. This would cater for common medical emergencies such as strokes, heart attacks, diabetes and asthma.
- An emergency trauma centre for injuries from crime and road accidents.
- An emergency gynaecology centre, primarily for miscarriages and ruptured tubal pregnancies.
- A secondary-level patient facility for HIV-related illnesses.
- An outpatients centre.

The annexe consisted of two theatres and a small theatre for septic cases, two x-ray rooms, a kitchen, a casualty section and administrative offices, Bloom said.

(98) Star 24/5/99

19 clinics run out of 50 essential drugs due to theft and mismanagement

(98) Star 27/5/99

By Anso Thom
Health Reporter

Mismanagement, theft and bad debt have led to a virtual collapse of medicine supplies to government clinics and Odi Hospital in Winterveldt.

Three North West government clinics and Odi Hospital, situated 40km north-west of Pretoria, have reportedly run out of more than 50 essential drugs and medicine supplies with patients suffering illnesses such as diabetes, hypertension, schizophrenia, epilepsy and asthma, forced to make do without any medication.

The situation is reportedly similar throughout the entire Odi district, which consists of 19 clinics, serving Winterveldt, Mabopane and Ga-Rankuwa.

Bad debt to the tune of R4-million by the North West Health Department has led to pharmaceutical companies and suppliers cutting supplies.

According to Winterveldt residents, health workers and doctors, the medicine supply system in the area has collapsed with clinics also running out of bandages, drip connections, condoms, antibiotics and pain killers. They have run out of more than 50 drugs on the Essential Drugs List.

A group calling themselves the Winterveldt Residents said appeals to North West Health MEC Dr Molefi Sefularo, Deputy President Thabo Mbeki and Health Minister Dr Nkosazana Zuma has fallen on deaf ears. They claim that the situation has worsened with less drugs and supplies arriving with each new consignment.

STEVE LAWRENCE

Not happy ... Andries Mhlanga is among the thousands of Winterveldt residents who cannot be treated at local government clinics. Winterveldt is Deputy President Thabo Mbeki's constituency.

Sefularo said the poor supply had resulted from poor management of cash flow systems within the department and, in particular, poor management at the Mmabatho medical stores.

He said an investigation into stock had revealed large-scale theft of drugs and medicines resulting in the arrest of seven employees.

Sefularo said he was confident that the appointment of Vuna Health Logistics Company to implement a new management system from July 1 would improve the management and distribution of medical supplies.

But a doctor said: "I can't see the situation improving. Vuna have taken over in Mpumalanga, but the province's problems have continued or worsened."

She said residents had no recourse, as most of them were poor and unemployed with 82% of the more than 200 000 residents obtaining care from clinics and the hospital.

Sefularo said it was an exaggeration to say that the system had collapsed, but admitted that an outsider could perceive it as such.

"We do owe various (pharmaceutical) companies a total of R4-million. We have agreed with the North West Finance Department to clear these debts," he added.

'I get turned away regularly, going 4km in wheelchair'

By Anso Thom
Health Reporter

The poster above Steven Ndaba's (61) head sums up just how desperate the situation in Winterveldt is – "Everybody wants to live, nobody wants to die" it reads.

Ndaba, who has been unable to access medication from the government clinic for the past three months for extremely high blood pressure, now stays at home and doesn't even bother trying to get medication.

Unemployed since 1994, Ndaba says he has come to accept his fate.

"Why should I go to the clinic. All they can do is take my blood pressure. I want medicine, not my blood-pressure reading," he says.

"You just have to look after your own problem. It is clear that you can't ask someone else to do it," says Ndaba.

On the other side of the Winterveldt, Andries Mhlanga (38) is in the same predicament as Ndaba, his needs are just more basic.

Confined to a wheelchair after a shooting incident 14 years ago, Mhlanga's body is covered in bed sores.

"All I need is bandages, but I get turned away regularly after going 4km in my wheelchair to the clinic.

"All I can say is that my heart is very sore," he says.

▶ Neglected Winterveldt
Pages 10 and 11

'Centre of hope' will help abused children

BEAUREGARD TROMP
STAFF REPORTER

28/5/99 (98) ARG

A place of hope in Green Point may help to end the heartache suffered by many abused children who have to endure the additional pain of having to recall the event several times over.

Abused children whose plight comes to light must recount details of the abuse to social workers, police and a host of other people involved in dealing with their cases. This was the grim picture painted by the co-ordinator of the newly opened Cape Town Child Protection Centre, Ria van der Heever, at the Somerset Hospital in Green Point yesterday.

"The idea is to spare the child the secondary abuse," she said.

The centre aims to better co-ordinate the different sectors of management and get them to work together more effectively. The parties involved include police, social workers, the health department, non-governmental organisations, the justice department and the education sector.

The centre will be used as a first port of call for the initial proceedings for dealing with a case of child abuse.

Similar pilot projects are running in Atlantis, Mitchell's Plain and George.

What makes the Somerset Hospital centre unique is that it is has a full staff complement of social workers, police, counsellors and volunteers, and is open 24 hours a day.

Stricter controls keep health staff safe from threat problem

HEALTH WRITER

Strict controls to help cut down verbal and physical attacks on health workers have been introduced at Mitchell's Plain community health centre after threats to the lives of staff became a regular occurrence.

In April, staff declared "enough is enough", tearfully telling a press conference about cocked guns being pointed at them and having their lives threatened – even outside the hospital when they were not on duty.

Rolene Wagner, head of the task team set up at the time to examine the issue, said several short-term measures had been put in place, including a walk-through metal detector at the hospital.

Other measure were:

■ Access control: only one escort to a patient is allowed into the hospital and are not allowed past the foyer unless patients are younger than 18, elderly or frail, or unable to communicate for themselves.

■ The day hospital has been declared a gun-free zone: security guards will not hold guns for safe-keeping, so that anyone carrying a firearm will have to take it away.

■ Strict search policy: anyone who triggers the alarm, or who makes security guards suspicious for any reason, will be searched.

Dr Wagner said the number of security guards at the day hospital had been increased and they were getting improved training. In addition, the local Anchorage Neighbourhood Watch was "acting as extra eyes in the community".

Closer links with the local police, who had given staff a special telephone number to contact them in emergencies, meant police warned the hospital of problems "that may be coming our way".

Dr Wagner told of an incident last week when a Dixie Boys gang member was killed.

"He was dead on arrival, but the gangsters were loitering outside. The new access controls meant, however, that they never got into the hospital, so keeping our staff away from the problem," she said.

The real problem, according to Dr Wagner, which would not be controlled by any short-term measures, was that health care services in the area were inadequate.

Health crisis looms

(98) Sowetan 22/6/99

By Bhungani Mzolo
Health Reporter

GAUTENG'S four major hospitals are on the verge of collapse, with intensive care units facing closure due to the freezing of doctors posts and funding by the government

And as many as 500 babies born with medically reversible conditions will die every year if these posts are not unfrozen before the end of the month.

The four are Chris Hani Baragwanath, Johannesburg General, Coronationville and Helen Joseph hospitals where posts have been frozen because of budget constraints imposed by the Gauteng department of health.

This was announced yesterday by Professor Ken Huddle, chairman of the medical advisory committee at Chris Hani Baragwanath Hospital at a press conference.

Medical advisory committees are statutory bodies appointed by the Department of Health.

Accompanying Huddle were Professors Keith Bolton, chairman of Coronationville and Helen Joseph Hospital advisory committees; Peter Cooper, chairman of the medical advisory committee at Johannesburg Hospital; and Professor Max Price, dean of Witwatersrand University's faculty of health services.

Huddle said a large number of posts would be vacated on June 30 as a result of staff leaving due to expired contracts. None of the hospitals have been given permission to renew their posts.

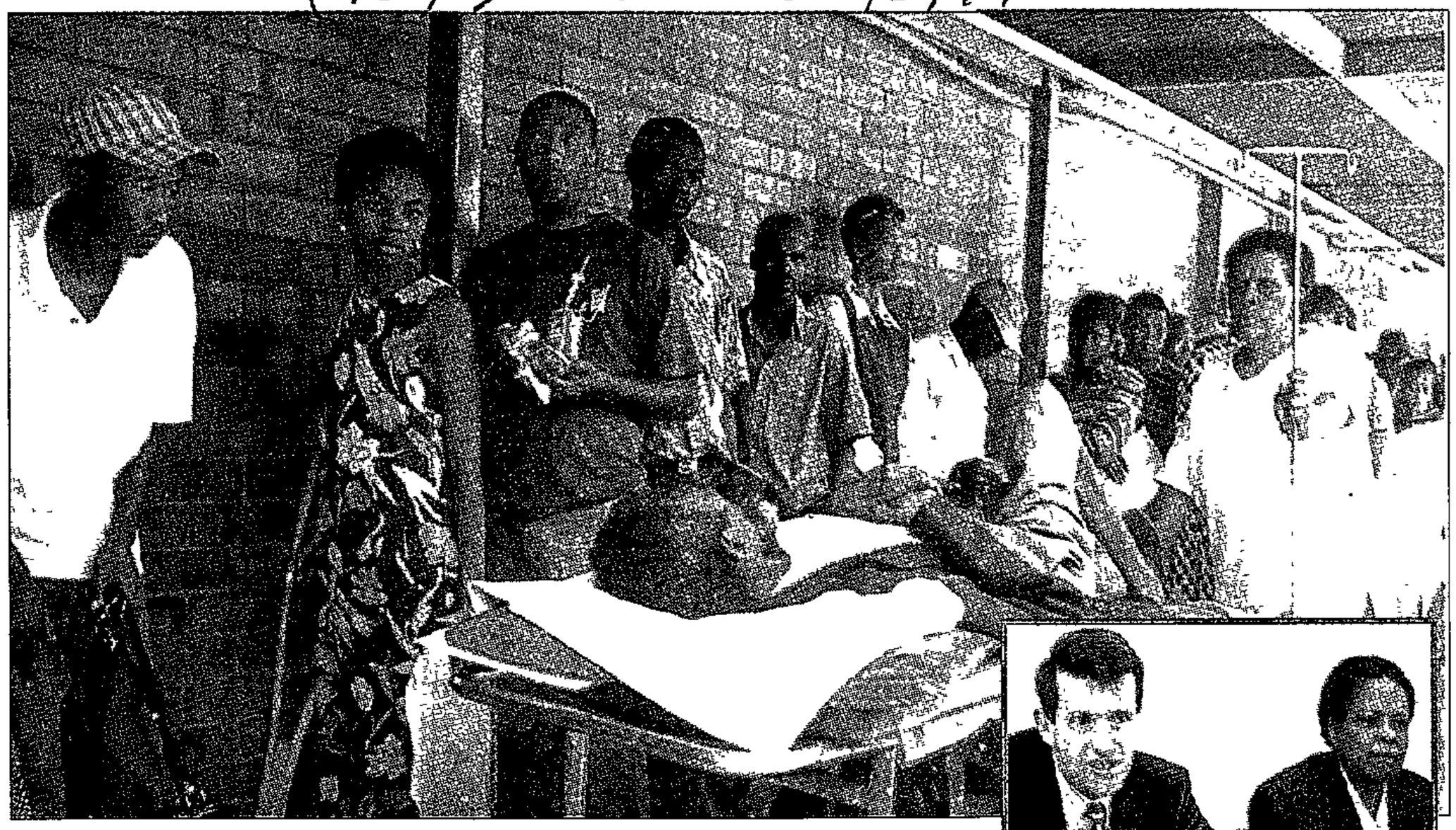
"This will precipitate a crisis in the service delivery of referral hospitals with many components of the service curtailed or closed," he said.

If no posts are filled this will result in the closure of intensive care units for children. In addition, there will be no 24-hour service, and no emergency services will be given after 10pm.

Baragwanath has a shortage of:

- 10 doctors in its paediatrics department;
- Beds in the adult section of the intensive care unit will be reduced from from 18 to eight;
- In the psychiatric department the loss of four out of 10 posts will result in the reduction of 155 beds to 115;
- Of the 3 362 posts at Baragwanath, only 1 215 are filled. The hospital needs another 160 nurses immediately to restore basic service;
- Failure to fill posts in the medical section will result in fewer patients being admitted or patients being sent to other hospitals which are already overloaded;
- In surgery only six out of more than 20 posts are filled. Further cuts will mean that patients needing emergency care will not be admitted or they will wait for hours;
- Twelve critical radiographer posts must be filled to restore even a basic service at Baragwanath. Only seven consultants fill the 20 posts. Patients with head injuries are now being transported to Natalspruit hospital for X-rays;
- Obstetrics and gynaecology departments may not be able to manage emergencies like ectopic pregnancies and incomplete abortions; and
- Trauma wards will have to be closed at certain times.

In response, Department of Health superintendent-general Dr Ralph Mgijima said the department asked the province for R300 million more than the R5,6 billion allocated.



Patients queue for medicine at the dispensary of Chris Hani Baragwanath Hospital. Often patients faint due to fatigue while others go home empty handed. Right: Representatives of the hospital, Professor John Petifor and Chief Matron Peggy Mhlambe, address the media at a press conference yesterday. PICS: PETER MOGAKI AND LEN KUMALO

'Only fittest will survive health delivery collapse'

BD 22/6/99 (98)

Stephané Bothma

HEALTH delivery at four major greater Johannesburg hospitals is on the brink of collapse and government will have to make a political decision about which services to close down, resulting in the deaths of hundreds of patients each year, says Wits University health sciences dean Max Price.

"We are talking about a process of natural selection during which only the fittest will survive," said Rhudo Mathiva, the director of adult intensive care at Chris Hani Baragwanath Hospital.

The crisis at the Chris Hani Baragwanath, Johannesburg, Coronation and Helen Joseph hospitals (serving a population of at least 10-million people) has been created by a complete moratorium on the filling of posts for many months due to budget constraints.

The medical advisory committee chairmen for the hospitals said yesterday Chris Hani Baragwanath alone had a shortage of about 2 282 staff members, including more than 100 doctors.

The situation was similar at other tertiary hospitals around the country.

Khangelani Hlongwane, a spokesman for Health Minister Manto Tshabala-Msimang, said he felt the problem could be solved if communications were directed properly. "We allocate money to the provinces and do not dictate to them how to use the money."

The doctors said a large number of posts at the hospitals would be vacated on June 30 as a result of normal rotations and contracts coming to an end. No permission had been granted for these posts to be filled.

The first closure at Chris Hani Baragwanath would be the neonatal intensive care unit consisting of 12 beds, which would affect about 500 of the 15 000 babies born at the hospital each year. "They will probably die without the respiratory assistance from the intensive care unit," said the head of child care at Chris Hani Baragwanath, John Pettifor. Twenty-four-hour paediatric emergency care would also no longer be available.

Chris Hani Baragwanath Hospital medical advisory committee chairman Ken Huddle warned yesterday that tertiary medical services in Gauteng would collapse unless vacant positions were filled without delay. Picture: ANDY KATZ

The closure of the Chris Hani Baragwanath neonatal unit will have a ripple effect, resulting in the closure of the unit at Coronation and Helen Joseph hospitals. Other services that will be negatively affected include those to accident victims, terminally ill patients, AIDS patients and cancer patients.

"We are in an era where the reality is that decisions will have to be made about who receives treatment and who gets turned away. We want guidance from government in this regard," Chris Hani Baragwanath medical advisory committee chairman Ken Huddle said.

It was unfair that the responsibility of who should live and who should die was being shifted on to individual doctors and nurses, Price said. "If the answer from the finance department is that there is no money, then government must spell out clearly to those dependent on state hospitals which services are to be cut and who is to be deprived of care. Government might wish to confirm with the public that its priorities are indeed right."

The crisis arose as government's primary health care programme was not successful, the doctors said. "Primary health care clinics are not manned by qualified staff and therefore patients stream to the tertiary institutions." Health care budgets were based on 1996 figures, which at the time were wrong, and still had not been adapted.

The doctors demanded that the moratorium be lifted, that total clinical staff be restored to October 1997 levels and that proper management structures be put in place at hospitals.

CAPE TIMES
TUESDAY, JUNE 22, 1999 ★

EMERGENCY UNITS TO CLOSE

Gauteng hospitals in trouble as services fail

ET 22/6/99 (98)

JOHANNESBURG: Critical staff shortages at Gauteng's top hospitals will see the closure of several emergency units at the end of the month. **ANSO THOM** reports.

IN an unprecedented move, top doctors at Chris Hani Baragwanath (CHB), Coronation and Helen Joseph hospitals yesterday called a press conference to speak out about the ultimate collapse of services which could lead to the death of hundreds of patients.

They painted a dire picture in which patients would be left to die or turned away because there would be no staff to treat them.

They said budget constraints on the Gauteng Health Department had resulted in an impossible situation where almost all posts in central hospitals had been frozen for many months.

A large number of posts were set to be vacated at the end of the month as a result of normal rotations and contracts coming to an end, with no permission granted for these posts to be filled.

But Dr Ralph Mgijima, Gauteng's hospitals superintendent-general, said they needed some R300 million more than the R5,68 billion allocated for this year to sustain services.

Professor John Pettifor, head of paediatrics at CHB, said they had been unable to fill any medical officer, registrar or junior consultant posts at the hospitals.

He said the freezing of 10 medical staff posts at CHB would result in the closure of the neo-natal intensive care unit and no emergency services for children between 10pm and 8am. The closure of the 12-bed neo-natal ICU would see the death of 500 babies at CHB alone, Pettifor warned.

The paediatric casualty at Johannesburg Hospital would also have to be closed at certain times after hours, with trauma casualty closed one or two nights per week.

Dr Rudo Mathivha, head of CHB's ICU, said the 2 600 beds were currently serviced by an 18-bed ICU. "This grim picture applies to all these hospitals."

Mathivha said unless more staff were appointed, they would have to cut 10 beds at CHB. "It's a simple case — don't have a car accident in Gauteng and don't get shot in Gauteng. If your child is asthmatic or has a peanut stuck in her throat, it's tickets. People are going to die."

Head of psychiatry at Wits, Dr Cliff Allward, said a mentally ill person who was suicidal and homicidal would not be admitted to the hospitals if the staff situation worsened. Joining the outcry, head of radiology at Helen Joseph, Dr Elaine Joseph, said patients at Johannesburg had to wait three weeks for a CAT scan and if the situation continued, people would have to wait three months.

She said specialised equipment at CHB broke down six months ago, leaving the hospital unable to treat gunshot wounds. "We have cried crisis for a long time and now we have reached the bottom line," she said. "We have coped and coped and coped to a point where we can no longer cope."

The chief matron at CHB, Peggy Mohlamme, said one nurse was left to look after 60 patients "who are covered in bedsores because of lack of staff".

Pharmacists also painted a grim picture of patients waiting eight hours in queues and exhausted workers dispensing medication without briefing patients.

In its response the Gauteng Health Department gave no indication on whether or not it would be able to fill the critical posts.

"When it comes to filling the mid-year rotational posts, the same constraints apply as to all other expenditure — namely, whether funds are available and whether the posts contemplated are a top priority in terms of maintaining services," said Mgijima.

He said provincial executives were working closely with hospital superintendents to find ways to ensure that the most critical of these posts were actually filled.

Khangelani Hlongwane, spokesperson for Health Minister Manto Tshabalala-Msimang, said he was unable to call the minister from a cabinet *bosberaad* for comment. "We appreciate the seriousness of the complaints they have tabulated and I am sure the minister will comment at the appropriate time," he said.

The hospitals serve about 10 million people from all over Gauteng, as well as referrals from other provinces.

having writ

CAPE ARGUS, **WEDNESDAY**, JUNE 23, 1999

City hospital chiefs fight to avert cuts in services

(98 ARG 23/6/99

'We are stretched to limit'

DI CAELERS
HEALTH WRITER

Western Cape hospital heads have warned that services are stretched to the limit and close to breaking-point.

But there are no immediate plants to cut hospital services in the province.

The provincial health service has lost 8 000 staff through cutbacks in the past three years and budget constraints leave nothing for new appointments, nor much room for movement when making decisions.

This has emerged after news from Gauteng that health delivery at four big Johannesburg hospitals is on the brink of collapse.

University of the Witwatersrand health sciences dean Max Price has said the Government will have to make a political decision about which services to close.

Tom Sutcliffe, superintendent-general of health and social services in the Western Cape, said health services in the province had been scaled down for the past three years, resulting in services that were stretched to the limit and close to breaking-point.

"Fortunately we have now reached ... greater financial stability and do not see any large cutbacks, but rather internal readjustments."

He said there were "no negotiables in the health department. Money is limited and does not allow any space to debate anything at all".

There were at present 24 480 staff in the health service and no new staff would be added.

Malitha Ramiah, senior medical superintendent at Red Cross Children's Hospital, said the institution lived "from day to day".

Attrition of nursing staff levels meant they often had to call in agency nurses to help them cope.

"If it continues like this, we may have to cut services," she said.

Revere Thomson, Tygerberg Hospital's chief medical superintendent, agreed, saying hospital administrators considered almost every day which services could, or could not, continue operating.

Meanwhile, vital equipment was ageing and becoming hard to repair. Budget constraints meant no new equipment could be bought.

"We are running close to the bone. We may not be in same position as Gauteng, but we are not far from it. We are constantly looking for more corners to cut without compromising the safety of patients."

On the hospitals' budget for the year, Dr Thomson said almost every department had reported it could not survive on the amount allocated.

Groote Schuur lost about 200 nurses last year, said senior medical superintendent Dennis Adams. A few were replaced, but wards had had to be closed and operations rescheduled.

Although the budget had been cut by 4% this year, forward planning aimed to keep costs within budget.

Bara's budget blues

Hospital authorities discuss current financial crisis

Sowetan 23/6/99

By Bhungani Mzolo
Health Reporter

CHRIS Hani Baragwanath Hospital senior superintendents yesterday held a day-long meeting to look into the hospital's budget, the institution's spokeswoman, Mrs Esther Vorster, said yesterday.

The meeting follows startling revelations yesterday by heads of government-appointed medical advisory committees of Baragwanath, Helen Joseph, Johannesburg and Coronationville hospitals that they were near collapse as a result of posts being frozen and inadequate funding.

Dr Ralph Mgijima, superintendent-general for the Health Department said while it recognised budget pressures for the hospital, "its top management has an absolute responsibility to manage available resources for the best possible returns in terms of patient care".

But according to Professor Ken Huddle, chairman of the medical advisory committee at Baragwanath, the impact of the failure to fill the posts would have meant that 12 clinics in and around Soweto would not have been able to refer critically ill patients to the hospital.

"This means that clinics would be banking up patients who should be seen at the hospital, but who would be refused entry because of shortage of staff," he said.

Alternative employment

Huddle said many of the specialist doctors were already making arrangements for alternative employment as most of their contracts ended this month.

"They have bills to pay and they cannot wait any longer without knowing whether their contracts will be renewed or not," Huddle said.

Senior superintendent at Baragwanath, Dr Bernice Peltz, said she has to double up as a doctor in the theatre. "I should have been at that media conference, for instance, but I couldn't as at the time I was in the theatre."

Huddle also warned that health services that took decades to build could be destroyed in months.

"If tertiary hospitals crumble, the whole system will collapse, with hospitals being able to treat only colds and flu," he said.

Professor Keith Bolton, chairman of the medical advisory committees for Coronation and Helen Joseph hospitals, said if Baragwanath were to close, there would be no way that other hospitals would cope.

"We will have to close in sympathy with Baragwanath."

Mgijima said the budget for Baragwanath was increased by 12 percent to R632 million this year, Helen Joseph up by 18 percent to R615 million and Johannesburg General by 34 percent to R165,5 million.

"Over the past few weeks, the superintendents of all three hospitals have been examining ways to prioritise funds within their hospital budgets to cover their most critical staffing requirements without overspending," Mgijima said.

Jo'burg hospitals play the waiting game

BD 23/6/99 (98)

Top doctor says they need an extra $300m, writes **Stephané Bothma**

One-week-old baby Lucy Dose became one of thousands of patients to be affected after the health department imposed a process of complete moratorium on the filling of posts in four major Gauteng hospitals this week. Her mother, Gladys, looks on while Chris Hani Baragwanath staff members attend to her. The hospital has a staff shortage of 2 282 and 100 doctors.
Picture. ANDY KATZ

ROBBING Peter to pay Paul would be the name of the game for the superintendents of Greater Johannesburg's four academic hospitals if critical posts were to be filled to ensure the continuation of some emergency units beyond the end of the month.

A grim picture was painted this week by the top medical staff of the Chris Hani Baragwanath, Coronation, Helen Joseph and Johannesburg hospitals of a virtual collapse of some vital health services in seven days' time is money was not be made available to fill hundreds of vacant positions.

Despite predictions that hundreds of people, including many babies, would die if extra money was not made available, the Gauteng health department remained adamant yesterday. Provincial health spokesman Jo-Ann Collinge said: "The hospitals will not be absolved from balancing their books.

"We have been working around the clock with superintendents of the hospitals to find savings to free up money (from other areas) to appoint staff in the units experiencing the most critical shortages."

However, doctors say using money meant for buying and maintaining hospital equipment to pay salary bills has been going on for a long time. This has resulted in another problem — no working equipment.

Johannesburg Hospital radiology unit chief Elaine Joseph said: "If you get shot in Soweto, don't bother to come to Chris Hani Baragwanath. The equipment needed to establish internal bleeding has not been working for months, resulting in patients having to be taken to Natalspruit Hospital on the East Rand for radiology services, then brought back to Bara for an operation." Based on information given by doctors about the dire situation at the hospitals, it becomes clear that most departments have reached a critical stage, with no room left for cutting expenses.

In addition to life-saving services like casualty and intensive care units facing closure, allied medical disciplines such as occupational therapy, physiotherapy and speech therapy are short of about 30 staff members at Chris Hani Baragwanath.

A shortage of staff has resulted in patients sometimes having to wait for eight hours for medication at the hospital's pharmacy.

With only 1 215 of the 3 362 general nursing posts filled, it often happens that a single nurse, working a 12-hour shift, is responsible for between 40 and 60 patients.

"The shortage of 5 medical officers in the intensive care unit will result in the closure of 10 of the 18 ICU beds at Chris Hani Baragwanath. This will leave eight beds to support a hospital of 2 600 beds and outside referrals. Full 24-hour cover by doctors will not be possible," medical staff said about the situation.

Under these conditions it seems unlikely that money will be found somewhere in the budgets already allocated to the hospitals, especially not the R300m that is needed said Gauteng hospitals superintendent-general Ralph Mgijima.

He said that to sustain services, hospitals in the province would need R300m more than the R5,68bn allocated for this year.

Collinge believes the budget crisis will not reach a point where vital units will be closed.

"This is an absolute priority, and every vacant post will be assessed in terms of gaps in service delivery.

"It is a real question of finding money in very tight places," she said.

Filling the posts would, as far as realistically possible, be the department's priority, she said.

The Democratic Party's spokesman on health for Gauteng, Jack Bloom, said the crisis could be avoided by outsourcing noncore functions such as catering and laundries, which would free up funds for the key priority of service delivery.

"Our public hospitals desperately need the efficiencies of the private sector which can be achieved through productive private-public partnerships," Bloom said.

He said it was unacceptable that trade union resistance had delayed for 18 months a tender for a study into outsourcing the seven laundries.

He said Gauteng premier Mbhazima Shilowa should personally intervene in the crisis by using his negotiating skills to persuade trade unions to co-operate in forging partnerships with the private sector for the good of the patients, who were the prime sufferers in the situation.

CAPE TIMES
WEDNESDAY, JUNE 23, 1998 ★

'YOU ARE WATCHING THEM DIE'

Staff cuts may close hospital baby units (98)

CT 22/6/99

JOHANNESBURG: Staff cuts and tight budgets may mean that those left dish out death sentences rather than save lives. **ANSO THOM and THEMBA SEPOTOKELE** report.

BABY X, just 10 days old, lies in a hospital bed, hooked to a ventilator, fighting for her life ... and she's lucky.

If she had been born two weeks later, Bed 12 would be empty, the ventilators switched off and Baby X would have died. For unless the state can find the money to replace junior doctors, registrars and medical officers leaving the unit at the end of the month, the neo-natal intensive care unit at Chris Hani Baragwanath Hospital (CBH) will close.

This will mean a death sentence for about 500 babies born in the Soweto hospital every year.

According to neo-natologist Dr Mantoa Mokhachane, Baby X would have had no chance of survival had she not been ventilated.

"When we take one baby off the ventilator, it doesn't mean we have won the battle because we have to take them off prematurely to make space for other babies. But she has a fighting chance."

Mokhachane said it was "demoralising, painful and terrible" to have to tell parents that there was no bed venitlator for their baby and that he or she would probably die.

Professor John Pettifor, head of paediatrics at CHB, said the freezing of 10 medical posts at the hospital would result in the closure of the neo-natal intensive care unit and no emergency services for children between 10pm and 8am.

Mokhachane said staff had to rely on old equipment to alert them to any problems with the tiny patients. "They can't watch them all the time as they should. There is one nurse to four babies.

"You feel helpless because in many cases you are watching them die," she said.

Top doctors at Johannesburg, CBH, Coronation and Helen Joseph hospitals warned on Monday that critical staff shortages at these tertiary hospitals would see the closure of several emergency units at the end of the month and the ultimate collapse of services.

The Gauteng Health Department yesterday said there was no need to panic, as medical superintendents in the affected hospitals were examining ways to re-allocate funds to cover critical staffing requirements.

Departmental spokesperson Jo-Anne Collinge said: "Despite a widespread perception of budget cut-backs, the budgets of all four hospitals have been substantially increased in this financial year."

FAILURE TO COMMUNICATE

A sickness in health care

CT 23/6/99 (98)

RESEARCH AT hospitals and clinics in the Western Cape shows that misunderstanding and miscommunication between doctors and their patients leads to an alarming waste of resources. Health Writer **JUDITH SOAL** reports.

THE old man walked out of Groote Schuur Hospital, carrying his patient file. He looked around for a while, seemingly undecided about what to do next, then went to the middle of the road and started walking along the white line.

When asked what he was doing, the man said his doctor had told him to follow the white line to collect his medication. Obviously the doctor hadn't explained that he meant the passage marked by a white line inside the hospital.

"This is just one example. There are so many examples, so many stories we have seen of how a lack of understanding gets in the way of health care," said the National Language Project's Yvonne Daki.

The NLP commissioned a qualitative study of health services in the Western Cape and found that resources were wasted because of communication failures.

"(Clinics) frequently see the same children with the same complaints back again a few months later (because) the mother had not understood and no change had taken place in their behaviour," said researcher Athalie Crawford.

The research report quoted the frustrations of primary health care doctors. "One of the big problems is non-compliance. If you could really explain it to a patient it would take away the cost of maybe R10 000 worth of treatment or save you an operation."

In response to this research the NLP started a project to train interpreters for the health sector. Twenty-two interpreters have been trained so far and many are now working in hospitals and clinics around the country.

"But it is just a drop in the ocean," Daki, who co-ordinates the project, said at a two-day conference on health communication yesterday.

Another speaker at the conference, Red Cross Children's Hospital Professor Dave Power, asked the audience to imagine trying to treat a patient without being able to communicate.

"Imagine that you are a doctor examining a baby and you can see all the tell-tale signs of HIV. Imagine trying to explain to the mother that you are worried the child may have a fatal illness; that she herself may have a fatal illness and that her partner may have a fatal illness. This is an almost impossible task unless you are very fluent in the mother's language and have a good understanding of the family. It is a very difficult conversation to have."

Power said a third of the 150 000 children seen as outpatients at Red Cross every year were Xhosa-speaking.

"Only a small percentage of these have a command of English. Yet very few doctors speak Xhosa and a few more but not that many nurses can speak it."

Power said interpreters trained by the National Language Project were invaluable.

"These interpreters have some medical training, they are culturally aware and sensitive and they can translate," said Power. "We can't imagine going back to the days without them."

But of course there is the question of funding.

"We have received overseas money for some years," he said. "We have been lucky now that we are able to arrange for long-term funding, but unfortunately it is true that at most hospitals and clinics there are no interpreters."

Idasa's Rhoda Kadalie said savings on crucial services like communication were a false economy and called on the government to provide funding for health interpreters.

"Failure to communicate effectively can lead to misdiagnosis, treatment failure and prevention failure. There is research to show this. I believe the costs of these failures need to be assessed by the government."

She said the constitution guaranteed South Africans access to health care, with the caveat that this be limited by "available resources".

"Now there is an argument that it is too costly to implement human rights. I argue that it is too costly not to," said Kadalie.

CAPE TIMES
THURSDAY, JUNE 24, 1999

PROVINCIAL CRISIS OVER

W Cape health system 'stable if not excellent'

(98) CT 24/6/99

WESTERN CAPE health services have lost a quarter of their staff and see 20% more patients than four years ago, yet they have managed to avert the crisis facing Gauteng hospitals. Health Writer **JUDITH SOAL** finds out how.

HEALTH services in the Western Cape are in a stable if not excellent condition, the provincial health department said yesterday.

Hospitals around the country have come under the spotlight this week after Gauteng medical professors announced that recent job losses and the freezing of additional posts from July 1 mean that essential services will face collapse. They warned that up to 500 babies would die annually because Chris Hani-Baragwanath Hospital would be forced to close its neo-natal intensive care unit and restrict its other services to children.

But in the Western Cape the worst of the crisis was felt more than a year ago and the staffing situation has since stabilised.

"There have been major cuts," said Fareed Abdullah, acting deputy director-general of health in the province. "Over the past four years we have lost 25% of staff, including 3 500 nurses, and closed 3 000 beds. Yet we are seeing 1,5 million more patients than four years ago — a 20% increase."

Asked how the province has managed to avoid the "utter collapse" that Gauteng hospitals are said to face, he replied: "We have shifted resources and patients from the academic hospitals to the primary care services. We drew up a provincial health plan four years ago and we've stuck to that."

The plan was conceived under former Health MEC Ebrahim Rasool, now provincial leader of the ANC, and survived the transition to his successor, the NNP's Peter Marais. The plan is based on the premise that it is cheaper to treat most patients at day hospitals and clinics and to refer only those requiring special attention to academic hospitals, which are more expensive to run.

