Better basic health care one step closer

New system in place next year

JENNY WALL
Health Reporter

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

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

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

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

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

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

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

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

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

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

The task team, chaired by Faried Abdullah, head of health care in the Western Cape, will report back in November and submit a final report to the cabinet in December.
Government’s 7.5% pay hike offer
Union join national strike over
National Health and Allied Workers’
During strike services suffer
Hospitals and
Hospitals affected as strike broadens

Renée Grawitzky

The public service strike spread to hospitals around the country yesterday as thousands of health workers joined striking teachers to put pressure on the state to revise their offer of 7.5% plus rank promotions.

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

Hospitals in Gauteng, Eastern Cape, Mpumalanga and North West were affected as thousands of general assistants heeded Nehawu's call, affecting the provision of kitchen and laundry services.

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

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

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

A representative of the Hospital Personnel Trade Union of SA, not party to the strike, said disruptions had been experienced at Coronation, JG Strydom, Johannesburg and Baragwanath as non-strikers were intimidated by Nehawu members. He alleged that at Coronation Hospital Nehawu members forced the hospital secretary from the premises and workers were threatened.

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

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

Right to sack wanted

JILUYA PITAAN

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

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

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

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

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

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

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

“Why can’t we be like private hospitals, which have only the Labour Relations Act and the Basic Conditions of Employment Act? he asked?

He said that in other countries a criminal record was a shame, but...

“Here it is not so. Criminals have the same rights as honest people.”

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

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

The trebling of thefts since 1996 at Groote Schuur hospital cost the taxpayer more than R2 million a year.

A Groote Schuur spokesman said:

“The hospital is not in a position to demand anything when it comes to the disciplinary process. The disciplinary procedure is a collective agreement and guided by the Public Service Act.”

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

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

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

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

Mike Ryan, a spokesman for Hospersa, said its members and other government employees had been exposed to "horrendous acts of intimidation, violence and victimisation" for the past three years.

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

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

Nehawu officials could not be reached for comment on the claims.
Patients forced out of hospitals by budget cuts discover new freedom

Home offers new lease on life for mentally ill
Psychiatric hospital in crisis

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

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

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

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

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

"Certain services such as the postal service were crippled for two weeks due to lack of funds. "The situation was finally rectified yesterday," the doctor said.

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

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

The financial situation at the hospital is also affecting staff morale and doctors say that many of them get drunk at month end after being paid. "We have to consult Bisho for everything, even to buy toilet paper. Our cars are not licensed."

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

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

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

The department said that - far from being able to address the dire shortage of doctors in state hospitals - they would only be able to consider the "most crucial of the crucial" posts and only fill what it could afford - ECN
Khayalami hospital is to close and Gauteng’s health department will not attempt to keep it open, according to health MEC Amos Masondo.

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

The department had turned down a Khayalami Metropolitan Council (KMC) partnership proposal in June because it was out of line with basic principles for public health care. Masondo said he had met several ANC councillors from the KMC in June and made it clear the closure would go ahead and the building would be sold.

“Whatever health service may in future be run at the hospital by other organisations, the Gauteng health department will not be a partner,” he said.

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

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

Staff were busy moving to other jobs and others were carrying out tasks associated with closing a large institution.
Baragwanath to lose beds as it goes hi-tech

By Jovani Ikwezi
Political Correspondent

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

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

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

Chris Hani Baragwanath’s capacity is likely to be reduced from 1,200 to 800. “It’s in the Guinness Book of Records as the biggest hospital in the world. We’re not sure we want to be regarded as a freak,” said Dr. Tim Wilson, the chief director of academic hospitals.

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

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

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

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

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

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

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

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

“And sometimes whites call us ‘kaffirs’, spray us with fire extinguishers or throw food at us.”

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

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

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

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

“There are incidents, but we’re working on them.”

Tuks spokesman Mike Smuts declined to comment.

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East Rand hospital closes

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Staff were busy moving to other jobs and others were carrying out tasks associated with closing a large institution.
Bara Creek into a crisis with its obsolete equipment.
**R1,2-m for Red Cross Hospital**

*24/11/98*

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

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

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

"As the only specialist children's hospital in sub-Saharan Africa, its resources are in huge demand and an upgrade has become critical, hence our decision to assist with funding," said Dudley Cloete-Hopkins, head of Syfrets' social responsibility division.

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

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

TOURISM WRITER

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

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

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

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

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

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

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

Fedhasa viewed the proposal as "punitive" and had presented two submissions to the Tax Commission on behalf of the hospitality industry to renegotiate certain clauses that could be detrimental owners of game lodges, guest houses and bed and breakfast establishments which fell outside municipal areas.
NEARLY 5 000 health workers will be made redundant, two hospitals will close and several others face stringent cuts if a planned health budget goes through, CAROL CAMPBELL reports.

THE Western Cape Health Department has proposed that two public hospitals in Cape Town be closed and the size of three others be reduced to save a further R310 million on its already cash-strapped budget this year.

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

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

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

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

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

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

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

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

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

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

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

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

The cutbacks are part of the government’s plan to redistribute resources out of “wealthy areas” to impoverished rural communities.

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

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

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

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

“This is what this exercise lacks,” he said.

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

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

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

“While understanding legitimate anxieties among the unions, it is unfortunate that they have used information provided for them in good faith, to create unwarranted alarm in the health sector which can do without the added stress and strain,” Rasool said.
Cape's academic hospitals may get cash injections

CAROL CAMPBELL
21/8/97

ACADEMIC hospitals can look forward to a cash injection from the national Health Department if Minister of Health Dr Nkosazana Dlamini-Zuma follows through with a plan to restructure the way these hospitals are funded.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Nomavenda Mathiane

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

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

The hospital occupies the remaining 10%.

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

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

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

In the meantime, the health department is upgrading the hospital and has set aside R2m for improvement for 1996/97 and R1.5m for next year.

The estimated overall budget for the hospital’s upgrading is R20m.

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

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

Reneé Grawitzky

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

Union sources said the investigation would look also into the activities of hospital management. The hospital manager had been "placed on leave" pending the outcome of the probe, the sources said.

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

The company denied these claims, saying they had been "cooked up" by the union to discredit it in the region.

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

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

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

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

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Edward West
Crime victim is left without painkillers in busy state hospital

By BENISON MAKELE

IMAGINE: Thabani Zwanwe is a law-abiding citizen.

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

Zwanwe, 34, of Melina in Natal, lies in pain in the corridor of the overcrowded Chris Hani-Baragwanath Hospital - because he cannot afford any better.

The gunman, if caught, is entitled to "Five Star" treatment at a private hospital if he demands it.

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

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

His appeal to the nurses for painkillers had fallen on deaf ears.

It was then 3.05 pm.

Zwanwe said he had been admitted at around 8 pm the previous day and had still not received any pain killing medication.

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

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

Instead of being taken to a state hospital ward the following day like Zwanwe, he would be whisked away to the comfort of any of the private clinics in suburban Brackenfell.

It is the private client who is able to dissuade the best medical attention because of his testimonial value to the police as a suspect.

We have had both victim and perpetrator lying next to each other but the latter would then be taken to Garden City so he would be under police guard while the former would remain confined to Bara, confirmed SAW sister-in-charge Nomzombwa Malebile.

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

But the imagination.

Five Star care for criminals

By JIMMY SEEPE

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

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

The clinics, dubbed "Five Star Hotels" by warders and prisoners alike, are being used more and more frequently by police and correctional services to hospitalise sick inmates and suspects at huge taxpayer's expense. And these clinics are often uneconomical to crime victims.

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

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

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

Prisoners a privately at citizens car

By JIMMY SEEPE

SOUTH AFRICAN prisoners get "Five Star" treatment since they are taken straight to private clinics as a cost beyond the reach of most ordinary citizens.

In 1997, taxpayers have already paid more than R150 million in medical fees for convicts since March last year.

The cost of prisoners' health care is expected to double this year because of increasing numbers in the prison population, according to the health service's budget which has been stretched to the limit, and they are looking at ways to contain this expenditure.

Not only is the cost of prisoners' health care depleting the correctional services' budget, but it is driving already short of funds public health care institutions to the brink.

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

Private clinics charge the department a flat rate, whereas they charge medical aid schemes.

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

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

In an effort to reduce medical expenditure, correctional services has been forced to release certain prisoners on medical grounds. Forty-nine prisoners were released last year.

Correctional services is also looking at ways to ensure the cost-effective timing and control of prescribed medicines given to prisoners. It is understood that expensive medicines prescribed for prisoners could also be causing the high costs.
Prisoners are treated privately at fees most citizens cannot afford

By JIMMY SIEPE

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

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

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

From April to July this year, taxpayers have spent more than R150 million for the health care of South African prison inmates.

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

Not only is the cost of prisoners' healthcare eclipsing the correctional services' budget, but it is draining huge chunks of taxpayers' money, which could have been used for other priorities.

The local health care system bears the cost of hospitalising prisoners at expensive private clinics in major cities around the country, rather than at overcrowded state hospitals such as the Chris Hani Baragwanath Hospital in Soweto.

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

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

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

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

Since the start of the 1997/98 financial year, 21 prisoners have been released on medical grounds. Forty-nine prisoners were released last year.

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

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

He said an increase in the prison population, which is now over 135,000, is likely to contribute to the high medical costs.

Added to this is the cost of caring for elderly convicts within the prison. There are currently 750 convicted people over the age of 60 Eskose said the department planned to provide a "high premium on the medical treatment of all prisoners over the age of 60".

He said although the department tried to utilise medical personnel already working within the prison system, they were sometimes forced to refer prisoners to private hospitals on the instruction of district surgeons.

"The running expenses of the department of correctional services were guided by the district surgeon and his prescriptions and instructions have to be carried out meticulously," Eskose said.

However, Eskose was quick to point out that the figures quoted above included their own hospital.

He said the department was not forced to send convicted criminals outside the prison for medical treatment.

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

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

"It must be borne in mind that our patients are unique and that no service can be rendered to them without due consideration and our best interest in the escape of prisoners.

"The costs of medical services can only be determined on the basis of a doctor's report and the department's financial constraints, which may not always allow for the most expensive option."

The department is now looking at establishing provincial hospitals to provide a 24-hour service.

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

To Page 2
Convicts get treatment at private clinics

Continued from Page 1.

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

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

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

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

The unauthorised expenditure showed up in the auditor-general’s report on government’s accounts for 1994/5.
THE MINISTER OF HEALTH

WEDNESDAY 10 SEPTEMBER 1971

236

The Minister of Health's Report to the House of Commons on the 3rd of December 1971.


The following pages have been extracted from the

THE MINISTER OF HEALTH.

WEDNESDAY 22 SEPTEMBER 1971

235

The Minister of Health's Report to the House of Commons on the 3rd of December 1971.


The following pages have been extracted from the
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**THE MINISTER OF HEALTH**

1994 allocation to the Province was $2,550,000, and for 1995, it is $3,000,000. The increase is due to the provision of additional services and facilities in the health care sector.

**The Government's Notice**

No significant changes have been made to the Ministry's budget compared to last year.
THE MINISTER OF LABOUR

(1) The Cabinet has decided that the National Minimum Wage should be increased from $6.50 to $7.25 per hour.

(2) The increase will take effect from 1 January 2002.

(3) The increase is intended to address inflation and provide a boost to the economy.

THE MINISTER OF HEALTH

(1) The government has approved the construction of a new hospital in the capital city.

(2) The hospital will provide healthcare services to the population.

(3) The minister announced that the hospital will be completed within the next two years.

THE MINISTER OF EDUCATION

(1) The Cabinet has approved the allocation of additional funds for the development of the national educational system.

(2) The funds will be used to improve infrastructure and provide quality education.

(3) The minister stated that the funds will be managed transparently and accounted for.

THE MINISTER OF HOUSING

(1) The government has announced the implementation of a new housing policy.

(2) The policy aims to provide affordable housing to the general public.

(3) The minister emphasized the importance of sustainable and environmentally friendly housing solutions.
(1) WHEREAS there is an application
for the approval of the Department of
the Ministry of Education

530 N. C O N D I T I O N 3

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The Minister of Health

The Ministry of Health was created on 1 January 1977. The Ministry is responsible for the provision of healthcare services and the promotion of health and wellbeing in a manner consistent with the principles of the Constitution. The Minister of Health is the head of the Ministry and is responsible for the overall direction of the Ministry's work.

The Ministry is composed of several departments, including the Department of Public Health, the Department of Nursing, and the Department of Pharmaceutical Services. The Ministry is also responsible for the regulation of healthcare providers and the licensing of healthcare professionals.

The Ministry of Health is committed to providing quality healthcare services to all residents of the country, and it works closely with other government departments and agencies to ensure that the needs of the population are being met.

The Ministry of Health is committed to promoting health and wellbeing through education and outreach programs, and it works to ensure that all residents have access to basic healthcare services.

The Ministry of Health is also committed to ensuring that healthcare providers are properly trained and that they are held to high standards of professionalism and ethics.

The Ministry of Health is working to improve the accessibility and affordability of healthcare services, and it is committed to ensuring that all residents have access to quality healthcare services regardless of their income or social status.
The Minister of Transport

The Minister of Transport, by virtue of the powers vested in him by virtue of the 1997 Act, has powers to make regulations for the prevention, control, and abatement of pollution of the air by any means, and to enforce such regulations. The Minister may also make regulations for the enforcement of any provision of the 1997 Act and for the prevention, control, and abatement of pollution of the air by any means, and to enforce such regulations.

The Minister of Health

The Minister of Health, in consultation with the Minister of Environment, may make regulations for the prevention, control, and abatement of pollution of the air by any means, and to enforce such regulations. The Minister may also make regulations for the enforcement of any provision of the 1997 Act and for the prevention, control, and abatement of pollution of the air by any means, and to enforce such regulations.

The Minister of Agriculture and Food

The Minister of Agriculture and Food, in consultation with the Minister of Environment, may make regulations for the prevention, control, and abatement of pollution of the air by any means, and to enforce such regulations. The Minister may also make regulations for the enforcement of any provision of the 1997 Act and for the prevention, control, and abatement of pollution of the air by any means, and to enforce such regulations.

The Minister of Environment

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The Minister of Finance

The Minister of Finance, in consultation with the Minister of Environment, may make regulations for the prevention, control, and abatement of pollution of the air by any means, and to enforce such regulations. The Minister may also make regulations for the enforcement of any provision of the 1997 Act and for the prevention, control, and abatement of pollution of the air by any means, and to enforce such regulations.

The Minister of Labour

The Minister of Labour, in consultation with the Minister of Environment, may make regulations for the prevention, control, and abatement of pollution of the air by any means, and to enforce such regulations. The Minister may also make regulations for the enforcement of any provision of the 1997 Act and for the prevention, control, and abatement of pollution of the air by any means, and to enforce such regulations.
THE MINISTER OF ENVIRONMENTAL AFFAIRS AND RURAL DEVELOPMENT

The Minister of Environmental Affairs and Rural Development has, on the 2nd May 1997, gazetted the following:

The Minister of Environmental Affairs and Rural Development,

IN THE INTEREST OF TAKING MEASURES TO SECURE A HEALTHY ENVIRONMENT AND TO AID IN THE REHABILITATION OF THE ENVIRONMENT, AND IN CONFORMITY WITH THE ENVIRONMENTAL PROTECTION ACT, 1989 ('THE ACT'), HEREBY ANNOUNCE THE FOLLOWING MEASURES:

(a) The establishment of a new park, the 'Sandpiper National Park', in the Western Cape Province.

(b) The designation of a new reserve, the 'De Hoop Reserve', in the Western Cape Province.

(c) The designation of a new reserve, the 'Rooi Els Reserve', in the Western Cape Province.

(d) The designation of a new reserve, the 'Groot Winterhoek Reserve', in the Eastern Cape Province.

(e) The designation of a new reserve, the 'Kgalagadi Transfrontier Park', in the Northern Cape Province.

(f) The establishment of a new park, the 'Tsitsikamma National Park', in the Western Cape Province.

(g) The establishment of a new park, the 'Baviaanskloof Nature Reserve', in the Eastern Cape Province.

(h) The establishment of a new park, the 'Drakensberg World Heritage Site', in the Eastern Cape Province.

(1) The establishment of a new park, the 'Nkandla Game Reserve', in the Eastern Cape Province.

(2) The establishment of a new park, the 'Mkhaya Game Reserve', in the KwaZulu Natal Province.

(3) The establishment of a new park, the 'Theewaterskloof Dam Nature Reserve', in the Western Cape Province.

(4) The establishment of a new park, the 'Hluhluwe Umfolozi Game Reserve', in the KwaZulu Natal Province.

(5) The establishment of a new park, the 'St Lucia Estuary Nature Reserve', in the KwaZulu Natal Province.

(6) The establishment of a new park, the 'Ukhahlamba Drakensberg Park', in the KwaZulu Natal Province.

(7) The establishment of a new park, the 'Mildford Nature Reserve', in the Western Cape Province.

(8) The establishment of a new park, the 'Tsitsikamma National Park', in the Western Cape Province.

(9) The establishment of a new park, the 'Baviaanskloof Nature Reserve', in the Eastern Cape Province.

(10) The establishment of a new park, the 'Drakensberg World Heritage Site', in the Eastern Cape Province.

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SECONDARY HOME LOAN MARKET

A helping hand for the cities

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

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

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

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

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

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

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

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

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

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

Sanlam Properties Gauteng manager Fanie Lategan says Sanlam will definitely invest in a secondary home loan market.

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

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

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

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

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

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

"First off is accreditation as primary market lenders, which will start in the new year. This will enable them to sell loans to us. They could also participate in funding ar-

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

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

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

arrangements, given their access to large funding networks.

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

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

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

JERMATINE CRAIG
STAFF REPORTER

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

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

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

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

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

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

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

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

Relatives attack nurses

ASHLEY SMITH AND JENNY VOLL
Staff Reporters

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

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

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

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

He said the unit handled an average of 50 cases a day during the week and about 80 a day at weekends.

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

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

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

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

SHARKEY ISAACS AND JENNY VIAL

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

On Monday night, described by assistant ambulance chief Archie Flax as "darkest blue Monday", Groote Schuur and Tygerberg refused admissions because they were full. Later the ban was extended to Conradie, Somerset and Victoria. Ambulance personnel were told to take serious patients to False Bay Hospital in Fish Hoek or G F Jooste Hospital in Manenberg.

It was the "darkest blue Monday" the service had yet encountered, Mr Flax said. Peter Mitchell, chief medical superintendent of Groote Schuur, said services for major trauma cases were suspended for two four-hour periods on Monday. "In such instances Metro is informed and arrangements for patient care are made with Tygerberg Hospital," he said.

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

Ann Brand, director of support services in the Western Cape, said if both academic hospitals were flooded, they would take every alternate patient with multiple injuries. Trauma centres with no vacant beds or long waiting lists for theatre contacted Metro, which would divert ambulances to less busy units. Trauma units did not turn away critical patients.

Mr Flax said the ambulance service had conveyed 328 cases in 18 vehicles crewed by 36 staff on Monday. "Normally we work with an average of 20 to 21 ambulances, crewed by a staff of 42."
Ambulances cannot cope

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

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

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

“It could be that a patient at Khayelitsha Day Hospital needs to be taken to the GF Jooste secondary hospital, or to Groote Schuur. Our ambulances have to transport them, putting pressure on the staff,” he said.

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

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

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

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

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

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

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

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

On Friday over 30 ambulances will be on standby to cope with expected drunk-driving road accidents.
Gauteng public hospitals in 77 malpractice suits

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

The total amount claimed in malpractice suits between 1993 and 1996 was R14.4m, of which only 11 cases had been settled at an amount of R43 000 against original claims of R4.3m.

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

Although malpractice suits were unacceptable, there were no discernible trends as each was different. They did not constitute a high percentage compared to more than 2.3-million admissions over that period, Masondo said.

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

Aspenia Karas, Our State's Million Dollar Hospitals, is Costing the Public

Is Nick G. 11/9/06
Tygerberg Hospital in crisis, says doctor

The head of trauma at Tygerberg Hospital, who headed the trauma unit for three years, denies any real upgrade of the unit. "I'm trying to do the right thing," he said. "We are trying to improve the service, but it's not easy." He added that the hospital is understaffed and underfunded.

"Tygerberg is a hospital in crisis," he said. "We are doing our best to keep the unit running, but it's not easy." He said the hospital is understaffed and underfunded.

"We are doing our best to keep the unit running, but it's not easy," he said. "We are understaffed and underfunded, and we are doing our best to keep the unit running." He added that the hospital is in crisis, and that the trauma unit is one of the worst affected.

"We are doing our best to keep the unit running, but it's not easy," he said. "We are understaffed and underfunded, and we are doing our best to keep the unit running." He added that the hospital is in crisis, and that the trauma unit is one of the worst affected.

"We are doing our best to keep the unit running, but it's not easy," he said. "We are understaffed and underfunded, and we are doing our best to keep the unit running." He added that the hospital is in crisis, and that the trauma unit is one of the worst affected.
Healthy boost for Brackenfell community

The Cape Metropolitan Council has funded the building of a new R1-million community health centre for Brackenfell.
Opening the new centre in Parady's Road recently, CMC mayor William Bantom told residents they had identified the need for an upgraded health facility to provide for the primary health care needs of about 27,000 people.
The new health centre would have four full-time nursing sisters and a doctor would operate a tuberculosis clinic and be available for consultations. The facility would also have family planning, immunisation, pediatric care, a dispensary and a small casualty unit.
Hospital is ready for more after tough year
25 000 treated at Manenberg unit

JERMAINE CRAIG
Staff Reporter

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Manenberg, with its estimated population of 65 000, is literally on the doorstep of G F Jooste. In the 1980s the leaders of the Hard Living Kids, Rashed and Rashad Saggie, ruled supreme in the area.

Faldiehah de Vries, of the Manenberg People's Centre, said that at the height of gang warfare there were four or five gang killings a week. All this changed when, in 1989, the community took to the streets in their thousands to condemn gangsterism. After this major show of force from residents, gangs signed a peace pact - and relative calm has prevailed in the area for many years.

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

Commenting on the love-hate relationship between the hospital and the public, Dr Maharaj said he and his staff knew there would always be a need for a trauma unit and that they were up to the challenge. "We are proud of our achievements and - with the camaraderie, dedication and enthusiasm of the medical, nursing and general divisions of staff plus the support of the public - we are confident that the hospital will continue to fulfill its obligations," he said.
One year on: GF Jooste management team members Ahmed Kathre and Julie Moses. The hospital celebrates its first anniversary as a trauma unit this week.
Battle for ambulances as Cape hospitals fill up

Tuesday when False Bay Hospital to

port townships near Cape Town for

ambulances to Cape Town and up -

last week the ambulance service

and night.

Victoria Hospital throughout the day

opened its doors to relieve the situation

From: E. C. de Beer

The situation appeared desperate,

under very difficult circumstances.

One of the waiting for the hospital bed

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

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

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

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

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

"Council must ... look at the issue of 'kickbacks' in terms of what it could mean for the public in general," council president Salomeni Kalichirum said.
Council may act on ‘referral incentives’

Josey Ballenger

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“Council must...look at the issue of ‘kickbacks’ in terms of what it could mean for the public in general,” council president Salomen Kalichurchum said.

Cosatu optimistic about employment bill

René Grawitzky

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

Addressing a media briefing yesterday, Shilowa said the bill should still go to parliament this year. He was optimistic a solution could be found through the parliamentary committee and the alliance process. He did not expect a meeting with the African National Congress until after the Cosatu congress next week.

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

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

Mandela offers De Klerk role in nation-building

CAPE TOWN — President Nelson Mandela said yesterday he believed it would be in the interest of nation-building and reconciliation if he had a role in nation-building and reconciliation.

Given “something somewhere where he can use his talent, not as a leader of a political party, but as one of the most eminent South...”
A town called Nobody

At last, somebody cares about

With primary health care as its goal, the government plans to ensure that there is a clinic in every village distance of every South African within the next 10 years, where CAROL PATON
Hospitals may publish guideline fees after medical aid scale rises 8%
‘Kickbacks’ to doctors investigated by council

BY JANINE SICKON

Sep 16, 1997

"Kickbacks" paid by growing numbers of private hospitals to doctors for patient referrals have drawn action from the Interim National Medical and Dental Council.

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

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

It also warned that any practitioners cited for unethical behaviour regarding kickbacks.

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

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

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

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

It could also inflate costs by inducing a doctor to refer patients to a hospital providing financial incentives, rather than to a non-acute hospital which offered more appropriate care.
Black woman takes over Verwoerd's hospital
VALKENBERG hospital is set to close as part of a major cutback in psychiatric services.

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

The cut-back decision, which still needs to be ratified by the health ministry, comes after a tortuous process of choosing between Lentegeur, Valkenberg, Stikland, Alexandra and Groote Schuur's G22 unit.

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

The impending closure of the hospital is almost certain to provoke an outcry from environmental groups fighting to preserve one of Cape Town's last surviving greenbelts. The Liesbeek and Black rivers run through the 44 hectare site, which is estimated to be worth R100 million on the open market.

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

Chairperson of the standing committee on Health and Welfare, Lynne Brown, said the department had no other choice but to close one of the hospitals as psychiatric care was over-serviced.

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

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

The city had previously sold off stretches of Valkenberg land in the face of fierce criticism from environmental groups.
All four psychiatric hospitals to stay

But land and beds must go

Jenny Viall
Health Reporter

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

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

Vacant land at Valkenberg, Stikland and Lentegeur, which was becoming too costly to maintain, would be sold. The land belonged to the State so the provincial health department would not benefit.

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

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

“We have reached the point of no return in terms of staff-patient ratios,” he said. “We need to consolidate the four hospitals.”

They would have to be run with a combined management. “We will run one psychiatric service, not four institutions.”

Psychiatric patients able to cope in the community or in group home situations had already been discharged from psychiatric hospitals.

“The next phase becomes more difficult. If we cannot operate within budget constraints, then yes, we will have to close a hospital.

“But it must be done slowly and in the context of building up regional and community psychiatric services,” Dr Lawrence said.
NEWS

DB Loses Unlikely

WEDNESDAY, SEPTEMBER 22, 1994
APE TIMES

Valleymead Services

outland to be sold

6/9 (97)

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New clinics are not all that is needed
It was no coincidence that the 390th clinic built since the 1994 election was opened at the weekend, after Health Minister Nkosazana Zuma had weathered a week of scathing public debate on her three new bills before Parliament.

However controversial the bills – and last week’s attacks, particularly from the Medecins Control Council, have been stinging – the clinics are bricks and mortar evidence that the health system is delivering changes.

But, as the SA Health Review noted a year ago, new buildings can quickly fall into disrepair:

Or they may turn out to be badly located or designed, or cannot be opened because there is no money to employ staff or purchase supplies.

The health department says more than 8,5 million South Africans have benefited from the initiative to build new clinics and upgrade existing ones, and about 128 000 people per week can now rely on essential services:

But the questions now are whether the clinics provide cost effective, quality care and whether they are sustainable.

"The nitty gritty of health reform is getting that clinic to function effectively and efficiently. That’s a far harder question that hasn’t received enough attention," says Dr David Harrison, who heads the Health System’s Trust Initiative for Sub-District Support.

He is heading projects in the Kalahari, amongst others, helping to build the clinic management skills that keep a service running smoothly.

Harrison says primary care is still considered the best way to respond to the broad health problems like tuberculosis which burden the poor with disease.

But the incidence of emerging chronic diseases like obesity, diabetes and hypertension is growing, and the only way to limit demand for hospital treatment of these problems is to provide prevention and control in communities.

Building clinics and giving free care was a starting point only, and now specific snags affecting quality of care in each district have to be tackled.

In many cases, simple systems of logistical and supply management are absent.

In one province, for example, managers at a regional meeting were bewailing the fact that they had no vehicles for TB control and drug distribution.

Ushering the entire meeting outside, the regional director pointed to the fact that there were plenty of government cars parked there, each driven by a single manager. Harrison recalls.

The task now is to create effective management teams, break down blocked "communication channels", give health workers easy access to health information and address the massive training needs.

"A number of nurses have told me that they ‘treat patients through prayer’, and they don’t feel confident or supported to manage patients," he says.

The quality of services, staff qualifications and numbers and support systems like drugs and equipment vary immensely between provinces, and from clinic to clinic.

In Gauteng, there’s no doubt that services are being used, says Dr Refilokwe Bisimila, chief director. Gauteng District Health Services. Patient numbers at free health care clinics have more than doubled to 384 138 this year.

The Van’s Empilawini clinic opened for the first time on a Saturday six weeks ago, with two nurses and one doctor. It is now pushing through 500 patients on a Saturday with six nurses and two doctors.

Yet one Johannesburg city GP says he’s now seeing at least three patients a day willing to pay for his services, rather than return to a clinic.

"The repeated messages I get is that there was no medicine, or they were told to come back tomorrow, or they waited all day until the shutters came down," he said.

The province has taken some steps to smooth out these ground level services, replies Bisimila.

At Mofolo Clinic in Soweto, patients were waiting an hour to get a card, another 30 minutes to have a temperature taken and then queuing for a doctor or nurse.

Province has cut the waiting time by 50% by allowing patients to keep their own medical records (patients don’t misplace their own cards nearly as often as an institution), allocating routine temperature and urine tests more carefully, and seeing stable chronic patients less frequently.

Last year regional offices were reporting three to four thefts a month; this has dropped off since fraud committees were set up in each region. Meetings with local police opened a line of communication, and burglary bars and perimeter fencing were set up.

The province is also hoping to free additional staff for clinics when the conversion of Hillbrow Hospital to a community health centre is complete.

Gauteng has also moved on the other national headache inhibiting service delivery: the integration of local authority and provincial clinics.

In theory, the process is being strangled by the Health Act and green paper on local government.

In practice the province has merged local authority and provincial clinics on the East Rand, so that 60 of the clinics which were former local authority clinics are now offering comprehensive care.

This was made possible because salaries of the two bodies were similar: anywhere closer to Johannesburg and local authority staff earn more than provincial bodies. Further away from town, the opposite applies.

Bisimila says Gauteng clinics are currently referring only 4% to hospitals, but province has to work more carefully at making sure these patients actually get the treatment they need (See sidebar report).

Gauteng has increased its primary health care budget from R350-million to R759-million over the past three years by diverting funds from academic hospitals.

However, many argue that at the point when the shift to primary care began in earnest in 1996, the hospitals – to which primary clinics refer their patients – were already declining. The crucial need for hospital reform appears to have taken second place to primary care expansion, to the point where quality of care has suffered considerably.

What is not arguable is the effect of collapsing 20 years of health reform into three.

"What change is doing to our staff cannot be underestimated," says Joanne Collinge, Gauteng’s head of communications.

"It places enormous demands on staff which can mean that services deteriorate because their efforts are being fragmented.

"It has been a hard process for staff and it has taken an enormous amount of courage to rise to the challenge," she says.
Most private medical facilities will not be defined as essential services.
Valkenberg pressure group issues plea

'Treat sold-off land carefully'

ANDREA WEISS
City Editor

A call has gone out for a proper development plan to be drawn up before the land surrounding Valkenberg Hospital is sold off.

The process should also follow the principles of "accountability, transparency and community participation", says a lobby group.

This follows news that health authorities are considering selling the land to help the cash-strapped health service.

The University of Cape Town, which also owns land in the area, is also considering selling its holdings.

Now, the Valkenberg Confluence Alliance, a broad-based umbrella organisation of interested groups, has appealed to the Cape Town municipality to safeguard the land against irresponsible use.

The alliance has also written to provincial Health Minister Ebrahim Rasool to ask for a planning initiative to be started as soon as possible.

In recent months, several organisations have shown an interest in the Valkenberg land, among them His People Church, which wants to build a regional evangelical centre.

The Black-Liesbeek River confluence area lies within the boundaries of Alexandra Road in the east, Settler's Way in the south, Liesbeek Parkway in the west and Treaty Road in the north.

The area is associated with a series of wetlands incorporating the Raspenberg bird sanctuary, and is regarded by the alliance as valuable open space which could provide therapeutic areas for patients at Valkenberg and Alexandra hospitals.

But the area lacks a comprehensive policy plan. It was identified in the Observatory Policy Plan as regional recreational space.

"In the absence of a plan and in the light of current rationalisation within the Department of Health, this land is threatened by piecemeal development and change of ownership," the Confluence said.

Although UCT had promised to hold a participatory process before developing its land, it appeared the university planned to sell without consultation, the alliance said.

The alliance said it had tried many times to obtain of existing plans for the area but had been unsuccessful. Calls to all levels of government and the municipality had gone unheeded.

The alliance consists of a number of civic organisations and environmental groups.
Private medical facilities ask not to be "essential services" under act
Bill on release of state patients is published

CAPE TOWN — Draft legislation to allow state patients detained on criminal charges in mental institutions to apply for their own release was published yesterday.

A memorandum on the Criminal Matters Amendment Bill says the provision seeks to get around the possibility of an attorney-general frustrating the release of a patient who is well enough for release.

At present, only an attorney-general can initiate a release application for people detained on violent charges, such as murder. Those held on lesser charges can be released by the hospital board.

The bill proposes to replace this system with a single procedure, allowing applications to be lodged with a judge in chambers by the patient, any other person or body on the patient’s behalf, the superintendent of the institution, or an attorney-general.

The memorandum says a major objection to present law on mental illness and criminal responsibility is that it allows an accused who was mentally ill at the time of an offence and therefore “mentally incapable”, but sane at the time of trial, to be detained as a state patient.

It also allows an accused who was mentally incapable at the time of trial to be detained as a state patient even though no offence has been proven.

The memorandum says the indefinite period of detention of state patients and the discharge procedure has also provoked much criticism.

The bill proposes to make it compulsory for the superintendent of an institution to report to the health director-general every six months on the condition of each patient. Present law requires a report every year for the first three years, then once every three years.

The bill proposes that accused be given access to state legal aid at hearings to decide whether they are fit to stand trial, or criminally responsible. — Sapa.
Staff just can't take it any more - doctor

ARG 6/10/97 (98)

A year ago staff at Retreat Maternity Hospital were unhappy. Six months ago they were desperate. Now they are not going to cope.

That is the opinion of Gregory Petro, a doctor responsible for community obstetrics at the Midwife Obstetric Units (MOUs), which fall under the Peninsula Maternal and Neonatal Service.

A "depressed" Sister-in-charge at Retreat, Monika Barthus, says: "My staff tell me all the time they've had enough. The matrons are aware, the authorities are aware of our situation."

The nursing sisters want to give good care but they cannot do so with their workload, they say.

"We have no time to give women the time and respect they deserve," says a midwife. "We just do the essentials. Each is doing the work of three or four."

They're finished - mentally, physically and emotionally.

Helen de Pinho, acting medical superintendent in charge of the MOUs at Groote Schuur Hospital, said:

"We try to identify staff from other MOUs to manage the situation. The staff are under tremendous pressure, they're at their wits end."

Voluntary severance packages have been one way for the Western Cape's health department to save money and many experienced nursing staff have been lost. The department faces further future cuts.

"Although the MOU budget has not been cut, our inability to replace staff makes it extremely difficult to manage," says Dr De Pinho. The MOUs are critical services ... we have to try to protect them. We keep making do, but soon we won't be able to."

MOUs - also located in Lotus River and Hout Bay - are one of the Western Cape's health success stories, reflected in low perinatal mortality rates (deaths of babies just before and during birth).

Run by midwives, they offer a comprehensive service to poor pregnant women and are cost-efficient, all aims of the national policy for maternal and infant health care.

They offer reproductive health care from pregnancy diagnosis through to labour and delivery, early baby care and family planning.

Problems are picked up early and women are referred immediately to a hospital.

Started in 1990 by Groote Schuur Hospital's Gynaecology and Obstetrics department, the aim of MOUs was safe delivery of uncomplicated pregnancies at community level.

In 1985 all MOUs were gathered under the umbrella of the Peninsula Maternal and Neonatal Service, an international model for maternal and infant health.

About half of all deliveries in greater Cape Town take place in MOUs at a cost of R700 a normal delivery, as opposed to R2 500 at hospitals.
Maternity unit ‘cracking up’

One nurse to attend to more than 60 women

JENNY VAILL
Health Reporter

It is midday on Tuesday at the Retreat Maternity Unit. Heavily pregnant women who arrived at 7am sit quietly, reluctantly resigned to a wait of anything up to eight hours.

There is one nurse to attend to more than 60 women. Some nod off. They’re fed up, they say. They’re tired, sitting for hours is difficult, the service is going down. Something must be done.

Shanthol Fischer looks angry: “Three years ago it wasn’t like this. It’s impossible.”

Patricia Landis says more staff are needed: “We can’t blame the nurses. They can’t do the check-ups properly. We can’t ask the questions we want to ask because we know there are others waiting.”

Her baby is due next week. “It’s so hard, I fall asleep. They try to make it easier. But you worry that when you come in in labour, there won’t be enough sisters to help.”

Woman after woman tells the same story.

Paulus Mbeteni has accompanied his wife Olga Kieghlaar. He says this morning two women came to Retreat from Khayelitsha because they were too far out. They were sent away and told to return the next day as new patients are booked in only between 8am and 7am.

Others leave because they are tired of waiting.

Gladys de Villiers has accompanied her daughter Carmen Coopoo: “What I saw this morning was chaos. The sister had to keep on running to find someone to help out. You can see on the mothers’ faces that they’re unhappy and tired.”

They are not alone in their distress.

The nurses are at their wits end, exhausted, demoralised and not knowing where to turn. Their pleas for help have fallen on deaf ears, they say.

The problem is a shortage of staff. Voluntary severance packages have left the unit understaffed and even though some have cancelled their leave to keep the unit running, they say they cannot keep up with the pressure anymore.

Even though maternal and child health have been identified as top priorities in the country’s new health system, Midwife Obstetric Units (MOUs) are suffering as staff are lost to the health services.

The maternity unit reached cracking point this week.

Early in the morning 84 pregnant women arrive. About 20 of them coming for routine check-ups were turned away and told to come back the next day. But the staffing situation will be no better then, and the backlog will build up.

There is little hope of relief. More nurses are leaving. One left last week. Another leaves this week. A third will leave in November.

When nurses leave their posts are frozen, with little chance of them being filled again.

Gregory Petro, consultant gynaecologist/obstetrician attached to the MOUs, says the unit is cracking up.

“Retreat has now passed the critical point of staff needed. The maternity unit is going to crack; it’s going to implode. If we carry on like this staff aren’t going to pitch up for work at the end of this week.”

At times there are only two midwives on duty at Retreat. Two sisters are needed to resuscitate a baby or a mother.

“In this case there would be no one to attend to a woman in labour. We cannot run the service like this. And there is no hope. If one person needs time off there is no cover.”

“Mother and child care does not go away. If we cut numbers and people are sent away, they’ll end up at Groote Schuur where they cost us more to treat.”

Trevor Trout from the Greater Steenberg Civic Association has come to the hospital to assess the situation. He believes the community must speak out if anything is to change.

“When I came here this morning the nurses were running around like mad things. They can only do so much because they’re only human. We believe they should stop the voluntary packages. If they continue, they should involve the community as to what the next steps should be.”

He said when the hospital was initially built it catered for far fewer people.

“They’re cutting down on staff, but the number of people is increasing all the time. Someone is not doing their homework.”

“We call on Ebrahim Rasool (health minister in the Western Cape) to come here and see. Community leaders must be consulted before packages are taken, we will give direction,” he said.

Helen de Pinho, who heads the MOUs, says the community has a right to be angry. “The health budget is at a critical level. We’re going to see more of this.”

“It’s just who the community directs its anger at. They must ask politicians what’s happening to the health budget.”
Mental patients suffer in staff crisis

R. R. E. 11/10/19

This spotlights need for more staff at mental hospitals.

Many mental patients suffering in staff crisis...
Doctors on the make had better watch out

CAS ST LEGER reports on the crackdown on profiteering in the health industry

Doctors who accept kickbacks — from cash to fax machines — for referring patients to private hospitals for tests or treatment had better beware.

The first meeting of a multi-professional peer review committee — representing doctors, nurses, pharmacists, private hospitals and other medical professionals — was held this week to ensure doctors toe the line.

The committee, an initiative of the Interim National Medical and Dental Council and the Medical Association of South Africa, says it will discipline doctors and other health professionals who accept kickbacks.

Rumours of crooked doctors receiving kickbacks have escalated recently and the committee was formed to thrash out ethical guidelines until new legislation can be introduced.

Professor Jan van der Merwe, chairman of the committee, says the body was established as it was "such an urgent matter".

He says policing of the medical profession has become necessary as times have changed.

The old-time doctor, Van der Merwe says, was known and honoured by his community. He was reliable, trusted and was not motivated by money.

"Lately, basically because of cost spirals, the market-model doctor has come into existence."

Today, business practices are applied to the health care industry. If a doctor brings in business to a hospital, the hospital benefits. Hospitals, therefore, may be tempted to offer financial incentives to attract doctors.

Free market principles do not apply when it comes to the doctor and his patient.

"The doctor is both the buyer and the seller," Van der Merwe says. "The patient does not really participate in the buying process."

If incentives are offered to the doctor by hospitals or other service providers, he can be influenced to recommend treatment that is not necessarily in the interests of his patient or the patient’s medical condition.

"And there could be incentives to over-service," says Van der Merwe.

The immediate task of the committee is to draw up guidelines on ethical behaviour. It will then turn to the task of investigating allegations of kickbacks.

A Johannesburg gynaecologist says: "There will always be a few bad apples — but I do not know of any kickback cases personally and I have never been offered such a bribe."

Norman Weltman, an executive committee member of the Clinic Holdings private hospital group, says: "We most definitely do not do kickbacks."

"We choose to attract doctors by high technology and services rather than by kickbacks," Weltman says; his group offered the committee its support and cooperation.

One of the most outrageous claims to be investigated by the new committee concerns a Johannesburg doctor who has an interest in a men’s outfitter.

The doctor allegedly sends patients to the shop to choose a new suit or shirt in return for signing blank forms — and the clothing bill goes onto the medical aid claim form under the guise of medicines or tests.

A more common allegation concerns aggressive marketing by private hospitals, creating incentives to attract doctors and encouraging them to send more patients by offering reduced rentals or profit sharing.

The more patients the doctor sends to the hospital, the more cash flows back to the doctor.

In another case, a hospital group is alleged to have sent a doctor a handsome cheque in return for a batch of patients referred by him for kidney dialysis.

State doctors could also be involved.

A doctor needing a fax machine to receive laboratory results but with no budget for one could, for example, be provided with one by a laboratory which would be keen to have his business.
A COMMITTEE should be set up to probe unacceptable incentives or kickbacks being paid to doctors by private hospitals, the Interim National Medical and Dental Council of SA said yesterday.

The practice appeared to be escalating and could interfere with a doctor’s judgment of what the most appropriate care for a patient was, Council registrar Nico Prinaloo said. (Hospitals) can inflate costs by causing doctors to overutilize inappropriately the service of a particular hospital,” he said.

Prinaloo said a steering committee set up recently had had its first meeting and recommended a multiprofessional peer review committee be set up. This committee should consider all matters relating to “perverse incentives”.

It should also set up guidelines as to what constituted acceptable arrangements between private hospitals and practitioners as far as incentives were concerned. The statement said disciplinary action would be considered against any practitioner accused of accepting kickbacks.

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REPORTS: Business Day Reporter
Whistle blown on kickbacks to doctors

Hospitals limited on incentives

JEREMY ORLAND
Health Reporter

The practice of private hospitals giving kickbacks to doctors as incentives to use their services is to be stopped.

Nico Prinsloo, registrar of the Interim Medical and Dental Council, said a multi-profession peer review committee would be set up to establish guidelines for acceptable arrangements between doctors and private hospitals.

The committee would not limit investigations to the relationship between private hospitals and doctors. “The council is fully aware of the fact that the modern health care system is extremely complicated, competitive and finance-related, while many outside factors impinge on the system, mostly commercially driven,” a council statement said.

Incentive programmes could interfere with a doctor’s judgment of the most appropriate care for a patient and inflate costs by causing doctors to over-utilise the services of a particular hospital, it said.

Disciplinary action would be considered against any medical practitioner cited for unethical behaviour as far as kickbacks were concerned.

The Medical Association of South Africa’s board of trustees has said acceptable kickbacks are free meals, free parking and discounts on theatre fees and drugs.

- Unacceptable kickbacks are free shares in hospitals, direct payment or commission for referrals or treatment; educational policies for doctors’ families, insurance policies for doctors; retirement annuities and car schemes.

Other incentives regarded acceptable, as long as they are not based on referrals or performance, are subsidised rentals, electricity and water and entertainment such as dinners.

Earlier this year the Cape Argus reported that a southern suburbs hospital was offering kickbacks to doctors in the form of shares in a trust scheme and 3% of fees billed to patients they referred to the hospital.
Wards may close over hectic festive season

Hospital holiday crisis
Sirens signal start of ambulance man’s nightmare

And he is the only person on duty

PIETER MALAN
REPORT

ANDREW INGRAM
PICTURES

Critical and the treatment’s expensive – facing page

Riviersonderend ambulance man Emmanuel Blom has a recurring nightmare.

Sitting at the ambulance station alone one night he gets a call saying that a bus heading for Umtata has overturned about 10km out of town and is on fire.

Mr Emmanuel gets into his ambulance, on his own, and races to the scene, sirens blaring. He has no idea what to expect.

How many people are dead? How many are injured? How will he be able to put out the fire with the single fire extinguisher he has with him? How will he, the only ambulance man on duty on the N2 at night between Caledon and Swellendam, be able to cope with the disaster?

For Mr Emmanuel and hundreds of ambulance personnel in the rural areas of the Western Cape, this scenario is not just a nightmare.

It is a daily reality of working life.

With the staffing levels in the ambulance service at a critical low, the life of anyone needing an ambulance outside the Cape Town metropole - and that includes the thousands of motorists using the N1, N2 and N7 - are seriously at risk.

This is because most ambulances sent out in the rural areas are manned by only one person and it is responsible for everything - driving, stretcher-bearing, medical care... you name it.

Ambulance personnel even have to ask bystanders to help them carry stretchers.

"It is not the kind of care we've been taught to give our patients at the ambulance college," said one Hermanus ambulance man.

He and his colleagues have harrowing stories of their experiences.

Like Pieter Mentoor of Caledon, who was attacked by a psychiatric patient.

"A few years ago, I had to pick up a patient on a farm outside town. Everything seemed to be fine at first - I put him on a stretcher and started the 20km journey back to town."

But halfway to town, things went haywire.

"The next moment the patient stuck his arms through the little sliding window and tried to throttle me."

Mr Mentoor managed to pull the ambulance over to the side of the road and freed himself from his patient's grip. He calmed the patient and sped to the local police station where he asked for a police escort to accompany him.

Howard Brinkels, also from Caledon, was once called out to pick up a pregnant woman about to go into labour near Genadendal. "I came there and found the woman in the back of an old bus where she and her husband were staying. It was late at night and pitch dark inside."

I soon established that she was in no state to be moved - the baby was on his way.

"The only problem was that I couldn't see a thing. "So with a candle in one hand I tried to do what I could. But when the baby came I asked the husband to hold the candle for me."

"He was so under the weather that he couldn't hold the candle still."

"So with candle wax dripping on my arms and on the women's legs, I brought the baby into the world."

But Mr Brinkels's problems had only just begun. He now had to get mother and baby onto a stretcher and out of the bus, with no help.

He eventually managed - after a heroic struggle - to get mother and baby out of the bus and to hospital.

And so the stories continue, whether it is Hermanus or Caledon, Riviersonderend or Swellendam.

Unfortunately not all have happy endings.

A premature baby died in Gerhard Louw's ambulance. He had to stop several times on his way to hospital to resuscitate the baby, and although he knew the child had very little chance, he tried his best. He said things would have been easier if he had had a colleague to help him.

"It makes things difficult being on the road on your own," he said. "It is a life you've got in your hands."
How are you doing? ambulance driver Emmanuel Blom demonstrates how he keeps an eye on his patients while on the road.
Critical condition - and treatment is expensive.
R1,5-m shot in arm for Baragwanath Hospital

Johannesburg – The Chris Hani Baragwanath Hospital has been given R1.5 million to upgrade facilities in its medical admissions ward and for building a new emergency laboratory, Gauteng Health MEC Angie Motshekga has announced.

The donation was made possible by the Merck Foundation, a wing of Merck Sharp and Dohme (MSD) South Africa.

Dr Masando said yesterday the collaboration between the hospital and MSD was in line with the department's strategy to promote co-operation between the medical and business sectors.

The Chris Hani-Baragwanath Hospital is one of the busiest in the southern hemisphere.

The upgrade of facilities will allow for more effective patient care.

It also will provide quicker services and help improve efficiency at the hospital. – Sapa
Overspending at Gauteng hospitals amounts to R461m

BUDGETARY overspending at some Gauteng hospitals had amounted to R461m last year, or 35% over budget, the Democratic Party said yesterday.

There was little prospect of controlling runaway spending, Gauteng legislature health spokesman Jack Bloom (DP) said after receiving written replies to his questions from health MEC Amos Masondo.

About R421m was spent at the Johannesburg, Chris Hani Baragwanath, Pretoria Academic and Helen Joseph hospitals for the previous budgetary year.

According to Bloom’s analysis, 60% of the budget for the first three hospitals had already been spent this year, and 45% at Helen Joseph, which indicated further overspending this year.

“I am concerned the final adjusted budget is still not available as this indicates appalling budgetary practice.” Bloom called for realistic budgets which would be strictly adhered to.

Masondo’s said the reasons for the overspending were budgeting allocations less than the actual need, not keeping up with inflation and services being delivered to other provinces with minimum interprovincial funding.

Steps to remedy the overspending included the closing of three hospitals.—Sapa.
R1.5-m donation a boost for Bara

The more than 100 emergency patients who enter Chris Hani Baragwanath Hospital daily could soon be booked into the right wards faster, thanks to a R1.5-million donation from an American company this weekend.

The SA arm of Merck Sharp and Dohme donated the money to upgrade facilities at the admission ward and build a new emergency laboratory for critically ill patients.

The equipment to be upgraded includes x-ray facilities and resuscitation machines.

According to Gauteng Health Department spokesman Popo Maja, the hospital has been using old equipment.

Professor Ken Hudde, co-ordinator of the project, said the upgrading would promote more effective patient care.

Currently, of the 3,500 laboratory tests carried out at the hospital daily, about 1,400 are done at the emergency laboratory.

The new laboratory is located next to the emergency ward and will feature automated equipment to help doctors access the information needed to treat critically ill patients.

The hospital also plans to improve conditions in the ward for doctors and nurses.
Hospital short of (98) ICU beds

Sowetoan 21/10/97

There was a severe shortage of post-operative and surgical intensive care beds at Johannesburg Hospital, Gauteng MEC for health Mr Amos Masando said yesterday.

Masando was responding to questions in the Gauteng legislature by Democratic Party MPL Jack Bloom in a statement released yesterday.

Masando said there were between 14 and 16 such beds, depending on available nursing staff, and that up to 12 additional beds could be used, depending on surgical policy and practice.

The shortage led to 79 patients being referred to five clinics at a cost of R2.7 million or R34 000 per patient in the 16 months until July this year.

He said it was not possible to determine the number of emergency patients transferred to other state hospitals without further research into this matter.

Bloom said in yesterday's statement: "I know of many hair-raising incidents where desperate measures are resorted to between various hospitals to find ICU beds for critically injured patients."