Over the past four years, in accordance with this plan:

● 700 000 out-patients have been shifted from academic hospitals to primary services.

● The number of patients attending community health services has increased by a third.

● 400 000 more patients are attending local authority clinics.

● The percentage of casualty patients seen at academic hospitals is down from 40% to14%.

● Patient admissions at academic hospitals have dropped from 38% of the total number of admissions to 30%.

Of course, not everyone is happy with the changes. The medical superintendent of Tygerberg Hospital was reported to have said yesterday that his hospital faces a similar crisis to those in Gauteng — even though no staff cuts are imminent. Groote Schuur and Red Cross Children's hospitals say they are extremely stretched but still functioning.

Abdullah knows all is not well in the health system. Staff are frustrated by budget constraints and patients unhappy with long queues. "I'm not saying we are providing excellent services by any means, but we don't have to manage a R400m shortfall like Gauteng," he said.

● See Page 15

Critical hospital positions will be filled,

BD 24/6/99 (98)

Stephané Bothma

Health minister says all provincial health departments are struggling with their budgets

ALL critical positions vacant from July 1 at greater Johannesburg's four academic hospitals would be filled, Gauteng health MEC Gwen Ramokgopa said yesterday.

Health Minister Manto Tshabalala-Msimang said appropriate measures were being taken to ensure that all important services, including emergency and intensive care, would be effectively maintained throughout the year.

"If need be, I will have to redeploy personnel from other areas so that these critical services are staffed," Ramokgopa said after doctors at the Chris Hani Baragwanath, Coronation, Helen Joseph and Johannesburg hospitals this week warned that unless the moratorium on employing medical staff was lifted, some essential units would have to close, resulting in the deaths of hundreds of patients each year.

The chairmen of the medical advisory committees at the hospitals said all posts had been frozen for many months and the situation would become critical on June 30 when a large number of post would be vacated as a result of normal rotations and contracts coming to an end.

Ramokgopa said yesterday she would not allow the health services in central Johannesburg hospitals to collapse, as hospital staff feared.

"The premier and I have been fully briefed by the top management of my department, and we are satisfied with the steps that have been taken by the department to address the situation."

Should the measures taken prove to be inadequate, Ramokgopa said she would not hesitate to approach the provincial treasury and the national health ministry for assistance.

Tshabalala-Msimang said all provincial health departments were struggling with limited budgets, to expand access and to improve service for millions who had poor or no services in the past.

"All categories of staff, all departments and all hospitals are faced with similar problems of learning to live within budget," she said.

Imploring all health workers to adopt a constructive approach, Tshabalala-Msimang said it was "certainly not in the interest of the public for us to exaggerate and be sensational" about whatever problems may exist.

While Pretoria's three large state hospitals also expressed concern yesterday about professional staff shortages, the picture they painted was not as grim as that of the central Johannesburg hospitals.

However, there were fears that staff might start quitting in droves due to an extra heavy workload resulting from frozen posts and limited budgets.

Garankuwa hospital needed 105 additional staff, including heads of departments, specialists and nurses, hospital superintendent Reg Broekman said.

He also expressed concern about his hospital's intensive care unit, which has only one doctor instead of the required five.

Pretoria Academic has 422 doctors' posts, of which 48 are vacant. Of the 48 frozen posts, 31 are for specialists and eight for heads of departments. The other posts are for doctors and registrars.

According to Pretoria Academic chief superintendent Zola Njongwe, of the 1 565 nursing posts, 419 were vacant.

Njongwe said the hospital was running on a budget of R473m while its projected spending was R498m.

Kalafong Hospital had 2 500 posts of which 400 were frozen, which had already resulted in the phasing out of 100 beds and the reduction of the capacity of some units.

says MEC

Health boss shrugs off Gauteng's hospital crisis

Sowetan 25/6/99 (98)

By Malcolm Ray
Political Reporter

AN air of optimism characterised a high-profile meeting of government health officials and senior members of the public health fraternity yesterday in an attempt to avoid a crisis in healthcare delivery in Gauteng.

Describing the meeting as "conciliatory", Gauteng health officials moved swiftly to play down fears of an impending crisis in four of Johannesburg's major academic hospitals.

The superintendent-general for the health department, Dr Ralph Mgijima, shrugged off speculation by medical academics this week of a possible paralysis in life-preserving neo-natal and paediatric services that could follow cutbacks in the funding of rotational medical posts when they are vacated at the end of this month.

He said the situation at the Johannesburg General, Chris Hani-Baragwanath and Helen Joseph hospitals did not constitute a "sudden crisis in the healthcare system that emerged out of the blue".

Mgijima was emphatic that the mass hysteria whipped up by ongoing media reports this week displayed a "total ignorance of the bigger picture".

"The rationalisation of resources in state-run hospitals must be seen in the context of the transformation of the healthcare system as a whole," Mgijima said.

He said attempts to eradicate the legacy of skewed resource allocation had to be borne in mind when considering budget constraints and consequent cutbacks in the allocation of funds to academic hospitals.

"In the current context, the financial net has been cast over a wider spread of people, including free healthcare for infants," he said.

Mgijima pointed to the reprioritisation of resources from academic hospitals which enjoyed "special attention" under apartheid to primary healthcare clinics and rural outreach satellite projects in black communities.

He conceded that healthcare delivery has proceeded slower than planned or desired by government.

But this, he said, "reflects some of the historical legacy and legitimate problems associated with fundamental socio-economic changes".

Regarding allegations by medical academics that the province had undermined its objectives by allocating a paltry budget to health, Mgijima said both allocation and expenditure patterns in the last two budgets were comparable with other middle-income developing countries in the world and should not be used as an excuse by health specialists to shy away from the real problem.

"What we are faced with is a cultural legacy of extravagant spending on expensive drugs and an incredible waste of precious human and capital resources at local level," Mgijima said.

Professor John Pettifor, head of paediatrics at Chris Hani-Baragwanath hospital, said he had no problem with the health budget per se.

"The dispute revolves around the power and authority of medical professionals to decide who is retrenched and who is employed," Pettifor said.

● See page 11

Referrals anger N West patients

(98)

Sowetan 25/6/99

By McKeed Kotlolo

GARANKUWA residents in North West, just a stone's throw from Garankuwa Hospital, north of Pretoria, are up in arms about hospital authorities who refer them to Odi Hospital for treatment.

A number of patients who were either refused treatment or referred to the tiny Odi Hospital near Mabopane have called on the Government to incorporate the two hospitals into North West because Garankuwa is closer to North West townships than any of the Gauteng areas.

They claim that they never had problems in the past and blamed the authorities for referring them to the small Odi Hospital which, in most cases, had no drugs. Attempts to contact Odi Hospital authorities for comment were unsuccessful.

Residents interviewed claimed to have files at Garankuwa Hospital.

Mr John Shilowa (79), of Winterveldt, told *Sowetan* at Garankuwa Hospital yesterday that he used to receive his treatment there. "Now I am waiting for a referral letter to Odi Hospital for the treatment of my continuously aching shoulder."

Medical superintendent at Garankuwa Hospital Dr Thuli Ntuli denied that patients from North West were being refused treatment and explained that referrals and emergency cases were treated.

Ntuli said Government policy was that provinces without the essential facilities should refer their patients to those provinces with the necessary equipment and services. "That is why the Northern Province, Mpumalanga and North West refer their patients here," she said.

Ntuli pointed out that "this should only be done through proper channels because the province with facilities would have to bill the province that referred patients for treatment".

She said, however, that "very ill patients and emergency cases are treated without referral or being asked where they come from".

Patients can only be referred to hospitals in their area after treatment when they are out of danger, said Ntuli.

She confirmed that people feeling the pinch were those in Mabopane, Garankuwa and neighbouring villages and townships.

Nursing the system back to health

By Malcolm Ray
Political Reporter (98) (85)

MOUNTING speculation this week of a crisis hovering over Gauteng's beleaguered healthcare system is ominous It throws into sharp focus he chasm between the long-term vision of an ffordable and efficient system and the immediate mpact of structural reforms on spheres that occuied pride of place under the old administration.

The issue: Operational budget constraints in our state-run academic hospitals in Gauteng have ed to a moratorium on the re-employment of proessionals once rotational posts become vacant.

This in turn has resulted in severe staff shortges. Essential life-preserving units are teetering n the brink of closure and patients are threatened vith insecurity.

The question: Does the current state of affairs onstitute a crisis?

The context is transformative. It throws up one f the unfortunate and little understood consequences of social transformation – change does ot proceed painlessly.

The problem is historical. Bedevilling the ealthcare system in Gauteng is a structural crisis f redistribution – overhauling the old racially kewed model and grafting something acceptable rom a human point of view remains an unreolved challenge.

In 1994 the Department of Health inherited a ighly fragmented and bureaucratic system that rovided healthcare on a racially and geographially dispersed basis.

The impact of the old system on low-income lack communities with marginal access to overtretched public hospitals is well-known. esource allocation was based on a racially segreated model in which tertiary medical institutions onopolised the dispensation of healthcare to ommunities.

The lion's share was concentrated in exclusive hite hospitals servicing a privileged elite. Very ttle attention was paid to the extension of health rvices to the poor

Thus expenditure on tertiary services was disroportionate relative to primary services on hich marginalised black communities were pendent.

By 1995 the Department of Health, headed by Nkosazana Dlamini-Zuma, moved quickly to velop a coherent national approach to restruce the system consistent with the redistribution iorities of the Government

An emerging consensus, in the words of the overnment white paper on the transformation of e health sector, was that the focus should be on e "appropriate mix of public and private serces , and how to move to greater equity".

However, although the new policy focused on e expansion of free or affordable primary healthcare facilities, the thorny issue remained the funding of the redistributive imperatives in a context where the Government's macroeconomic policy was cemented in a philosophy of fiscal austerity in the public sector

Further, the bloated budgetary burden of servicing accumulated debt limited spending on social sector services like health and was arguably the catalyst in 1996 for a deficit-reduction macroeconomic strategy

In short, the vision of a restructured healthcare system based on the principle of social equity could not match the demand for affordable and accessible healthcare on the ground

Initial initiatives to reform the system nevertheless achieved varied levels of success since 1994. These include

- The rationalisation of 14 departments into one national department and nine provincial departments, together with a devolution of responsibility to provincial government. More pertinently, provinces are primarily responsible for delivery in the health social expenditure category.
- A significant shift of resources from tertiary to primary services, allowing for more clinic visits per person per year than under the previous system
- The construction of 393 new primary healthcare clinics and 152 clinics extended by December 1997.
- Progress in establishing a district health system, including the demarcation of districts in the provinces

There were clear limits to the degree of change envisaged. The introduction of the medium term expenditure framework by the Department of Finance, modelled on the notion of "roll-over budgeting", was a clear acknowledgement that social transformation objectives would have to be aligned to what was realisable.

By linking spending to service delivery, the Government aimed to contribute to more effective use of public money.

It was unlikely, the argument went, that additional funds for social expenditure would be sourced from the national budget The fortunes of health were integrally woven into this state of affairs. Despite new and innovative budgeting procedures that devolved power to the provinces based on a "block grant" from central government, formidable financial obstacles remain

In the case of Gauteng, a 7,6 percent increase in the provincial allocation to health this year was reduced by a 2,6 percent roll-over deficit last year, thus disabling medical institutions from breaking out of the financial impasse. And this, in part, accounts for the moratorium on employment and this week's chaos.

The question is whether a budgetary allocation outside the constraints imposed by a deficit management approach to expenditure would have led to a desirable outcome.

Health researcher Warren Karfchik makes the point that South Africa's expenditure on health is as high as its equivalents in most middle-income developing countries.

Karfchik suggests that the financial malaise of local medical institutions in Gauteng has less to do with the amount allocated (which has increased in real terms) than the management of resources at institutional level.

For Karfchik, the devil is in "management of existing expenditure", which is proving a harder challenge than developing a new expenditure framework.

"In the context of fiscal discipline," he argues, "the reality is that only through greater efficiency and effectiveness of expenditure will the provincial health department be able to deliver its objectives and maintain a macroeconomic balance."

This is indeed the core issue. And its resolution requires that power and authority to reorganise staffing levels is pitched at institutional level. It is a clamour from medical professionals this week that dovetails with the provincial government's vision.

The Gauteng health department has already introduced a "decentralisation strategy" and several cost-saving measures to boost revenue at this crucial level.

According to a recent project plan by the department, the overall objective is to: "Facilitate the decentralisation of public health service management in selected hospitals and districts in order to create a provincial network of dynamic, efficient, responsive and accountable hospitals and district health services for the delivery of good quality and accessible services."

The proposal is worthy. Unfortunately, Karfchik maintains, insufficient attention has been paid to sequencing and managing the introduction of the new system, which has meant that the process has been accompanied by enormous political and administrative difficulties that continue to impede delivery.

Reprioritisation, the elimination of bureaucratic waste and a sufficiently pro-poor approach to budgeting are lost on badly coordinated operational budgets where "far too much still goes towards recurrent costs," according to provincial health superintendent-general Dr Ralph Mgijima

Be that as it may, recent initiatives indicate that the Government is concerned enough. The policy framework is in place.

Success in this vital sector requires a sense of urgency to implement existing policy

Patients queue at the dispensary of the Chris Hani Baragwanath Hospital for medicine every day. Some faint in the queue, while others leave empty handed.

PIC: LEN KUMALO

Saweton 25/6/99

'Health crisis in all provinces'

By Bhunganl Mzolo
Health Reporter

THE crisis at Johannesburg's major hospitals affected all provinces, the National Education Health and Allied Workers Union (Nehawu) said yesterday.

The union was responding to a warning made earlier this week by doctors at Chris Hani Baragwanath, Helen Joseph, Coronationville and Johannesburg General hospitals that unless certain posts were unfrozen, hospitals would be forced to close.

Nehawu general secretary Mr Fikile Majola said while appreciating the media exposure of the situation in Gauteng hospitals, "we believe that the alarmist approach causing public panic by a group of doctors in positions of power will not solve the problem".

Majola said the union called on the doctors to collaborate with relevant authorities and be part of the solution

The union said it welcomed the move to unfreeze the posts, but said it called on the Government "to release all essential frozen posts even before finalising the new plans".

Nehawu said it rejected the suggestion by the Democratic Party to privatise certain sections of the health services in order to employ more doctors. (98)

Nehawu said the solution to the problem required constructive engagement by all the stakeholders through participation in the process of transforming public hospitals into people's institutions that cared for patients and inspired confidence in workers.

Saweton 25/6/99

CP 27/6/99

Hospital without water for two days

(98)

By MALOSE MONAMA

THERE was near-commotion at the Jubilee Community Hospital in Hammanskraal this past weekend when patients went up to two days without bathing because of a lack of water.

The hospital was hard hit, especially the theatre and the maternity ward where sterilised water and drips (normal celine) had to be used to wash the hands of doctors and nursing staff following involved and messy procedures.

The lack of water was reportedly caused by a burst pipe which took the water authorities days to fix.

The hospital was without water from Friday to Sunday.

The water shortage was not restricted to the hospital – the whole community of Temba township was adversely affected.

Hospital patients were understanding for the first two days but became agitated when it took long for the authorities to repair the damaged pipe.

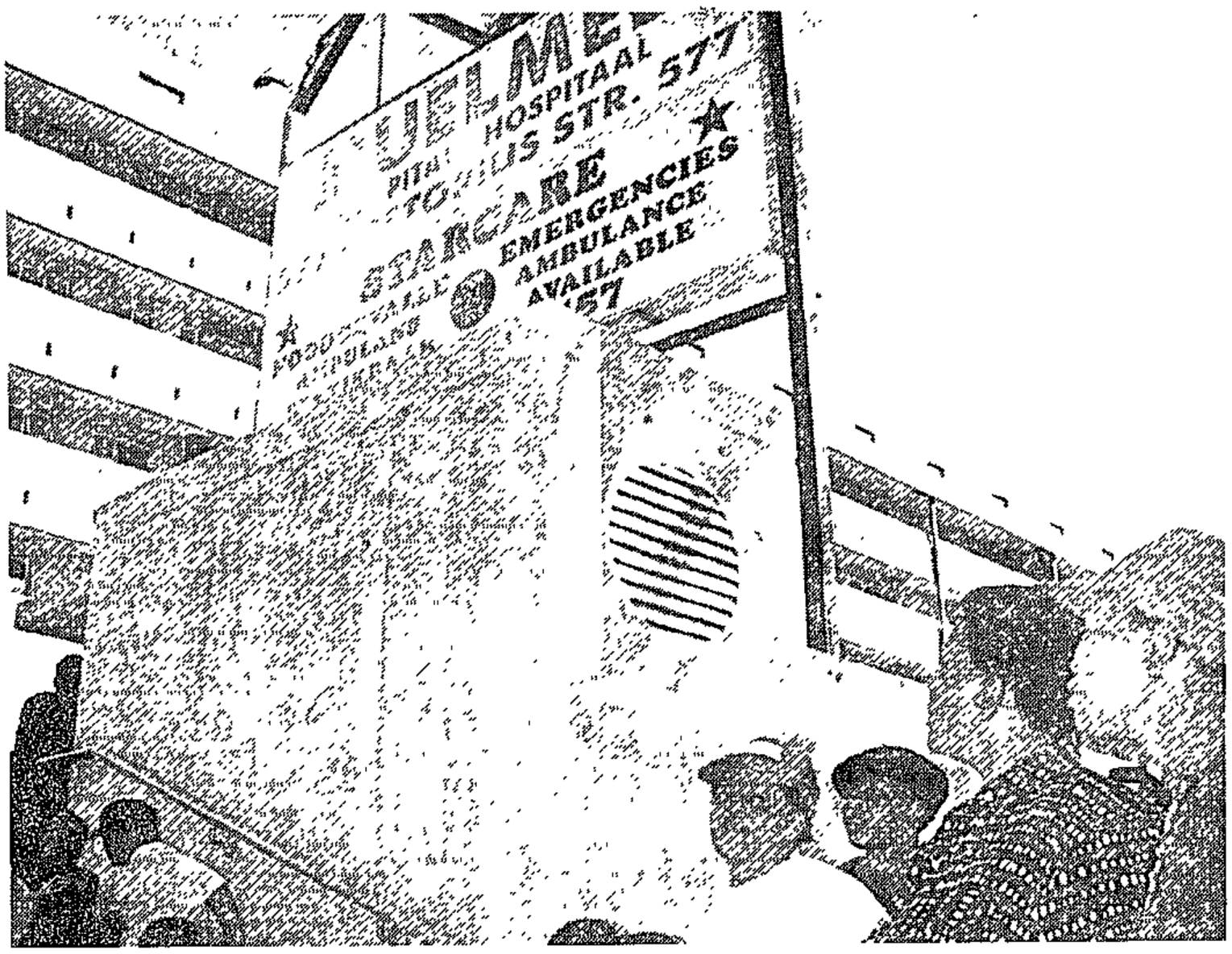
Angry patients had to be restrained, and calmed down by nursing staff, who brought whatever water they could from their own homes.

Local government authorities brought in two truckloads of water to the hospital to quell what was turning into a volatile situation.

Jubilee Hospital superintendent Dr Nadackel Sebastian said they had been seriously inconvenienced but he was happy that the water supply had been restored.

Sebastian said there had been delays in providing meals to patients, but nothing serious had been reported.

"There were no deaths and we did not have to transfer patients because of the problem," he said.



DON'T GIVE IN . . . Give us two hundred rands or we are not going back to work, workers outside Muelmed Hospital threatened management this week *Picture: Sipho Maluka*

Hospital cleaning, catering staff holding out for R200 raise

CP 27/6/99

(98)

By MAPULA SIBANDA

WORKERS this week vowed they would do everything in their power to drive three private hospitals in Pretoria to a virtual standstill. Members of the National Union of Hotels, Restaurants and Catering for Commercial and Health Workers Union (NUHRCCHAW) who have been on strike for three weeks said they would not go back to work until their demand of a R200 raise is met.

Blowing whistles and drums, the workers said they would disturb patients and doctors until their demands were met.

Management has so far agreed to give them R105, which they have since rejected.

The cleaning and catering services of the three hospitals, Muelmed, Heart Hospital and Astrid, continue to be affected as the more than 90 members refuse to return to work.

(98) cp 27/6/99

Helen Joseph Hospital pillaged – claim

By MALOSE MONAMA

AMBULANCES, which as a rule are not subjected to random security searches are allegedly used to smuggle out medicine, surgical equipment and other valuables looted from the impoverished Helen Joseph Hospital in Auckland Park, Johannesburg.

This startling revelation was made to City Press by the hospital's staff members who could "no longer stand aside and watch" public property plundered.

The thieving at the hospital has reportedly reached such alarming proportions that if you are a hospital employee and have the right connections, you can buy your monthly supply of either chicken or beef from the hospital kitchens for a 'nominal' fee.

The pillaging is allegedly not restricted to any particular department. According to City Press sources, brand new linen (sheets and blankets) has gone missing from the laundry while very little of the groceries meant for patients actually reach them.

Our sources, who asked not to be named for fear of victimisation said because of the looting certain important medical procedures could no longer be performed at the hospital as the relevant equipment had been stolen.

The medicine that disappears from the hospital pharmacy according to our informants, is mostly that which is expensive like Losec, Rocephine and Augmentin, which are administered in the form of an injection.

Written consent is required from the hospital registrar before these medicines are dispensed of, City Press has reliably learnt. The registrar is normally a senior specialist doctor.

Our sources say while the hospital's records would indicate that these medicines had been ordered and delivered, most of it however cannot be accounted for.

"There is a need for Judge Willem Heath. Only a judicial inquiry can expose graft that goes on here," said our informant.

The alleged plundering has, according to our sources been reported to the hospital authorities who have done nothing to curb it. "The matter was also reported to the trade union."

Attempts to get comment from the hospital authorities proved futile. Messages left for hospital superintendent a Dr Manning and secretary had not been returned at the time of going to print.

KZN hospitals receive a reprieve

(98) CP 27/6/99

By ZAKHELE SHIBA

In the wake of media reports this week of the imminent collapse of services at some Johannesburg hospitals, City Press takes a look at the state of health care in other provinces

KWAZULU-NATAL'S major hospitals received a reprieve when the health ministry said it would not freeze any posts. But the health department continues to suffer a brain-drain as disgruntled nurses and other health workers leave for greener pastures.

The health department, led by health MEC Zweli Mkhize, has admitted it is experiencing a problem with the exodus of nurses for greener pastures in the Middle East and the United Kingdom.

Nurses in the province are not prepared to work in rural areas. Those still working at Prince Mshiyeni Memorial Hospital in Umlazi township want a reason to leave the controversial hospital, City Press found this week.

Patients lead a dog's life at the hospital. They bring their own blankets when they are admitted, owing to the shortage of blankets and linen, National Education Health and Allied Workers Union (Nehawu) provincial chairperson Sidumo Dlamini said.

The hospital, which serves thousands of township residents, is dubbed *KwaMshiy'azafe*, which literally means "leave them to die".

Unverified reports claim that some people have died while waiting in queues to be treated.

Hospital superintendent Dr Robert du Pont did not respond this week to a list of questions faxed to him by City Press about conditions at the hospital.

Nehawu's Dlamini, a male nurse and shop steward at the hospital, said there were countless problems at Prince Mshiyeni Memorial Hospital, but added that these could be solved.

"Nurses are disgruntled because they are overworked. They do not get normal days off and are not consulted by management when work schedules are changed. That is why they are leaving for greener pastures," said Dlamini.

Nehawu provincial secretary Bheki Mtolo said some nurses have left for countries like Saudi Arabia and the UK.

"This is a national problem. Nurses leave for overseas countries because they get better incentives there," said Mtolo, adding: "The areas mostly affected are the medical and surgical wards."

Dlamini said the image given in the media of Prince Mshiyeni Hospital was "sometimes exaggerated", and Nehawu was unhappy about this. He said Nehawu disciplined its members if they were found to be negligent when performing operations.

However, health spokesperson Dave McGlew believes it's not all gloom in KwaZulu-Natal's hospitals. There's no need to press panic buttons just yet, he said.

He said there were a few reported incidents of negligence which had been reported to the ministry and thoroughly investigated.

He said the health department was given a budget of R4,6 billion, of which 70 percent was for salaries. However, some of the budget allocation was being spent on deadly diseases like TB, HIV/AIDS and cancer.

McGlew said the provincial health department was doing its utmost to provide the best service possible, but it had not been able to satisfy everyone.

He said KwaZulu-Natal had 70 hospitals which served more than 10 million people every year, including patients from neighbouring countries like Mozambique and other SA provinces.

According to McGlew, the provincial government has already built 137 new clinics since 1994, bringing to 440 the number of clinics in KwaZulu-Natal.

"We want to offer primary health care to everyone. We already have 185 000 patients visiting the new clinics every month," he said.

Superintendent Sibusiso Mhlambi of King Edward VIII Hospital in Durban said they have borrowed community service doctors to keep their hospital running normally.

A major problem was nurses who left for overseas, but their posts were regularly filled when advertised. Mhlambi said the hospital had 1 630 beds but they were running short because of the number of HIV and TB patients in the Durban metropolitan area.

Meanwhile, Osindisweni Hospital in Verulam, north of Durban, which treats up to 5 000 patients every month and admits between 850 to 900 patients monthly, does not have a shortage of beds, linen and blankets.

Hospital spokesperson Dr Donald Murray said they were supplied with new linen last month. Their budget for this year is R28 million.

The superintendent of Addington Hospital, Dr Jill Hurst-Road, said they would be presenting a business and management plan for this financial year to the superintendent-general of KwaZulu-Natal.

Some of the province's hospitals have said they will soon terminate their 24-hour emergency service.

DISCHARGED ... A patient leaves the King Edward Hospital in Durban

Mpumalanga medical chaos

By DUMISANE LUBISI

AT the beginning of the year, most hospitals in Mpumalanga were crippled by medicine shortages, overcrowded mortuaries and insufficient food. Witbank Hospital is still short of food. Shongwe Hospital near Malelane is in dire need of nurses and there is a shortage of ambulances across the province.

Chief Director for provincial health, Dr Gulam Karim, said most problems arose towards the end of the financial year, due to budgetary constraints. Despite being at the beginning of the financial year, the 350-bed Shongwe Hospital in Schoemansdal, is suffering a severe staff and medicine shortage.

Many doctors have stopped referring patients to Rob Ferreira Hospital - the province's third largest - because of its deteriorating state. They refer them instead to the private Nelspruit Medi-Clinic.

Rob Ferreira was only seven months through its budget last year when it had to cancel all surgical operations after it ran out of intravenous drips and other basic medicines, which were not delivered on time. The health department had to bail out the hospital in February just hours before its electricity supply was to be cut because it had failed to pay a R500 000 bill.

Karim assured Rob Ferreira was now fully-functional, as was the province's second biggest hospital, Themba Hospital, in KaBokweni near White River, brought to its knees last month, with decomposing bodies piled five-deep in faulty fridges and patients forced to take cold baths because of power cuts, which also prevented doctors from sterilising surgical instruments.

The newly built Tonga Hospital, south of Malelane, has its own problems.Contractors at the hospital locked the new maternity wing just hours before Thabo Mbeki, flew in to officially open it, because the department owed them R736 000. They opened it just before his arrival, after they were promised the bill would be settled. - African Eye News Service

Get well but don't talk to us

By DAN DHLAMINI

YOU NEED shock absobers when trying to enquire about sensitive issues at small hospitals in the North West.

At Ottosdal racism is rife, and hospital management and members of the white community have declared this state-aided hospital their own property.

Black patients from Lestsopa township are constantly referred to Wolmaransstad's Nic Bodenstein hospital, which is also not very friendly to black patients.

The MEC for health, Dr Molefi Sefularo has ordered that racism be eradicated with immediate effect and announced his intention to deploy black doctors on a full-time basis at this previously lily-white hospital.

City Press was confronted with arrogant and rude behaviour this week at Nic Bodenstein while trying to establish the circumstances that led to the death of a patient, Boitumelo Mahiwa (21), after giving birth to a healthy baby girl last Saturday.

A rude clerk who insisted on addressing us in Afrikaans flatly refused to let us speak to the superintendent, Dr G Blaauw for two days. Despite having left several messages Blaauw has yet to respond to our enquiry.

However North West MEC for health Dr Molefi Sefularo this week reassured the communities in the province that all hospitals were operating normally.

A confident Sefularo said although a huge chunk of the North West Province was rural, the province was in the forefront of hospital management in the whole country.

He said his department had created cost centres in the hospitals to enable managers of each of those sections to control and manage their own budgets and that this was going smoothly.

Sefularo said the total budget allocation for 1999/2000 was R40,5 million, of which R10,8 million was for ongoing projects from the previous financial year and R30,2 million was for new projects.

A conditional grant of R15 million was provided for hospital reconstruction and rehabilitation and planning has commenced.

Cape health services in mess

By QUENTIN WRAY

GRAHAMSTOWN – The Eastern Cape's health services are in absolute chaos and have no hope of improving unless the government spends a lot more money on health than it has to date.

This warning was issued by PAC Health and Welfare secretary Dr Costa Gazi who said he deplored the fact that South Africa's world-class institutions were being degraded, state run facilities were not being adequately financed and even the "flagship" primary health care services were underfunded.

He said the Eastern Cape was worse off than other parts of the country as it did not have access to top-class medical schools and most of the people here relied on public health care.

He said the situation was especially bad in the former Transkei where the provincial Health Department seemed to be moving towards shutting rather than upgrading district hospitals.

On a positive note, Gazi said he welcomed the appointment of Dr Mantombazana Tshabalala-Msimang as national Health Minister.

"She must demand more money, health services must be made more efficient and the devolution of responsibility to local authorities must be speeded up."

He said unless primary health care improves, more people would be suffering from diseases which required hospitalisation.

Gazi said the government was only paying lip service to this policy as primary health care facilities were facing budget cuts and were not being properly maintained.

He said posts were being frozen in a "haphazard way" which precluded planning by management – you cannot plan if you cannot control staff numbers as salaries consume about 80 percent of the Eastern Cape health budget.

A different picture of the situation was painted by provincial Health spokesperson Ms Nomsa Gantsho.

Gantsho claimed that the government's policy of shifting scarce health resources from tertiary institutions such as hospitals to primary health care facilities was working in the Eastern Cape. She claimed there were no staff problems at clinics, that drugs was available and that she "had not heard of any maintenance problems at clinics".

Gantsho said research showed that drug availability had risen from below 25 percent in 1994 to more than 80 percent in 1998.

She said previous staffing problems at clinics had been sorted out by the redeployment of nurses from provincial hospitals to the clinics.

She admitted there were staffing problems at the provincial hospitals as staff who had left had not been replaced in terms of the employment moratorium put in place by the provincial government.

She said that the Health Department was "working on getting the moratorium lifted". –ECN Weekend

Health care system sick

By ZOLILE NQAYI

TIGHT budgets, staff cuts and cutbacks on services are threatening to turn to South African public hospitals into death centres.

The collapse of health care services in public hospitals could spell disaster for the majority of South Africans who cannot afford private health care.

Despite an increase in the number of patients treated at Western Cape public hospitals it appears that the situation is under control in this province.

However, although all hospitals in the Western Cape are not in the same dire straits as Gauteng hospitals, their superintendents have warned that they are stretched to the limit.

"The primary effect in budget cuts is the reduction of staff. Approximately 8 000 members of staff were lost over a period of three years. In the last financial year there was a net loss of 2 100 staff.

"This has resulted in forced bed closure, people working harder, and waiting times for all services, including cold surgery and primary services is longer," said Sutcliffe. The reduction in staff is taking place at a time when these hospitals are seeing an increasing number of patients.

Some secondary effects, according to Sutcliffe, were that cut backs on consumables had to be introduced, an increasing backlog on equipment maintenance and an inability to replace outdated equipment, as well as the scrapping of planned new services and projects.

According to the Western Cape Health Department, the province also avoided a collapse in the public health system by sticking steadfastly to a plan introduced four years ago under the former MEC for health, Ebrahim Rasool.

Rasool's plan was in line with former Health Minister Nkosazana Zuma's strategy of providing sufficient primary health care locally, which works out cheaper than admitting patients at a hospital.

Meanwhile, the National Education Allied and Health Workers' Union in a statement said the crisis at public hospitals was a national issue brought about by fiscal policies adopted by the government.

Labour drains health budget

(98) Sowetan 28/6/99

Hospitals should get incentives, such as collecting and keeping outstanding service fees owed to them, suggests the Institute for Democracy in South Africa's Budget Information Service.

WHILE Gauteng spends proportionately more money on health services than any other province, a number of its hospitals have recently been reported to be "in crisis".

In many respects this "crisis" has been the result of building budgetary pressure

On the one hand, there is increasing demand for central hospital services. On the other, financing of these services has reached maximum levels and is set to decline.

Due to budget and labour rigidities within the Gauteng health sector, the one area that can absorb some of the pressure is the delivery of specialist health services through consulting specialists

In the current financial year, Gauteng budgeted to spend a larger proportion of its health budget on academic hospitals than in the previous three years.

The academic health budget has grown by almost eight percent compared to the two percent of the health budget as a whole.

The increase in the budget of academic health services represents a short-term response to the increasing demand for these services. Much of this demand is due to spillovers from the primary sector in Gauteng and from the tertiary sector in other provinces (Gauteng hospitals currently provide 43 percent of nationwide specialist services)

Large numbers of people from other provinces and countries are using these services, while Gauteng has to pay for them. In the recent budget hearings, Gauteng's portfolio committee on health said conditional grants from the Government do not deal with this adequately and that more research was needed on this "spillover effect"

If Gauteng is increasing spending on academic hospitals, why are they running out of money?

Although the academic services budget has increased, the overall budget context is exerting internal and external pressure on academic hospitals There are three reasons:

● Budgetary pressure within the academic services programme makes increases on personnel costs unlikely. Instead, the dramatic increase in personnel costs within this vote over the last four fiscal years demands a decrease

Growing personnel expenditure in the academic hospital budgets has squeezed out non-personnel expenditure such as medicine and equipment. Spending on medicine and equipment decreased by 32 percent and nine percent respectively in 1998-9 from the previous year.