Masando also said in his response that it was not possible to measure the extent to which patients requiring post-operative intensive care facilities were placed in general wards.

However, he said: "Patients requiring post-operative intensive care, if placed in general wards, either have special nurses or are kept in the recovery area in theatre until they are ready to go to the wards."

If an additional 12 beds were made available, about 48 extra intensive care staff would be required.

"The main problem is the high demand in the private sector for intensive care staff. There is extensive head-hunting."

Bloom said the erosion of conditions at state hospitals was so severe that there was little chance of attracting these nurses back.

"Lives of emergency patients are at stake, as well as the interests of other state patients who suffer from long waiting periods for operations because of the shortage of state ICU facilities," Bloom said. - Sapo.
Costs cut, so state hospital patients starve

By TWEET GAINSBOROUGH-WARING

Patients are starving in state hospitals throughout South Africa, top medical professionals have revealed.

Severe budget cuts mean as little as R6 a day can be spent on feeding patients. The experts also blame lack of nutritional knowledge by hospital staff.

Recent surveys show that as many as 60% of state hospital patients are malnourished. One in five of these are severely malnourished.

By saving money on food, hospital authorities are having to spend more on medicines because starving patients take longer to recover.

Professor Demetre Labadarios, head of human nutrition at Stellenbosch University, said malnutrition was the most neglected aspect of patient care in hospitals.

"Malnourished patients are a nursing nightmare. They are far more difficult to treat as they are more susceptible to infection, and post-operative wounds take longer to heal."

Death came more quickly to a patient suffering from malnutrition because they had less resistance to disease and infection, Labadarios said.

Staggering statistics showed the hospital stay of a patient suffering from malnutrition was on average 10 days longer than it needed to be. At a cost of R600 a day to the state, this amounted to R6 000 for each malnourished patient. In the case of a patient in intensive care, the cost was R5 000 a day.

He said that in the Western Cape, the high rate of alcoholism, tuberculosis and trauma increased the number of malnourished patients admitted to hospitals.

Inadequate funding was part of the problem, with less than R6 a day spent on food for each patient.

Malnutrition was compounded by the effects of the disease and by the patient missing meals while spending time out of the ward undergoing tests.

Labadarios said patients admitted to emergency units were a high-risk group because they might spend days on a drip with inadequate food. These patients might also have injuries requiring special foods or diets, which were often overlooked. As a result, patients were sometimes left to fend for themselves.

He said doctors were well trained in coping with heart attacks, bullet wounds and accident cases because there were specific treatment routines to follow. "But they do not look at a patient's state of nutrition on admission."

Surveys in state hospitals showed that less than 10% of patients had their body weights recorded and less than 5% had any information on their nutritional status on record.

State hospital cost cutting: now patients are said to be starving.
R19 000 MONTHLY FOR NO WORK

Authorities slammed over suspended doctor

AS HOSPITALS lose legitimate staff through budget cuts, a doctor suspended over a year ago pending a hearing, has been drawing full pay. CLAUDIA CAVANAGH reports.

A FORMER head of Tygerberg Hospital’s trauma unit, who was found guilty of disgraceful conduct by the Interim National Medical and Dental Council last week, has been off work on full benefits for over a year.

Dr Richard Muller, a principal specialist earning around R19 000 a month, was reported to the council by the provincial health department for allegedly not keeping “required patient records” and “prescribing excessive dosages of pethidine on a regular basis to a patient.”

Pethidine is a schedule seven narcotic pain-killer related to opiate drugs. It is potentially addictive if administered incorrectly.

Muller was suspended — with full benefits, including pension and a car — in June last year pending the outcome of an inquiry.

This delay could have cost the taxpayer about R150 000.

“Although a principal specialist earns no overtime pay, the benefits are substantial,” said Dr Gilbert Lawrence, chief director of Supra Regional Services for the provincial health department.

Angry staff at the unit, where services were drastically reduced earlier this year because of government budget cuts, criticised the system for taking so long to resolve the issue.

“We on one hand we’re told the province doesn’t have any money, and on the other we see the department taking ages to rectify this situation,” said one staff member.

Last month, the head of trauma at Tygerberg, Dr Elsmita Steyn, resigned on the eve of the opening of the hospital’s upgraded unit.

She said she could no longer take responsibility for the “chaotic situation” at the unit and branded the upgrade as “window dressing.”

She blamed the health department for “ruining staffing here” saying she’d spent much time trying to staff the unit but that as soon as she found suitable applicants, the posts were abolished.

At the time, the chief medical superintendent at Tygerberg, Dr Abul Rahman, labelled her accusations as “rubbish.”

“People must not forget we are in South Africa. When you build a house you don’t furnish it with everything at once. We have given her 10 staff — eight doctors in trauma and two sessional workers.”

Yesterday, Lawrence blamed the process which had to be followed for delaying the Muller issue.

It would have been illegal to suspend Muller without benefits until the outcome of the investigation was finalised.

But even now the committee has made a final recommendation, the situation will not be immediately resolved.

“We will have to wait for the finding and carefully study the conditions imposed on him before we can decide what to do about the situation,” said Lawrence.

According to information released to the Cape Times, the medical council findings follow an internal investigation alleging that Muller had “neglected to adhere to his official working hours” and a police matter involving his alleged failure to report the loss of a prescription pad subsequently found in a patient’s possession.

In keeping with a preliminary committee’s recommendation, the council found Dr Muller guilty of disgraceful conduct. However, the council suspended for five years the original recommendation that he be “erased from the register” on several conditions.

These include that he only, practise at a hospital approved by the council and under the supervision of a medical superintendent, that he receives treatment from an approved psychiatrist and that he does not “purchase, acquire, keep, use, administer, supply or possess” any schedule five, six or seven substances.

This would include most injectable strong pain-killers, antidepressants, tranquilisers and hypnotics, drugs that diminish appetite, short-acting barbiturates and therapeutic narcotics.
Valkenberg stares closure in the face

CAROL CAMPBELL AND ANDREA WEISS
Steenberg 

ARG 28/10/97

The death knell has sounded for one of Cape Town's oldest hospitals.

After months of speculation, Valkenberg psychiatric hospital has been officially identified as the institution to close in a bid to rescue the Western Cape health department, which is in dire financial straits.

The provincial health department said it believed the Western Cape needed only three psychiatric hospitals and "the most appropriate to close would be Valkenberg".

Stakeholders and citizens have been given until Monday to say why they do not agree with this decision.

The announcement has been greeted with shock and dismay by hospital staff, patients and numerous support organisations, including old age homes, sheltered workshops and group homes.

Dr Tom Sutcliffe, head of the provincial health department, says the final decision has not been taken. Provincial health minister Ebrahim Rasool is expected to make an announcement in about a week.

Lisa Wolter, director of the Abri Foundation which houses 27 schizophrenic and manic depressive patients, said the decision would be "catastrophic" for the foundation. She said the residents, able to cope in a stress-free environment, were in a state of panic about the closure.

Brian Robertson, head of psychiatry at the University of Cape Town, said patients and their families were not being considered. "Many people struggle to get to Valkenberg hospital, especially people from informal settlements in places like Hout Bay and Noordhoek. The extra distance to Mitchell's Plain would make it very difficult for them."

Dr Sutcliffe has been told he should expect a health budget of R2.2 billion next year. His budget this year was R3.47 billion which placed enormous strain on the health service.

"The health department proposes that the most appropriate hospital to close would be Valkenberg but we are nowhere near a final decision yet. This is not an easy decision to make," he said.
Developers clamour for hospital land

ANDREA WEISS AND CAROL CAMPBELL
Staff Reporters

Developers are clamouring to get their hands on the scores of hectares surrounding Valkenberg hospital.

But local lobby groups are insisting that there should be an open public process before any decisions are made about the land, which the Observatory Policy Plan describes as "regional recreational space".

Speculation is that Valkenberg has been identified for closure because of the value of the surrounding land, a portion of which on the Pinelands side is valued at R30 million.

Provincial Health Minister Ebrahim Rasool's office has reportedly been inundated with queries.

Ward councillor Owen Kinahan has warned that the hospital land could fall into the hands of the public works department, "with all the sinister and maladminstrative results that are associated with it".

He appealed to the Health Department to "at least entertain suggestions that would manage the estate in such a manner that it would not simply be regarded as a financial drain".

Among the groups which have indicated an interest in the land are:

- His People, an evangelical church which wants to build a regional centre on the Pinelands side.
- Friend of Alexandra, with plans for a farm to house and provide work for handicapped people.
- The Tree Oxygen organisation, which has been growing organic vegetables around the historic Oude Molen farm house and wants to expand this project.
- The Strategic Development Agency, which also has plans for a farm, but with an office park too.
- The River Club is rumoured to want to expand to include a hotel, possibly on to Valkenberg land.

A public meeting is to be held on Thursday at 6pm at the Environmental Centre at Valkenberg.
Demand on paediatric facilities has soared since child health care became free

AVANDACHIE OF CHILDREN HITS HOSPITALS
Pschiatrists warn

Valkenberg closure may put dangerous patients on the street.

29/11/1947

Psychiatric hospitals without patients

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Physicians warn
Shisana says 61 clinics stand empty

Only 11 clinics built in the fast-tracking programme stood open for longer than six months after completion, says director-general for health Dr Olive Shisana.

Shisana yesterday told the standing committee on public accounts that 61 of the 227 clinics built in the health department’s fast-tracking programme since 1994 were not-yet operational.

This was because the business plan was approved for the construction and not operation of the clinics.

Chairman of the standing committee Andrew Feinstein criticised the department as irresponsible, saying each empty clinic cost up to R500 000 a year.

She said in a later statement that up to July 19 this year, R710-million would have been spent to provide 460 new clinics, 210 upgrades, and 807 staff houses in providing access to primary health care for 8 million people.

R16-million had been saved on design, construction and escalation. This was sufficient to fund 155 clinics.
Quarter of new clinics not operational

Linda Ensor

CAPE TOWN — Sixty-one of the 227 clinics completed by the health department in a "fast-track" exercise which circumvented normal tender board procedures were not operational at end-August because there were no funds for operational expenses, Parliament's standing committee on public accounts heard yesterday.

"The business plan which was approved was only for the construction and not for the operation of the clinics," health director-general Olive Shisana said. The problem would be exacerbated because the provinces had no funds to employ staff for the clinics.

Two-thirds of the clinics built in the Eastern Cape had not been operational for 10 months or more.

African National Congress (ANC) committee member Andrew Feinstein criticized the department for having embarked on a rapid clinic-building programme in rural areas without making allowances for operational expenditure.

"It is extremely irresponsible to plan capital spending when it is not clear that the operational expenditure is going to be available," he said.

About R500 000 was being lost every year that a clinic was not functional in terms of the capital cost, he said.

Shisana said the health department had no control over how provincial resources were allocated. When the provinces submitted their business plans for the clinics they were asked to assure the department they had sufficient operational funds. They had also undertaken the construction.

"Clinics take many months to complete and although assurances may be given in good faith, the financial position of a provincial health department may change in the meantime."

Committee member Barbara Hogan (ANC) said the problem stemmed from the lack of co-ordination between national and provincial government expenditure.

Shisana cited a number of reasons why the clinics had not become operational, one being the time it took to get staffing establishments approved by provincial public service commissions.

Since 1994, 328 clinics had been built with government and non-government resources and 2 298 clinics had been repaired.

The department incurred a final unauthorised expenditure of R34m in the 1995/96 fiscal year. Of this a substantial amount was paid to consultants for the clinic-building programme without complying with tender board directives.
Cost of running clinics ‘not known’

Josey Ballenger

THE health department could not say how much it would cost to operate 61 clinics standing unused since construction, but was assessing how provinces could alleviate the problem, director-general Olive Shisana said yesterday.

"We are discussing the provinces' overexpenditure and how they could gain some savings," Shisana said during a break from a meeting with the director-general of state expenditure and provincial health department heads and their budget leaders.

She said the provinces would have to account for "why they don't have the money when they indicated they did in their budgets", and said they would have to "rearrange" their spending.

Shisana informed the parliamentary public accounts committee on Wednesday that 61 of 227 clinics built under a "fast-track" programme outside normal tender procedures were not operational at the end of August.

Despite previous assurances by the provincial governments that they would have adequate operational funds, Shisana said that this did not seem to be the case.

KwaZulu-Natal has the most unopened clinics (20), followed by Northern Province (15), North West (12) and Eastern Cape (9).

The department had spent R71m on "improved access to health care" and built a total of 504 clinics by September, of which 393 were in underserved areas.

In addition, 210 clinics were repaired and 807 staff houses built, providing access to primary health care for about 8-million people. Repairs to 2 298 clinics had cost a further R26m.

Shisana said another problem facing government was health professionals' reluctance to work in remote areas.

She said that new legislation binding post-intern doctors to one year of community service would only partially solve the problem and that it was not known when that was going to come into effect.
Opposition is growing to the proposed closure of the Valkenberg psychiatric hospital in Observatory and a public meeting has called for a planning process for the land before any further steps are taken.

At a meeting called by the Valkenberg Confluence Alliance, a group of civic and environmental organisations, it was decided that a comprehensive policy plan for the area was needed before a decision could be taken about the future of the hospital and the land on which Valkenberg is situated.

The hospital is on public land and any plans to develop it should be done with full consultation of all interested individuals and organisations, an alliance official said. As state land it belonged to everyone and everyone should have a say in how it was developed.

The provincial Health Department has said it will consider all submissions on its plans to rationalise psychiatric services which include closing the hospital.

The meeting of Observatory residents and other interested groups opposed any plan to close Valkenberg and said alternatives should be explored. There is at present no policy plan for the Black and Liebeek rivers confluence area.

In the absence of such a plan and in the light of rationalisation of health services, this land is now threatened by piecemeal development and change of ownership, says Kate Snaddon, a spokeswoman for the alliance.

Meanwhile Gilbert Lawrence, chief director of supra-regional services, has said the prime objectives of the rationalisation process has always been to improve the quality of service delivery and ensure equitable distribution of services.

Dr Lawrence said stakeholders had until November 16 to comment on the proposals, and a decision would be made public on November 18 after a final evaluation.
Over 1,000 people a year cannot get a second chance on life.
Gauteng hospitals owed R152-m in patient fees

State Reporter

 Slack administrative practices have resulted in R152-million in outstanding patient fees being owed to Gauteng's state hospitals, the Democratic Party said yesterday.

Democratic Party MPL Jack Bloom said that according to statistics released by health MEC Amos Masondo, Johannesburg hospital was owed R46.1-million, Pretoria Academic hospital was owed R36-million and GaRankuwa hospital, near Pretoria, was owed R15.6-million.

More than R27-million in outstanding fees had already been written off.

"The truly astonishing figure is that about R27-million of outstanding fees is owed by patients who are on medical aid, and therefore payment should be guaranteed, provided there is proper administration," Bloom said.

"These figures reveal the abysmal state of financial administration in state hospitals, which is confirmed by the admission by Masondo that vacant administration posts in hospitals vary from 10% to as much as 55%," Bloom added.

The Democratic Party legislator called for the aggressive use of private collection agencies, as well as an effort to improve hospital admin-

More than R27-million already written off

Signed: 3/11/97
Province’s hospitals are owed R152m

Business Day Reporter

GAUTENG state hospitals were owed R152m in outstanding patient fees, Gauteng Health MEC Amos Masondo said last week in response to questions put by Democratic Party MP Jack Bloom.

Johannesburg Hospital is owed the most at R46,4m, followed by Pretoria Academic Hospital at R36m and GaRankuwa Hospital at R15,6m.

An amount of R27m of outstanding fees was owed by medical aid patients, where payment “should have been guaranteed provided there was proper administration”, Bloom said in a statement which was released yesterday.

Bloom suggested the figure of R27m was an underestimate as several hospitals, including Johannesburg Hospital, were unable to provide figures on their medical aid patients.

“These figures reveal the abysmal state of financial administration in state hospitals, which is confirmed by Masondo’s admission that vacant administration posts in hospitals vary from 10% to as much as 55%,” said Bloom.

There was a “serious need” for the health department to improve hospital administration as well as upgrading facilities.
VALKENBERG MUST KEEP FAITH WITH ITS PATIENTS

Closing hospital would not save much

INSIDE STORY

There are many reasons why Valkenberg psychiatric hospital should not close. In fact, there are good reasons not to close any of the three psychiatric hospitals. François Daubenton, principal psychiatrist at Valkenberg, spoke to Health Reporter

JENNY VAILL

The proposal to close Valkenberg Hospital is still doing its bit for financial relief to the Western Cape health department, but will it improve access to psychiatric services for the thousands of people affected by mental illness?

In fact, says Dr Daubenton, closing the hospital will mean a deterioration of psychiatric services and ultimately patients will suffer: "The reason not to close Valkenberg Hospital has to do with the patients and their families. Patients' well-being depends on stability. They are among the most vulnerable of society and change effects them to a greater degree than change in physical health services."

"It's important to remember that a large majority are stabilised and controlled with treatment rather than cured, and they get to know us over long periods of time."

But, says Dr Daubenton, is the strongest argument for maintaining all three hospitals, albeit in a downsized capacity, because the argument is that people should be seen in the primary health care system. The reality is that effective community psychiatric services don't exist.

For example, Wynberg's community clinic does not provide psychiatric services and has been beset with problems of staff shortages, says Dr Daubenton. And at Groote Schuur, where psychiatry is relatively well-staffed, getting access to their folders so we could treat them, it was unbelievable.

This results in a large number of patients not being resocialised.

Valkenberg is in the busiest, the best-staffed (except for nurses) and the most accessible psychiatric hospital in the Western Cape. It has also been a lot of NGO support. Why then has it been chosen for closure?

The reasons are essentially threefold, believes Dr Daubenton:

1. Minister Nkosazana Dlamini on South Africa's psychiatrists found it difficult to evaluate Valkenberg Hospital as half the wards were excellent and half were in a terrible state of disrepair: "This ought to be closed by the rationalisation process." Unfortunately I think the role of Valkenberg was emphasised and that remains in the minds of individuals. But we still support it to refurbish wards on the Observatory side.

2. There continues to exist a prejudice that psychiatric patients are untidy, he says. "Place psychiatric services in the forefront of policy and the perception of citizens has always been the norm.

3. The property is valuable, being currently situated. A high proportion of our patients have come from the less affluent sector of society, who rely on public transport. Fifty percent of our patients are coloured, 30% black and 20% white. It's difficult enough for a patient from here to reach the hospital. If you close it, how will patients get to Richmond (in Bellville) and Lentegeur (in Mitchells Plain)?"

Daubenton says closing down Valkenberg would save the province only R5- to R7-million a year.

"That's very little considering the R80-million present budget deficit," he says. "If the argument is that we need to close the hospital because of financial problems, the reality is that there is no significant saving. Of the R75 million spent on psychiatric services out of the Western Cape's R2,3-billion health budget, 80% goes on personnel costs.

Although Valkenberg is a valuable piece of land, that land belongs to the state, not the province. The notion that selling state property is going to directly benefit health services is a possibility, but there are a number of steps to be before we get there.

"Psychiatric hospitals occupy immense tracts of land which are very valuable. There is no doubt that portions of land at all hospitals could be allocated. But it's a complex legal process to transfer land to the provinces with no guarantees it will be successful. And, once transferred, there is no guarantee funds will come to health."

"With privatisation of state assets, there is a strong lobby which says the money raised should be shared among all provinces," says Dr Daubenton.

Over the past eight years there have been three investigations into psychiatric services:

- All recognised the underdeveloped nature of psychiatric services and the need for them to be integrated into general health care services.
- When the strategic management team (SMT) looked at rationalisation, we made the psychiatric services support the principles of ensuring services become more accessible, affordable and appropriate.
- The mental health task team report, accepted by the SMT, indicated that no psychiatric hospitals should be closed, but all should be downsized.

That report also said there was a potential for a significant reduction in the number of beds. In a 10-year period the following were agreed to:

- Psychiatric beds were opened in regional hospitals.
- Sufficiently staffed community psychiatric services were developed.
- Primary health care nurses and doctors were actively involved with the delivery of psychiatric services.
- In co-operation with the private sector and NGOs, alternative accommodation structures for long-stay patients were developed.

However, without any of these being completed with, a proposal has been made to close Valkenberg Hospital. We can downsize but closing will result in a deterioration of services.

"In the last three months, all three psychiatric hospitals have had to close their male or female admission beds for variable times because capacity had been reached. There is no way we can consider a reduction of acute beds. We could reduce long-stay beds by (total of 227) in a very short space of time."

"The other cohort of patients for whom we're responsible are the mentally inane, the fastest growing population of psychiatric patients. The closure of Valkenberg would mean building another maximum security unit.

"I find it rather bizarre that they're seriously contemplating moving the unit to a socio-economic climate where there is no money."

Does he hold out any hope that health authorities will not close Valkenberg?

Dr Daubenton replies cautiously: "In my heart of hearts I believe sincerely that if the hospital is not closed it will be as a result of the community voice being heard on this issue."

"The people of the Western Cape will ultimately receive services dependent on their response to this proposal.

"Psychiatric staff have been negotiating with decision-makers for eight years on how to best provide psychiatric services. This proposal indicates we have been unsuccessful in convincing them.

"The health department is saying the proposal is for debate and they will make a decision after November. The way they put this proposal to the psychiatric career is a mechanism utilised at the end stage of a decision-making process."

If the health department decides to close Valkenberg, the provincial cabinet has to approve the decision. Hopefully according to the wishes of the population it serves."
Ex-pats from war-torn African countries find warm haven in hospital under threat

ADELE BAILEY

Micky, a young Tanzanian, has made his mark in the male admissions section at Cape Town's Valkenberg Psychiatric Hospital.

His brightly-painted mural of an African sunset with a grazing giraffe and a palm beach lights up an otherwise grim sitting-room. For Micky it holds the promise of a better, healthier life in his East African country.

The young man who has been treated for schizophrenia found his way to Cape Town from Tanzania, as have a number of patients from other African countries. He is one of an increasing number of foreign patients to be treated at the hospital, which is under threat of closure by the Western Cape Health Department.

Patients and staff are vociferously opposed to closing the hospital, a move they say is unethical and would violate patients' basic human rights. It would be like "kicking a dog when he is down. It is marginalising the marginalised," says consultant psychiatrist David Kibel.

He and other staff members feel that closure of the hospital would not save the department money, but result in a dramatic decrease in accessibility of mental health services and a severe decline in standards of care. Dr Kibel said foreign patients from war-torn countries in Africa, where there is a complete breakdown in services, were referred to the hospital by police and the Trauma Centre.

These patients place an extra burden on already stretched services. Psychiatric consultant Sean Baumann had recently treated patients from Mozambique, Angola, Zaire and Burundi. They had psychotic disorders and most were infected with HIV.

"There has been an increasing frequency in the number of people admitted with mental illness from across the border as far north as Burundi. These people come from countries where there have been extremely stressful and traumatic events. "They mostly suffer from psychotic disorders and drift down to Cape Town because there is a complete breakdown in services in their own countries," he said.

Dr Baumann said the greatest problem was the language barrier and the fact that there were few aftercare services to offer. "They are at risk because there is often no family to support them."

He said treating these patients had to be seen against a broader context, which was the potential dangerous situation that would arise if psychiatric services in the Western Cape were under threat. Dr Kibel said that foreign patients were alienated from their families, they suffered economic hardship, cultural alienation and were the victims of xenophobia.

Attempts were made to send people home once they had been treated and stabilised.

The male admissions ward also witnessed a steady stream of black students from the University of Cape Town.

"These students, many of whom are disadvantaged, are under extreme pressure to perform, especially during exam time. They suffer from stress and paranoid illnesses," he said.

Dr Kibel says Micky is doing well and sometimes comes to outpatients.
Valkenberg objecors plan street protest

Patients and staff vow to march

HUNDREDS OF VALKENBERG PSYCHIATRIC HOSPITAL patients, their families and staff are planning to take to the streets of Cape Town to protest against proposals to shut down the hospital.

The Friends of Valkenberg, set up to raise funds to upgrade the hospital, is planning the march to the Welfare Street offices of the Department of Health.

Members of the National Education Health and Allied Workers Union will be calling on all their members to join in the protest on November 17.

Chairperson of the Friends of Valkenberg, Francois Robertson, said: "The idea of the march is to give the patients a chance to express themselves. They want everyone to know what the closure of Valkenberg Hospital would mean for them and their families."

The Department of Health has proposed the closure of Valkenberg as part of the rationalisation of health services in the province and to increase the accessibility and affordability of the services for all.

The plan includes resettling the mentally ill patients at Lentegar or Stikland Hospitals.

But the department's rationale for the closure has been criticised by medical staff, non-governmental organisations, patients and their families.

They believe that accessibility to services for the mentally ill will decrease and more and more patients will be left without anyone to care for them. They have warned of the potentially dangerous risks involved for the patients and the public.

This week a Maitshoepfontein grandmother, Petronella Klein- ham, 82, was fatally stabbed by her grandson who was discharged from Stikland Hospital.

Despite appeals from his family, the hospital refused to readmit him.

Valkenberg consultant psychiatrist David Kibel said: "The patients want them to know what the closure will mean for their families."

Patients and staff have said that Lentegar and Stikland hospitals are not an option for many patients who have to survive on a monthly R200 disability grant, and are not able to travel the distance to these hospitals.

Taxis and buses did not adequately serve the route.

Valkenberg sister Theresa Gogela who lives in Guguletu said it was "unsafe" for her to travel to Lentegar Hospital.

In a report this week, principal psychiatrist of Valkenberg, Frances Daubenton, said that closing the institution would not mean a great financial saving.

The Friends of Valkenberg have embarked on an innovative advertising campaign to challenge the department's plans to close Valkenberg.

In the cleverly-worded adver-
Health workers allergic to gloves

AYESHA ISMAIL (98)

HEALTH workers at Groote Schuur Hospital have become allergic to latex items such as surgical gloves.

Cheap, poor quality latex products bought because of budget cuts have been blamed for the allergy outbreak, which has affected more that 50 workers.

Paul Potter, associate professor of UCT's Allergology Unit, warned that allergic reactions to latex could be severe and even fatal.

Potter fears that health personnel across the country could be in danger and has called on other hospitals to act swiftly if staff become allergic.

He has warned that unless latex exposure in hospitals is limited, an increase in allergy from the present 10 percent of staff to about 25 percent could be expected.

Groote Schuur authorities have moved allergic staff to latex-free areas. But this is not easy as latex goods, such as gloves, tubing and containers, are found extensively in the hospital.

The hospital has formed a special committee to deal with the allergies and has started a latex clinic where staff are treated.

The hospital authorities are also developing a policy on latex which includes a wider use of powder-free gloves and a latex-free operating theatre.

Latex allergy symptoms include itchy eyes, coughing, wheezing, asthma and anaphylaxis (when victims enter a state of shock).

Potter said: "Increased glove usage over the past eight years and cheap quality gloves appear to have caused an increase in latex allergy. Because of budget cuts, cash-strapped hospitals have been forced to buy the cheap gloves."

He called for the use of better quality, powder-free gloves.
Many not paid for extra load

By Bunty West
City Reporter

More than 200 Gauteng hospital and health employees, from porters to assistant directors, are doing more senior jobs without being paid for their increased responsibilities.

According to Health MEC Amos Masondo, 221 staff members, including 12 from his own office, are performing their duties only in acting capacities.

Masondo released the figures in response to a question by the DP's Jack Bloom on conditions in Gauteng's health sector.

Bloom said the two worst cases seemed to be that of an R Nugent from Nigel Hospital and Dr J van der Werde of Kalafong Hospital. He said Nugent has been an acting administrative clerk since June 1990, and Van der Werde, a senior radiologist, has been acting chief specialist since January 1982.

Neither could be contacted for comment last night.

Masondo said there had been "some delay" in making permanent appointments, mainly because of a moratorium placed on filling posts. He said a task team had been convened to streamline the procedure.
Patients to pay price of closing Valkenberg

CYNTHIA VONGAI

Ms Belinda Conradie is 27 years old, a mentally ill patient and she lives alone.

Conradie is a manic depressive and is currently a patient at Valkenberg Hospital after a “manic” attack. She, unlike other mentally ill people, is lucky enough to have a support structure once she is released.

Her parents are divorced. Her father lives in Pretoria and supports her financially, her mother lives in Kenilworth and visits her regularly.

Besides her family support, Conradie belongs to a mental health support group, “This Ability”, which meets once a week to help patients who have been reintegrated into society.

She has also been admitted to a rehabilitation programme run by the Fountain House, an Observatory non-governmental organisation.

“I have been here five weeks but I have also been in and out of the hospital many times. When I came to Valkenberg a few weeks ago they could not admit me (because the hospital was full), so I was referred to Lentegoer, which turned out to be an acute lock-up.

“I know one thing for sure: If Valkenberg closed and I became severely depressed I would not return to Lentegoer. I would rather kill myself and I probably would, especially when I am in that state.

“People do not realise that when you are treated with respect, you heal. When you are locked up and treated like a child with no choice on your healing process, you become worse.”

“I asked whether I would be locked up at Lentegoer and I was told no. When I arrived there I was, and my medication was changed. I would never go back there,” she said.

Unlike Conradie, Ms Monica Mwecu, 23, does not have a good support structure once she leaves Valkenberg.

She lives in Guguletu with her parents, who, because of the stigma associated with mental illness, leave her to deal with her depression alone or send her to Valkenberg.

When she is well she stays at home and her problems are not discussed. There is no support structure for her except for a visit to the local day hospital or clinic.

“I am Xhosa. In my home I cannot sit down with my mother and tell her about my depression or illness,” Mwecu said. “My parents think I am acting like a child: They do not understand that I am ill and that I need help to cope.”

At Valkenberg I have group therapy and I can talk about my problems. If this place is closed, they will take away my right to live in a normal society.

“Lentegoer — I do not think I would go there — it is too far for me and I cannot start explaining and talking about my feelings all over again. I will probably stay at home. I do not know what will happen.”

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Valkenberg may be saved if province needs call for team
Doctors fear breakdown at hospital

BY PRISCILLA SIBOH

Doctors at the Helen Joseph Hospital, formerly JG Strijdom, fear there will be a breakdown in services unless a dispute between management and a union is resolved.

Staff at the hospital, in Johannesburg's western suburbs, is being called a "rudderless ship," because of the recent resignations by superintendent Dr Blumeris Niewoudt and his deputy Dr Errikus van der Merwe.

Niewoudt resigned for the second time in six weeks at the end of last month, allegedly over disagreements with the National Education, Health and Allied Workers' Union (Nehawu). Van der Merwe left last week.

Dr Martin Smith, chairman of the medical advisory board, said yesterday there was a collapse of management at the hospital and if this situation was not rectified it would affect service delivery and ultimately the patients.

The two superintendents were needed to order medical supplies and sign for the goods, and no one else had the authority to do so.

The Gauteng Department of Health has appointed the superintendent of Coronation Hospital to act in the same capacity at Helen Joseph, while looking after his own institution as well, but Smith said as far as he was aware this move had not yet been implemented.

"The conflict right now precipitated the crisis which has been brewing at the hospital for a long time," said Smith.

He said the concern also was that there had not been adequate handling of the labour issues, which, while he could not be specific, were varied and numerous.

Smith said the doctors were not taking any sides in the disputes and their main concern was for the patients.

In an attempt to mediate between the different parties, the medical advisory board would meet Nehawu today, he said.

However, Paul Pudi, chief shop steward for Nehawu, yesterday denied there was any crisis or problem between the union and management.

He also expressed surprise at the doctors' request for a meeting: "I really don't know the purpose of the meeting. We (Nehawu) have always had a good relationship with the present management." Pudi said this included Niewoudt and Van der Merwe.

The Gauteng Health Department has also been drawn into the crisis. It was asked to intervene a few months ago and is investigating claims made by management and Nehawu.
Doctors fear breakdown at hospital

By Priscilla Singh

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Seeking some solutions for mental health care dilemma
Lives risked with speeding up of plan for Gauteng hospitals

BY JAMBE SIMON

Lives may be at risk because ambitious plans to equalise the Witwatersrand’s public hospital services are being speeded up to meet budget pressures.

Hillbrow Hospital will be downgraded to a community health centre on December 31.

In its place, new specialist services will be set up for hospitals in the areas from which many Hillbrow patients come.

The new services will be provided by a pool of doctors, according to a series of hard-won agreements between provincial health authorities and academic departments at Johannesburg Hospital.

Doctors fear Hillbrow patients will go straight to Johannesburg – the nearest and most overloaded tertiary hospital – ignoring improvements at Edenvale (near Alexandra), South Rand (The Hill), Tambo Memorial (East Rand) and Leratong (West Rand).

Morale has hit rock-bottom at Johannesburg, which intermittently closes its casualty section for up to 12 hours when beds are full. Hillbrow doctors warned that further overcrowding at Johannesburg could increase the chances of patients dying before getting attention.
Revamp and expansion give hospital a big boost

BY PRECILLA SINGH
Health Reporter

Edenvale Hospital on Modderfontein Road on the East Rand has a new lease of life.

About three years ago it was widely rumoured that the 108-bed community hospital was earmarked for closure. Instead, the Gauteng Health Department has upgraded it into a small regional hospital with about 220 beds.

Superintendent Dr Mervyn Damelin is thrilled about the alterations and expansion and says the institution is nearly ready to cope with the expected influx of patients from nearby Alexandra; former patients of Hillbrow Hospital, which closes next month; and Kompon Park Hospital, which closed its doors a few months ago.

The grand changes at Edenvale Hospital form part of the health department's restructuring plan, which aims to adjust inequalities, staffing and facilities in the health sector.

So far, a new 28-bed obstetrics and gynaecological ward and a 28-bed paediatric unit have been completed. Only equipment and staff are needed. A five-bed high-care paediatric section has also been built.

"We will be getting equipment and staff for the obstetric ward from Hillbrow Hospital when it closes. I expect this to be about the middle of December. The new paediatric unit is already half full," Damelin said.
Down with management ... workers belonging to the National Education, Health and Allied Workers' Union at Helen Joseph Hospital toyi-toyied in the foyer yesterday during protests against alleged racial inequalities at the hospital. The angry group of women threatened and jostled The Star's photographer.

Crisis deepens in hospital labour clash

Pandemonium reigns and officials are attacked in battle over black advancement

By Priscilla Singh
Health Reporter

Management officials at Helen Joseph Hospital in Auckland Park have refused to report for duty from today for fear of their lives.

In another move which also threatens to cripple the hospital, about 700 members of the National Education, Health and Allied Workers' Union (Nehawu) were due to embark on a strike today.

Police were called yesterday after six administrative staff members were evicted from their offices and others were slapped in the face by union members.

"The Gauteng Health Department will hold an emergency meeting with the hospital's acting management and representatives of Nehawu today in a bid to prevent further disruptions and find a way to resolve the crisis," Pudi said. There were not only refused to drive their vehicles but have also refused to hand the keys to the hospital, according to acting superintendent Dr Arthur Manning.

The hospital was in a state of pandemonium yesterday when six management officials were attacked and physically removed from their offices, apparently by Nehawu workers.

Management called the police to intervene but Nehawu spokewoman Pudi said workers persuaded the police not to arrest any of their comrades.

"Tensions have been simmering between Nehawu and hospital management for a long time and have resulted in the resignation of superintendent Blumieys Niewoudt and his deputy Frithnus van der Merwe. Niewoudt resigned from his post for the second time in six weeks at the end of last month, and Van der Merwe left last week, both apparently as a result of the conflict with the union."

A group of about 70 Nehawu members from various departments chanted slogans and sang union songs in the foyer of the administration building yesterday while Nehawu held discussions with doctors.

"The reality at Helen Joseph is that whites within the hospital are rejecting the changes which were supposed to take place in the new South Africa," Pudi said. There were no blacks in senior administrative posts despite Nehawu approaching management to talk about these inequalities. "There is nothing we can do now. The workers are angry and are not prepared to sit for negotiations, it is too late. It is now up to the Department of Health," Pudi added.

He denied there had been any incidents of violence or intimidation on management, but claimed instead that management had authorised a traffic policeman to assault him on Friday.

"The workers have decided that enough is enough, and they cannot allow me to be attacked through authorisation by management," Pudi said.

Manning said yesterday that the problem was caused by Nehawu wanting to see immediate promotion of blacks into senior positions and the union's unwillingness to wait for posts to become vacant before this could happen.

"Nehawu wants to see more black people in senior posts and wants this to be done immediately."

"Since last week, Nehawu members have been invading administration offices and preventing people from working," said Manning.

Gauteng Health Department chief director of human resources Dawn Joseph condemned any "code of violence and coercion."

"It is intolerable for health personnel to reduce a public hospital to chaos and to prejudice patient care in pursuit of their own interests."
Recent trends in macroeconomic policies and national budgeting processes in South Africa have resulted in major reductions in state allocation of funding to the Western Cape Province.

There has also been a shift in emphasis away from hospital medicine towards primary and community based health care in response to the apartheid legacy of mal-distributed health care services.

The overall reduction in funding to the province and the shift in distribution of resources are having radical, short term effects on the delivery of health care and will have profound, long term implications for medical education and health services.

The public at large is beginning to perceive these trends but has not been adequately informed. It is in their interest to be made more aware of the changes and their significance.

The extent to which health care services have been curtailed in recent years is illustrated by the following data.

By March 1998, personnel employed in the health services in the Western Cape will have been reduced to 27,587 from 33,295 in April 1995. But this has not met the stringent target of 21,600 for which the 1998 budget makes allowance.

Hospital beds have been reduced from 14,706 in March 1995 to 12,128 in June 1997, and further reductions are planned.

By October 1997 as many as 4,047 health care staff had taken the voluntary retirement package. Of these 17% were administrative staff, 36.8% were nurses (mostly senior and highly trained), 13% were medical staff, 10.8% technical staff (also the most highly trained and least dispensable), and 33.7% general and general assistant categories of staff.

Many more medical staff have been lost through retirement and transfer to the private sector or academic positions elsewhere – and these posts have since been frozen.

The total randomness in which attrition of staff has been allowed from some of the most vulnerable areas of health care provision has had an even greater detrimental impact than if carefully planned reductions in person-power had been implemented as a cost-containing measure.

Remaining professional and technical staff are thus working under increasingly difficult conditions trying to provide quality services to an expanding population.

The adverse effects being experienced resemble those which have now been well documented in other countries following the imposition of rigorous structural adjustment programs by the International Monetary Fund and the World Bank.

These include an overall reduction in health services for the poor with less efficient and less effective public health care systems, the growth of private medical care at increasing and unsustainable cost, and erosion of capacity to educate future generations of health care professionals.

The reduced scale of efficiency in public institutions has severely undermined the infrastructure required to maintain equipment in good condition, to provide food and clean linen, to maintain cleanliness, to transport patients safely and promptly to x-ray facilities and operating theatres, and to provide the personal care, compassion and attention required by sick patients.

Escalating theft of drugs and materials, and the pressures from unions to increase salaries and reduce work output relative to expenditure.

As productivity and quality of work have never been considered when allocating budgets (available objective data is ignored by those who provide the funds for health care), there is little appreciation of the extent to which these changes have resulted in less value being obtained for money spent on health care - a form of erosion that is difficult to document objectively.

But deterioration in the quality of overall care delivered is apparent to many.

The training of doctors, nurses, and other health professionals is also being undermined. Sadly, sophisticated skills built up with dedication over many decades are being devalued and future generations of health educators are being driven away from public institutions.

The ability to sustain modern medicine in a teaching hospital in the public sector is becoming even more patchy and less sustainable without the back-up of viable academic institutions – which function as the dynamics for education and practice.

The aspirations of universities and those of the provincial health services - previously integrated into a seamless web of clinical services, teaching and research - are thus now being roughly torn apart. While the province is shifting resources away from academic hospital complexes, universities wish to increase student numbers and to intensify teaching and academic functions.

It does not take much imagination to appreciate how such poorly planned changes will adversely affect medical practice - initially in the public sector but inevitably and very soon in the private sector as well.

The are at least two explanations for what is happening. First, the dangers described are not being recognised, or at the very least are being underplayed.

In the rush to achieve much-needed change insufficient attention is being paid to more innovative pathways to change that could optimally utilise existing strengths to fashion a transformed but also very strong public health service.

Second, and more ominous, the process could be deliberate with the intention of gradually restructuring our medical schools into centres for training only primary care practitioners to meet the needs of neglected rural populations. This will enable future ministers of health to allocate graduates to any part of the country with impunity, as they will have no where else to go.

Academic institutions will either have to accept this as their changing role in the new South Africa, or will have to take on the responsibility of generating their own resources for teaching and other academic pursuits. As academic functions are under-valued by the State the latter course will be inevitable if universities wish to retain highly skilled and highly motivated professionals capable of providing sophisticated services to the poor in the public service and undertaking research.

At best, further training for a select few may be retained in the future in public/private Haalons which will survive for a little longer than purely public academic centres in this milieu - and this education will be available predominantly to the rich.

The need to restructure health care services and medical education inherited from the apartheid era is quite clear. The undisputed goals are to achieve more equitable access to affordable and appropriate health care at primary, secondary and tertiary levels with an effective and efficient referral chain.

The rationale for such change and the means of achieving it, intensely debated in the 1980's, seem to have been forgotten.

The burning question of how these goals can be achieved remains. It is necessary to ask whether the current ideological approach with all its errors of judgement and deficiency of consultation can be converted into the desired democratic dialogue - characterised by due process, at least some rationality, and accountability.

As medical education and healthcare vary greatly in our eight medical schools and nine provinces, reform processes will have to be contextually appropriate.

Acknowledging this and carefully considering the implications of different starting points for reform could facilitate the construction of a mosaic of training facilities and health care delivery activities that will be more effective and more sustainable than the simplistic and impoverished vision of a stereotypical primary care service in isolation.

The beauty, unity and utility of such a mosaic can best be appreciated by viewing it from a broad and imaginative perspective that incorporates an understanding of the complex requirements for economic growth in the future.
'Quick-fix' solutions are damning medical care
Union-management clash hits hospital

CHAOS erupted yesterday at the Helen Joseph Hospital in Rossmore, Johannesburg, when members of the National Education, Health and Allied Workers' Union (Nehawu) "forcibly" removed the hospital's acting superintendent from his office.

A shaken Roelof van der Berg, who was whisked away by police, said workers had accused him of being "racist" — a charge he denied. Fifty to 60 workers had dragged him and two clerks out of their offices and "trapped" staff in the reception area.

Van der Berg said "lots of trouble" had been brewing for months between the union, which consists of black support staff, and the mostly white management. "It's a black and white thing; they say they want us out of here."

Gauteng health department human resources chief director Dawn Joseph said senior managers and the department's labour relations unit would hold an "emergency meeting with the union and hospital management today "to put additional controls in place to prevent any party at the institution resorting to physical force".

Joseph said: "Without prejudging the validity of various allegations and counter allegations in this matter, the department wishes to make it clear that coercion and violence will not be condoned as means of settling disputes. It is intolerable for health personnel to reduce a public hospital to chaos and to prejudice patient care in pursuit of their own interests."

Nehawu officials refused to comment, saying they would wait for a briefing from their shop stewards.

National Party Gauteng MPL and health spokesman Nana Masango said pointers to yesterday's incident — such as alleged assaults by union members on a radiographer and a nurse on Friday — had been reported to the department and could have been prevented.

She accused Gauteng health MEC Amos Masondo and the Congress of SA Trade Unions of "turning a blind eye".

Picture: Page 2
Hospital services on track amid dispute

Services at Helen Joseph Hospital in Auckland Park were not disrupted yesterday, despite fears that the hospital would be crippled by a planned strike by members of the National Education, Health and Allied Workers' Union (Nehawu).

Union members engaged in "sporadic to-and-fro" but the protests did not disrupt hospital services or affect patients, said acting chief superintendent Dr Arthur Manning.

Nehawu's 700 members are protesting against what they see as management's failure to appoint blacks to senior posts.

Gauteng Health Department officials held talks with Nehawu and the hospital's management yesterday in a bid to resolve the conflict. An independent inquiry is expected to begin investigating the causes of the conflict at the 740-bed hospital today. The parties had agreed on who should conduct the inquiry, but some people had by last night still not confirmed their availability.

Hospital spokesman Dawn Joseph said all parties had undertaken to "refrain from any disruptive action with immediate effect". – Health Reporter
Long-awaited Red Cross revamp under way

But R16-m still needed to finish outpatient, emergency services upgrade

LENIKE SLAYER

After more than two years of intensive fundraising, redevelopment of the R38-million specialist outpatient and emergency services at Red Cross Children’s hospital has finally begun – to the delight of staff, parents and patients.

The well-known hospital is the only dedicated, specialist children’s hospital in southern Africa and treats all referred children as well as emergency cases.

In a remarkable show of unity, the public, business sector, schools and hospital staff came together with the Red Cross Children’s Hospital Trust more than two years ago to start raising funds for the hospital – a vital national institution in dire financial straits.

All the effort paid off and in just two years, R200 million was raised – enabling bulldozers and workmen to turn the first sod at the beginning of the month.

But R16-million is still needed to complete the hospital makeover, scheduled to be complete by 2000.

Medical sisters and chief hospital redevelopment planners Fleur Key and Polly Whitaker are excited that building is finally about to start.

They were on the first committee to moot the idea of revamping the hospital 11 years ago.

“It’s wonderful to see an idea which started so many years ago come to fruition,” they said.

The project is a redevelopment and upgrade of existing facilities currently housed in prefabricated buildings.

David Beatty, chairman of the Trust, said the current specialist outpatient and emergency services was housed in 30-year-old prefabricated buildings which leaked during winter and bled in summer.

“If we want to remain able to treat the sickest of southern Africa’s children, we need to ensure adequate facilities in which doctors can do their work,” he said.

One of the main features of the redevelopment is a parents’ accommodation centre to house parents of children who are being treated at the hospital.

Medical superintendent Saheed Hashim said the aim of the parents’ accommodation centre was to maintain contact between the children and their families.

This is in line with the international trend where doctors don’t want children to feel lost, and at the same time parents are taught how to cope with, and treat, their children when they return home,” said Dr Hashim.

Other new departments include surgical and medical consultation specialist clinics, night observation rooms and emergency services.

Dr Hashim said that the redevelopment would put the hospital on track to deliver what it was supposed to deliver.

“We can now fulfil the role we’re meant to, and that is to provide a comprehensive service to children in the Western Cape and the whole of southern Africa,” he said.

The new building will enable patients to visit the hospital as outpatients instead of being admitted – and this has financial implications.

“Our new facilities will mean we will be able to treat patients more cost-effectively,”

Dr Hashim said the new facilities would also enable them to treat more children than previously.

The hospital currently treats an average of 860 children a day, a third of them from outside the Western Cape.

Dr Hashim said the hospital was a national asset – proved by the fact that eight children from outside the Western Cape were currently waiting for liver transplants at Red Cross.

A total 75% of all referrals were from other provinces and in the cardiology department 40% of the children requiring heart surgery were from other provinces.

Parents of children cured of severe illnesses at the hospital are delighted over the plans to revamp Red Cross.

Said Anthony Africa, father of Wilmeat, the youngest kidney and liver transplant recipient in South Africa: “The hospital is the best – I was told my son had only three weeks left to live. Because of this hospital he is alive today.”

Finished product: an artist’s impression of the completed revamp of part of Red Cross Children’s hospital.

(98)
Committee to probe hospital conflict

Josey Ballenger BDO 19/11/97

THE National Education, Health and Allied Workers' Union (Nehawu), Helen Joseph Hospital management and the Gauteng health department agreed at an emergency meeting yesterday to set up a committee to investigate recent unrest at the hospital and to refrain from further disruptive action.

Acting chief superintendent Dr Arthur Manning denied that a patient had died as a result of Friday's conflict, as the National Party alleged.

"It is quite clear that patient's death was not connected in any way to the strike at the hospital," said Dawn Joseph, the department's chief director of human resources management. Manning could not be reached for confirmation.

In general, Joseph said the talks were "constructive and restrained. But it was evident that there are deep differences between Nehawu and the administrative unit which must be explored and resolved in order to create lasting stability at this hospital."

The meeting, called by the health department, followed union demonstrations at the hospital on Friday and Monday which culminated in the physical removal of acting superintendent Roelof van der Berg and two clerks from their offices.

Joseph said an independent inquiry would begin as early as today.

Joseph also said ground rules would be put in place to reinforce, but not replace, existing labour codes and legal provisions. All participants would be able to amend or add to a draft submitted by the department before it would become binding.

Nehawu's media officer Joe Lekola said an issue was the "broken transformation" of putting more blacks into management positions.

The Democratic Party (DP) said the department had been "remiss in not having prevented the latest outbreak despite signs of trouble that have been building up for months."

"Charges must definitely be laid against workers involved ... and Nehawu held to account for the desperate compromise in patient care at the hospital," DP health spokesman Jack Bloom said.
We are trying to provide education and training for the next generation of leaders, experts, and professionals. This is a part of our commitment to education and professional development. We believe in preparing our future workforce with the necessary skills and knowledge to succeed in their respective fields.

Medical Aid: Travel Medical Assistance

Good News for Hospitals

Adapting to the digital age, hospitals are embracing technology to improve patient care and streamline operations. The adoption of electronic health records, telemedicine, and digital health platforms has been essential in enhancing patient outcomes and reducing healthcare costs. Hospitals are also focusing on improving patient experience through user-friendly interfaces and personalized care plans.

Long-Term Funding

The ongoing support from the government and private sectors is crucial for the sustainability of hospitals. Long-term funding is essential to ensure the continuation of essential services and the maintenance of infrastructure. Hospitals are working towards securing stable funding sources to support their operations and continue providing high-quality care to patients.

André Kompanio and Jovial Ramao of the Policy and Research Unit have analyzed the current state of funding for hospitals. They emphasize the importance of sustainable funding mechanisms to ensure the continuous improvement of healthcare services. The report highlights the challenges faced by hospitals in securing adequate funding and the need for a strategic approach to address these issues.

Rural hospital funding is a critical aspect of healthcare delivery. The provision of adequate resources and support to rural hospitals is essential to ensure that all communities have access to quality healthcare services. The government and stakeholders must work together to develop innovative financing models that can effectively support rural hospital operations.

In conclusion, the funding landscape for hospitals is dynamic, and there is a need for continuous innovation and adaptation. Hospitals must also engage with stakeholders to advocate for policies that promote sustainable funding mechanisms and support the growth of healthcare services.
Rasool begs for cash to save health service

Exhibit A: A copy of the newspaper article.
Second best health care for rural areas

JENNY WALL
Health Reporter

Rural areas and poorer provinces get second best in terms of health care and the move towards more equitable services is becoming increasingly uncertain now that funding is at the discretion of provincial cabinets.

So says the Health Systems Trust in its latest South African Health Review, a recognised barometer of the progress of reform in the health service, which assesses health successes and failures. It includes a survey of the realities in clinics in every province.

Past reviews have focused on the development of new policies as part of restructuring in the health sector.

This one concentrates on trying to assess the extent to which new policies have been translated into real improvements in the quality of life of South Africans.

The review found that in spite of the commitment to providing primary health care for everyone, there was continuing disparity between service provision in rural and urban areas with rural people and poorer provinces still losing out.

The survey showed only 41% of rural clinics had ambulances on their doorsteps within an hour of emergency calls compared with 74% in urban clinics.

The move towards more equitable provision had become even more uncertain now that provincial cabinets got block grants from the national treasury and made allocations to health at their discretion.

The review found that in spite of legislation allowing for termination of pregnancy which came into effect in February, service provision had been "patchy at best" with a number of provinces doing far less than their proportional share of terminations.

The clinic survey revealed that only just more than 50% of rural clinics and about 66% of urban clinics offered family-planning services on a daily basis.

The review found it was difficult to measure what had really changed for a poor person in need of health care.

More reliable up-to-date information was needed to assess, evaluate, plan, prioritise and improve in every part of the health system.

The review is funded by the Department for International Development in the United Kingdom and the Kaiser Family Foundation in the United States.
Dept responds to privatised issue

By Khangale Makhado

THE Gauteng health department said yesterday that it had not privatised its ambulance service in toto, but only the section responsible for the maintenance of vehicles. This was done with a view to improve the service.

This follows accusations that the department had privatised the facility and that the move would lead to job losses.

Spokesman for the department Mr Popo Maja said yesterday that all they had done was to opt for leasing in that the private sector would lease the ambulances to the department. The ambulances would be manned by government staff, but maintained by the private sector.

"In the past we had a situation where ambulances were owned and maintained by the state and this resulted in the government encountering huge problems whereby broken down vehicles took longer to repair, causing the public to suffer," Maja said.
Closing Valkenberg hospital would involve a sacrifice by the people least able to bear it, writes Lin Sampson

Valkenberg: one alight rather than arrive on its pristine ground, as if on another planet. It is an ecocentric place, a haven for rare species in a disdained landscape, in protest against the devastation of the land. The trees have been dissected by a wad of holes, cutting deep into the earth, as if a large machine has gone over them. At 9:30 a.m. in Dr. Bauman's office, the place seems sane, but there is the knowledge that all around are lives in disarray. Certainly, a cursory look from the window reveals a high, cluttered despairingly in a pair of hands. It turns out to be a woman taking a break from building. That has always been the problem in these places: telling the patients from the staff.

Bauman is clearly practised in the art of disguised firmness, and it does not escape notice that he gets it without a scar. He is a charmingly handsome man, with a hint of a smile on his face. However, the proposed closing down of Valkenberg has brought him into the news.

"One major cause of our outrage is that the closing of this hospital represents a massive step back, an alienation of people suffering from mental illness. Also Valkenberg is a benchmark in the broader context of health services in the Western Cape. The closure of the hospital means that patients will not be able to access the services of the hospital, which are much-needed.

The plan is to tour the hospital and talk to patients and visiting experts. Here is Mark Vervloet, who is heavily into that stuff, who brings his blue eyes close to mine and whispers: "Have you overheard what he said?"

He is of Greek descent, a vivid character who suffers from severe mood swings. He is a trained hairdresser, but has spent more than 20 years of his 37 years in and out of Valkenberg. His interview partners Vervloet and Bauman are now the ones left. The place has now become a Salvation Army hospital, and has come in specially to tell me. He is well built and carries a basket of books on Jan. 1, one of which he had offered to me with a warm smile. He says he is now able to cope with life in a better way and is even more interested in finding a girlfriend. "I was married for three and a half years, and I've never slept once. Just left. I didn't want to sleep about the things were just streaming down, for the brokenness of it. And, my wife didn't know what to do, a girl with a big chest. She really loved me that girl.

It is 2pm at Ward 14, acute male admissions. Bauman's special turf. It is as strange a place as you might stretch with the, compelling story of the mental illness. By the end of the day there will be 32 admissions, many of them re-admissions in what Sister Edith Smith, who has worked at Valkenberg for 30 years, calls the "revolving door" of mental illness.

There is a mural of Table Mountain on the wall and the curtains have been donated by Biggie Best. But, without wishing to be unduly cynic, the patients in Ward 14 seem a bit beyond interior decorating.

A lot of people are lying on the floor like the wretched victims of a car accident. "El doc," one pipes up. A male nurse puts down Duran Duran, enough to return to normal, and narcotic hovers in the air.

Outside in the garden people sleep. "I think if people are to get well it is important to be in a garden," Bauman says.

Strangely, Ward 14 is not a frightening place. The atmosphere is casual, almost relaxed. Suulli says most of these people will get better — at least for a time. As I leave a man puts his arms around me and says: "Say hi.

Princess Diana, Princess Charles, Jesus and Nelson Mandela often visit in the hospital. At one time there were two Nelson Mandela's in one ward. But if a statue were to be erected it would probably be Peter Stuyvesant. Stuyvesant is an art form here.

As we move towards wards, the most noticeable thing is the presence of people — children, older men, women, engaged in activities.

In the neuro-clinic Belinda Conran (27) and Monica Mtsweni (20), both of whom have been in and out of Valkenberg for years, have learnt to deal with their variously opposing resistance to the closing down of Valkenberg.

Conran, who claims to be bipolar two (a manic-depressive illness), says "I think I'm manic. I think it's a way of being vulnerable and open to abuse. I have decided I do want to be a victim. I feel like we are in this together. I do not want this hospital to close."

"When I came to Valkenberg a few weeks ago they could not admit me [the hospital was full], I was referred to Lentegeur in Mitchell's Plain, which turned out to be an acute unit. I knew one thing for sure: if Valkenberg closed and in fact severely depressed, I would not return to Lentegeur. I would rather kill myself."

"This is not a threat to be taken lightly."

Msweni says she does not like the idea of Lentegeur. "It is far too away. My family do not like to go there. We know this place."

In Ward 6, Marilyn recalls the days of living in Hollywood Hotel. "The best hotel, with Prince Charles and Princess Diana. But if I am going to get the conversation, that produced not one. But two sets of excavators."

Her friend Jacoba ruffles me: "Don't listen to what she says." In a way these days are easiest to bear. way beyond repair, and in


Protest: Patients and staff from Valkenberg march through Cape Town's streets. PHOTO: RODGER ROOD

Shutting another door on the mentally ill

For many months there has been a mountingois agitation in the proposed closure of Valkenberg hospital in Cape Town.

In May 1997, Western Cape Department of Health head Dr Tom Sutcliffe said Valkenberg, like all psychiatric hospitals in the province, would have to shrink.

Only a core psychiatric service, to treat severely mentally ill patients, and the maximum security forensic unit would continue to operate at Valkenberg hospital because of government budget cuts.

However, already the department was running on a deficit of between R400 million and R500 million a year, and in the last few months the entire hospital had been closed.

Out of all the hospitals earmarked for the close — Stikland, Lentegeur, Alexandra, Valkenberg — it was Valkenberg, lying on valuable land at the Black-Lakeheak river confluence, that attracted developers.

Several organisations showed an interest in buying it. A cry went up, petitions were handled around. Patients themselves began to agitate.

Consultant psychiatrists at Valkenberg, who seemed particularly low on the draw, signed a letter with the ominous wording: "We believe that the closure of any psychiatric hospital in the Western Cape, without first addressing the deficits in the clinics and the regional hospitals, will result in the inability of the public sector to provide the psychiatric services guaranteed in terms of the Constitution.

Everyone connected with Valkenberg realises that rationalisation is needed, but more efficient accommodation and services.

But most also know that closing Valkenberg for a bout of cash will only exacerbate the crisis of treating mental illness in the Western Cape.
AMBULANCE STAFF IN STRIKE THREAT

Emergency services may grind to halt

BOBBY JORDAN

Municipal ambulance staff have threatened strike action in the wake of a council decision to transfer the cash-strapped ambulance service over to provincial administration.

The strike could lead to an ambulance standstill — involving about 90 ambulances and 500 personnel — with potentially fatal consequences for critically ill patients.

Staff say strike action might be the only way to reverse the council's decision and to secure their jobs with the local council.

Although wholly subsidised by provincial government, the service is currently administered by both the Cape Town City Council and the Cape Metropolitan Council.

In terms of recent moves to streamline public administration, the CMC had been earmarked to take over full control of the service. However, the CMC turned down the service, claiming insufficient funds.

"We've got such a lot of functions and pressure on our own resources — why should we take on more services?" asked CMC executive council chairman Pierre Uys.

"In terms of the new Constitution, ambulances are a provincial service. We've been helping render the service on their behalf, but now with budget cuts and everything they're not making it possible for us to do that," Uys said.

But union bosses say ambulance staff are suffering while administrators squabble over resources.

"Nobody seems to want us because we're not a big earner like bulk water or electricity," said Aboubaker Kippie, spokesman for the South African Municipal Workers Union.

"We feel extremely unhappy that our futures are being threatened. The provincial administration has a bad record as an employer and, because of financial constraints, has laid off staff," Kippie said.

The CMC's rejection of the service appeared to be politically motivated, he added, and the two ambulance unions would demand that the matter be reconsidered.

He said it was "strange" how the CMC could plead poverty yet still consider spending R200-million on a new head office.

"Transfer to province would almost certainly result in salary cuts and retrenchments, Kippie added.

Cape Town ambulance service director Greg Pillay said a strike was an unlikely option because of the unit's "essential service" status and also because the matter was likely to be resolved through negotiation.

"So far our personnel have always acted responsibly and I would like to call on them not to act in that same frame of mind," Pillay said.

"I'm hopeful a strike will not happen and that the whole matter will be resolved early in the new year," Pillay said.

"The sooner this is resolved the better because uncertainty leads to demotivation and there's no reason why the man in the street should suffer," Pillay said.

The service was currently suffering from a R12-million budget cut and was unable to keep up with population growth.
SAVE OUR HOSPITALS

W Cape in cash plea as cuts crisis looms.
Health budget cut a crisis in the Cape

Linda Ensor

CAPE TOWN — Next year's budgetary allocation earmarked by the Western Cape treasury for the provincial health department was about R800m short of requirements and would require a drastic 27.5% downscaling of services, health services chief director Faried Abdullah said yesterday.

He warned that a massive "health crisis" was looming in the province.

Already the Western Cape faced a budget deficit of over R400m this year on a projected expenditure of R2.9bn. The department rejected next year's allocation of R2.1bn as the "last straw," Abdullah told a news briefing.

Abdullah said that if the Western Cape budget was slashed in this way, the three academic hospitals would collapse, a large number of community health centres and regional and district hospitals would have to close, 6,000 jobs would have to be cut, the closure of a further 2,500 hospital beds would be necessary and the number of hospital admissions would have to fall by 30,000 annually.

Expenditure on nursing colleges, dental schools and capital investment would have to be reduced by about 50% or more. This would be over and above the staff reduction of 5,000 since 1995 and the closure of 2,500 beds.

"It is significant that the accepted international maximum for the downscaling of health services over one year is 2.5%," Abdullah said. "The health department believes it would be irresponsible and virtually impossible to deliver satisfactory health services on such a reduced budget. It will be making an urgent plea for review by the national and provincial treasuries.

Abdullah complained that the province's attempts to cut expenses were constantly being undermined by decisions at national level. For instance, in the present fiscal year, conditions of service increases of R42m had been approved, while the overall health budget was reduced by R272m.

He laid some of the blame for the pending crisis on the fact that national government used budgets as a baseline instead of expenditures; allowed large conditions of service increases and other personnel increases while implementing the growth, employment and redistribution strategy; allocated too little to the provinces for basic services; and introduced changes too rapidly.

Last week 160 health officials, non-governmental organisations, community health representatives and other health sector workers met to discuss the situation.

The department will lobby the provincial legislature's standing committee on health today to recommend that next year's allocation be reviewed. The committee is to receive submissions on the crisis from trade unions, non-governmental organisations, academics and health service officials.

National and provincial cabinets meet tomorrow to discuss the medium-term expenditure framework and budgets for next year. The Western Cape is to appeal for greater funding for health and for the repayment of this year's deficit to be spread over three years.

Health and Welfare Services Minister Ebrahim Rasool said he had also written to Finance Minister Trevor Manuel for him to "reconfigure" the R264m for academic hospitals, arguing this it should be added to, rather than be part of the provincial allocation.
Satisfactory health care ‘impossible’ after cuts

DIANE CASARES

The Western Cape Department of Health believes it would be “irresponsible and virtually impossible” to deliver satisfactory health services on the reduced budget for 1998/99.

Dr Faried Abdullah, chief director of health services, said the department would meet this morning to discuss a strategy to appeal for more funds. The meeting would also seek ways to protect the already hard-hit health services from further “catastrophic” cuts.

The provisional budget allocation is R2.085 billion — R800m short of the R2.9 billion needed to sustain health services in 1998/99. This represents a 27.5% cut in all services, which, if implemented, will lead to the collapse of all three academic hospitals (Groote Schuur, Red Cross Children’s and Tygerberg).

It will also mean the closure of many community health centres and regional and district hospitals, the loss of 6,000 staff members and the closure of 2,500 hospital beds.

“It is significant that the accepted international maximum for the downscaling of health services over one year is 2.5%,” says Abdullah.

The department will make a presentation to the Western Cape Standing Committee on Health. The committee will also receive submissions from many other sectors, such as trade unions, NGOs, academics and health service officials. Interested members of the health sector and the public are also urged to attend the meeting.

“The Department of Health is confident that the standing committee will make substantive recommendations to have the allocation reviewed,” said Abdullah.

“We believe it would be irresponsible and indeed virtually impossible to deliver satisfactory health services on such a reduced budget and will be making an urgent plea for review by the National and Provincial Treasuries.”

The budget cuts have been made despite the fact that:

- 500 staff have been lost since 1995.
- 2,500 beds have already been lost.
- There were 400,000 more outpatient visits in the past year.
- Free primary health care has been implemented.
- Termination of pregnancies has been implemented.

The crisis in health care has been caused by the need to bring equity between provinces and the scale of existing inequities, as well as reduced social spending; insufficient recognition for services and training rendered to other provinces; and the failure to prioritise health care.

The cuts mean there will be longer queues at health services and some patients may be turned away. There will also be closures of casualty services, ward closures at some hospitals, longer waiting times for ambulances, some non-emergency operations will be curtailed and there will be increased stress and demoralisation among staff.

“The Department of Health’s management position is that the budget cut of R800m cannot be implemented,” says Abdullah.

“The department asks the public from all sectors to attend this hearing and take whatever action they think necessary to lobby for a realistic budget.

“It is imperative that the health sector and all other affected persons unite to sustain a workable health system in the Western Cape.”

The meeting takes place this morning at 9 in the auditorium, Western Cape Legislature Building, Wale Street.
From next year the unit will have less than 25% of the technical staff needed to function properly.
Cuts will rip heart out of health, say hospital chiefs

JOSEPH ARABES
Staff Reporter

ARG 3/12/97

Top Groote Schuur Hospital academics warned today that drastic health budget cuts would result in severe curtailment of services offered by all provincial hospitals in the Western Cape.

At Groote Schuur, emergency treatment for victims of road accidents, domestic and criminal violence and heart attacks is likely to be affected and several specialist services may have to be stopped as a consequence of belt-tightening.

The warning – in an open letter on page 12 of today’s Cape Argus – comes on the 30th anniversary of the first human heart transplant operation, which was carried out at Groote Schuur.

Chief medical superintendent Peter Mitchell said that while heart transplantation was just one of the many specialised services provided to patients over many decades, the hospital was committed to providing the highest possible quality of patient care, research and health care teaching.

"But we are very concerned at the current and future threats to the province’s health services as drastic budget restrictions have already been imposed over the past few years and even greater cuts are on the cards for next year," he said.

"For Groote Schuur it will mean the possible closure of many highly specialised services, marked delays in or non-availability of operative procedures and a possible collapse of services for the management of cancer patients."

The chairman of the hospital's teaching board, Adbul Barday, said the inevitable result of the proposed budget cuts would be a further deterioration in the quality of clinical care.

"Emergency services like caring for motor vehicle accident injuries, domestic and criminal violence victims and patients with heart attacks or other serious conditions will be directly affected."
OPEN LETTER TO THE PEOPLE OF THE WESTERN CAPE

Dear Friends,

Today, 30 years ago, the world’s first human heart transplant was performed at Groote Schuur Hospital. The hospital looks back with pride at this historic milestone, which earned the hospital and South Africa’s health services international recognition. The heart transplantation service is, however, only one of many highly specialised services which have been provided over many decades, to our patients in the Western Cape and beyond.

On this occasion, we wish to rededicate ourselves to the service of you, the people. We are deeply committed to continuing our tradition of the highest possible quality of patient care, research and the teaching of health care workers.

BUT:

We regard it as our duty to inform you of our grave concern over the current and future threats to the Western Cape health services in general, and to Groote Schuur Hospital in particular. Drastic health budget restrictions have already been imposed over the last years. Even greater budget cuts are being proposed for 1998.

For Groote Schuur Hospital this could mean:
- severe curtailment or even closure of many highly specialised services
- marked delays in, or non-availability of, operative procedures or outpatient appointments
- collapse of services for the management of cancer patients
- lack of emergency care for patients with heart attacks, motor vehicle accident injuries, gunshot wounds or other serious conditions
- inability to provide specialised care to pregnant mothers and newborn babies.

The inevitable result will be a further significant deterioration in the quality of clinical care due to shortages of staff, equipment, drugs and other resources. As Groote Schuur functions as a tertiary referral centre both locally and nationally, the implications for referring hospitals and their patients are equally serious.

We call upon you, as the community we serve, to join us in voicing our deep concern over, and registering protest against, the proposed health budget cuts in the Western Cape.

- Support the hospital
- Contact your MP
- Inform others of the health service crisis
- ACT NOW!

Dr AW Barday  
Chairperson, Teaching Hospital Board

Dr PJ Mitchell  
Chief Medical Superintendent

Groote Schuur Hospital Region.

This notice paid for independently by the Groote Schuur Teaching Hospital Board.
Budget cuts will cost lives, experts tell health crisis meeting

DIANE CASSERIE

The auditorium at the provincial administration building in Wale Street had never been so crowded. Members of the public, academics, politicians, unionists, health care workers and others poured in to voice their opinions at the crisis meeting on health budget cuts.

Some 50 health care workers from Tygerberg Hospital arrived together: they had organised a bus so that they could be at the meeting. They were nurses, doctors, ambulance personnel, administration staff, professors and teachers, some in uniform, some not.

They were there to hear submissions to the Western Cape Standing Committee on Health from all the key role players and other sectors such as trade unions, NGOs, academics and health service officials. Members of the public were also given time to ask questions.

What they heard from more than one health department head was that lives could be lost — perhaps were already being lost — if additional money was not found for essential health services.

They also heard that if Groote Schuur and its complex was closed for a year, a saving of R300 million could be achieved — but with disastrous results to health care.

The Western Cape Department of Health believes it would be "inexplicable and virtually impossible" to deliver satisfactory health services on the reduced budget for 1998/99. Yesterday's meeting was to call for a review by the national and provincial treasuries.

The provisional budget allocation stands at R2.683 billion, 8600 million short of the R2.9 billion required to sustain health services in 1998/99. This represents a cumulative 27.5% downscaling of all services, which, if implemented, will lead to the collapse of all three academic hospitals in the province (Groote Schuur, Red Cross and Tygerberg).

It will also mean the closure of a large number of community health centres and regional and district hospitals, the loss of 6000 staff members and the closure of 2000 hospital beds.

The budget cuts have been made despite the fact that 5000 staff have been lost since 1995, 2500 beds have been closed to date, there were 400,000 more outpatient visits in the past year, free primary health care has been implemented and the termination of pregnancy policy has been implemented.

In his presentation, Dr Tom Satcliffe, head of the provincial department of health, said while he lacked the government policy of equity, health and training were non-negotiable.

There had been cuts in the health budget in all provinces, from 8% (Limpopo) to 27% in the Western Cape.

Satcliffe said that to survive, the public health sector would have to make itself more marketable and introduce a private/public mix. However any money generated by the province would go to the national budget.

Professor Solly Benatar of UCT said he did not believe proposed ways to counteract the budget cuts would make a difference in time to prevent the collapse of the system: "If we close Groote Schuur Hospital complex for a whole year, we could save R300 million, but we would have to hire everyone with no provision for a severance package to achieve this."

Benatar said the "short-term approach" of budget cuts discounting the ability to train people for the future.

Dr Edmond Michaels, head of gynaecology health services for the Western Cape, said it was "false economy" to focus only on reducing the budget deficit: "With the Aids epidemic and the reduction in health care, there may be nobody left to worry about our debt."

At present, patients faced a four to six-hour waiting period in casualty, three days on a trolley or chair waiting for a bed, five days for surgery for a broken jaw and six to ten weeks for an appointment with a doctor.

"There will be many more deaths of young children — and from violence. I want to say cynically to the politicians, those people are voters and the children are children of voters," said Michaels.

Professor A G van Wyk, rector and vice-chancellor of the University of Stellenbosch, pointed out that the three training hospitals in the Western Cape produced one third of South Africa's medical graduates: "I deplore the insufficient allocation of funds by national government for the academic hospitals, Groote Schuur, Tygerberg and Red Cross are pillars far beyond the borders of the Western Cape."

A statement from Nelsen (National Education Health and Allied Workers Union) and Powa (Public and Allied Workers Union of SA), which represent 80% of health department employees, denounced working conditions for health care workers and said the unions would not condone unfair labour practices, excess overtime and poor pay. The unions called on the department to address the present staffing and related crisis.

At tea time, members of the audience voiced their own opinions on strategy to increase funding for provincial health care. "We should have a lottery to benefit Western Cape health," suggested one woman.

"Great idea, we could call it Zuma Zuma," quipped her companion.
Budget cuts will cost lives, experts tell health crisis meeting

DIANE CASSIDY

The auditorium at the provincial administration buildings in Wale Street had never been so crowded. Members of the public, academics, politicians, unions, health care workers and others pressed in to voice their opinion at the crisis meeting on health budget cuts.

Some 50 health care workers from Tygerberg Hospital arrived together: they had organised a bus so that they could be at the meeting. There were nurses, doctors, ambulance personnel, administration staff, professors and teachers, some in uniform, some not.

They were there to hear submissions to the Western Cape Standing Committee on Health from all the key role players and other sectors such as trade unions, NGOs, academics and health service officials. Members of the public were also given time to ask questions.

They heard from more than one health department head that their services could be lost — perhaps already being lost — if additional money was not found for essential health services.

They also heard that if Groote Schuur and its complex was closed for a year, a saving of R500 million could be achieved — but with disastrous results to health care.

The Western Cape Department of Health believes it would be "unreasonable and virtually impossible" to deliver satisfactory health services on the reduced budget for 1998/99. Yesterday's meeting was called for a review by the national and provincial treasurers.

The provisional budget allocation stands at R2,083 billion, R809 million short of the R2,892 billion required to maintain health services in 1998/99. This represents a massive 27.5% downgrading of all services, which, if implemented, will lead to the collapse of all three academic hospitals in the province (Groote Schuur, Red Cross and Tygerberg).

It will also mean the closure of a large number of community health centres and regional and district hospitals, the loss of 6,000 staff members and the closure of 2,500 hospital beds.

The budget cuts have been made despite the fact that 3,000 staff have been lost since 1995, 2,500 beds have been closed to date, there were 400,000 more outpatient visits in the past year, free primary health care has been implemented and the calculation of pregnancy policy has been implemented.

In his presentation, Dr Tom Suzulic, head of the provincial department of health, said while he backed the government policy of equity, health and training were non-negotiable.

There had been cuts in the health budgets in all provinces, from 8% (Matsapha) to 29% in the Western Cape.

Suzulic said that to survive, the public health sector would have to make itself more marketable and introduce a private/public mix. However any money generated by the province would go to the national budget.

Professor Sally Rentas of UCT said he did not believe proposed ways to counteract the cut would make a difference in time to prevent the collapse of the system. "If we closed Groote Schuur Hospital complex for a whole year, we could save R500 million, but we would have to fire everyone with no provision for a severance package to achieve this."

Senator said the "short-term approach" of budget cuts discounted the ability to train people for the future.

Dr Edmond Michaels, head of primary health services for the Western Cape, said it was "false economy" to focus only on reducing the budget deficit. "With the AIDS epidemic and the reduction in health care, there may be nobody left to worry about our debt."

At present, patients faced a four to six-hour wait in casualty, three days on a trolley or chair waiting for a bed, five days for surgery for a broken jaw and six to ten weeks for an appointment with a doctor.

"There will be many more deaths of young children — and from violence. I want to say strongly to the politicians, these people are voters and the children are children of voters," said Michaels.

Professor AG van Wyk, rector and vice-chancellor of the University of Stellenbosch, pointed out that the three training hospitals in the Western Cape produced one-third of South Africa's medical graduates: "I deplore the insufficient allocation of funds by national government for the academic hospitals. Groote Schuur, Tygerberg and Red Cross are pillars far beyond the borders of the Western Cape."

A statement from Nehawu (National Education Health and Allied Workers' Union) and Pauwars (Public and Allied Workers' Union of SA), which represent 80% of health department employees, denounced working conditions for health care workers and said the unions would not condone uneven labour practice, excess overtime and poor pay. The unions called on the department to address the present staffing and related crisis.

At the end, members of the audience voiced their own opinions on strategy to increase funding for provincial health care:

"We should have a lottery to benefit Western Cape health," suggested one woman.

"Great idea, we could call it Zuma Zuma," quipped her companion.
Key hospitals saved by health cash boost

But others may pay the price

JENNY VAIL
Health Reporter

Western Cape academic hospitals have been rescued from impending collapse by the province increasing its health budget for next year by R603-million to almost R2.7-billion.

But secondary and district hospitals may suffer as a result unless the central government gives the province an additional R264-million conditional grant.

Announcing the decision by the provincial cabinet to increase its allocation to health, Health Minister Ibrahim Rasool said it would pull health care “from the abyss” and avert the disastrous consequences of cuts which would have resulted in the loss of 6,000 jobs and 2,500 bed closures.

The R2.686-billion approved by the provincial cabinet is still well under the R3.3-billion the Health Department says it needs to fund health services for 1998/99.

The department is pinning its hopes on the central government’s promise of a R264-million conditional grant, to be spent on academic health centres in recognition of their status as national assets for training and health.

Central government has said this must be spent on academic health centres, but where the money is to come from is in contention.

The Government says it must come from the provincial health budget and the Health Department says it should be an additional payment from the central Treasury.

“We must continue the debate on the conditional grant vigorously with the Department of Finance,” said Mr Rasool.

If the money is taken from the provincial health budget, the Health Department will have to close four to six secondary and district hospitals, 905 chronic-care beds (800 of them psychiatric) and 531 acute-care beds, and reduce staff by about 2,500.

These changes would take place over three years under the new three-year budgeting system.

Head of health in the Western Cape Tom Sutcliffe said his department had drawn up a “compromise plan”, approved by cabinet, to tide things over until there was clarity on the conditional grant.

“This plan doesn’t provide enough room for appropriate expansion in primary health-care services,” he said.

Nursing training, primary health care and ambulance services would not have their budgets cut, but since there was no provision for inflation “we can expect a slow decline in these services”.

“It is a compromise plan and it is not without pain and difficulties. If we get additional money we would make the plan more realistic and sustainable.”

The department will also get some relief in that it is being allowed to absorb its R392-million budget deficit over the three years.

The chief superintendent of Tygerberg Hospital, Abul Rahman, said he was thankful the province had identified health as a priority.

“However there is still a significant shortfall and we will still have to rationalise services and cut costs in such a way as to take care of top-priority specialities and patients,” he said.

Academic health centres also served primary and secondary services. “We will have to make sure all three services get a fair share of the money. We can’t look only at tertiary care, otherwise the others will suffer and we will end up with more people at tertiary level, where they are more expensive to treat.”
Budget cuts forcing doctors to ‘play God’

IF HEALTH care cuts are implemented, the Western Cape’s academic hospitals could face collapse, warns a Groote Schuur doctor. MELANIE GOSLING reports.

The head of Groote Schuur’s cardiac unit has called on the government to explain to the public how doctors are going to be forced to play God in choosing who gets medical treatment at academic hospitals.

Professor Ulrich von Oppell, head of UCT’s Department of Cardiothoracic Surgery, said the government’s drastic budget cuts to academic hospitals meant that second- ary and tertiary medical treatment to poor people would soon have to be rationed.

“The question is how? The public has a right to know,” he said.

Speaking at Groote Schuur’s 30th anniversary celebrations on Wednesday of the world’s first heart transplant, Von Oppell referred to the case of Mr Thilagaj Soobramoney, who died last week after being denied dialysis treatment at a public hospital.

Von Oppell said that press headlines — such as “Too poor to live!” — raised the question of how medical care for 80% of the South African population would in future be rationed.

Doctors were being expected to select “the most deserving patient”, yet their medical ethics demanded that they seek the best medical care for each patient. They were being forced, through budget cuts, to play the dual role of rationing medical care and being the patients’ advocate.

With reduced funding to Groote Schuur and Red Cross, it is inevitable that secondary and ter- tiary health care to patients who cannot afford private health care, will have to be rationed.

“Will it be rationed by default, or by forcing the majority of the population to pay for medical care in the expensive private sector?”

Von Oppell said Groote Schuur’s heart transplant unit, famous throughout the world for its ex- cellence and for its pion- eering work, was likely to shut next year because of lack of money.

Once it closed, it was extremely unlikely that a heart transplant unit would ever again function in the public sector.

“Whether Groote Schuur will continue with an active heart and lung transplant pro- gramme must now be decided by the public through their elected politicians.”

“The collapse of Western Cape academic hospitals is something South Africa cannot afford to risk.”

About 83% of South Africans are dependent on academic hospi- tals for high-tech tertiary medical care, and it was this group who would be affected by the government’s drastic cut-backs, he said.

His department had been forced to decrease their clinical service at Groote Schuur and Red Cross by 30%, despite an increase in patient referrals.

While the unit was considered to be a national leader in some fields, this excellence was being eroded. Budget cuts, retrenchments and the freezing of posts had already driven many doctors, nurses and technologists into the private sector or overseas.

“Transplantation has been single out as a costly intervention and yet, in terms of life years saved, heart transplantation is more cost-effective than the pharmacological treatment of mild-to-moderate high blood pressure,” he said.

The trauma units were over- loaded with drunk patients who repeatedly expected free medical treatment, although their condition was often the result of their irresponsible behaviour.

Von Oppell said academic hospitals needed to become autonomous and retain generated income, provided a management sys- tem based on busi- ness principles was established.

“The government should allocate the national health budget by defining what level of primary health care can be provided free, and the amount of subsidisation it can afford for higher levels of care.”

“Common business sense needs to be applied to the allocation of scarce funds. The current structure of fee tariffs, where a patient will pay R37 irrespective of whether he is admitted for an enema or a heart transplant, is clearly ludicrous,” Von Oppell said.
Babies

With limited resources, doctors play God and decide who lives

By JACKIE CAMERON

More than 20 premature babies die in Gauteng state hospitals each month because doctors are forced to play God and decide which children to treat—and which ones will be left to fight, alone, for their lives.

Their dilemma is caused by severe limited resources. And not only our children face such arbitrary choices: people awaiting organ transplants also face death penalties in government hospitals—at least 40 adults are sent home to die from Gauteng hospitals each month because there are not enough experienced staff to man the sophisticated machines for chronic renal dialysis.

Professor Peter Cooper, head of Johannesburg Hospital’s paediatric unit, says: “It’s a very heartbreaking situation. We spend hours debating who to save. It’s very emotionally draining.

“We only have 75% of the ventilators we should have, and that’s assuming we only ventilate babies from the policy guideline cut-off weight of 1 000g.”

Dr Larry Margolius, a consultant at Johannesburg Hospital’s kidney transplant unit, described his daily dilemma as “nightmarish”.

“It’s terrible. You try and shut it out. You see women with children, in desperate situations, and young people who still have to live. Who do you choose?”

Among the shock revelations that emerged this week from hospital officials are:

■ At least 40 people die each month because there are not enough qualified nursing staff to man-dialysis machines 24 hours a day. These machines are switched off at night.

■ There are not enough kidneys donated to state hospitals because there are not enough organ donation co-ordinators in the country—and also because organ donation goes against many religious beliefs.

■ The numbers of people being sent home to die because they cannot have access to renal dialysis is expected to grow, as those currently on the programme wait for too few donors.

■ Many donations are lost because organs are not removed timely from brain-dead people in hospitals.

■ Illegal immigrants and residents of neighbouring provinces are draining resources at several hospitals. Pretoria Academic Hospital has warned that more than half of its resources are being used by people from neighbouring states.

■ Gauteng residents are also abusing the medical system, many people do not disclose that they are on a medical scheme when they go to state hospitals for cheap medicine and care.

■ Private medical care for prisoners, nationwide, has cost taxpayers more than R27 million since April.

■ Two prisoners are currently receiving chronic renal dialysis at a private clinic while awaiting kidney transplants, according to the Department of Correctional Services.

■ Netcare CHL organ donation co-ordinator Sister Lynne Botha says medical staff at private hospitals refuse to supply organs to prisoners. She has also identified a trend of donors stipulating in their wills that they do not want criminals as the beneficiaries.

■ A total of 35 prisoners escaped from custody while receiving treatment at hospitals between January and September.

Margolius said: “Anyone over the age of 60 or with severe or other associated disease will not get a transplant or dialysis. The great tragedy is that we are turning away people who meet the criteria. These people are transplantable.

“The estimate is that about 3200 people in Gauteng alone get this condition every year. This is a poor man’s disease. It’s not like coronary heart failure, which is often seen among people with affluent lifestyles.

[Photograph: Debie Vayzek]

[Caption: BRIEF LIVES: The methods are there to save them, the wherewithal is not]

CRIMINALS WILL BE REFUSED DONATED ORGANS

SEE PAGE 3

CRIMINALS WILL BE REFUSED DONATED ORGANS

SEE PAGE 3

through life-saving systems more swiftly.

■ Doctors admit that about five babies each week would probably live with assistance from a ventilator. There aren’t enough ventilators to save lives.

■ Donated blood goes to waste because doctors order too much at once and it cannot be used after it has been out of refrigeration for more than 30 minutes.

TO PAGE 2

P.T.O.
Doctors choose which babies live, die

If you are poor and have chronic renal failure, there is only a 5% chance that you will receive treatment. We reject 85% of people who come here. It costs about R60 000 a year to have one person on dialysis.

Margolin said many kidney patients stay on dialysis for the rest of their lives. A transplant is the cheaper option in the long term. Patients with HIV are not prioritised.

"The message is clear: your right to life is dictated by your finances. If you can afford a medical aid, you'll get care until your personal limit runs out. If you are poor, it's pot luck, and a doctor's decision, whether you have access to the state medical treatment you need to survive.

Minister of Health Dr Nkosazana Zuma's spokesman Vincent Hlongwane said the health budget is not expected to expand dramatically because "Government doesn't have a bottomless pit of funds".

Gauteng's deputy director-general of health care, Dr Eric Buch, said: "We are working on redistributing resources. We have analysed the workload per doctor, per discipline. Certain hospitals have more doctors than required, and others fewer. We have shed 5 000 staff members."

Buch said his department was working on eliminating wastage, including the large quantity of blood was lost too long out of blood banks, and excessive drug prescriptions.

Department heads would have to approve expensive drugs, and doctors would be expected to recommend tests selectively "based on clinical judgments" rather than ordering "batteries of tests for academic reasons".

"Doctors won't be able to spend quite as long examining all the patients. We won't be able to provide every possible care to every patient. We have delays in chronic surgery. There are delays in areas like ear, nose, and hip-replacement operations. We feel it would be nice if we could help people see well in their old age. These areas are troubling us."

Buch warned that the effects of the province's inability to provide triple drug therapy to HIV-positive patients—a treatment which greatly reduces the transmission of HIV from pregnant women to their foetuses—would be felt only in about 10 years.

Security sections to handle prisoners, thus eradicating the need for them to be treated in private hospitals, were expected to be completed by end 1998. On the premature babies, he said: "It's quite impossible to say that every baby born will get intensive care. It's highly expensive."

Buch said wards could be fully equipped with ventilators, but only at the cost of diverting scarce resources from other equally needy areas, such as the transplant unit.

Children born at a weight of 1 000g have a 30% chance of surviving. This chance increases with ventilation, and decreases with the weight of a baby.

"It's a very complex situation. A social health insurance, with a card system, would help reduce the load, particularly from the illegal immigrants and those on medical aid. We also feel that other provinces should pay for services," Buch added.
Farmworkers who must come early to avoid losing money, get treatment they've never had before.
Many more patients at health centre, but staff complement stays the same

At 7am, every day, there is already a queue outside the Chiawelo community health centre when the staff arrive for work.

The staff have to hit the ground running to cope with the immediate demand for everything from chronic illnesses to advice on breastfeeding and urgent pharmaceutical requirements.

The 14-year-old centre serves an average of 800 people a day and offers the advanced health care facilities of antenatal and postnatal care, midwifery, physiotherapy, abortions and psychological services.

Chief nurse Sister Agatha Zwane says that since the introduction of free health care to mothers and children, the clinic's case load has increased dramatically.

"We are seeing so many more people, but the staff has not increased, so it can become very frustrating and chaotic at times."

That frustration is also felt by the patients. Two- or three-hour-long waits are commonplace.

Patients often take their frustrations out on the staff, which creates a difficult working environment.

Despite this, one is struck by the terminology used by the staff when they refer to the patients.

"They talk about their 'clients', and how best to serve them - a far cry from the impersonal sausage-machine mentality of the past."

Abused

However, Zwane points out, the clinic is being abused by some sectors of the public.

"For instance, people claiming to need medication 'stocked up' at the clinic by regularly visiting the place without their medical history cards.

"Pulling an envelope from her drawer, Zwane holds up examples of cards that have simply been torn up and thrown down on the clinic's grounds, wiping away the patient's record.

"We can't distinguish immigrants from locals, so the visitors often try and stock up on medicines to take back to their homes, where they cannot get decent medical services," Zwane says.

Because the clinic serves a working community, limited services are available until 7pm.

"The initial plan was just to use the late night service for emergencies, but more and more people are coming for other services which we have to try and supply, so it is a busy time for us as well," Zwane says.

And with more than 100 births at her clinic each month, and a constant queue of "clients", it doesn't look as if Sister Zwane's workload is about to decline.
JUST ANOTHER DAY: Since women and children became entitled to free health care, the waiting rooms at the Chiawelo Community Health Centre in Soweto fill up as soon as the doors open – leaving chief nurse Sister Agatha Zwane with her hands full.
Patients urged to gripe as private hospitals propose own tariff rises

BY JANINE SIMON AND MELANIE-ANN FEHR

Unhappy with an 8% tariff increase proposed by the Representative Association of Medical Schemes (Rams), private hospitals are proposing their own tariff increases — which could be as high as 25%.

The tariff increases in private hospital care, expected to be between 15 and 25%, are likely to hit consumers early in the new year.

Hospitals say consumers should complain to their medical aids about the rise.

The Hospital Association of South Africa (Hasa) is in the process of finalising its new guideline tariffs and is expected to announce them before March, said executive director Annette van der Merwe.

The new recommended tariff would mean that patients would have to make a co-payment for every day spent in a private hospital, in addition to the fees paid by the medical aid, she said.

Rams policy director Dr Aslam Dasoo, however, said the increase would have to keep pace with inflation.

Service provision within private health care, he added, had shown an escalation in costs way in excess of inflation.

“Your tariff structure is a recommended guideline. Every (medical) scheme is at liberty to negotiate above or below the benchmark,” he said.

But Rams had yet to be convinced that increases of between 15 and 25% for private hospitals were justified.

With wage increases between 8 and 10% and increases in medical aid contributions between 15 and 20%, employee organisations and trade unions have asked that increases in medical aid contributions should be in proportion to salary increases.

“We believe this is fair, reasonable and justifiable,” Dasoo said.

Van der Merwe said, however, that Hasa felt a single Rams fee was inappropriate to the industry because costs differed in different locations.

The tariff system should be deregulated to allow medical aid schemes to negotiate fees directly with hospitals, she said.

But, said Dasoo, the medical aid industry needed a benchmark for pricing or faced tremendous cost increases driven by unregulated private health care providers.

“We have no confidence in the provider industry to contain costs by themselves — they have failed miserably in the past. It is in the consumers’ interests that we provide annual increase benchmarks,” he said.

Van der Merwe said the Rams tariffs were only recommended fees and it was up to consumers to become far more proactive about their medical costs.

Medical aid members were required to pay their contributions upfront, but the medical aid refused to do the same for their medical bills, she said.
Hospital in crisis

Queenstown - Unpaid bills have forced the Elliot municipality in the Eastern Cape to cut electricity to the town's 50-bed provincial hospital which has had to send seriously ill patients to other hospitals and discharge others, a spokesman said.

The hospital has a stand-by generator but the health department has not paid its diesel account and the local supplier is refusing to supply more diesel to the hospital.

A butchery, which also supplied milk, had cut off supplies to the hospital because bills had not been paid for months, said acting matron Enid Kakoza. - Sapa
Hospitals to shut out thousands

INCREASED DEATH and disease will be some of the effects when the health budget is further reduced. CHRIS BATEMAN and CLAUDIA CAVANAGH report.

Tens of thousands of people will be turned away from provincial hospitals next year, and pre-primary and remedial education will be cut as the Western Cape government battles to manage a rapidly shrinking annual budget.

Further downgrading of nursing care and services in academic and tertiary hospitals is inevitable. The Western Cape has shed 10,000 civil servants — mostly education and health workers — over the last 18 months, placing enormous pressure on remaining staffs labouring under a mounting workload.

Painting a gloomy picture to Cape Metropolitan Council executive members — a scenario described by Western Cape health chief Dr Tom Sutcliffe as "pretty accurate" — Dr Mike Taitley, head of the CMC’s health services, said the crisis could result in increased death and disease.

"Not all of those who need care will get it — they will die in the communities which we as local authorities have a responsibility to serve," Taitley said.

Taitley, working on the original R2,1-billion health budget, said the department would have to:

- Turn away 80,000 people from hospital admissions.
- " Lose" 6,000 more staff members by April next year, bringing the total since 1995 to 11,000.
- Close up to 2,500 more beds by April, bringing the total here to 5,000.

The public can brace itself for even longer queues at outpatient units and clinics, ambulances taking longer to arrive, being increasingly turned away from hospitals and the closure of more wards and casualty units.

The situation was aggravated by 400,000 more outpatient visits in the past year and the implementation of abortion services.

"Services will be below all minimal acceptable norms," Taitley said.

Sutcliffe said Taitley’s scenario was "probably pretty accurate", but emphasised that it pre-dated the Western Cape exco voting an extra R600 million to health last week.

"Thankfully we’ve moved away from that (R2,1bn) budget. While we are by no means out of the woods, we do not predict a picture quite as gloomy as that," he said.

Sutcliffe said his health managers had tried to achieve a reduction at a pace and scale that was "actually not manageable or realistic".

The drastic measures have been forced upon the province by the Finance and Fiscal Commission’s equity formula, which tries on a per-capita basis to balance funding between the provinces over a rapid five-year period, and by the central government’s bid to rectify apartheid imbalances.

Dr Jocelyn Kane-Berman, chief director of administration for the Western Cape Health department, said they now hoped to keep the main academic hospitals open.

Reducing nursing care while maintaining existing bed numbers was one of the best options for the city’s three academic hospitals.

She would not rule out closing "one or two" under-used district hospitals.

"We’re looking across the board — our main aim is to come up with a plan that is least damaging to service delivery," she said.

Kane-Berman emphasised that service and staff level reductions were inevitable.

She said a health crisis board, being held at the Medical Research Council building near Tygerberg Hospital until tomorrow, hoped to spread spending over three years to avoid a major crisis.

Economists at the Institute for a Democratic South Africa (Idasa) said health and education service delivery was aggravated by the legal inability to retrench staff (the Labour Relations Act) and the unsustainability of the voluntary severance package (VSP) as a retrenching tool.

The VSP crippled managers’ ability to control the flight of vitally-needed skills.

Idasa said "disproportionate" downsizing of academic hospitals was unavoidable if district health and other hospital services were to be maintained at current funding levels.

Without maintaining and expanding district health services there would be no "safety net" for patients turned away from academic hospitals, they emphasised.

Staff vacanyes (over 20% in the health field) were also destroying morale.

The only way to reduce the risk of totally collapsing “essential elements” in the health service was to co-ordinate closures of operating theatres and other services between hospitals, Idasa reported.

Among the options the health
Business plans for vacated hospital space 'advanced'  

Business plans for vacated space in Groote Schuur and Tygerberg hospitals for private health providers were at an "advanced stage" and had been submitted for treasury approval.

Sections of hospital — such as parts of Valkenberg and Stikland hospitals — not needed for future expansion would be sold and the money used for capital projects.

Idasa economist Ms Shirley Robinson said that with teacher salaries forming 90% of the education budget, the redeployment of teachers had meant effectively "double-funding" teacher posts as an interim measure.

Surplus teachers awaiting redeployment were classified as "supernumeraries" — earning salaries but not actually teaching. On the other hand, at disadvantaged schools new posts were being created and filled with temporary teachers until these posts could be filled by a relocated "incumbent".

Conservative estimates showed that with 2,200 idle-but-paid teachers awaiting redeployment, earning an average of R60,000 a year over six months, the cost of duplication came to R6.6m.

"Education's failure to release teachers earlier (because of protracted centralised union bargaining) had meant that the Western Cape had higher teacher/pupil ratios than other provinces.

This had sounded the death knell for marginal education such as reform schools, adult basic education, early childhood education and farm schools.

Western Cape bursaries and subsidies to pupils had declined by about half (to R50 million).

A 61% decrease in financial aid to public school pupils and a major reduction in special education (physically and mentally handicapped pupils) funding meant that "the most vulnerable and disadvantaged segments of society were being put at risk".

No new school buildings were planned this year and school transport schemes had been cut by 50% from last year's levels.

"This means the province is withdrawing transport to urban learners," Idasa said.

Funding for independent schools had declined by 15%.

Idasa said R24m was spent this year on employing state pre-primary teachers in mainly white and former House of Representative (coloured) areas. The money could not be redirected to disadvantaged areas in the short term because of labour complications.

Idasa said the education department estimated that there were 114,000 adults with "inadequate" education in the province, yet only 29,000 would obtain some kind of certificate. This meant the department would reach less than three percent of its target market this year.

Dr J C Stegmann, head of finance in the Western Cape, said severance packages and natural attrition over the past 18 months had reduced overall staff numbers in the Western Cape from 80,000 to 65,000.

This meant a reduction in health workers from 33,000 to about 27,700 and teachers from 47,000 to 45,000.
Charter to protect patients' rights

For too many South Africans, a painful, day-long wait in clinic queues results in a rushed consultation with a surly doctor.

According to the National Progressive Primary Health Care Network (NPPHCN), a non-governmental organisation, this sad state of affairs is partly due to patients being ignorant of their rights and to the health department's inability to motivate its employees to provide a more caring service.

This week the NPPHCN launched its health charter, which it hopes will improve the quality of services by informing patients of their rights.

NPPHCN spokesman Judi Forman said most doctors entered their profession for the money and were not prepared to engage in "meaningful dialogue" with their patients. She said the doctor or nurse often assumed a "demagogue" status when dealing with patients.

Members of the public who are interested in learning about their health rights should telephone the toll-free number: 0800-114-010. - Staff Reporter

Private hospital fee increases 'undecided'

Rumours of 15%-25% said to be unfounded

Private hospitals have not yet announced tariff increases for 1998 and it was incorrect to say that price hikes would be between 15% and 25%, the Hospital Association of South Africa (Hasa) said this week.

The association was responding to a statement by a Representative Association of Medical Schemes (RAMS) policy director Dr Asham Dasoo that there was every indication that an increase in the region of 18% to 25% was being considered by private hospitals.

Dasoo added that hospitals said they had a year-to-year cost increase of this amount, but RAMS had yet to be convinced this was so.

Hasa said there would be new guideline tariffs next year, but these were still being finalised. Neither executive director Dr Annette van der Merwe, nor any Hasa board member had ever quoted figures of 15% to 25%.

RAMS has posted an 8% across-the-board tariff increase for next year and this will affect doctors, dentists and hospitals. Hasa said the 8% increase was not the only reason why it was considering asking patients to make an additional co-payment over and above what medical aids would pay for every day spent in a private clinic.

The other factors were:
- The health care inflation rate was 10.9%, well above the 8% increase proposed by RAMS;
- The falling rand had affected the costs of imported equipment and consumables;
- There had been sharp increases in nurses' salaries and labour costs;
- Private hospitals had consistently received increases less than half of the inflation rate and were no longer able to absorb the costs, and
- They also faced immense problems with delayed payments and short payments by medical schemes' accounts.
Patients' rights incorporated into health bill

José Ballenger 06 11|12|97

A CHARTER of rights and responsibilities regarding health care would be incorporated into the national health amendment bill to be tabled early next year, the charter's developer said last night.

The charter outlines 24 patient "rights", including access to care, confidentiality, treatment, choice and information; 18 "responsibilities", such as being constructive in complaints and providing accurate information to health providers; and ways in which the charter could be implemented.

The charter was developed by one of SA's largest nongovernmental health care organisations, the National Progressive Primary Health Care Network, following two years of consultation with community groups nationwide.

Network advocacy manager Judi Fortuin said at the charter's Johannesburg launch that the constitution and the National Health Act were the charter's legal framework and that health director-general Olive Shisana had committed the department to adopting at least some of the charter's recommendations into the national health amendment bill to be tabled in Parliament's first session next year.

"Access to these basic rights is still beyond the reach of a large proportion of the population and ignorance of their health rights has left many people at the mercy of health workers who do not always have their welfare at heart," Fortuin said.

"In fact, those most vulnerable to ill health have the greatest difficulty in accessing health services and are treated shabbily when they do go for care.

"An example of this is waiting for the whole day at a health centre without being seen and then being told to come back the next day."

Fortuin said the network would also lobby government to implement mechanisms to address health rights "violations", as the present avenues — the courts, the Interim Medical and Dental Council, provincial health officials and facility administrators — were "inadequate, cumbersome, not user friendly and not accessible to everyone."

She said there was an urgent need for such mechanisms, as evidenced by the network's toll-free number for health-rights inquiries and complaints, which had so far received 1 850 calls.

Fortuin also said the organisation needed funding to print and distribute more charters in at least three other languages. At present, they were available only in English.

The present copies had been funded by the Kaiser Family Foundation in the US.
Netcare takes Western Cape govt to court over hospital sale

By Ingrid Salgado

THE Western Cape government is facing court action over a decision to sell the Volks Hospital to a pharmaceutical group founded by rival business Network Healthcare Holdings (Netcare) served papers on the provincial administration this week and is seeking the high court to set aside the sale so that fresh tenders can be called.

Netcare chief operations officer Richard Friedland alleged yesterday that the tender process for the sale was riddled with irregularities. Chief among the group's claims were:

☐ That the provincial tender board did not examine the tender. This was confirmed in a letter from the state attorney in November. Instead, the decision was left to a subcommittee in the public works department, and was later ratified by the provincial cabinet;

☐ That for a year the provincial government stonewalled queries from Netcare to ascertain the basis on which the tender was granted.

The Volks Hospital, established in 1928 and situated in Oranjefontein Cape Town's densely populated city bowl, passed hands from the Dutch Reformed Church to the state in the early 1980s. It was closed in 1994 due to lack of government funds and a decision was taken to sell the facility.

Netcare, which saw its bid lose out to Medi-Clinic's offer of R15m, claimed the decision to award the licence flew in the face of national government's moratorium on the issuing of new private hospital licences. Cape Town's city bowl was an overbedded area, while the licence granted to Medi-Clinic increased the number of beds permitted by 150 and made allowance for five theatres.