The response of the provincial health department was to budget less for salaries in order to safeguard other important areas of expenditure.

Why did personnel costs increase so dramatically? Because the health delivery is a labour-intensive operation, and the nature of the labour market is crucial to understanding resource allocation and constraints in this sector.

In a bid to retain skilled staff by aligning public sector salaries to the private sector, personnel expenditure was increased dramatically in the mid-90s.

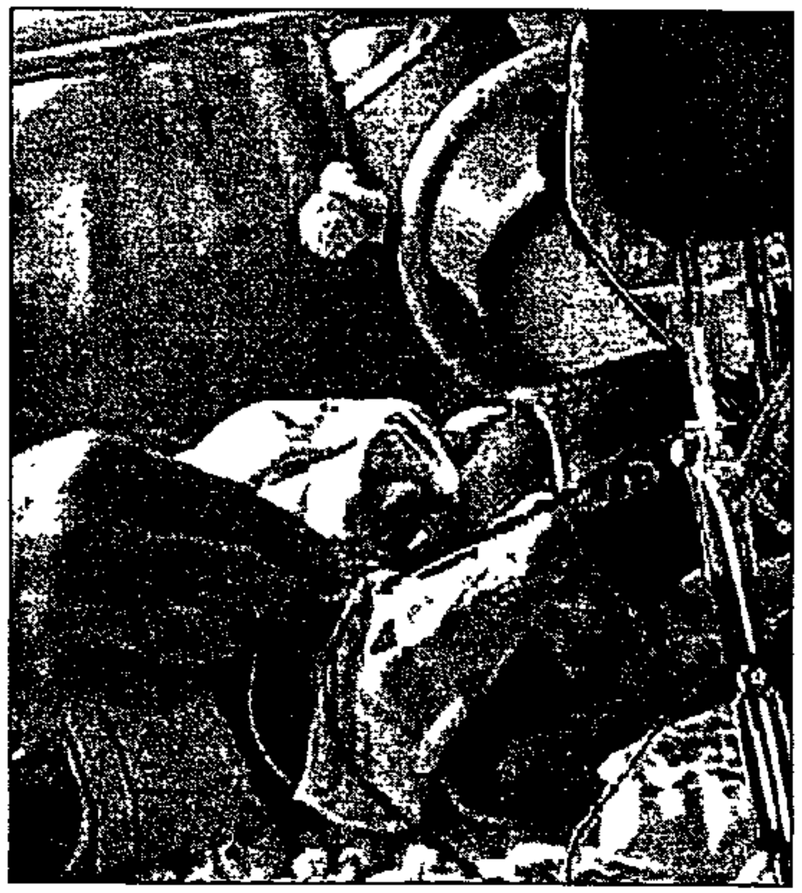
This had a disproportionate impact on academic hospitals (and provinces with tertiary health services) since the largest disparities were in the salaries of specialists.

The 1996 wage agreements with public sector unions further bound the Government to a three-year period of set increases in conditions of service. The effect has been a disproportionate increase in personnel spending.

● Within the health budget, there is little space to further prioritise spending towards academic health services. In the medium-term, the Government is trying to shift spending towards primary health care, which will take the load off tertiary institutions and allow for more cost-effective delivery for the sector as a whole.

It also intends redistributing tertiary and secondary services more evenly between provinces. One of the implications of increased spending on academic hospitals in Gauteng has been inadequate shifting of funds to primary health care services.

● Third, within the overall provincial budget there is no space to shift funds to the health budget from other votes. Gauteng has already spent more per capita on health since 1995-96 than any other province. Further increases



would not be possible without hindering the province's ability to deliver a package of social services to its population.

The only other source of funding for academic services is through conditional grants Since 1998-99, Government has introduced conditional health grants aimed at compensating provinces with tertiary services for the spillover effect.

Conditional health grants that impact on tertiary hospitals include central hospital grants, training and research grants, redistribution of specialised services and hospital rehabilitation programmes.

These grants are designed to maintain the delivery of specialist services countrywide, while allowing for a redistribution of capacity. However, provinces with existing tertiary capacity are facing a real decline in funds targeted to maintain these services. In real terms the redistributive and hospital rehabilitation grants have kicked in at the cost of conditional grants going to existing central and academic hospitals.

The option to reduce staff across the board does not exist. The 1996 Public Sector Agreements left provinces with a very expensive voluntary severance retrenchment tool for permanent staff

The pressure to spend less on salaries therefore impacts first on contract staff The Gauteng health department is retrenching the only people that it can.

The department vowed that no critical services would go unstaffed. It plans to address the crisis by redeployment from other medical services to academic hospitals.

This is problematic given the distribution of skills between permanent and contract staff. In other sectors, such as education, it is easier to redeploy staff Teachers can be more easily retrained and redeployed than orthopaedic surgeons.

The result of this rigidity in staff deployment is over- and understaffing in "pockets" It is difficult to move people to where they are needed because of specialised skills.

One of the proposed solutions to the crisis has been to provide better incentives to hospitals to collect service charges owed to them. Currently hospitals hand over all their income to the provincial government.

If they were allowed to keep part of this money, they would be more motivated to collect it. Such strategies are being investigated in several provinces.

A factor that has to be taken into account, however, is the lack of systems and people to track these payments. Even if hospitals gain control over funds, it will take time for the extra money to be available.

The second solution that has been suggested is that certain hospital services be privatised. Such solutions will meet resistance from unions and it is not clear that the private sector will indeed be interested in taking over some unprofitable public hospitals.

The outsourcing of peripheral functions such as catering and emergency services seems to be a more viable option. Eastern Cape has taken the innovative step of making sections of public hospitals available for private practitioners.

In exchange, doctors devote part of their time to patients in the public wing. Innovations such as these will be jeopardised by the Government's plans to bar public sector doctors from private work.

While the changes to academic hospitals are painful, it must be borne in mind that they are in line with national policy to prioritise primary health care and to establish inter-provincial equity

The short-term response has been to cut personnel costs, given the need to maintain a balance between expenditure on salaries and on other items, such as medical supplies and equipment.

What is needed in the medium- to long-term is a provincial and national effort for innovative solutions that take cognisance of services required and the competing demands on existing public funding.

Dispensary nightmare for sick

(98) Sowetan 29/6/99

While doctors and nurses battle to cope, patients have to wait hours for treatment at Soweto clinics, writes ***Charity Bhengu***

By Charity Bhengu

IN SMALL groups they leave their homes as early as 5am to be among the first to be attended to by primary healthcare nurses at clinics in Soweto.

Despite having risen early, mothers with children on their backs, the elderly and sickly are always welcomed by the overcrowded waiting rooms and long winding queues at the dispensary

It was the same case at Zola Clinic

There are about 1 000 patients from nine locations and three informal settlements with a total population of about 500 000 people.

The doctors and 17 nurses are working like maniacs to please the impatient crowd.

The room is filled with screams from hungry babies, groaning from the sickly and constant complaints from the elderly

They are a difficult bunch to please.

When the clinic opened at 7am and the dispensary at 8.30am, the crowd was already waiting anxiously.

Later that day Matron Nobantu Makedama said the clinic had already attended to 650 patients and referred nine cases to the Chris Hani Baragwanath Hospital for a second opinion

"Except for the overcrowded dispensary, everything is running smoothly," she said.

She attributed the overcrowding at the dispensary to shortage of drugs and material. There were some people who kept coming back to check if their drugs were still out of stock.

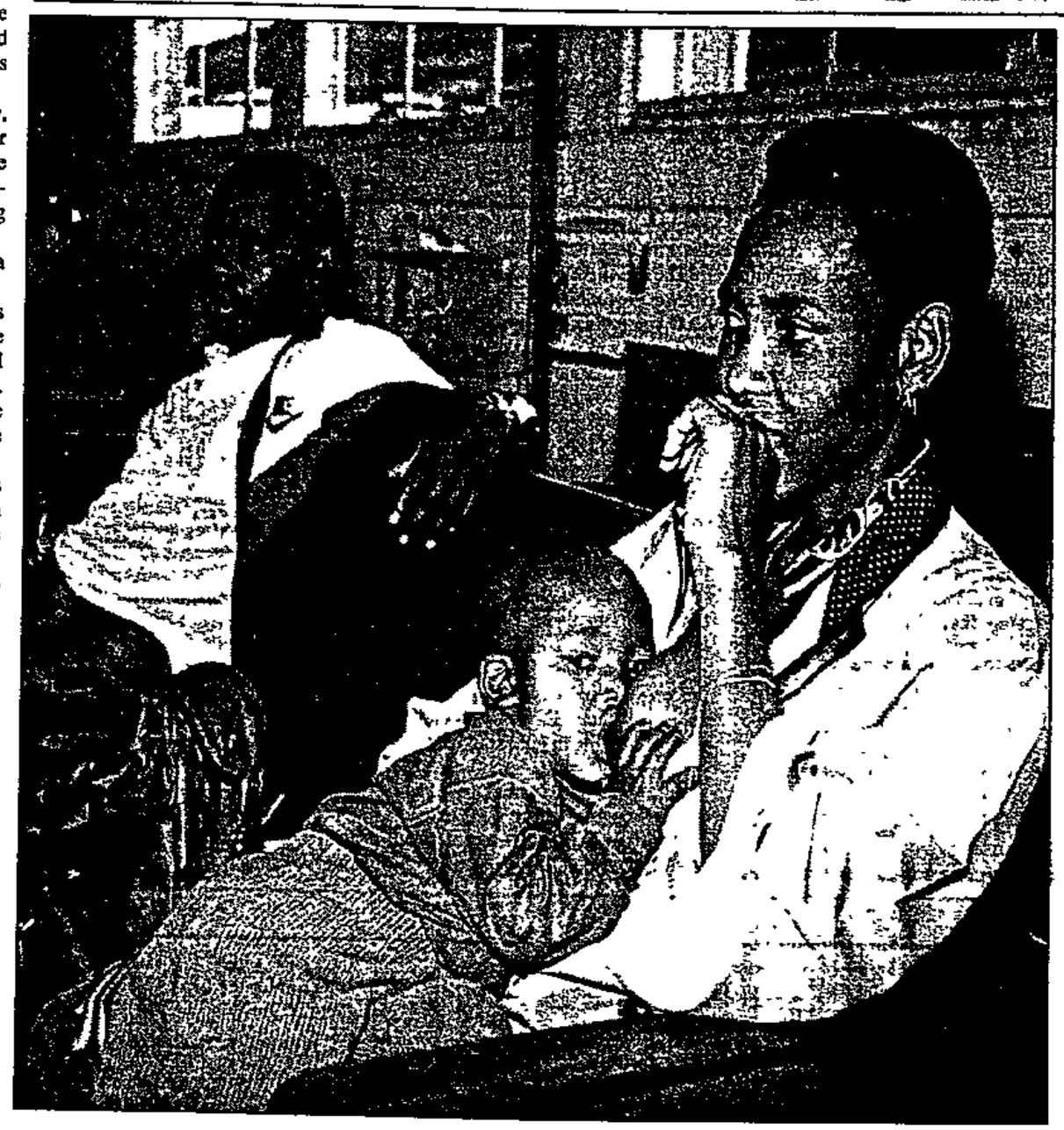
Sometimes people left with an incomplete supply of two instead of five drugs

Makedama said this has been going on since late last year.

"Soon we are going to find ourselves referring more patients to Bara because of the shortage of drugs," she added.

Her sentiments were echoed by Mrs Nomsa Ncube, who said twice she was not given her treatment because of a shortage of drugs. She said: "I might be turned back without any treatment again"

Next to her was Mrs Mumsy Radebe, who was complaining of long queues which were moving at a snail's pace. She said: "There are three clerks who are supposed to be attending to us but half the time they rush off to tea or lunch, leaving us out here in the cold. If they are not doing that, they are always talking to their lovers on the telephone."



A woman feeds her child while waiting for to be attended to at the Soweto Clinic. PIC: PETER MOKGAKI

An old lady, Maisy Maepa, said they sometimes have to stand in queues all day until the dispensary closes at 4pm. She said: "There are people here who are diabetic and supposed to eat at specific times. They are going to collapse anytime"

Sowetan learned that some members of the public were abusing the free health service.

While an overwhelming number of them went to clinics for genuine reasons, others queued up for illnesses that could be treated at home.

There were also those who would go to clinics on Monday mornings for a doctor's letter, thereby wasting their scarce resources.

Makedama said a number of the patients were filling the queues to wait for Panado tablets.

Many were on medical aids and had come to the clinic to avoid paying for drugs, while others were suffering from self-induced problems such as alcohol and tobacco.

Half of the patients were likely to waste the drugs by not finishing their treatment, thereby prolonging the illness and eventually coming back for more medicine.

Gauteng health regional director Dr Ayesha Mangera said: "Yes, we get odd cases of people coming to clinics on Monday mornings, pretending to be sick but we have means of dealing with them."

The worst kind of abuse, however, of the health resources was when people go "shopping around for expensive drugs", straining the resources intended for poor people.

Mangera said: "This is a real cause for concern. It costs a fortune to treat people who are suffering from high blood pressure, diabetes and asthma. Their drugs are so expensive a general practitioner could not even afford them."

Knowing this, people go from one clinic to another "shopping" for these drugs.

Mangera said the issuing of a national health card to patients would solve the problem.

"Health workers would then be able to tell if a person has been to another clinic for the same drugs."

On the other hand, Mangera said the primary healthcare system was coping.

The big clinics like Lillian Ngoyi, Chiawelo, Zola and Mofolo offer a range of 24-hour services, including maternity, X-rays, operations and short-stay

"Clinics would not be banking up patients who should be seen at the hospital because of staff shortages."

Of the between 800 to 1000 patients seen daily by each Soweto clinic, only about four percent are referred to Bara.

"We do most of the work at the primary healthcare level. In fact, we off-load most of the work which was being done by the hospital in the previous years," she said.

Mangera, who is in charge of clinics, said. "The medical experts, who predicted a crisis in the clinics if posts were to be frozen at the hospitals, are alarmist."

She said some of them had never visited the clinics and were not aware of the amount of work being done by primary healthcare. "Their speculations were unfounded."

Bara spokesman Esther Vorster confirmed that after 4pm when many clinics were closed, "the hospital referred a large number of patients to Lillian Ngoyi".

Since 1994 the Soweto primary healthcare system has developed credible services. Their work with Bara has resulted in an enriching experience for both the hospital and clinics.

R13-m bill for safety cuts deep into health care budget

(98)

HEALTH WRITER
ARG 30/6/99

Violence is taking an enormous toll on the Western Cape's health budget in terms of treatment, operating and theatre costs, as well as security for health workers which last year cost the province a total R13-million.

That's the word from Alan MacMahon, chief director of operations in the provincial health department, during a tour yesterday of Cape Town hospitals by new Western Cape health minister Nic Koornhof.

Dr MacMahon said that while money for security was well spent, it was a pity it was necessary to divert such large amounts to defend staff and institutions.

Discussing health budget cuts in the province, Dr MacMahon said the Western Cape had "bottomed out" and could not cut anything further.

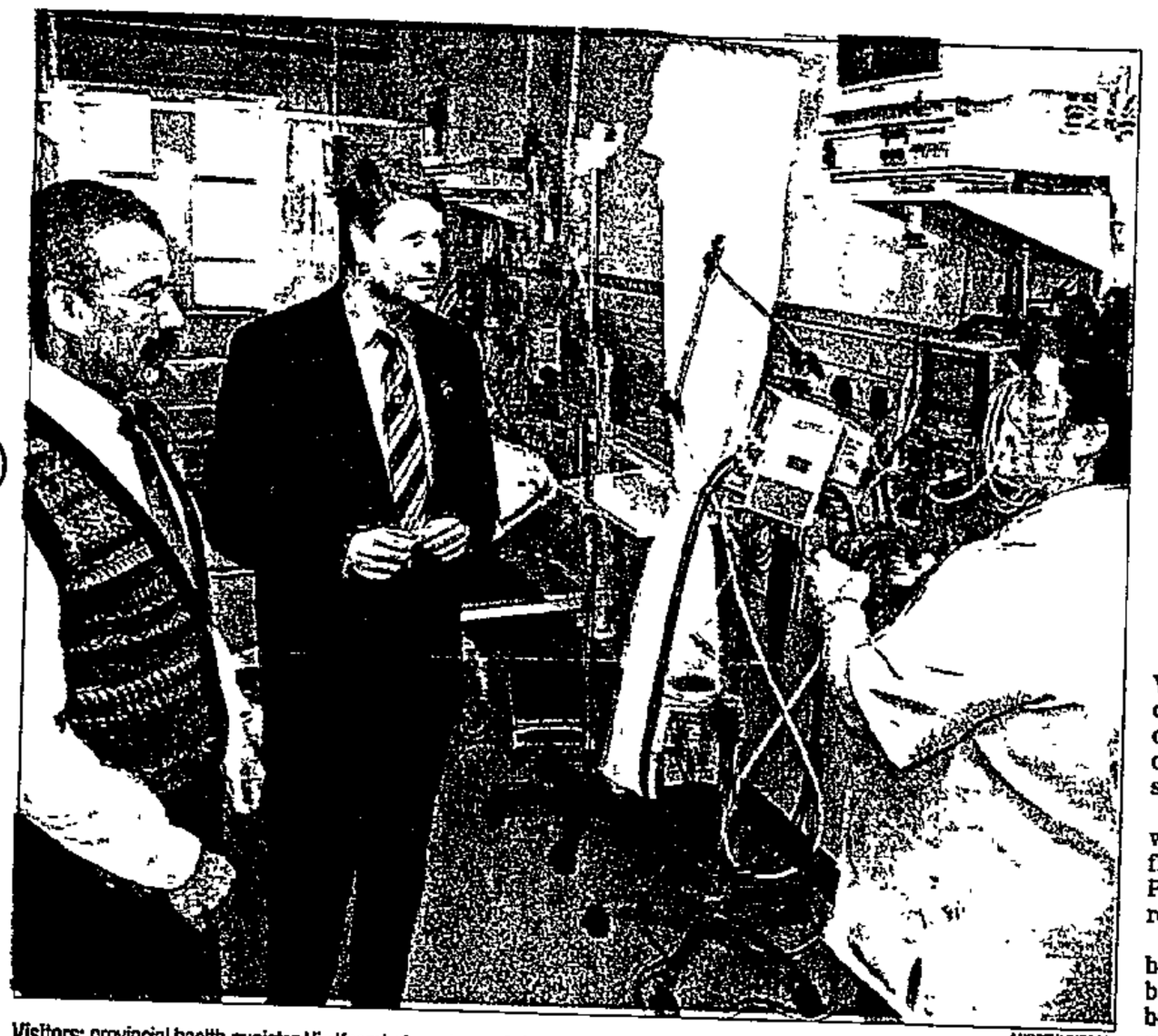
Huge cuts had had to be made in spite of an increase in the number of people using the health service.

In addition, voluntary severance packages had left the province with insufficient support structures – there was a shortage of nurses, a shortage of physiotherapists and occupational therapists, as well as administration staff.

"We are asking a lot of the support staff we do have, in fact it is amazing what we are asking of them and I don't believe we can take any more staff cuts," he said.

The province was "stretched and under pressure and it is difficult to keep services going, but a lot of that has to do with the standards of service we are used to providing".

Dr MacMahon said the Western Cape had a legacy of good health service. The province had started from a high base relative to other parts of the country and people expected that good service be maintained.



Visitors: provincial health minister Nic Koomhof, centre, at G F Jooste Hospital yesterday with Norman Maharaj and Marilyn Paris

ANDREW INGRAM

Weekend trauma pushes hospitals to breaking point

(98)

'Never enough beds to serve the people'

Weekends characterised by car crashes, stabbings, gunshots and other assaults are pushing an overburdened Peninsula hospital service close to breaking point.

At the weekend, trauma unit staff were forced to spend precious hours finding hospital beds when three Peninsula hospitals filled up as a result of the violence.

G F Jooste Hospital in Manenberg and Victoria Hospital in Wynberg were diverting patients from before midnight on Saturday; Somerset Hospital reported its intensive care unit full and Groote Schuur Hospital was stretched to the limit.

Hospitals in greater Cape Town and ambulance services co-operate in terms of the "diversion of ambulance policy", which aims to short-circuit the problem of ambulance staff taking patients to hospitals too full to accept them.

But hospital chiefs say this often means they have to spend valuable hours phoning around to locate available beds in other hospitals.

Wayne Smith, deputy director of the Western Cape Health Department's emergency medical services, said Metro staff dealt only with medical superintendents who alerted them to the fact that their hospitals were full. Before they could do this, however, the superintendents had to find hospitals where beds were available to give Metro staff an alternative destination.

Ria Kirsten, senior medical superintendent at Victoria Hospital in Wynberg, said one of her medical officers woke her about 1am on Sunday after she had spent about two hours trying to find a bed in the Peninsula for a patient they had resuscitated and stabilised.

"I told her we had to accept that if there was no bed for the patient we would treat him on a trolley as that was the only alternative."

DI CAELERS

HEALTH WRITER

Dr Kirsten said the problem was eventually solved by adding a third patient to their two-person intensive care unit and taking a nurse out of one of the wards to care for the patient.

Hospital superintendents in all the hospitals affected at the weekend reported constant juggling to ensure they found beds for patients.

Dr Smith said the amount of crime and violence, especially during month-end weekends, meant that, no matter how good the system, there always would be a limit on the number of available hospital beds.

Medically, there are three codes of patients: code green who are walk-in, walk-out; code yellow who need to be admitted; and code red for whom treatment is a matter of life and death.

Dr Smith said hospitals were not allowed to divert code-red patients until they had been resuscitated and stabilised. Code-green patients were always treated.

The problem lay with the code-yellow patients for whom hospitals needed to find beds before they could be admitted.

Dr Kirsten said Victoria Hospital served about 400 000 people, but had only 153 beds. The hospital was "chock-full".

"On Sunday night, we were 103% full. Always trying to find beds in other hospitals causes an amazing amount of stress among personnel. Every day we have to transfer four to six patients," she said.

Norman Maharaj, senior medical superintendent of G F Jooste Hospital in Manenberg, which started diverting patients from 11pm on Saturday, said they had only 157 beds, but served an area of close to a million people.

"These are never sufficient beds to serve all these people, so we have to divert ambulances to other hospitals within the metropolitan region who at that time have the capacity to deal with our excess patients," he said.

Otherwise, the hospital stayed open and functioned normally for cases not requiring admittance.

"By its very nature, trauma escalates over the weekends, particularly long weekends and month-end weekends, and I would like to have 500 beds or more to deal with this huge population.

"Because of our situation closest to the coalface (in Manenberg), we cannot do the job with only 157 beds," said Dr Maharaj.

Both he and Dr Kirsten were full of praise for their staff.

Dr Maharaj said he was "quite proud" they did not close down more often in spite of the lack of capacity.

Dr Kirsten said it was due only "to the loyalty, dedication and guts of the personnel who work here that we can deliver the standard of service we do".

Groote Schuur Hospital chief medical superintendent Peter Mitchell said the hospital was functioning "on skeleton staff", particularly in the trauma unit, and had been extremely busy at the weekend.

The doctor who is forced to play God ...

ARGUS CORRESPONDENT

Johannesburg – "It's stressful. I make decisions I am not supposed to make. I decide who lives and who dies. My decision could be wrong, but I am forced to play God."

These are the words of Dr Mantoa Mokhachane, neonatologist at Chris Hani Baragwanath Hospital for the past five years, who daily decides which sickly babies should be placed on a ventilator and which should die.

"On many occasions I am faced with a situation where I have one (ventilator) bed and two babies.

"The decision lies with me as to which one will die and which one will live. I can only make a decision on the strength of the baby's prognosis.

"But you never know, you may be wrong. I have treated many babies that looked like they were dying, but pulled through.

"It has always been like that at Bara. Even when we tell them we have no beds, the patients arrive.

"When I tell the parents that we have no bed its almost as if it doesn't register. I will explain to them that we have no (ventilator) bed and that we will administer oxygen, but that the baby will probably die.

"Still they will ask me when I think they will be able to take their baby home," says Dr Mokhachane.

When asked how she copes with a baby's death, she says, "We cry and that baby stays with us for a long time. That baby always comes back.

"Sometimes I will be ventilating another baby and I will remember that baby I had been unable to ventilate It is very traumatic to all of the staff when a baby dies.

Dr Mokhachane, who works long hours and sometimes seven days a week, says she had no intention of leaving.

The neonatal ICU has been in the headlines for the past week after doctors said the specialist unit would have to close today because of critical staff shortages.

But the unit was thrown a lifeline yesterday when 12 medical officers, doing community service at Johannesburg Hospital, volunteered to transfer to the hospital.

PUBLIC HOSPITAL CRISIS (98)

PILING ON THE PRESSURE

New Minister faces full agenda

FM 2/7/99

The crisis facing public hospitals is the first test facing the new Health Minister, Manto Tshabalala-Msimang, and hospital managers have wasted no time in bringing the issue to the top of her agenda

Academic hospitals have been brought to their knees over the past five years by systematic underfunding. Gauteng and the Western Cape have been short-changed by at least R100m/year.

Vacant posts have been frozen, wards boarded up and routine maintenance cancelled. Many of the brightest and best have taken voluntary severance packages

Public hospital administrators have finally had enough. They are being forced by budget cuts to play God, but, faced with a new wave of staff losses, have chosen to lay the burden of which services to cut at the door of government.

Tshabalala-Msimang is a new broom whose appointment has been welcomed by the health sector, but she faces a daunting task.

"She will travel a gentler path and be more diplomatic than (former Health Minister Nkosazana) Zuma, though perhaps less firm," says a close friend from the medical aid industry. "I don't know whether she has Zuma's strength, but she is very much a woman of the ANC "

The former chairman of the parliamentary health portfolio committee was sent to Coventry in 1996 after her outspoken criticism of Zuma over *Sarafina 2*. She was shunted into the position of Deputy Justice Minister and rendered invisible.

Tshabalala-Msimang is a qualified doctor who completed her doctorate at the Leningrad Medical Institution in 1969 The young KwaZulu-Natal student thought she was learning the medical lexicon in Russian, but, on moving back to the West, was relieved to find it was in fact Latin

In 1980 she obtained her Masters in public health from the University of Antwerpen and, during her 28 years in exile, worked as a registrar in obstetrics and gynaecology and a medical superintendent, among other posts.

Her years abroad moving in diplomatic circles with her husband, ANC treasurer-general and former SA High Commissioner to London Mendi Msimang, have given her a certain poise. "Gentle, soft and charming" are adjectives her friends use to describe her; even DP health spokesman Mike Ellis is smiling

"We worked well together," he recalls, adding that for the first time since 1994 there is the possibility of a positive relationship developing between the public and private health sectors.

"What will be fundamental to her success is the advisers she appoints," says Ellis. "Zuma surrounded herself with yes-men who gave her appalling advice "

There are some immediate measures she should take to shore up the public hospital system: devolve decision-making powers to hospitals and allow them to retain revenue. Without these key reforms, public hospitals will continue to be run inefficiently.

Medicine theft is thought to be as high as 50%. And public hospitals are incapable of billing accurately or enforcing payment. The Health Department estimates that medical aid patients under-pay public hospitals by R1bn/year.

Tshabalala-Msimang will also have to work with Finance to recalculate hospital grants to provinces so that their annual budgets reflect conditions on the ground.

Since 1994 the Health Department has been rapidly redistributing funds away from academic hospitals towards the building of clinics and those provinces lacking tertiary facilities But the disintegration of a world-class public hospital system has been the price paid for the chimera of equity.

Yes, Zuma built a few hundred clinics, providing many of the poorest with basic health care for the first time in their areas, but doctors say many clinics are so poorly resourced that patients continue to stream to hospitals And when these people really need secondary or tertiary care, the institutions they could always rely on are on the brink of collapse.

Under these conditions the wealthy will continue to pay a high premium for private care while the poor will just get sicker. Some will die, like kidney patient Thiagraj Soobramoney, who was denied free dialysis after the Constitutional Court ruled that the State's obligation to provide health care is not absolute

"We are talking about a process of natural selection during which only the fittest will survive," warns Rhudo Mathiva of Chris Hani Baragwanath Hospital

This week, Baragwanath — which has a shortage of more than 2 000 staff members, including more than 100 doctors — may have to close its neonatal intensive care unit, which saves the lives of about 500 babies every year Services to accident victims, the terminally ill and patients with Aids and cancer are also under threat across the province

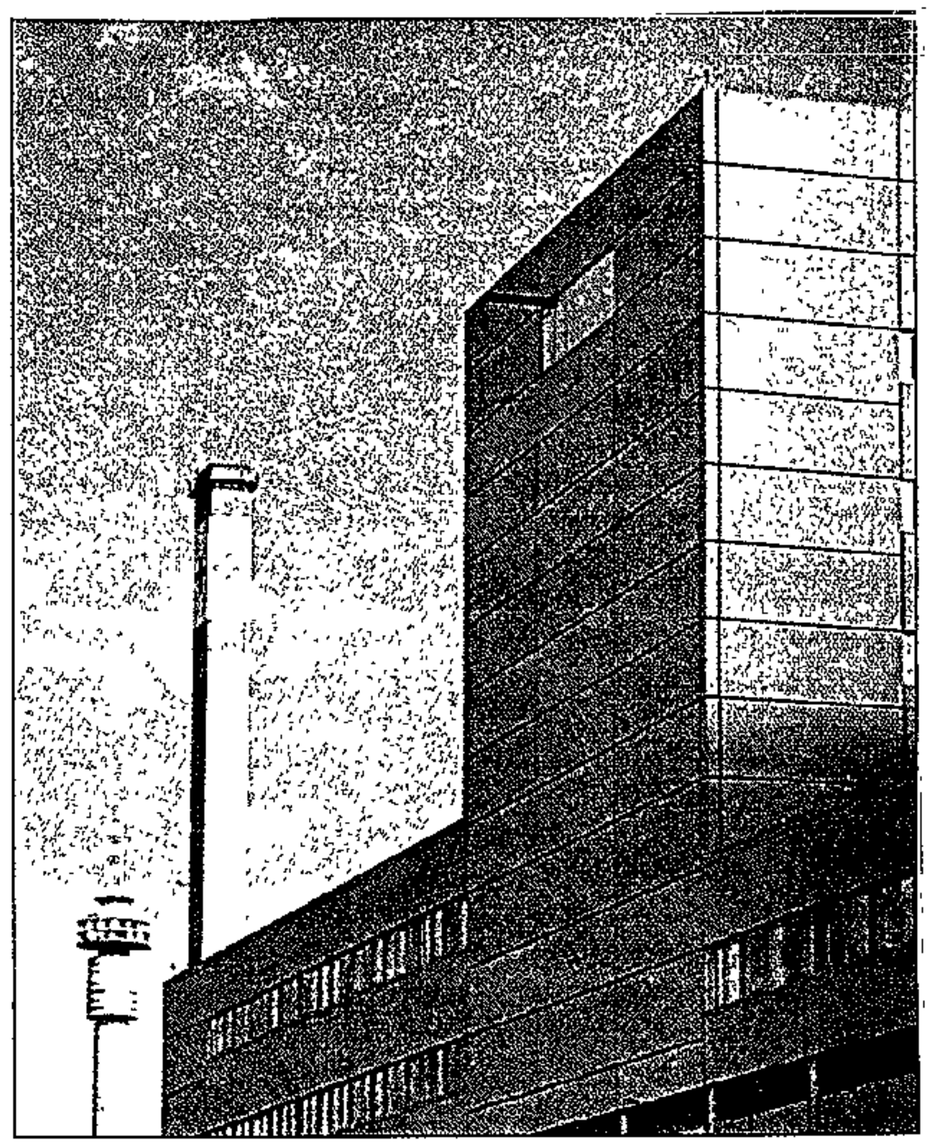
The fact that the Health Department has never spelt out what services public hospitals should be providing is at the root of the problem. This, and the fact that hospital budgets have been cut so rapidly, has meant that national assets have been dismantled in an irrational way.

The new Minister must inject order into this process and work with the institutions to chart a more compassionate way forward.

Claire Bisseker

>> What will be fundamental to her success is the advisers she appoints <<

Mike Ellis, Democratic Party, Health spokesman



***Jo'burg Gen** . . hospital managers have been quick to attract the attention of the new Minister*

Two top doctors leave Johannesburg General

(98) BD 2/7/99

James Eedes

THE resignation of two of Gauteng's top public sector doctors has driven certain health services at Johannesburg General Hospital very close to collapse, says Jack Bloom, the Democratic Party's Gauteng spokesman for health.

In a strange development, Gauteng's health department denied knowing of the departure of Professor Werner Bezwoda, head of the cancer unit, and Dr Eric Klug, a senior cardiologist.

"As the employer, we have not received any letter of resignation," health department spokesperson Popo Maja said.

Neither doctor was available to comment nor were staff at the hospital revealing anything, but there were reports of Klug holding a farewell party this week. Bloom says Bezwoda's departure for private practice could lead to the collapse of the cancer unit if others left with him.

If the rumours are true, it will be another blow to Johannesburg Hospital, still reeling after the transfer — despite staff shortages of its own — of 12 community doctors to Chris Hani Baragwanath in Soweto.

The move was aimed at plugging critical shortages at Baragwanath owing to a moratorium on the hiring of medical staff in Gauteng hospitals. Specialist departments at Johannesburg Hospital are now under pressure.

"Gauteng health MEC Gwen Ramokgopa has pulled the wool over everyone's eyes with a totally inadequate and cynical response which intensified the crisis at Johannesburg Hospital while providing scant extra assistance for Baragwanath," Bloom said.

Gauteng's health promise

A HEALTH service charter, aimed at strengthening the Gauteng government's commitment to offer a high standard of health care in hospitals and clinics, will soon be unveiled, health MEC Dr Gwen Ramokgopa said yesterday.

Speaking during the debate in the provincial legislature on Premier Mbhazima Shilowa's state-of-the-province address, she said the charter would be presented to the provincial executive council within weeks.

Should it be accepted, this plan would ensure that all people have access to basic health services and that free health care is provided for children under six years of age and pregnant women.