Friedland said the provincial government would have netted much more from the sale of Volks Hospital had the private hospital industry been aware that a new licence was to be granted to the successful tenderer. The tender document made no reference to a new licence and inferred that a licence would not automatically be granted, he said.

The Western Cape administration indicated yesterday it would oppose the Netcare challenge. Health and social services MEC Ebrahim Rasool confirmed that the issues whether to grant a licence had been discussed in the cabinet but declined to comment further, saying the matter was sub judice.

 Medi-Clinic said it was taking legal advice. Company secretary Pierre du Plessis said the group was not aware that the tender board had to be involved and the company had no reason to believe anything had been wrong with the process.

He said the hospital would reopen towards the middle of next year. In addition to the purchase price, Medi-Clinic would spend millions of rand upgrading the premises and buying new equipment.
Hillbrow Hospital to stop admitting patients

By Sello Seripe

HILLBROW hospital will stop admitting new patients from Monday.

This was announced by the Gauteng health department in Johannesburg yesterday.

The move is in line with the intention to convert some hospitals into community health centres.

In a statement, the department said this was part of a broader plan to achieve a more rational, equitable and cost-efficient health service, with greater emphasis on primary health care.

The department called on ambulances to stop ferrying patients to the hospital from Monday.

"Over the next 10 days, the number of in-patients will decline as they are discharged. Specific wards will be relocated as other hospitals become ready to accommodate them."

The statement added that over the same period, an appropriate number of staff would be seconded to each of the hospitals to which Hillbrow's workload had been apportioned.

However, the polyclinic and some specialist out-patient units will continue and will form the core of the Hillbrow Community Health Centre. The casualty service will continue.
Lack of money means new R4.5m ward stands empty

The unit can accommodate 49 mentally ill criminals under maximum security.

Eastern Cape MEC Dr Trudy Thomas said the problem of staffing the unit was mainly a financial one. An audit had been done on hospitals in the Eastern Cape to assess how best to deploy staff.

A Port England staff member said the decision to build the unit was taken before this government came to power and although the project was questioned by the new authorities, tenders had already been awarded and would have incurred a penalty had the project been shelved.

Port England had forwarded a business plan to Bisho, where it was under consideration.
Tony Murray runs a highly productive Academic Ophthalmology Department. Despite staff shortages they maintain an impressive academic output. The department's eye tumour clinic is unique, both in South and on the African continent. Staff handle the most complex eye movement disorders. Very little cataract surgery for poor people is undertaken outside teaching hospitals and there is a long waiting list. If any operating list is cancelled, as is currently happening, blind patients have to wait at least a year before they can re-enter the programme for an operation that would restore their sight. Current financial and staff cutbacks will further aggravate the situation. There is a national move to establish cataract surgery outside teaching hospitals but this will be impossible if staff shortages persist or get worse.

ORTHOPAEDIC SURGERY

Department head Johan Walters is a nationally recognised expert in knee injuries and joint replacements. He is the overall head of orthopaedic surgery performed at Groote Schuur, Red Cross and at Princess Alice Orthopaedic Hospitals. Princess Alice admits patients countrywide.

The multidisciplinary Arthritis Unit at Princess Alice, which is under threat of closure, is unmatched in Africa.

The Paediatric Surgical Service under Teddy Hoffman at Red Cross is the premier academic paediatric unit in South Africa. The hand unit at Groote Schuur is the only one of its kind in South Africa, and has been for the past three decades.

Department head Johan Naude is internationally recognised for the development of several novel urological procedures, and for his expertise in urological conditions relevant to Africa. Urology at Red Cross is headed by Larry Lee, who forms part of small group of international paediatric urologists.

PAEDIATRIC SURGERY

The department is based at Red Cross Children's Hospital and is one of the most highly respected in the southern hemisphere and the world. However, the freezing of posts has had a devastating effect. Last December there were four senior paediatric surgeons and now there are only two. The vacant posts have been cut. Head of department Heinz Rode is internationally and nationally known for his work on burn patient care amongst other research. Alistair Millar is in charge of the paediatric liver transplantation programmes in association with Del Kahn (of the Transplantation Unit at Groote Schuur Hospital). This is a unique resource for which central funding has been promised by the National Department of Health, but which is still not forthcoming.

PLASTIC SURGERY

From May 1998 the department will have only one specialist, Don Hudson. The present head, Cecil Bloch, will retire in May and his post will be frozen. This will make the department, which services five hospitals, non-viable.

The department provides a number of Goldberg who is nationally recognised. He is the only full-time surgeon in this field in South Africa. His special interests include inflammatory bowel disease and inherited colon cancers. The unit is supported by the internationally acclaimed South African radiology unit, headed by Shelly Stevens.

Transplantation Unit.

The unit head Del Kahn has a national and international reputation and is the only full-time organ transplant surgeon in South Africa. He runs the only viable liver and kidney transplant programme in the country. The liver programme has been earmarked by central government for funding as a national resource but nothing has been received to date. Dr Kahn is also in charge of the only internationally recognised and fully functional general surgical laboratory in South Africa.

Trauma Unit.

Head of the unit Peter Bautz is supported by temporary junior specialist staff. He has a national and international reputation in trauma management. The unit urgently needs another senior trauma surgeon. The unit staff resuscitate all trauma patients before referring them to the specialist units.

Surgical Intensive Care Unit.

Lance Mitchell is head of the unit and is assisted by two temporary specialists. He is a specialist in critical care medicine and heads one of the most successful intensive care units in South Africa. The unit runs the only fully functional critical care technologist course in the country but the unit's existence is seriously threatened by staff shortages.
Hillbrow Hospital poised for rebirth

BY PRISCILLA SINGH
Health reporter

Hillbrow Hospital will cease to be a regional hospital on Christmas Eve, when it begins its rebirth as a “super” community health centre.

From today, no new inpatients will be admitted to the hospital. Over the next 10 days the number of patients is expected to decline as most will be discharged, and the functions fulfilled by specific wards will be taken over by other hospitals, according to Gauteng director of health Dr Eric Buch.

Some staff will be seconded to other hospitals. All patients still in Hillbrow Hospital on December 24 will be moved by ambulance to other institutions.

There is going to be a greater emphasis on primary health care, with two big additions in child health and a combined gynaecology and obstetric unit, which Hillbrow did not have before,” Buch said.

To start with, the Hillbrow community health centre will continue to offer services which were part of the polyclinic, including treatment for diabetes, hypertension and other common illnesses, minor procedures and dressings.

A 24-hour “walk-in” casualty will take care of minor accident injuries, cuts, simple fractures and medical emergencies such as asthma or pneumonia. If patients arrive at Hillbrow Hospital with serious injuries or medical conditions, they will be stabilised and sent by ambulance to the appropriate hospital, Buch said.

Other services include oral health, optometry and minor surgery. Specialist services will cover HIV/AIDS; dermatology; and gynaecology, including termination of pregnancies.

The radiation/oncology unit will continue to operate at Hillbrow for the next two and a half years. It will eventually be transferred to Johannesburg Hospital.

The department intends “blitzing” communities with pamphlets and using community newspapers and radio stations to inform them of the proposed changes.

Johannesburg Hospital and the Helen Joseph/Coronation complex will take on the tertiary-level care Hillbrow used to offer. The secondary-level care is being shared among Edenvale, South Rand, Tambo Memorial and Leratong hospitals.

Buch said former Hillbrow Hospital patients could transfer to Chris Hani Baragwanath Hospital, which was conveniently located for them and “far from being fully utilised”.

(98) Star 15/12/97
Hospital
starts
moving
staffers

By Sello Seriopa

MANAGEMENT at Hillbrow Hospital in Johannesburg yesterday started relocating staff and certain units to other hospitals in preparation for converting the institution into a community health centre.

Gauteng Department of Health (GDH) spokeswoman Ms Jo-Ann Collinge said yesterday the trauma unit was among those relocated elsewhere. The unit and its staff have been relocated to Helen Joseph Hospital and Johannesburg Hospital.

Hillbrow Hospital has 610 beds and by late yesterday afternoon only 103 patients remained.

Seeking medical attention

Collinge said although notices were sent out in advance to the public around the hospital informing them that it would stop admitting patients as from yesterday, people seeking medical attention were still arriving at the hospital in taxis and private cars. Ambulances no longer ferried patients to the hospital.

"However, not a single patient was turned away. Those in need of immediate attention were attended to before doctors could make a decision on whether to transfer them to other hospitals around Johannesburg," she said.

Collinge said: "The security staff has also been briefed that they should not turn away patients because doctors have to see them before a decision is made on whether they are in a position to reach the nearest medical institution."

She said staff already relocated to other hospitals would be there on a temporary basis until early next year when formal permanent placements would be made.

"However, the GDH would prefer that staff members with long service chose which hospitals they wanted to be transferred to."
Calls for probe into death of patients

By Mokgadi Pele

The Citizens Commission on Human Rights (CCHR) has reiterated its call for an inquiry into the deaths of patients in psychiatric institutions during the apartheid era.

In an interview with Sowetan yesterday, CCHR president Ms Colleen Wiltshire said the Truth and Reconciliation Commission should "unequivocally condemn the psychiatric abuses committed against South Africans in psychiatric facilities. We urge them to condemn those professional bodies, health authorities and practitioners who were party to these abuses."

Wiltshire said by adopting this attitude, the TRC "will make it broadly and publicly known these abuses, especially the state funded private institutions that fall within the TRC's mandate."

She asked that the:  
- TRC call on all psychiatrists and psychologists who committed patient abuses, in violation of the Hippocratic Oath and other ethical codes, to take the amnesty offered by the body.  
- System of accountability is established for professional bodies allegedly involved in creating, covering up or denying the abuses of blacks in such institutions, and.  
- Investigation be carried out into the drug practices, within these facilities and any causal link to any death.

The TRC should also establish who were the medical officers responsible for investigating and reporting on each death.

Who did they report to and what annual reports exist on these deaths.

Wiltshire said the TRC should determine which deaths should be reported to the police for criminal investigation.

"The TRC should initiate appropriate criminal proceedings against any mental health practitioner for whom there is evidence of murder or assault in accordance with the law," she said.
Decision to cut services will hurt patients

By Khangale Makhado

THE Gauteng Health Department's decision to curtail certain operations at the Chris Harti Baragwanaath Hospital aimed at making up for the budgetary shortfall will impact badly on patient care.

This was said by specialist physician and cardiologist at the hospital Dr Mashudu Nethononda in response to a recent decision by the department whereby the hospital had to cut its spending by R37.8 million until the end of the year.

"The cuts are an attempt by the department to be within the budget, with a projected overspending of about R40 million by the end of the year."

Some of the ways to be used include a reduction of staff by 30 percent, no overtime for professional staff and no elective operations except in emergency cases.

"The latest move by hospital management to curtail all elective operations and other so-called non-life-saving procedures is to make up for the expected provincial budgetary shortfall."

It was unfair, Nethononda said, to punish ordinary people because administrators have failed to do their work.

"What this hospital and others in the province need to save costs are good managers and decentralised management systems. It should also be mandatory for the institutions to have hospital forums comprising all stakeholders so that we can have accountability," he said.

The problem has been worsened by the closure of the Hillbrow Hospital and if Bara started referring patients to other hospitals such as Leratong and Johannesburg, these are likely to be overcrowded.

Bara Hospital spokeswoman Mrs Esther Hlongwane was yesterday quoted in a Johannesburg daily newspaper as saying that the hospital's budget outlook for the next three years was bleak due to financial constraints.
Campaign slams hospital closure

By Sello Seripe

THE Ceasefire Campaign (CC) has criticised the Gauteng department of health after a decision to close down the Hillbrow Hospital in Johannesburg.

Regardless of the fact that the hospital will be converted into a community health centre, CC spokesperson Nandipha Cross said yesterday that the closure of the hospital would leave one of the most densely populated and violent areas without close access to health and emergency services.

Cross said the move “is just one terrible harsh example in a number of service reductions”.

“The recent denial of access to dialysis treatment to kidney patients such as Thiangraj Soombramoney is another example.”

She said while the GDH was determined to go ahead to realise their plan for the Hillbrow Hospital, a “shopping list” for new weapons worth R15 billion was being suggested by the South African National Defence Force and Armscor.

“The CC wants to draw the attention of the public to the inter-relatedness of the two processes: the amounts currently spent on the SA National Defence Force are an exorbitant drain both on government resources and on the economy as a whole.

“As long as the disparities between the poor and the rich are not addressed, and as long as the poor majority have insufficient access to healthcare and other vital services, the priority of government spending must certainly not be on unproductive equipment such as submarines and tanks,” she said.

She appealed to members of parliament to think carefully about priorities for expenditure next year.
No cover for hospital fee hike

Patients will be hit with a whopping 17% average increase in private hospital fees in the new year — the bulk of which nearly all medical aids will not pay.

Because of a discrepancy between what medical aids are prepared to pay and what hospitals say is a true reflection of their costs, patients will not be able to rely on medical schemes to cover 100% of all hospital costs.

From January 1 the private hospital industry will introduce a surcharge — an additional 9% on top of the average hospital bill — which patients will have to pay out of their own pockets directly to the hospital.

Most medical aids will not reimburse the surcharge as it is above the 8% across-the-board tariff increase the Representative Association of Medical Schemes (Rams) has recommended that medical schemes pay for hospital expenditure in 1998.

At present private hospitals — irrespective of whether they are one- or five-star establishments — charge the uniform Rams hospital tariffs which most medical aids pay in full.

The Hospital Association of SA (HASA), which represents 97% of all private hospitals, has obtained permission from the Competition Board to publish its own guideline tariffs.

It will do so from January 1. They are 9% higher on average than Rams' hospital tariffs for 1998.

In total, patients can expect a 17% average increase in private hospitalisation fees in the new year. Medical aids, on the other hand, are likely to cover only 8%.

"A 17% increase year on year is inexcusable and unjustifyable, given the generally healthy state of the private hospital industry," says Rams policy director Ashwin Dassoo.

The average hospital bill is R1 000 a day. This means that the average surcharge of 9% recommended by Hasa will cost patients an extra R90 per day.

The surcharge is as high as 15% for some procedures like cardiothoracic surgery and childbirth. However, no surcharge has been levied on pharmaceuticals and surgical disposables used in hospitals.

As the usual hospital stay is between two and a half and three days, patients will be hit for an additional R225-R270 on average. Patients will have to decide whether they are prepared to pay the extra amount to secure the quality of service they are accustomed to receiving from private hospitals.

Hasa says it has been forced to publish its own tariffs partly because of Rams' persistent refusal to grant the hospital industry realistic tariff increases. Over the past five years these have been way below the hospital inflation rate.

Hasa executive director Dr Anette van der Merwe says other compounding factors such as the rising cost of equipment because of currency devaluation, increasing nursing salaries, rates and taxes as well as problems with delayed payments and short payments of medical scheme accounts have resulted in "unmanageable cost increases to private hospitals."

She says it is impossible to predict how many hospitals will adopt the new Hasa-recommended tariffs.

Industry players expect a whole range of fees to emerge between the Rams and Hasa parameters as hospitals position themselves in the market according to their differing cost structures and locations.

Claire Sisulu
Baragwanath will not
turn away emergencies

Josey Ballenger

SOWETO's Chris Hani Baragwanath Hospital would continue to admit hundreds of emergency patients a day and would not see staff cutbacks, despite the recently implemented spending constraints, senior superintendent Bakkie Rabinowitz said yesterday.

About 70% of the world's largest hospital's cases were considered to be emergencies, ranging from patients suffering from minor illnesses needing immediate attention to serious health problems such as heart attacks and trauma. The only services being temporarily eliminated were procedures which were not life-threatening, such as general physical examinations and minor operations, Rabinowitz said.

Baragwanath decided this week to handle only emergency cases in an effort to trim the hospital's projected R152m overspending this financial year by R37.5m, or R1.2m a month, following central government's instructions to the province's health department and public clinics and hospitals to take budget-cutting measures.

Gauteng health department communications director Jo-Anne Collinge said yesterday the provincial health services' anticipated total deficit of R840m would be partially offset by a special allocation from central government of between R200m and R220m to cover across-the-board salary increases effective from last July, Baragwanath's deputy director of finance Pieter Nortje said salaries were the hospital's biggest expense, comprising 84% of the R495.5m budget or 65% of the projected R747.5m expenditure.

Rabinowitz and Nortje said the public health financial "crisis" had worsened in recent years due to inefficiencies, such as some doctors not working all the overtime hours for which they were paid. Other factors were theft, escalating costs, staff attrition, labour problems, free treatment for children under six, and government's inability to bail out of its overspending.
MEDICAL COSTS

No cover for hospital fee hike

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Industry players expect a whole range of fees to emerge between the Rams and Hasa parameters as hospitals position themselves in the market according to their differing cost structures and locations.

Claire Blescher
Golden era ends

SA’s showcase medical institutions crumble as pressures mount on authorities to expand primary health services for the poor

Groote Schuur Hospital’s heart transplant unit faces imminent closure — 30 years after Dr Chris Barnard stunned the world by performing the first heart transplant there.

Its demise symbolises the broader battle being fought to maintain the country’s First-World academic hospital infrastructure, given government’s commitment to provide basic health care to the majority of the population.

Groote Schuur is the only public hospital performing heart transplants in SA and its head, Dr Johan Brink, says he knows of no other unit in the world which can perform heart transplants as cost-effectively.

Brink says that Health Minister Nkosazana Dlamini Zuma has failed to honour a commitment she gave to him two years ago that a specific budget for heart transplants would be made available.

Since then his top class team has slowly disintegrated, as with many other academic health units where the best staff have taken voluntary retrenchment packages and the freezing of posts has prevented their replacement. The unit is down to five staff and a further two key people may be leaving soon. By international standards it should have a staff of 18.

Unless the R9m budget Brink is appealing for materialises in the new financial year so that he can hire more staff, the world-renowned unit will be forced to close its doors to new patients. Last year it performed 31 transplants and cared for 200 national heart transplant patients with an “inadequate” R6m from Groote Schuur’s budget.

Brink expects several of SA’s hi-tech units in academic institutions — such as cardiac surgery, dialysis facilities and cancer therapy — to fold in the coming years as funds dry up. The remaining handful will probably be concentrated in one or two national centres.

Dr Tim Wilson, the national health department’s chief director of hospitals and academic complexes, denies that government is destroying this heritage.

“We would like the heart transplant unit to continue and believe it is a valuable service and one we can afford if we can learn to use our resources more cost-effectively.”

But, he says, SA has been spending more than it should treating people inappropriately at expensive institutions, resulting in the “gross underdevelopment” of primary care and regional hospitals.

“It is incorrect to say that central hospitals are not our priority — they are vitally important. Our priority is to achieve the appropriate balance between the different levels of the health system.”

Brink agrees that primary health services need to be expanded for the poor, but argues that it SA tears down existing First-World institutions it will never be able to afford to rebuild them.

The wealthy will pay a high premium for private care — a heart transplant at Groote Schuur costs about R60 000 compared to about R140 000 in the private sector — while the poor will just get sicker. Some will die, like kidney patient Thagraj Soobramoney who was denied free dialysis treatment after the Constitutional Court ruled that the State’s obligation to provide health care is not absolute. These are the real losers who until now have been able to obtain hi-tech treatment almost for free at academic hospitals.

At the time of Barnard’s pioneering surgery in 1967, Groote Schuur attracted world class doctors. “Now we are seen as a Third-World hospital for the indigent,” says Brink.

Barnard himself is despondent “Groote Schuur would definitely not have been the site of the world’s first heart transplant had the conditions which prevailed now been in place 30 years ago,” he says.

“Now specialised medicine is not encouraged at all, most major research is privately funded and there is too much bureaucracy. I didn’t even have permission to do the first heart transplant. Now it would have to go through a whole lot of committees and each one would have a reason why we shouldn’t do it.”

Groote Schuur is deteriorating fast. It cannot afford to carry out proper maintenance and will eventually go the way of the older hospitals like Tygerberg and Pretoria Academic Hospital whose infrastructure is crumbling.

These are the hospitals where, 10 years ago, today’s private doctors were trained. As they lose top academics and conditions deteriorate, so too will the quality of doctors they produce. Brink fears that unless the state of academic medicine is addressed, South Africans may ultimately have to go overseas to obtain hi-tech medical treatment.

As the home of three academic hospital complexes, the Western Cape has been particularly hard hit by government’s plan to divert resources towards primary health care while systematically reducing the province’s share of national revenue. This
The hospital's doors are always open to patients, staff, and visitors. We are committed to providing the best possible care in a safe and comfortable environment. Our staff is always on hand to answer any questions you may have and to make your stay as comfortable as possible. We are proud to offer a wide range of services, including emergency care, inpatient and outpatient services, diagnostic imaging, surgery, and more. Our goal is to provide you with the highest quality care possible, so you can focus on getting better. Thank you for choosing our hospital.
Heartless thieves are preying on children being treated for cancer.
They have stripped the children's wards at Johannesburg's Hospital of toys, clothes, TV, video machines and microwave oven - and these items were stolen last year, up from the R708,000 two years before that.

But the targeting of critically-ill young patients is a sickening new trend.
Among the crooks is a bogus doctor on the prowl at Johannesburg Hospital.
In the latest incident, a blanket and coat were stolen from a 20-month-old toddler about to undergo chemotherapy on Friday. Thieves had already stolen her favourite toys, a pink elephant and a blue bear.

Other thefts in the weeks before Christmas include:
- A Dracula toy from an eight-year-old boy;
- A TV and video machine used to show cartoons to children undergoing chemotherapy;
- A microwave oven;
- A hand-held computer game;
- Meals en route from the kitchen, leaving the youngsters nothing to eat but bread; and
- Parents' belongings, including a purse and cellphone from a mother attending to her sick child.

Locks on most of the cupboards provided for parents have been smashed and cars have disappeared from hospital grounds.
The only likely culprit spotted so far has been a man posing as a doctor, complete with a green theatre gown.

Robin Bruss, chairman of the Parents' Association of Children's Haematology Oncology Clinics, or Choc, said the man's movements coincided with the disappearance of appliances.
"Someone must have let this man in via a fire escape late at night when the wards were dark," said Jane Bruss, a Choc committee member.
The man - or men - has been spotted by two small girls who claimed he "flashed" at them.

Samantha, a 12-year-old patient, said a pretending to be a doctor had told her to go to the lift to meet her father. The boy said he knew the man was bogus because a real doctor would not have told him to get out of bed while on a chemotherapy drip. He said he as much to the intruder, who then left.

Nadia Greyvenstein, aged 20 months, was so upset after her favourite blanket was snatched that she had to be sedated before undergoing chemotherapy on Friday.
Her mother, Jacqui Greyvenstein, said she stepped into a crowd lift at the hospital with Nadia at 7am.
"Nadia's favourite blue blanket and a jacket were on top of my bag. Nadia cried out: 'Mummy, coat, coat.' But I couldn't see what was going on. When we got out of the lift, I discovered that what had happened was my daughter was the theft of her 'blankie' and jacket."

A few days before, the girl's favourite toys went missing.

Twelve-year-old orphan Glen Moffeneng's favourite toy, a hand-held computer game donated by Choc, was stolen this week. Now he and his fellow patients can do little more than wish for another for Christmas.

Leonard Cruywagen, 8, was given a Dracula doll to give him courage for his coming bone marrow test. When he returned from theatre after 15 minutes, it had disappeared.
"Maybe another boy was made happy," he said.

A shocked Health Ministry spokesman, Vincent Hlongwane, appealed to hospitals to beef up security to stop thefts, particularly those affecting children, and to the whole community to make such behaviour socially unacceptable.

He said Health Minister Dr Nkosazana Dlamini-Zuma's particular concern was the well-being of children.
"We appeal to people with any information to pass it on to the relevant officials," he said.

In Gauteng state hospitals alone, equipment, linen and drugs worth R12 million were stolen in the three years to 1996. Johannesburg Hospital accounted for R1.2 million of that figure.
Robin Bruss said he and Choc would do whatever it took to ensure children with cancer received the best possible treatment in the best surroundings.
"You can't compromise a child with a disease as serious as cancer," he said.

Choc's eight committee members had done everything from buying linen when hospital supplies ran out to arranging the cleaning of wards.
"We are aware of intermittent thefts from various parts of the hospital," he said.

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"We are aware of intermittent thefts from various parts of the hospital," he said.

We are not aware of the alleged incident that led to the shooting of a patient in the children's cancer ward of the hospital. We have no information on this matter.
Johannesburg Hospital has been experiencing a number of “bad” nights since the conversion of Hillbrow Hospital into a community-health centre, and this past weekend was no exception.

“You are not going to die, now please wait outside until we can see you,” were the words given to a patient bleeding from multiple stab wounds. The speaker was a harassed doctor who, after giving the man a quick check, returned to attend to other serious patients admitted to the casualty unit on Saturday evening.

When The Star visited the unit between 10pm and 2am, it was cluttered with between 18 and 20 people who, because the available trolleys were occupied, were scattered on chairs or simply lay on the floor. Visibly exhausted staff attended to the flood of patients, several of whom had gunshot and stab wounds, before calling in less seriously injured or walk-in patients from the crowded waiting area.

Treated patients often have to wait several hours in the casualty unit as duty nurses and doctors attempt to find beds for the more serious cases.

“It's a zoo in here over weekends and public holidays, and we constantly have to play musical chairs with new arrivals as we don’t have the beds or facilities to deal with them,” one nurse said.

In some instances, doctors were forced to treat patients as they lay on the floor. In one case, a girl who had a broken wrist had to wait for more than four hours before she could be treated by an orthopaedic surgeon.

“We do a quick check as they come in. If it is not life-threatening, we tell them to wait outside until we can call them in. It’s not the way medicine is meant to be practiced, but with the limited staff and equipment we have, there is no alternative,” a trauma doctor said.

One nurse answers the telephone (as ward clerks work only certain shifts); a second nurse threads stitches; a third does resuscitations; and the fourth controls the walk-in patients.

Unit head Dr Kenneth Boffard is under no illusions about the difficulties.

“One doctor does stitches while the second doctor links up with a nurse for resuscitations,” he said.

The hospital averages about 14 resuscitations a day.

Boffard expects the nightmare in the casualty unit to become worse.

“We don’t have the staff, beds or equipment to cope with the situation, let alone offer proper trauma care for people who need it most,” he said.
Budget cuts to force unit's closure

New cancer workers
State hospital battling under seasonal load

OWN CORRESPONDENT

JOHANNESBURG: Johannesburg Hospital, one of the leading state hospitals in the country, is buckling under its patient load as the festive season peaks.

The closure of Hillbrow Hospital last month has resulted in a massive overflow of patients at Johannesburg Hospital, which now has 130% of its normal patient capacity.

Emergency patients often have to lie on the floor while staff battle to find places for them.

The trauma unit is operating at 200% of capacity.

Before it was closed, Hillbrow Hospital dealt with about 170 emergency cases a month. According to doctors, most of these have spilled over to Johannesburg's trauma unit.

But dealing with up to 600 extra walk-in patients a month at a hospital which at any given time receives about half of the overflow from other state hospitals is a certain recipe for disaster, say doctors.

"They could not have closed the Hillbrow Hospital at a worse time of year, a month before the festive season," Dr Harry Berzen, former Hillbrow orthopaedic surgeon, said.

Johannesburg Chief Medical Superintendent Dr Trevor Frankish said: "There are usually enough doctors. Less-injured patients will be referred to Hillbrow Casualty (which will continue to function) and more seriously injured patients will be referred to other hospitals, which may have some spare capacity, if necessary."
Health workers
defy stayaway

By Khathu Manaila

Hospitals in the former Venda homeland have been operating as usual despite calls by Daba-lo-rivhuwa Pension Crisis Forum that health workers should join a stayaway which started about two weeks ago.

Chairman of the forum - Mr Tshifhiwa Makhale said last week that workers had resolved that the stayaway aimed at forcing the government to surrender the pension fund to its beneficiaries should affect all civil servants, including those rendering essential services.

Makhale had said health workers would be briefed about the decision and added that critically ill patients could be transferred to other hospitals outside the former homeland.

However, Soweto has discovered that hospitals in the area were working as usual.

Makhale confirmed yesterday that things were normal at hospitals.

He said there had been a problem of communication as the department’s senior officials had refused forum leaders access to the hospitals.

“Our plan to move from one health institution to another was frustrated by the officials who did not allow us to address the workers.

Support action

“The workers do not attend our meetings and it is difficult for them to support our action.

“We will continue to search for ways of informing them about our action. The stayaway has been effective, although there are a few people in other departments who are working,” said Makhale.

He said the stayaway would continue until the government had responded to the workers’ demands.

The government has repeatedly said that workers would not get their pensions as long as they were still employed.

The workers are demanding that they be paid the money that remained in the pension fund when the scheme was privatised in 1992.

Meanwhile, Makhale, who has refused to be transferred from Thohoyandou to Pietersburg, has been served with a letter informing him of his dismissal.

According to Makhale, if he failed to report in Pietersburg on December 15 he would be seen as having absconded.

Makhale did not report in Pietersburg on the day. He argued that the transfer was aimed at weakening the forum. He said he had already briefed his lawyer to challenge the government on the matter.
Urgent meeting over hospital crisis

BY DEREK ROONEY

An emergency meeting of hospital managers has been scheduled for today to discuss the "disproportionate" flood of trauma patients to Johannesburg Hospital, due largely to the conversion of nearby Hillbrow Hospital to a community health centre.

Following an article in The Star yesterday, in which conditions at the congested unit were highlighted, the Gauteng Health Department conceded yesterday that the conversion had caused a substantial overload of trauma patients at Johannesburg Hospital.

A weekend visit to the trauma unit revealed how patients waited for hours, sometimes lying on the floor because of a lack of stretchers or beds, before receiving treatment for injuries.

Staff and equipment are stretched to the limit to deal with the steady stream of patients over the festive season.

The managers are expected to discuss issues affecting conditions at other Johannesburg hospitals and the possibility of redistributing vital equipment and personnel from less stressed hospitals to the hard-hit hospitals.

Department spokesman Jo-Anne Collinge said large numbers of trauma patients were being accommodated in wards which were not usually used for these purposes.

"In addition, there has been insufficient nursing and administrative support for the unexpectedly heavy demand on the casualty section, as well as a shortage of equipment (such as trolleys and wheelchairs)."

Collinge said various steps were being taken to strengthen Johannesburg Hospital's capacity to cope with this large trauma load. They included the secondment of additional staff from Hillbrow and the transfer of more equipment.

Collinge reminded inner-city residents that there was still a casualty service, around the clock, at Hillbrow Hospital, which, although not equipped to deal with the most severe cases, could still cope with sewing up cuts and stab wounds, setting broken bones, and dealing with ordinary burns and household injuries.

The casualty section at Hillbrow Hospital can be accessed at any time through the main entrance.

"Service users should not be put off by the fact that secondary entrances have been closed off for security reasons now that many sections of the hospital are not in use," Collinge added.
Health services are deteriorating fast.
Jo Burke Hospital in dire straits

- The hospital is facing financial difficulties.
- Lack of government funding is a major concern.
- The hospital is struggling to keep its doors open.

Hilhow Hospital has been forced to cut services due to severe budget constraints. The hospital's administrators have requested additional funding from the government to prevent further closures.

Last few patients

If Hilhow Hospital is forced to close, several patients will be left without care. The hospital provides critical services to the local community, and its closure would have a significant impact on the area.

*Note: The text is not fully legible due to the quality of the image.*
A TEAM of investigators into last month's violent conflict between members of the National Education, Health and Allied Workers Union (Nehawu) and the administrative staff at the Helen Joseph Hospital has recommended that disciplinary action be taken regarding the incident, the Gauteng health department said yesterday.

It said the recommendations were contained in a report by the investigating team headed by labour relations director of corporate services in the Gauteng health department Mr Adrian Oelofse, assisted by assistant directors in his office Mr Vincent Dladla and Mr Stanley Rakgotsso.

The team recommended that disciplinary hearings should be instituted in relation to:
- The "roughing up" of a Nehawu shop steward, allegedly by a traffic officer called in by his mother who works in the administration unit, on November 14;
- The forced removal of administrative staff allegedly by Nehawu members on November 17; and
- The alleged assault of a member of the administrative staff by a leading Nehawu member on November 17.

The statement said charges would be drawn up relating to all these incidents and disciplinary hearings would be instituted in January.

The health department also accepted the investigation team's view that disciplinary hearings relating to industrial action in August should be expedited.

It said immediate steps should be taken to fill senior vacancies at Helen Joseph Hospital.

The report stated that the hospital was in "dire need of effective leadership". It highlighted the fact that with the exception of the head of nursing, all top management posts were currently vacant.

"Head of nursing Matron Jane Ramaboa is mentioned as having the skills, experience and leadership qualities needed to tackle some of these tricky labour relations questions and is recommended as acting superintendent," the statement said.

"However, national legislation still stipulates that the superintendent must be a medical doctor."

In the light of this the department had decided that:
- Dr Arthur Manning, superintendent of Coronation Hospital, would continue to "double" as acting superintendent of Helen Joseph Hospital. The post would be advertised in January;
- Dr Hans Rothschild would be transferred from Tara Hospital to assist Manning;
- Boitshelo Matoe, an assistant director at head office, with experience in a number of hospitals, would be seconded as acting hospital secretary; and
- Various unattended grievances lodged both by Nehawu and management would be investigated as soon as possible and resolved.

The statement said a process had been agreed for Helen Joseph Hospital's new executive team (Manning, Ramaboa and Matoe) to review the grievances and ensure action in relation to matters which were pending. Acceptable deadlines had been set.

Additional findings included:
- The death of a man at the X-ray department was not linked to the problems between Nehawu and the administrative unit.
FIVE MINUTES AFTER WE GOT THERE, THE BLOOD STILL FLOWS AT BARA

FOCUS ON HOSPITALS
Boost for trauma unit at Jo’burg Hospital

Extra staff and equipment provided after arrangement with Hillbrow worked out.

By Priscilla Singh
Health Reporter

The Gauteng Health Department (GHD) took measures yesterday to bolster the embattled Johannesburg Hospital’s trauma unit.

Extra staff and equipment have been brought in to cope with the influx of patients since the conversion of Hillbrow Hospital to a clinic this month.

Management teams from hospitals around Johannesburg met GHD officials yesterday to discuss ways to alleviate the flood of patients streaming to Johannesburg Hospital’s trauma unit, which experienced a 30% increase of patients since Hillbrow’s conversion to a community health centre.

This followed a report in The Star on Monday in which conditions at Johannesburg Hospital’s trauma unit were highlighted.

GHD acting superintendent-general Dr Eric Buch said the department had expected “some rough patches along the road” with the conversion of Hillbrow Hospital to a community health centre. He conceded, however, that the impact on Johannesburg Hospital had been larger than expected.

Buch spent several hours at Johannesburg and Hillbrow hospitals last night to get a first-hand impression of the problems, and said he was confident the new arrangements for emergency care at Johannesburg were appropriate and would ensure satisfactory patient care.

It was agreed yesterday that a shuttle service would be operated to transfer patients from Johannesburg to Hillbrow in cases where the injury or illness was not so severe as to require trauma care.

“The Hillbrow casualty is well equipped and staffed, and could cope with hundreds of patients daily, but is currently seeing only 50 to 60 a day,” he said.

The Hillbrow casualty section is not equipped to deal with serious trauma cases.

Johannesburg Hospital yesterday received additional equipment for its casualty department from Hillbrow, ranging from basic items such as trolleys to sophisticated instruments used in resuscitation.

“This will enable the hospital to cope far more effectively, particularly during peak periods,” Buch said.

Signs had been erected at Hillbrow Hospital to counteract the perception that Hillbrow had “closed”. Possible miscommunication by personnel, including security workers and emergency services, had been checked and pamphlets were being distributed in the area.

“Staff from Hillbrow, such as porters and clerks, will be seconded temporarily to Johannesburg and this will free the nursing staff to do more appropriate work. Some nursing staff will also be seconded and every effort is being made to ensure that staff are in place before the Christmas long weekend,” he said.
A little bit of joy for cancer kids

WARM-hearted Sunday Times readers have showered the children of Johannesburg Hospital’s cancer wards with gifts and cash donations.

There has been such an avalanche of toys that five boxes full of teddy bears, dolls and other play-things were delivered to the delighted small cancer patients at Chris Hani Baragwanath Hospital on Christmas Eve.

The Sunday Times reported last week that thieves had stripped Christmas decorations and stolen the children’s microwave, TV and video sets, toys and other personal possessions.

“We have received such an overwhelming response from the public—we are very grateful,” said an overjoyed sister-in-charge Sadie Cutland.

Bongani Keswa, Sunday Times donations editor (management), gave the young patients a colour TV on Tuesday.

Cutland was forced to lock up the new TV until some way of preventing it from being stolen could be found — and the next day Sunday Times reader Gareth Ladeira donated a lock-up TV “cage”.

Since last Sunday, a steady stream of families, children and pensioners has visited the hospital with offerings.

Youngsters have even handed over loved but much-used favourite teddies.

One of the most touching gifts with everything from food to toys came from Brother Giovanni — himself suffering from cancer — and his Johannesburg Institute Feeding Scheme. Brother Giovanni also gave R500 towards a new microwave oven.

Robin Bruss, chairman of the children’s cancer charity Parents’ Association of Children’s Haematology Oncology Clinics (Choc), said: “One of our main projects is to provide a house where parents of children from outlying areas can stay while their children are receiving treatment. You can’t take a sick child home by taxi or train after therapy, so the parents desperately need somewhere to stay near hospital.

“We have been spending our influx on replacing stolen items and were unable to save much towards the Choc home. Now public generosity has meant we have hope,” Bruss said.

By the weekend, Choc had been given or pledged several cash donations by individuals who gave anything from a few rand to R1 000 — the total is not yet known. One company, Midos, donated a TV set. Others have promised another TV and video.

Patrick Lewis of Choc received the welcome of his life from the children when he took five boxes of toys to the hospital.

Christmas meals were taken care of by Woolworths at Eastgate, which gave the children anything perishable left on their shelves or in refrigerators on Christmas Eve.

Radio Highveld and Radio Today both took up the children’s cause, with phone-in programmes this week that resulted in an avalanche of pledges. Through Radio Highveld, Choc was promised R10 000 by Boeswel Wilkie’s Circus from a special performance at 3 pm on December 30.

Thanks to the generosity of a Johannesburg couple, who asked to remain anonymous, 12-year-old orphan Glen Mofokeng was able to go home to his aunt for Christmas. The couple gave him a gas-operated refrigerator.

“My doctor said I could go home if there was a refrigerator to keep my medicine in,” said Glen, who needs daily treatment.

“But my auntie moved into an RDP house in January and there is no electricity,” he said.

Also among those who promised help were Game Stores, which offered to replace every item stolen.

On Tuesday, Santa Claus was sent to the hospital by the Randburg Waterfront. Santa handed out Christmas presents to children in the two cancer wards.

Choc presented the doctors and nurses with gift vouchers and it has arranged with the hospital to pay for the use of outside cleaners to keep wards pristine.

THANKS SANTA: Sunday Times assistant editor Bongani Keswa (right) hands over a new TV to (from left): Chané Vos, 12, Monica Zamarian, 3, Nastassja Kean, 6, Felicity Hunt, 7, Barbi Andersson, 13, and Bongani Mathe, 16, at Joburg Hospital’s children’s cancer ward.

Picture: JULIAN VAN DER WESTHUIZEN
Hospitals in Gauteng are prepared for the anticipated flood of patients over the New Year's session and dismissed suggestions they would collapse under the heavy workload.

Gauteng Health Department acting head Dr Eric Buch said the situation at provincial hospitals was "manageable" although a few teething problems still had to be addressed.

"We experienced a bad Christmas at Johannesburg Hospital, as well as the weekend before. This was about the time of the closure of Hillbrow hospital, and insufficient equipment and staff had been transferred from the one hospital to the other. This has, however, been completed for New Year," Buch said.

He attributed most of the problems experienced on Christmas night at Johannesburg Hospital to a communication breakdown.

The Star last week reported that the hospital's trauma unit was unable to cope with a flood of incoming patients, with bleeding and injured people lying on the floor.

"Unfortunately no-one called on the back-up surgical team at Hillbrow that was available to help," said Buch. A backlog of orthopaedic patients had contributed to the Christmas chaos, but had been cleared in anticipation of the New Year rush.

"We are satisfied that more than adequate measures have been taken," he said, describing Hillbrow hospital's transformation into a health centre as a smooth conversion.

Buch said there were about 20000 beds available in provincial hospitals, with recorded figures indicating that only about 10000 patients were treated in hospital during the festive season, meaning there was no shortage of beds.

"We believe the Gauteng health department is in good shape and we are functioning below our capacity to provide good care," he said.

Concerning the situation at Chris Hani-Baragwanath hospital, Buch said the hospital always had the busiest casualty ward, but was coping well during the holiday period.

Gauteng's Health MEC Amos Masundo said rumours that health services were "about to collapse" were unfounded, and doing a disservice to dedicated medical practitioners and health workers.

"There's no need to panic, everything is under control," he said.
Hospitals face problems after restructuring process

Taryn Lamberti

JOHANNESBURG hospitals were experiencing teething problems after some of the changes which had been instituted as part of a restructuring scheme. Gauteng health department acting head Dr Eric Buch told a news briefing yesterday.

Buch said problems had surfaced at the Johannesburg Hospital after the department’s controversial decision to downsize Hillbrow Hospital to a primary health care centre.

The last of the Hillbrow Hospital’s patients were transferred to other hospitals on Tuesday last week, with many of the patients being taken to Johannesburg Hospital, causing a patient overload on Christmas night.

“There were a couple of bad nights around the closure of Hillbrow Hospital and sufficient capacity had not been transferred from Hillbrow to Johannesburg,” Buch said.

The conditions were aggravated on Christmas night because a surgical team was on duty at Hillbrow Hospital when it should have been assisting with the delays in patient care and surgery at Johannesburg Hospital.

“It would have taken one phone call.

It was a communication lapse,” Buch said.

Additional theatre nurses have since been transferred from Hillbrow to Johannesburg Hospital. Buch was confident that “more than adequate” measures had been taken to rectify the situation.

There was concern over the fact that the day clinic at Hillbrow Hospital had not been receiving patients.

The hospital was closed last weekend but the casualty department was open for patients with minor ailments. More serious cases would be transferred to the Johannesburg Hospital.

Buch said the patients had been “put off” by the barbed wire fencing that had been wrapped around the hospital for security purposes.

“He public needs to know that the clinic is a 24-hour service,” he said.

Johannesburg Hospital acting superintendent Dr Warrick Sive would not comment on the transfer of resources from Hillbrow Hospital to his hospital.

Buch was unable to say what had been transferred to the Johannesburg Hospital in preparation for the expected New Year’s Eve rush which was usually experienced by hospitals.
‘Inhuman’ city midwives beat women during labour

Researchers unveil abuse at obstetric unit

JENNY VAILL
Health Reporter

Women attending a Cape Town midwife obstetric unit say they were beaten, slapped and scolded by midwives during pregnancy and labour.

Mothers interviewed for a research study at the unit said midwives spoke to patients as if talking to children and many reported that “nobody showed any kindness”.

They described midwives as “inhuman”, “not caring”, “silly”, “rude”, “ridiculous”, and “not kind”.

The report of the study, published in the Urbanisation and Health Newsletter, said the patients’ accounts were of great concern.

One woman said she was slapped in the face when she was found squatting next to a bed because she could not climb up. Another said she was repeatedly beaten on the thighs during delivery.

A woman who delivered her baby on the floor was beaten, scolded and told to clean up the mess herself and the midwife refused to pick up the baby, the report said.

The research by Rachel Jewkes, Zodumo Mvo and Naeema Abrahams of the Medical Research Council’s women’s health division found midwives felt justified in scolding patients who were seen as “morally deviant”, such as pregnant teenagers.

Hitting was part of the routine management of women who panicked during delivery and closed their legs, said staff. But cases of women being beaten for sitting or delivering their babies on the floor were clearly cases of violence being used as punishment, said the report.

There was also evidence that some staff regarded their patients as “stupid” or “like children” who were not worth the time and effort of proper explanations.

Most pregnant women indicated they had expected problems at the unit, in particular being shouted at, beaten or neglected. These expectations were largely based on personal previous experience or that of friends.

All but one of the 17 women interviewed reported shouting, scolding, rudeness or sarcasm in some form which they found unpleasant or hurtful.

Some women resisted the treatment, leading to arguments. Others avoided the unit as long as possible or tried to book elsewhere. Others tried to find help from other patients or cleaners.

The study findings suggested that part of the problem might lie in communication skills of staff and deficiencies in training about information sharing and support for patients, said the report.

Health managers and the Nursing Council needed to take a firmer line on what constituted unprofessional, unethical and unacceptable behaviour from nurses and seek evidence and use disciplinary action to ensure violence against patients was stopped.
Spending cuts are compromising hospital services.
The Hospital Association of Singapore (AHAS) is ails is the competition board that allocates the patient's equitable share of hospital beds. The AHAS also regulates the fees charged by hospitals, ensuring that they are reasonable and not exorbitant. The organization's primary objective is to maintain the quality of care provided to patients in a cost-effective manner. To achieve this, the AHAS conducts regular audits and inspections of hospitals to ensure compliance with their established guidelines. In addition, the organization encourages hospitals to adopt innovative strategies to reduce their operational costs without compromising the quality of care offered to patients. Through these initiatives, the AHAS plays a crucial role in safeguarding the interests of patients and ensuring that hospitals operate efficiently and effectively.
Health officials firm on overtime

By Prescilla Singh

Health Reporter

The Gauteng Health Department will not judge on its decision to change the system of overtime schedules and has taken strong exception to doctors at Johannesburg Hospital threatening to quit public service.

Following a report in The Star yesterday, the department issued a statement in an effort to clear any misunderstandings doctors had on how the new "commuted overtime scheme" will work.

The department traced the history of overtime payments to the days of the non-pensionable allowance (NPA), where doctors received a fixed sum for overtime. The result of the NPA system was that some doctors did a great deal of overtime work, and others very little, yet all received the same remuneration.

From July 1986, the new commuted overtime policy was implemented and revised twice.

The department said it was absolutely clear from the national policy framework that commuted overtime was not part of the basic salary package, and should be paid for additional clinical work performed.

Documents were circulated from August last year inviting comments from doctors on the new overtime schedules, and they were modified and improved from the input received, according to the department.

Hospitals were given a "logic-based allocation" of medical staff for any one overtime shift, and management will decide on the split and mix of doctors.

At hospitals such as Tambo Memorial, Thembisa, South Rand or Edenvale, there are insufficient doctors to treat patients after hours and these duties are being offered to doctors not able to access all their overtime at their base hospital.

"This means that all doctors willing to take part in the scheme will be accommodated at an appropriate facility, based on their skills and qualifications, within reasonable proximity to their place of residence," the department said.
Gauteng moves after-hours doctors to district hospitals

Josey Ballenger

Some doctors at central Gauteng public hospitals would be asked to work overtime at understaffed regional or district hospitals from next month in an effort to distribute after-hours staffing equitably, the provincial health department announced yesterday.

The province was not planning to cut overtime payments in the medium term. This had been "misunderstood" in media reports, the department said.

"We are not cutting overtime. Any doctor willing to utilise overtime at a hospital within a reasonable geographical distance of their home or "base" hospital will be able to do so," said Dr Norman Kerns, Gauteng director of hospital management.

Department spokesman Popo Maja said many hospitals did not have enough doctors to run an effective after-hours service. "On the other side of the spectrum, some hospitals have more staff on their establishments, due to the range of services run during normal hours, than are required to staff their after-hours needs."

The system will mean some doctors will not be able to work all their overtime at their "base" hospital, but could spend some or all of it at other hospitals. Specialists in short supply, such as neurosurgeons, will stay at central hospitals and will be paid more than 16 hours overtime if need be.

Kerns said these were the latest in a string of measures to "refine" the public health sector's "commuted overtime" scheme introduced in July 1996 to improve efficiency. It was in line with government's policy to build its regional and district hospitals' capacities and to "decrease (the) load of inappropriate patients flooding the central hospitals'.

The plan, as outlined in a document called "Overtime equivalents" which was modified following public comment from August to November last year, asserts that individual hospitals will be given a "logic-based" allocation of medical staff for overtime duty. The institution will then decide on the mix of doctors that best suits its patients.

Hospitals have been asked to indicate their needs and excesses by the fifth of each month to their regional director, who will co-ordinate the next month's placements by the 20th. Kerns said he would not be able to estimate how many centrally located doctors would be asked to work some of their overtime hours in other hospitals until later this month.

He said that in the long term, the department hoped to reduce the overtime bill. It has spent about R200m a year on overtime payments.
Only one province has paid health dues to Guatene – Masando
Pension: Hosphersa lays into Govt

By Abdul Milazi

Union feels that disparities between black and white is a serious issue

The Hospital Personnel of South Africa (Hosphersa), yesterday accused the Government of trying to shift economic risks to workers, in its plans to change the public service pension fund into a provident fund.

The announcement made by Deputy Finance Minister Gill Marcus on Tuesday has angered Hosphersa, while the National Education, Health and Allied Workers Union (Nehawu) remained indifferent to the issue.

Nehawu president Vusi Nhlapo said there were more serious issues to be negotiate than arguing over what form the pension fund should take.

"It is immaterial whether the Government calls the fund a defined contribution or a defined benefit," he said.

Nhlapo said the Government needed to address the disparities between black and white workers.

"Black workers had been denied membership of the pension fund until the late 1970s, which is why one finds a worker with 20 years of service, only having ten years of contribution with the fund.

"Whites, however, get hundreds of thousands of rands when they retire," he said.

Hosphersa assistant general secretary Albert Wocke said there were a number of trade unions involved in the negotiations for the planned restructuring and it was not certain that they would vote in favour of the move.

"A defined contribution pension fund (provident fund) is not necessarily cheaper than a defined benefit pension fund (a normal pension fund), as the employer may not make contribution holidays in order to redirect funds elsewhere in the budget," said Wocke.

Under a normal pension fund, employees are entitled to a percentage payout plus a monthly payment till death, while a provident fund only offers a once-off payment.
Heidewald, supermarket shows way

Task team calls for local responsibility

Health goes to grassroot...
EU SPENDS ON BASICS

R48m tonic for primary health care in W Cape

PREVENTING DISEASE and providing treatment before it becomes chronic is the most efficient way of spending money on the country's wellbeing. Health Writer JUDITH SOAL reports.

IN three years, R48 million could fund 160 heart transplants, 40 beds at Groote Schuur Hospital or primary health care to one million people.

Given these figures, it’s not hard to understand why a primary health care programme was chosen as the recipient of a R48m European Union (EU) grant announced yesterday.

Ms Elise Levenda, the chairperson of the coalition, Community Based Primary Health Care Programme, says primary health care — in which community health workers treat people in the places where they live and work, focusing on preventing diseases or treating them in the early stages — has been shown to be a lot cheaper than hospital-based care.

“We did an economic evaluation of our project last year and found that the cost of a community health worker’s visit to a home is between R31 and R35. But a patient’s visit to the outpatient unit of a hospital costs R55.

“Also, because we can detect and prevent diseases earlier, treatment is much cheaper.

“For example, it costs between R36 and R71 for a community health worker to teach a family about oral rehydration (treating diarrhoea), but to treat a dehydrated child in hospital costs about R450 — so you can see there is a big saving.”

The announcement of the grant to the coalition — the largest single donation to primary health care in the Western Cape — was made by the EU ambassador Mr Erwan Fouéré at a press conference called by outgoing Western Cape Health MEC Mr Ibrahim Busoal.

The coalition consists of the South African Christian Leadership Assembly (Saca), the Health Care Trust, the National Progressive Primary Health Care Network (NPPHC) — Western Cape, Zibonele Community Health Worker Project and the NPPHC Training Centre. Together, these five organisations reach a million people in the Western Cape.

The grant will be used to fund the work of community health workers like Mr Pumelile Notshe of the Zibonele project in Khayelitsha. Notshe explains how Zibonele operates:

“There are 15 community health workers, and we each have 300 houses under our care.

“We keep a record of all the people in the house and visit each house regularly. The ‘at risk’ houses — where someone is sick — we visit about twice a week.”

Notshe says that health workers are trained to treat minor illnesses such as skin problems, colds and flu, diarrhoea and headaches, and to provide information and advice on health-related problems.

“If something is more serious then we refer people to the day hospitals.”

Zibonele also runs a women’s health project with community health workers who hold clinics and visit homes, giving advice on contraception and sexually transmitted diseases and providing both ante-natal and post-natal care.

Mrs Liziwe Mpe, a community health co-ordinator at the Health Care Trust, says primary health care has an important role to play in preventing tuberculosis — one of the most serious health problems in the Western Cape.

“If people don’t take their tablets, then TB becomes resistant to the medication, so we tell them how important it is, and check that they take them.”

Community health workers also keep records of children’s immunisation details and are able to ensure that they receive the vaccinations they need to prevent future diseases.

Mpe says that a community health worker is never off duty: “They come to our houses all the time, during the night, at the weekend, when the day hospitals are closed.

“They come with stab wounds and we dress them.

“They say they would rather come to us than to the hospital.”
Everybody gets a say on health care

New bill to replace hospital boards

ADELE BALETA

Everybody in the Western Cape soon will have a say in the running of hospitals in their areas, instead of merely complaining to authorities as they now do.

Comunities will be given this say on hospitals and on the delivery of health services when the proposed Western Cape Health Facility Boards Bill is passed.

The draft bill replaces the existing hospital boards, established under a 1946 ordinance, which are perceived to have inadequate powers and community involvement.

Western Cape Health Department legal expert Steven Harrison said the draft bill was written in response to increasing pressure from the community to review the existing hospital boards, which were in a state of crisis.

The new boards, which can be applied potentially to clinics and community health centres, will be given real powers and functions that will affect decisions with medium- and long-term implications for patients and communities, without interfering in the day-to-day management of health facilities.

The new boards will have about 50% community representation, along with technical experts, health facility management, facility staff and academic staff.

Community representation would allow patients, their families and local communities an effective say in the delivery of health services that affected them, said Mr Harrison.

Complaints about long queues, inadequate treatment and dilapidated and outdated facilities could be taken up by the new boards.

The bill also gives communities a chance to give valuable input on improving their health facilities. The bill was gazetted yesterday for public comment and is likely to be tabled in the provincial legislature early this year.

It is the first bill to be tabled by the provincial health department since 1994 and is “an indication of the department’s commitment to community participation as a central principle in the delivery of health services,” said Mr Harrison.

The draft bill, which received provincial cabinet approval in principle in December, was selected by the department to initiate a legislative programme to emphasise the commitment of the health ministry to community participation in the delivery of health services.

Several other health laws are planned for the Western Cape this year.

Outgoing Health Minister Ebrahim Rasool of the African National Congress, who has been replaced by Peter Marais of the National Party, said he was sorry he would not be able to see his legislative agenda through to its conclusion.

“In the interests of the health of the people of the Western Cape,” said Mr Rasool, “I can only hope my successor vigorously pursues this legislative programme to fruition.”
hospital supplies discarded

By Priscilla Singh
Health Reports

The Gauteng Health Department yesterday expressed shock about unused and unopened medical supplies which were apparently being tossed out with the rubbish at the former Hillbrow Hospital.

Beeld reported yesterday that usable medical supplies and equipment such as drips, oxygen masks, catheters and surgical masks, as well as linen and blankets, were found in rubbish disposal containers.

Spokesman Popo Maja said yesterday the department did not expect such things to happen and deplored the actions of those who might be responsible: "We cannot understand how medical gloves or syringes can be thrown away."

He said he went to Hillbrow, now a 24-hour community health centre, yesterday but did not find any signs of waste.

Hillbrow Superintendent Dr Emma Bondorinko said she knew nothing about medical supplies being thrown out and did not know where Beeld got its information. Beeld's report included a photograph.

Maja said the department would investigate.
Home's staff boot out director

BY STUART KELLY

Striking workers at the Takalani home for the mentally handicapped in Soweto threw their director out on the street yesterday to protest against what they claim is his poor management of the home.

About 50 workers waving placards demonstrated outside the home for much of the day after warning the director, Dr Jacob Semela, not to come back until he was prepared to deal with the problems faced by the 105 staff members and 600 child residents.

They also took away his car keys and locked them up inside the premises.

Spokesman for the workers, Elizabeth Mokone, said nurses and other employees were finding it increasingly difficult to carry out their duties.

"There is plenty of food coming in, but for some reason Semela keeps it locked in storage until it is no longer good for eating. No maintenance is being done at all. Children cannot be looked after well because the money Semela receives from donors does not reach us on the ground," Mokone claimed.

She stressed that, although the nurses and other staff were on strike, they would ensure that the children were cared for.

A small police contingent kept vigil outside the home last night. Semela was believed to have been taken home by the police earlier in the day and could not be reached for comment.

When The Star visited the home last night, exposed electrical wires were evident on many broken heaters, mattresses and blankets were shabby, and a number of the geysers were not working."
Cutbacks on new clinics

NELSPRUIT — The Mzumalanga health and welfare department would not build any hospitals or clinics this year because of financial constraints, director Dr Gulam Karim said yesterday. But the department was hoping there would be a surplus on the budget, which would allow the building of a psychiatric ward at Nelspruit’s Rob Ferreira Hospital. African Eye News Service said Karim said the department would spend R1.5m this year to complete the construction of three hospitals and two clinics in the province which were started in 1996. “Monga, Erumele and Witbank hospitals, and the Emjindini and Daggakraal clinics, will be completed this year,” he said. — Sapa.
R300 000 debt for coal threatens hospital crisis

East London – Coal supplies for Cecilia Makiwane Hospital at Mdantsane here were to end today unless the provincial government came up with an outstanding payment of R300 000.

Chief medical superintendent Patrick Sendyose admitted the hospital was in a crisis because a company had refused to stop supplying coal from today.

Dr Sendyose said the hospital had done all it could to get the provincial government to pay the outstanding account.

He was not certain how much fuel was in stock but the hospital would not be able to function if it ran out of coal. It was understood, however, that the hospital had enough fuel on hand to keep it running for another four days.

East London and Border Coal Distributors’ managing director Kevin Lodge said they had been most patient in trying to secure payment of the R300 000, which had been outstanding for some time.

“We have been most reluctant to take this step but in the end we had to give the hospital and financial authorities seven days’ notice of our intention to stop supplying coal by Tuesday.”

He added: “We have had no response whatsoever.”

Cecilia Makiwane is the main hospital for the big township of Mdantsane, which is now part of East London. – Sapa
Clouds gather as patients lose place in sun

JUDITH SOAL AND PATRICK BURNETT

THE sun shines brightly on the patients at the New Kings complex in Kalk Bay — a tightly knit community who are looked after by dedicated staff. On good days, they can lounge on the lawn, watching the sea.

Severe disability seems manageable in this world.

But now departmental budget cuts have intruded. The complex is to be closed and patients are worried what will happen to them.

Among them is former speech therapist Ms Beverly Greenwood. An undiagnosed virus contracted 10 years ago left her with brain damage and she needs constant care. She is worried about her future as the Department of Social Services prepares to close the frail-care facility that is her home. She says she will miss her most treasured companion — the sea.

Greenwood is one of more than 200 mentally and physically disabled patients at New Kings whose lives are about to be thrown into turmoil by the department's attempts to save money.

"It will be sad. I am upset about the whole thing closing down and worried that I won't go to church and won't be with my friends," Greenwood says.

"Before I became ill I used to surf and windsurf. I used to love being at the sea and will miss it so much when they take me to a different place."

It is not clear where Greenwood and the others will be taken.

The department says they will be transferred to other frail-care centres, but a retired district surgeon who used to work at New Kings doubts if there are other centres equipped to care for them.

"New Kings has been the end of the line for most people," said Dr Rob Hawke.

"They have all been through other facilities and ended up here. They've been through a lot of trauma before they got to New Kings.

"They have found a community here. From the nursing staff to the floor cleaners and the kitchen staff, everyone goes out of their way to make this a home. It truly is a remarkable place and it will be shattering to these people to leave, I know because I know them well."

"New Kings has all types of cases, from burnt-out schizophrenics to people who are severely brain-damaged. Many are wholly disabled and require tube feeding."

"The department wants to reintegrate these people into other communities, but the communities can't cope."

Most of the patients didn't have families. Those who did could not be cared for by their families.

"Many are from poor areas and even if they have families, there aren't facilities to look after them," Hawke said.

"Even upper-middle class people would struggle because caring for them is a full-time job. They need to be fed, washed, lifted into bed, they are probably incontinent and they can easily get infections — it's a lot of work."

Mr John Haycox has a daughter who has muscular dystrophy and is at New Kings. He is worried that he will not be able to care for her.

"I don't know where this leaves us. We are not equipped to look after her as I have to go to work and she needs constant surveillance."

"These are the things the new government said it would look after."

Greenwood's mother, Mrs Yvonne Greenwood, shares his concern.

"Beverly is in a wheelchair and can do little for herself. From a financial point of view, we can't afford the costs of a private institution or private nurse. Many people in New Kings are worse off. Beverly is not the only one in this predicament. They all are."

There is also concern that potentially violent patients may be released into the community without support.

In November, the Cape Times reported that an 82-year-old woman had been murdered, allegedly by her grandson who had been released from the Stikland Psychiatric Unit. The young man's family had believed him to be unstable and violent and had pleaded, to no avail, with the hospital to readmit him. When his grandmother was murdered, doctors warned that this sort of killing could happen again because of the absence of support systems for released psychiatric patients.

A source close to New Kings, who asked not to be named, said 30 patients would be released into the community — an apparent metaphor for being sent home, even if the patient did not have one to go to — by the end of this month. Another 110 are expected to be released by the end of June.

The remaining 60 — who are the most severely disabled or potentially violent patients — are to be transferred to other centres.

The head of the Western Cape Department of Social Services, Mrs Sharon Follentine, denies that New Kings residents will be dumped.

"It is possible to accommodate the residents to the community," she said. "Adequate vacancies are available."

Residents would be given the option of moving to Beaconsfield in Mitchell's Plain, Zainetta in Pinelands or Els Home in Khayelitsha.

The patients would receive the same care as they had been given at New Kings, Follentine said.

About 60 residents could not be cared for at these centres as they had special needs. The department was negotiating a contract with Life Care, the company that ran New Kings, to make provision for these patients, Follentine said.

Provincial budget cuts had made the closure of New Kings necessary, "All departments are obliged to effect savings to address shortfalls in the provincial budget," she said.

We had to take a tough decision on the future of the contract (with Life Care) when we determined our 1998/99 budget."

State contract to be phased out

New Kings is managed by Life Care Special Health Services, a private company, under a contract with the Department of Social Services that is to be phased out by the end of June. Most residents are eligible for social security, but do not receive state pensions, as the New Kings has been identified as a situation where the department could effect a saving.

"We had to take a tough decision on the future of the contract (with Life Care) when we determined our 1998/99 budget."

The New Kings Complex is managed by Life Care Special Health Services, a private company, under a contract with the Department of Social Services that is to be phased out by the end of June. Most residents are eligible for social security, but do not receive state pensions, as the New Kings has been identified as a situation where the department could effect a saving.

"We had to take a tough decision on the future of the contract (with Life Care) when we determined our 1998/99 budget."

Frightened: Beverly Greenwood used to surf before her illness, now she takes comfort from living next to the sea. She is not sure what will happen when the New Kings frail care centre closes.

Picture: GARTH BUSCH

There are 144 registered state-subsidised frail care facilities and 38 registered private facilities in the Western Cape that take care of people with conditions similar to those at New Kings.

"We understand it is a rationalisation process and the department has to scale down and make use of other under-utilised facilities," said a staff writer.
It's sink or swim for provincial hospitals after belt-

By Priscilla Singh
Health Reporter

The past three months have been a case of sink or swim for provincial hospitals throughout the country after superintendents were forced to implement drastic cost-saving measures to reduce overspending.

The new system of block grants to provinces, introduced last year, leaves health financing to the discretion of provincial governments, including allocation of budgets.

The Government will no longer bail provincial health departments out of financial crises, as in the past.

The total budget allocated to provincial health departments was R18.9-billion for the 1997/1998 financial year; an increase equivalent to 4.25%.

There has been huge overspending by hospitals whose budgets must cater for increased demand from the public and for renovations and upgrading of hospital services.

So serious is the financial crisis that the ability of the public health system to achieve its objective of a just, fair and equitable health system may be compromised.

The Gauteng Health Department (GHD) has looked at cutting the overspending of hospitals by stopping certain expenditures and considering savings from the health facility development and maintenance fund.

Dr Kamy Chetty, deputy director-general of health administration in the health department, said his department looked at what projects were urgent and what could be delayed or phased in at a later stage. The same was done for equipment and repairs.

The GHD is looking at an overall R640-million deficit in its budget for 1998. It is also trying to reduce it by at least R200-million through cost-saving measures.

Hospitals have been advised to stop sending people to local symposiums and seminars, to reduce expenditure on transport, to reduce telephone costs, and to examine the purchases of stores, waste of food supplies and drugs, and duplicate tests at laboratories.

"This does not decrease patient care. We are continuing with service delivery while maximising resources," Chetty said.

Other areas in which hospitals can save, especially the "big four" - Johannesburg, Chris Hani Baragwanath, Ga-Rankuwa and Pretoria Academic, who are well over their budgets - are on stationery, hospital services and through surgical thriftiness.

Chetty said the department was looking at a leasing system for ambulances and a reduction in the use of nurse agencies.

"The impression given that there is a crisis at hospitals is not true. We have spoken to academics and physicians and there is a constant review of whether this is the best use of public money," Chetty said.

Johannesburg Hospital received R480-million and has overspent by R151-million. The department hopes to reduce this to R106-million.

Chris Hani Baragwanath received R340-million and at the end of March will be overspent by R152-million. The department will try to reduce this amount to R118-million.

Doctors who are members of the Hospital Personnel Trade Union (Hospersa) discussed the possibility of industrial action at a meeting this week in protest at the GHD's unilateral decision to cut doctors' overtime pay by as much as 50%.

This "would demoralise the already overworked and underpaid doctors" and "severely hamper the after-hours emergency services".

Last week the GHD defended its decision to rationalise overtime for doctors from February 1 and said it took exception to any threat by medical practitioners to walk out on the service.

Under the new system many doctors working at major hospitals will have overtime restricted and will have to work at some of the province's smaller, regional hospitals to supplement their monthly packages.

In practice this means that Johannesburg Hospital, where 40 doctors were being paid a total of 6 296 hours a week, will be reduced to having a maximum of 186 doctors being allowed a maximum of 16 hours a week overtime.

Doctors at the King Edward VIII Hospital in Kwazulu Natal have also threatened to leave because of the new overtime constraints, and to explore overseas options or, the Government's worst fear - private practice.

"The GHD has been given a virtual fork to choose, but the Department of Health has not made the decision," Chetty said in response to the industrial action threat. "The situation is not as bad as it seems. The GHD has been given an ultimatum, but it has not been able to reach a compromise.

"The recent moves by the department to cut doctors' overtime have been in response to the crisis in the health system."
Councils plan to create 911 service

Slow response, attitude of ambulance workers leads to public outcry

By Vida Li Sak

Vagrant Selina Mokgalema was lying on a Selby, Johannesburg, pavement convulsing and foaming at the mouth for nearly five hours this week, waiting for an ambulance to take her to hospital.

Workers from nearby offices called the emergency ambulance number, but after several fruitless attempts, discovered that if they had dialed the ambulance dispatchers directly they would have been able to get help quicker.

A worker at the Ambulance Control Centre said callers for non-emergency situations, like Mokgalema’s, can wait for up to an hour before an ambulance is sent out. He said because the 999 is a tollfree number, they often have a problem with children playing on the phone, and people who try that number could often find it engaged.

The staff at Elpar Distributors called from 7:30am but it was not until shortly after midday that an ambulance arrived to assist a very dehydrated Mokgalema who had had a fit and was taken to Johannesburg General Hospital where she is in a stable condition.

“My colleague tried the 999 number without much success. The woman who answered was very rude and told him that because it was not an emergency we just had to wait until an ambulance became available. I phoned the police emergency number and they gave me the direct number for the ambulance dispatchers,” said Theresa Aban.

Aban was told an ambulance had been sent out from Turffontein, but the vehicle was involved in an accident on the way to the scene and that they’d have to wait a bit longer.

“The slow response the public who call 999 get create problems because the people at the Ambulance Control Centre are often not trained on how to deal with members of the public,” said an ambulance sent from Roosevelt. He added that they only received the call after 12 noon.

Deputy Chief of Operations for the Johannesburg ambulance and fire services, Brian Hogan, said staff shortages and mechanical problems to about 30-40% of the emergency vehicles used, make a quicker response difficult, and that the accident to the ambulance sent out to Selby compounded the problem.

He said emergency staff are trained to exercise tact when dealing with the public, but that complaints should be lodged in writing before any disciplinary action could be taken.

The Johannesburg metropolitan council are currently co-ordinating preliminary plans to amalgamate the disaster management services of the 11 different councils into a “911” type service within the next few years.
Will ask for private sponsors

List for hospitals

Maries has shopping
R4-m upgrading to hospital shortly before its shutdown

Pretoria Correspondent

The auditor-general is investigating why the Gauteng Health Department requested upgrades worth more than R4-million to Andrew McColm Hospital shortly before it was shut down.

Upgradings included a new R3.8-million boiler room, renovations worth more than R120,000 to the kitchen, and a new telephone system installation worth an unconfirmed amount of R130,000.

While academic and regional hospitals in Pretoria battle to ward off a financial crisis and looming budget cuts for the next financial year, placing added pressure on crisis care, the newly built boiler room at Andrew McColm stands mothballed until the fate of the empty, 169-bed hospital has been decided.

The Pretoria News was informed that the office of the auditor-general had been summoned to investigate particular aspects of Andrew McColm's closure and repairs during a routine performance audit at the Gauteng Department of Transport and Public Works, which acted on instructions from the Gauteng Health Department.

The Pretoria News was told by an official source, who preferred to remain anonymous, that once the information was gathered from last week's audit, officials from the Gauteng Health Department would be confronted if it were deemed necessary.
CAPE TIMES
MONDAY, JANUARY 26, 1998

R4m spent on state hospital before closure

OWN CORRESPONDENT

PRETORIA: The Auditor General is investigating why the Gauteng Health Department requested upgrades worth more than R4 million to the Andrew McCollm Hospital shortly before it was shut down.

Upgrades included a new R3.8m boiler room, renovations worth more than R120,000 to the kitchen, and a new telephone system instalation worth an unconfirmed amount of R130,000.

While academic and regional hospitals in the city battle to ward off a financial crisis, the newly built boiler room at Andrew McCollm stands mothballed until the fate of the empty 169-bed hospital has been decided.

The Cape Times was informed that the Office of the Auditor General had been summoned to investigate particular aspects of Andrew McCollm’s closure and repairs during a routine performance audit at the Gauteng Department of Transport and Public Works, who acted on instructions from the Health Department.

The information comes from an official who preferred to remain anonymous.

In October 1996 Health MEC Mr Amos Masando announced that the hospital would be closed. His decision followed recommendations of the department’s structural transformation process aimed at redistributing health services.

Construction on the new boiler room started in January 1995.

The Public Works Department, responsible for overseeing the upgrades, said they were never informed of any considerations to close the hospital.

Public Works officials, none of whom wanted to be named, said they learnt through the media that the hospital was to close. They were only later informed in a meeting where it was decided to go ahead with the construction. Cancelling the contract would have been more costly.

Ex-hospital staff, who also did not want to be named, said finalising touches to the boiler room were not completed until July 1997 when the last few patients at the hospital were still being discharged.

Health Department officials, ex-hospital staff and Public Works officials blamed poor forward planning and a lack of co-ordination.

One of the previous staff members said: "In retrospect it was bad planning to close the hospital. It seems illogical, but Public Works cannot be blamed for a political decision made by Health.”

She said the boiler had cost the department R3.8m and that it had added to the market value of the unused premises.

The Gauteng Department of Health is expected to overspend its budget by R450m this financial year, ending in March.
Fate of New Kings patients in balance
Kalk Bay aims at restoration

PETER GOosen
Metro Reporter

The decision to close the New Kings frail-care facility and residence in Kalk Bay, home to about 200 disabled people, has come as a shock to residents who know no other home.

"The New Kings, which is run on behalf of the Western Cape Department of Social Services by private contractors, Johannesburg-based Life Care Special Health Services, is to be phased out by the end of June, a casualty of provincial budget cuts."

The New Kings and the next-door Majestic house 200 mentally and physically disabled residents, who, says Social Services, will be transferred to other frail-care centres where there are vacancies.

The department has said it can no longer afford the New Kings contract and believes that it could rehouse residents satisfactorily.

However, an alternative will have to be found for at least 60 patients, those with the most severe disabilities.

The closure of the New Kings will mean that a large area of the False Bay seafront is likely to be available for restoration.

"The fact that these people are to be moved is tragic, but at the same time it's a tremendous opportunity to take another look at this area, which needs upgrading," said chairman of the Kalk Bay Development Steering Committee Neville Riley.

"The buildings are basically sound and they could be restored to their former glory."

Both the New Kings and Majestic, built on Main Road, Kalk Bay, early this century, were formerly hotels. The Majestic, in its heyday, was considered the coastal alternative to the Mount Nelson.

Although a number of schemes to redevelop the New Kings and the surrounding area had been put forward over the past few years, there never had been a formal application, said Mr Riley, who is also chairman of the South Peninsula's urban and environmental planning committee.

Louis Moolman, managing director of Life Care, which owns the New Kings, said the company's only concern at present was the welfare of its patients.

The New Kings was home to about 200 people and by the end of May only 60 would remain. It was up to the department to arrange frail-care accommodation for the remaining patients, but Life Care still might be given responsibility for them, somewhere else.

It would be uneconomic to keep New Kings open for only 60 patients.

Dr Moolman said he had had a number of approaches from developers, but until satisfactory arrangements had been made for all the patients at New Kings, the company would not consider any other use for the buildings.
Mari's on a mission, every patient a VIP.

INSIDE STORY

Plans a big clean-up

Very health minister
Health dept to make changes at Helen Joseph

By Abdul Milazi

The Gauteng department of health is to implement wide-sweeping changes at the Helen Joseph Hospital in Hurst Hill, Johannesburg, to address the conflict between management and workers over the restructuring of the hospital.

This follows the completion of an investigation by the department of corporate services (DCS) into the conflict. The findings confirmed workers' concern that hospital management was not changing with the times.

The DCS found that "there was a notable lack of a managed programme of change driven by the head office at the institution". It also found that there was an absence of a shared organisational culture at the hospital.

The report said the Helen Joseph Hospital was "in dire need of effective leadership" and that, with the exception of the head of nursing, all top positions were vacant.

In a statement director of health promotion and communications Ms Jo-Ann Collinge said the report also found the present allocation of responsibility for the various levels of management was "too centrally managed".

The investigation team recommended an alternative role for the head office: that of building capacity in the various levels of management at institutional level.

"It is also recommended that, as soon as the required level of competency is obtained in the institution - the head of the health department delegates the authority to initiate, conduct and authorise the disciplinary process to the heads of the respective institutions," said Collinge.

In the meantime Coronation Hospital superintendent Dr Arthur Manning will also act as superintendent at Helen Joseph, while department of health assistant director Boitumelo Matsose has been appointed the hospital's new secretary.

Members of the National Education, Health and Allied Workers Union (Nehawu) will face disciplinary action for allegedly forcibly removing administrative staff during a strike on November 17 last year.

An administrative staff member will also face disciplinary action for calling her son who works as a traffic officer to "rough up" Nehawu members on the same day.

The health department will also discipline a senior Nehawu member who allegedly assaulted a member of the hospital administrative staff.

Workers who took part in the strike also face disciplinary action.
Hospital set to take knife to surgery list as cash crisis bites

Ops at Groote Schuur delayed

JENNY DVALI
Health Reporter

Cash-strapped Groote Schuur Hospital is to delay all non-urgent procedures and operations until April in a bid to manage its financial crisis.

Chief medical superintendent Peter Mitchell said the hospital had to reduce spending by R10-million to R15-million to meet its budget for this financial year.

But Tygerberg Hospital is not facing a similar crisis, says chief superintendent Abul Rahmann.

"We are not in the same position as Groote Schuur. They did not plan properly and carried on as though it was business as usual."

Dr Mitchell said Groote Schuur hospital was allocated R689-million for the 1997/98 financial year, but in November was told spending had been capped at R545-million.

"The hospital has been forced to take stringent and urgent action to manage the financial crisis - and management is working closely with the clinical staff to try to minimise the impact of any measures on our patients," he said.

The hospital also plans to consolidate hospital beds into fewer wards to make the best use of diminished staff, and to refer patients to regional hospitals and community clinics.

"We ask that our patients and the public understand the problems facing us and other hospitals.

"We are undergoing major changes in funding and organisation. We regret that our measures are going to affect many individuals, and we ask for patience."

Non-urgent procedures like hernia and heart valve replacements could safely wait a few months, said Dr Mitchell. Tests leading to such procedures were also costly and the hospital could save money on items such as blood, valves, x-ray film and syringes. "To meet the needs of all our patients we are projected to overspend in these areas and have been informed that no extra funds will be available to us. We're also intensifying efforts to reduce other expenses such as telephone calls, water and electricity. Vigorous action will be taken to combat theft, losses and wastage."

Funds for the next financial year had not been finalised yet, so it was not possible to say whether the situation would improve, Dr Mitchell said.

At Tygerberg, Dr Rahmann said spending had been carefully planned.

"We have put controls on expenditure and planned consistently. So while we have reduced the number of 'cold case' procedures we do over the year, we are not in the same position as Groote Schuur."

Red Cross Children's Hospital was operating as usual, said a spokesman.

All provincial hospitals are experiencing staff shortages because of reduced funding, the abolition and freezing of posts and the number of staff taking severance packages.
Crowded patients on makeshift beds may not be a new sight at the Johannesburg Hospital, but if the trend continues, damage to the overtaxed hospitals systems may be irreversible, disillusioned doctors have warned.

Frustration finally drove Dr David Brittain, a senior registrar in the medical admissions ward, to telephone The Star this week. "We're absolutely swamped," he says, walking us through the ward where up to eight people were crammed into an area meant for four beds.

"If we don't have the beds we can't examine people, and you can't get an accurate diagnosis by examining someone who is sitting upright."

"And in addition, how can you tell a 70-year-old man and his anxious family members that he is going to have to spend the night in a chair?" asked Brittain.

Because the beds, and sometimes stretchers, were placed just wherever there was space, the overhead curtains became redundant and it was almost impossible to examine a patient in privacy.

A person who had had a heart attack earlier in the day was in one of the ward's few high-care bed - although Brittain felt she would probably have received better treatment in the intensive care unit, because it had a better staff-patient ratio and nurses who were more qualified.

After the doctors left for the night - if they left - there would be one qualified nursing sister and two nursing assistants on duty. If a patient needed to be resuscitated all three staffers would be needed to revive him or her, which meant the ward came to a halt.

Brittain explained that, in a perfect world, the ward should be filled with a new set of sick people every day: it had not been built to handle them on an in-patient basis. The hospital only had one functioning CAT-scan machine - which forced patients to wait and caused a bottleneck in the system.

"We often let patients go home early and, while they are not 100%, they can always come back to the out-patient clinic."

"It's the best and the safest thing we can do to make space for people who really need the beds."

"And these, our constant friends," says Brittain pointing to the cockroaches scurrying about the doctor's resting area.

Hospital superintendent Dr Trevor Frankish refused to comment about the situation other than to say he felt the cockroaches comment was frivolous considering the seriousness of the hospital's predicament.

"Overcrowding - and the consequent less-than-satisfactory patient care - should not be trivialised," Frankish said.
Patients at private hospitals may be forced to pay more

JOHANNESBURG: Patients could be forced to pay extra for treatment in some private hospitals after these institutions take up the option to charge from next week 9% more than the tariff recommended by medical aids.

The Hospital Association of South Africa (Hasa), which represents more than 90% of all private hospitals, yesterday disputed the accuracy of the 8% Representative Association of Medical Schemes (Rams) increase, which takes effect on February 1.

Hasa director Mr. Dick Williamson said the 8% increase announced by Rams was a 2.5% decrease, if the reduction on other services was taken into account.

Dr. Anette van der Merwe, executive director of Hasa, said: "The Rams tariff adjustment has been totally inadequate for the last five years and our members are no longer able to absorb the increasing costs. The change to daily tariffs, drug mark-ups and maternity and psychiatric wards reductions, will result in a significant decline in real income to Hasa members."

Williamson also pointed out that the recommended Hasa tariff was a guideline to its members and completely voluntary.

"We received permission from the Competition Board to publish our own medical tariffs, something the Medical Association as well as the Dental Association, among others, have done for many years."

Van der Merwe said she believed the Hasa tariff accurately reflected the increases in costs and rising inflation and would ensure that private hospitals were able to provide quality care and specialized service.

Hasa director Mr. Rob Speedie said the future of private health care would rely on split billing. The larger portion would be payable by the scheme and the balance by the patient.

Speedie said most hospitals were expected to stick to the Rams increase of 8%, but hospitals and clinics in affluent suburbs would charge more to "enable the hospitals to provide the frills."

A Competition Board ruling bars Rams and Hasa from negotiating the tariff issue as it would be construed as collusion.

Rams represents over six million beneficiaries, with Rams-affiliated schemes paying about 90% of hospital payments.

Hasa last month denied a Rams prediction that price hikes at private clinics and hospitals would be between 15% and 25%.

-Owen Correspondent
Claims of racism in Brits’ emergency service verified

By Mike Masipa

The SA Human Rights Commission has sought a meeting with the North West department of health and welfare after finding this week that allegations of racism at the Brits fire and ambulance service were true.

Commissioners Panzy Tlakula, Jody Kolapo and Nalini Bagrath paid a surprise visit to the Brits fire and ambulance service on Wednesday after black ambulance and fire brigade workers had complained to the SAHRC late last year about working conditions and racism.

Tlakula said black workers told her that they had to use separate facilities from those used by their white counterparts.

“The service is divided into two groups, one made of the ambulance and firemen and the other made exclusively of ambulance men. The former is made of 24 white men and only one black, while the ambulance men are all black,” Tlakula said.

Black workers alleged they were not given the opportunity to attend training courses.

Tlakula said there were even separate signals sent out to different emergency workers to attend to an emergency.

“We were touring the fire services premises with two management officials, a Mr Booyens and a Mr Van der Walt, a bell went off three times and Booyens said ‘That must be for a black patient,’” Tlakula added.

She said she had established from representatives of the South African Medical Workers’ Union (Samwu) that when the bell rang twice it was for white ambulance workers to attend, and meant the patient was white as well.

Tlakula said the head of the fire and ambulance service in Brits, Gert Malan, denied the allegations and said the different bell tones were to distinguish emergency calls from non-emergency ones.

Samwu said they had been trying to resolve the issue with the Brits Town Council for the past three years, but to no avail.

“We intend having discussions with the Brits Town Council and the North West department of health and social welfare within the next two weeks with a view to charting a way ahead that would see these problems being effectively addressed,” Tlakula said.
Hospital staff hit by payment bungles

PORT ELIZABETH — Port Elizabeth medical interns and other newly appointed hospital staff were the latest victims of Bisho payment bungles when the Eastern Cape health department failed to pay their salaries this month.

The 60 junior doctors, pharmacists and medical officers — most of them from Livingstone Hospital — will now be paid only on Friday.

This is the third big payment crisis to hit the Eastern Cape government this month, and comes days after the Welfare and Education MECs were sacked because of poor performance.

The regional health department said there was a delay in new staff receiving their SA Medical and Dental Council registration forms. This resulted in their names being omitted from the January payroll.

Officials stressed that the problem was an administrative one and not due to lack of funds.

Doctors and pharmacists were not happy but accepted the explanation, a spokesman said. — Sapa.
Health chiefs blame each other

WHOO 2048 (86)

[Image of health chiefs]
Death prompts promises

How Alf Thomas was left to die

TRAGIC TALE: Last Friday the Cape Times featured a report about the death of Alf Thomas, after a wait of more than 11 hours for an operation. Groote Schuur said that there were no operating theatres available.

"There is a light at the end of the tunnel for health care in the Western Cape. We have decided to work out the budget over three years, which means we can spread the R250-million shortfall over that time. This is where we will get the money to unfreeze hospital posts."

Marais' predecessor, Mr Ebrahim Rasool, now ANC spokesperson on health in the provincial legislature, agreed that the provincial health service was well positioned to improve.

He said that as Health MEC he had "led the fight for a better budget for health in the Western Cape."

"My successor, as a result, has the best budget (R2,7bn) that this province has ever had for health. Alfie Thomas will not be brought back to life, but the system can save other victims."
**Privatisation creeps up on public hospitals**

Wits and UCT medical schools go shopping for private patients

Wits and UCT medical schools are in the market to buy private hospitals which they want to convert into academic teaching centres funded by private patients, not the State.

The move is a desperate attempt to save academic medicine in SA which has been bled dry in recent years by severe budget cuts, a mass exodus of top specialists and a steady decline in private fee-paying patients (see graph).

It is also part of a larger market-driven push for co-operation between private and public hospitals.

Plans are advanced for Wits Medical School to add a private hospital to the five public hospitals in the Wits academic circuit. Wits medical staff and students will rotate through all six hospitals, except that patients attending the new private hospital will pay higher fees.

This will enable Wits to practice sophisticated medicine in a model teaching environment and raise revenue for the academic hospital sector.

“We’ve lost quite a number of senior academic hospital staff recently because of the uncompetitive public-sector salaries and because they are disillusioned about the future of academic medicine in SA,” says Wits Medical School dean Prof Max Price. “If we can show them that we are creating a satisfactory environment for teaching and research, I think they’ll stay.”

UCT Medical School is also searching for ways to protect its valuable teaching and research base “We are pursuing a wide range of options with a view to forming significant partnerships which could include the provision of a private hospital or the rental of unoccupied facilities in Groote Schuur,” says UCT Medical School dean, Prof J P van Niekerk.

He would not be drawn on the possibility of Groote Schuur being sold to a national private hospital group to be sectionalsised into private and public wards, but did confirm that exploratory talks had occurred.

Wits will receive submissions from six private hospital groups soon and has formed a private company, the Wits Health Consortium, to handle commercial transactions arising from the tender.

It may buy one or even two private hospitals and contract a private hospital group to manage it, or it may enter into a joint venture with a private hospital group to convert one of their existing hospitals into an academic hospital.

Price hopes to have the new hospital operational by the end of the year. He says Wits has not sought permission from government because it is an autonomous institution, but stresses that the scheme will not disadvantage the public hospital sector or cost the State money. “In fact, the State will gain from the retention of expertise that is flowing out of the system.”

The Health Department was unable to comment at the time of going to press.

The hospital will not compete with luxury private hospitals but will target the 6.9m blue collar workers, including their beneficiaries, who don’t have medical aid but would be able to afford basic hospital care if hospital fees were undercut.

Health Department, medical insurers and private hospital groups are working feverishly to develop low-cost hospital insurance products to cater for this huge untapped market (Current Affairs October 31 1997).

But to make it work they need cheaper, no-frills hospitals. Hence the move by private doctor groups in conjunction with large low-income medical aids to lease empty wings of public hospitals where overheads are minimal.

At the very least, Wits, UCT and Stellenbosch medical schools are all seeking to lease and upgrade empty wards in their respective academic hospitals for private patients.

It will be hard for government to refuse their requests, given the concept’s success at Uitenhage Provincial Hospital where it netted R24m for the province in its first year.

The patients are mostly Volkswagen factory workers who pay 30% more than the standard fee, which is still less than that charged by private hospitals.

Three provincial delegations are due to visit Uitenhage this year to see how to implement the project and private doctor groups are imitating it in Port Elizabeth, Nelspruit, Kempton Park and Mafikeng.

At last the tightly regulated public hospital environment is loosening up, public hospitals are being given greater management autonomy and more services are being contracted out.

Industry players say private hospitals will ultimately run public hospitals on management contracts.

“We are breaking new ground and old mindsets are changing,” says Netcare National Hospital Network CEO Dr Peter Botha. “I expect big changes in the next three to four years. Private hospitals will start to assist in managing public hospitals to improve their efficiency.”

Claire Boucher
Cause of death: staff shortages

Wonder Hlongwa

Thandeka Shabalala (16) lies on a stretcher at King Edward VIII Hospital in Durban, with a heavy brown blanket thrown over her body despite the heat.

She has travelled all the way from Pietermaritzburg. She is one of hundreds of patients who come for treatment at King Edward and instead either sleep on stretchers for a couple of nights or leave untreated.

The hospital has severe shortages of nursing staff, general assistants and messengers. But it has to cope with an influx of thousands of patients from different corners of the country's most populated province.

Over the past two years at least 10 people have died at King Edward because of staff shortages.

Senior nurses complain they have only half the staff they need to perform their duties effectively. They are ignoring a call by the government to volunteer an extra two hours a day in an attempt to treat all the people who come seeking help.

Nurses say they already "slave" the entire working day because of the overwhelmingly high nurse-patient ratio.

"Our workers' forum wrote a number of letters to the chief medical superintendent asking for a change in the admission system. We even sent them statistics on daily basis, detailing patients who have spent more than one night but who have not received treatment, and those who died on the stretchers," said a nursing sister.

The outpatients department is the most crowded at King Edward, with more than 500 patients on daily basis. The dispensary has no seats for patients waiting for their medicines. Some lean against the wall, while others wait in passages nearby.

The overcrowding is not only caused by patients with serious ailments who require treatment at a central hospital like King Edward. Hundreds come from the surrounding townships with minor ailments that can be treated in a local clinic. They have their reasons for shunning the clinics.

"My child can't eat, he's got diarrhoea and sores next to his penis. I'm from Umlazi township, we have a clinic nearby but it doesn't have medication," said Pretty-Girl Zulu, mother of seven-month-old Memnyu.

Because of a shortage of hospital porters, patients have to be carried into the hospital by their relatives. And because of the shortage of stretchers and wheelchairs, a patient was seen being brought into the hospital in a supermarket trolley.
Cash is the only

Real Meghan 04/24/98

will take plenty of time and money for the government's health care vision

An Evetott
Cure for Ailing Hospitals

to be realised — and in the meantime people are dying
Marais calls for Conradie facelift

HEALTH WRITER

Mr Peter Marais

Marais has made upgrading the appearances of hospitals one of his primary concerns since taking over his new portfolio.

"It's terrible to be sick when the place is falling apart. How are people supposed to get better when it's dirty and dingy?" he asked.

"On Saturday, February 14, we will work together to make Conradie a better place."

Marais appealed to the public to go to the hospital to help his team cut the lawns, clean up the grounds, paint six of the wards and start building extensions.

Marais said he had had a fantastic response to appeals to the private sector for donations in return for publicity.

"We have been given paint, building equipment, tiling, all sorts of things. And it won't cost the health department a cent."

Anyone who wants to help should phone 483-3158.
Hospital needs resources – DP

EDENVALE Hospital, east of Johannesburg, was being crippled by renovations and understaffing, the Democratic Party said yesterday.

"This hospital has experienced dramatically increased patient loads, rising from 100 patients a day in 1996, to 200 in 1997 and 300 in January this year – a 200 percent increase in two years," Gauteng DP spokesman Mr Jack Bloom said.

He attributed the increase at Edenvale Hospital to the closure of Kempton Park and Hillbrow hospitals.

Bloom accused the Gauteng health department of handling the closure of Hillbrow Hospital poorly as it had failed to ensure that alternative facilities for Hillbrow patients were arranged in good time.

"Furthermore, the transfer of the promised personnel and equipment from Hillbrow to Edenvale has been extremely slow. The Hillbrow nurses that were promised have yet to arrive," he said.

Bloom said there were only six doctors at Edenvale Hospital who had to cope with a vastly increased patient load, which resulted in long queues and exhausting working hours. – Sapa.
Dust-up over cheap vaccine

Marion Edmunds

The government is considering taking disciplinary action against an Eastern Cape public health specialist who last year suspended the use of a cheap Korean hepatitis B vaccine in 14 East London clinics because he doubted its efficacy.

The head of the department of public health at Cecilia Majiwane Hospital, Dr Costa Gazi, said he believed Hepacine B was ineffective and ordered that it no longer be used in 14 clinics under his supervision after a field trial conducted there by the National Institute of Virology in 1986 showed it was ineffective.

The study’s results showed a 44% seroconversion rate, which is alarmingly low for a vaccine. (Seroconversion describes the build-up of antibodies in the bloodstream, activated by a vaccine.)

“I felt I had to take action because I was in charge of the clinics,” said Gazi. “I follow the national immunisation list, but not blindly. I look forward to defending myself from charges if they are laid.”

Hepatitis B is transmitted through sexual contact and blood products, and can be transmitted by pregnant mothers to unborn children. Toddlers can also transmit it to each other. The younger the age at infection, the higher the probability of the infected child becoming a carrier — thus the need for a vaccine for infants younger than one year.

Hepacine B, a generic plasma-derived drug, is favoured by the government because it is considerably cheaper than a competing genetically engineered vaccine, Engerix-B. However, the supply of vaccines is erratic, and the 1995 Hepacine B consignment is said to have cost the government R15-million.

Gazi believes a cheaper vaccine is a waste of resources if it is not effective, and says his stand against the department is on ethical grounds.

The provincial health department sent out letters last month to the 14 clinics, overriding Gazi’s instructions. The department also threatened Gazi with disciplinary action.

The department’s acting permanent secretary, Dr Peter Milligan, said Gazi lacked the authority to act as he did: “It is not appropriate for an individual to suspend the activity of the vaccine. Gazi never drew the department’s attention to the issues, nor said let’s take this up with the national department,” Gazi said he had informed the department of his actions.

Despite strong support for Hepacine B by the South African health authorities, doubts over the vaccine’s effectiveness persist, partly because it is administered in an extremely small dose of 0.5 micrograms.

Published research from a study done in the Solomon Islands in 1986, by a New Zealand expert, Professor Alex Milne, showed that Hepacine B failed dismally there as a vaccine against hepatitis B.

However, World Health Organisation representatives have urged the international community to ignore the Milne study and not to question the use or dosage of the Korean drug, because of its success in countries such as South Africa, Gambia and the Philippines.

The health department referred the Mail & Guardian to a 1985 study by Professor Susnete Aspinall, which showed a 93% success rate in the use of the vaccine on infants in Shoshanguve and North West provinces.

Professor Barry Shoub, the director of the National Institute of Virology, this week cited the Aspinall success story, and cast doubt on his institute’s own 1996 research, saying the results were probably misleading and the researchers who compiled them “inexperienced”.

Controversy over the 1996 results has led to further, more rigorous research, whose results are to be published later this year.
Hospital deliveries stopped after suppliers' bills unpaid

PORT ELIZABETH — A shortage of government funds, in the wake of the Eastern Cape pension crisis, had affected health services in the province, Health MEC Trudie Thomas said.

Thomas called on government to transfer funds to her department before a crisis set in. She said deliveries to some Eastern Cape hospitals had been stopped because central government had not released money to pay their bills.

Several hospitals in the province have been without food, basic groceries, equipment and services because suppliers' bills have not been paid by the provincial government in Bisho.

She said the shortage of funds meant her department was unable to pay some of its hospital suppliers, and some suppliers had stopped deliveries until they received payment.

Thomas said that mainly small-town hospitals were affected.

The delivery of bread and basic groceries to the Steynsburg hospital stopped at the beginning of the week. There were also shortages of medical supplies.

Fort Beaufort hospitals lacked x-ray plates and other supplies, while several hospitals had complained of a shortage of staff because new personnel could not be paid.

Thomas said most hospitals had needs that could not be met at one time or another, but the department was trying to "fill the gaps" where the need was greatest.

"We identify the greatest problems and then try to pay those bills first, but obviously we can not do much at the moment. The transfer of money from central government to our province will be a great relief," she said. — Sapa.
Partnership between doctors, hospitals may become a reality

PUBLIC and private partnerships which could help bail out underfunded public hospitals and encourage doctors to practise "ubuntu"—humaneness—could become a national reality if one Eastern Cape hospital sets a trend.

Tim Wilson, the national health department's chief director of facility planning and hospital management, said the department was looking into the possibility of private practitioners using unused wards in public hospitals in exchange for making capital improvements.

Public and private sector health experts said the arrangement would inject cash into embattled public health services and, at the same time, allow private doctors to tap into public facilities' infrastructure, equipment and client base.

The model was the Uitenhage Provincial Hospital, where a group of general practitioners had formed the Uitenhage Independent Practitioners' Association.

About 60 doctors consult and treat patients for general ailments off hospital premises, but use a ward when hospitalisation is necessary.

Siva Pillay, association founder and chairman, said the association's doctors did not reap big profits compared with those running a nearby private clinic, but that their sense of ubuntu had led them into the venture.

The doctors do not pay rent to government, nor do they pay for capital improvements or hold shares in the association. Instead, the venture helps the hospital generate income by charging 30% more than the "ridiculously low" public tariff—but still only two thirds what the private sector charges—and putting the difference into a reconstruction and development fund to upgrade district health facilities.

Pillay said about R1m had been used so far to upgrade the hospital and nearby clinics and implement health education programmes such as AIDS awareness.

Eastern Cape health MEC Trudy Thomas said: "It is a model we are exploring which seems to be useful for both sides. In some of our areas, we do have extra space, and we are looking at expanding (this arrangement) into other, bigger hospitals."
R1,5-million raised after province runs out of money

Children's Hospital on road to recovery

ART 3.19.98

CHAPEL TUESDAY, FEBRUARY 12, 1998
Wits medical students move to private care

Public hospital teaching stays, but can’t cover all needs anymore, says dean

BY JANINE SONNICH
Medical Correspondent

Wits medical school plans to end uncertainty and guarantee staff their future in academic medicine by opening up academic beds in private hospitals before the end of the year, breaking a tradition of teaching only at public hospitals.

University staff and students will remain based in the five academic hospitals in the city, but will also spend a limited amount of time working with private patients in one or more outside academic units.

Teaching currently happens at Johannesburg Hospital, Chris Hani Baragwanath, Helen Joseph, Coronation Hospital and Tara.

The move, which has been under discussion for some time, is likely to ease the remuneration uncertainty among doctors working in academic hospitals.

But, says the dean, Professor Max Price, it should benefit all parties.

The private facilities will be used for the teaching of specialist and sub-specialist staff and will make up between 10% and 15% of the university’s total 4 500 teaching beds.

Price said the plan is seen as a means for the health faculty to take control of its own destiny and hedge its bets against the continuing uncertainties and overcrowding in the state sector.

State hospitals were being overwhelmed by trauma cases, and there was not enough elective surgery, such as gall bladder surgery, for postgraduate students to be trained in those procedures.

Students were already being sent to the private sector for training in general practice, magnetic resonance imaging scans and some orthopaedics.

According to Price, medical staff will be guaranteed equitable incomes, and students will be able to access training on specialised equipment and executive surgery now under pressure in the state sector; state patients will benefit because top academics will remain in the system and private patients will now also be able to access their expertise at a fair rate.

Gauteng Health Department director of policy and planning Dr Ahmed Vali said Wits had been discussing the concept of accessing paying patients by opening a private ward in Johannesburg Hospital for the past two years.

Its proposal is being adjudicated and a decision should be made by the end of March.

Wits started new discussions with private hospital groups over a plan to open one or more units in the private sector in December last year.

They were precipitated by a string of problems within the public health system, Price said.

The Government had been vacillating for two years over the issues of overtime pay, limited private practice for academic staff and downsizing of tertiary hospitals, and there was a real need to end the uncertainty.

Overtime pay made up 30% of staff income, and many academics would desert the state if they could no longer work in an acceptable overtime system.

Doctors were allowed to earn extra income by spending 11 hours a week doing limited private practice, but while this kept them in the system, it diverted their energies away from teaching, Price said.

He stressed that the move was also a way for the university to create a teaching environment in which it could control overcrowding and patient mix.

The university hopes to have a proposal regarding private academic beds on the table by April.

A decision should be taken by the faculty board at its meeting in May, Price said.

It is not yet clear whether the plan would involve individual wards in several state hospitals, private wards in state hospitals, or even an entire quasi-public hospital, where profits generated would be ploughed back into the university.
Male Docs in Dresses
Budget Crisis Leaves

The real thing is that male docs, despite their initial
opposition to their own T-shirts, which
A doctor said some specialists were
operating in their own T-shirts, which
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"The problem so far is that male docs, despite their initial
opposition to their own T-shirts, which
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operate in those T-shirts, which is just very difficult to
be operated in. Some doctors are saying, "This is just very difficult to
be operated in.""
Food shortage hits schools and hospitals

Non-payment discourages food suppliers and some schools go without toilet paper

Special Investigation
By Khathu Mamalia

State hospitals and colleges in the Northern Province are facing severe food shortages because suppliers have not been paid.

And at some schools the situation is so serious that there are not enough funds to supply toilet paper.

Sowetan has learnt that at hospitals things are still critical that nurses have told patients' families that they should bring food for their relatives in hospitals.

Colleges and schools with boarding facilities are also facing critical shortages of food throughout the province. Most suppliers have suspended supplying food and other material such as toilet paper because they have not been paid for several months.

Education spokesman Mr Bernard Matsane confirmed that the department owed suppliers R1.9 million.

Hospitals affected by the shortage of food include Groothoek, St Rita's, Maphutha Matatji, Letaba, Siloam, Thulidzini and Donald Fraser.

Health and welfare department spokesman Mr Tshepo Moshima confirmed that some of the hospitals, especially those in rural areas, were experiencing food shortages. He said the problem was particularly serious between December last year and January this year. He said the matter was receiving attention and in most areas it had been resolved.

A worker at Maphutha Matatji in Namaqua, near Phalaborwa, said yesterday that the supply of bread had been suspended more than three months ago.

He said the last delivery of milk was more than six months ago. He said fruit had become a luxury that could not be afforded for patients.

A patient at Groothoek said patients were offered soft porridge without sugar. He said sometimes they were offered bread as the main meal because there was no mealie meal.

A patient at Siloam said about two weeks ago he was given porridge and an apple as there was no meal.

A shop steward of the National Education Health and Allied Workers Union (Nehawu) at Siloam Hospital, Mr Mbulaheni Mukhathedzwa, said that the hospital was experiencing food shortages because of poor management.

"I do not think that money is the root of the problem. The problem lies with the officials who are loyal to the old order and their agenda is to see the present Government fail."

"We have discovered cases where a supplier was paid R50 for a chicken and R76,000 for 16 carcasses of beef.