Ramokgopa's remarks came after outcries from opposition political parties, doctors and medical professors who said health services in Gauteng were in a crisis.

They accused the government of making them "play God with the lives of thousands of babies" at various hospitals in the province.

Ramokgopa said these people should be disappointed that their recent prediction that "doomsday will fall on Gauteng on July 1" did not materialise.

The MEC assured the people of Gauteng that their government was doing everything possible to improve health services.

These included a new public health system that would contribute to the overall attainment of equitable and sustainable socio-economic growth and development of the province.

"The commitment of the premier to ensure that the provision of a comprehensive, accessible public health system will receive urgent attention, is welcome," said Ramokgopa.

She earlier brushed aside criticism against her department for not lifting the moratorium on the appointment of doctors and other health officials, but instead shifted 12 doctors from Johannesburg Hospital and one from Ga-Rankuwa to Chris Hani-Baragwanath Hospital in Soweto.

Sufficient steps were taken to deal with the current problem, Ramokgopa said. – *Sapa*

Hospital chief quits in despair

Unit head warns of collapse

ARG 5/7/99 (98)

DI CAELERS
HEALTH WRITER

The head of the trauma unit at Groote Schuur Hospital has quit – leaving behind "intolerable" work conditions in a medical service devastated by budget cuts and spiralling violence.

As he left South Africa today for a new job in Saudi Arabia, Peter Bautz warned that the training of doctors would be devastated if teaching hospitals like Groote Schuur were allowed to collapse.

"We are looking at the total destruction of medical standards in South Africa if the cuts continue," he said.

Dr Bautz, who has held what he described as a "godawful" job in "the Siberia of surgery" for five years, is the third trauma unit head at a Peninsula hospital to give up in the past 18 months.

Elmien Steyn, of Tygerberg Hospital, and David Bass, of Red Cross Children's Hospital, have already moved out of the trauma arena.

Dr Bautz, who left his job last Wednesday, is to spend at least two years setting up a trauma unit at King Faisal Hospital in Riyadh.

His gynaecologist wife, Dee McCormack, and their three children will accompany him.

He said he was leaving behind a trauma unit that dealt with gunshots, stabbings and multiple injuries 24 hours a day, seven days a week

"The problem is that major trauma is getting worse. Gunshot wounds, particularly, have increased and now account for about 80% of our surgery," he said.

SARAH WYLLIE

Peter Bautz: 'Trauma messes with your head. You see death and dying all the time'

"It is an almost unsustainable workload. We have lost our best theatre nursing staff, and teaching and training is also under threat because of diminished resources."

Groote Schuur's trauma unit sees about 1200 patients a month, admitting an average of 320. About 1000 have gunshot wounds. By comparison, it is regarded as significant in a country like Britain if a trauma unit treats five gunshot wounds a year.

Dr Bautz said: "It messes with your head. You see death and dying all the time. Death of course is a part of trauma but we're just seeing more and more of it."

Groote Schuur Hospital as a whole, according to Dr Bautz, is running on a skeleton staff, but the trauma unit is particularly badly affected, with a staff allocation totally out of proportion to its workload.

His own job left him almost no time at home between late-night call-outs, ordinary duty schedules and staff training, teaching, research, outreach, administration and battling to maintain standards.

"No one who works in trauma is afraid of hard work. But what's going on now in the trauma unit at Groote Schuur is the equivalent of driving from Cape Town to Johannesburg in second gear with your foot flat on the accelerator – the engine lasts only so long," said Dr Bautz.

He is concerned for the unit's staff, who he says face burnout very quickly.

"The seniors are slightly protected by the junior staff. The junior staff have to be rotated every three to six months or they undergo personality changes.

"With the seniors, it just takes them a little longer to burn out."

Dr Bautz said workloads were "inhuman" and that if hospitals wanted to hold on to trauma staff, their numbers had to be

To page 3

Groote Schuur trauma chief quits 'Siberia of surgery'

From page 1

(98) ARG 6/7/99

increased. "Staff levels are severely inadequate. It's the same with nursing staff – the turnover is so high because people can't carry that kind of workload."

Groote Schuur's trauma unit continued to offer world-class medical service and the people he worked with were among the best.

"But you have to lead by example when you're expecting too much from people. I thrashed myself and I thrashed my staff.

"The front-room registrars get no weekends off for 10 weeks. It's inhuman to expect that from anyone."

Dr Bautz spent a total of eight-and-a-half years in the trauma unit. He said working there meant you became tolerant to a point. But "you get affected by it as well".

"All the multiple gunshots, all the suffering: Trauma is not a happy speciality; it's known as the orphan speciality."

His work has left Dr Bautz cynical about the criminal justice system. He said there were many laws but no law enforcement.

"There is just no respect for human life. It's no longer a case of punching you in the face and taking your money; now people are out to rape, to kill and maim. There is almost a sickness in society."

His cynicism extends to the health service, which he said was "devastated" by staff cuts and lack of money for research or new equipment.

"We are heading for a major collapse if the present cutbacks carry on. Teaching hospitals are being destroyed.

"Groote Schuur is still probably one of the Rolls-Royce provincial hospitals in South Africa, but how can it continue that way for long?"

Dr Bautz said if the teaching hospitals were destroyed, "we will see the tragic results of that in 10 to 15 years' time, when the poorly trained professionals are all we have when it comes to replacing the older specialists.

"We are looking at the total destruction of medical standards in South Africa if the cuts continue."

Doc's move rocks hospital

(98)

TREVOR OOSTERWYK
STAFF REPORTER

ARG 6/7/99

The replacement of Peter Bautz as head of the trauma unit at Groote Schuur Hospital is being addressed as a matter of urgency, says the hospital.

This was the response to yesterday's Cape Argus story on Dr Bautz's decision to quit after five years of service and take up a surgery post in Saudi Arabia.

Dr Bautz said working conditions at the hospital had become "intolerable" and called it "the Siberia of surgery", warning that teaching hospitals faced collapse.

Peter Mitchell, chief medical superintendent at Groote Schuur, said the replacement of Dr Bautz was a high priority. He acknowledged "the immense contribution" made by the trauma head.

His departure was not just a great loss to the Western Cape, but the whole country. Dr Bautz's contribution was not only in service delivery, but also in teaching and research.

Dr Mitchell said staff at the unit were exposed to tragedy and death daily. The hospital had implemented an employee assistance programme available on a 24-hour basis. Staff were given debriefing sessions and got group and individual counselling. He confirmed that Groote Schuur was under severe stress and sustained pressure as a result of soaring violence in the Western Cape that "is symptomatic of a societal pathology".

"The reality is that the trauma unit budget is a reflection of the wider health budget. As such the financial resources are inadequate and in real terms have been decreasing," said Dr Mitchell.

Hospital staff crisis forces all-day queues for medicines

(98)

ARGUS CORRESPONDENT

Johannesburg – A critical shortage of pharmacists is forcing patients to queue for up to eight hours for medication at Johannesburg Hospital's dispensary.

Pharmacy services are just another link in the hospital chain which, according to health workers, is on the brink of collapse.

A pharmacist at Johannesburg Hospital, who did not want to be named, said that "half-frantic people are screaming at us because they have been waiting so long. I have just dispensed medication to people from Standerton and Volksrust because their clinics don't have drugs."

Less than 12 pharmacists were forced to deal with "well over a thousand" patients on one day. "We just can't cope any more," he said.

Quadriplegic Barbie Lalloo said she was preparing to wait for eight hours in the queue.

"This is frustrating. I wake up very early in the morning to be here in time, but I will only be going home after eight hours of waiting for my medicine."

Sanah Mashishi said she had to take the day off work to collect her medicines.

ARG 7/7/90

Church, government in bid to save hospital

(98) BD 8/7/99

Pule Molebeledi

DURBAN — KwaZulu-Natal health MEC Zweli Mkhize yesterday denied "rumours" that St Mary's hospital in KwaMagwaza near Melmoth would close down "soon" due to financial difficulties.

Mkhize said bilateral meetings between the health department, the hospital and Anglican church Zululand diocese would be held soon to discuss mechanisms to help run the hospital.

The state funded institution, which is not state owned, received a R9m subsidy allocation for the 1999/2000 financial year from the health department, but felt it was not enough and asked to be bailed out.

Mkhize and the health department said they would reconsider the subsidy, as the mission hospital provides services to disadvantaged communities.

He commended the "excellent" services rendered by the only hospital in the sparse rural area of Melmoth which plays a crucial role in health services.

Mkhize, who met representatives of the church to discuss their plight on Tuesday, said the church was considering handing over the hospital to the department in an attempt to save it.

Hospital management was told to calculate how much money it needed to survive.

Mkhize said: "Since the department realises the important role being played by St Mary's, it agreed it would investigate ways to save the hospital."

Hospital crisis: death of two babies fans concern

THE Gauteng health department is conducting two investigations into healthcare and will assist hospitals from next week with budget-driven service planning.

This was revealed by chief director of hospital services in Gauteng, Dr Laetitia Rispel, as concern grew over reports that two babies had died in a Johannesburg hospital due to staff and equipment shortages.

Rispel said initial investigations "contradicted" newspaper reports that two newborn babies had died at the weekend in the Coronation Hospital, despite attempts by a medical officer to save one by ventilating her manually for eight hours.

According to management at the Helen Joseph Hospital, the Coronation's sister hospital, only one child died and she was manually ventilated for two and a half hours. We need more information about the baby's condition before coming to a conclusion about its death," Rispel said.

The results of the inquiry would be presented to the Health Professions Council to determine if the baby received adequate treatment.

Rispel said while she acknowledged that there was pressure on doctors and nurses in under-staffed hospitals in the province, it was important to bear in mind that a recent healthcare system survey had revealed that Gauteng hospitals received more per capita for healthcare than the national average.

"I am not denying that there are problems. We would like staff to know that they are our most important resource and that we are taking steps to address the present situation," Rispel said.

The health department had planned meetings to assist hospital administration with budget-driven service planning.

Rispel said that in the past hospitals were not compelled to stay within their budget but the "Government's commitment to fiscal discipline has now made it necessary for hospitals to learn to manage their budgets properly and to ensure that taxpayers' money is put to optimum use." – *Sapa*

Health rights charter to stop abuse of patients

(98)

By Bhungani Mzolo
Health Reporter

A HEALTH rights charter to safeguard patients' rights against abuse by healthworkers at clinics and hospitals was launched yesterday.

It aims to improve the quality of health care services and to raise awareness among patients and healthworkers, according to Ms Khathatso Mokoetle of the National Progressive Primary Health Care Network (NPPCHN).

A comic strip titled *Health rights charter – your passport to health rights,* was produced. It showed how patients' rights may be infringed and what recourse they had.

"We see the charter as a way of bridging the gab between healthworkers and patients," said Ms Jo-Anne Collinge, spokeswoman for Gauteng health.

The NPPHCN said access to basic rights such as education, housing, water, electricity, refuse removal, sanitation facilities, nutrition and health was still beyond the reach of most South Africans.

It said disadvantaged communities did not think health rights were for them.

"The circumstances of their lives such as travelling vast distances, long waiting times, lack of money, the disrespectful attitude of health care providers and lack of knowledge about when, where and how to seek appropriate health services are experienced by many people as disempowering and dehumanising," it said.

The Network said health rights charters had been developed in Free State, Gauteng, KwaZulu-Natal, Mpumalanga, Northern Province and North West.

Dr Louis Claassens, speaking on behalf of Health Minister Manto Tshabalala-Msimang, said the Department of Health was also developing a complaints procedure for both the public and the private sectors.

Patients who feel that their rights might have been infringed should phone 0800 1140 10.

'What crisis? It's been

(98)

While health officials play down the state of Gauteng's top teaching institutions, patients admitted to Ward 567 at Johannesburg Hospital pay the price. LAURICE TAITZ reports

ST 11/7/99

IT IS Wednesday morning. Dr Peter Hsu has been on duty since 7am in the medical intake ward, a transit point for patients referred from casualty for specialised treatment.

A "welcome" notice says patients stay here for 12 to 24 hours. Hsu says: "The cases range from pneumonia and TB to strokes and renal failure. In short, these people are very sick." This makes Ward 567 an ideal training ground for young doctors.

11.20am — "We have 56 patients already," says Hsu, "and we haven't even started the day."

The ward bustles with activity. In the section on the right are the most critical cases. Porters bring in new patients on stretchers and in wheelchairs. Student doctors throng the nurses' station.

"I don't want you to sit in a wheelchair with a heart attack," says Hsu to a new patient. "We will try to get you an ICU bed."

A letter from a former patient is tacked up on the notice board. "I hereby wish to express my greatfullness (sic) to all the doctors, nurses and staff trying to serve and save lives. PS The government must do something about the conditions of all the hospitals."

There are supposed to be four doctors, but instead three interns work overlapping shifts over 24 hours, supervised by a registrar.

11.45am — Seven beds are cleared. There are six nurses on the 7am to 7pm shift.

"Officially," says Sister "Delly", "we have staff to run 15 beds. But we offer 33 beds. When we run out, we use stretchers, chairs and the floor. We still have patients lying here from last week."

Some of the patients have blankets. They bring their own.

12.15pm — There are three empty beds. The two phones ring and Hsu is called to speak to a doctor from Standerton Hospital, where they have admitted a woman with renal failure. The doctor is told not to send her. "At least she's got a bed there," says Hsu.

12.30 pm — The beds are full. Patients sit in chairs and on stretchers. In the chaos, three eager medical students spend 20 minutes with the wrong patient.

A woman is wheeled in. She has breast cancer and severe chest pains. Her chair is pushed between the beds of two male patients. "We need privacy to examine her," says Hsu. As her case grows more urgent and she moans from the pain, the doctors ask a 75-year-old man suffering from dementia to sit in a chair while they use his bed to examine her.

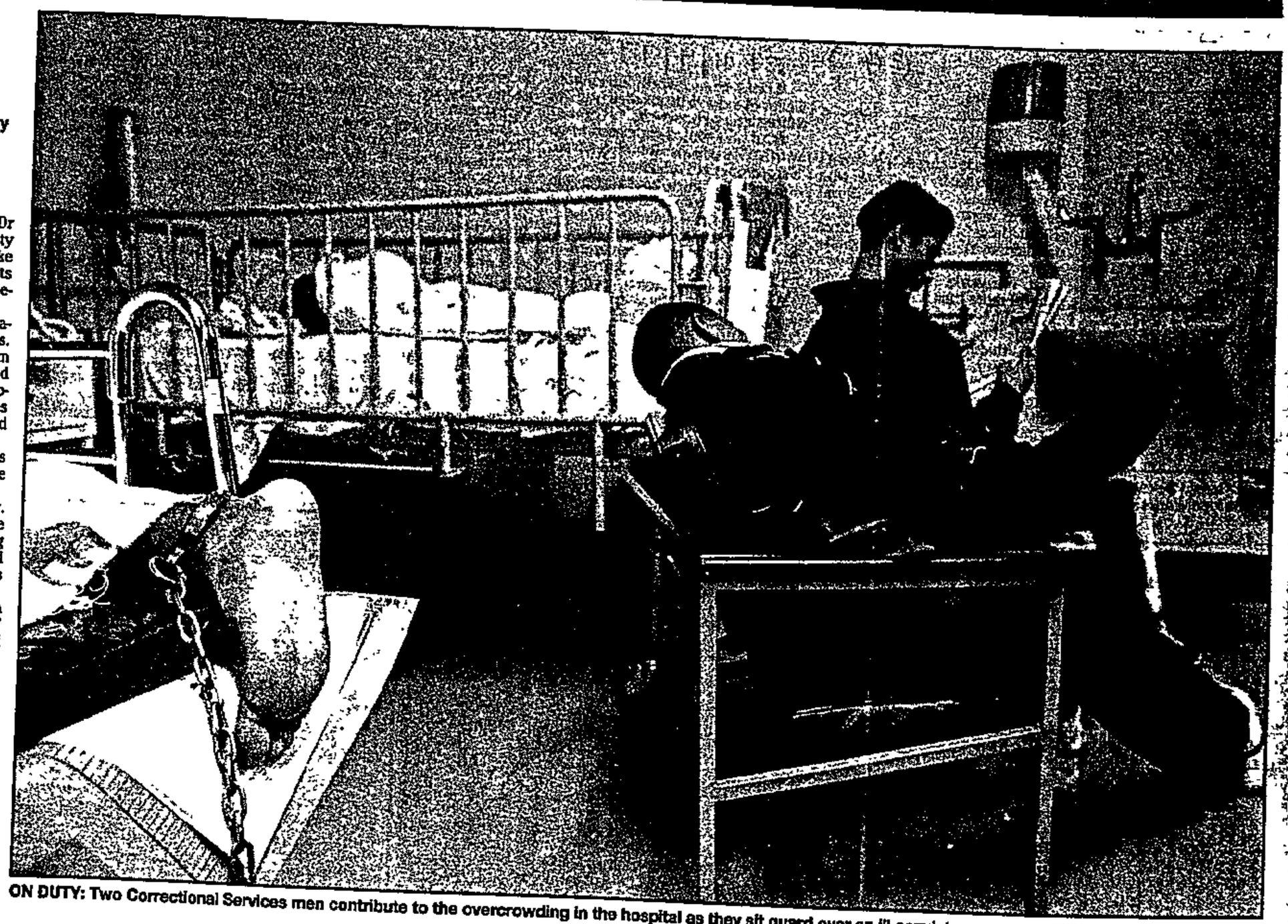
1.15pm — Dr Heidi Lombard, an intern on duty, calls it a "normal" day. Says intern Dr Colin Winter: "We are supposed to be learning, but when you have to admit 26 patients on a shift, it's bad for me and it's bad for the patients. To move patients out of this ward, you dump them any place that has a spare bed. Then you spend two days looking for them."

1.30pm — There is a persistent buzzing in the nurses' station as a patient rings for assistance. But the staff have their hands full. A cockroach runs along a desk. More than 30 minutes go by before bed 16 is attended to.

3pm — More calls from casualty. There are now more than 50 patients in the ward. A 75-year-old man is admitted in a chair. He was discharged from Chris Hani Baragwanath the day before. His limbs are ice cold. His family brought him in after he suffered a stroke at 4am. He is slumped over. He cannot speak or move his head.

"Of all the patients," says Hsu to a nurse, "he should have a bed. He's elderly. There's no dignity in sitting here in a chair. He's right next to the dustbin. At least get him onto a stretcher. We can't let him die in a chair."

2.15pm — The doctors are weary. One says: "We don't worry about giving people the best care. We have to give them the cheapest care. We call it 'veterinary medicine'. You don't speak to the



ON DUTY: Two Correctional Services men contribute to the overcrowding in the hospital as they sit guard over an ill convict

Pictures: KAREL PRINSLOO

like this for years'

ENTERING THE CHAOS: A hospital porter and a nurse discuss what to do with a patient who has just arrived from casualty

IN THE PICTURE: Dr Rakhee Singh, one of the three registrars on the ward. Examining x-rays is consultant Dr Peter Hsu

Exhausted doctors play a heartbreaking game of musical beds in a hospital straining to cope

patient or ask questions."

4.45pm — When there is no more space, doctors say, the hospital starts diverting ambulances to other hospitals. But the ambulance staff sometimes just dump the patients, knowing they cannot be turned away once there.

5.10pm — There are 58 patients in the ward. "That's nothing," says a nurse. "Monday night was our busiest. We admitted 19 patients in the day and 29 during the night."

Dr Karen Wolfowitz says none of the night patients were examined on beds — "They were all on the floor."

She complains that the ward has no outgoing telephone lines. "How are we supposed to call poison control or the Institute of Virology when we have emergencies?"

5.45pm — There are 59 patients. A frail, elderly woman lies on a stretcher with an oxygen mask. She keeps taking it off. She can't stop crying. The nurse taking her history asks what medication she has been taking. The woman, who is from an old age home, can't answer most of the questions. Then the nurse asks her: "Tell me what I am wearing." "Nothing," she replies, and continues to cry.

She is placed between a heart attack patient and a convict in shackles. Two Correctional Services men sit on guard at the foot of his bed

"Talk to the government about this," says one nurse, wringing her hands. "Talk to the super super," another says wryly. They all laugh.

5.50pm — There are 63 patients. The ward smells of urine and unwashed bodies. A woman wanders around vomiting into a clear plastic bag. She has her boots on and wants to go home.

"I never learnt about this at nursing school," says one of the nurses. Her colleagues remind her: "Today it's better. At least we haven't had to resuscitate a patient That takes five people, and then what happens to the other patients?"

6.35pm — Dr Laetitia Rispell, the chief director of hospital services for the Gauteng Department of Health, breezes into the ward and out again in less than a minute. No one bats an eyelid The staff are all too preoccupied. She misses by seconds seeing a patient fall out of bed and hit his head on a chair. A minute later, the ward runs out of needles.

6.45pm — It's 15 minutes to knock-off time for the day shift nurses. "I can't. It's enough for one day," says one nurse, heading out of the door.

7.10pm — It's pandemonium as the night staff come on duty There are 70 patients in the ward The nurses chat about jobs in Saudi Arabia and Britain. "You make a contract, they pay you thousands of dollars and you come back after a year feeling much better."

8.55pm — Three patients are moved out "You are going to a bed," a nurse tells an old man who has been lying on a stretcher all day

A charter of patients' rights at the door mocks: "Every patient has the right to privacy, respect, dignity" — all of which are in short supply.

9.50pm — Two doctors struggle to examine a patient in his chair. He is immobile. More patients are wheeled out to other wards. The noise level stays constant — hacking coughs, rasping breath, moaning and the nurses' chatter.

11pm — Dr Rakhee Singh, whose shift finished two hours earlier, is opening a file for a patient because it hasn't been done. A nurse mutters. "When you leave, you don't really want to come back."

11.20pm — The ward has run out of needles, basic painkillers and glucose strips used to test blood sugar. It has quietened down. A call to casualty confirms that this is because patients are being diverted to other hospitals.

1.20am — Two malaria patients are being sent up. The ward is down to 50 patients.

3am — The lights go off A disoriented patient wanders about. The nurses put him back in bed with the rails up.

A 70-year-old man wakes up, sits on the edge of his bed and babbles in Zulu. Like many patients, he is fully dressed.

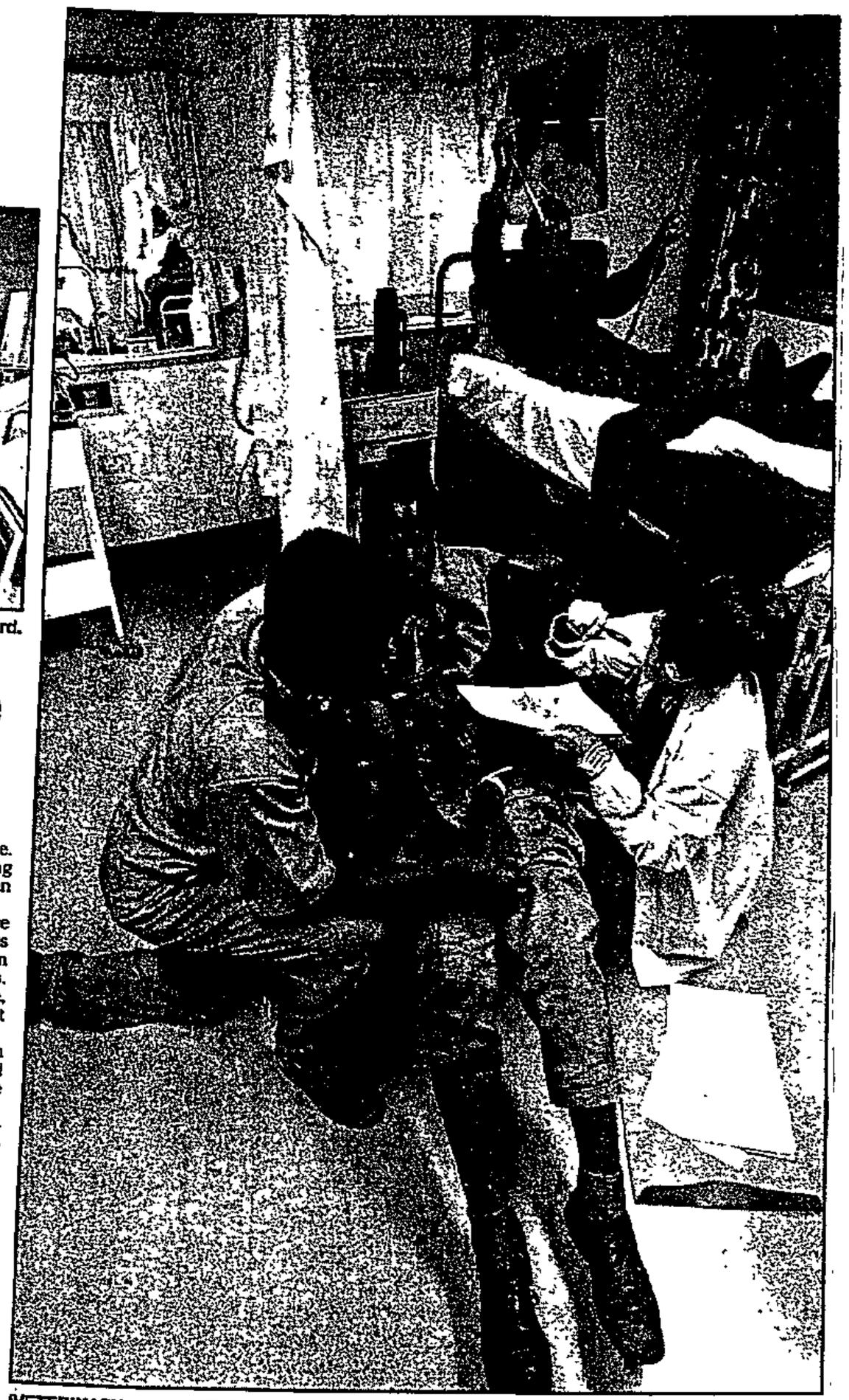
An overdose case is brought in from casualty. A policeman, he says he accidentally overdosed on sleeping tablets. He is not sure how he got to casualty or what happened to his shoes. He wants to go home. He has an important hijacking case the next day. It has been postponed nine times.

4.05am — The lights are back on. Two more patients are admitted. One of them is in severe respiratory distress. "He won't last," says a nurse, as the two doctors rush to put him on a ventilator.

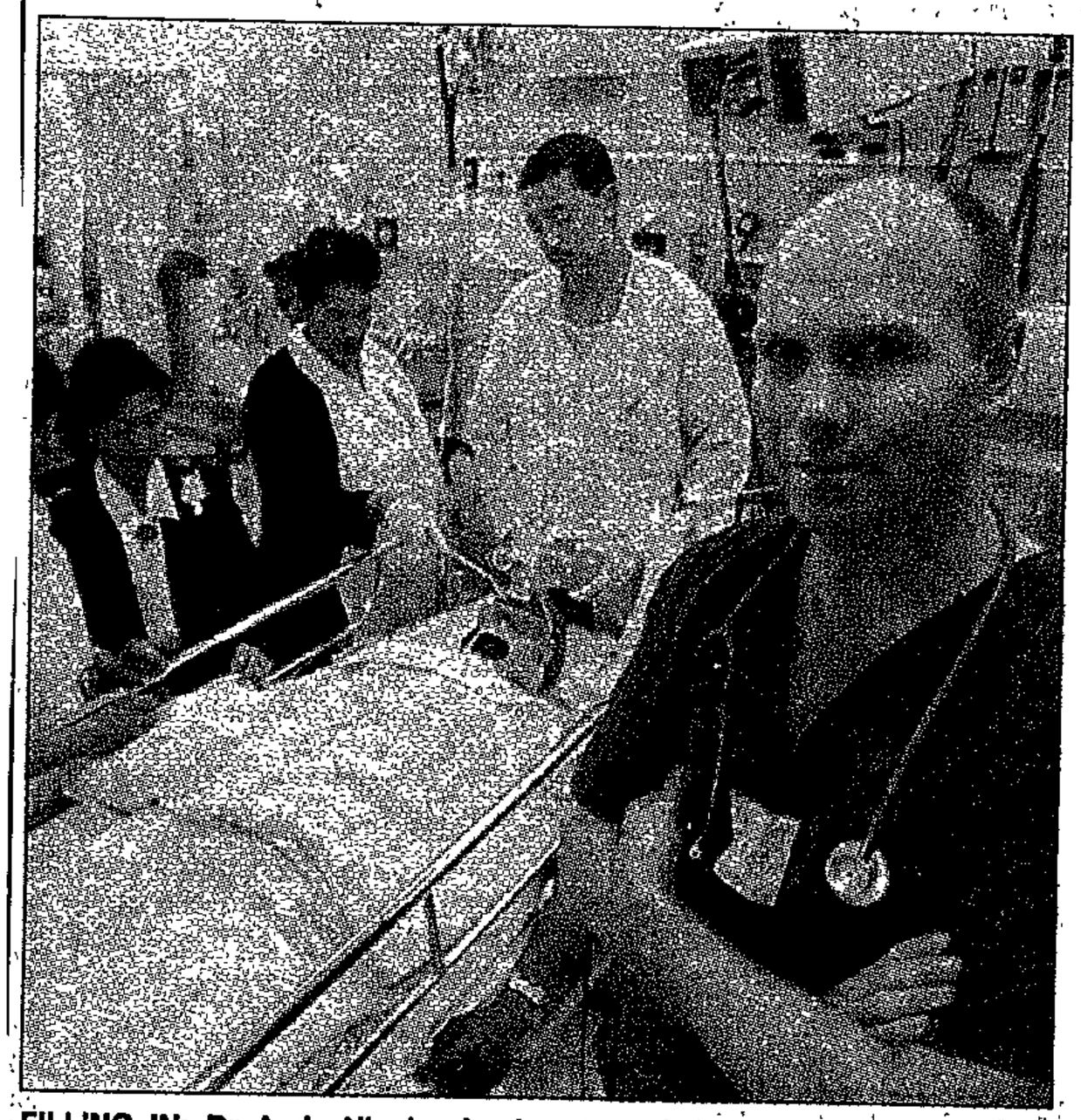
5.15am — The elderly man sitting on the edge of his bed starts talking to Jesus. The nurses work on.

5.45am — A patient critically ill with cardiac failure vomits on his bed. Another cardiac patient gets out of bed to tell the nurses the woman in the bed next to his needs a bedpan. It is the patient from the old age home. She is awake and she is crying again.

6am — Another overdose patient. The nurses neaten up their station and get the paperwork in order for the next shift. The sister in charge says there are no empty beds for the day shift.There are 55 patients in the ward. As the sun comes up, the phones start ringing.



'VETERINARY MEDICINE': Two doctors struggle to examine a patient in a chair, the only available place. 'We don't worry about giving people the best care. We have to give them the cheapest care. You don't speak to the patient and you don't ask questions,' says one doctor



FILLING IN: Dr Andy Nicol, who has temporarily taken over where a stressed-out Dr Bautz left off Picture: TERRY SHEAN

Wanted: A top surgeon with a stomach for gore

JANET HEARD (98)

ST (CM) 11/7/99

GROOTE Schuur Hospital is scouting around for a new trauma unit head following the sudden departure of Dr Peter Bautz last week.

It is a tough search: the job entails research, teaching, surgery and administration. The hours are unforgiving; stress levels sky-high; and the pay uncompetitive, with most experienced surgeons opting for private practice.

To top it all, the unit is understaffed and under-resourced, with Bautz warning on his departure — to a new job in Saudi Arabia — that working conditions were intolerable because of budget cuts and spiralling violence.

Bautz's post was immediately frozen because of the staff-cuts policy, but the hospital is certain it will be opened within days. Bautz, a senior principal specialist who quit the job in despair after five years, left at short notice. "The job requires a special kind of person, and to me it is the most exciting job, because you are being useful, you are saving lives," said Professor John Terblanche, the head of the surgery department at the hospital and UCT.

The candidate must be an experienced surgeon able to deal with most areas of the body, have an expertise in resuscitation and show a real commitment to medicine, he said.

Dr Andy Nicol, one of two specialist consultants at the unit, this week took up the reins as acting head.

"Bautz's departure is a great loss. It is very sad to see someone with such great capabilities go," said Nicol, who may be in line for the post.

He empathised with Bautz. "It is a burn-out kind of job. People get tired of dealing with death and suffering, and they say there is a five-year time frame."

Nicol echoed Bautz's warning that services at the hospital had reached a critical level and that if finances were not found, the hospital faced collapse.

The number of gun shot victims has doubled in seven years — last year 1 449 victims were treated at the unit. Yet nursing posts have been cut from 167 in 1997 to 135.

This week Nicol wrote appeals for finance to private companies. "If the government can't afford more money, we have to get it from somewhere."

Plan for new hospital CEOs

(98) Sowetan 13/7/99

By Bhungani Mzolo
Health Reporter

GAUTENG Premier Mbhazima Shilowa announced yesterday the signing of a proclamation for the appointment of chartered accountants as chief executive officers at certain government hospitals.

Shilowa, who was accompanied by MEC for health Dr Gwen Ramokgopa made the announcement during a surprise visit to the Johannesburg Hospital.

Together with the Chris Hani Baragwanath, Helen Joseph and Coronation hospitals, Johannesburg Hospital announced last month that unless certain key doctors' posts were filled, children may die and other departments may have to close or their working hours be shortened.

However, Shilowa said he did not believe that the situation at these hospitals concerned doctors only.

"It is disturbing for me to hear people say unless you provide us with doctors, we can't move. Nurses are also very important," he said.

Shilowa said he and his team planned to visit all hospitals to find out for themselves what the situation was.

The premier also announced that his administration had approached firms of auditors to help hospital managers with accounting and how they spend the taxpayers' money.

"Johannesburg Hospital, for instance, gets about R600 million annually, and the public would like to know what that money was spent on."

However, there were some confrontations between doctors and the premier at some departments.

When Shilowa found a patient who had not been seen by a doctor for more than 20 minutes in the medical admission ward, he demanded to know the reason for the delay.

Professor Barry Jeffe, its head, explained to him that there were no spare beds for the patients to sleep on, and that the doctor who would attend to the patient was still seeing other patients in another ward.

Sopa starts initiative to 'save' local hospitals

By Bhungani Mzolo

THE Socialist Party of Azania (Sopa) announced its "Save our hospitals" campaign yesterday which would begin with a demonstration at Chris Hani-Baragwanath Hospital today.

Sopa spokesman Mr Kunta Mohamed said the campaign aims to improve conditions at all hospitals and to protest at Government policies whose "stringent budgetary prescriptions perpetuates the crisis in the public health sector".

Bara is one of four health institutions that were in the news recently after senior doctors said that unless more medical staff were employed, they faced closure.

Sopa called on the Government to scrap its Growth, Equity and Redistribution programme; reverse all moratoriums on staff appointments, particularly at under-resourced hospitals; stem the flow of professional staff to the private sector; and increase pay for all health workers.

It has also called on the Government to improve security measures for health workers and patients; improve medical services for patients; and root out corruption and theft of hospital resources.

"We believe with sufficient political will, the deterioration in public hospitals can be resolved," Mohamed said.

Copies of the memorandum would be sent to health MEC Gwen Ramokgopa, Premier Mbhazima Shilowa, Health Minister Dr Manto Tshabalala-Msimang and President Thabo Mbeki.

(98) Sowetan 27/7/99

JOINT VENTURE WITH GROOTE SCHUUR

New 'private' hospital

CT 28/7/99 (98)

A MEDICAL CENTRE which aims to bridge the gap between state health care and the elite private health system will be opened by UCT next year. Health Writer **JUDITH SOAL** reports.

THE UCT Medical Centre, a private hospital that caters for people with jobs but without medical aids, is to open in vacant wards of the new Groote Schuur building early next year. Construction work will begin next month.

The centre, which is a joint venture between the university, the German private health care group Rhön-Klinikum and local private health care groups, was recently granted a provisional licence from the provincial health department.

"The main thrust of the centre is to offer value-for-money health services to blue-collar workers," said Keith Lindsay, an interim spokesperson for the partnership. "It will fill the gap between the overburdened state health care system and the elite private health care system." Lindsay said the details of the project would be released later this week.

Provincial health and social services chief Tom Sutcliffe said his department was meeting representatives of Stellenbosch University today to discuss a licence for a similar venture at Tygerberg Hospital.

"We think this is an imaginative opportunity for health care in the province," said Sutcliffe. "Properly managed and run, it will benefit the teaching hospitals, bring in extra revenue for the state and provide more options for people needing health care."

The UCT Medical Centre will consist of 124 in-patient beds, four operating theatres and offer a range of specialist services.

"The province will not subsidise the project in any way," said Sutcliffe. "On the contrary, we expect it to generate income for us."

According to a recent cabinet decision, 50% of the money raised in this way will go back into the provincial health budget, rather than being added to the central pool of provincial funds, as usually happens.

Critics of private-public partnerships say they can drain experienced personnel from state hospitals. Sutcliffe denied this.

"According to our contract, they will not be able to recruit key personnel like nurses from Groote Schuur," he said.

Another criticism of low-cost private health services is that they benefit the very patients who can afford to pay for health care, leaving the state to pick up the bill for those who can't.

"That is a risk, yes," said Sutcliffe.

"We do want to encourage (paying) patients back into state facilities, but the fact is we don't have the resources to do this at the moment. We hope the net revenue we gain through this venture will make us more competitive."

He also denied that facilities were being taken away from the poor to allow private companies to make a profit.

"The wards they will use are standing empty," he said. "We can't afford to run and staff them. If we could there is no way we would be discussing this."

The new centre will also extend the teaching platform offered by UCT.

"Through the private clinic, medical students will be able to (treat) a greater range of illnesses."

The plan is for the hospital to offer a no-frills version of health care based on models developed by Rhon-Klinikum. It hopes to attract the people who will be covered by the Social Health Insurance scheme promised by the government.

Rhön-Klinikum has been discussing ways to get in on this market with UCT for over two years.

An earlier plan to build a new private teaching hospital on the Valkenberg grounds was rejected by provincial health authorities.

Although this project has received the go-ahead from Health, it still has to be approved by the Provincial Treasury, Tender Board, Department of Works and the cabinet.

The politicians are being careful, but the talk at Groote Schuur yesterday was that it is a done deal.

Academic warns of resignations as private-practice talks deadlock

BD 29/7/99 (98)

Linda Ensor

CAPE TOWN — The health department has reached a deadlock in its negotiations with the medical profession for a postponement of the abolition of allowing public sector doctors to undertake private work on a limited basis.

Armed with evidence of abuse of the system — some senior doctors take off most of the day, leaving juniors in charge — the department issued a ruling last year that limited private practice would end from September 1. It has not budged from this position.

The SA Medical Association (Sama), which wants to have the termination date extended for another year, took the dispute to the Commission for Conciliation, Mediation and Arbitration after year-long talks with the department broke down.

However, no resolution was reached and the association applied for arbitration on Friday.

Sama, the SA University Vice-Chancellor's Association and the medical schools' committee of deans supported the delay so that ways could be found to address the threat to incomes.

The University of Cape Town's (UCT's) deputy vice-chancellor, Dan Ncayiyana, has warned that there will be mass resignations of public hospital doctors, especially in Gauteng, if they are not allowed to undertake limited private practice.

The public service would lose its specialists, most in demand by the private sector and critical for teaching purposes. Taking away private work, which has become an integral part of some doctors' pay, would slash family incomes by as much as 30%, Ncayiyana said yesterday.

One of the options under discussion is remunerated work outside the public sector, but there is less control of outside work under this system compared with limited private practice.

Whereas limited private practice was extended on a blanket basis to all doctors, the other system would require doctors to apply to their heads of department or hospital superintendents, who would decide on the number of permissible hours and hold the doctors to account.

Ncayiyana said the department had shown some sympathy for this idea.

However, he said that limited private practice had been successful at UCT and the University of the Free State. At UCT it was stipulated that doctors must conduct their private practice at the hospital, had to form themselves into a group with one billing system and had to make their patients available for teaching purposes.

Western Cape health MEC Nic Koornhof is in favour of extending limited private practice for another year. "If we do not allow doctors to practise privately we will not attract the best people to our hospitals. If academic hospitals break down, they will be gone forever. It is foolish to think we will be able to build them up again," he said.

Regarding his provincial health strategy, Koornhof said AIDS would be a high priority and that he would ensure that an interdepartmental approach was adopted to deal with it.

Other challenges are to bring more black doctors into the service and to increase the number of primary healthcare nurses. Koornhof also hopes to involve the private sector in primary health care through the establishment of workplace health centres.

W Cape defies doctors order

Continue private work until January 1, Koornhof tells state medics

(98) ARG 30/7/99

The provincial health ministry has given the okay for state doctors in the Western Cape to continue limited private practice until January 1 next year, in contravention of a national health department ruling.

Last year's ruling by the national department that state doctors should cease all their limited private practice on September 1 sparked fears of mass resignations of public hospital doctors.

Ending limited private practice could slash doctors' incomes by up to 30% in Gauteng and between 15% and 20% in the Western Cape.

Yesterday, provincial health minister Nick Koornhof said the Western Cape would definitely not toe the national department line

State doctors here would be allowed to continue limited private practice until the end of the year, by

DI CAELERS

HEALTH WRITER

which time an alternative system would be instituted.

"We are not ready to stop limited private practice here and believe it would be very unwise to do so now, when any resignations would impact severely on upcoming exams," said Mr Koornhof.

"I am in dialogue with the national department and the national minister to explain our position and we hope other provinces throughout the country will follow our example."

The national department, which has evidence of abuse of the system, is currently deadlocked in its negotiations on the issue with the SA Medical Association.

The association wants the system to continue for another year.

The association took the dispute to the Commission for Conciliation, Mediation and Arbitration last Friday after year-long talks with the department broke down.

Dan Ncayiyana, deputy vice-chancellor of the University of Cape Town, warned of mass resignations if doctors' incomes were effectively slashed without an alternative system in place.

Top academics were in high demand overseas while other doctors would certainly be lost to the private sector.

"In Gauteng, limited private practice accounts for about 30% of state doctors' income and in the Western Cape the figure is about 15% to 20%.

"That is significant when you have financial commitments," said Professor Ncayiyana.

The Western Cape system differed from that in Gauteng where doctors determined their own private practice commitments.

At Groote Schuur Hospital, doctors did their private practice within a controlled system within the institution, their patients were available for teaching purposes and there was a communal billing system.

"The fact is that three years ago the government promised to improve doctors' salaries by a certain percentage and if that had ever happened, limited private practice would never have been necessary," said Professor Ncayiyana.

In the Western Cape, the provincial ministry is already consulting about a new system and wants to use the last few months of the year to get it ready.

The new system is called "remunerated work outside the public sector" (RWOPS), and hopes are that it will help keep state doctors in their jobs at state hospitals.

While all state doctors could enjoy limited private practice, the new system would require doctors to apply to their heads of department or medical superintendents, who would decide on the permissible number of hours they worked privately and hold the doctors to account.

Mr Koornhof said: "We have started negotiations, everybody is on board, everybody is being kept fully informed and has given their input.

"The system of RWOPS is the way we will probably go."

Top academic hospitals set to get 'private' wards

(98) ARG 30/7/99

DI CAELERS
HEALTH WRITER

New low-cost private medical facilities at greater Cape Town's two major academic hospitals, with 124 beds each, are expected to be in operation next year.

The new "private hospitals" at Groote Schuur and Tygerberg hospitals, aimed at providing health care to people with jobs but without medical aids, will use empty ward space and provide income for the provincial department of health.

The Groote Schuur initiative, to be called the UCT Medical Centre, has been granted a provisional licence and the department is expected to give the go-ahead for the Tygerberg/Stellenbosch University venture soon.

Provincial health and social services head Tom Sutcliffe said the two universities would enter into collaborative agreements with private sector partners in respect of the facilities' management and operation.

A recent Cabinet decision stipulated that half the income generated by these ventures go directly into the provincial health budget.

The two new hospitals will also not be allowed to recruit key staff like nurses from the tertiary institutions.

"This is a critical step toward addressing the budget cuts which have been experienced by the department over the past few years," said Dr Sutcliffe.

"These initiatives are also important mechanisms to retain key professional staff in our facilities and to maintain a medical environment in which all categories of health professionals can practise their disciplines to the highest professional level," said Dr Sutcliffe.

The finalisation of the two licences is subject to final approval from key provincial roleplayers including the Cabinet, Treasury and the Tender Board.

Approval for the lease of space is also still outstanding.

Workers say racism exposé led to dismissals

CT 2/8/99 (98)

ERIC NTABAZALILA

THIRTEEN black workers at the all-white Alta du Toit Aftercare Centre, a mentally handicapped institution in Bellville, believe they were retrenched recently because they exposed racist practices.

But the institution's director, Rian Basson, said the 13 affected staff members were retrenched "as our cost effectiveness forced us to outsource some services".

Ten of the retrenched workers have been absorbed by the contract company, Feedem Catering Services, while the remaining three have not.

They are Dinah Swartz, Sarah Wilson and Anna Raats. All had spoken openly about racism at the facility.

Racist practices at the centre came to the fore three months ago when the *Cape Times* published an article that black staff ate off blue plates while white staff ate off white plates.

When the issue of the different coloured plates for different races was raised, Basson said the institution had "ran out of white crockery".

Asked whether the practice of using different plates for different races was continuing, Basson said: "To use the issue of different coloured plates for different races is not an issue. We don't see it as a problem as we don't interpret it like other people."

He said the institution itself was still a whites-only institution because people tended to stay at the institution until they died.

"This means it is difficult to get new people," said Basson.

But the workers said: "We don't know on what grounds we were retrenched and what the criteria were. One was told that she is a good worker, but her only problem is that she must keep her mouth shut.

"We know we have been retrenched because we talked to the newspaper.

"After we reported the racism, Basson told us that we had put the institution into disrepute and we needed to do something. This is the result of our actions."

ANC member of the provincial legislature Tasneem Essop said she was organising a lawyer as it appeared that the workers were not informed of their rights pertaining to retrenchment.

"We cannot allow institutions which are funded with public funds to cater for certain races and practice open racism," she said.

Hospital's bleak diagnosis

Health MEC hears how big cuts drain Groote Schuur

ARG 3/8/99 (98)

Heavy patient loads, staff under extreme pressure, "primitive" equipment and the difficulty maintaining standards of excellence in the face of severe budget cuts.

That is the picture at Groote Schuur Hospital, where every head of department, one after another, reported exactly the same kinds of problems and concerns to provincial health MEC Nick Koornhof during a visit to the hospital yesterday.

Mr Koornhof has been visiting state hospitals and clinics across the Peninsula, and talking to staff and patients, in an effort to assess the extent of the problems with which he has to contend.

Heads of department were blunt. Dudley Werner, cancer unit professor, told Mr Koornhof cancer patients at the hospital could not get available state-of-the-art drugs because the budget simply did not allow for them.

DI CAELERS
HEALTH WRITER

Even in respect of support drugs, used to prevent patients relapsing, doctors had to make a "Sophie's Choice" about who would get the limited drugs available.

Professor Werner said his annual budget was R760 000 whereas his counterpart at the University of Natal got R14-million and at the University of the Witwatersrand it was R9-million.

He pointed to equipment costing millions of rands that had been bought through the proceeds of public fundraising campaigns. "We have to be innovative if we want the equipment and the province cannot buy it," he said.

In the cardiac clinic the message was almost identical. Clinic head Patrick Commerford told Mr Koornhof they had never kept up with the latest available equipment and that this was "quite simply the biggest problem".

"We have the medical, nursing and technology staff but no equipment. In terms of catheterisation equipment ours is 10 years behind, it's primitive. For the doctor working with it, the image is like working under water," Professor Commerford said.

He was concerned the hospital was falling further and further behind.

Zephne van der Spuy, professor of obstetrics and gynaecology, said it was difficult to maintain the services they would like to with the severe shortage of resources.

Dave Woods, professor of neonatology, said babies were always the end of the queue when it came to money. "Because the patients are small, the budget is small," he said.

The constant battle for funds has reached such severe proportions that departments within the hospital are apparently in open competition for money.

"Everyone is fighting for their survival," Professor Woods said.

A final word came from the hospital's head of nursing, Catherine Thorpe, who, when asked whether the most serious problem was staffing or equipment, said staff were vital, because at least then there was someone to keep the ageing equipment going.

LEON MÜLLER

Reduced to begging: provincial health MEC Nick Koornhof, right, gets the lowdown on equipment problems in the Groote Schuur Hospital's cancer unit from Dudley Werner. Behind them is the ageing Linac cancer treatment machine that Cape Argus readers raised funds to replace

Cansa to care for patients at home

(98)
ARG 3/8/99

DI CAELERS
HEALTH WRITER

Hospital budget cuts, and a spiralling increase in HIV infection and AIDS, has forced the Cancer Association to step in with home-based care.

The shift in emphasis from its previously supportive role to one that is hands-on emerged during Cancer Week this week, when Cansa Western Cape appealed for increased public support.

The shift, which will effectively mean having to raise more money to meet the demands, comes at a time when non-government organisations throughout the country are feeling the pinch.

Cansa Western Cape provincial director John Malone said decreasing hospital budgets had a direct impact on the demand for services from non-government organisations like his own.

In the past six months alone, the demand for services from Cansa Western Cape had increased by 23%.

The organisation's public relations co-ordinator, Karin Comer, said the harsh reality was that terminally-ill patients could no longer spend long periods taking up beds in state hospitals.

"We have to be pro-active about the situation and step in. Many of these patients don't even have basics like food," she said.

Last year South Africa had about 50 000 new cancer cases, about 17 000 of them in the Western Cape. During 1998, Cansa looked after about 40% of the Western Cape's load in some form or another.

HIV and AIDS is expected to further push up cancer statistics, and Theresa van der Merwe, head of health promotion for Cansa Western Cape, said the latest national cancer register showed incidence already on the rise.

Kaposi's sarcoma, distinguished by purple blotches on the skin, was a cancer related directly to AIDS and, between 1993 and 1995, registered cases of this type of cancer in South Africa rose from 139 to 221. In Uganda and Zimbabwe, this was the most common form of cancer.

"This is what we are heading for in the next couple of years and we have had to restructure and re-organise to meet this head-on. We must work in partnership with the national and provincial health and welfare departments, and other non-government organisations," Mr Malone said.

People would have to be cared for at home because "sheer numbers" meant hospitals would simply not be able to cope.

"Hospitals will be there for the medical treatment of people, but organisations like ours will have to be there for the home-based care. The days of staying in hospital for 10 to 14 days are over," Mr Malone said.

Ms Comer said that while Cansa was becoming more responsible for cancer patients, it was at the same time having to fight harder for a share of the donor pie.

"Even the state hospitals are being forced to do their own fund-raising now. We've never had to compete with them before."

Mr Malone said AIDS was going to demand resources in a country that had no excess resources to speak of.

"We are going to have the AIDS epidemic on our doorstep, while we are still challenged to meet the needs created by other, existing epidemics."

Call to direct resources to help public health sector

(98)
Sowetan 4/8/99

By Bhungani Mzolo
Health Reporter

SOUTH Africa's healthcare system needs a shift of resources from private to public where there is need for them, chairman of the Leratong Provincial Hospital board, Mr Jethro Tshabalala, said yesterday.

He was speaking during a media conference to announce the members of the recently formed hospital board.

He said in order to redistribute resources more equitably, medical practitioners at individual levels would have to consider leaving their comfort zones and contribute in some way to the public healthcare sector.

"The main concern is the self-interest in the profession. The bulk of financial and human resources are in the hands of the private healthcare sector, which looks after only 20 percent of the population. However, the public sector with far fewer resources has to account for the needs of 80 percent of the population," Tshabalala said.

He said doctors, pharmacists, funders, pharmaceutical manufacturers and hospitals need to come together to work out a strategy of how they intend investing resources into the public sector.

"South Africa's doctors would be vital to this process as doctors do not measure their success by profits but by the country's infant mortality rate and state of the health of the nation," he said.

Tshabalala said the main functions of Leratong Hospital's board included making recommendations to hospital management about improving financial management of the institution.

Strike hits the tummy at Groote Schuur

(152) ARG 5787/99 (98)

THABO MABASO AND JEREMY LAWRENCE
STAFF REPORTERS

The public service workers' strike at Groote Schuur Hospital has forced administrators to change patients' meal schedules.

And members of the same union, the National Union of Public Servants and Allied Workers (Nupsaw), demonstrated outside the Cape Town Magistrate's Court today to protest against the Government's latest wage offer.

Groote Schuur Hospital spokeswoman Philippa Johnson said the meal changes had been prompted by staff shortages.

"We now have to give the patients their main meal in the evening. Previously, patients got this meal at midday," she said.

Serving the main meal needed more staff, and more of those on duty were working at night.

Nupsaw, which has 88 000 members nationwide, is demanding a 10% wage increase. The Government has offered all public service unions 6,3%. Other public service unions have suspended their strike pending the outcome of wage talks with the Government.

In the Western Cape, a spokeswoman for Tygerberg Hospital said everything was functioning normally.

But Mrs Johnson at Groote Schuur said about 70 workers, mainly kitchen staff, were taking part in the strike. The linen and pharmacy departments were also affected.

At the Cape Town Magistrate's Court, interpreters, clerks and state prosecutors from other courts were expected to join the demonstration later today.

Nupsaw shopsteward Vuyisile Nyameli said: "Nupsaw has made a revised offer of 8,5% and has vowed to continue the strike until its demands are met. We are expecting to hear the outcome from the bargaining chamber on Friday. The Government is degrading the workers with its offer."

■ Reuters reports from Johannesburg that Anton Louwrens, an official in the 190 000-strong Public Servants' Association, said that if there was no progress in tomorrow's talks in Pretoria, unions could unite in striking.

Hospital staff fund beds

(98)

By Bhungani Mzolo
Health Reporter

AT least six women will have cause to celebrate National Women's Day when they give birth in very pleasant surroundings at the Chris Hani-Baragwanath hospital today.

This is as a result of an initiative by a group of doctors, who as individuals, have raised money and bought new, specially designed beds for the labour ward.

The beds have comfortable springs, headrests and mattresses. "When women give birth, they need a bed on which they can turn around and change positios without causing discomfort," said Hendrina Khanyile, a project organiser.

Dr Baron Matonhodze said they took the initiative to fundraise when they saw that most of the hospital beds were old and there was no money to buy new ones. Matonhodze, a specialist, said he was appealing to the public to help raise the money for more new beds "We have already managed to buy six beds at R6 000 each and we hope to raise enough money to buy nineteen more," he said.

Sowetan 9/8/99

MAIL & GUARDIAN
August 6 to 12 1999

Health care still in critical state

m+G 6-12/99 (98)

Peter Cooper

RIGHT TO REPLY

Aaron Nicodemus's article on the South African health care system, "An almost clean bill of health for the new system" (July 16 to 22), claims that in response to warnings, the government unfroze posts in Gauteng. This has certainly *not* happened at the hospitals in question.

The purpose of this response is not to pick holes in Nicodemus's article, but to provide a somewhat different perspective to what many of us perceive as a major crisis in the health care system that is not being adequately addressed.

I doubt anyone would defend the apartheid-based health care system. Indeed, many of us who still work in the public health sector fought hard against that system, often jeopardising careers.

The public health care system no longer favours whites over blacks. Some redistribution has taken place between urban and rural dwellers, and between primary health care on the one hand and secondary (hospital) and tertiary (specialist) care on the other.

However, what is frequently not highlighted is that there has been no overall increase in spending on public sector health care.

The increased levels of expenditure on primary health care have resulted in decreased expenditure on hospitals and tertiary-level care This decrease includes hospitals such as Chris Hani Baragwanath, which previously catered only for black patients.

The most serious misrepresentation made in Nicodemus's article is that the system being put in place will provide equal access to health care for the labourer and for the stockbroker

The fact is that private-sector health care consumes more than 50% of health care spending for only 20% of the population. What has occurred over recent years is that tertiary care in the public sector has received progressively less funding and resources, while this has continued to increase in the private sector

The gap between the care at tertiary level for the labourer and the stockbroker (who would presumably be covered by medical aid and have access to private health care) has continued to grow.

If all of those making decisions about allocation of resources for health care had to use the public health care system, I suspect some of the decisions made could be different!

Representatives of the health departments at national and provincial levels frequently imply that health institutions, and the tertiary hospitals in particular, are inefficient and wasteful

This is certainly true to an extent, and there is no doubt that a better management system and a more efficient financial accounting system would lead to savings.

However, what is seldom admitted is that these savings would only have a limited effect on the current overspend of many of the tertiary hospitals.

Figures indicate Johannesburg hospital now provides primary and secondary care to five times the population that it did 10 years ago (an increase of 500%!), while the numbers using its specialised services have more than doubled. Over this time, the numbers of staff have decreased — surely this represents a major turnaround in efficiency?

Johannesburg hospital now provides primary and secondary care to five times the population that it did 10 years ago. Over this time, the numbers of staff have decreased

During 1998, a hospital cost analysis of nine tertiary/academic hospitals was commissioned by the national health department A number of accounting firms were involved and the final report was compiled by Price-WaterhouseCoopers

This report confirmed that costs of patient care in the academic hospitals are far less than the private sector. In my own department at Johannesburg hospital, intensive care for babies and children is provided at approximately one-quarter of the costs in the private sector, with similar survival figures.

These costs could not be substantially reduced without an increase in mortality and a greater risk of brain damage in survivors.

In the final report, it was stated that most academic hospitals overspent their budgets The report suggested, "In most cases the budgets allocated to the hospitals were simply just not sufficient."

A consultant from the national health service in the United Kingdom reported that the savings needed to bring Johannesburg hospital back to budget (estimated to be 20% for this financial year alone) would not be achieved simply through eliminating cost inefficiencies.

His report stated: "A rough estimate based on experience in the UK would suggest that savings of about 100% over a two to three-year period might be possible."

In other words, budget cuts as they are now being implemented must imply major cuts in service.

The effects of these cuts were described most effectively by the editor of the *South African Medical Journal*, Professor Dan Ncayiyana, who wrote in an editorial about academic hospitals: "The present cuts have been too sudden and too deep, threatening to scuttle our training programmes for doctors and for other health professionals, and to leave indigent South Africans without access to care beyond primary and secondary levels.

"Sadly, that would further deepen the already scandalous chasm in our two-tier system, and create a situation where the politicians and other well-to-do continue to be able to get their heart valves and hips replaced, but not the poor."

This was written in August 1998 — the situation in Gauteng's hospitals is now much worse.

The Gauteng health department's recent decision to transfer 12 community-service doctors from Johannesburg to Chris Hani Baragwanath hospital has already had consequences For example, children arriving at night with surgical emergencies such as acute appendicitis from central and northern Johannesburg have to be referred to Chris Hani Baragwanath hospital, since Johannesburg hospital no longer provides a 24-hour paediatric surgery service

Other cuts in service are inevitable, and the current total moratorium on the filling of posts will ensure such cuts will be totally illogical and random — wherever the next round of resignations occurs will determine where the next cut in service takes place.

As suggested by Ncayiyana, medical schools will have to look at new and innovative ways of maintaining their standards of teaching, and this is likely to involve partnerships with the private sector.

Where will this leave tertiary care for those not able to afford private health care? This is one of the central questions seldom addressed openly by the national and provincial health departments

Should the treasury not allocate more money for health care, and the health departments maintain the current financial cut-backs for tertiary-level care, then the politicians and administrators should take the responsibility for these cuts in services — not the clinicians who are currently being forced to make life-and-death decisions on a daily basis.

Dire straits: Children in this paediatric casualty ward have to share beds because of a lack of resources. PHOTOGRAPH: NADINE HUTTON

Professor Peter Cooper works in the department of paediatrics at Johannesburg hospital and Wits University. He is chair of the medical advisory committee at Johannesburg hospital

Caring for sick children is their mission

'Mini-hospitals' doing amazing job

(98) ARG 24/8/98

Getting better: for this two-year-old tuberculosis patient, being treated at Sarah Fox Children's Convalescent Hospital in Athlone is a much better option than being sent home. Sarah Fox is one of three hospitals caring for ill and neglected children

BRENTON GEACH

With their club feet, amputated limbs, burn wounds, genetic bone deformities, dislocated hips, rheumatoid arthritis, cancer and, increasingly, AIDS, the children are a far cry from traditional images of carefree youth.

DI CAELERS

HEALTHWRITER

They are the hundreds of sick and injured children who, without the care being offered by the city's less-heralded convalescent hospitals, would seldom have the opportunity of ever really getting well.

Deprived home circumstances mean the children cannot be cared for at home, budget constraints mean hospitals like Red Cross Children's Hospital cannot have patients taking up valuable bed-space for long periods – making the role of convalescent hospitals vital.

Maitland Cottage Home in Newlands, the Sarah Fox Children's Convalescent Hospital in Athlone and St Joseph's Home in Montana care for nearly 300 children.

Alan MacMahon, chief director of the provincial health department's supra-regional services, says there is no way the big hospitals could function without these three hospitals. Red Cross would have to double in size to cope with all the children in need of hospital care in the Peninsula.

"Yet Maitland, Sarah Fox and St Joseph's remain really low-profile in terms of getting financial help, in spite of the amazing job they are doing," says Dr MacMahon.

"Without them, hundreds of ill children would be sent back into communities where conditions mean they cannot possibly be appropriately cared for."

The amazing job they are doing is obvious. The children's welfare is paramount and everything possible is done to ensure they lead normal lives despite their condition.

St Joseph's Home has a fully-fledged school and at Maitland Cottage, where most of the patients are attached to complicated-looking pulley systems, beds are pushed together to ensure their education is disrupted as little as possible.

Maitland Cottage Home matron Jean Schreiber says the hospital caters to orthopaedic trauma patients who are first stabilised at Red Cross and then transferred for surgery and recovery.

The children's stories are tragic; one small girl cries frantically when she sees the camera. The staff explain she is totally traumatised, far away from her home in Transkei where she stepped on a piece of glass and a traditional healer put dung in the wound. She lost her leg at the knee after she developed gas gangrene.

> *'Without them, ill children would be sent to homes where they could not be cared for'*

At Sarah Fox, which has 60 beds officially but 62 patients, the stories of neglect and deprivation continue.

This hospital cares mostly for children with nutritional problems who have tuberculosis and HIV/AIDS, who have been battered, abandoned or burned.

One small girl happily pushing a toy truck down the aisle of one of the wards has lost half her bowel as a result of untreated worms. Another stares from his cot, huge eyes uncertain at the attention. He has been abandoned and staff are negotiating with social workers about his future.

Medical superintendent Frank Friedlander says most of the children need continued treatment and nursing care, but cannot go home because of the socio-economic circumstances in which they live.

"It is amazing to see how they flourish here. They come in not wanting to socialise, not making eye contact, but a couple of weeks later they are such different children you wonder what they're doing in hospital," says Dr Friedlander.

On to St Joseph's Home where matron Sister Simone Gorgen says they care for 150 children ranging from those with cancer, burns and diabetes, to those with rheumatoid arthritis and congenital disease.

The three hospitals are all Government-aided, but are forced more and more to turn to fundraising to meet their enormous need.

Mrs Schreiber points out that there is so much need in terms of children throughout the country that pinning down any financial help is difficult.

"There are homeless children, AIDS babies, streetchildren – all more high-profile causes than our hospital, in spite of the fact that we are picking up all the orthopaedic trauma from Red Cross and caring for about 90 children in great need," says Mrs Schreiber.

Maitland Cottage Home is an operating hospital which pushes up their costs dramatically – one staple they put in a child's leg costs R448, and up to six staples are commonly used on a patient.

The three hospitals all care for about 99,9% indigent children, and the free care for children younger than six applies to them, too, so fees are mostly non-existent as revenue.

In a year, Sarah Fox has collected only R7 000 in fees, as a result of a car accident insurance claim.

They rely heavily on donations and volunteers to fill in for staff.

Mrs Schreiber says Maitland Cottage Home had to close a 20-bed ward because of staff vacancies and other staff away on maternity leave. Sarah Fox has cut eight beds and qualified nursing staff who leave are not being replaced.

■ Anyone wanting to make donations or volunteer, can call Linda at (021) 404 3486.

BRENTON GEACH

Tackling his maths: he may be flat on his back to correct a chronic infection of his femur, but Mandilikhaye Maiho, 13, of Philippi, gets on with his maths lesson, anyway

Bara cuts services to kids with disabilities

(98)

By Charity Bhengu

CERTAIN services to children with disabilities would no longer be provided by the occupational therapy unit at Chris Hani-Baragwanath Hospital because of a staff shortage.

Gauteng Department of Health spokesman Mr Popo Maja said yesterday the services were being rationalised and that group sessions would be offered instead of individual therapy.

He said the department would be looking at seconding more occupational therapists but after conducting a need analysis of the unit.

He said: "Individual therapy is extremely time consuming and because of a staff shortage, the unit can no longer offer the service."

Acting occupational therapy department head Ms Jane Young said the unit had been reduced from 20 therapists to four in seven months.

She said the four therapists in the paediatric section would be leaving at the end of the month.

Young said: "There would be no occupational therapists in the paediatric section and hundreds of children with cerebral palsy, intellectual and learning disabilities, spinal cord or head injuries won't receive therapy. New patients would have to be turned away."

Occupational therapists treating adults have also been reduced from 10 therapists to three.

Therapists treating psychiatric patients had also been cut from three to one in the last six months.

In the burns unit, about 25 children are seen at one time.

Ten children are seen for brain injuries per week and 300 per month for cerebral palsy

Some 20 children are seen for mental disabilities and 10 for congenital deformities per week.

Improved efficiency in state hospitals 'tops the list'

ARG 25/8/99

(98)

HEALTH WRITER

State hospitals are at the top of Health Minister Manto Tshabalala-Msimang's list of priorities.

She said she hoped that decentralised hospital management would mean more efficient institutions.

Currently, management of 15 hospitals countrywide, including the 10 biggest in South Africa, was being decentralised and a critical element of new management teams was "an agility to respond rapidly to changing circumstances," she said.

"We need to see hospitals operating efficiently, being more responsive to users and offering a conducive work environment for staff.

"Decentralised management is central to achieving that."

Hand in hand with that effort went the need to speed up implementation of the hospital rehabilitation programme which would see appropriate incentive schemes introduced to support management reform efforts, she said.

Cape clinics in poor health as budget falters

(98)

MOSES MTHETHELELI MACKAY ARG 28/8/99

Western Cape clinics have little hope of being upgraded and maintenance backlogs have already reached an estimated R15-million.

Clinics throughout the province have been hard hit by budget cuts.

Some offer only partial services, others have operating theatres that don't function, and there are staff shortages all round, according to Gilbert Lawrence, deputy director-general in the province's health and social services department.

The province's primary health care infrastructure was relatively sound, Dr Lawrence said. But the concern was that financial difficulties made meeting any future needs virtually impossible.

The Kraaifontein and Delft community health centres offer only partial services because they can not afford the necessary equipment and basic furniture.

Operating theatres at the Retreat and Mitchell's Plain community health centres are not used because of shortages of resources.

Some district hospitals are also not fully operational.

Although 52 new clinics have been built in the Western Cape and another 29 upgraded since 1994, and four are currently being built, R15-million is still needed to maintain existing centres.

Statistics for patients visiting primary health care centres show that numbers have doubled during the past five years.

Dr Lawrence says there are 297 vacant posts at district hospitals and 264 posts at community health centres.

That is over and above the several hundred vacant posts created by voluntary severance packages and natural attrition.

Staff at the Community Health Services Organisation, which operates the primary health care centres, was reduced 2 500 to 1 924 in 1997.

Low cost clinics do well

(98) CP 29/8/99

By SIMBA MAKUNIKE

Primary health care group, Prime Cure this week said it would invest more than R100 million in the next two years to set up an additional 74 clinics in the country.

Spokesperson, Dr Mario Greyling told the City Press the 26 clinics already established by the group in various parts of the country were doing well and playing a pivotal role in the provision of health care services for the poorly paid.

He said the group was not borrowed but could go on the market to raise funds for expansion.