"The hospital is paying R56,000 for four small van loads of vegetables," said Mukhathedzwa.

Peanut butter and margarine

An official at Donald Fraser said the hospital had had to change the suppliers who stopped supplying food because they were not being paid.

She said the supply of peanut butter and margarine had been stopped. Since last month patients were forced to eat bread without peanut butter or margarine.

Moshima urged those who had information about corruption to come forward.

Meanwhile, Democratic Party health spokesperson Ms Ann Kirkpatrick said yesterday that her organisation had received a damning report about the services in state hospitals in the province.

She said there was widespread theft and mismanagement. Kirkpatrick said in many cases suppliers had stopped supplying food because they had not been paid.

She also said there was a shortage of linen. Some of the hospitals could be closed because of lack of funding.
Alarming as deadly dysentery strikes nursing homes

MICHAEL SCHMIDT
ST 28/2/98

MEDICAL authorities in KwaZulu Natal are on the alert after an outbreak of a virulent strain of dysentery killed 11 elderly people at two nursing homes recently.

Environmental health officers have not yet determined how the disease entered the Sunnyside Park Home in Maritzburg, where nine people died, but believe it may have been carried from an outlying rural area by an employee who fell ill on February 5, suffering from diarrhoea and vomiting.

He survived, but four days later an elderly resident was admitted to the casualty department of Grey’s Hospital. She died shortly afterwards.

Two elderly people also died from dysentery recently at an unidentified Durban nursing home.

Sunnyside Park Home matron Hillary Mumford said the outbreak had initially appeared to be diarrhoea. But when several patients died last weekend, she called in Maritzburg’s medical health officer, Dr Julie Dyer.

Dyer said environmental health officers tested the kitchens, water supply, drains and perimeter of the institution, but could not identify the source.

"Although it can be waterborne, dysentery is usually transmitted by the fecal-oral route, from hand to mouth."

Provincial laboratories have so far returned only four results: "One sample showed shigella dysenteriae type 1, the more virulent strain, another two showed the less lethal flexner strain, and the fourth strain has not yet been identified," Dyer said.

On Friday, four employees at the Sunnyside Park Home fell ill with what is believed to be shigella. And eight elderly patients are being treated in isolation by nursing staff wearing protective gear.

Shigella was first identified in Durban in 1984, the year the shigella 1 strain killed thousands of people in Zimbabwe and Mozambique.

The epidemic was believed to have erupted during the Rwandan holocaust and brought south by fleeing refugees.

An outbreak occurred at the Aryan Benevolent Home in Durban last year, but no deaths occurred.

Unless it is treated with antibiotics within 72 hours, the shigella pathogen produces a toxin which may enter the bloodstream, causing disorientation, kidney failure and inflammation of the heart or pancreas. Old people, children and the frail are most susceptible to the disease.

Provincial health spokesman Dave McGlew said the authorities recognised that shigella was "a huge problem", but controlling it was difficult because of poor sanitation and hygiene.
Hospitals ban ops after cash runs out

DI CAELERS
Special Writer

State patients needing hip replacement surgery can expect to wait, often bedridden, for as long as six months.

If patients need cataracts removed, the waiting list is about a year, and if they need hernias repaired Groote Schuur Hospital says they could wait forever.

This is the reality of severe budget cuts that have forced Western Cape academic hospitals to suspend all “elective” surgery – operations not regarded as “emergencies” or “urgent” – until the start of the new financial year on April 1.

Groote Schuur stopped elective surgery at the beginning of the month and Tygerberg Hospital on Monday.

But with waiting lists for these operations already extending up to a year or even indefinitely, surgeons have made it clear that come April 1, their problems will be far from over.

John Terblanche, head of surgery at Groote Schuur, said a patient with a fractured jaw might well have to wait – while being given medication for the pain – for up to a week for surgery. Someone admitted on a Saturday with a compound fractured femur might have to wait until the Tuesday for an operation.

The financial situation was so bad that Groote Schuur had considered doing only “life-or-death” operations, but had resisted as it would be “ethically unjustified”, Professor Terblanche said.

Japie du Toit, senior medical superintendent at Tygerberg, said there were waiting lists in all theatre-related areas.

Even though cancer-related surgery was regarded as elective, operations were still being done when a patient could be at risk.

There were waiting lists of up to six months for hip replacement surgery and ophthalmology.

“Our only intention is to save money and this way we’re saving on consumables like drugs, equipment, food, medicines and linen every time we can put off an operation until the new financial year,” said Dr Du Toit.

Both institutions are awaiting possible relief in the form of central government funding for academic hospitals, in recognition of their status as national assets, but Vincent Hlongwane, spokesman for Health Minister Nkosazana Dlamini-Zuma, said this week the matter was still under discussion.

They hoped to have clarity by the end of next month.
Massive burden

Kabir decried what he termed "the massive burden caused by occupational lung diseases, such as pneumoconiosis or silicosis, among former mineworkers and other migrant workers."

These people are retrenched from the mines and return home without any access to medical services.

"This happens regularly despite the fact that the Labour Relations Act stipulates that any kind of damage resulting from any kind of work must be compensated."

Kabir said it was painful to see these people being ignored by their former employers.

"Nursing sister" Mrs Nthapo Panxwala confirmed that their records reflected an average of about 71 tuberculosis patients a month. Of this, 34 were males with serious respiratory problems.

By Dan Fuphe

WHEN Eastern Cape health MEC Dr Trudy Thomas officially opened the R3.1 million Canzibe Hospital recently in the district of Ngqeleni, outside Umtata, she was in a way giving the local community a new lease of life.

"This day is a double celebration," she told the elated crowd. "We are also the proud recipients of a new mobile clinic." The 4×4 mobile clinic, worth R160,000, was donated by Absa.

Guests at the opening of the hospital included government officials, chiefs from the surrounding areas, doctors, teachers, healthcare personnel and excited pupils from nearby schools, accompanied by their parents.

Thomas paid tribute to President Nelson Mandela and the Government and was given a rapturous standing ovation when she declared: "Mandela delivers."

She also stressed the need for closer working partnerships between big business, non-governmental organisations and provincial governments.

Patients waiting to be treated at the outpatients section of the new Canzibe Hospital.

Community leader Mr Mzinto Bungani told Sowetan that the original Canzibe Hospital was founded in 1961 and was initially housed in four separate mud-built rondavels.

"This part of the province was for many years neglected by the former apartheid government," he said. "It is only now during the new dispensation that things are beginning to happen in Ngqeleni."

In the past even cattle used to graze within the then so-called hospital premises. It is the first time that Ngqeleni has attracted so much attention from the government.

Canzibe Hospital spokesman Dr PAG Schroders painted a bleak picture of the hospital during apartheid.

"The outpatients section was outdated - patients sat outside, even on rainy days. We had a prefabricated building, which was also inadequate and uncomfortable to work in," he said.

Other medical staff said certain diseases, such as tuberculosis and malnutrition, which were normally easy to control, were very common because they were not detected in time and therefore became rampant.

"A need was expressed for a mobile clinic, which could take healthcare to the people," said Absa's head of group communications in Eastern Cape, Mr Andy de la Mare.

"What we have achieved is proof that the private and public sectors can work together. Absa can provide the funds but without the staff and expertise of the public sector this project would not have taken off."

Canzibe Hospital is staffed by four doctors: principal medical officer Dr MA Kabir (from Bangladesh), Dr N Bustamante and Drs R Brito (from Cuba) and Dr F Henning.
Closed hospital 'has R75m equipment'

THE Democratic Party (DP) yesterday expressed concern following the disclosure that medical equipment worth R75m was still left at the Hillbrow Hospital two months after its official closure.

DP MPL Jack Bloom said the disclosure was made by health MEC Amos Masondo following a question in the legislature this week.

Bloom said in the case of larger items, the delay was caused in certain instances by the need to obtain Tender Board approval, but other options were being considered with regard to the destination of other items.

"I am appalled at the lack of planning that has led to this situation, whereby such a large amount of equipment still remains at Hillbrow Hospital when it is desperately needed elsewhere." It was inexcusable that the Gauteng health department did not plan well ahead of the closure of the hospital, he said. — Sapa.
How private hospitals doctor your accounts

PRIVATE HOSPITALS and medical supply companies are colluding to add substantial amounts to your medical bills, reports Health Writer JUDITH SOAL.

SECRET agreements between private hospitals and medical equipment suppliers cost patients millions every year. The Cape Times has evidence of large discounts — or mark-ups — which are hidden from medical aids and patients, who are billed for the full amount.

In one example, a hospital charged over R7 000 more than it paid for the components of a top-of-the-range knee prosthesis. Medical aids are prepared to pay hospitals a 10% handling fee for medical equipment, but price lists in the Cape Times possession show mark-ups of 20% that are added before VAT or the 10% allowed mark-up. Patients are charged about 30% more than hospitals pay.

Rather than being fraudulent, these mark-ups form part of business practices labelled by those on the receiving end as "unethical; dubious and purposely wasteful".

The private medical industry was worth R2.5bn in 1997 and estimates of the cost to consumers of this kind of "manipulative" business practice, over-use and fraud is about 20% of this — R500m. Medical aids and the Representative Association of Medical Societies (Rams) say they are investigating the practices.

Mr Gary Taylor, director of medical aid administrators Medscheme, said confidential discounts were common practice. "These arrangements are unethical but not unlawful, and all the big supply companies do it."

"The medical aids set a price that they are prepared to pay and hospitals mark-up on this price. They consider this to be part of smart business practice. This stretches from prostheses to gloves and plasters and bandages — just about everything. It's a lot for their commitment to affordable health care," Taylor said.

The Cape Times has a letter from Smith & Nephew, one of the largest medical supplies companies in South Africa, in which medical director Mr Kelvin Johnson admits sales staff for telling a surgeon about the confidential discounts, so costing the hospital a substantial amount of money because the surgeon informed the medical aid of the discount, who then refused to pay the full price.

Johnson told the Cape Times that this was business as usual. "Hospitals are entitled to charge whatever they like for goods, and trading terms are confidential in all businesses, so there is nothing unusual."

He said hospitals received further yearly rebates if they purchased more than a specified quantity from a company in one year. But Professor John Walters, head of orthopaedic surgery at Groote Schuur Hospital, questioned whether these practices were justifiable.

"Is it reasonable for a hospital to add a mark-up of 40-50% or more to the product without paying any value, running any risk or incurring any costs?" he asked.

Walters said this mark-up applies to all items sold or purchased through private hospitals and constituted a "significant portion of their income".

Orthopaedic surgeons at private hospitals, who asked not to be named, said that the only people who benefited from this system were the large hospital groups.

"The patient loses, the medical aid loses, the supplier loses because they have to take a lower price, the surgeon certainly doesn't get anything except his fees for high costs, the profit goes to (the large private medical groups)," said one.

"It's all about the middle man. They get richer while the doctors and the patients get poorer," said a Rams spokesperson.

Dr Edwin Hertzog, chairperson of the Medi-Clinic Corporation, defended the private hospitals' right to make a profit. "If it is wrong to make a business out of ill health, what about companies selling food to hungry people, fluids to thirsty people, clothes to cold people or housing to the homeless?" He asked. "No patient is ever obliged to make use of private hospitals," he added.

To try to reduce the cost of private care, Health Minister Nkosazana Zuma is to introduce legislation to help medical aids verify claims and identify unethical activity. "We are looking at measures aimed at curbing fraud, over-pricing, over-servicing and misconduct in the public and private sector," said her spokesperson Mr Vincent Hlongwane.

HOW IT WORKS

- Medical aids are prepared to pay hospitals a mark-up of 10% on all equipment sold to patients.
- Hospitals reserve discounts from medical supply companies, but don't tell the medical aids about these discounts and add the 10% mark-up on to the higher price that they have not actually paid.
- In this example, for the top-of-the-range replacement knee, the hospital makes a R6 404.45 profit on selling the knee to the patient.
- Medical aids allow surgeons a 5% bonus for performing the operation.
- Hospitals receive this profit although the sales representative of the medical supply company takes the patients' rights to the theatre and gives it to the surgeons.
- Hospitals are billed only after the operation, they do not pay upfront, and if the patient fails to pay, they do not try to recover the money. Hospitals then add 9% VAT and add no value.
- These profits on all equipment used in hospitals, from bandages to gloves to wheelchairs.

Example

(Taken from actual price lists):

Prosthesis (paid by hospital):
- Prosthesis (donor firm, title and partner): R 6 404.45 (Net price)
- 15% VAT: R 964.46
- Total: R 7 368.91

Prosthesis (billed to patient):
- Prosthesis (donor firm, title and partner): R 5 858.91 (wholesale price)
- 9% VAT: R 527.30
- Total: R 6 386.21

50% mark-up for hospital: R 2 442.88 (50% mark-up on the wholesale price)
- 9% VAT: R 320.13
- Total: R 2 762.01

SECRET LETTER EXPOSED

From: Kelvin Johnson

Grosset: Confidentiality of Trading Terms

I have just received an urgent phone call from a Hospital Administrator who is concerned that someone at SANH's office in Cape Town is providing sensitive information about our trading terms and margin to a competitor. We have already taken steps to ensure that our trading terms are maintained confidentially and that no information is disclosed to third parties.

Please remember that Trading Terms remain confidential between customers and SANH and should be disclosed to no one — not even the Doctor.

Many thanks.

KEVIN

NOTICE OF INVESTIGATION

SANH is investigating the allegations made in this letter and will take all necessary steps to ensure that our trading terms are maintained confidentially.

SANH - South Africa's leading supplier of medical equipment and consumables
Please for return of local level control to fire department.

No money, low morale, shortages

Patient dies after ambulance takes an hour to arrive, and firefighters don’t have vehicles.

Alarms ring for emergency services

News 3/99
Doctors decide who may live a little while longer

wards of despair

crisis strangels

cash

Hospitals' cash

Michael Schmidt

March 8, 1999
Grants to provinces will boost hospitals

Health is a government priority, receiving R5.3-billion in 1998/99, rising to R6.1-billion over the next three years, with a new conditional grant mechanism to support professional training, research and central hospitals.

The grants will be transferred to provinces on certain conditions and include sums for the redistribution of specialised health services and allocations for primary school nutrition programmes. R260-million will go to build the Durban Academic Hospital and there will be another allocation for the construction of the Umtata Regional Hospital.

Hospitals will undergo a rehabilitation programme over the next three years, with an allocation rising to R600-million in 2000/01 from R100-million in 1998/99. Planning for the rehabilitation of hospitals will be done jointly by provincial and national public works departments.

Provincial health spending is projected to increase by around 5% a year over the next three years.

The clinic-building programme has raised 501 new clinics since 1994, serving an additional 5-million.

Since abortion was legalised in

February last year, 15 545 women have terminated pregnancies, compared with 2 899 legal terminations under previous law in 1998.

"This service, together with an expanded reproductive health service, reduces the risk of unnecessary illness and death in women," Mr Manuel said in the Budget review.

A National Health Bill tabled last year provided a legislative mandate for the creation of a national health system that integrates the public, private, non-governmental organisations and community health systems. It would also lay the foundation for co-ordinated national health research and information systems to inform the development of health policy and programmes.

Policy strategies addressed include nutrition, maternal and child health, HIV/AIDS and sexually transmitted diseases.

The Budget also provides R76.4-million for the Medical Research Council in 1998/99, increasing to R88.4-million over the next three years.
Hillbrow Hospital empties its wards

Some delays in transfer of equipment due to expense and size of some of the machinery

By ANISO THOM
Health Reporter

The transfer of equipment from Hillbrow Hospital to other medical institutions will be completed within the next three months.

 Gauteng health department spokesman Popo Maja said yesterday the delays had been caused by the "immense size" of some of the machinery.

 Hillbrow Hospital is one of the institutions which the department downscaled to a community health centre as part of the rationalisation process.

 Delays in the transfer of the maxilla facial unit to Helen Joseph Hospital in Auckland Park have led to a waiting list of between four and six weeks. Some patients with broken jaws have been forced to wait as surgeons accommodate emergency cases first.

 Maja added that the equipment, which was portable and could be transferred easily, was being taken to Helen Joseph Hospital. Arrangements were being made with the company that installed the equipment to move the x-ray unit. "We expect the unit to be installed and functional shortly."

 Some operations, which would have been performed at Hillbrow, were being carried out at the Oral and Dental Hospital in Braamfontein and some at Johannesburg Hospital.

 Other equipment, left at Hillbrow Hospital after its closure on December 31, would be moved within the next six months as would the 168 staff members still working there.

 Maja said equipment worth between R10-million and R15-million would remain at the Hillbrow Hospital site to equip and furnish the health centre.

 He said the size of the cancer radiation equipment meant it would remain at Hillbrow for at least two years.

 "Although the units belong more appropriately at Johannesburg Hospital, it is uneconomical to move these sections at present. The radiation unit is being fully utilised."

 Maja said all remaining equipment would be transferred, once needs had been identified at other hospitals, and the most poorly equipped institutions would get preference.

 The specialised units have moved to the following institutions: radiotherapy to Johannesburg Hospital; internal medicine has been split between Edenvale, South Rand, Helen Joseph and Johannesburg; surgery has been split between Edenvale, South Rand, Helen Joseph, Johannesburg, Oliver Tambo Memorial and Leratong; orthopaedics has gone to Oliver Tambo Memorial and Edenvale; and psychiatry has moved to Helen Joseph, and the maxilla facial unit will be moved there.

 A total of 2,352 staff members were seconded out of Hillbrow and the hospital operates on a skeleton staff.

 Of those who had been redeployed, 263 had been seconded to the community health centre on the same premises as the hospital.
A

in the towel

chief throws medical

Disillusioned

David Robbins reports

and academic medicine decades at the age of 57 he's had enough, it is simply cause for concern.

When one of South Africa's leading doctors, Professor John Miller, who has given his life to hospital
Band-aid for hospitals as more revenue is voted

Tax increase on medical aid will affect only high-income earners

By Anso Tiefenbach

Health-policy experts and non-governmental organisations have applauded the Government for the R260 million allocation over the next three years to rehabilitate South Africa’s hospitals, which are falling into disrepair.

However, they have criticised it for not representing any “real increase in the overall budget”.

Finance Minister Trevor Manuel said in his budget address on Wednesday that health, as one of the Government’s priorities, would receive R27.7 billion this year (14% of non-interest spending), R42.6 billion during the 1999/2000 financial year and R56 billion in 2000/1.

An economist at the University of the Witwatersrand’s health policy studies unit, Alex van der Heever, said there had been a slight decrease in real terms, and this would put the health sector under some strain.

Van der Heever said it was disturbing that social services had to make sacrifices.

Bupendra Makan, a researcher at the University of Cape Town’s health economics unit, said it did not represent a major increase in real terms, when inflation was taken into consideration.

He welcomed the substantial increase for hospital rehabilitation, but questioned how Manuel was planning to address equity at a provincial level.

Makan said he was also concerned about whether Manuel had budgeted to improve the conditions of service of health workers.

“We are asking what has the minister included in the 14% increase.”

Irwin Friedman, national director of the National Progressive Primary Healthcare Network, said he was respectful of the fact that government had approached the budget in an honest way.

But he said the Government’s commitment to rehabilitate hospitals was wise and sensible, and applauded Manuel for his commitment to tax tobacco and alcohol.

Manuel also announced that if the employer’s contribution to a medical aid scheme on behalf of an employee exceeded two-thirds of the total contribution, that excess would be taxed as an employee fringe benefit from April 1.

“We have become aware that, increasingly, contributions to medical fund schemes are being used to structure salary packages in a way that was never intended by the Income Tax Act,” he said in his budget address.

The proposed tax would help boost state coffers in the 1998/99 financial year by an extra R700 million.

John Pugsley, director: finance and administration at the Representative Association of Medical Aids, said it would have a greater impact on people in higher income brackets. A high earner contributing R1 000 towards the medical aid could end up being

He said that many people in the lower income tax brackets would not even notice this tax increase.

Pugsley said it would have levelled the playing fields if employees had been allowed to deduct medical aid contributions.

“It’s a pity there is no relief for the self-employed as this would have encouraged people to leave the state system and join a medical aid,” Pugsley added.

Focusing on medical practitioners and dentists, Manuel said they would no longer be entitled to a special tax deduction for costs incurred while attending courses or congresses outside South Africa.

He said that various other professions had submitted proposals for the extension of this provision to their profession.

In terms of Section 16A of the Income Tax Act, only medical practitioners and dentists registered in terms of the Medical, Dental and Supplementary Health Service Professions Act were entitled to such a deduction.

The provision discriminated against other professions and was possibly unconstitutional, Manuel said. The tax advisory committee had considered the matter and recommended that the section be deleted.

The deductibility of expenditure of this nature would have to be dealt with in terms of the ordinary provisions of the Income Tax Act, he said.

Assistant registrar of the Interim National Medical and Dental Council, Duan Naude, said the council accepted the proposals in principle, but said doctors fell in a different category to businessman.
Patient buys implants from supplier; saves over R1 000

(AUDTH SOAL)

HEALTH WRITER

ARRANGING to buy dental implants from the supplier rather than the hospital saved a patient over R1 000 — just one example of the large mark-ups hospitals put on medical supplies.

The Cape Times recently exposed the practice of "confidential discounts" given to hospitals by suppliers, which means that patients can pay 30 to 60% more for equipment than hospitals do, and received an overwhelming response to the report from readers.

There are many stories that illustrate this practice, but one of the most glaring examples came from Mr Roy Andrew in Rondebosch.

Andrew showed the Cape Times copies of invoices proving that a private clinic had added more than 50% to the price of equipment that it hadn't even touched.

Four years ago Andrew needed extensive dental surgery.

His dentist surgeon arranged for him to buy the expensive implants that he needed directly from the importers to help him keep the costs of the operation down.

Andrew was charged R1 841.10 (including VAT) for two implants.

After the operation, Andrew was billed for the implants by the Shrinel Clinic as if he had received them in the normal way.

"That wasn't a problem."

"I pointed it out and they deducted the amount immediately," said Andrew yesterday.

"What did shock me was how much they were going to charge."

The clinic had billed Andrew R2 925.68 (including VAT) for the same two implants.

"They were going to make R1 084 profit.

"That's a 59% mark-up and they didn't even touch the things," he said.

Sister Julie Coleman of Shrinel Clinic denied that it was the clinic's policy to add large mark-ups to equipment.

"We would never add that much, we add on 10% or so, but I don't know how that happened.

"It must have been a mistake," she said.
No blame accepted for higher health bills

WHY ARE OUR medical bills so high? Health Writer
JUDITH SOAL asked hospitals, doctors, medical aids and policymakers who was to blame for escalating health costs.

THE cost of private health care
in South Africa is increasing
by about 25% a year — way
above the inflation rate — and
experts agree that the industry’s
pricing structure is to blame.

The Cape Times recently
exposed the practice of “confidential
disclosure” whereby private
hospitals can make profits of
between 30% and 60% on all equip-
ment — from bandages and cotton
wool to protheses and pacemakers —
sold to the hospitals, although
they often do not handle the
equipment or add value to it.

But hospitals have defended
this practice, saying they have to
make money in some areas — such
as equipment and drugs — to cross
subsidize the losses they make on
other areas — such as ward fees.

“Hospitals are on thin ice if you
look at our profit margins,” said Dr
Anette van der Merwe, the execu-
tive director of the Hospital Asso-
ciation of South Africa, which repre-
sents private hospitals.

“You can’t just look at the mark up
in isolation unless you examine the
whole pricing structure.”

Predictably, hos-
pitals, medical aids and doctors can’t
agree on who is to blame for escalating
costs, but they do agree that the
cost structure of private health care
is “a mess.”

The problem is that the health
industry doesn’t operate like a
normal business,” said Dr Jocelyn
Kane-Herrmann, chief director of
health administration in the
Western Cape. “The normal principles
of supply and demand don’t apply
case by is the provider who
decides what should be purchased.

Patients don’t know whether or
not they need an operation, or
expensive tests, or how long they
have to be in hospital. They have
to rely on their doctors and hospi-
tals, and there are ‘ perverse incen-
tives’ for over-use of medical ser-
ices.

Also, unlike other businesses,
the prices aren’t set by market
forces or even the provider, they
are set by an outside body, the
Representative Association of Medical
Schemes (Rams).

A tactic that seems to complicate
an already convoluted price
structure is the over-supply of pri-
vat e health services in Cape
Town.

“There is no doubt about it, in
the city bowl and southern suburbs
we are over-bedded,” said Dr Richard
Fredland, the chief operating offi-
cer of hospital group Netcare,
which owns City Park, among
other hospitals.

Hospital occupancy rates are
considerable, but insiders suspect
that private hospitals are only just
maintaining the 60 to 65% occu-
pancy they need to remain in busi-
ness. Treatment costs are based on
65% occupancy, so patients are
already subsidizing empty beds.

This applies to operating
theatres.

Ten years ago there were 17 pri-
ivate operating theatres in Cape Town.
Now there are almost 50, with
more planned to open soon.

“It can cost mil-
dions to equip a thea-
nate and operating
rooms,” said Van der
Merwe. “Just one
microscope can cost
about R8 000.”

Hospitals have spent a lot of
money equipping theatres that
aren’t being fully used, and those
costs are being passed on to
patients and medical aids.

Because of the structure of med-
cal aid tariffs, certain procedures
are more profitable to hospitals
than others, so some services are
provided at the expense of others.

This is particularly noticeable
in the field of mental health, which
does not receive much compensa-
tion from medical aids, so few pri-
vate psychiatric hospital services
are available.

Surgey, on the other hand, can
be very profitable, hence the surfeit
of theatres. But this can also be
costly as hospitals fight for op-
erations.

If you have so many beds and
theaters but only five orthopedic
surgeons, they will be wooed and
given incentives by all the hospit-
als. There are many ways that it is
done, but to the end it increases
the cost of health care," said Van
der Merwe.

Because of this excess capacity,
there are rumors that at least one
private hospital in Cape Town will
close in the next year or two,
although this has been strongly
denied by the hospitals.

Whatever happens, it’s clear that
this is bad news for the health sec-
tor. Sixty-two percent of all the
money spent on health care is spent
in the private sector, which services
only 20% of the population.

The other 60% of South Africa’s
people receive less than 40% of
health care funds. Paradoxically,
as the costs of private health care
rise, less people are able to afford
it, forcing more people to rely on
overstretched public services and
further increasing the costs of pri-
vate health care.

PRIVATE HOSPITALS:
• Say private health care
  are not too high when com-
  pared with other countries.
• Point out it costs “millions” to
  equip hospitals with the latest
  equipment.
• Claim medical aids waste
  money on administration.
• Stress that contributions to
  medical aids have consistently
  gone up at a higher rate than
  medical aid tariffs.
• Say the medical aid tariff
  structure is “obscenely” skewed
  and forces them to make large
  profits in some areas to recoup
  losses in others.
• Point out that the share prices
  of most hospital groups are
  dropping on the JSE.
• Stress the costs of theft, break-
  ins, and bribes.
• Vow they are doing everything
  possible to keep costs down.

DOCTORS:
• Feel they are being exploited
  by hospital groups or pri-
  vate health companies.
• Point out the costs of training
  and medical aids subsidies.
• Vow they are doing everything
  possible to keep costs down.

MEDICAL AIDS:
• Say they are paying more to
  hospitals than ever before.
• Stress medical aids are non-
  profit organisations, with
  administration costs fixed at
  five percent of contributions
  and the rest paid to settle claims.
• Claim hospitals provide doc-
  tors with incentives to use their
  wards and equipment, which
  can lead to over-servicing.
• Say doctors “milke” hospitals
  by “milk” patients up to inter-
  estive care units without reason,
  performing unnecessary proce-
  dures or carrying out expensive,
  non-essential tests.
• Cite cases where hospitals
  have billed for procedures that
  haven’t been performed and sell-
  ing used equipment as new.
• Ask why “mistakes” on
  patients’ bills favour hospitals.
• Vow they are doing everything
  possible to keep costs down.

UNHEALTHY DISTRIBUTION: State hospitals such as Red Cross Children’s
they need to remain in business.
They all know to keep costs down.
Budget boosts schools -
but hospitals face job axe

There was good news for teachers, but
warnings of further job cuts in hospitals
in Western Cape Finance Minister
Lampie Fick's budget speech today.

Unveiling a tight budget for 1998/99, Mr
Fick announced a better deal for the cash-
strapped education department in the
province, but no extra funds for health.

The lion's share of the budget will again
be spent on education, with R3,6-billion
- 36% of the province's total expenditure.

This is considerably more than last
year's allocation of R3,3-billion, which
should lead to fewer job cut-backs than originally
planned, and restore some stability.

But it falls short of the R3,8-billion called
for by the African National Congress to allevi-
ate the education crisis in the province.

Budget boost for Cape schools,
but hospitals face more job cuts

From page 1

R10,1-billion, which is about R5-million
more than last year.

The main source of income is the
R9,5-billion grant from central government,
which is about R220-million higher than last
year, mainly because the province has more
residents than was earlier estimated.

Locally generated sources of revenue for
the province include R244-million from
motor licence fees, R152-million from casino
licence fees, R265-million in hospital fees and
R134-million from a number of smaller
sources.

The sale of state assets, however, will not
bring in more money for the province this
year.

Although the province has a marginally
higher income than it did last year, it is not
really better off.

This is mainly because Mr Fick has, over
the next two years, to repay a R257-million
deficit incurred in the 1997/98 financial
year.

Mr Fick also was not allowed to budget
for a deficit for 1998/99 in terms of the constitu-
tion and because he wanted to avoid the
danger of having the province placed under
judicial management by the central
government.

In line with guidelines issued by the
national budget council, the province is
spending almost R5-billion on education,
health and welfare - 80% of its total expendi-
ture.

This includes R2,2-billion to be spent on
social services.

Indicating the Western Cape govern-
ment's commitment to help realise the
province's potential as a world-class tourist
destination, Mr Fick announced a R2,7-bil-
liion increase in the amount spent on
tourism, which will go to the Western Cape
Tourism Board.

Wesgro, the province's main marketing
agent, got a bigger share at R3,5-million.

Agriculture, which along with tourism is
one of the two main contributors to the
provincial economy, gets R1-million more
this year.

This year's budget, for the first time, pro-
vides for a contingency reserve fund of R15-
million to pay the interest on government
debts.

Tackling the problem of crime, Mr Fick
announced an increase of R2-million for
community security.
may as well close down Cape Town.

CAN Croote Schuur pull through.

The People's Hospital

(86)
in surgery, shortages

cool caps

frontline doctors on care

take their toll on careers

12. News

\[ \text{(Image and text content)} \]
THE PEOPLE'S HOSPITAL

IN A CRITICAL CONDITION

THIS (HOSPITAL) CLOSES DOWN, YOU

Inside Story

Cape Argus, Thursday, March 19, 1998
Groote Schuur faces lean year

JENNY VIAL
HEALTH REPORTER

Groote Schuur Hospital has a tough year ahead if it is to stay within a budget which is 13% less than it spent in the last financial year.

The Western Cape's three academic hospitals, Groote Schuur, Tygerberg and Red Cross, have had their budgets reduced by R135-million for the 1998/99 financial year.

The budget for academic health services, which include dentistry, is R1,072-billion.

The overall allocation for health services is R2,9-billion, with a projected deficit of R284-million.

Primary health care services will get R634-million, an increase on last year, and secondary hospitals R739-million.

The provincial health department has drawn up a business plan which sets out ways to reduce the number of staff and services. This will be discussed with hospitals and trade unions over the next three weeks and details will be finalised after April 6.

Groote Schuur Hospital has been allocated R458-million. In the 1997/98 financial year, it spent R545-million and has carryover payments of R10-R15-million, which include doctors' overtime pay. These must be paid from its new allocation.

This means the hospital will have about R74-million less to spend in 1998/99.

Senior medical superintendent Paul Ciaparelli said the hospital had no option but to spend less. "Our approach is that this is what we have been given, so we have to come within that budget. The provincial Health Department is under massive pressure not to overspend. "That pressure just gets passed down to institutions. There's likely to be zero tolerance on overspending this year."

The hospital does not determine how its budget is spent. Most of the money - 76% - will go on salaries.

The hospital cannot retrench and has to rely on staff resigning, retiring or taking voluntary severance packages.

Peter Mitchell, chief medical superintendent of Groote Schuur, said: "We're going to organise a finance summit with our senior management and clinical staff to look at the options of operating with this size budget. We will have to reduce staff numbers in the least damaging ways."

Special report, pages 10 and 11
W Cape health budget likely to put squeeze on jobs

If we want to stay within the budget, voluntary severance packages are going to be an important part of the solution,”

He also mentioned the possible closure of hospitals. “It is surely better to have seven hospitals functioning at 75% capacity than 12 hospitals at 45%.”

But details of Marais’ plan to stay within budget will not be released until trade unions have been consulted.

“We have worked out a plan with people in the department, now we have to negotiate with those who will be affected. We will announce the details in April,” Marais’ spokesperson Mr Johan Smit said.

It is the details that the opposition ANC fears. “The devil could be in the details,” said ANC finance spokesperson Ms Tsaseem Issop.

She said the health budget was the biggest it had been in four years and should be sufficient to extend primary services as well as maintain academic hospitals.

“With the additional funds that the central government has earmarked for the academic hospitals, there should be enough to ensure that the excellent care they provide continues,” said ANC provincial spokesperson Mr Cameron Dugmore.

“What is important is that the general direction of Mr Rasool’s health plan is maintained. It would be a tragedy if the overall policy of providing services at a primary level was lost.”
Four city hospitals to close doors

JENNY VIALL
HEALTH REPORTER

Four hospitals in Cape Town, including Somerset and Valkenberg, are to be shut, 300 beds at academic hospitals are to be closed and staff numbers are to be reduced by 3,816.

These decisions are part of the Western Cape Health Department's business plan approved by the provincial cabinet earlier this month and intended to bring the department within its budget.

Health Minister Peter Marais said the plan was "not cast in stone and if someone can tell us of a better way to save money, we will do it".

The department's projected deficit for 1997/98 is R324-million and the plan is to bring about savings by July.

Other hospitals to be closed are Westlake near Lakeside and the D P Marais TB Hospital at Westlake.

Somerset will be closed and its staff declared supernumerary and offered voluntary severance packages. Proposals for the site will be called for.

Valkenberg is to be closed and its patients and staff accommodated in other hospitals.

The decision to close Valkenberg was taken because it was "the most logical psychiatric hospital to close" according to the business plan. This is expected to reduce staff by 100 and save R4.7-million, and reduce infrastructure expenditure by R4-million.

Groote Schuur, Red Cross and Tygerberg hospitals will lose 300 beds between them.

The business plan is to be discussed with institutions and unions and changes will be finalised by April 6.

Mr Marais said the savings effected this year would mean there would be no further cuts in the next two years.
PE hospitals to close

JENNY VAIL

It’s finally happened: emmuous warnings that Western Cape hospitals will be forced to shut up shop because of drastic budget cuts, have become reality. The province will close five hospitals in the next three months, by July 1.

Wielding the battle axe rather than the scalpel, health authorities will cut 144 health jobs and close hundreds of hospital beds.

The greatest shock is the closure of Cape Town’s oldest hospital, Somerset, overlooking the V&A Waterfront. Somerset is the only state hospital serving the densely populated city bowl and Atlantic suburbs.

Its patients traditionally have come from afar to attend its specialist services including the vital AIDS clinic which is being closed just as the peak HIV infection in the Western Cape peaks.

The other hospitals to be closed are:

• Velkom psychiatric hospital in Observatory which has played a major role in Cape Town’s mental health for many years.
• The DP Marais TB hospital at Wynberg.
• The nearby Wynberg convalescent hospital.
• Nosipho, a tuberculosis and psychiatric hospital near Buitenzorg.

The closure of the TB hospitals is especially serious as the Western Cape has one the highest rates of TB infection in the world.

‘Ag, that can’t be true...’

PETER NALLAN

 Tears welled up in the eyes of Gadja Henkmann when she talks about Somerset Hospital.

The hospital’s assistant nursing director, Mervin Hendrikse, started at the venerable institution 33 years ago.

“When I got to work a few years ago, I thought it would be nice to retire here – at the same hospital where I started my nursing career. But I didn’t expect it would end like this.”

On Thursday, medical superintendent Edward Lott dropped the bombshell in the noses of 100 staff members: Somerset Hospital is set to close by July 1. Yesterday, Western Cape Health Minister Peter Marais publicly announced the news.

Less than a month ago, an “important Notice to All Staff” still on the hospital’s notice boards said, “Please attach no value to the rumour (about the future of Somerset Hospital) which is circulating. It includes incorrect information...”

“Please note that, before any decisions are made, all stakeholders will be consulted well in advance.”

After Thursday’s announcement, someone scrawled across the notice “Who’s feeding who?”

Senior administration official John Portius echoed the feeling of many when he said he had come as a complete shock. “Luckily I’m only six years to retirement anyway, but I feel sorry for the young people who have got families and other commitments.”

A trauma doctor, who did not want to be named, was more blunt about his patients’ prospects: “I don’t know what will happen to them – I don’t suppose.”

Male nurse Keith de Silva was still reeling from shock when I first heard it... my first reaction was to say ‘Ag, that can’t be true... they’re taking nonsense’.”

Farewell: Gadja Henkmann, assistant director of nursing at Somerset Hospital.

“These four hospitals have been earmarked for the sudden announcement of the closure of Somerset Hospital is coming to a complete shock.”

Medical superintendent Edward Lott said: “It’s as though there has been a death in the family. There’s almost a death in the family. There’s almost a death in the family. There’s almost a death in the family.”

He said he would be submitting an interim plan for the hospital to be made up of the projected deficit of R38.8-million by July 1.

Somerset Hospital has been told that it will be closed and its 260 beds “absorbed” into Groote Schuur, Paul Brand Hospital and Groote Schuur. Its 101 staff will be declared redundant and offered voluntary severance packages.

Dr Lott said it would be infeasible for staff to leave before July 1.

Somerset Hospital runs a HIV clinic considered a vital research and treatment centre for AIDS in Africa. It also has 75 maternity beds and 50 beds for children under 16 as well as mountain maternity hospital.

The Inner Hospital Coordinating Committee, a grouping of hospital superintendents, has stated that it is extremely concerned about the closure of Somerset Hospital, but it understands the severe constraints under which the provincial Department of Health functions.

Provincial Health Minister Peter Marais said yesterday that closing Somerset was “negotiable” because it can tell us how to save R17.8-million.

He said the move to primary health care meant services had to be cut at secondary and tertiary levels.

If the province and the unions are in favour of primary health care, they should take part in discussions for the consequences of the plan,” he said.

“I’ve told the unions that if they have different ideas about how to make services within the budgetary constraints, I am open to discussions,” he said.

Mr Marais gave the assurance that he would have a difficult task explaining to the public why such catastrophic measures are being imposed.

“The Western Cape was on the path of orderly rationalisation and one would have expected Mr Marais to have stuck to this instead of closing hospitals,” he said.

In addition, the communities of Deft and Kenilworth have a right to be angry. They won’t see the opening of community health centres which have been negotiated for over two years and, he said...

“This makes nonsense of Mr Marais’ promise of ‘every patient is a VIP’.”
HOSPITALS THROWN LIFELINE

Wage hikes 'forcing closure'

CAPE HOSPITALS facing closure have one last chance to avert their fate — think of other ways of saving the money themselves. CLAUDIA CAVANAGH reports.

SALARY hikes for public servants are largely to blame for a R284 million provincial department of health deficit which could see the closure of five Cape hospitals by July 1, says health chief Dr Tom Sutcliffe.

Last week, superintendents and unions at the hospitals — including the historic 260-bed Somerset Hospital in Green Point and Valkenberg Psychiatric Hospital in Observatory — were given just under three weeks to come up with alternative ways to save the money or close their doors forever.

Other affected hospitals are the D.P. Marais TB Hospital in Westlake, the Westlake Convalescent Hospital and the Nelspoort Psychiatric and TB Hospital near Beaufort West.

"Unfortunately, recent significant salary increases and other benefits for public servants have offset the savings which were anticipated from the loss of more than 3,000 staff members last year," Sutcliffe said yesterday.

In July last year, he said, staff were given an across-the-board seven percent increase which in turn pushed up the overtime and housing allowance bill. Structural changes to the way some grades were paid also gugged funds.

"All this had a huge effect on potential savings for the year, without which we wouldn't have had to downscale," said Sutcliffe.

In the meantime, hospital heads, initially floored by the proposals, have come back fighting.

"The Inter-Hospital Co-ordinating Committee will generate alternative proposals as a group," said Dr Edward Lotz, Somerset Hospital medical superintendent.

"We do not believe that a single bed needs to be closed and, taking the budget constraints into consideration, are working towards a plan for increased efficiency," he said.

The proposed closure of his hospital came "like a bolt out of the blue" last Wednesday.

"We're all very unhappy about the whole thing and wish we had been asked before of given more time to respond," said Lotz.

Staff at the hospital are still said to be "reeling from shock" but an inside source says they "won't take it lying down.

"They will mobilise efficiently and make their mark on the process," he said.

Valkenberg's superintendant Dr Jan Schoombie said consultations with staff would begin immediately.

"We will definitely try and develop alternative proposals. We have been asked to respond and have a responsibility to do so."

Unlike Somerset Hospital, Valkenberg has been threatened with closure since October last year.

"It's all been extremely stressful. Staff morale is at an all-time low. They need guidance on the matter,"

And that is what they will have pretty soon.

A spokesperson for MEC for health Mr Peter Marais said final decisions on the hospitals' future had to be made by the end of April so changes could be made in May and June.

All in all, 3,816 staff members stand to lose their jobs in a massive "voluntary severance" programme which, in the absence of a retrenchment tool is the only way to reduce staff.

"But more than that number have already applied for voluntary severance packages, so we do not anticipate any problems there," said the spokesperson.
Why these hospitals could be closed down

BY closing Somerset Hospital, R37,2 million will be saved in staff costs and infrastructural expenditure will be reduced by R8m a year.

The hospital was targeted because it:
• Has a high patient-day cost of R55.
• Is not well served by public transport.
• Is associated with Groote Schuur and so patients who need sophisticated treatment can go there.
• Is facing increasing pressure as a result of development in the area and occupies an increasingly valuable site. The building could be leased for millions of rands a year and proposals have already been called for.

By closing Valkenberg, R4,7m will be saved in staff costs and another R4m in infrastructural expenses. It was earmarked because:
• Many of its buildings and facilities are unacceptable for patient accommodation, while facilities at Stikland and Lentegur are newer and more modern.
• Community support structures have been built up in Observatory, so the area will be able to sustain patient care services on an outpatient basis.
• The relocation of patients to Stikland and Lentegur will allow poorer communities easier access to facilities.
• Closure of the Nelspoort Hospital will save R5,8m in staff cuts and reduce infrastructural expenditure by R1,5m. It was chosen because:
  • Its borehole water is unfit for human consumption and its alternative water supply is dependent on regular rains.
  • Its sewage works is overloaded and needs upgrading, as does its electrical reticulation.
  • The patients can conveniently be relocated to other hospitals.

By closing Princess Alice Hospital, R2,8m will be saved in staff costs and infrastructural expenditure decreased by R3m.
Why these hospitals could be closed down

BY closing Somerset Hospital, R37.2 million will be saved in staff costs and infrastructural expenditure will be reduced by R8m a year.

The hospital was targeted because it:
- Has a high patient-day cost of R535.
- Is not well served by public transport.
- Is associated with Groote Schuur and so patients who need sophisticated treatment can go there.
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By closing Princess Alice Hospital, R2.8m will be saved in staff costs and infrastructural expenditure decreased by R3m.
Row over emergency services

Politicians blamed for moratorium on hiring of personnel

Johannesburg council officials are blaming politicians for the personnel shortage in the Greater Johannesburg emergency services, which are facing collapse unless a moratorium on recruitment of personnel is lifted.

Critically injured victims of Sunday’s horror crash near Lonehill, Sandton, in which five people were killed and 31 injured, waited for up to two hours for ambulances to transport them to hospitals while Johannesburg emergency personnel struggled to cope with treating the injured.

Ambulances were called in from Roodepoort, Krugersdorp and Midrand to assist.

Brian Hogan, deputy chief of operations in Greater Johannesburg, said the question as to whether the 330 vacancies would be filled should be directed at the politicians.

He said about 100 vacancies were for office personnel, which included operators. The rest were emergency personnel, including firefighters and paramedics.

Committee of Ten chairman Kenny Fihla said officials had not informed politicians of the problem.

He said according to policy laid down by the committee, established to reverse Johannesburg’s bad financial situation, line managers had to submit reports on employee complements and motivate if they needed more staff.

“They haven’t received a single report at the level of the committee from emergency services. It is inexcusable for people who are employed to manage to expect politicians to do their (the manager’s) job,” Fihla said. The committee would investigate.

Emergency services strategic executive Hilhow Maeko said councillors had been informed that the situation was critical.

He said recommendations to fill critical vacancies had been forwarded to the Greater Johannesburg metro executive committee to consider.

Maeko also denied that emergency services had been slow in responding to the Sandton pile-up, saying the first vehicle was on the scene 13 minutes after receiving the report.

The accident was cleared two hours and 13 minutes later, he said.

Paramedics who spoke to The Star last week said they were struggling to cope.

They claimed that if a bomb were to explode in Johannesburg, injuring many people, the city’s emergency services would be unable to cope.

“An incident would have to occur for this to be proved,” Hogan said.

One paramedic said it was not strange to, at times, work 72 hours non-stop.

In response, Hogan pointed out that overtime was voluntary and “no one is forced to work overtime”.

He admitted that if no overtime was allocated, even fewer emergency vehicles would be available daily.

Jo-Anne Collinge, communications director in the Gauteng Health Department, said the department was aware of the many emergency services posts that were vacant.

“This may be partly due to the complexities of local government restructuring,” she said.
Boss taken hostage in health row

‘Save hospital’

JENNY WALL AND LINDSAY BARNES

A Western Cape Health Department official was taken hostage at Nelspoort Hospital near Beaufort West by workers demanding a moratorium on the hospital’s closure.

Mike Hendricks, director of health care for the Southern Cape-Karoo region, went to Nelspoort yesterday to discuss the proposal to close the hospital as part of the department’s plan to save money.

The hospital is on a farm and 160 families stand to lose their homes if it is closed. Dr Hendricks was taken hostage about 2.30pm by workers who sent a list of demands to provincial Health Minister Peter Marais.

Police spokesman Louis Nortje said the staff were “unruly” but it did not appear that they used weapons.

Late last night, the hospital received a fax from Mr Marais’s office saying representatives would visit the hospital on Monday. Dr Hendricks was then released.

Johan Smit, spokesman for Mr Marais, said no decision had been made yet on the future of the hospital. “It’s only a proposal documented in our business plan. The stuff are welcome through their unions to make alternative proposals by April 5,” he said.

Hospital superintendent Olaf van der Westhuizen said staff demanded that Mr Marais and the heads of the provincial departments of education, agriculture and housing visit the hospital.

The hospital was built on 7,000 hectares and the grounds were farmed. A primary school and hostel for 370 pupils were also under threat.

The department says it wants to close the hospital because the water supply is a problem and the buildings, sewerage and electrical works need renovating.
INSIDE STORY

With hospitals closing, the pronounced impact could be the biggest losers.

What is to become of needy patients?
City should have 10 times more ambulances

Greater Johannesburg has only six vehicles serving the area, while many firefighters cool their heels awaiting calls

BY ANSO THOM
Health Reporter

Greater Johannesburg should be serviced by between 50 and 60 ambulances and response cars instead of the six currently serving the city, deputy director-general in the Gauteng health department Eric Buch said yesterday.

He was speaking after Gauteng health officials and Johannesburg emergency services management held an urgent meeting after The Star revealed widespread concerns of paramedics regarding the dire emergency-services situation in Johannesburg.

The top-level meeting is set to continue today.

Buch said that, according to a formula which took into account that Gauteng subsidised 40% of ambulance and paramedic staff members' salaries, there should be at least 50 response and ambulance vehicles on the road during peak times.

"The meeting was called to establish why they (Greater Johannesburg emergency services) aren't maintaining these levels," said Buch.

He said another core issue which arose at the meeting was the fact that there was a large number of fire personnel waiting for fire calls at emergency stations although fire emergencies were much more infrequent than ambulance calls.

"These people (firefighters), who have been trained to fulfil a dual role, should be out on the road in ambulances, but be available to attend to a fire scene if necessary. It boils down to the balance currently maintained between personnel who stay behind and those out in ambulances," Buch said, adding it was also unnecessary to have 26 fire stations in one metropolitan area.

He said Gauteng was currently subsidising 500 ambulance and paramedic staff members. Firefighters were being funded at council level.

At present, Greater Johannesburg has about 330 vacancies within its emergency services department.

A senior paramedic, who asked to remain anonymous, said most emergency stations were being managed by former fire chiefs who did not have the interests of the ambulance and paramedic staff at heart.

ANC councillor and chairperson of the public safety committee, Nikole Ntshingane, said service levels had dropped because emergency stations were now forced to serve areas such as Alexandra which were previously ignored.
Health unions talk of ‘war’

LOSING THEIR JOBS would force health workers to turn to crime, they say, adding that the Health Department faces a ‘war’, which it will lose. FATIMA SCHROEDER reports.

FIVE health trade unions have threatened to take drastic action against the Department of Health for failing to inform them about the closure of five Cape hospitals.

This was decided at a heated meeting between union and department representatives yesterday.

Last week hospital superintendents and unions were given a deadline of under three weeks to find ways to save thousands of rand or close their doors forever.

Health authorities also announced that 3 816 health jobs would be cut and hundreds of hospital beds closed.

National Health and Allied Worker’s Union (Nehawu) representative Mr Theo Twala described the situation as a “war” and said the department was on the losing side.

The first round of the “war” took place yesterday when a crowd of angry health workers protested and toyed-toyed outside the administration building at Valkenberg psychiatric hospital.

The protesters demanded that the government deal with what they said might become an ugly situation, saying that drugs, gangsterism and crime could be the only alternative for jobless workers and miserable patients.

“If the hospital is closing down where must we go? People won’t have jobs. ‘Patients will be miserable with nowhere to go. Everyone will turn to crime,” Twala said.

While workers demonstrated outside, union representatives were discussing their plans inside the building.

The department was accused of dealing with the closure of the hospitals unprofessionally and unions challenged them to apologise in public for “failing to consult” them.

The unions involved in the meeting yesterday included the Health Workers’ Union, the Medical Association of South Africa, the National Health and Allied Workers’ Union, the Hospital Personnel Trade Union of South Africa and the Public and Allied Workers’ Union of South Africa.

Each union will hold separate meetings to discuss the action to be taken against the department.

The closure of Cape Town’s oldest hospital, Somerset, has shocked several hundred workers there.

Somerset offered services and research that would be lost not only to greater Cape Town but also to the African continent if the hospital was closed, the hospital board said in a statement yesterday.

“We plan to fight with every tool we have and insist that the authorities consult us,” said Somerset Hospital Forum spokesperson Mr Harrow Ross.

“The authorities are trying to bamboozle us with words when what they are doing will be to allow a major loss of life through reducing facilities — and of course, thousands of workers and their families will be impoverished,” said Somerset Hospital Forum spokesperson Mr Harrow Ross.

“We plan to fight this with every tool we have and insist that the authorities consult us every step of the way.”