For R45, patients can access the clinic's services such as diagnosis, pathological services, medicine, family planning, treatment of wounds and burns, immunisation and the treatment of primary diseases.

It also provides occupational therapy facilities for major industries.

Greyling said the group spent about R42 million developing the clinic management software.

Each patient is logged into the clinics's computer system which has a comprehensive database.

The high technology ensures low costs, accurate diagnosis and proper control and distribution of medicine, as well as sound financial and human resources management.

Greyling said the database also enabled the clinic to identify problem areas in terms of primary diseases.

"We have entered into a number of partnerships with the national and provincial departments of health and other organisations to fight the causes of some illness . . . so it also helps us to be proactive," he said.

The Prime Cure Clinic is owned by TSM, which has a controlling stake of 48 percent.

Praxis owns a 16,6 percent stake while Tarkus Holdings BV has a 25,3 percent shareholding.

The rest of the shares, 10,1 percent, are owned by the clinic's management.

Health chiefs in juggling act

ARG 7/9/99

Patient load compounds budget cuts and staff shortages

(98)

DI CAELERS
HEALTH WRITER

Cape Town has a sound primary health care infrastructure – but without enough staff and money to get new health centres fully operational, the delivery of services to patients is still not up to scratch.

Since 1994 the province has effectively improved primary health services to the people in the region, building new clinics and community health centres across the Western Cape. But health care officials readily admit the province remains severely hampered by budgetary constraints and staff shortages.

Another "downside" – in terms of money – is that dramatically improved access to the health service has put added pressure on regional hospitals, which have lost out in the funding to primary health care.

But despite lingering problems, health officials believe they have "stayed ahead of the game", certainly in terms of buildings, if not staffing levels.

Alan MacMahon, chief director of the provincial health department's supra-regional services, says: "Everything we do, we have to look at it again and see if we can do it smarter." He says with budget cuts, all levels of service have suffered too.

The patients suffer – long queues make them frustrated and angry and often lead to outbursts. The staff suffer – they not only work long hours and see hundreds of patients a day, but also often suffer abuse.

But Dr MacMahon and other health officials believe there is hope for a much improved system. Already, since 1994, 52 new clinics have been built across the Western Cape, and another 29 upgraded. In greater Cape Town, 26 new clinics have been built, 20 of them on the Cape Flats. The province now boasts 52 community health centres, 278 clinics, 108 mobile clinics and 51 satellite clinics.

A new community health centre, planned to start operating 24 hours a day by the year-end, has recently been completed in Delft, and upgrades are being carried out at clinics in Crossroads, Nyanga and Manenberg.

Kathy Hillman, deputy director of district health services, says the patient load at community health centres alone has increased by 1,5 million people. Local authority clinics are also dealing with much larger numbers of patients.

Traditionally, she explains, local authority clinics were geared to deal with preventive and promotive health, and provincial clinics with curative medicine. Now, with primary health care's "one-stop shop" focus, facilities are being combined to provide the best possible service.

For example, in Mitchell's Plain where there are two clinics – historically one for curative and the other for preventive health care – adults are now seen at the (provincial) community health centre and children at the local authority clinic.

Provincial director of health policy and planning Krish Vallabhjee says new and improved clinics, free primary health care, free health care for children younger than six, and termination of pregnancies were enormous steps already taken.

"Primary health care facilities take care of the biggest part of the burden of disease in communities."

From an access point of view, says Dr MacMahon, the province has done well in keeping up with fixed health care facilities, even in developing areas like Khayelitsha.

But from a service point of view, like waiting times, they are still not happy. One idea they are looking at to address long queues is the introduction of a booking system.

Ms Hillman calls health a "bottomless pit" but says there is firm agreement that while the financial emphasis during the past five years has correctly been on primary health care, things now have to start stabilising. "It is correct that the emphasis should be on primary health care but if we don't pay some attention to the next two levels, primary health care will ultimately collapse."

The bottom line, they say, is that they have made the start to providing a better health service for everyone in the Western Cape. Now they have to juggle finances and resources to ensure its future success.

New health centres since 1994

- Brackenfell
- Nomzamo, Strand
- Guguletu
- Mitchell's Plain
- Khayelitsha (five new clinics)
- Brown's Farm (two new clinics)
- Crossroads
- Uitsig, Elsies River
- Masiphumelele, Noordhoek
- Kasselsvlei, Bellville South
- Delft
- Macassar
- Matroosfontein
- Nyanga (two new clinics)
- Gordon's Bay
- Marconi Beam, Milnerton
- Strandfontein
- Goodwood (two new clinics)
- Kensington

Britain 'wants to forge water partnerships'

(123) CT(MR) 1/9/99

JOHN FRASER

Johannesburg – Britain offered yesterday to help remove a serious pain in the neck for millions of South African women who walk long distances every day to fetch water.

The bid to "forge a new partnership" in the provision of fresh clean water and sanitation was made by Richard Caborn, the British trade minister, at a conference on water privatisation in Sandton.

Caborn told the water conference that Britain had successfully completed its own water privatisation programme and UK water firms were now expanding their activities around the world.

He said the global market for water schemes would reach $10 billion over the next decade.

"What we in Britain have gained is a valuable knowledge of the benefits and pitfalls of privatisation," Caborn said. "We are also experienced in construction, in major water projects overseas."

He said as South Africa moved towards its own goals in the reconstruction and development programme (RDP), British companies were ready to offer their commitment and entrepreneurial flair.

The British minister held up the latest in-flight magazine of South African Airways, which carried an article on South African women who rise at 4am and walk 15km to get water.

He asked the audience to imagine having to do that "every day for the rest of your lives"

EXPERIENCE ON TAP *Richard Caborn, the British trade minister, tells a conference on water privatisation yesterday that his country's firms have valuable knowledge to offer* PHOTO: SELWYN TAY

Caborn, a founding member of the British anti-apartheid movement, said that ending the "pain in the neck" for the women who carried pots of water on their heads was a serious challenge in which Britain intended to assist South Africa.

Earlier, Ronnie Kasrils, the minister of water affairs and forestry, said he believed Britain had much to offer South Africa in extending water provision to all.

"There are 8 million South Africans without access to adequate water supplies, and 20 million without adequate sanitation," Kasrils noted.

Since the launch of the RDP in 1994, water supplies had been made available for more than 4 million people, he said

The development of private-public partnerships in water provision was "one of the major challenges" facing South Africa because the country had limited public finances.

"There is not enough government money to meet the backlog of water and sanitation services," Kasrils said

"The challenge is to ensure that the public sector engages in more risk-taking exercises"

He told the audience of mainly British businessmen that South Africa was not looking for "off the shelf" water schemes but rather "the intelligent application of knowledge and experience"

He said water provision must become available "at a national level. It must be affordable, efficient and sustainable

"The transformation of the economy is a strategic objective which must be achieved through public-private partnerships," Kasrils said.

B to tackle decaying urban areas

(123)

CHARLES PHAHLANE
POLITICAL CORRESPONDENT

ARG 1/9/99

The National Assembly's housing committee will start discussing legislation today to regulate the residential rental market and stimulate urban regeneration in dilapidated areas of cities.

Mpumi Nxumalo-Nhlapo, the director-general of the Housing Department, said yesterday the Rental Housing Bill would provide stability to the rental market by addressing the problem of non-payment and non-provision of services. It would also encourage private investment and lead to urban renewal through the renovation of dilapidated flats.

The nine provinces would fund a tribunal to settle disputes between landlords and tenants.

The tribunal was expected to deal with technical disputes and its rulings would be equivalent to an order from the Magistrate's Court. But people could still appeal to the normal courts if they were dissatisfied with the ruling.

The Rental Control Act of 1976 would be repealed. Existing rental subsidies to white, coloured and Indians would be phased out in three years and replaced by the new policy.

The subsidies for rental housing envisaged by the new bill would be object subsidies, which means the building and not the individual would be subsidised.

Housing Minister Sankie Mthembi-Mahanyele told a Bureau for Economic Research conference in Johannesburg yesterday that the government was focusing on reducing the backlog of about 2,3 million homes after spending the past five years building houses for the poorest of the poor.

She said the government would start focusing on the inner-city areas to buy and regenerate old buildings.

It would launch a national savings campaign to awaken the "slumbering financial potential" in communities.

"With 2 500 savings clubs in KwaZulu Natal alone, there is no telling how much money we can marshal to establish the financial clout needed to focus on housing development," Ms Mthembi-Mahanyele said.

SA NEWS DIGEST

☐ WATER ET(BE) 2/9/99 (123)

Researcher says no to 'incompetent' UK water privatisation industry (232)

The labour movement yesterday lambasted an offer by Richard Caborn, Britain's trade minister, for the UK to help South Africa with water privatisation projects. Caborn made his offer to "forge new partnerships" during a Johannesburg workshop on private sector finance for the water industry.

David Hall, the director of the London-based Public Services International Research Unit, said: "Unfortunately, the facts do not support the claims that the UK water companies have anything to offer the world." The unit is mainly funded by public service unions. Hall said UK water companies were unpopular in the UK for exploiting an essential service, and outside the UK they had failed to provide a better and more profitable service than local authorities.

Hall provided examples of UK water company failures. These include Biwater in the Philippines, which had been "charging the highest water rates in the world" and Thames Water in Jakarta, which is accused of overcharging. – *John Fraser, Johannesburg*

Hospital equipment safety crisis

(98) ARG 14/9/99

HEALTH WRITER

Medical equipment at Western Cape hospitals and clinics, described as ageing and often unsafe, will cost R300-million to repair or replace.

This was pointed out by health MEC Nick Koornhof, who said the health service had lost more than 8 000 staff in the past three-and-a-half years, and closed 3 500 hospital beds.

Speaking at a press conference yesterday, Mr Koornhof said health services here were stretched to their limit, "and their continued stability cannot be guaranteed, literally, from day to day".

Hospital doctors, some of them inexperienced, were seeing more than 120 patients a day and nurses were routinely expected to cope with over-full wards.

Discussing ways to address the overwhelming problems, Mr Koornhof said further rationalisation of academic hospitals could be expected, to eradicate all duplication.

The provincial health budget had fallen from R3-billion in 1997/98 to R2,9-billion in 1999/2000.

To address the equipment backlog, which Mr Koornhof said was getting progressively worse, he is examining the possibility of "private finance initiatives" which he said worked very well in Britain.

He is also considering a special millennium appeal to raise funds for hospital equipment.

"The equipment backlog has been identified as a priority area should any additional funds become available," Mr Koornhof said.

'Gauteng hospitals rife with neglect'

BD 14/9/98 (98)

Pearl Sebolao

ALLEGATIONS of widespread ill-treatment, abuse, neglect and assaults on patients at Gauteng hospitals were heard yesterday by a commission of inquiry into patient care in the province.

The commission, appointed by Gauteng premier Mbhazima Shilowa to investigate problems relating to patient care in the province's public hospitals, is holding a three-day public hearing at Coronation Hospital in Johannesburg.

Most of the allegations were levelled against the nursing staff, accused of lacking compassion and dedication. Complaints against doctors centred on not explaining their diagnoses and arriving late, if at all, when summoned for emergencies.

Witnesses also testified about lack of urgency in the treatment of patients and not being informed when relatives died in hospital.

An employee at Chris Hani Baragwanath in Soweto told of how the operating theatres often had to cancel operations because of linen shortages. Staff sometimes used paper towels to cover patients, which often fell off during procedures.

Nancy Ngcwala told the commission that nursing staff at Natalspruit Hospital on the East Rand told her to "mind her own business" after she complained about a child who was neglected and left to eat her own excrement. Ngcwala had been visiting her sister, who suffered burns and whose bandages were not changed for days.

Ngcwala's mother, who was admitted to the same hospital after suffering a fit, was given a plastic cover used for corpses at mortuaries to wear as a gown because there was a shortage of linen. She said her complaints about this were ignored.

Her mother died hours later.

"To make things worse, we only knew of her death when visiting her the following day," Ngcwala said.

A woman who spoke to members of the commission's investigation team during on-site investigations last month was assaulted and denied medication by nurses at Chris Hani Baragwanath Hospital, her sister said.

Maria Mashele said she now feared for her sister's safety.

Mashele had also previously written a letter to the Gauteng health department complaining that visitors had to wash and feed the patients while "nurses sit and drink coffee".

Sue Levine, whose sister Barbara was admitted for a cardiovascular condition at Natalspruit Hospital, said the doctors refused to give her sister treatment for asthma or the massive bedsores which she had developed while in hospital. Barbara later died of an asthma-related condition while in hospital, and the hospital tried to cover it up, Levine said.

The commission will today hear submissions from hospital management and the provincial administration. A final report will be handed to government in two weeks.

Picture: Page 3

Lessons learnt from UK hospitals

(98) BD 14/9/99

Cash-hungry Western Cape medical facilities look to British private financing initiatives as a model

Linda Ensor

CAPE TOWN — The Western Cape, faced with a R300m medical equipment backlog in its hospitals, is looking towards the UK model of private finance initiatives whereby equipment remains privately owned.

"Medical equipment is ageing and in many instances it is no longer safe, cost effective or efficient enough to still be in service," health MEC Nic Koornhof said in his policy speech in the provincial legislature yesterday.

The backlog was getting worse each year but the department could not afford to replace major equipment as the health budget remained virtually static, at about R3bn, despite the inflationary increases in wages and goods.

The budget cutbacks meant that during the past three-and-a-half years the department had shed 8 020 posts and lost 3 500 hospital beds.

Koornhof said a conference would be held with the British trade and industry department to understand the system of private finance initiatives. Equipment could either be leased or hospitals charged for use of it. Also under consideration was a special Millennium Appeal campaign to raise funds.

Public private partnerships were in the offing as were two pilot projects in Groote Schuur and Tygerberg in the pipeline. Pilot hospitals were also being allowed to retain their own revenue.

Other initiatives announced were the tabling of a Provincial Health Facilities Board Bill, so as to ensure greater community involvement in running of hospitals. Also planned were an HIV-AIDS desk in the ministry and a provincial HIV-AIDS council of specialists.

Koornhof said the council would be tasked with a complete review of the provincial AIDS policy and would advise on need for legislation to bind business and other government departments to more meaningful participation.

"I wish to introduce a massive enhancement of HIV-AIDS awareness within my ministry. HIV-AIDS is the most serious risk we face," he said. HIV incidence was doubling every 13 months and by the end of the year would be at about 10%.

Various measures would be adopted to improve financial management. A departmental business manager would be introduced and the provincial ordinance amended to allow appointment of CEOs into the hospitals on the basis of managerial skills and qualifications.

It would no longer be mandatory to have a medical qualification. Performance management agreements would be signed with all hospitals by 2002.

Koornhof said provincial health services were "stretched to their limit in most cases and continued stability cannot be guaranteed from day to day".

Hospitals admit patient care is of a low standard

BD 15/9/99 (98)

Pearl Sebolao

MANAGEMENT at Gauteng's state hospitals admitted yesterday to problems with inadequate management, expired medication being kept at hospitals and a lack of dedication by staff which contributed to sub-standard patient care.

Giving evidence at the second day of public hearings by the commission of inquiry into hospital care practices in Johannesburg, the managers said that the incidents of abuse, neglect, starvation and assaults of patients were isolated cases.

Zulelka Rhemtula, a pharmacist at the Chris Hani Baragwanath Hospital in Soweto, told the commission that some of the wards kept medication which had long expired. There was "a possibility that these drugs could find their way to the patients", she said.

Rhemtula also told of a shortage of qualified pharmacists. The hospital had to cope with 12 pharmacists, who also had to attend to the hospitals eight satellite dispensaries. "Since the hospital does not have one central dispensary, this sometimes results in the dispensaries not opening at all."

A representative of the National Education, Health and Allied Workers' Union at the Pretoria Academic Hospital told the commission that the hospital still had separate facilities for different racial groups.

She also cited three cases of racist assaults on black nurses by white staff and accused management of a lack of urgency in dealing with the problem.

Marianne van Taak, also from the Pretoria hospital, admitted to rife absenteeism and a lack of dedication by nurses but denied there were separate facilities for black and whites.

Chris Hani Baragwanath neurosurgeon Dr Rasik Gopal told the commission that some of the management and supervision problems were as a result of absent department heads.

Gopal said there had been little transformation at academic hospitals where the department heads were running their departments from academic institutions and were not permanently deployed at the hospital.

He recommended that there should be a separation of research and clinical posts so that clinical staff were left to run the hospitals

Dr George Varughese, a superintendent at the Natalspruit Hospital where a 13-year-old boy was assaulted by a "mentally confused" patient, told the commission that psychiatric and medical patients were treated in the same wards because the hospital did not have a separate psychiatric facility.

One doctor said they could not guarantee patients' safety, saying that in order to control the psychiatric patients they had to sedate them.

Health services likely to come under pressure

Linda Ensor (98)

BD 15/9/99

CAPE TOWN — The health services of local governments and provincially aided hospitals will come under pressure over the next few years because of increased personnel expenditure and the small rise in central state funding, according to the fiscal review.

High personnel costs mean that there is little room for the funding of nonpersonnel items, which is projected to remain well below 1995-96 levels in real terms.

The report notes that since 1995-96 the setting of primary care as a priority and personnel cost pressures in the context of budget constraints have severely affected hospital budgets.

The increased use of private services by medical aid members and wealthy individuals had reduced revenue from public hospitals.

The report said the channelling of hospital revenue to provincial revenue funds provided little incentive for revenue collection by hospitals. Fee structures had been updated only sporadically and revenue collection had been unequal and inefficient. Mechanisms were being introduced to stimulate revenue generation by the hospital sector. "Mechanisms for revenue retention are now being explored in Gauteng and Western Cape."

Provinces compared

Province	Poverty [1] rate	Welfare and social security expenditure per capita, 1999/00	Public sector as % of total employed
Eastern Cape	70,7%	R 1107	17,4%
Free State	63,4%	R 882	8,7%
Gauteng	17,3%	R 609	4,4%
KwaZulu-Natal	51,9%	R 854	9,8%
Mpumalanga	57,3%	R 710	8,5%
Northern Cape	54,9%	R 486	6,9%
Northern Province	59,1%	R 601	21%
North West	62,1%	R 786	9,3%
Western Cape	28%	R 1056	4,9%
SA	50%	R 1859	8,6%

[1] The proportion of the provincial population below a poverty line that places 50% of the total country's population in poverty

Graphic: KUBEN DAVID Source: INTERGOVERNMENTAL FISCAL REVIEW 1999

Between 1995-96 and 1998-99 consolidated health expenditure grew at a rate of 10% a year against an inflation rate of 7,8%. This was due mainly to the sharp increase in provincial health expenditure in 1996-97 of about 20% in real terms to deal with the amalgamation of previous homeland administrations and the financing of new reconstruction and development programme projects.

Consolidated expenditure growth rates subsequently fell to 7,5% in 1997-98 and 2,4% in 1998-99, as provinces tried to contain over-expenditure. Consolidated health expenditure is projected to grow at an average annual rate of 4,6%, from R23,4bn in 1998-99 to R26,8bn in 2001-02.

Personnel costs, however, grew faster than aggregate expenditure at 9% a year and the share of expenditure on personnel increased from 59,7% in 1995-96 to 64,2% in 1998-99. As a result, essential inputs such as pharmaceuticals and medical equipment were crowded out, often resulting in worsening provision of services.

Abuse of patients under the spotlight

(98)

Sowetan 14/9/99

ALLEGATIONS of nurses assaulting patients, wrapping them in plastic normally used on corpses in mortuaries, and relatives being forced to wash the patients, were reported to the commission of inquiry into hospital care practices yesterday.

The commission, appointed by Gauteng Premier Mbhazima Shilowa to investigate problems relating to patient care in the province's public hospitals, is holding three-day public hearings at Johannesburg's Coronation Hospital.

The commission was appointed after criticism of hospitals for gross violation of patients' rights, with the initial focus on the Chris Hani-Baragwanath, Natalspruit, Pretoria Academic, Sebokeng and Tembisa hospitals.

Natalspruit Hospital on the East Rand was portrayed as one of the worst, with numerous complaints of nurses assaulting patients, including children and the elderly.

One of the witnesses, Ms Catherine Ngqola of Katlehong on the East Rand, told the commission how she was told to "mind her own business" after complaining about a child who was neglected and left to eat her own excrement.

Ngqola had been visiting her younger sister, a burn victim whose bandages were not changed for weeks.

The sister, like other patients in the ward, was never dressed and complained of occasional assaults.

Ngqola said on another occasion she found her mother, admitted after suffering a fit, wrapped in plastic because there was a shortage of linen.

Asked by commissioner Dr Fazel Randera if the plastic was in fact not one of the plastic-like blankets used to warm patients, Ngqola said she found her mother's body wrapped in the same plastic that was used in mortuaries. Her mother died hours later.

"To make things worse, we only knew of her death four hours later when paying her a visit on the following day."

The allegations were echoed by Ms Sue Levine, testifying on the much publicised gross negligence of her late sister, Ms Barbara Whittaker.

Whittaker's treatment at the same hospital was the subject of a special commission of inquiry earlier this year.

Levine told the commission the hospital's staff caused Whittaker to "die a very slow and painful death" refusing to attend to her massive bed sores, and instead accusing her of "complaining too much". – *Sapa*

All agree: Gauteng's hospitals are sick

(98)

BD 17/9/99

While the finger of blame was pointed in all directions, no person or entity was willing to take responsibility, writes **Pearl Sebolao**

THE bleak picture painted of abuse, neglect and ill-treatment by former patients at Gauteng state hospitals during public hearings on patient care this week was "only the tip of the iceberg", the chief investigating officer says.

Bruno Luthuli, who has spent the past three months trying to unravel the extent of the deterioration of hospital services for the commission of inquiry into health practices, said only a few of the many cases investigated were heard by the commission.

The cases illustrated in dramatic detail the crisis faced by the public health system in Gauteng.

Luthuli did not want to elaborate on what else the commission had been uncovered, saying this would pre-empt the commission's findings, which are expected to be handed to Gauteng premier Mbhazima Shilowa, who appointed it, in two weeks.

Some of the allegations made by witnesses at an emotionally charged hearing included assault, the withholding of medication and food to "difficult and demanding" patients by nurses, a patient being forced to use soiled linen and a child who was attacked and killed by a mentally unstable patient sharing a ward with him.

During the hearings the finger of blame was pointed by everyone. Although none denied the existence of problems, no one was prepared to take direct responsibility for the perceived collapse of quality care at hospitals.

The patients blamed nurses and doctors for poor service. Hospital management blamed staff shortages and the health department. The department in turn blamed financial constraints, poor hospital management, fragmented policies of the past and patients for bypassing primary health-care facilities, thus overburdening hospitals.

Even the media was not immune from blame: it came under fire for creating "hysteria with negative reporting", one observer said.

One of the commissioners, Dr Fazel Randera, pointed out that the aim of the commission was not to vilify the hospitals or the professions who ran them. Hence it had steered clear of identifying individuals named in allegations.

"The public hearings are not a witch-hunt, but are designed to get to identify the problems and to try and come up with solutions so that we can avoid similar situations repeating themselves," Randera said.

However, he said where the commission felt disciplinary action should be taken against individuals, recommendations would be made to the relevant authorities.

It was evident during the proceedings that some of the participants — hospital managers in particular — were upset by the allegations and took these as a personal attack on them and their abilities.

The nursing staff, against whom most of the allegations of maltreatment were levelled, did not make submissions to the commission, but the perceived attack on the nursing profession by those who attended the hearings as observers elicited defensive reactions and sent tempers soaring.

During a lunch break at the hearings, two senior nurses confronted a group of student nurses and reprimanded them for wearing skimpy white uniforms.

The students were later reported to their superior, who told them to leave the proceedings because their attire drew negative comments and presented a bad image of the nursing profession.

Randera said it was unfortunate that the nurses were not represented at the hearings, but said their omission was not deliberate.

During onsite inspections they had been informed about the hearing. There were also public notices posted at hospital and advertisements in the media, but they failed to take the opportunity to fully participate in the hearings, he said.

Randera said the investigation into patient care at state hospitals did nonetheless manage to generate a substantial response by all those affected or who depend on the public health care system.

After three months of intensive investigations and onsite inspections, the commission undoubtedly managed to come up with an identifiable list of problems leading to poor patient care.

Among the difficulties highlighted at the hearing were the long waiting times at hospitals, equipment and staff shortages, budgetary constraints and lack of work ethic and compassion by some of the hospital staff.

The commission now faces the task of unravelling the testimony brought before it and deliberating on some of the recommendations suggested by patients, management and provincial officials during the hearings when compiling its final report.

These proposals include closer ties between clinic and hospital services, a toll-free number for patients to complain and the establishment of a medical ombudsman with powers of redress.

Gauteng district health services chief director Refik Bismilla said while it was true that hospitals were overcrowded, rather than "bashing each other", everyone connected to the health-care service, including the department and politicians, needed to take collective responsibility for failing to raise public awareness on how best people could use health-care facilities.

The commission's most important task, however, would be to ensure that its findings and recommendations were communicated to everyone, especially the professionals who should be implementing them.

Dr Rasik Gopal, a neurosurgeon at Chris Hani Baragwanath Hospital, pointed out that the problems brought before this commission were the same as those raised before the Mokoena commission of inquiry at Baragwanath last year.

Gopal said although the Mokoena report came out several months ago, most people at the hospital had not seen the report or its recommendations.

"I hope its not going to happen with this commission's report," Gopal said.

Bara's important role in Africa (98)

By Mokgadi Pela

CHRIS Hani-Baragwanath Hospital has a history of the good, the bad and the ugly, depending on which side of the admission desk one is standing.

The hospital administration had come under fire, even before Chris Hani's name was added to the hospital's title. People accused it of being a bad place because of the "appalling conditions" that patients found themselves in: no hospital beds, constant labour action, and doctors quitting for fear of their lives.

On the flip side, Chris Hani-Bara has also had an admirable history of caring and compassionate healthworkers and dedicated doctors who saw working at the hospital as a vocation of human concern.

It also has one the best-equipped and staffed cardiology units, burns unit, prenatal and post natal care, and advanced gastro-enterology unit manned by among the most experienced specialists in South Africa and from abroad. It trains health workers from all over the continent.

It's HIV research unit was chosen as one of the nine research stations throughout the world.

The fact that it is in the biggest black township attests to its apartheid background and its legacy

Chris Hani-Bara was servicing more than two million people before 1994. But it was under-equipped, understaffed and overcrowded. These factors precipitated the protracted doctors' strike in 1988.

In answer to questions in the National Assembly on October 26 1994, then health minister Dr Nkosazana Zuma said Baragwanath, with 3 205 beds, had been allocated R321 million while Johannesburg Hospital, with 897 beds, had been allocated nearly R368 million.

Other factors have added to the burden of the hospital, among them recent acts of crime, chief of which are theft of vehicles belonging to staff and general lack of security with thugs doing as they please, as well as the closure of wards and the freezing of posts due to inadequate funding.

Not surprisingly, many doctors, nurses and other staff members complain of low morale. They say this has resulted in a number of highly qualified specialists leaving for greener pastures.

Despite its numerous problems, it is unthinkable to imagine Soweto without Bara, as it is commonly known. No wonder the revered institution features in the Guinness Book of Records.

Sowetan 20/9/99

Crime plagues 'top hospital'

Sowetan 20/9/99 (98)

By Mokgadi Pela

ALTHOUGH experts at Chris Hani-Baragwanath Hospital agree the institution has some of the best units and brains in the world, security and decreasing budgets make it difficult to maintain an appropriate level of service

Dr James McIntyre, specialist obstetrician and gynaecologist, says both the reproductive health unit and prenatal research unit are internationally recognised and doing work that is relevant for South Africa.

"All the work we do on family planning and reproductive health is helping to improve services throughout the length and breadth of South Africa. Over and above that, our institution provides excellent training opportunities for medical and nursing staff. The link with universities further strengthens the hospital for the good of patient care," McIntyre said.

Turning to security, he says attacks on healthworkers inside hospital premises and theft of vehicles are cause for concern. "We want to stay focused on what we know best, namely, providing optimum healthcare to patients and world-class research," McIntyre says.

Sowetan has established that in the 1997-8 financial year, Bara was allocated R556 569 000 while the figure for 1998-9 stood at R631 801 000.

The head of gastro-enterology unit, Professor Issy Segal, says their section provides training for healthworkers from all over the continent in the African Institute of Digestive Diseases. "It's been very successful and we are just about to move into new state-of-the-art facilities."

He concurs with McIntyre that security remains the biggest problem at Bara. As for facilities, "We have to improvise."

Head of the renal unit Dr Ivor Katz said he and his team often undertake groundbreaking research. They are due to present three papers at the forthcoming African Association of Nephrology in Abidjan, Cote d' Ivoire.

His biggest headache is decreasing budget that impacts on providing dialysis to patients. "For dialysis to be effective, you need a good social support system. You should have transport and money that will enable you to attend sessions regularly," Katz says.

The Chris Hani-Bara renal unit provides dialysis to 150 patients a month.

Head of the cardiology unit Professor Pincus Sareli says Bara's cardiology unit provides continued training for doctors from as far afield as Botswana, Kenya and Nigeria.

Sareli says the background to the frustrations at the hospital are South Africa's apartheid past.

SOWETAN Monday September 27 1999

Hospitals (98) count cost of violence

sowetan 27/9/99

GAUTENG'S high level of violence is being manifested in the province's state hospitals where over a million casualty admittances – arising from gunshots, stabbings, assaults and vehicle accidents – were recorded in 1998.

Gauteng health MEC gave these statistics in reply to questions by Democratic Party MPL Jack Bloom in the provincial legislature last week.

Bloom said in a statement yesterday the high trend continued in 1999 with 615 000 persons admitted between January and August.

The Johannesburg Hospital treated 6 555 gunshot victims in 1998, followed by the Chris Hani Baragwanath Hospital with 3 201 and the Oliver Tambo Memorial Hospital with 2 032.

Bloom said the Chris Hani Baragwanath Hospital was the busiest overall. The hospital treated 105 000 patients last year, followed by Johannesburg Hospital's 80 000, Natalspruit's 65 000, Helen Joseph's 54 000 and the Pretoria Academic hospital's 48 000 patients.

The cost to the state, for 16 of the 23 hospitals for which statistics were available, was an overwhelming R340 million a year.

Chris Hani Baragwanath Hospital alone spent an average of R12,3 million a month or R148 million a year to treat these patients, Bloom said.

He said according to Ramokgopa the Chris Hani Baragwanath Hospital was in dire need of a new casualty department. Various financing initiatives were being pursued in this regard

Bloom said the figures were "truly tragic" as they reflected the high levels of violence in society and the lack of sufficient road safety measures.

"We can add an extra 20 percent if we include casualties at private hospitals, and this means that one in every seven people in Gauteng can expect to end up in a hospital casualty department every year," he said.

Bloom added that casualty departments were unfortunately notoriously overstretched especially over weekends

Bloom said prevention was feasible, cost-effective and desirable. – *Sapa*

Bid to control private hospitals

Health industry slams draft Bill, which will lay down details regarding care, equipment and even training

(98) ST 3/10/99

RANJENI MUNUSAMY

NEW health laws will spell out how private hospitals must operate, including the type of care they should provide, the equipment they can use and even the training they must give to staff.

The legislation, set to be piloted in KwaZulu-Natal and in a new draft National Health Bill, requires all hospitals, both public and private, to apply for "certificates of need" that will state what services they can render.

The chief director of hospital services for the national Department of Health, Dr Tim Wilson, said the legislative move was spelt out in the White Paper.

It states: "To avoid duplication of expensive equipment in certain geographic areas, all equipment should be purchased through a system of control [and] be used optimally by both the public and private sectors."

This would mean that entire specialist units and departments at hospitals could be shut down if there are similar services at other institutions in the area.

"Whether we are in the public or private sector, we need to keep our prices down. It would be much cheaper for everyone to make maximum use of available equipment," Wilson said.

But some private health-care providers have branded the legislation as "draconian", saying it may undermine the ability of owners to run their hospitals.

Dr Jack Danchin, chairman of Amalgamated Hospitals, which administers four institutions in KwaZulu-Natal, said the new laws could spell the end for the private health-care sector.

Certificates of need to operate hospitals would be issued for a maximum of five years but could be granted for only two, at the discretion of the ministers.

"Who in their right mind would invest millions of rands in a private health-care facility which could be closed down in two or three years?" he asked.

"It is totally unreasonable that a private institution can be told by someone else who it can employ and what equipment it can use.

"We are risking our own money if we have too many beds or too much equipment. The concept of restructuring the sector to add beds where there is a shortage is not practical. If they close us down here, I am not going to rush off and build a hospital in Ulundi."

Dr Richard Friedland, chief operating officer of the Netcare Group, which owns 44 private hospitals in the country, said he could not comment because he had not yet seen the draft Bill.

"However, any legislation which purports to close down facilities would have to be questioned," he said.

He said Netcare's policy was to foster strong relationships with the public sector.

The managing director of the Hospitals Association of South Africa, Dr Annette van der Merwe, said she did not want to comment on the legislation because it was still in draft form.

'Hospitals have problems, but give good care'

Xolani Xundu

INVESTIGATIONS into hospital care practices in Johannesburg were complete and a report would be made public next week, Gauteng premier Mbhazima Shilowa said yesterday.

Shilowa said he was encouraged that the commission of inquiry appointed to investigate the matter made its findings and submissions without fear.

He said he was also encouraged that the findings made it clear that the public and the media should understand there were problems in hospitals, but that good service was also being provided.

"One death because of negligence is one death too many. We should place the issue within its particular context," said Shilowa.

The Gauteng legislature would indicate what steps each hospital should take to reduce waiting times for patients.

Importantly, hospitals should be able to tell people that not all ailments needed to be treated at a hospital, but that some could be dealt with at local level in a clinic.

Hospitals would also have to take steps to make sure they eliminated the theft of linen and medicines and improved security.

Shilowa said the legislature had budgeted R25m for capacity building and management in various hospitals in the province.

He said there was no moratorium on the recruitment of staff, but hospitals should come up with reasons for wanting more people.

He also indicated that staff could be moved around from areas where there was a surplus to where there were shortages, if the need arose.