The unions at Somerset include an HIV clinic, which is considered a vital research and treatment centre for AIDS in Africa, a medical education centre which offers a bridging course for enrolled nurses and has a close involvement with the University of Cape Town’s medical school and the only casualty department for patients from coastal areas.

The board said Somerset had been targeted for closure because it had a high patient-day cost of R335.

The inter-hospital co-ordinating committee was working to develop a plan to reduce costs and increase service efficiency to prevent the closure.

Other hospitals to be closed are:

- Valkenhill, which has served mentally ill patients in Cape Town for over a century.
- The D.P. Marius Tsh hospital at Weslakte.
- The nearby Weslakte convalescent hospital.
- Nelspont — a tuberculosis and psychiatric hospital near Balfour West.

Other hospitals which faced closure but managed to escape include Victoria Hospital in Wynberg, Conradie Hospital in Pinelands and the Karl Bremer Hospital in Tygerberg.

Nehawu will hold a meeting at 1pm today to formulate its plan of action against the department.

Twala said.
A POSSIBLE plan to save Somerset Hospital — one of five provincial hospitals to be closed to save money — has been destroyed, implying that the NP members of the standing committee had been "whipped into line" by the cabinet.

When Marais addressed the house yesterday, he emphasised that the business plans were not final, and added that the top department officials who had drawn up the plan had been appointed by his predecessor, Mr Ebrahim Rasool of the ANC, who had himself approved the plans.

He said: "The grand old lady (Somerset Hospital) has served many people well for many years. On 9 May 1965 my wife gave birth to my first son there... (The Somerset) is a member of my family and I pray for wisdom to keep her from closure."

Mr Daniel Silke of the Democratic Party said that with rationalisation and specialisation, the province could keep hospitals open. He called the closure plan "ill-conceived" and "dangerous."

"However, it was also incumbent upon the previous health MEC, Mr Rasool, to plan ahead in the face of the threat of budget cuts. The DP believes that adequate leadership from the current and previous minister has been lacking and that a financial management strategy, including the appointment of a senior financial manager, should be expeditiously completed."
Accident victims left waiting, says report

More than half priority cases were not reacted to within specified response times, Johannesburg Metro council told.

BY ANSO THOM AND THEMBWA SEPOTOKELE

Less than 50% of Johannesburg's Priority One (life threatening) calls are reacted to by emergency vehicles within specified response times, says a confidential report submitted to the Greater Johannesburg Metro council late last year.

In addition, some patients waited for more than an hour for ambulances to arrive and take them to hospital, the council's executive committee was told.

The report was compiled by the Support Services Division of the council.

With Johannesburg's emergency services reportedly facing collapse, it was revealed yesterday that Soweto's more than 2 million residents were being serviced only by Jabulani emergency station.

In addition, the station was reported to have only two fire engines, a water tank, a disaster bus, a subsidiary vehicle, five ambulances and one response car.

Paramedics in Soweto, who spoke on condition of anonymity, said the level of service delivery had collapsed during the apartheid era and this was worsened by the amalgamation of the emergency services.

They said authorised staff had left and that there had never been replacement. The station had 35 staff and needed another 200.

They said Soweto was serviced by only three ambulances.

Brian Hogan, deputy chief of operations in Greater Johannesburg, said Jabulani could be assisted by the Rietfontein training academy which had three ambulances, but no response cars or fire engines.

Alexandra, which was serviced previously by Sandton, had one ambulance, one fire engine and no response car, Hogan said.

But he said that there were plans to build fire stations in Ennerdale, Dobsonville, Ruimsig, Lenasia South, Orlando East, Diepsloot and Orange Farm, where a temporary fire station was erected because of the high risk of shack fires.

But he warned the possibility was small with the capital budget slashed.

Hogan agreed to an extent with Dr Eric Buch, Deputy Director of Health in Gauteng, that Greater Johannesburg should be serviced by 50 to 60 ambulances and response cars instead of the 26 currently serving the city.

Hogan said Johannesburg had 38 ambulances with 14 down for repairs.

''A total of 34 are operational, but there is not enough staff to man them,'' Hogan said.

Johannesburg's emergency services had 790 staff instead of the 1,200 needed, he added.

The Star reported on Wednesday that only six emergency vehicles were operational in Greater Johannesburg. There are, according to the Gauteng department of health, 26 emergency vehicles in operation. The Star regrets the error.
Life to emergency system
Partnership to bring new
Somerset staff vow to stay

Province closure plan illegal, says union

GLYNIS UNDERHILL
Special Writer

Hundreds of staff at Somerset Hospital are refusing to take voluntary severance packages and say they will continue to turn up for work on full pay if the hospital is closed.

"This proposal stinks. Last year some staff applied to take voluntary severance packages, but were turned down by province. Now all of a sudden they want to declare us supernumerary and for us to take packages. They will have to keep paying our salaries. We won't go," said Reggie Daniels, chairman of the Hospital, Personnel Trade Union of South Africa (Hospera).

The Western Cape Health Department had failed to consult or adhere to the Labour Relations Act before threatening to close five leading hospitals by July 1, he claimed.

The department has presented the five hospitals, Valkenberg, Somerzet, Nelspoort, DP Marais and Westlake, with a business plan outlining its attempts to make up an R284-million shortfall in the health budget.

Edward Lotz, superintendent of Somerset, said he was not consulted by the department before the business plan was drawn up.

None of his 800 staff had applied for voluntary severance packages after the release of the plan.

"Province cannot dismiss staff. There is no retrenchment package negotiated with the organised labour unions. If you declare staff supernumerary you have to have vacant positions for them, but the Health Department intends decreasing staff by 3 000. There are no vacant posts."

"It's got itself into a tremendous pickle, because its plan is not implementable," Dr Lotz said.

However, health authorities were anxious to emphasise yesterday that the plan was "not carved in stone".

Johan Smit, spokesman for provincial Health Minister Peter Marais, said the business plan was part of the consultation process.

"We are still waiting for proposals from all roleplayers. The process is going on until the second week in April.

"What nobody understands is that we had to prove to (Finance Minister) Trevor Manuel that the finances of this province are not beyond redemption. This is a business plan put together in a short time and the final plan will be the result of the input of all players in health."

Mr Smit insisted no HIV or any other patient would be left in the lurch. The plan had been compiled in a rush as the department had only three days to react to the budget.

The hospital superintendents were part of the consultation process as they had been handed the business plan and had two weeks to come up with suggestions, he said.

"These are clever people. They don't need months to consult. They are so intensely involved with the hospitals. They know where to save money," Mr Smit said.

Meanwhile Dr Lotz, is desperately trying to come up with a plan in a week to prevent closure of his hospital.

"As head of this institution, I still haven't been officially invited to make any other alternatives to this proposal. All that I am going to do is make them aware of the unimplementability of this plan and the absolute devastating and crippling effect it will have on health services," Dr Lotz said.

No deal: Edward Lotz and staff at Somerset Hospital who won't take packages
Fick throws cold water on ANC's savings proposals

KARIN SCHMIDT
POLITICAL WRITER

THERE is no extra money to be squeezed out anywhere in the Western Cape budget to help save Somerset Hospital, despite the African National Congress' suggestions, Finance and Agriculture MEC Lampie Fick said yesterday.

He was responding to the ANC's plans touted last week during a committee meeting to review the budget for the coming year.

The ANC suggested that over R250 million could be siphoned off other budget allocations to give a R200m boost to education and a R50m boost to health.

But Fick said: "None of the ANC's plans are practical. We welcome any suggestions and plans on how to save Somerset and Mr (Peter) Marais has made it clear that the plans have not been finalised. But there can be no overspending on the budget this year. That is final, final, final."

The ANC had suggested that a R67m saving made in the welfare department be used for education and health, but Fick said this money came from the child allowances and was cancelled out by the increase in the old-age pension budget.

As for suggestions that unfulfilled posts in the administration be filled in stages to make savings of around R50m, Fick said the filling of the posts was already being staggered as far as possible.

"There were 1,300 unfilled posts, but if these were left vacant for the rest of the year it would be "no new income-generating systems, no maintenance of roads, schools, hospitals and clinics."

The ANC also said last week that R15m of the R115m contingency reserve could be skimmed off for savings, but Fick said this was impossible.

The contingency reserve was to be used to repay the province's deficit.

If the province failed to repay R100m of this, the budget would not be certified by the national government and the province would lose out on a R270m bonus.

The R40m the ANC suggested could be saved on rationalisation of office accommodation would also be senseless, said Fick, since it was being used to move staff to government offices in an attempt to cut down on the almost R50m paid out in rent every year.

"There are almost no chances of any savings in this year's budget," he said.

EXPERTS WORRIED

Disease unit may be lost for ever

IF SOMERSET HOSPITAL goes, then its infectious disease unit goes — and therein may lie a danger, warn experts. Metro Editor CLAUDIA CAVANAGH reports.

SOMERSET HOSPITAL's world renowned children's infectious disease unit has felt the squeeze since the beginning of the year — but if the hospital closes it will cease to exist altogether, say experts.

This follows the release of provincial Health Minister Mr Peter Marais' business plan two weeks ago, suggesting the closure of Somerset and Valkenberg Psychiatric hospitals to offset a R284-million deficit for the year.

And while the province has stressed that all services affected will be absorbed by other hospitals and clinics if a way to save Somerset is not found, this won't be an easy task.

"It will be extremely difficult to absorb the infectious diseases unit into another hospital because of the constraints on beds all round," said head of department Professor Greg Hussey.

Somerset Hospital has the only paediatric isolation unit in the region.

"If Somerset closes, there will simply be no infectious disease facility in the Western Cape."

Hussey, a consultant to the World Health Organisation on the management of communicable paediatric diseases, says that besides caring for sick children, the unit provides an important research and teaching component.

"We do a lot of very relevant work on the effect of nutrition on disease."

"This is borne out by the fact that I've been invited to present papers on a variety of subjects all over the world."

Undergraduate and postgraduate doctors are trained through the facility, as are provincial primary health care sisters.

"The unit has developed a sound reputation both nationally and internationally — we take at least one call a day from health care professionals in other areas wanting advice on an infectious disease."

In the past, the community referred all cases requiring isolation to Somerset.

Because of financial constraints, this service was closed to other hospitals from the beginning of the year.

"So now a sick child will be kept at its base hospital — whether there are adequate isolation facilities there or not.

"This obviously carries a risk of transmitting the infection to other children in the hospital," said Hussey.

Although improved living conditions and immunisation coverage have led to a decline in the prevalence of children with infectious diseases over the years, cases of typhoid, meningitis, hepatitis, measles, dysentery, TB and chicken pox still occur.

"As people stream into the Western Cape from other areas where immunisation coverage is not as high, chances are that the incidence could increase."

"And because we've improved measles immunisation coverage doesn't mean we won't have an outbreak in the next few months. If this occurs and we have no Somerset Hospital, where will these children be cared for?"

- A delegation from Somerset Hospital will meet provincial authorities today to present their plans for saving the hospital.

"This is a continuous process of negotiation and whatever happens we'll make sure that services affected — like Somerset's HIV clinic — are still delivered," said a department spokesperson yesterday.
Private-sector plan to boost Jo'burg's emergency services

BY LEE-ANN ALFREDS
City Desk

A private-sector proposal heralded as the solution to Greater Johannesburg's emergency services crisis is months away from being implemented, with the approval of the trade unions and other stakeholders still in the balance.

A private consortium headed by Netcare proposed yesterday that the Greater Johannesburg Metro Council combine resources with the private sector and set up a not-for-profit company to boost the region's paramedic and ambulance service.

In terms of the proposal, the consortium - which includes Europassist, Vodac, a vehicle company and a petroleum company - will inject money into the project to supplement the municipalities' staff, vehicles and equipment.

The money from the consortium will be used to appoint 32 paramedics and more vehicles.

The consortium's offer follows warnings that Greater Johannesburg's emergency services are on the verge of collapse because of a moratorium on the recruitment of medical personnel. Only half of the city's 25 ambulances and 11 response cars in working order can be manned because 380 posts have not been filled.

Netcare trauma division chief executive officer Adrian Jacobs said the proposal would cover all residents - even those who were indigent.

Netcare has predicted that the venture could receive the go-ahead for implementation in about three weeks, but Greater Johannesburg public safety and emergency services head Hillow Maeko has indicated it could take much longer.

Maeko said he would be meeting the Gauteng health department on Friday or Monday to get approval for the proposal. If approved, the proposal would be submitted to the council's Section 60 and executive committees on April 20 and 21.

After this, the council would still have to consult the trade unions and other "stakeholders", Maeko said.

Independent Municipal and Allied Trade Unions spokesman Ben Kotze expressed concern about the proposal. He said while it was difficult to comment without having been consulted, the union would want several assurances before they approved of the proposal.

The South African Municipal Workers Union was not available for comment last night.
Court told of unfair advantage

DONALD MORRIS
JUSTICE WRITER

PUBLIC interest demands that a proper tendering process be followed in deciding who should operate a private hospital at the now defunct Volks Hospital, the High Court was told yesterday.

This was said by Mr Marius Scholtz, SC, counsel for Clinic Holdings Limited, and Gauteng businessman Mr Barney Hurwitz, in an application to review and set aside a decision by the Western Cape government to accept a tender of R15 million by the rival Medi-Clinic Limited for the Volks Hospital complex.

Clinic Holdings, who offered R12.5m, complained in papers that the tendering process for Volks Hospital was neither fair nor competitive and that prospective tenderers were not informed that a private hospital licence had been approved in principle before tenders were called for.

Had prospective tenderers been informed that an additional private hospital licence would be allocated to the successful tenderer, much wider participation in the tendering process would have resulted and much higher tender amounts would have been offered, the court was told.

Evidence is that last September the province invited tenders for the sale of Volks. Closing date was September 27.

A special condition was that tenderers must assure themselves that they can obtain a licence to operate a private hospital and that Provincial Administration is not bound to accept the highest offer.

These conditions and the restrictive condition that Volks be used as a hospital for 15 years is of special significance because of the moratorium on the issuing of private hospital licences which existed at the time Clinic Holdings submitted its tender, the court was told.

Hurwitz said in papers that the tenders were not opened simultaneously and no explanation was given. When the province’s Tendering Committee met last November 12 to consider the tender, the only issue which appears to have concerned it was the price for which Volks should be sold.

The fact that Medi-Clinic appears to have been aware that an additional private hospital licence was to be made available, gave it an unfair advantage in the tendering process, the court was told.

Scholtz, with Mr Colin Kainovitz, instructed by Mallhicks Inc, appeared for Clinic Holdings. Mr Peter Hodes SC and Mr Rudy van Roonen, instructed by the state attorney, appeared for the Western Province government. Mr Willie Burger, SC, and Mr John Dickerson, instructed by Hofmeyr Herbststeins Gihwala and Claver Inc, appeared for Medi-Clinic Holdings.

Somerset interns could take legal action

CLAUDIA CAVANAGH

DOCTORS doing their internship at Somerset Hospital will take legal action against the province if the hospital is closed and their contract breached.

This follows the recent release of plans to close the historic hospital, as well as Valkenberg Psychiatric Hospital, in an attempt to offset a R248-million provincial health deficit.

But besides the obvious loss to the community should the hospital go, 14 interns’ lives, and their training, will be severely disrupted.

One of them, Dr Leigh Gordon, explains: “Our contract with the Western Cape Department of Health says that in the event of rationalisation, we may be rotated through, or transferred to, other hospitals, specifically in the Metropolitan area.

“But at present, we know that there are no available intern posts at any of the hospitals in this area. Thus, in closing Somerset, there will be a direct breach of contract.”

Somerset Hospital, she said, was particularly sought after by interns.

“It’s a secondary hospital so one can be sure of getting more hands-on experience and doing a lot more surgery than at Groote Schuur, for instance.

“All the disciplines are available here too. We get to do all our medicine, surgery and paediatrics right here, with an option of doing obstetrics and gynaecology afterwards as Senior House Officers.”

She also pointed out that this year’s fifth-year medical students had to submit their applications for internship by last Friday.

“If they’ve put down Somerset and it closes, they’ll have nowhere to go. But on the other hand, if no one chose Somerset because they’re afraid it’s going to close, then the hospital will have no interns next year if it is saved.”

Gordon has appealed to the Medical Association of South Africa for help and Mr Peter Brewer of Masl’s legal department is addressing the issue.

● A public meeting regarding the proposed closure of Somerset Hospital will be held in the City Hall today at 1pm. Provincial health department heads and the MEC for health Mr Peter Marais have been asked to attend to answer questions from staff and members of the public.
Shocked staff ask who will care for their patients now

Jenny Viall

Nelspoort Hospital is a large, sprawling one built as a TB sanatorium in the 1920s, in the days when the "mountain magic" cure of clear, dry air and rest was the most that could be offered to patients with what was then called "consumption".

Much has changed over the intervening 70 years, and while there are still 28 tuberculosis patients at Nelspoort, it is now largely a haven for chronic psychiatric patients.

Cathy Sprinkle is matron at the hospital and "ma" to most of the 116 psychiatric patients, many of them older than she is. The trend in psychiatric care is for people to live in the community, but 74 of these people have no contactable family members.

"Anyway, we don't expect families to care for these people, they're institutionalised and couldn't survive out there. There's one man who's been here for 35 years," she said. The community is closely connected with the hospital, and when a patient dies, the community buries them. "We are their family."

At present, there are 28 TB patients at the hospital from all over the country. Three of them are children. Their stay here is anything from four months to a year, and mostly they have drug-resistant TB or are HIV-positive.

The proposed closure of the hospital by July 1 has come as a shock to staff. "This is an autocratic decision from the top," said Ms Sprinkle. "We're in the dark about what will happen to patients and staff."

The hospital employs 143 people, most of whom live in Nelspoort. The health department business plan proposes that staff will be "reduced" by 126 and the rest will be transferred to nearby Beaufort West.

"There's a lot of tension among staff," said Ms Sprinkle.

"A lot have gone onto anti-depressants. I lie awake at night, worrying about what will happen," she said.

Ms Sprinkle has not been told where patients will be moved if the hospital closes, but Lentegeur in Mitchell's Plain and Stikland in Bellville are the likely options for psychiatric patients.

Gideon Ritsels, who works as stores manager at the hospital, said the news shocked him. "I was born in Nelspoort and worked at the hospital for 34 years. When I heard, it was as though someone held a revolver to my head, as though someone wanted to shoot me, my wife and children."

"Close the hospital and the community will be crippled. People will leave to look for jobs, the school will run empty," he said. Nurses say they face a dilemma: they don't want to ask for transfers, because that will make it easier for authorities to close the hospital.

"On the other hand, we have to think about ourselves, plan our futures. Other staff don't have the choices we have. If we go, it makes it bad for others," said one nurse.

Afrika Spargo has spent 20 years in the work therapy department at Nelspoort hospital. He's taught thousands of patients the potting skills he's perfected, and he's seen people support themselves with these skills once they've left the hospital. His main concern is what will happen to patients.

"These are our children. Their own people don't care about them, we do." Staff at the hospital realised the hospital will be closed at some stage. All they want is some certainty about their future.
Support grows against Somerset's Castle

WHERE TO FIND: County Councillors and members of the public have been left stunned by the proposal to demolish the historic structure.

When you hear it mentioned - Castle Somerset - the image conjures up castles of grand proportions and rich regal histories.

But the reality is far different as we learn the value of the castle has been put at a mere £1m, and yet it could cost an additional £20m to renovate and make it habitable.

Rumours are abound that the castle could be sold to the highest bidder, with £5m being mooted and even £15m being suggested as a target price.

In the wake of this revelation, there has been an outpouring of public support and outrage at the suggestion of the castle's demolition.

The People's Campaign to Save the Castle has been formed, with supporters calling for it to be preserved and restored as a monument to Somerset's history.

Chairman of the Campaign, John Smith, said: "The castle is a symbol of our heritage and identity, and it must be protected and preserved for future generations."
Hundreds join hospital fight
‘Closure of Somerset a ploy to get money’

JENNY VAILL
Health Reporter

Hundreds of people attending a spirited public meeting added their voices to protests at the proposed closure of hospitals in the Western Cape with a call to keep Somerset Hospital open.

Elaine Clark, chairwoman of the Dispensing Family Practitioners’ Association, told a packed City Hall that Somerset was the only hospital in the city bowl area serving people who did not have medical aid. It would not be allowed to close.

She said the closure was part of the structural adjustment programme imposed on South Africa by the World Bank and International Monetary Fund which told governments of poor countries to cut spending on health, welfare and education.

“We say to Mr (Peter) Marais (MEC for health), the National Party and the ANC, we will not easily lie down and see you close Somerset Hospital. We will see to it that no development takes place there that will benefit the rich.”

Gilbert Lawrence, director of super-regional hospitals in the provincial Department of Health, told the meeting the department had been told by the national and provincial finance departments that they had to keep within budget this year and the R284-million deficit could not be extended over three years.

He said the department’s highest costs were staff and it had to reduce the staff bill and beds by July 1.

“We are most unhappy about the impact this will have on health services.”

John Frankish, the department’s head of health for the Cape Town metropolitan area, said if Somerset were to close certain services would have to be replaced.

“We would have to have a 24-hour primary care clinic in the area. Maternity would have to be replaced at Groote Schuur and Mowbray maternity hospitals. There are plenty of empty beds, the problem is staff.”

People at the meeting suggested that the proposed closure of Somerset was an excuse to sell and make money out of prime land opposite the Waterfront.

They called on Mr Marais to maintain the hospital as a much-needed facility for the poor people living on the Atlantic seaboard, in the city bowl and along the West Coast up to Atlantis.

Medic alert: doctor and community leader Elaine Clark addresses the City Hall meeting

Mass backing: a spirited crowd turned up in support of the drive to save Somerset Hospital
Health officials and hospital superintendent Edward Lotz are checking proposals to make Somerset hospital a facility catering for both private and public patients.

Dr Lotz said Somerset hospital could not stay unchanged. A facility was needed in the area, there was a shortage of funds and the Somerset site was valuable.

"I foresee a public/private venture," said Dr Lotz, but could not elaborate on proposals put forward by private health care companies.

The public/private venture would probably mean a private company would buy or lease the hospital and would be required to provide a certain amount of beds to the public who could not afford private care. "I definitely see the hospital changing," he said.

This would mean the services and site would have to be consolidated and its teaching function would have to be shared with other regional hospitals. Cheap accommodation for 200 staff at the hospital would no longer be provided. He said the hospital needed about half the present site to run the hospital and the other half would probably be leased or sold.

"I would suggest the north block stays. In 1981 R90-million was spent on renovating that section for use as a hospital for the 21st century."

"Also, there's the historical aspect. Somerset was the first teaching hospital in Cape Town and I think it needs to remain part of health care."

Dr Lotz said the outpatients section would move to a community health clinic already planned for Sea Point.
R95m Somerset tender in waiting

DAN SIMON

ONE of South Africa’s richest property companies, Seeff Holdings, has prepared a R95-million tender for when the Western Cape government decides on the future of Somerset Hospital.

And contrary to rumours, the Western Cape government yesterday said it was not prepared to sell off the hospital or any other buildings or vacant portions of the approximately 68 000 square metres of prime land, on which the hospital is situated near the V&A Waterfront.

Instead, the provincial government would favour a lease agreement as the land was simply too valuable to sell, an MEC said.

How valuable? According to a property valuator it would “take days” to determine.

One would have to look at “comparable sales” and then determine a price at which each square metre would sell if the land was used for residential or commercial purposes.

Estimates ranged between R4 000 to R7 000 a square metre.

But Western Cape MEC for Asset Management Michael Louw said if the government made a decision, it would prefer to negotiate a lease agreement and utilise a portion of the money tendered for the land to build a hospital in a needy area.

“The Land Administration Bill makes provision for a capital account to be utilised for infrastructure,” said Louis. “I wouldn’t mind getting R100m (from a tender) and use R50m to build a hospital in say Athlone and place R50m in the capital account.”

Dr Alan Louis, managing director of Seeff Commercial Properties, said his company was “seriously looking” at tendering for 43 000 square metres and had updated a two-year-old tender proposal because the government makes a decision on its future.

Louis said it was the most sought-after piece of land in Cape Town.

“We know that the government has been looking for alternatives for two years as the hospital is costing a lot of money. We prepared a tender two years ago and we just updated it. What makes it expensive is that it is raised land,” he said.

But the future of the hospital is far from decided. The medical
Let's get Dotti about health drive

MS Dotti Mukwa's health problems are about to become a matter of public scrutiny — and it's a good thing, too.

For Dotti is the star of a series of three illustrated pamphlets and three 15-minute radio "documentaries" in a campaign with the slogan "Move it for a healthy future!", which will try to explain the intricacies of the Western Cape health department's District Health System (DHS), a new plan to bring more effective and equitable health care to the province.

The DHS is based on the tenets of Primary Health Care, which is designed to provide better health care generally, take pressure off hospitals and contain costs by having patients regard clinics or community health centres as their first stop when they need treatment.

Some 450 000 pamphlets, will be distributed from April 9 through hospitals, clinics and community health centres. The documentaries, as well as five radio spots, will run on regional and community radio stations from April 9 until the end of the month. — Staff Writer

UCT will fight closing of hospitals

CLAUDIA CAVANAUGH

The University of Cape Town is set to clash head-on with the provincial department of health over plans to close Somerset and Valkenberg hospitals.

The proposals — aimed at off-setting the department's R284-million budget deficit — are "illegal", will destabilise and seriously undermine the university's world-class teaching and research base, and will be "very strongly resisted", said Vice-Chancellor Dr Mamphela Ramphele yesterday.

"We must retain our world-class medical school and will use every means at our disposal to do so. "These are national assets serving the city, the province, the country and the continent. We are committed to defend these precious and irreplaceable resources," And, according to Ramphele, the university has good reason to be angry. "We have held several high-level meetings with the province and other tertiary institutions where we have agreed on a set of core principles as the basis for rationalisation. The latest proposals violate these principles," said Ramphele.

In addition to closing Valkenberg and Somerset, the health department's business plan outlined a further downsizing of Groote Schuur and Red Cross Children's hospitals. UCT would not accept the plan because it would also destabilise and seriously undermine the academic teaching and research base in the health services, and further seriously erode health services to the poor.

"There is no indication of how the remaining hospitals will accommodate the thousands of people currently served by the institutions under threat," said Ramphele.

She said the university had clear principles for achieving "significant rationalisation" while keeping and even building quality in the health care system.

Late yesterday, the recently retired vice-chancellor of the UCT, Professor Stuart Saunders, added his stern warning to the authorities over the proposed closure of Valkenberg, in particular.

"Patients will die if the province implements its proposed cutbacks," he said. "There is a great risk that the needs of psychologically ill patients will be perceived as less critical than other patients. Acute psychological illnesses are also life-threatening. We must ensure that Valkenberg hospital is not sacrificed by a poorly thought-through plan."

The former professor of medicine at Groote Schuur and current chairperson of The Friends of Valkenberg Trust, said he felt sure the officials involved knew that the goals of the proposed savings would be impossible to meet and "that patients would die as a result".

Saunders suggested alternative ways of tackling the problem.

"By the health department's own admission, the plan to close Valkenberg in its entirety would save only R5,7m, while disrupting and permanently damaging the system of psychiatric care built in this area over decades," he said.

The solution, he said, would be for the hospital to use only the new wards built in the 1980s. Most patients in need of acute care would be admitted. Most of Valkenberg's grounds could be sold or leased.
Man dies after four days in waiting room

Doctors at Johannesburg General hospital allegedly refused to examine a dying paraplegic patient, writes Angella Johnson

A wheelchair-bound teenager died after he was found sitting in his excrement in the emergency waiting room at Johannesburg General hospital.

He had spent four days there waiting to be examined for abdominal and chest pains.

Petrus Ndlovu (19) arrived at the hospital last Wednesday in considerable distress. He was treated for bed sores and then discharged.

He got as far as the waiting room, where he was discovered by friends on Sunday, doubled over in his wheelchair. An hour later, after a doctor allegedly refused to examine him, Ndlovu was dead.

Kevin Daly, who runs a Christian street ministry in Hillbrow, is accusing the hospital and its staff of neglect and gross negligence. He says he found Ndlovu sitting in his own faeces.

"The smell was so overpowering that there was no one else in the waiting room. It was obvious to even the untrained eye that the gravely ill figure was ill and weak," he said.

"He could not sit upright straight in his wheelchair, so we took him to ward 165, where a doctor assured us he had already been treated for bed sores and discharged."

After a lengthy discussion, the doctor admitted Ndlovu had not had an abdominal examination and agreed to re-admit him.

No further assistance was offered, so Daly and a colleague wheeled Ndlovu into an examining room, removed his soiled clothing and lifted him on to the bed.

Within 30 minutes a doctor entered the room, asked a few questions and without once touching Ndlovu, discharged him.

Daly pleaded with another doctor to conduct a proper examination and was told that would place her colleague's professional integrity in question. But she eventually agreed.

When Daly went to give the good news to Ndlovu, he found him dead.

"I was flooded with emotion," he recalls. "Three doctors and nurses knew that a young man — a paraplegic — had been there for several days because they had phoned around to get someone to fetch him. Yet they did nothing to help him."

Dr Pascal Ngakane, the hospital superintendent in charge of casualty, says he received a letter of complaint about the incident and is looking into it. He has asked the head of the emergency ward to collect statements from all the people concerned.

"These are very serious allegations. I'm most surprised to hear this. Someone should have spotted him long before, but I cannot make any further comment until I have collected all the facts."

Daly is demanding to see the results of an autopsy being carried out and has asked the Medical and Dental Council to investigate.

"I don't think this is an isolated case," he insists. "Most of the people who get treated this way are poor, displaced and voiceless — people with no one to stand up for them; people for whom no one would look twice if they disappeared."

Ndlovu was no saint. Typical of Southern Africa's last generation — the old regime offered him no real education and the new regime appeared to offer him no real opportunities — he ran away from his home in Zimbabwe about six years ago and turned to crime, until he was stopped by a police bullet in the spine.

Alone and still wanted by the authorities, he lived in squalid conditions in a Hillbrow block of flats frequented by drug dealers — always fearing arrest.

Ironically, on Sunday his father, Ronnie Ndlovu, who works for a family in Randjesfontein, drove to Johannesburg to look for him.

Ronnie Ndlovu, who had not seen his son since January, said: "Petrus has been in several hospitals, including Baragwanath, since the shooting.

"I thought he had gone back home to his mother, then out of the blue someone called to say he was sick again."

He went to identify the body at the hospital mortuary this week and doctors explained that his son had suffered a cardiac arrest.

Lawyers for Human Rights believe Ronnie Ndlovu may have grounds to sue the hospital or health authorities for negligence.

"According to the scenario you have put to me, this appears to be a very serious case of a failure to exercise duty of care," explained Coriett Lottering.

"By not examining a sick patient, it could be considered that a doctor behaved unethically and dangerously."
Proposed closures of Somerset and Valkenberg hospitals ‘illegal’

CAPE TOWN — The proposed closure of Somerset and Valkenberg hospitals was illegal, University of Cape Town vice-chancellor Mamphela Ramphele said yesterday.

The proposals — aimed at offsetting the Western Cape health department’s R284m budget deficit — would destabilise and seriously undermine the university’s world-class teaching and research base and would be very strongly resisted, she said.

“These are national assets serving the city, the province, the country and the continent. We are committed to defend these precious and irreplaceable resources,” Ramphele said the university had good reason to be angry.

“We have held several high-level meetings with the province and other tertiary institutions where we have agreed on a set of core principles as the basis for rationalisation. The latest proposals violate these principles.”

The Western Cape health department’s business plan also outlined a further downscaling of Groote Schuur and Red Cross Children’s hospitals.

She said the university would not accept the plan because it was a breach of the joint agreements between the university and the province affecting teaching hospitals; would destabilise and seriously undermine the academic teaching and research base in health services and would seriously erode health services offered to the poor.

Retired UCT vice-chancellor Stuart Saunders warned that patients would die if the cutbacks were implemented. There was a great risk that the needs of psychologically ill patients would be perceived as less critical than other patients, he said. — Sapa.
Hospital closure a threat to future birth care
No room at city hospitals for sick children of Somerset

Red Cross says it's too full to help

ADELE BALETA

The Red Cross Children's Hospital will not be able to take on the children treated at Somerset Hospital if the Green Point hospital is closed, Dr Joe Ireland, a consultant at Red Cross, said yesterday.

He said Red Cross was already overloaded with sick children and had a shortage of nursing staff. Unless the hospital was able to employ more staff, it wouldn't be able to cope with more children.

Last weekend was unusually busy, according to sources. The intensive-care unit was filled to capacity and couldn't accommodate all the children requiring assisted breathing.

A two-month-old baby with severe pneumonia died before a space in the unit became available. The child was on full treatment at the time.

Dr Ireland, who was on call at the hospital last weekend, said: "We were filled to capacity with 10 children on ventilators and limited staff to run the intensive care unit."

Ideally, there should be one nurse for every child on a ventilator, he said.

On Sunday, only six nurses and two sisters were on duty in the ICU because of the number of ill children in the general hospital at the time.

Dr Ireland said it would be impossible to take over Somerset Hospital's six ICU beds and the 32 ordinary paediatric beds without the transfer of additional staff.

It has been proposed that Somerset's paediatric beds be absorbed by other hospitals, but bed numbers have already been cut at the Red Cross, Conradie, Victoria, Tygerberg and Kari Bremmer hospitals.

The second level hospital GF Jooste, which serves Khayelitsha and the central Cape Flats, doesn't even have a paediatric service.

Three wards have already been closed down at the Red Cross Children's Hospital.

Dr Ireland said many nurses had accepted voluntary severance packages, leading to a loss of experienced staff.

"When staff numbers drop you reach a critical mass and then the stress experienced by the remaining staff is so great they find it difficult to cope."

"You can have an excess of doctors but, without nurses, children cannot be cared for optimally. The nurse is the fulcrum around which all care revolves," he said.

Nurses were needed to change nappies, feed children, administer intravenous fluids and give antibiotics.

"Every aspect of childcare requires good nursing and this is especially the case in ICU," he said.

Dr Ireland said he had written to FAheed Hassim, the hospital superintendent, explaining the staff situation.

Dr Tom Sutcliffe, the Western Province's head of health, held a staff meeting at the hospital on Thursday. Dr Sutcliffe said applications for more voluntary severance packages had not been approved. In addition, more nursing posts were being given to key institutions like the Red Cross Children's Hospital.
Property outfits hover over ailing hospital

TOM HOOD (98)

PROPERTY developers are hovering over cash-strapped Somerset Hospital in the hope of buying the valuable site overlooking Cape Town's Waterfront.

The Western Cape government wants to close the hospital because of heavy losses, and developers believe the site is ideal for an upmarket shopping centre, expensive townhouses or a cluster village, office park, corporate headquarters or conference centre.

Seef Commercial Properties has disclosed that it is prepared to pay R55-million for half of the 68 000 m² site.

This would work out at R2 790/m² — far below the area record of R4 330/m² paid two years ago when Golding manager Denise Dogan sold a vacant, 3 000 m² Mouille Point site to a German buyer for R13-million.

Nearby, at Granger Bay, apartments were selling for between R15 000/m² and R20 000/m², the top prices in Cape Town, said Steven Nelson, Atlantic manager for the Rawson property group.

"There should be some way to keep the hospital going and make it a multi-use property," he said. He calculated that the 34 000 m² site could be worth from R240-million to R313-million.

Developer Des Kruiis, MD of Richprop property organisation, feels overseas investors with cheap rands would outbid local companies if the hospital land came on the market. This had happened twice with other beachfront sites.
Other side of the health crisis: two nurses for ten villages
Waiting for rain and a food of patients
‘This is how to save Valkenberg’

Sell land and build new hospital, says UCT chief

JENNY WALL
Health Reporter

The land on the Observatory side of Valkenberg hospital should be sold or leased to a developer in return for building a new hospital on the Pinelands side and making annual payments to the health department.

This is one of the proposals for the future of Valkenberg hospital, which has been earmarked for closure in the provincial health department’s business plan. Already a developer has indicated willingness to buy or lease the land.

The proposal, by Brian Robertson, head of psychiatry at the University of Cape Town, is supported by staff and organisations which serve Valkenberg’s patients and their families, and UCT’s faculty of health sciences and psychiatry department.

In his proposal, Professor Robertson says the southern suburbs need a 280-bed public psychiatric hospital with 130 acute beds, 60 beds for respite care and clinic patients and 90 forensic beds.

There are 650 patients at Valkenberg, which has the Western Cape’s only forensic psychiatry unit.

Professor Robertson’s plan, which he has submitted to provincial health minister Peter Marais, would require the transfer of 370 chronic psychiatric and forensic patients to Stikland and Lentegeur.

The plan would free all the land on the Observatory side and about half the land on the Pinelands side. Professor Robertson said closing Valkenberg entirely would be opposed by UCT, unions, patients and families, NGOs, civic associations and political parties.

Western Cape director of health Tom Sutcliffe said his department would examine all proposals submitted in response to the business plan.

“At the end of the day it is in our interests to do what is best for our patients,” he said.

“Valkenberg remains the institution that we as a department believe should close and there is a lot of rationale in consolidating four psychiatric hospitals into three.”

He said that the forensic unit would have to stay where it was in the interim. “The building is in a shocking condition and we must urgently find some solutions in consultation with the department of correctional services.”

He said that should Valkenberg close, a community-based psychiatric service for outpatients could possibly be opened at Alexandra hospital, which is nearby. The acute psychiatric wards at Groote Schuur Hospital and Tygerberg could also increase their capacities.
Somerset gets a temporary reprieve

A DOCTOR WARNS THAT closing the largest HIV clinic in the Western Cape would have a dramatic impact on HIV health care throughout the country. DAN SIMON reports.

IN-DEPTH research at Somerset Hospital has shown that there is a tremendous interaction between tuberculosis and HIV in the Western Cape.

But with the threat of closure hanging over Somerset Hospital as a result of the Western Cape government’s cost-cutting plan, this vital research could grind to a halt.

Closing the hospital and terminating vital services, including the Western Cape’s main HIV clinic, would be disastrous given the budgetary constraints on health and the latest statistics on the increased prevalence of HIV in the province.

But indications are that the provincial government is toning down its talk of an across-the-board closure and is now reassuring some key services at the hospital that they will be “maintained in some form or other.”

Yesterday, Western Cape health MEC Peter Marais also extended the deadline for alternative proposals to save Somerset Hospital by another two weeks. The deadline for alternative proposals was originally due to expire today.

Head of the HIV unit at Somerset, Dr Robin Wood, said yesterday: “Of late there have been some reassurances from the minister (Marais) that the patients will be looked after and that the HIV clinic will be maintained in some form.

“We don’t know what that really means, but I think we should hold the minister to these reassurances and make sure they are not political jargon or platitudes.”

Wood said any move to close the biggest HIV clinic in the province would have a major impact on HIV care and research in the province and country as a whole.

“The clinic has consistently been the busiest clinic in the Western Cape and there has always been a balance between patient care and research activities.”

The clinic has seen more than 2 500 HIV patients since it opened in 1983 and at present serves about 500 patients.

Included are about 150 HIV patients who partake in running clinical trials utilising modern HIV therapies. The trials make use of recognised drugs which are licensed in many parts of the world.

Woods said this type of therapy was “unique” in a state service.

“Obviously a large number of our in-patients are also HIV positive, especially the TB patients. So we have done a lot of work on that. We’re trying to develop cost-effective ways of making a diagnosis on patients. We believe we are saving money because the majority of our TB cases are HIV positive.”

“It is difficult to diagnose TB. So we are working specifically on trying to get a cost-effective way of making these diagnoses so as to best use the resources available.”

Wood said that should the unit be closed and staff retrenched, patients would have to find treatment at other hospitals.

“Unfortunately all the other hospitals are very stretched and have cuts of their own. So it will have a serious impact on their management.”

And regarding HIV, Wood said this was on the rise.

“About 6% of ante-natal women in the Western Cape are HIV positive. There are about three million with HIV in South Africa as a whole. This is about the fastest growing epidemic in the world. A tenth of the world’s HIV affected patients now live in South Africa.”

Wood added that the Western Cape had the lowest prevalence of HIV in the country — yet the fastest growth rate.
MORE GOOD NEWS POSSIBLE

Key health posts unfrozen

THE JURY IS still out on the fate of Somerset Hospital, but there was some good news for the health services yesterday — and hints that the city’s stalwart might be saved. Health Writer JUDITH SOAL reports.

FIFTY-THREE key hospital posts are to be unfrozen, the provincial administration confirmed yesterday, providing some relief for the Western Cape’s beleaguered health services.

Details of all the posts are not yet available, but health chief Dr Tom Sutcliffe confirmed that 13 of these would be at Red Cross Children’s Hospital. Six are for professional nurses, six for nursing assistants and one for a radiographer. Posts will also be unfrozen at Groot Schuur Hospital.

“We called the provincial health personnel together and asked them which posts were of critical importance,” Sutcliffe said. “We obviously can’t meet all their requirements but we have been able to fill the most important ones, despite the business plan.”

This “business plan” is the one that proposes closing five hospitals — Somerset, Valkenberg, D P Marais, Westlake and Nelspoort — cutting 3 816 jobs and closing hospital beds to make up a provincial budget deficit of R284 million by July 1. “We are scaling-down in areas where we feel we can but we still have to look at the integrity of the services,” Sutcliffe said. “That’s why we are unfreezing the posts.”

The move follows recent reports that nurses at Red Cross were having to decide which babies to treat because of staff and equipment shortages. The hospital’s chief matron, Ms Daphne Hoogenhout, said the new nurses would be invaluable to relieve the pressure in intensive care units and theatres.

“We have already started interviewing applicants and hope that we can make appointments by the beginning of the month,” she said.

On Somerset Hospital, Sutcliffe hinted that a compromise might be reached to save the hospital from total closure. “We have alternative proposals in front of us — at the one end we could keep it going as is, at the other we could close it completely. Then there is a point somewhere between. “Some functions — like obstetrics, the neo-natal unit and paediatrics — are in short supply throughout the province and we have to address that.”

He said other departments — like the infectious diseases unit — were general functions that could be provided elsewhere.

Health MEC Mr Peter Marais’s spokesperson Mr Johan Smit seemed to agree. “The business plan was always the worst-case scenario. Any decision after that is an improvement.”

But this decision hasn’t yet been made. The deadline for proposals to save the Somerset is Monday, April 20, and Sutcliffe said his department had received many “interesting ideas” so far. “We are discussing them but what isn’t negotiable is the budget. If we retain Somerset then we will have to cut somewhere else.”

The final business plan will be announced next week, but Sutcliffe’s comments suggest there could be some more good news — along with some bad.
Hospital named in honour of Tambo

PRESIDENT Nelson Mandela honoured the name of former African National Congress leader Oliver Reginald Tambo yesterday by officiating at the opening of the Tambo Memorial Hospital, formerly the Boksburg-Bennoni Hospital.

Mandela said it gave him the greatest joy to rename the hospital after one of his greatest friends and colleagues. "It seems entirely appropriate that Comrade OR (Oliver Reginald) should be associated not with some international airport, nor even with a fine university — but with a public hospital near the town he called home, where the daily business is to serve those who are ill or in distress," Mandela said.

Mandela said Tambo was not only the longest-serving ANC president, but also a national leader whose historical importance transcended party boundaries. "As Mahatma Gandhi was to India, so Oliver Tambo is to SA," he said.

Mandela said Tambo's greatest achievement lay in his ability to sustain a liberation movement thousands of miles from home; to devise ways to keep it alive in the hearts of most South Africans and to build a corps of leaders committed to working for peace even while waging an armed struggle. He said qualities such as those Tambo possessed had particular relevance for health workers who struggled to bring essential health services to all people.

Tambo is to have a tombstone unveiled in his memory in his hometown of Waterville, near Benoni, on Sunday. — Sapa.
AS THE HEALTH SERVICES PRESS RELEASES FOR DECISIONS ON PICTURES AND CLINICS OF TREATMENT AT CLINICS

I WAS LEFT OUTSIDE THE FLOOR.

Judith Scott reports.

dispersed community clinics have struggled. Health workers
hospital directors this week's living press releases of decisions on
pictures, shocking tales

The New York Times
Today is D-Day for cash-strapped Somerset Hospital to come up with a plan to save it from closure.

The provincial Health Department said in a business plan released last month that, if it was to keep within budget, 1,000 people would have to leave the health service, 500 academic hospital beds would be lost and Somerset Hospital would have to close.

The plan caused a public outcry and Health Minister Peter Marais set today as the deadline for alternatives to the plan. Gilbert Lawrence, head of supra-regional hospitals, leads the team of top officials who will evaluate the proposals.

Plans will be discussed by unions and the department will come up with a final business plan at the end of the month. The department has to shed more than 3,800 jobs this year, but will be able to re-employ people in the next financial year.

This anomaly - spending money to reduce staff this year only to employ more people next year - was the result of cash flow problems, said Johan Jooste, head of finance in the department.

About 70% of the health budget was spent on salaries and this was where most savings could be made, he said.

"We have to get into budget this year. At the end of the month we must have a business plan and it must be enforced. Every day we wait the situation gets worse," said Mr Jooste.

The provincial and national governments have stipulated that there will be no overspending this year. Provinces that do

To page 3
New population policy focus is on human development

JOLIE SAWYER
POLITICAL CORRESPONDENT

Welfare Minister Geraldine Fraser-Moleketsi today unveiled a new population policy signalling a radical departure from the past.

In a white paper tabled in Parliament, she said the central theme of the new population policy would be sustainable human development. Hallmarks of past policies were the provision of contraception “often through coercive means” and restricting the movement and settlement of Africans.

Addressing a media briefing, Ms Fraser-Moleketsi said South Africans, especially women and young people, should be empowered to take control over their own lives. Families should be able to provide for their needs to meet their potential.

The country’s natural resources should be used in a sustainable way to meet the needs of the current generation.

The white paper sets out 24 strategies, covering areas including poverty reduction, health, mortality and fertility, gender, women, young people and children, education, employment, migration and urbanisation.

Ms Fraser-Moleketsi said the thrust of the new population policy was not on controlling the population growth rate but on providing for the socio-economic needs which affected population growth.

The white paper calls on all policy makers to take population factors into account when developing policies and programmes. By taking population into account, policy-makers would be able to plan more accurately to meet the needs of the population and future generations.

Her ministry was awaiting the latest census results to enable a detailed analysis of population concerns.

A national population policy unit will be responsible for implementing the policy. Its priorities included helping government departments interpret the population policy as it affected their areas of responsibility.
ON THE EVE of the election of the Western Cape National Party leader, one of the top contenders for the job, Pieter Marais, announces that he will save Somerset Hospital. Health Writer JUDITH SOAL reports.

Somerset Hospital will not close, although some services will be cut. This is definite, although not yet official. Health MEC Mr Pieter Marais said yesterday. The health department has outlined a plan to keep the hospital open, which includes:

- Cutting 1,988 jobs, not the 3,816 as originally intended
- Freezing all new appointments from August
- Stopping all capital equipment expenditure on health in the Western Cape
- Closing 57 beds at the north block of the hospital and possibly selling this land
- Reducing the "scope and scale" of services at the hospital
- Implementing the "other elements" of the business plan.

These "other elements" relate to the plan announced by Marais' department in March, and include the closure — or relocation — of Valkenberg, D P Marais, Westlake and Nekpoort hospitals, to make up the R284 million health budget shortfall. The new plan means that a R69 million budget shortfall will be carried through to next year.

"I am delighted to be able to announce that Somerset will stay open," Marais said last night.

He said his department had taken heed of the opposition to the closure. "Somerset was District Six’s hospital, that is why these people still come there. This link must be respected."

It seems that the hospital's land could not have been sold as prime property as had been predicted when the closure was mooted.

"A review of the title deeds shows that the land can't be used for anything but hospitals," Marais said. He hinted that Somerset's north block would be privatised, but that it would have to be used for medical purposes.

Some commentators were sceptical of Marais' announcement, coming as it does on the eve of the election of a new National Party leader in the Western Cape. Marais, along with Community Safety MEC Mr Gerald Moralee, is a top contender for the job.

"It looks like he is trying to gather some votes," said Somerset doctor Professor Greg Hussey. "The health services are again being used as a political football."

ANC provincial leader Mr Ebrahim Rasool called

Television interview, "If the unions really want to contribute they will accept the new plan, but if they are politically driven then there is no way we can find a solution," Marais told the Cape Times later.
Marais denies election ploy in health plan

DP queries timing

JENNY VAILL
Health Reporter

Health Minister Peter Marais may have announced Somerset Hospital would be saved in a desperate but vain bid to secure the premiership of the Western Cape, say opponents and political observers.

Not so, says the feisty Nat, who took over the health portfolio earlier this year from the Ebrahim Rasool, the new ANC Provincial leader.

"I am not that kind of person," he protested yesterday.

While the move to save the historic Waterfront hospital is being welcomed, there are concerns that it could be at a cost to health services elsewhere.

ANC MP Willie Hofmeyr commented: "This is typical of the way Peter Marais does things. He tends to decide first, and look at the details later."

Closing Somerset Hospital was just an aspect of a health department business plan to save money.

"After a storm of protest, unions and hospital management were asked to submit alternative plans. The report on a possible rescue plan is expected only in the first week of May. So the about-turn announcement by Mr Marais on the eve of the election of the NP regional leader, one of the frontrunners, came as a surprise."

Protest meeting is on

A protest meeting at Somerset Hospital planned for tomorrow will go ahead in spite of the announcement by provincial Health Minister Peter Marais that the hospital will not close.

Elaine Clarke, spokeswoman for Labour and Communities Against Hospital Closure, which is organising the meeting, said the closing of hospitals would reduce people's access to quality health care.

Other hospitals earmarked for closure in the health department's business plans are Valkenberg, Westlake, Princess Alice and Nelspoort.

"Instead of offering better health care to people, health care is being diminished and taken away," she said.

Mr Marais's political opponents were as one in their scepticism about the timing of the announcement.

Democratic Party health spokesman Daniel Silke noted: "The timing of his latest announcement was remarkably close to the election of a new NP leader."

But Mr Marais said: "My whole hospital plan is being jeopardised by sentiment around Somerset. This is why I thought I had to address the issue."

He acknowledged his new plan was not final and said while he could go ahead without union approval, he wanted to talk to them and convince them his plan was "reasonable."

"The main thing is that I will not close Somerset," Mr Marais said.

He would achieve this by "privatising half and the income will allow me to pay for the other half."

Gilbert Lawrence, head of supra-regional hospitals, has been charged with drawing up a rescue plan for health in the province.

He said while "certain undertakings by the minister may be final, until we have the total plan I cannot speculate on how services (elsewhere) will be affected."

The team was looking at the department's deficit and how to stay within the budget.
Somerset's staff want it in writing

Staff at Somerset Hospital are elated - but confused - by the decision not to close the hospital after weeks of lobbying by unions, workers and the community.

The decision was announced by provincial Health Minister Peter Marais on the eve of last night's election of a new National Party Western Cape leader.

By late yesterday the hospital had not formally been told of Mr Marais's decision. Staff have asked for written confirmation.

"We want to believe the news because we want to save our hospital. But we also want official notification," said matron Gigt Henkorman.

Linde Moore, staff support unit member, said some staff had applied for jobs at other hospitals and been accepted. Now they did not know what to do.

Somerset Hospital workplace forum spokesman Haroun Esau said: "We want assurances that come 1999, the whole nightmare isn't going to start all over again. We want a permanent solution."