On the issue of taxi violence, Shilowa said taxi ranks and routes in Soshanguve would be closed and would only be reopened when the provincial legislature was satisfied that peace prevailed.

"We are going to act decisively on this matter at an appropriate time. We are going to arrest people who transgress this, impound their vehicles, and the police will continue to monitor and patrol the area," he said.

BD 7/10/99

CAPE TIMES
FRIDAY, OCTOBER 8, 1999 ★

RATES INCREASE SLATED

Row over tariff hike at private hospitals

ET 8/10/99 (98)

GOING to a private hospital from next year is going to be a costly exercise should these hospitals implement the suggested tariff hike. Health Writer **JUDITH SOAL** reports.

FROM January a woman going to a private hospital to have a baby by Caesarean section might be asked to put down a R10 000 deposit. People having hip replacement surgery could be told to pay R30 000 before they are allowed in the door. Even if you are just having an X-ray, they are likely to make you pay upfront.

If you can't afford it, you will be sent away — untreated.

At the moment, private hospitals accept patients who belong to medical aids without asking for a deposit. If the hospital's rates are higher than medical aid rates, the patient will receive a bill for the difference after they have been treated.

Now, because of a dispute between medical aids and private hospitals over tariff increases, this arrangement is likely to fall away.

On Wednesday the Hospital Association of South Africa (Hasa) announced it was recommending a 9,5% tariff increase to its members from January. The Board of Healthcare Funders (BHF), which represents 170 medical schemes, slammed the move immediately.

"All indications are that inflation will be in the region of four to five percent," said BHF chief executive officer Aslam Dasoo. "Because of this we are recommending a 4,5% increase to our member schemes. How can hospitals suddenly demand a 9,5% increase?"

He said hospitals were holding consumers to ransom.

"Everyone says 'oh, never mind, the medical aids will pay'. We are saying the medical aid can't pay. If we were to meet this tariff increase, we would have to ask members to increase their contributions way above the inflation rate and we don't believe this is fair."

Dasoo said if private hospitals implemented the 9,5% tariff increase, medical aids would pay their portion of the bill directly to the member and not the hospital.

"Our contract is with the patient. Until now we have paid the hospitals as a matter of convenience, but if they want to go off with these ridiculous increases, we will only deal with the patient."

In response, Hasa's Martin Weltman said hospitals would ask patients to pay for services upfront.

"We all know what people are like. If you get a sudden windfall from the medical aid, you are likely to go and buy a new fridge or go gambling, then when the bill arrives you've got nothing left. That's why we need a deposit."

Weltman insisted the tariff increases were necessary to cover the cost of importing expensive equipment from overseas.

"Also, we are having to pay our staff overtime for the first time. Until the new Labour Relations Act was instituted, we were exempted from overtime payments. Because we work 24 hours a day and seven days a week, this is very expensive."

Dasoo remained unimpressed.

"Why are they hiking rates across the board if it is just for equipment. We would be more than happy to discuss a special rate for equipment with them. And they aren't the only ones having to pay for overtime. All businesses are having to do it. Why do private hospitals think they are special?"

South Africa has about 200 private hospitals with a bed occupancy rate of about 60%.

CT 14/10/99

Red Cross can now get a move on

(98)

JUDITH SOAL
HEALTH WRITER

THE ophthalmology department at Red Cross Children's Hospital has never had a room long enough to do proper eye tests on children with bad eyesight.

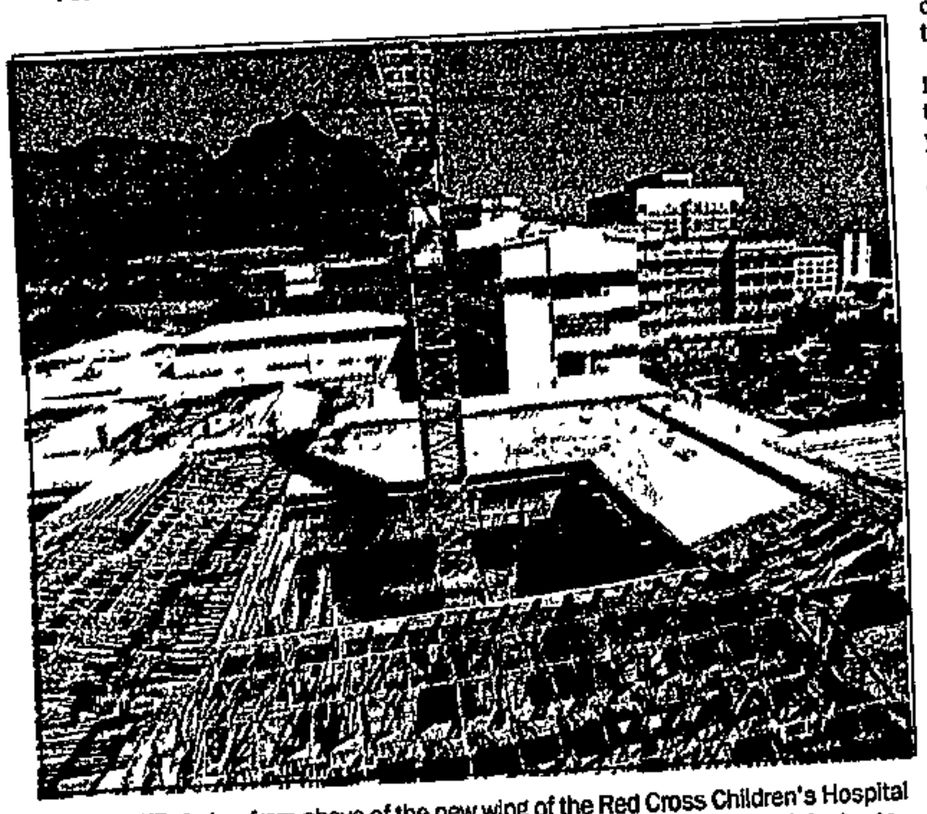
Specialists have had to use mirrors to simulate the length of the standardised tests.

When the new wing of the hospital opens next year, the mirrors will be a thing of the past

"For the first time they will have a room that is the right length to do the tests properly," said nursing sister Fleur Key, as she showed a group of doctors and donors around the construction site of the new outpatients' unit yesterday.

Also for the first time, there will be sound-proof rooms, where the delicate adjustment of hearing aids can be done without the intrusion of lawnmowers outside.

Allergy specialists will be able to talk to parents in private about their children's condition, rather than having to share a room with four others.



BIRD'S-EYE: A view from above of the new wing of the Red Cross Children's Hospital that will house the outpatients' unit and the medical emergency section. It is due to open next year Donors, staff and friends of the hospital were taken on a tour of the construction site yesterday. *PICTURE: DENZIL MAREGELE*

Surgeons say they will finally have a space to consult in peace.

The names of the clinics in the new wing reflect the changing face of public medicine: The Pfizer Laboratory, the Lanzerac Education Room, the Caltex Child Care Centre, the Old Mutual Cardiology Clinic

They also reflect the hard work of the Children's Hospital Trust, who have — so far — raised R30m of the R43m required for the redevelopment.

"Over 140 000 children are seen in the outpatients' unit every year, and thousands come to the medical emergency centre, so they will all benefit," said the trust's Niccy Bishop.

"At the moment the emergency room is like a cupboard in a rabbit hutch. Once this is finished it will look more like the ER you see on television"

Dodging cement and ladders and wearing hard hats instead of surgical caps, the group of surgeons who inspected the site yesterday said they liked what they saw.

"Is there an architect in the group? Can we put a skylight just here," asked paediatric surgeon Alistar Millar.

"Why are we half the size of neuro -logy?" moaned the head of paediatric surgery Helns Rode.

The redevelopment of the children's hospital has been planned for 11 years.

The trust started raising money in 1995, and the first phase of the project, which included the accommodation centre for parents, was completed in November 1998.

The second phase is the new wing, which will replace the old, prefabricated buildings that were erected in the 1960s and '70s.

It should be completed by June. The entire project, funds willing, should be over by March 2001

● Anyone who wishes to contribute towards the Children's Hospital Trust can phone (021) 686-7860.

Limited private practice to end

(98)

By Bhungani Mzolo
Health Reporter

THE controversial policy of limited private practice, in terms of which doctors employed by the state could also do private jobs, comes to an end on December 31, according to an agreement between the Department of Health and the South African Medical Association (Sama).

The agreement was reached after Sama, representing doctors and dentists, took the matter to the Commission on Conciliation, Mediation and Arbitration.

A number of doctors argued that the abolition of the practice would lead to many doctors leaving the public health system and moving to private practice.

But according to Dr Stephen Hendricks of the Department of Health, limited private practice was a privilege the department afforded doctors in allowing them to do private jobs – such as teaching or working in their surgeries – once they had finished their eight-hour work day as required by the department. Doctors first had to get permission from the director-general.

"The parties are confident that this agreement was in the best interest of the public," Hendricks said.

He did not believe that the abolition of limited private practice would lead to an exodus of doctors from government hospitals. The parties committed themselves to working together to ensure the availability of the required expertise within the public health system, he said.

"Furthermore, the parties committed themselves to deliver healthcare services to the population in line with the comprehensive primary healthcare policy of the country," Hendricks said.

Sowetan 11/10/99

PUBLIC HOSPITAL DOCTORS

SHORT-SIGHTED MOVE (98) FM 15/10/99

Private work ban fuels exodus

From January 2000, public-hospital doctors may no longer be allowed to supplement their salaries by doing private work. The imminent ban on limited private practice by the Health Department — which allows doctors to spend no more than 11 hours a week treating private patients — has already resulted in the resignation of 20 doctors from Wits Medical School, including almost the entire oncology unit.

A further 100 Wits doctors have applied for permission from the province to continue seeing private patients under the general instrument provided to civil servants who moonlight, known as Rwops (Remunerative Work Outside the Public Sector). But if the province grants them permission to undertake private work only outside office hours, as it has indicated, more resignations are on the cards.

"The combination of the moratorium on appointments and the ban on limited private practice is crippling the ability of the province to provide hospital services to the community," says SA Medical Association spokesman Dave Morrell, Wits professor of anaesthesia. As a result, his department has been forced to close its surgical intensive care unit. "For the Health Department, coming out within the budget seems more important that what services are lost," he says.

For Prof Werner Bezwoda, a top academic in charge of Wits' department of clinical haematology and oncology, the ban is the last straw in the ill-treatment of academic medicine. Three of his staff have resigned with him and two more will leave unless the Health Department agrees to partially privatise his unit. The idea is for the team to run the unit on a contract that stipulates how many hours must be devoted to public patients. It would be free to treat private patients and to manage its own budget.

Arnold Pronto

Max Price

"It would be a distinctly positive development," says Wits Medical School dean Prof Max Price.

In the Western Cape, doctors and health authorities are also negotiating a novel solution to the problem. The University of Cape Town has proposed turning a mothballed floor of Groote Schuur Hospital into a 125-bed private ward.

Generating income for the hospital and the doctors from private patients would enable the hospital to retain top-class specialists and preserve the quality of medical technology and the teaching environment, says UCT deputy vice-chancellor Prof Dan Ncayiyana.

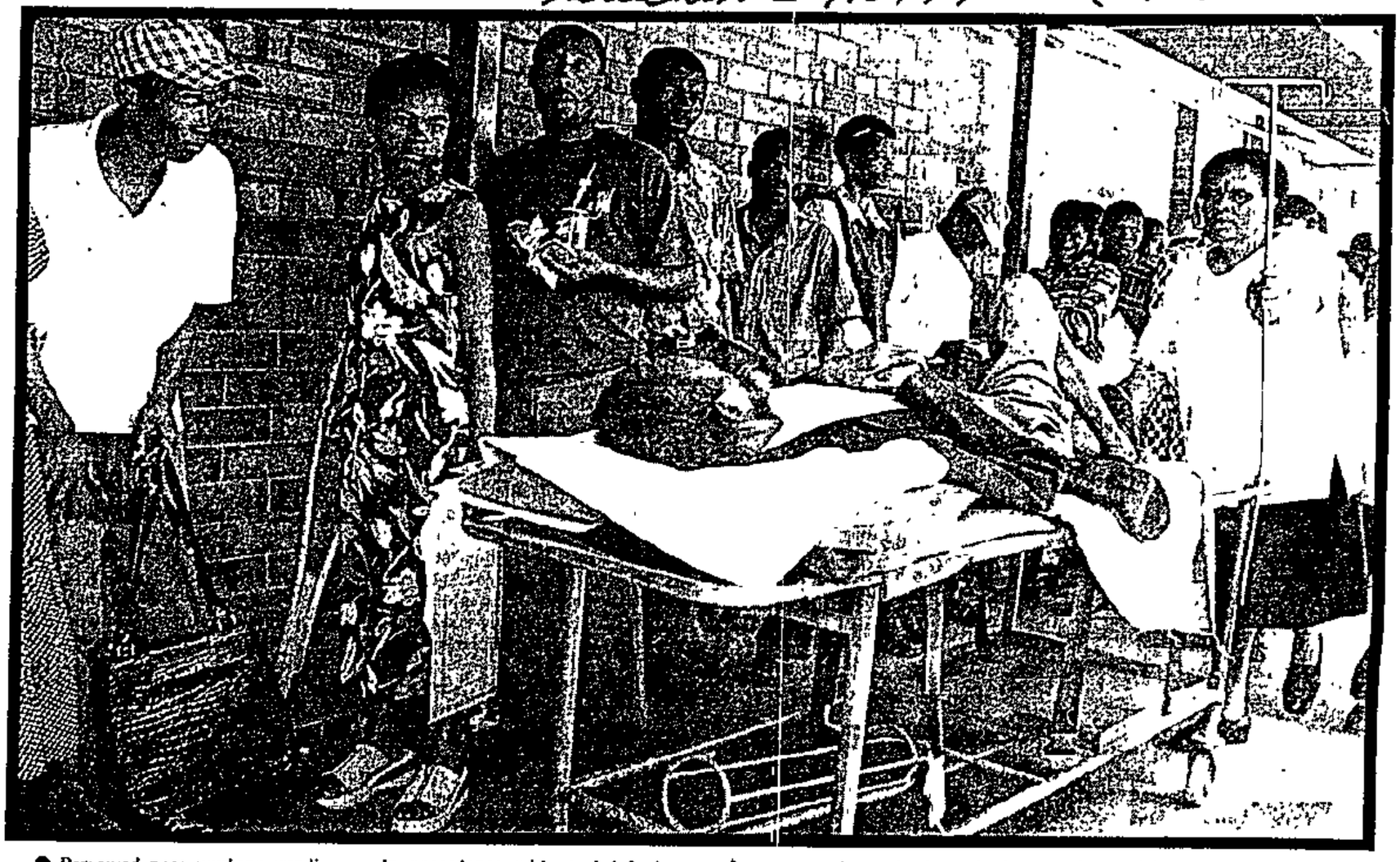
As a result of this plan, which is expected to be approved within six weeks, there have been no resignations at UCT over the ban. But were the project to be called off, "we'd see a haemorrhage of staff".

It's time politicians realised the gains from public-private-sector partnerships. Innovative solutions and improvements to the regulation of the system are required, not a blanket ban. If anything, it will deepen the public hospital crisis.

Claire Bisseker

Gauteng hospitals' sick state of affairs

Sowetan 20/10/99 (98)



By Bhungani Mzolo
Health Reporter

THE report of the commission of inquiry into hospital care practices at several Gauteng hospitals, released by the provincial health department yesterday, confirms that the quality of healthcare at many of them is fast deteriorating.

According to the report, the morale of hospital staff – including nurses and doctors – is also at an all-time low.

The commission was appointed by Premier Mbhazima Shilowa in July. The institutions investigated were Chris-Hani Baragwanath, Pretoria Academic, Sebokeng, Natalspruit and Tembisa hospitals.

An initial commission of inquiry into the state of patient care at all provincial hospitals was appointed by the then premier Dr Mathole Motshekga on May 5.

In July this commission submitted what it called an interim report in which it sought approval for an extension of time to continue its brief.

The second commission was given the brief to investigate only five hospitals in the hope that what was found there would give an adequate reflection of the situation at all state hospitals.

It is to the credit of the commission that it completed its task on time, which included visiting all five hospitals, collecting and checking information, conducting independent investigations and hosting public hearings.

The commission made several findings:

- There were complaints by patients that they spent too long waiting to be seen;
- A general uncaring attitude of professional and supportive staff;
- A shortage of linen which often resulted in the cancellation of surgical operations;
- Patients using dirty linen or being asked to bring their own;
- The poor and inadequate quantity of food for patients;
- Relatives having to feed and bath patients;
- Pharmaceuticals not being available at certain times, which forces patients to return to the hospital the following day just to get medicine;
- The poor state of security of both patients and their belongings; and
- Poor communications between staff and patients, and between management and patients.

The commission also made several other findings which it said impacted negatively on hospital patient care. These included:

- The lack of money for hospitals due to the overall budgetary limitations imposed by the department of health;
- The problems caused by lack of adequate nursing and medical staff, or lack of inappropriate equipment and facilities;
- Perceived poor working conditions as a result of staff shortages and inadequate facilities;
- The uncaring attitude of staff, including their refusal to assist needy patients, arrogance, intimidation, lack of confidentiality and poor communication;
- An unacceptable level of incidence of intimidation and harassment of patients by staff;
- Lack of cooperation from some staff and the pressures brought to bear on nursing staff when support staff who are categorised as essential leave their work to take part in marches; and
- The extent to which nurses and doctors have been accused of being negligent and indolent in discharging their duties.

In accordance with its brief, the commission made several recommendations to the provincial government on how to improve this state of affairs.

The commission recommended that "disciplinary procedures be instituted when staff are unwilling to assist patients, fail to adhere to codes of conduct or intimidate patients."

On managing the budget, the commission recommended that the hospital management should introduce measures to prevent overspending through joint financial committees or regular reports from all departments.

However, a number of specialists and heads of departments in these hospitals have already pointed out that there cannot be any cutting back on any service, whether relating to staff or equipment, without further diminishing the quality of patient care.

Concerning the shortage of linen, the commission recommends that hospitals give this priority to avoid cancelling operations. However, most hospitals have already been doing this for some time – without much success.

On filling vacant posts, the commission recommended that the department provide hospitals with a policy and procedural framework and organise the necessary training.

But surely what hospitals need more urgently is the necessary funding to pay for posts.

Perhaps the commission's most important recommendation is to conduct thorough research "on the impact of new policies or policy amendments to hospital budgets and infrastructure to allow the national cabinet and provincial executive to make informed decisions."

But, on the whole, the commission's recommendations seem to indicate that it did not want to be the bearer of bad news – whether to the Government, hospital management or public.

The recommendations are couched in language that is both apologetic and non-committal.

In a foreword chairwoman Maria Rantho writes: "It is important that the public out there and the media understand that undoubtedly there are problems in hospitals, but equally there are good services provided by dedicated, committed health professionals and support staff."

Sick state of affairs

Damning report on healthcare reveals abuse of patients

(98)

Sowetan 20/10/99

By Bhungani Mzolo
Health Reporter

A SHOCKING picture of patient neglect, uncaring attitudes by health workers and poor quality of food, intimidation, harassment and arrogance emerged when the commission of inquiry into hospital care released its report yesterday.

The report found that in the hospitals under investigation, there were shortages of linen, resulting in the cancellation of surgical operations and patients being asked to bring their own linen to the hospitals.

The commission, which was appointed by Gauteng Premier Mbhazima Shilowa in July, was asked to investigate hospital care at Chris Hani-Baragwanath, Natalspruit, Pretoria Academic, Sebokeng and Tembisa hospitals.

The appointment of the commission came after reported incidents of patients dying from neglect at government hospitals and from assaults by staff.

In June, specialists and heads of departments at four academic hospitals warned the health department that unless certain key posts of doctors, nurses and pharmacists were filled, the health system faced collapse.

The commission's findings showed there is a poor state of security for patients. It said there was a poor state of communication at all levels, between staff and patients, and between hospital management and patients.

Other factors impacting negatively on patient care are:

- Financial constraints experienced by hospitals due to the overall budgetary limitations;
- Internal constraints experienced by hospitals in varying degrees due to lack of equipment, medical officers, nursing staff and inappropriate facilities;
- Perceived poor working conditions as a result of staff shortages and various inadequate facilities;
- An uncaring attitude of staff who refuse to assist patients, and who are arrogant, lack confidentiality and are poor communicators;
- An unacceptable level of incidents of intimidation and harassment of patients by staff;
- Lack of cooperation from some support staff and the pressure brought to bear on nursing staff because support staff are not categorised as essential service workers and often leave work to take part in labour marches; and
- The extent to which nurses and doctors have been accused of being negligent and indolent in discharging their duties.

The commission made several recommendations, including improving the generation of revenue; organising regular forums for hospital managers to share ideas on the budget; paying attention to communicating with hospital management and making additional funds available for the plan to restructure services.

DP slams hospital care report

(98)

By Bhungani Mzolo
Health Reporter

THE report by the commission of inquiry into hospital care practices, which was released by the Gauteng government yesterday, has been slammed for not being strong on ways to address patient grievances.

Democratic Party spokesman on health Mr Jack Bloom said he was disappointed that the commission did not call for the establishment of an independent public health protector.

"All those people who appeared at the hearings had very real problems and I was disappointed that the commission did not call for the establishment of a stronger mechanism for the redress of patients' grievances," he said.

Bloom called for an independent office of an ombudsman, which would funded by the state

Addressing a press conference after the release of the report, Gauteng MEC for health Dr Gwen Ramokgopa said most of the problems identified were shortcomings that were well known to the management of her department.

"Many of the commission's recommendations coincide with and confirm initiatives that are already in progress in our health services," Ramokgopa said.

She said the provincial cabinet had already allocated an additional R25 million to boost management capacity for transformation

In addition she had approached the national Health Ministry about additional funding for capital work at Pretoria Academic Hospital.

She said new tariffs would be introduced at hospitals so that those who were able to pay could do so.

Automatic billing systems were being upgraded at all hospitals.

On the abuse of patients by staff, Ramokgopa said her department remained intolerant of unethical behaviour by staff members.

Sowetan 20/10/99

nquiry proposes hospital remedies

Pearl Sebolao (98)

THE Gauteng government has been advised to fill key posts in hospital services by immediately freezing all noncritical administrative posts in the province.

A commission of inquiry into hospital care practices also proposed that the provincial health department provide hospitals with a policy and procedural framework on filling posts and organising training.

The commission's key recommendations focus on the strengthening and review of management structures, efficient budget management and health-care ethics, as well as the "hospitality side of patient care".

The commission, appointed by Gauteng premier Mbhazima Shilowa in July to address poor patient care in the province's five hospitals, made at least 94 proposals in its report released yesterday.

The department should establish an equipment database and perform regular audits on the serviceability and utilisation of equipment, while letting hospitals tender for the use of private sector equipment as a way of addressing the shortage of equipment and facilities.

"Managers also have to be seen to be managing the hospitals," said one commissioner, Dr Fazel Randera. The department should prioritise a review of hospital structures and powers, using a "fresh approach outside conventional public service blueprints", and conduct an awareness campaign on ethical conduct, the commission said.

Managers needed to step up supervision of junior staff, ensure adherence to work hours and use disciplinary measures to deal with misconduct.

Health MEC Gwen Ramokgopa said new tariffs would be introduced. Those who could afford services would be obliged to do so. Unemployed or indigent people would be catered for. The new tariff structure would be staggered according to affordability levels. Automated billing systems in hospitals would be upgraded by next June.

Measures to address financial constraints, identified by the commission as negatively affecting patient care, would be announced soon, Ramokgopa said.

The department said better management alone would not enable it to stretch resources. A fundamental reorganisation of services was needed. Randera said patients waiting in long queues, the way patients were treated and attitude problems could be alleviated in a year.

BD 20/10/99

MAIL & GUARDIAN
October 15 to 21 1999

Ghosts paid while people die

(98) M+G 15-21/10/99

Peter Dickson

The Department of Health in the Eastern Cape is battling to maintain hospitals after R15-million was lost through paying salaries to people who had died or resigned.

Not even the much-vaunted volunteer Cuban doctors, deployed in the province by the government in February 1996 to address the shortage of doctors in rural areas, have escaped the cash-flow chaos. At Queenstown's Frontier hospital, one surgeon has resigned and returned to Cuba after working unpaid for four months.

Another, the hospital's only qualified anaesthetist, has worked unpaid since January, while other Cuban doctors at the hospital last received payment in July.

Late last week, following the first-ever summons of a permanent secretary to appear before a parliamentary committee by the speaker of a provincial legislature, Department of Health permanent secretary Dr Siphiwo Stamper admitted that "between R12-million and R15-million" had been blown on ghost salaries. Stamper was summonsed after sending an apology half an hour before he was due to give evidence before Bisho's public accounts committee two weeks ago.

Stamper faced two months in jail or a R4 000 fine if he ignored the summons, which included orders to produce reports by accounting consultants, the main ledger for 1998/99, reconciled expense accounts and the appropriation accounts and related statements for 1997/98 and 1998/99, the department's training plan, and a list of courses/workshops presented to date and the number of officials who had attended them.

The committee had rejected an earlier report from the department, saying it had not answered questions adequately enough for it to be able to report to the legislature.

It also emerged that health department finance director Pakisa Peppetta had not read the auditor general's report.

Stamper told the committee that up to R15-million had been lost through paying salaries to people who had died, resigned or transferred to other provinces, as well as to people who had received double salary payments.

Compounding this was a "chaotic" revenue collection system. The department was busy removing the ghosts from its payroll and setting up processes to recover the money, he said, before admitting that the department had not followed proper auditing procedures and that staff shortages in the department's finance directorate included no deputy directors for financial planning or control and no assistant directors for bookkeeping, revenue collection, transport, provisioning or administration.

Stamper said that the department needed R300-million, which it had not budgeted for and could not afford, to address the staff shortage. He also told legislators that administration had "crumbled" in some hospitals because of the staff shortage and that "unscrupulous" people had taken advantage of the situation.

SOWETAN Wednesday November 3 1999

Acclaim for patients' charter

Sowetan 3/11/99 (98)

By Bhungani Mzolo
Health Reporter

THE launch yesterday by Health Minister Manto Tshabalala-Msimang of the National Patients' Rights Charter has been hailed as a positive step towards creating a culture of human rights.

Several organisations and individuals involved in human rights, among them the Commission for Gender Equality, the Public Protector and the Human Rights Commission (HRC), praised the charter.

"The right to life and the right to health are two of the most important human rights," Ms Flora Motsitsi, of the Public Protector's office, said. "And without health, the right to life means very little."

She was supported by the HRC's Ms Shirley Mabusela, who said: "The patients' charter provides a yardstick by which to measure health care given to patients."

She said the challenge now was to ensure that all patients and health workers knew about and implemented the charter.

Among other things, the charter states that every patient has the right to a healthy and safe environment; to participate in decision-making; to access to health care; to knowledge of his or her insurance or medical aid scheme; and to the choice of health service.

It also says every patient has the right to be treated by a registered health care provider; to confidentiality and privacy; to informed consent; to refuse treatment if he or she so wishes; to be referred for a second opinion; to have continuity of care; and to complain about health services.

The launch of the charter comes barely a week after the publication of a damning report by the commission of inquiry into hospital care practices in Gauteng, which found that staff at hospitals were indolent and arrogant, and that patients were routinely assaulted and their property stolen.

More damning was Tshabalala-Msimang's claim that findings of the commission matched findings by her own departmental inquiry, and she had committed herself to upholding the rights as spelt out in the charter. "We need to write, talk and demand these rights and educate our fellow citizens about health rights.

"May this effort inspire all of us, rich or poor, urban or rural to take individual and collective responsibility for our health, and to build a health system that is relevant, appropriate, effective and efficient. And above all, one that is free from the shame of patients' rights abuse," she said.

CAPE TIMES
FRIDAY, NOVEMBER 5, 1999 ★

'IMPOSSIBLE TO REPLACE STAFF'

Mounting debt forces more hospital cuts

CT 5/11/99 (98)

DON'T blame the nurse when she tells you your hernia operation has been delayed. Western Cape state hospitals are cutting back because they are running out of money — again. Health Writer **JUDITH SOAL** reports.

WESTERN CAPE hospitals are preparing to further cut back the services they offer after predictions they will accumulate an R80 million debt this year.

The head of health and social services in the province, Tom Sutcliffe, said yesterday his department could not afford to maintain services at their present level.

"We have just finished our projections of expenditure until the end of the year and it's clear that we don't have enough cash," Sutcliffe said. "We have no choice but to cut back."

"Cold" or non-emergency operations like cataract removal, hernias and hip replacement surgery will be reduced, meaning the already long waiting lists will extend even further.

Alth ugh no jobs will be lost, Sutcliffe said it would be "virtually impossible" to replace staff who leave.

"This will inevitably lead to closure of some beds and facilities as our already overtaxed nursing staff cannot do more than they are doing."

The department hopes the cuts will reduce the deficit from R80m to R25m.

Sutcliffe said he was concerned about the impact the latest cuts would have on the training of medical students.

"Teaching hospitals require a broad spectrum of patients, which is now denied, and modern equipment, which we are unable to replace. But to retain services at the present levels would require funding the deficit from other areas of health services, in particular primary care and rural services. This is not acceptable," he said.

Academic hospitals have been faced with diminishing budgets and staff losses for the past five years, as the priority of the health ministry has shifted from costly medical interventions towards primary care facilities that can reach more people for less money. The theory is that primary health care will relieve the burden on the tertiary institutions, because diseases will be detected early and cured before they become acute.

Health policy analysts across the spectrum agree this is the only way to improve the health of the 80% of South Africans who don't have medical aid and are often denied access to even the most basic of health services.

Yet it is a bitter pill for academic hospitals who have lost over 2 000 posts since the restructuring began. Academic hospitals like Groote Schuur, Red Cross and Tygerberg still consume the bulk of the health budget and proportionately more than other countries with a similar economy. Their remaining staff are struggling to maintain their proud reputations.

A health "business plan" instituted last year was intended to keep hospitals within budget, but Sutcliffe said an unexpectedly high increase in trauma cases had led to the anticipated shortfall.

"We are being called on to spend a higher proportion of our resources on trauma," he said.

"Many patients enter our facilities as a result of alcohol, smoking, drugs and violence. These people are crowding beds and resources required by others."

He said the situation was not as serious as the recent well-publicised claims by hospitals in Gauteng that they were unable to function because of budget cuts.

"This is more like a short-term cash crisis," he said.

"Things will return to normal by the end of March."

Provincial health MEC Nick Koornhof said the announcement had been made to protect health workers from disgruntled patients.

"It is unreasonable to expect our nurses and doctors to bear the burden of explaining to the public why our services must, in some instances, be reduced," he said.

He said the department was negotiating with the provincial treasury to ensure a "realistic" budget for health over the next three years.

Corvettes before kids

Hospitals chief slams state for spending scant resources on weapons

ADELE BALETA

Africa's only dedicated children's hospital, Red Cross in Cape Town, will have to take the drastic step of closing its doors to sick children for three months if it is to stay within budget for this financial year.

This warning comes as Western Cape hospitals face huge service cuts as they run out of funds.

At a crisis meeting at Red Cross Children's Hospital this week, provincial hospital chief Tom Sutcliffe attacked the government for spending money on corvettes instead of children.

The head of paediatrics, David Power, said the hospital needed to save R7,3-million by March. With operational budgets already cut to the bone, its only option would be to stop delivering a service.

Addressing a packed meeting of concerned staff, he said key medical and technical staff had gone, strategic equipment was not working, beds had been closed and services were failing.

If the hospital, which has garnered huge public support, was shut over the millennium celebration period the Cabinet would maybe take notice, he said.

Dr Sutcliffe, the provincial head of health and social services who was invited to hear about the plight of the ailing hospital, said he was "disturbed" by the country's apparent lack of commitment to health care.

There was an upswing in economic growth, the deficit before borrowing had dropped, and yet the extra money was spent on corvettes. "We thought it would go to education and health," he said.

This week Dr Sutcliffe said in a press statement that his department had run out of cash and Western Cape state hospitals would have to cut back even more, because predictions were that by the end of the year accumulated debt would be R60-million.

He believed this was a short-term cash crisis and that an unexpected high increase in trauma cases had led to the shortfall.

Some beds and facilities would close, cardiac surgery would be reduced and non-emergency operations would be delayed. No staff would lose their jobs.

At the meeting, Dr Sutcliffe admitted the voluntary severance package, the tool used to "right-size" the public sector, was "blunt", "dumb" and "unintelligent".

He said the department had not taken into account the United Nations Convention on the Rights of the Child in this budget but he had instructed the budget committee to do so as a "non-negotiable" in the next budget.

At the meeting, Professor Power said while there was no waiting list for cardiac surgery two years ago, it now stood at 120 patients.

The problem with babies with heart abnormalities is that they cannot wait. They are prone to lung infections and heart failure if operations are not performed at this crucial time in their lives.

Paediatrician Louis Reynolds said South

To page 2

Cape hospital chief slams cutbacks

From page 1

Africa had ratified the UN Convention on the Rights of the Child and in so doing had made a legal and moral commitment to ensure that the health and development of children is a national priority.

He said Section 28 of South Africa's Constitution devoted a section to the "best interests" of the child. He questioned whether the health department was aware of these articles and whether it had given priority to children in the allocation of scarce resources.

Dr Reynolds said government had to submit a detailed report every five years to the convention committee which concerned itself with whether cuts in public spending linked to fiscal adjustments took adequate account of the resulting impact on children.

Trainee-specialist Jonny Taitz, who works at Red Cross, said the Department of Health spoke of cutbacks and moratorium on posts last year but that this "dip" would even out by this year and there would be growth.

"We bought this line as a hospital, as professionals and as members of trade unions. Now there is deep disappointment that nothing has changed 18 months later. There is no growth and instead more cutbacks. Enough is enough. We are here to save lives," he said.

Dr Taitz said the shocking state of health services made a mockery of Health Minister Manto Tshabalala-Msimang's launch this week of a Patients' Rights Charter.

"I don't think we are extravagant. We have been cut to the bone. If there is no money then provincial Premier Gerald Morkel and Dr Tshabalala-Msimang must tell the people that we cannot deliver a service.

"We cannot buy equipment and we are cutting posts. We cannot even train medical doctors and nurses. We have to come clean."

Dr Taitz added that when President Thabo Mbeki said the "people have spoken" after the election, one of the things they spoke for was adequate health care and it was the government's responsibility to deliver.

Provincial health minister Nick Koornhof said Dr Sutcliffe's announcement had been made to protect workers from disgruntled patients. Negotiations with the provincial treasury were continuing to get a realistic budget for the next three years.

Plans to rationalise E Cape hospitals

MHG 12-18/11/99 (98)

By Peter Dickson

The Eastern Cape Department of Health, its hospital care services threatened with financial collapse within five years by an overload of Aids patients and its budget facing over-expenditure of R225-million this year as it struggles with a near billion-rand shortfall, went public this week on plans to rationalise state hospitals and seek private-sector partnerships.

Eastern Cape MEC for Health Dr Bevan Goqwana said his department's budget for this financial year was R2,8-billion, but it needed R3,5-billion to make ends meet and rationalisation is the only way out of the provincial health care system's costly mire of repetition and duplication of services.

Port Elizabeth's three state hospitals — Provincial, Livingstone and Dora Nginza — and East London's Frere and Cecilia Makiwane state hospitals are within a 30km radius of each other and a committee is investigating which hospitals will be rationalised.

Goqwana's plan is to cut the average patient stay in hospitals — costing R400 per patient daily and with one out of every four patients being treated for Aids and Aids-related illnesses — from 11 to three days.

Goqwana said the provincial Aids rate had risen from 15,9% to 18% in only six months, according to the latest antenatal clinic survey, and was one of the reasons for the department overspending its budget this year. Port Elizabeth, Mdantsane and the Transkei area along the KwaZulu-Natal border have the highest infection record.

Other widely prevalent drains on the health care system were obesity — half the province's women compared to 29% of its men are obese, Goqwana says — as well as chronic asthma (8%) and high blood pressure (12%).

He added that 45 out of every 1 000 Eastern Cape children died at birth, and that 59 out of every 1 000 would die before the age of five. He said the maternal death rate was 150 out of every 100 000 mothers, but this ratio would "increase drastically" as Aids began to take its toll.

Tuberculosis affected 311 out of every 100 000 people, half of them directly related to Aids.

Bisho legislators last week learnt that health department expenditure on its 33 000 personnel alone, due to unbudgeted and long-overdue promotion salaries, would exceed the budget by R625-million. Of the R1,9-billion personnel expenditure budget, the legislature's health committee reported, R1,1-billion had already been spent in the first six months of the financial year.

The provincial treasury and the national Department of Finance last Friday promised a R400-million bailout, taking over-expenditure down to R225-million, but the Bisho health department will not be able to meet its R50-million revenue collection target despite a new patient billing system.

Goqwana says the department is experiencing "transformation difficulties" among new and old senior officials, while the finance division is severely short-staffed at senior level.

Goqwana told a media briefing this week that rationalisation would not mean large-scale staff retrenchment or closure of casualty and outpatient departments, but hospitals would be honed to specialise in certain areas and patients transferred to the appropriate facility best suited to them after initial treatment.

State-aided hospitals, many situated close to each other and predominately in former "white" areas, would be downgraded to daytime health centres that outsourced chronic care, the two provincial drug depots cut to one and drugs barcoded for specific clinics, district health department offices scrapped in favour of a few regional offices, and chief executive officers with sound business management skills brought in to run hospitals.

SOWETAN Friday November 26 1999

Sowetan 26/11/99 (85) (98)

District health system works

By Bhunganl Mzolo
Health Reporter

THE KwaZulu-Natal health department is making huge strides in ensuring that healthcare services reach even the most remote rural areas, through its district health system.

The stated health policy of the national Government is the provision of affordable, quality healthcare to all South Africans through primary healthcare services

However, the practical task to make health accessible to all, falls on the provincial governments.

As many new clinics were built and others upgraded in some provinces, disturbing reports began to surface of drug shortages at the newly built clinics; clinics becoming white elephants because of poor resources, particularly in rural areas; patients being turned away by nursing staff and clerks; a lack of transport to go to the new clinics; and of hospitals becoming overcrowded as others are closed

Besides such problems, KwaZulu-Natal also still has to contend with the ever-escalating HIV-Aids pandemic, malaria and tuberculosis.

It is also ranked among the poorest provinces in the country, along with Mpumalanga and Eastern Cape. Despite this, the province appears ready to face its challenges and problems

Health MEC Dr Zweli Mkhize recently allocated R20 million for the next five years to combat the Aids pandemic. Using the mass media, the campaign aims to involve every sector of the community in the fight against the disease.

Last month, Swaziland, Mozambique and South Africa also signed the Lebombo Spatial Development Initiative, in which R40 million was allocated to controlling the spread of malaria.

Northern KwaZulu-Natal, southern Mozambique and the eastern parts of Swaziland, where there is a particularly high incidence of malaria, will be the major beneficiaries of the programme

But it is on its district health system that KwaZulu-Natal pins its hopes to make healthcare accessible to all, as well as to help in its many other health problems

The province has been divided into seven health regions. Durban, Empangeni, Ladysmith, Newcastle, Pietermaritzburg, Port Shepstone and Ulundi.

These regions have in turn, been subdivided into 25 districts. This means that each region is roughly made up of three districts

In addition to the establishment of health regions, hospitals have been graded into district hospitals, then regional hospitals, and provincial hospitals.

All the clinics as well as primary health centres, fall under the districts. In the last five years the Department of Health has built more than 120 new clinics under its clinic building and upgrading programme.

The district health system – which is the vehicle for the delivery of primary healthcare services, including free health service to pregnant mothers and children under six years – demands that patients are first seen by a clinic before they are transferred to a regional hospital or to a provincial hospital in the case of specialised care or major operations.

As Dr Olaf Baloyi, chief deputy director, puts it, "The principle is decentralisation"

Baloyi who is in charge of the district health system, said a positive spin-off of the creation of this system is that the department gets early reports of what is happening at district level

For instance, in the Ulundi region Baloyi has been able to get a morbidity profile (diseases common in the area) and a mortality profile (diseases people die of) for both children and adults

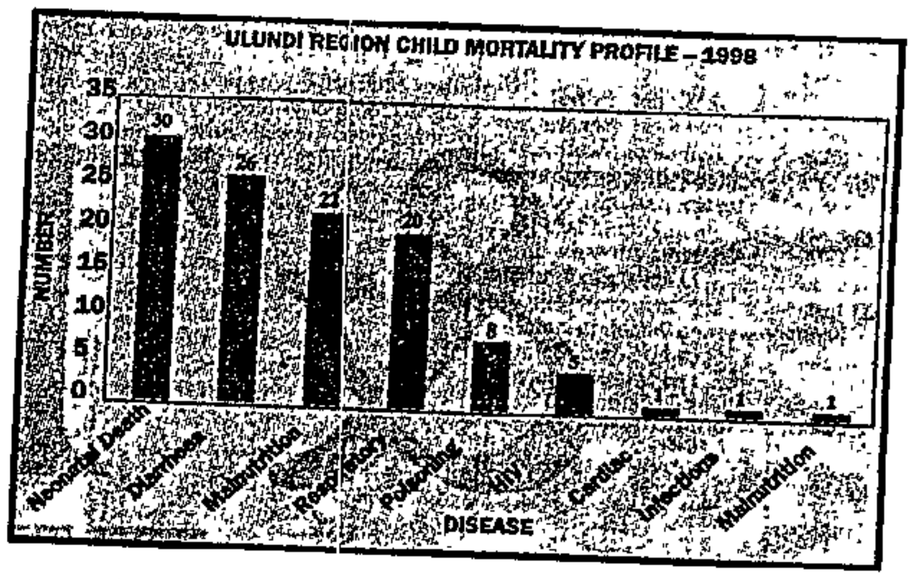
For children the morbidity profile shows that respiratory infections, diarrhoea, trauma, infections and malnutrition, rank high

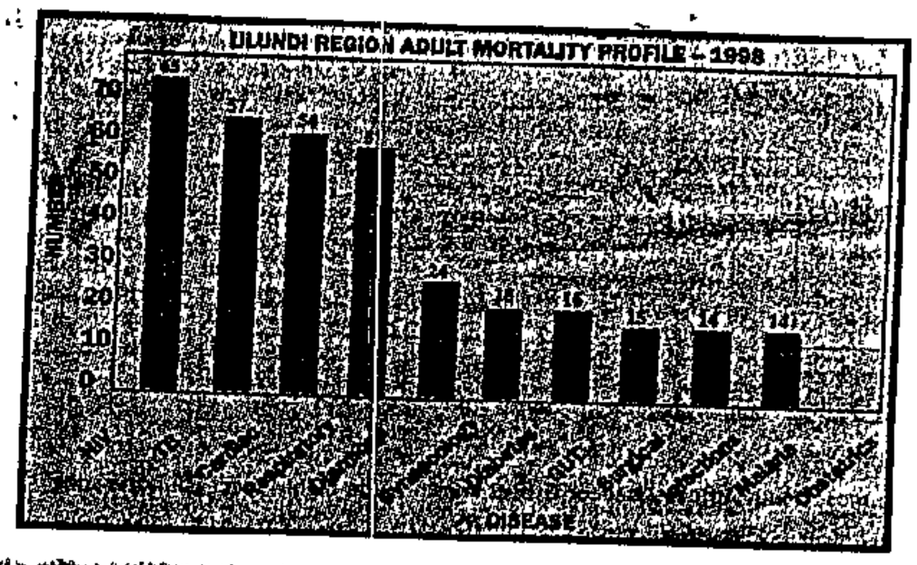
The mortality profile includes all these conditions as well as HIV and poisoning

For adults, obstetric and gynaecological problems rate very high, as well as trauma, diarrhoea, respiratory infections, tuberculosis and HIV.

"Because each region receives information directly from its own districts, we are best able to plan where the money is to be spent so that we do not waste it on less serious problems," Baloyi said

KwaZulu-Natal has reason to be proud of its implementation of the district health system – one of its regions, Ladysmith, was recently voted number one during a competition involving all nine provinces on this system.





Groote Schuur cuts services as funds dry up

(98)

JUDITH SOAL
HEALTH WRITER
~~AR~~ CT 30/11/99

DON'T expect to get an appointment at Groote Schuur Hospital until April next year — unless you qualify as a medical emergency. Even if you already have an appointment, it may be delayed.

The hospital's medical superintendent Peter Mitchell said yesterday that Groote Schuur had decided to further cut back on services to try to stay within budget.

"Inevitably there will be longer waiting times for clinic appointments, admissions and operations," he said. "We realise these steps may inconvenience patients and in some cases affect recovery and treatment. We are doing everything possible to limit the impact on health."

Earlier this month the provincial department of health announced that health services would be scaled down because the academic hospitals were expected to run up a R80m loss this year. Yesterday's announcement by Groote Schuur fleshed out just what this means to patients.

From tomorrow:

- Bookings for new non-urgent outpatients cases will only be scheduled for after April 1.
- Existing bookings may be rescheduled to after that date.
- 200 beds will be unavailable.
- Only emergency cases will be treated.
- Diagnostic procedures will be reduced.
- Patient transport services will be reduced.

"These measures have been financially unavoidable," said Mitchell. "We have given them serious thought and introduce them with the greatest reluctance."

Groote Schuur is said to be in the worst financial trouble of all academic hospitals, although Red Cross Children's Hospital has also been forced to cut back on non-emergency procedures. Tygerberg Hospital is running within its budget.

Provincial Health MEC Nick Koornhoff said his department was trying to resolve the financial crisis at Groote Schuur.

"I am seriously looking into the position at the hospital and will come up with certain proposals to stabilise the hospital and, through good management, ensure that the same problems don't arise in the next financial year," he said.

He said it was "possible" that the hospital could be helped this year.

"We have had a series of meetings with Groote Schuur and another *bosberaad* is scheduled for Saturday. We will do everything possible to assist them."

Groote Schuur hit by new cutback

ARG 30/11/99 (98)

Groote Schuur Hospital will close 200 beds tomorrow in a new cutback as the province tries to reduce an anticipated R80-million health debt for the year.

Patients waiting for surgery considered "non-urgent" will be especially hard hit and many could find their operations rescheduled to more than four months away.

Groote Schuur chief medical superintendent Peter Mitchell said yesterday that from tomorrow the hospital would deal with emergency cases only.

This would continue until April 1 when the situation would be reassessed in accordance with next year's budget. – Health Writer

Housing subsidy scams under spotlight

(123) ARG 5/11/99

CHARLES PHAHLANE
PARLIAMENTARY BUREAU

Government is looking at ways to stop the misuse of housing subsidies to eliminate fraud, says Housing Minster Sankie Mthembi-Mahanyele.

Ms Mthembi-Mahanyele said her attention had been brought to cases where migrant workers with houses in the countryside accessed subsidies with a view to selling the property immediately after assuming ownership, and hence defeating Government aims of providing decent shelter. Some people let their houses and continued to live in shacks.

"We are looking at the law to see if we cannot tie people to our products. We are looking at drawing up a document on what we expect from beneficiaries. This is a new problem and we are hoping that soon we will come up with a solution," Ms Mthembi-Mahanyele said.

The fraud was not yet widespread, but Government was tightening administrative and management systems to eliminate it.

Government was also going ahead with a programme to wipe out the eyesore squatter camps that had become part of South Africa's landscape. Government was upgrading informal settlement areas that could be upgraded, while other informal settlements might be demolished.

Mthembi-Mahanyele

The housing department was replacing shacks in Franschoek, Marconi Beam and Emfuleni in the Western Cape, and Alexander Far East Bank and the Tsutsumani area – which was replaced by the All Africa Games Village.

People must dismantle shacks and hand in the zinc sheets salvaged before they could live in the new houses.

Ms Mthembi Mahanyele announced seven appointments to the people's housing board, and said the board would seek ways of developing people's capacity to use the people's housing process and find ways of raising awareness of it.

Million apply for homes as plan gains momentum

PARLIAMENTARY BUREAU

Government's programme of upgrading the country's informal settlements was gaining momentum, and more than a million applications for low-cost housing subsidies have so far been received.

Housing Minister Sankie Mthembi-Mahanyele yesterday said this proved Government's commitment to provide basic housing. The subsidy targeted low-income earners and the unemployed, going up to R16 000 per grant for the lowest earning category.

The minister said to avoid continued existence of shacks once houses were built, people were bound by the grant agreement to dismantle their shacks before moving in to the houses.

She said Government was also paying particular attention to encouraging inner-city movement and providing quality, low-cost houses in these areas. She said the project would ensure cities were deracialised, reversing past housing trends.

"We will also concentrate on the quality of houses we produce to ensure that they have proper infrastructure. A house must survive at least 40 years, and not be hastily developed as was done in the past."

Informal settlements being upgraded in the Western Cape included those in Franschhoek, Marconi Beam and Emfuleni.

Mrs Mthembi-Mahanyele also announced seven appointees to the People's Housing Board.

Million seek housing grants

(123) CT 5/11/99

PHINDILE NGUBANE
PARLIAMENTARY BUREAU

GOVERNMENT'S programme of upgrading the country's informal settlements was gaining momentum and more than a million applications for low-cost housing subsidies have so far been received.

This was according to Housing Minister Sankie Mthembi-Mahanyele, who yesterday said this proved government's commitment to provide basic housing opportunities.

The subsidy targeted low-income earners and the unemployed, going up to R16 000 per grant for the lowest earning category.

Mthembi-Mahanyele said that people were bound by the grant agreement to dismantle their shacks before they could live in their new houses, to avoid the continued existence of shacks once houses have been built.

She said the government was also paying particular attention to encouraging inner-city movement and providing quality, low-cost houses in these areas.

She said the inner-city housing development project would ensure cities were de-racialised, reversing past housing trends, and added: "We will also concentrate on the quality of houses, to ensure that they have the proper infrastructure. A house must survive at least 40 years, and not be hastily developed as was done in the past."

Among informal settlements currently being upgraded were those in Franschhoek, Marconi Beam and Emfuleni in the Western Cape. In Gauteng, shacks in Alexander Far East Bank were being replaced, while those in the Tsutsumani area had been replaced by the All Africa Games Village.

Mthembi-Mahanyele also announced seven appointees to the People's Housing Board who would seek ways of developing people's capacity to utilise the People's Housing Process (PHP) by raising awareness of its benefits. The PHP was tasked with assisting communities in accessing their subsidy as a group and coupling this with their own savings to build houses of a bigger size and better quality.

The challenge is to house squatters

Sowetan 9/11/99 (123)

By Mbulelo Musi

As South Africa prepares to enter the new millennium, one of the biggest challenges facing the Department of Housing in particular is the mushrooming of informal settlements and the resulting unplanned urbanisation.

Gauteng, being the economic hub of the country, is most affected. Thousands of people from other provinces, as well as other countries, migrate to this province every month. As Gauteng is the smallest of all nine provinces, with a territorial surface of 17 010 square km, the issue of land scarcity becomes even more acute.

There are more than 200 informal settlements in Gauteng alone. Out of the estimated population of 7,3 million people in the province, about 200 000 families live under those conditions.

Most of the informal settlements are characterised by a lack of infrastructure such as roads. Unhealthy conditions like water-borne diseases are also rife.

In most of these areas, there is no electricity. This results in such areas becoming havens for serious and violent crimes such as murder and rape. Many gangsters use these areas as hideouts as most are not easy for police to access.

Land invasions have also become associated with the mushrooming of informal settlements. A recent case is Lawley, where people were encouraged to settle on land which is a danger to the community as it is dolomitic. There are also no plans to develop the area.

During the removal of unoccupied and partially constructed shacks to stop further expansion in the area recently, confrontations ensued that resulted in the death of one person.

This confirms the urgent need for the Government and society to devise means to ensure the curbing of land invasions.

Recently Gauteng housing MEC Paul Mashatile visited the three Thokoza hostels as well as Zonke Izizwe informal settlement on the East Rand. He told residents that the Government wants to convert the hostels into family units over the next five years.

The department has already set aside millions of rands for this purpose. The Thokoza hostels upgrade programme alone has been allocated R13,5 million.

With regard to Zonke Izizwe informal settlement, Mashatile announced that R32 million has been allocated to build 2 000 houses over the next two years.

To address the problem of informal settlements in general, the housing department devised creative programmes to upgrade the informal settlements into habitable places.

These programmes entail the installation of essential services such as electricity, clean water and sanitation, bulk services and infrastructure, the issuing of title deeds as well as the construction of houses.

Those who qualify for the Government housing subsidy scheme of up to R16 000 must be:

- A South African citizen or have permanent residence status;
- Over 21 years of age;
- Have a dependent/s;
- Be a first-time home owner; and
- Earn up to R3 500 a month

Over the next five years the housing department will strive to build viable communities through the provision of tenure, essential services and houses.

To date, more than 40 000 residential sites have been formally planned in Gauteng at a cost of more than R50 million under the Mayibuye informal settlement upgrading programme.

Title deeds are also being issued on a continuous basis and the construction of houses is under way in many informal settlements.

To accelerate the pace of delivery over the next five years and improve the quality of services, 37,5 percent of the almost R1 billion annual budget of Gauteng's housing department will be used to upgrade informal settlements.

This naturally poses a tremendous challenge given the commitment of the Government to ensure integrated development. By their very nature, informal settlements undermine planned and integrated development.

To address the problem in a sustainable way will require close cooperation between communities, the Government, the private sector and civil society.

Changing the living conditions of people in informal settlements is not just an issue of bricks and mortar. It is about restoring the dignity of communities.

It should therefore be pursued with more vigour, speed and dedication than ever before.

The Government's allocation of more resources into housing augurs well for the future.

(The writer is the deputy director of communications in the Gauteng department of housing.)

SAHT bidders to be named

(123) Sowetan 9/11/99

By Shadrack Mashalaba

THE Government is expected to announce the names of the preferred bidders vying for a share of the South African Housing Trust's (SAHT) assets to be sold off any day from today.

In July the SAHT announced it was starting the process to dispose of its assets following the ratification of the move in September last year These consist Khayalethu Home Loans, which focuses on retail finance and Nu-Way Housing Developments which specialises in low cost housing development in townships.

According to Chris Stephen, a former head of KPMG Management Consulting who is overseeing the process, they have already submitted their recommendations to the Government and are waiting for a response on their choice of preferred bidders.

Stephen said the assets will be sold separately. He said the closing date for submission of bids for assets of Nu-Way was October 11 and that of Khayalethu was October 13.

The Government is expected to realise about R650 million from the sale.

The SAHT was formed in 1986 to develop and finance housing projects while at the same time creating jobs through its projects. The Government owns 89 percent, while the private sector holds 11 percent of the assets.

Parties interested in the bidding had to submit their registration forms to FBC Fidelity Bank. FBC Fidelity is currently under curatorship. However, Stephen said this had not affected the process as the bank was only playing an advisory role.

"Their contribution is over now. The process has always been driven by the board of the SAHT. We are well on schedule to complete the process this month," Stephen said.

"Our task now is to start negotiations immediately the Government has announced the names of the preferred bidders."

Housing minister to get tough on landlords

By Joshua Raboroko

MINISTER of Housing Sankie Mthembi-Mahanyele plans to get tough on unscrupulous landlords who are not looking after their properties but charge their tenants massive rentals, particularly in former white suburbs and informal settlements.

Tabling the second reading of the Rental Housing Bill in the National Council of Provinces yesterday, the minister said the Bill would change the present scenario in the rental housing market.

She said the unscrupulous landlords would feel the heat when the Government implemented the Bill aimed at regulating the housing market.

The Government will also take action against thuggery from legal tenants who steadfastly refuse to pay for services as well as those who invade private property and refuse to move out or pay for services and rentals.

According to Government sources these practices are rife mostly in areas such as Johannesburg's former white suburbs of Yeoville, Berea, Joubert Park, Hillbrow, Malvern and others.

Mthembi-Mahanyele said the adoption of the Bill will see the introduction of rental tribunals that were poised to play a vital role in stabilising the housing market.

"Both the landlord and tenant will be protected against any form of abuse because they can make use of mediation in resolving conflicts arising from rental housing."

The Bill will also normalise the rental market which was ravaged by the introduction of the Rent Control Act of 1976 and which targeted people on the basis of colour and race.

The new Bill will protect tenants from exploitative landlords, while at the same time the landlords will be protected from unreliable tenants who turn a blind eye to their responsibilities.

Future now looks bright for SA hostel dwellers

(123) Sowetan 18/11/99

By Mbulelo Musi

AT LAST there is hope for a better future for thousands of people living in hostels. The violence, insecurity, degradation and despair that gripped communities living in hostels for decades seems set to be replaced by a life of happiness, security and certainty about the future.

This follows the announcement by Gauteng housing MEC Paul Mashatile that the Gauteng department of housing will inject R165 million into the upgrading of hostels over the next three years.

During his visit to Diepkloof and Meadowlands hostels recently, the MEC emphasised that the thrust over the next five years will be to convert hostels into family units where families can live in peace and harmony.

Mashatile announced that more than R21 million has been allocated to upgrade Diepkloof hostel alone. This is scheduled to start during the current financial year.

An initial R500 000 will be given out within the next few weeks to start the process.

The upgrading of Meadowlands hostel into family units is already under way. Phases 1, 2 and 3 were completed at a cost of R31,8 million. Planning for phase 4 is at an advanced stage and more than R7 million has already been allocated for the 2000-2002 period.

The Meadowlands hostel upgrading programme is regarded by many as a trailblazer and a pointer to the future. Essential services such as electricity, water and sewerage systems are being installed.

Single-sex rooms, where more than 10 males used to share one room in the past, have been replaced with a single bedroom, kitchen, dining room and toilet for a family.

The community has also raised the need for a primary school, the improvement of the water pipe system and roads.

Mashatile pledged to consult with other MECs to see what could be done to address these concerns.

Upgrading programme

The department is currently involved in the development of no fewer than 25 hostels throughout the province. Last year alone more than R54 million was spent on the upgrading programme.

However, there are still huge challenges ahead. Hostels are a complex matter to tackle. They were designed in the 1960s as part of the migratory labour system under apartheid.

Their sole purpose was to ensure that black people were deliberately excluded from the social, political and economic mainstream of development.

Gauteng housing MEC Paul Mashatile recently announced that hostels will be upgraded to the tune of R165 million over the next three years.

Today more than 200 000 families (about one million people) are estimated to be staying under congested conditions in hostels. These hostels were designed to be single-sex and were often divided along ethnic lines.

In some instances, 20 families shared one toilet. In most hostels there was no electricity, sanitation was poor and there was no proper infrastructure.

Hostel inmates were mostly isolated from the broader communities. Consequently serious conflicts ensued, precipitating unprecedented violence and crime, particularly from the 1970s to the early 1990s.

Scores of people were killed or maimed, families were displaced and property worth millions of rands was destroyed. Numerous peace initiatives were undertaken to bring normality and stability.

Through the Kathorus Presidential Project, the Government spent R600 million to rehabilitate properties that were destroyed and to bring back normal life to the hostels.

Religious, political and cultural formations, non-governmental organisations and community-based organisations also took part in various initiatives aimed at bringing peace and stability.

But the process of upgrading hostels is not just about bricks and mortar. It is not about electricity and infrastructure only.

It is primarily about redefining the role and place of thousands of people who were subjected to inhuman conditions and oppression. It is about restoring the lost dignity of a people.

Most importantly, it is about entrenching a culture of human rights and therefore giving meaning to our young democracy.

History teaches us that everlasting peace and stability is finally achieved when the actual material conditions and quality of life of people are changed for the better.

Housing, being one of the basic necessities of life, is vital in the realisation of this goal.

Therefore the decision by the Gauteng housing department to prioritise hostels can only be in the best interest of society as a whole. But it is clear that huge resources and hard and persistent work are vital for success.

Critical significance

In this regard, partnerships between the Government, private sector, communities and civil society is of critical significance. Regular consultations, accountability and transparency in both planning and the actual use of resources is important.

The phasing out of hostels may well turn out to be one of the litmus tests of the extent to which South Africa has been able to give meaning to reconciliation, reconstruction and development.

The focus and prioritisation of the conversion of hostels into family units is a step in the right direction and augurs well for the future.

(The writer is deputy director of communications in the Gauteng department of housing.)

Findings on nonpayment

(123)

Xolani Xundu

SOCIAL and economic changes such as rapid urbanisation and rising unemployment are the main contributors to non-payment of municipal services, a survey by the Helen Suzman Foundation has found.

The survey, Not so close to their hearts, was released yesterday and was conducted among 1 754 residents in townships and informal settlements.

Researcher Bill Johnson says the conventional approach to the non-payment of rent and rates assumed the problem is a product of the political history of rent and rates boycotts.

However, the influx of the unemployed to the urban areas and HIV/AIDS means that many people will remain non-payers. For the latter group, medical bills will be more pressing.

Even if people have money, they will be more likely to spend it on private consumption than paying for their rates and services. "Less than 1% of our respondents thought a television licence was worth spending money on," says Johnson.

The survey revealed that although half of the respondents believe poverty is the reason for non-payment, affluent and poor households are equally likely to say they cannot afford to pay. Johnson says some communities which have become 100% payers are in poor towns.

BD 26/11/99

Housing officials to get training

MD 20/11/99 (123) BM(179)

Bid to speed up delivery of houses to the country's homeless depends on skills

Robyn Chalmers

A TOTAL of R10m will be allocated to provincial housing departments to improve skills among officials as part of a sweeping programme to accelerate the low-cost housing programme.

The decision was ratified at the latest interprovincial committee of housing MECs (housing Minmec) meeting with Housing Minister Sankie Mthembi-Mahanyele.

It was agreed also that only SA barcoded identity documents and permanent resident permits will be accepted when applying for government housing grants.

This follows problems with applicants using identity documents from the former homelands and receiving more than one subsidy.

Mthembi-Mahanyele said: "Tightening up the loopholes will ensure that the subsidy grant reaches the people it was meant for."

The national housing department said that each province will receive between R1m and R1,6m of the R10m allocation for the current financial year.

"Given that accelerated delivery of homes to the poor depends upon the ability of officials to perform at their optimum level, (it was) decided to beef up training."

The government recently announced the board of trustees for the People's Housing Process. The policy focuses on poor families living in urban and rural areas, using subsidies to allow people to build their own homes. It helps these people obtain access to technical, financial, logistical and administrative support, either as individuals or on a collective basis.

The department has brokered an agreement with tertiary institutions in all the provinces to offer training courses following the success of the first pilot project conducted by Wits University where the first crop of officials was trained.

The housing Minmec agreed that identity documents from SA's former homelands could not be used when applying for subsidies as they were substituted by the barcoded identity documents used in the most recent national elections. The housing department has since established a link between the National Data Base and the home affairs' population register

In addition, the national housing subsidy data base has been linked to all deeds offices countrywide.

New housing funds needed

State subsidies for the poor not sustainable, says minister

(123) ARG 30/11/99

CHARLES PHAHLANE
PARLIAMENTARY BUREAU

The housing department was seeking alternative funds to deliver houses to the poor since housing subsidies would not be sustainable in the long term, Housing Minister Sankie Mthembi-Mahanyele said.

Ms Mthembi-Mahanyele said in a telephonic interview that the country had a large young population who would enter the housing market placing pressure on Government funding.

"In the long term subsidies would not be sustainable. We have a very young population which is going to grow and their housing needs will be more," she said.

Other forms of garnering housing resources included the Peoples Housing Process, which combined peoples' savings with institutional subsidies, and the Gateway project where mortgage bonds were packaged and sold to investors as one unit thus reducing interest rates, she said.

The Government had committed an extra R75-million from the Poverty Relief Fund, which was in addition to the housing budget, for building houses.

The Jobs Summit agreements would also see labour and business contributing towards housing delivery which will create jobs.

She denied suggestions in a paper by the Centre for Development and Enterprise that the housing budget would shrink over the three years of the Medium Term Expenditure Framework because of Government dissatisfaction with housing delivery.

Ms Mthembi-Mahanyele said people should understand that there were many demands placed on the budget from other departments.

She said the budget would decrease slightly in the second year of the MTEF but increase in the third year.

This decrease was caused by the lead time required to draw up new projects which could take up to seven months from the drawing board to the field. During that time funds were not needed as much as when projects were already under way.

A meeting with all provincial housing ministers had decided that only barcoded ID books would be accepted when applying for a subsidy, she announced.

This would eliminate fraud as people used the former TBVC states ID books to access more than one subsidy.

The meeting had also decided to allocate R10-million to train provincial housing officials in housing policy and structures.

The training programme was the result of a study to find the causes of slow delivery.

Ms Mthembi-Mahanyele said the focus of her department was on eliminating gaps to ensure accelerated housing delivery.

Hospital closure put on hold

(98) MG 17-22/12/99

Aaron Nicodemus

North-West province has given a stay of execution to Derdepoort Community hospital on the Botswana border, after the *Mail & Guardian* reported last week on its imminent closure. Although most of the hospital's services will still be shut, the provincial government has agreed to keep emergency services going.

The public provincial hospital, which serves about 22 000 people, is scheduled to close on December 31. This week a provincial health representative, Molefi Sefularo, said it has always been the department's intention "to keep the emergency services of the hospital intact even after the closure of the hospital".

This is in marked contrast with what hospital staff understood to be complete closure of the hospital, dispersal of its equipment and redistribution of employees by December 31. The December 3 memorandum that announced the closure of the hospital stated nothing of continued emergency services.

"We're not happy that it will only be open for emergency services. We need a proper hospital," said Moses Matel, chief in the Pitsedisulejang village. But, he adds, "half a loaf is better than no bread".

The community that had been served by Derdepoort knows that closing the hospital will create a precipitous drop in the quality of health services. Although 40 years old, Derdepoort hospital has held up remarkably well, and everything works. This is not the case at the government clinics in the village or, to some extent, other nearby hospitals.

"The clinics in the villages are not well equipped, and Moreteletsi hospital [a nearby hospital where patients will now be referred] is falling apart," said chief Isaac Nkele of Pitsedisulejang village. "We come in a big predicament."

The community, which had a hand in building the facility with the Dutch Reformed Church in 1949, is also worried the provincial government will privatise the hospital and take it away from them completely.

In fact, the provincial government had explored several privatisation options, either leasing the hospital to the Botswana government or ceding it to the nearby Madikwe Game Reserve, a government parastatal. This week Sefularo's representative adamantly denied the facility would be privitised. "These were mere suggestions which were never accepted by the department. It is unfortunate that in the article, mere suggestions were equated with department policy," said Cornelius Monama.

Last week provincial district manager Jarhard Henning said ceding the facility to the game reserve was a possibility, but that the hospital would still belong to the government "as the game reserve is a government parastatal". Local chiefs understood that ceding the hospital buildings to the game reserve would effectively take it away from their community.

Plans to remove furniture and equipment from the hospital have temporarily been put on hold, according to hospital employees, who say Henning has angrily called several employees into his office to have them explain why they talked to the press.

Provincial health officials decided to close the hospital earlier this year after it was determined to be "providing health services to the people of Botswana at the expense of the South African taxpayer". The closest South African villages are 48km and 55km away, while Botswana villages are only 3km away. Per patient costs at the hospital were nearly six times higher than the provincial average, and before Botswana admissions were halted, more than half of its patients were not South African.

The only time the hospital was consistently used by South Africans was when it was a tuberculosis hospital. But when the government implemented a new policy where TB patients are treated at home and at clinics, the government removed these patients and shut the hospital's TB wing.

The provincial government objects to hospital employees calling the closure "a terrible waste". Such arguments "defy logic", Monama said this week. "Closing the hospital is a saving. Keeping it open as it is is a waste." He said that thousands of rands worth of medicines expired because "they were not used as there were no patients. This confirms our contention that the hospital is almost always empty. That is why we are distributing drugs where they will be used."

Monama also objected to community members and hospital employees who said the decision to close the hospital was concluded without their input. He said the minister personally went to Derdepoort to discuss the closure with staff, traditional leaders and other stakeholders.