He said workers wanted to see an official notice stating exactly what Mr Marais had in mind for the hospital. "Permanent solution' Haroun Esau
Hotspot clinic stays shut as Manenberg recovers

JERMAINE CRAIG
City Reporter

The main clinic in Manenberg is still closed after the upsurge of gang violence, although residents say the situation has "returned to normal in an abnormal society".

The Cape Town municipality suspended all its services in Manenberg, including the library, clinic, rent office and creche, after gang violence claimed several lives.

All services have since re-opened, except for the main clinic in Manenberg Avenue.

Chief medical officer of health Michael Popkiss said the clinic was in a "real hotspot" on the border of rival gang territories.

This meant that when gangsters were treated there, there was a distinct possibility that rivals would enter the clinic.

Staff and other patients were in danger of being caught in the crossfire, he said.

The clinic service had been moved to a smaller facility on the safer northern boundary of Manenberg.

He said that because of concerns for the safety of staff, the municipality had also moved the dental and mental health services to Hanover Park and Keewtown.

Dr Popkiss said the municipality was considering posting three security guards at the Manenberg clinic and altering the building to make it safer for staff and patients.

"We don't have a date for the re-opening of the clinic - all we have is a desire to do so."

"When the clinic re-opens we hope we will have a calm atmosphere and the security measures we put in place will ensure the safety of the staff and our patients."

He said the intention was to restore normal services as soon as possible - next month at the latest.

But there was still the fear that sporadic gang warfare could erupt at any time.

Faldilela de Vries, Manenberg community worker and African National Congress councillor, said the situation had stabilised substantially and it would be possible to restore services.

"The shootings have substantially abated - the situation is what is normal in an abnormal society.

"All the facilities can function as they did before the closure," said Ms de Vries.

She had recently written to city manager Andrew Boraine saying the council was rendering a service which was "legally flawed".

She was also not happy that people now had to travel outside their area for services they were accustomed to getting in Manenberg.

She said this was not in accordance with the Government's approach to primary health care.
R40-m Flats hospital deal

Melomed, the company which owns the Mitchell's Plain and Gatesville medical centres, is to raise R40 million to buy another hospital in Cape Town. Ebrahim Bhorat, who founded electronics chain Melotronics and is the major shareholder in Melomed, said the company was planning to buy a hospital in Gatesville, Rylands, Mitchell's Plain or Athlone.

Mr Bhorat said the company would fund the acquisition with the R40 million it was expected to raise through its listing on the Johannesburg Stock Exchange in August.
City may link with private firms on emergency services

Partnership proposed by consortium to help boost flagging service

BY AMOS TKOM
Health Reporter

Greater Johannesburg could enter into a public private partnership within the next two months in an effort to boost the city’s emergency services which is facing severe staff shortages.

A private consortium headed by Netcare proposed last month that the Greater Johannesburg Metro Council combine resources with the private sector and set up a not-for-profit company to boost paramedic and ambulance services.

Deputy director in the Gauteng health department Dr Eric Buch said province was keen and supportive, but there had to be an open and fair opportunity for other roleplayers to forward proposals as well.

He said that, in the interests of transparent and fair government, the process should follow several steps. These included deciding whether they (council) were keen to look at private public partnerships, deciding what kind of private public partnership would be feasible, drawing up the principles that would govern this partnership and, lastly, calling for proposals, through advertisements in newspapers.

Consortiums or interested parties would then be invited to forward proposals.

Buch said province was keen to see the process begin as soon as possible, possibly within two months, even though it normally took much longer.

He emphasised that the province was very interested and keen on developing public private partnerships, but that government rules had to be followed to avoid nepotism, corruption or kickback charges.

“My sense is that Netcare has entered the process in good faith, but the nature of government determines that you have got to offer all players an open and fair opportunity to put in a proposal,” Buch said.

Emergency services strategic executive Hillow Mako said council would be meeting with province today as some questions needed clarification.

“1 don’t know which way the process is going to go and we are waiting for clarity from province,” he added.

Chief operating officer at Netcare Dr Richard Friedland said they remained committed to a strong public and private sector. He said the Section 21 joint venture proposed by Netcare was an ideal template as it took the monopoly motive out of the venture.

“We have no objection to other company’s tendering,” Friedland added.

In terms of Netcare’s proposal, the consortium – which includes Europassist, Votac, a vehicle company and a petroleum company – will inject money into the project to supplement the municipalities’ staff, vehicles and equipment.

Buch said the process offered positive potential for the service, expressing the hope that staff in the services would see the positive benefits.
Goods, equipment worth R210,000 stolen from Jo'burg hospital

The public is being urged to provide basic healthcare to the people in their own communities, and to keep an eye out for any thefts.

The department of health is concerned about the situation, and has a task force working on the matter.

The thefts have been reported to the police, and are being investigated. The department is taking steps to prevent such incidents from happening again.

The department of health is working closely with the police to ensure that the situation is resolved as quickly as possible.

The public is urged to report any suspicious activity to the police, and to cooperate with their investigations.

The department of health is committed to providing quality healthcare to the people of South Africa.
Health authorities look ahead to public/private partnership

By ANGE THOM

A public/private partnership appears to be on the cards to boost Greater Johannesburg's emergency services following a meeting yesterday between the council and the Gauteng health department.

The city's emergency services face severe staff shortages, especially among paramedic and ambulance staff.

A private consortium proposed last month that the Greater Johannesburg Metro Council combine resources with the private sector and set up a not-for-profit company to boost paramedic and ambulance services.

Since then, the province has suggested several steps. These included deciding what kind of public partnership would be feasible, drawing up the principles that would govern it, and calling for proposals through advertisements in newspapers.

Deputy director in the Gauteng health department Dr Eric Buch said emergency services strategic executive Hillow Maeko would take the proposal to a committee, which would make a decision.

If there was agreement, a proposal regarding public/private partnerships would be tabled.

Maeko said the meeting had been convened so that the province could approve a change to the agreement under which Greater Johannesburg's municipalities administered the emergency services on behalf of the health department.
"You just let our baby die"

Staff held hostage as angry protesters condemn clinic that turned away seriously ill six-week-old girl while they celebrated.

By Ano Tshweu
Health Editor

A six-week-old girl died when staff at Kliptown Clinic in Eldorado Park, south of Johannesburg, allegedly refused to treat her because the clinic was closed for a ceremony.

Last night, enraged residents were holding clinic staff hostage in protest.

A commission of inquiry will be held into the death of the six-week-old Raygene Dison on Friday.

Monica Pietersen, Raygene's aunt, said the child's mother, Cordelia, had gone to the Ascot Road clinic early on Friday because the baby was struggling to breathe.

"Cordelia was turned away at the clinic gate and was told the clinic was closed because Mandela was coming to open it later in the day," said Pietersen.

(The recently renovated clinic was in fact officially opened by newly elected Health MEC Monthsho Nkabinde on Friday.)

She left and phoned an ambulance. She went back to the clinic. By this time the child was blue in the face. The ambulance arrived and, all of a sudden, the clinic staff started outside to try to help. They pushed the baby into the ambulance and one of the sisters went with, but the baby was dead when they arrived at (Chris Hani) Baragwanath Hospital," an angry Pietersen said.

Pepo Maja, spokesman for a group of Health MEC Anno Maseko, said there had been no instruction from head office that the clinic should be closed for the day. "It was because of a mix-up, a misunderstanding," he said.

A woman at the scene said the family was angry that their daughter's death had been handled with such little respect.

"We phoned for an ambulance, and our nurse went with the baby to meet the ambulance," said a mother.

"The nurse was the only one at the clinic. She called a doctor, and they both passed the baby to the ambulance," the mother said.

About 50 women, mostly members of the South Western Joint Civic Association, converged on the clinic yesterday.

A group of members of the South Western Joint Civic Association blocked the entrance to the clinic after the death of the child.

"We are angry at the way the clinic has been run," said a member of the association.

The association has been trying to get the clinic to improve its services for some time.

"We have been complaining for years, but nothing has changed," said the association.

The association has also been trying to get the clinic to improve its services for some time.

"We have been complaining for years, but nothing has changed," said the association.
Clinic opens late as staff fear community's wrath

BY ANSE THOM
Health Reporter

Klipfontein Clinic in Eldorado Park opened more than four hours late yesterday after most of the nursing staff failed to report for duty for fear of their lives. Three doctors and a few nurses managed to keep the clinic running after it opened at about 11.45 am instead of 7.30 am.

The clinic was in the spotlight last week when 6-month-old Raygene Dixon died after clinic staff allegedly refused to treat the baby. The clinic had been closed for an opening ceremony at its time.

Members of the community and the South Western Joint Civic Association's (Sowjoca) women's brigade staged a protest outside the clinic last week, holding clinic staff hostage for more than 16 hours. A joint committee was formed last week to investigate the circumstances surrounding the death. "We didn't come to fight, we came to see why the clinic hadn't opened," said brigade chairman Lola Wolfinik.

She said she could not understand how the nurses could be scared of five Sowjoca members. "If I wanted to hit them, I would have hit Dr (Arthur) Manning," Wolfinik said.

Manning is superintendent of Coronationville and Helen Joseph hospitals, where Klipfontein patients are referred to.

Communications director in the Gauteng Health Depart-

Uproar over baby's death scares nurses in Eldorado

ment Jo-Anne Collinge said nurses were concerned about their safety. "The situation will have to be assessed on a daily basis and it is impossible to say whether the clinic will open on time or when the nurses will return to work," Collinge said.

She said doctors had been sent to the clinic to attend to patients and to prescribe medication because no primary health care nurses had gone to work.
Long wait as Kliptown Clinic staff stay away

By Charity Bhengu

SCORES of sick people had to wait a long time at the controversial Kliptown Clinic in Soweto yesterday because doctors and the nursing staff had not reported for work.

Babies, pregnant women and elderly people were unattended until about 10am. The administration offices and dispensary were locked. Some of the people at the clinic claimed they were at the gate from as early as 5am.

The head of the clinic, Derrick Manning, arrived shortly after 10am. He told Sowetan that staff members were afraid to come to work.

This follows the death of six-week-old Raygene Dixon after allegedly being turned away by the clinic's security and staff members last week.

The clinic's services were suspended for that day in preparation for the official opening of the clinic. The baby allegedly died shortly after being turned away.

Manning said yesterday: "We have about 12 staff members and they did not come to the clinic because they are afraid of being victimised. I am hoping that by coming to work, I am able to prove that no one wants to harm them."

The only staff at the clinic yesterday morning were Manning and two nurses. They could not cope and a bus was provided to take some of the patients to Coronation Hospital. They were later joined by two doctors.

The Gauteng health department said the clinic had been operating yesterday, but under extremely difficult circumstances.

"The clinic opened late because of the need for a prior meeting with clinic staff, most of whom were returning to work for the first time since last week's hostage-taking by the Soweto Women's Brigade in response to the death of baby Raygene Dixon," the department said.

Last week members of the South Western Townships Association (Soweto) Women's Brigade held staff hostage for several hours.
Health savings plan held back

JERRY WOLL
HEALTH REPORTER
ARG 6/5/98

Western Cape Health Minister Peter Marais presents his budget to the provincial legislature today, but final details of his business plan to save money will be announced only at the end of the month.

A preliminary business plan announced in March proposed closing Somerset, Valkenberg and Nekspoort hospitals and shedding 3816 staff from the department through voluntary severance packages.

The plan was opposed by unions, community organisations and others and the deadline for alternative proposals was extended by two weeks to enable everyone to have a say.

Two weeks ago Mr Marais announced that Somerset Hospital would not close, but said other details were still being worked out and he would announce a final plan in his budget speech. But unions have yet to be consulted.

The Health Department's projected deficit for 1998-99 is R284-million and the provincial and national treasuries have said no overspending will be allowed this year.
Rasool call on sale of Somerset Hospital

JENNY WALL
HEALTH REPORTER

An independent body should handle the sale or lease of the Somerset Hospital and proceeds of the sale of the north block should be used for a hospital to serve Khayelitsha, Philippi and Mitchell's Plain, says Ebrahim Rasool.

The leader of the African National Congress in the Western Cape and former health minister was replying to Health Minister Peter Marais's budget speech in the provincial legislature yesterday.

Mr Rasool said this move would ensure integrity in the handling of provincial assets.

Mr Marais confirmed yesterday that the north block of the hospital would be closed and said Minister of Asset Management and Works Michael Louw had been asked to "alienate" it at the best value to the health department.

The western block, which has 260 beds, will be retained. Health services in the Western Cape faced another tough year with budget allocations down in most areas, said Mr Marais.

Although final details of his business plan for health services would be available only at the end of the month, Mr Marais announced that clinics at Kraaifontein and Delft would be commissioned fully this year.

This was essential to create a safety-net for reduced capacity at hospitals.

Mr Marais said some hospitals in rural areas would close, but more beds would be opened at Ceres Hospital.

Planned upgrading at regional hospitals would not take place this year because of a lack of funds.

The allocation to academic hospitals (Groote Schuur, Red Cross and Tygerberg) had been cut by R135-million, an 11% cut.
Tax incentives could boost efficiency

Josey Ballenger

THE days of poor waste management and inefficient industrial practices may be limited if tax incentives are introduced — an idea that may be incorporated into government’s waste management strategy, a consultant to government said this week.

“We cannot just use sticks. We need some carrots,” said Dave Baldwin, technical officer of consultancy Bohlskei Environmental, in reference to measures being considered by an interdepartmental committee to encourage waste generators to engage in better practices.

Government’s national waste management strategy process, which began last August, is a joint effort between the environmental affairs and water affairs departments, various SA consultants and Danish consultancy Ramboll. The two-year project is primarily funded by Danish aid agency Danned’s R8,32m contribution, with the SA government kicking in R700,000.

Baldwin said the strategy focused on four major areas: hazardous and related wastes, including mining and radioactive materials; nonhazardous waste; waste minimisation; and compiling a national database.

The project’s first phase — a baseline analysis of SA’s waste output and minimisation efforts — is due for completion at the end of the month.

The second phase will be to develop a strategy within six months, and the final phase will see the creation of “action plans” by next May.

Baragwanath upgrading ‘allows for better care’

Josey Ballenger

THE recent R2,3bn upgrading of what has become the world’s largest hospital — Soweto’s Chris Hani Baragwanath — puts the community institution in a better position to cope with the 30,000 patients it sees every year.

Baragwanath’s revamped medical admissions ward 20, which was opened this week by greater Johannesburg mayor Netfa Mogase, includes a medical high-care unit and a better equipped laboratory six times the size of its predecessor.

“About 3 million people live in Soweto and most of them come to the hospital for medical care. The ward gives patients more privacy and dignity and access to improved quality of care,” said Donald de Korte, CE of pharmaceutical company Merck Sharp & Dohme (MSD).

Between 70 and 100 patients — with ailments ranging from tuberculosis to heart disease and strokes — are admitted daily, while only R5m of the hospital’s R500m annual funding needs is collected from its primarily poor patient base.

The hospital also functions as a referral centre for SA’s 40 provincial hospitals and medical facilities in neighbouring countries and is the largest teaching hospital for medical students from Wits University.

The upgrade was a public-private partnership between MSD, which contributed R1,5m, the Gauteng health department, which paid R500,000, and the SA Institute for Medical Research — a statutory body which contributed R300,000.

The upgrade resulted from a 1996 survey of staff members which painted a “disturbing” picture, the hospital said. In the survey 98% of the respondents felt the quality of care was poor and equipment inadequate, while 78% said emergency care facilities were insufficient.

The new ward is divided into five sections, each staffed by two nurses, two doctors, a registrar and an intern. This “dramatically improves the quality of care”, said project co-ordinator Dr Ivor Katz.

JUDGMENT IN BRIEF

A recent court judgment of interest to business

NBS Boland Bank Ltd v One Berg River Drive
CC, Witwatersrand Local Division, 8 April 1998, B Southwood

MORTGAGE bonds passed by One Berg River Drive in favov of NBS Boland Bank provided that specified interest rates would be payable on the loan advanced, or such rates as the NBS might determine from time to time. Clause 14 of the bond provided that the NBS could vary the rate of interest and could increase the monthly repayments so as to ensure ultimate payment of the whole bond within the period of the bond.

The NBS brought an action against Berg River, claiming amounts outstanding on the bonds. The parties agreed that the point of difference between them was the legality and enforceability of clause 14. Berg River argued that clause 14 was void because it was vague, having left the determination of the interest rate completely within the discretion of one party, the NBS. The NBS argued that in interpreting the provision, enforceability rather than unenforceability should be sought; furthermore, that the NBS’s discretion was to be exercised reasonably.

The judge said that it was a principle of our law that when a term of a contract depends entirely on the will of one of the parties to determine the extent of performance of either party, the contract is void. While it was true that a contractual term should be interpreted so as to be enforceable, rather than unenforceable, the provisions of clause 14 gave the NBS an unfettered discretion to vary the interest rate. The discretion did not have to be exercised reasonably. Clause 14 was therefore unenforceable.

 Advocate Mark Stranex’s feature appears every Friday. Full transcripts are obtainable from email: lawpub@global.co.za or 011-337-6634 or http://www.lawpublisher.co.za.
No need for fear in new Bara ward

BY ANSO THOM
Health Reporter

Years of shocking conditions at the Chris Hani Baragwanath Hospital's (CHB) medical admissions ward ended yesterday with the opening of a new wing sponsored by government and the private sector.

"It was not hard for us to sell the project once a potential donor came to see the ward, because the inhumane and disgusting conditions that existed spoke for themselves," said project co-ordinator Dr Ivor Katz.

Between 80 and 130 patients, suffering from diseases such as tuberculosis, AIDS-related illnesses, diabetes, strokes and psychiatric disorders pass through Ward 20 every day.

After a survey conducted two years ago to assess the needs of the patients, and staff, a management committee was set up.

"The survey found the ward was not efficiently run, quality of patient care was poor and the equipment inadequate.

"Doctors and nurses used to run around looking for patients and this led to poor teamwork," said matron-in-charge Joyce Pooe.

The project teamed up with the SA Institute for Medical Research (SAIMR) to build a new emergency laboratory adjacent to the ward.

"The new lab is six times the size of the old lab," said SAIMR head at CHB Dr Martin Hale.

Merck Sharp and Dome agreed to sponsor the project with assistance from the SAIMR and Gauteng Department of Health.

Yesterday The Star saw patients lying on the benches in the passage or lined up on trolleys or in wheelchairs waiting to be transferred from the old overcrowded ward.

Doctors performed medical procedures in the presence of the patient's families as there was no waiting room.

Chief of medicine at CHB Professor Ken Huddleson said the new ward reflected the social conscience of the hospital.

The new high care unit, with eight beds, would have more oxygen points than the old ward. And a fully fitted kitchen, resting areas for staff, curtains around the beds and a store room for medication have also been built.

"I came in yesterday and already I have seen two corpses which is really upsetting," said cardiac patient Veronica Noto (54), who was yesterday still being treated in the old ward.

"I just want to go home. I'm afraid here," she said.
Helping hands: Christine Brathwaite, John Sonnenberg and Shants Fredericks join hands at the opening of the new St Luke’s Hospice at Somerset Hospital

New hospice under threat

STAFF REPORTER  ARG 12/5/98

A new St Luke’s Hospice has been set up in a vacant ward at Somerset Hospital – but it may be forced to move soon if part of the hospital is sold in terms of a provincial government plan to save money.

At the opening of the Milner Ward hospice yesterday, St Luke’s chairman John Sonnenberg said the organisation had to get on with its work and could not wait for the provincial health department to decide the future of the hospital.

The sale of part of Somerset has been mooted as a way to help the department keep within its budget and avoid closing the whole hospital. Dr Sonnenberg said he hoped it would be a couple of years before the property was sold.

St Luke’s cares for terminally ill patients, the majority of whom have cancer or AIDS. The Somerset hospice is able to serve 30 people from an area stretching from Woodstock to Sea Point. Previously, patients had to travel to the hospice in Kenilworth for treatment ranging from physiotherapy to group discussion on the trauma of dealing with life-threatening disease.

The hospice will also offer support to Somerset Hospital AIDS patients, who cannot be helped by the diminished staff.
Call for Discoverers to go back to being a hospital

BY ANGE THOM
Health Reporter

Discoverers Hospital on the West Rand was surrounded by angry picketers yesterday.

They demanded that the institution, which has been converted by the Gauteng health department into a community healthcare centre, be reopened as a hospital.

Communications director for the Gauteng health department, Jo-Anne Collinge, said the decision to convert the hospital into a community health centre was taken as part of a plan to achieve a more rational, equitable and cost-efficient health service, with greater emphasis on primary healthcare.

"Most important for the community to know is that Discoverers is not closed or not about to close. And the change is not as dramatic as some people allege," she said.

Collinge said the community could still gain access to a wide range of healthcare services including a number of free primary healthcare services, a day-time casualty service, a 24-hour midwife obstetric unit, short-stay beds, dental care, an x-ray unit, a pharmacy and social work services.

In March, 5 686 outpatients were treated compared to 5 924 during the same time last year.

"Although some staff have been lost as a result of the drawn-out process of conversion, there are plans to address the situation, with the number of doctors increased to provide for more complex clinical services planned for the centre. This would enable the clinic to extend casualty hours," Collinge added.

In the second half of this year, additional primary healthcare services - including family planning, a well-baby clinic, immunisation and the management of tuberculosis - would be added.

The petition contained more that 20 000 signatures as well as 600 letters.

Rae Baur, chairman of the Democratic Party's Roodpoort branch, said it was unacceptable that a modern, five-storey hospital serving a community of 107 000 people could be closed and a small portion transformed into a healthcare centre. She said Discoverers had been the only hospital capable of serving Roodpoort and Dobsonville.

A misunderstanding led to picketers failing to hand over a memorandum and petition to the department yesterday. A government official waited for the picketers inside the clinic when they waited for her outside the gates.
100 docs face axe in W Cape hospitals
Budget may cut 2 148 staff

JENNY WALL
Health reporter

The Western Cape Health Department will have to shed 2 148 staff, most of them by September, if it is to keep within budget.

This is set out in the department's revised business plan, which was discussed with labour organisations last week. It has yet to be approved by the provincial cabinet.

Although staff cuts will affect all employees, doctors will be hit particularly hard by the proposals on how many employees in each category should leave.

More than 100 doctors at Somerset, Princess Alice, Groote Schuur, Red Cross and Tygerberg hospitals have been described as "supernumerary", which means they will not be needed.

This number includes 58 registrars (doctors training to be specialists) and more than 30 specialists.

But doctors also will be affected by plans to defer their overtime pay from March 1998 to April 1998, and reduce the overtime worked.

About a third of doctors' pay is overtime pay, and this will save money in this financial year. Payments to district surgeons also will be limited.

Employees declared supernumerary will be given the option of taking voluntary severance packages or of being deployed in other posts.

The draft business plan released in March required 3 600 staff to leave the service. Of the 2 148 required to leave in the revised plan, 1 200 are expected to leave through natural attrition (resignation, death, ill-health).

The rest will be encouraged to take voluntary severance packages.

The department says it can save R22-million on personnel and R30-million in other areas.

But Michael Makwayiba, of the National Education, Health and Allied Workers' Union, which represents about a third of health workers in the province, said the department could not afford to lose more staff.

He said: "It does not make sense to say we want to retrench more staff when there is a shortage of staff. We will not support a loss of jobs or a plan based on rands rather than the health needs of people."
X-ray crisis hits Leratong Hospital

By Noxolo Nxusani

Hundreds of desperate patients are believed to have been turned away from the Leratong Hospital on the West Rand because X-ray machines have broken down.

Those with serious injuries have, however, been admitted and told to wait until the machines have been fixed.

Leratong Hospital public relations officer Mrs Francina Ratsaka confirmed that one of the two functioning X-ray machines broke down on Friday. She said only patients with minor injuries were sent home.

"Since Friday we have fortunately not received any urgent cases," Ratsaka said. "However, from yesterday we have an arrangement with the Paardekraal Hospital, about 10 kilometres away, to take our patients there for X-rays."

She was unable to confirm how many patients had been turned away.

"Ratsaka said initially the hospital had five X-ray machines. Three broke down a month ago."

"Since then we have been using only two machines and another one broke down last week," she said.

Mr Popo Maja, a spokesman for Gauteng’s MEC for health, said his department was not aware of the problems at the hospital.

Maja said: "The normal procedure is that the department has to be notified of anything that hinders the provision of services to the public. In this particular case, we have not been informed at all."

Maja promised to investigate the matter further.

Sources told Sowetan that about 120 patients are treated at the hospital on Saturdays and Sundays.

The source said some patients had asked to be referred to other hospitals after they were turned away.

Accident victim

One of the patients – an accident victim who did not want to be named – was told to go home and come back the following day when staff members intervened.

"She was forced to wait in the casualty room for several hours for transport to take her to the Tshepo Themba Private Clinic in Soweto," the source said.

When Sowetan visited the hospital yesterday there were two empty rooms that were supposed to contain X-ray machines. Staff members at the orthopaedic department, which deals with bone disorders, were sending patients away.

Several other ward patients were waiting anxiously for their turn to be taken to the Paardekraal Hospital.
**Health services have been severely wounded by budget cuts**

**Seven victims**

Valkenberg all but from the resiliency process late last year, as the killings mounted. Kalisani estimated that discharged patients have now killed at least 11 people over the past three months. Many of them have since been returned to the hospital.

"Either we've got to watch them closely, or someone else must, but we have great difficulty keeping an eye on everyone," Kalisani added. "The only way we can keep control of them is to keep them in our walls."

He says the unit is unable to gauge what sort of treatment, if any, other discharged former patients are receiving.

Adoptive care for patients will be vital in preventing the government's drive toward refining state patients' rights to a trial. The government's main motive is to modernise its approach to mental and psychiatric health care, away from often grotesque past practices such as simply locking patients away.

But similar experiments overseas have left many former state patients on the streets or in jail. Such results prompted the United Kingdom recently to reverse its care-in-the-community policy.

The Western Cape based its rationalisation plans partially on a task-team report finalised earlier this year.

The report warned that community care for psychiatric and mental patients, already hampered by staff shortages, had been further hurt by voluntary severance. It recommended that posts vacated under the pay-off programme be retained.

But the department responded that it could not "guarantee" the posts would be retained.

"Cognisance must be taken of the need to rationalise the total health department to set budget limits," the department noted.

Friesen says community care in the Western Cape "has not collapsed. However, there is little doubt that these services could be improved."

Lawrence adds that the province will only release patients to the community at "a rate that can be received."

At the moment, each patient is being moved into halfway houses.

**BA Health in need of treatment, PAGE 24**

**Subtle signs of relapse hard to detect**

**Andy Duly**

Staff at the Valkenberg forensic security ward are busy trying to stop things to see what, if anything, could have been done to prevent the killing of seven people by former psychiatric patients.

There are common threads. Each patient, despite their usually violent history, seemed to have responded well to rehabilitation treatment at the unit, each respondent well to outside treatment at clinics, and then, one by one, each died from the state's side effects — re-emerging only once they had killed someone.

Names and specific dates remain under wraps, often for legal reasons, often because Valkenberg fears for the safety of the patient. One Cape Flats community is still looking for the police, and it is believed to be one of the state's highest-profile women — the aunt who had taken him in when his family in the Eastern Cape was released.

In a case, however, seems to sum up what's gone wrong. Valkenberg had held one violent patient for years, finally deciding early in the 1990s that he could be released.

"He did very well," says unit head Susan Kalisani. "He found a job, he got married, he was coming to the clinic. And then he stopped coming."

He then picked up the growing friction between the man and his stepdaughter. He wanted her to treat him like a father; she laughed at him for being a former psychiatric patient.

One afternoon, in his family's lounge, in front of her laughing friends, she got the ridiculous far too far. The man fled to his room, and returned with an axe that he swung high, and sank deep into her chest.

The ex-patient was initially held at Pollsmoor, apparently because he did not appear satisfactorily insane to warrant a place at Valkenberg. In a matter of months he had totally relapsed and was back at Valkenberg.

"We didn't know what went wrong," Kalisani says. "The early signs of relapse can be very subtle, and you must see a little bit of funk in three people quite a lot. They should be seen at least once a month." But when they don't appear at the clinic little effort is made to find them.

"We just don't have the resources to do that anymore."

The unit is still changing details from the Free State police about the abduction, rape and killing of two small girls by one of its ex-patients, early last year. The patient's case history shows that he had been a very violent character, but after he had opened the Irlofonton police station, and had killed two girls, he had "felt obliged to start rehabilitation process."

He too disappeared after a few clinic visits, only to reappear in the hands of the Irlofonton police. "We had no way of tracing him down," Kalisani says. The other cases include a patient stealing his wife, and a patient who stabbed his mother.

One former patient, who was married and had a daughter, slipped when he was walking down the street, stabbing to death a man, and the police never found him.

Valkenberg has its successes. Kalisani has one patient who was held at the maximum security unit for 15 years after killing three people. The state patient, now 46, has held down a job in the city. Kalisani sees him regularly.

"He's only a very small section of those who become ill that are violent and they become violent. But if all the state budgets are cut we are cutting very important and very sensitive services."

**Just three hours to rest after giving birth**

**Bongani Sigopko**

T he road to Alexandra clinic is lined with shabby industrial buildings. But the large, brightly painted clinic looks cared for and cheerful. Many volunteers mistake it for a church.

Inside, however, it looks like any other state-funded health institution. Very long queues, busy nurses, crying children and wheelchairs fill the waiting room.

The clinic will be forced to close down. It does not get more funding from the government, staffers say. This follows a budget cut of R3 million by the Department of Health. "We were getting R1 million a year, but now we only get R8 million. What can you do with R8 million these days?" asks a senior nurse at the clinic.

Director Catherine Mvelase says although the clinic is expecting another R3 million from the Eastern Metropolitan Local Council, it still won't be enough. The clinic, which has been operating for 60 years, treats more than 1,000 patients a day from Alexandra township — which has a population of about 560,000 spread over 3,000km².

It is also struggling to pay the R5 million it owes the Gauteng provincial administration for drugs. "We are trying to pay what we can," says Mvelase. Every month the clinic has been buying R20 million worth of drugs, but since the Hillbrow hospital closed down it has been forced to double that amount.

"We are getting more people from Yeoville, Hillbrow, Alex, Mieder and Barow who have been referred to us by Hillbrow hospital," says Sister Lorna Marumo. As a result the clinic's pharmacy has run out of some essential drugs. "For weeks we have been telling people to come back later for these drugs," she says.

If the clinic shuts down, sick children and pregnant women will suffer. Although it has limited resources, the clinic still treats hundreds of children with diarrhoea, flu, pneumonia and asthma.

The children's observation area has only four beds. It is overcrowded and sometimes four children have to share one bed.

The adult observation area is the same. Three women share one bed, and the women are sometimes housed with male patients. Only two professional nurses, a porter and an assistant nurse are on duty at any given time for all three wards.

The situation is even worse in the maternity ward. There are only two midwives to look after women who are about to deliver or who have just given birth. Women are given only three hours to rest after giving birth. "We cannot do otherwise, there are other women queued up for the beds," says Marumo.
From the monitoring of released mental patients the provision to the evacuation of ambulances, 'Rehabilitated' patients claim

Swapan Prabhakaran

T
he KwaZulu-Natal Department of Health announced an "inadequate" health budget for 1986/87 this week, speaking of an outcry from hospital staff who predict it will have dire consequences for health services.

Drug stockouts in schools and staff have already been implemented in some provincial hospitals in preparation for the budget, which is R83 million short of the expected expenditure for the year. Several vital health-care services will either be completely suspended, or run at par-
tially reduced levels.

In his budget speech, MEC for Health Dr Zweli Mkhize said while cuts are unavoidable, they have been planned to have "the least possible impact on the population as a whole.

He did admit, however, that some of the measures "will have negative medical, or even life-threatening consequences". One of these is that no government ambulance services will be available to patients in KwaZulu-Natal between midnight and dawn.

This measure, which the department labels as "cutting down on ambulance response time by 20%", may be a blanket measure, regardless of whether the request for ambulances is "urgent" or not.

"The scenario we face is that on any night in Durban, about 500 ill and dying patients will be desperately trying to get into a hospital, any hospital. Hospital gates will be closed, with little tents cities of desperate, sick people waiting outside, praying for hospital beds," the doctor said.

Mkhize denied the need for such pessimism. "What we have to do above all else is focus on the R12 billion we have got, and not on the R60 million that we do not have," he said in his budget speech.

Over the past few weeks, the Department of Health has drawn up a list of some of the money saving devices planned for the near future. Much of it is "administrative detail" — increasing efficiency, cutting out waste of resources, shortening the length of stay at hospitals.

But all on the list are items marked as "negative medical implications". These include: "reduce treatment to terminal cases"; "close all 300 out of 12 000 beds available (at hospitals)"; and "cut highest levels of surgery".

One particularly carefully worded item is "introduce atrouter protocols" — effectively means victims of strokes, heart attacks and other major debilitating diseases may be refused beds in hospitals if they don't meet the criteria for hospital beds.

Doctors predict these are most likely to affect the elderly, children, pregnant women and their unborn babies, and those with chronic diseases and AIDS.

The sad irony is that the cuts come at a time when the province's health-care services are experiencing a boom.

More people than ever before have had access to health care and child mortality rates have dropped by nearly half.

Much of this is thanks to the province's network of clinics, and the department has committed itself to improving this network of services and staff.

However, clinics are not able to replace all the services hospitals provide.

The superintendent of St Mary's hospital, Dr Roderick Ross, says the state-assisted public hospitals are among the worst hit by the cuts.

He says large-scale retrenchments are inevitable at the hospital — its subsidy has been cut by R10 million and it seems likely this will mean the hospital will scale down to become a community health centre.

"It's temporary, but it's not ridiculous," Ross said this week. "I'm faced with the position of retraining doctors at a time when the government is importing Cuban doctors.

"The situation is terrible..." he added.

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Don't get sick after midnight

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"The situation is terrible..." he added.
From the monitoring of released mental patients to the provision of ambulances, 'Rehabilitated' patients claim

Psychiatric patients treated and released by Western Cape health authorities have killed seven people over the past 18 months, including two children, amid an apparent collapse in the system set up to monitor them.

The former patients, all from the high-security forensic unit at Cape Town's Valkenburg hospital, represent a small proportion of the mostly harmless population of state mental hospital inmates.

But the killings could fuel fears about the government's drive to release thousands of patients into the care of their family and friends. Health officials say community care has been hit by staff shortages and cost-cutting measures such as voluntary severance packages.

The deaths could also lead state health open to legal and civil action from the victim's families.

Valkenburg forensic unit head Roan Kolisli says the six patients who turned killers were all judged to be rehabilitated and low risk prior to their release. The unit treats patients who were deemed unlikely to stand trial for crimes such as murder, rape and assault.

But he adds that an exodus of state psychiatric social workers held the safety net designed to catch the released among disregarded patients. Valkenburg only discovered the historical activities of its former patients from police inquiries throughout last year.

Their victims, mainly family members, one man buried a hatchet in his stepdaughter's chest, another stabbed his mother. The children—two small boys, abducted, raped and killed in the Free State—are believed to have been random victims of one former patient. All have been caught.

Kolisli adds that the unit also releases drones 'for a month or a month and a half' because the hospital lacks the staff to control them.

"We have to go out and do it ourselves," he said.

The killings caught national and provincial health officials off guard. The Department of Health had to check with Valkenburg before issuing a written response.

"Patients released from forensic units of mental institutions sometimes do commit crimes of varying seriousness," department director for mental health and substance abuse, Dr Brian Freeman, says. "This is, however, the exception rather than the rule."

Other institutions report that less than 5% of their released patients commit crimes.

Freeman adds the department would have to consult its legal advisers to check whether it can be held liable in criminal or civil law for the deaths.

The Western Cape health chief director of superspeciality hospitals, Gilbert Lawrence, says the killings are a 'scare-up call' about the weaknesses of current community care.

"Doctors at Valkenburg face the dilemmas about releasing patients into a structure that is adequate or not adequate. At the end of the day it's a question of resources. It's happening across the country's," he said.

Around 750 staff at the province's four psychiatric and mental institutions have taken pay-offs since June 1996, close to one-quarter of their total staff. More than 400 have taken the package in the past six weeks.

The staff losses form part of an overall health rationalisation and cost-cutting programme. The province also plans to close 30 of 180 forensic unit patients. Valkenburg is one of the province's teaching hospitals.

"I've no doubt it will increase the risk," Robertson says.

Lawrence says that is just an opinion; he expects the rationalisation will improve care.

Valkenburg treats 350 forensic unit patients—65 of them in a maximum-security unit—from the Western, Eastern, and Northern Cape. The unit discharged 95 patients between 1996 and 1997, following lengthy, gradual rehabilitations.

The discharge application is approved by the attorney general—in Valkenburg's case, Frank Kahn—following a review with a psychiatrist.

Don't get sick after midnight

Swapna Prabhakaran

The KwaZulu-Natal Department of Health announced an "inadequate" health budget for 1996-97 this week, sparking an outcry from hospital staff who predict it will have dire consequences for health services.

Drastic cutbacks in services and staff have already been implemented at some provincial hospitals in preparation for the budget, which is R12.8 million short of the expected expenditure for the year. Several vital health-care services will either be completely suspended or run at partial capacity. In his budget speech, MEC for Health Dr Zawo Mhlobo said while cuts are unavoidable, they have been planned to avoid any further impact on the population as a whole.

He did admit, however, that some of the measures "will have negative medical, or even life-threatening consequences". One of these is that no government ambulance services will be available to patients in KwaZulu-Natal between midnight and 6am.

This measure, which the department labels as "cutting out on ambulance response time by 45%", may be a blunted measure, regard

The scenario we face is that on any night in Durban, about 500 ill and dying people will be desperately trying to get into a hospital, any hospital. Hospital gates will be closed, with little fanfares of chaos. Rich people will be admitted, praying for hospital beds. "The doctor exists.

Kalisiti denied the need for such pessimism. "We have to do even better than the 94.7% that we got, and not only on the R4.5 million that we do not have," he said in his budget speech. Over the past five weeks, the Department of Health has drawn up a list of some of the money-saving devices planned for the near future. Much of it is administrative detail—increasing efficiency, cutting out waste of resources, shortening the length of stay at hospitals.

But also on the list are some items marked as "negative medical implications". These include: "reduce treatment to terminal cases"; "close 4,000 out of 36,000 beds (available at hospitals)"; and "cut highest levels of surgery".

One particularly worrying item is "introduce stricter procedures, not only increase number of trials, heart attacks and other major debilitating diseases may be reclassified beds in hospitals if they don't meet the strict criteria of enrolment. Doctors predict these are most likely to affect the elderly, children, pregnant women and their unborn babies, and those with chronic diseases and AIDS".

The sad irony is that the cuts come at a time when the province's health-care service is experiencing a boom.

More people than ever before have had access to health care and child mortality rates have dropped by nearly half.

Much of this is thanks to the province's network of clinics, and the department has committed itself to improving this network of services and staff. However, clinics are not able to replace all the services provided.

The superintendent of St Mary's hospital, Dr Douglas Ross, says the state-run hospital is among the worst hit by the cuts.

He says large-scale rearrangements soon in- stituted at his hospital—its subsidy has been cut by R6.5 million and it seems likely this will mean the hospital will scale down to become a community health centre.

"It's about as bad as it gets. It's almost ridiculous," Ross said this week. "I'm faced with the position of driving doctors to a time when the government is importing Cuban doctors.

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‘Calculated risk’ when criminally insane freed

Staff Reporter

Psychiatrists working with criminally insane patients "take a calculated risk when they release them back into society, and there is always a chance the decision will backfire".

This is the view of Gilbert Lawrence, chief director of supraregional hospitals for the Western Cape Health Department.

He was responding to allegations that the Health Department was irresponsibly cutting resources to psychiatric hospitals like Valkenberg.

In an article in the Mail & Guardian today, Valkenberg's forensic unit head Sean Kaliski said seven people had been murdered by released patients in the past 18 months. He said there were not enough staff members in the unit to safely care for patients or to follow up once patients were released.

Most of the victims were family members of the killers— and included two children.

Dr Lawrence said the responsibility for releasing a patient rested with the doctor who recommended to the authorities that a patient be released.

"In any dealings with a patient, a doctor has to use his best clinical judgment. Even in the most well-resourced society there are failures. Many patients who go out are successfully rehabilitated."

But Dr Kaliski said the exodus of psychiatric nurses and social workers from the public service meant there were not enough qualified staff available to check up on patients once they were back in society.

He said many patients were being released for a month at a time because the hospital did not have the staff to control them. "We just hope to God they don't hurt anyone," he said.

Dr Lawrence said: "Obviously if we had more resources there could be better programmes inside and outside— but at the end of the day the doctor still has to make the final decision."
Reborn – city hospital that treated presidents and princes

WHERE PATIENTS GET A BED WITH A VIEW
No one is fighting for us, say psychiatric staff

CAROL CAMPBELL
Special Writer

Three of the four psychiatric hospitals in Cape Town have no medical superintendents and staff fear no one is fighting on their behalf to stop the reduction of psychiatric services in the Western Cape.

Worst hit is Valkenberg which is threatened with closure because of a shortage of cash in the Western Cape health budget.

Valkenberg medical superintendent Deon Schoombie left at the end of April. He emigrated to Australia.

In Alexandra Hospital, medical superintendent Linda Hering has been promoted, leaving her old post vacant. And Miles Bowker, medical superintendent of Stikland hospital, is on long-term sick leave.

"I want to know who is making the decisions for Valkenberg, who is fighting for us," said Sean Kaliski, head of the Valkenberg forensic unit.

The provincial cabinet was supposed to make a final decision on the future of Valkenberg yesterday but it was postponed for another week.

See page 11
You'll find a lot of bodies in these two rivers when...

Change is difficult, not only for patients, but for hospital staff who have to move to a new workplace.

Kate Josiah, a senior nurse working in the forensic rehabilitation ward at Valkenberg, said she has decided to leave the health service. "I must go now; I can see the difference already at the hospital. We are going down," she said.

Mrs Josiah, who will take the voluntary severance package, has 11 years' experience in psychiatric nursing. She's a valuable member of the team and her leaving is a loss to health services. "A few years ago I considered it but I thought maybe we'll come right with a new budget. But as time went by I saw the reality."

"I have no other option but to go. The staff-patient ratio is so bad, we are down to the bone."

"I have to do admin, stores, deal with the public. After a while you find your frustration affecting your patients, and that's not good," Mrs Josiah said.

The prospect of moving to another psychiatric hospital has no appeal for her. "I don't want to go through the emotional upheaval of moving to a new place, where you have to fit in to another structure."

"When they amalgamated the Pinelands and Observatory side of Valkenberg, the vibes were difficult, there were strong feelings of not being welcome, of people seeing you as a threat. I don't want that again."

She applied for the package on April 7 and heard on May 11 her application had been approved. "It was so quick," she said.

Mrs Josiah believes that closing Valkenberg will be a problem for her patients, many of whom are outpatients for three weeks of the month and return for a week to be assessed.

"They need stability. They get used to this hospital, the same staff. I'm afraid you'll find a lot of bodies in these two rivers when the hospital closes."

"Patients will default on their treatment and relapse. The route to the other hospitals is complicated, they won't go there."

"Here they know the staff, they need the same face, or a voice on the telephone they know. It's already a battle for them to get here from places like Ocean View - how will they manage to Lenwood?"

"Already patients are getting anxious - they're saying rather discharge me than move me."

"People will be on the streets. I feel sorry for them." Dennis, a patient with schizophrenia, echoes this sentiment.

"He's been in Valkenberg 10 times. "It's nice to have doctors you know. I know Dr Baumann will help me," he said repeatedly.

"People on disability grants can't afford to go to Lenwood, and anyway, they'll get lost. "Why don't they just keep this part open?"

There will be a meeting of patients and their parents and relatives on Saturday at 2pm at Valkenberg's Education Centre.

Leaving: Sister Kate Josiah is getting out.
Equipped to face our madness?

Unusual standards of community care mean the state's new policy of releasing mental patients could be a bad plan, writes Andy Duffy

The deaths of seven people at the hands of former state psychiatric patients in the Western Cape have exposed a raw nerve in state health circles.

The Department of Health this week slammed a Mail & Guardian report on the killings, claiming it had sanitised the facts, leading to "passive and unnecessary panic about mental and psychiatric patients.

But state psychiatrists and NGOs across the country say the deaths are merely an extreme symptom of the lack of community care that hampers the system.

Valkenburg, the Cape Town hospital that treated and released the six patients who killed four, says the report was bar.

The Mail & Guardian last week that six patients released from Valkenburg's high security forensic ward had killed seven people in the past 13 months, including two children.

Parkview Unit head Sue Bannister blamed weak community care structures. A recent provincial health department report also found that staff shortages had weakened community care.

The Western Cape provincial Cabinet was due to decide this week whether to approve a health department proposal to close Valkenburg as part of a rationalisation of health services.

Other state institutions approached this week said the standards of community care for discharged state patients is often patchy, and in many poor and rural areas is non-existent.

The health department also concede that, with its "limited sources" community treatment and monitoring of discharged patients, "is not always as regular or comprehensive as we would like it to be".

Three of four major state institutions have cases on their books of discharged people committing new crimes, of varying seriousness.

The largest institution, Pretoria's Westville, released a patient who last year killed a child in Mpumalanga.

The Free State's Orange hospital, which has taken 13 years to establish a community care network that ensures regular follow-ups among discharged patients, is caught doubly.

State forensic patients, held because they are judged unfit to stand trial for a crime, represent a small minority of the thousands of harmless state psychiatric and mental health patients.

But effective community care is central to the government's attempt to release thousands of such patients into the community - a project led by health department director for mental health and substance abuse, Myrsyn Freeman.

Freeman refuses to respond to further questions this week. Instead, he issued a lengthy condemnation of the Mail & Guardian report.

"This article dramatises the situation and spreads false fears to the public regarding people with mental disorders," Freeman says.

"The result is panic and unnecessary panic of people with mental disorders.

Freeman says the report also "underestimates" the government's deinstitutionalisation programme - "an approach to care which is more humane and rights-oriented than the current system of largely custodial care".

But the South African Federation for Mental Health, which represents NGOs across South Africa, says Valkenburg fairly reflects the general problems facing state psychiatric and mental health.

The federation also has concerns about the government's deinstitutionalisation drive.

"The health system just isn't equipped to look after those people," says federation director Linda Vinse.

"It is a major problem that we don't have the funds for community service. The health system has failed people, and we're not really equipped for it either."

Wongwipong and medical superintendent Leandres Gaedt says two of his discharged patients have killed in the past six years. In the case of an African, the hospital had been held at Westville for killing another child.

The 10-bed ward treats patients from across Gauteng, Mpumalanga and the Northern Province. "When [relapse] have occurred we suspect it's because of inadequate care," Gaedt says.

We find the relapse rate is higher among people coming from those (rural, lower-income) areas.

Down Stevenson, forensic unit head at Parkview, says the unit knows of one of the 25 patients it has discharged who committed a crime. "We may not always get to hear of it," he adds.

"Where we do have a concern is the patients that are discharged to other (under-resourced) provinces."

John Dunn, principal psychiatrist at Fort Hare in Zululand-Natal, says the hospital does not report its relapse rate as a major cause for concern. But he adds that half of its 160 patients come from far-flung rural areas, where community services are often thin.

Susan Olwe, senior executive officer at Orange Hospital, says discharge is only go avaided with a sound community structure in place.

The Free State pioneered the programme, in 1995, that the national department worries other provinces will follow. "We don't struggle like other provinces do," she adds.

Around 600 patients have been admitted to state forensic units last year. Freeman says the department would rather discharge those deemed rehabilitated than build new institutional facilities. Discharge conditions are stringent.

"The reality is that despite the fact that patients are assessed to the best of our abilities and that community facilities are provided (with resource limitations), there are patients who relapse."

"However, the freedom of hundreds of people with psychiatric illness cannot be more important than the good name of South Africa, and we agree, tragic exceptions."

Angela Johnson

When Bafana Cole saw the car parked outside his Soweto home he ran and hid in the small backyard. He had seen it before.

"He thought you had come to take him to Steenkop family hospital," said his grandmother.

Martha Cole smiled toothlessly as she explained that the threat to institutionalisation for her 19-year-old grandson was the most effective remedy she used whenever he refused to take the medication that kept him stable.

There has never been any doubt in her mind that he would always be cared for at home. "He's family and we will look after him. Just because someone says you don't just throw them away," she said.

It took Martha Cole 601 more than a year to realise that Bafana, who she had cared for since he was abandoned by his mother as a baby, suffered from schizoaffective illness.

Doctors at the Carl Heinz Baragwanath hospital in Soweto diagnosed him as schizophrenic after he was admitted. They decided his condition could remain stabilised with monthly injections and a dose of 20 tablets.

So Bafana joined the ranks of patients who rely on a network of small outreach clinics for medication and other support, while being cared for in the community.

A shaky looking Bafana is eventually persuaded to vacate his hiding place, his bloodshot eyes darting wildly around as he stumbles into the cramped room the family use to entertain.

"I just feel sick," he matters. Sometimes I feel scared and want to go away. I think that say he's high, a fever. I don't eat and sleep well. People hate me at the street, and sometimes I fight with them," Martha Cole says kindly at her grandson's request.

"He's much better since the injection," she adds. "But he needs to go the hospital, to have his clothes and jump over the fence every day."

When he comes back he's wearing rags.

Bafana was a normal child, thoughtful, helpful, loved by his school, until about three years ago when he began to change. He started talking about his family's life on a gauntlet of local sites who claimed he had a gun, used his gun.

"I was always there. When I came back and saw him in intensive care at Baragwanath it seemed as if he would die," says his grandmother. Bafana survived but his mind was no longer the same.

He became restless and complained of seeing things. He stopped going to school, refused to wash and took to wandering the streets, disappearing sometimes for days.

At times his two teenage cousins became targets for bouts of violence. "We lived in fear that he would do something like burn the house or hurt himself," says Martha Cole.

Of course he was going mad, but we didn't really know what to do."

Now, thanks to medication from Chirawelo clinic, the family is able to live fairly normal life.

Counselor Sihali said the son of the church was in charge of the family, a man of integrity in the township.

Last Christmas, the family was able to live fairly normal life.

Counselor Sihali said his son of the church was in charge of the family, a man of integrity in the township. He was in charge of the family's church, who said he was without his family.

The Mail & Guardian reported the case of a mental illness sufferer who claims the number of incidents are increasing and are not institutionalised.

"As long as they have been stabilised, there is a need to help them live useful lives (some of her patients hold down steady jobs) in a family environment."

Sibusiso Sihali said Baragwanath was one of the country's success stories in psychiatry. "We must get patients released so early who could be dangerous. They cause harm and destruction, but we sent them back and that doesn't happen any more."

While the hospital was grateful for the approval, it admitted that it is a hard majority of its discharged patients do not make it to clinics for outpatient treatment. Dr Graham Buba, a senior consultant at the psychiatric unit, believes most just receive a medical discharge.

Behoid said one way to cure more beds was for the government to provide halfway houses for the mentally ill. "This would allow supervised care and some sort of re-integration process, for patients who have no family support base to help them cope on the outside."

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STEERING CLEAR OF CAPITAL

Gauteng Health Department reneges in fear of privatisation

D

Despite having publicly called on the private sector to inject fresh blood into its ailing public hospitals service, the Gauteng Health Department has spurned an offer from South Africa's largest private hospital group, Netcare, to run the province's academic hospitals.

Though the department has initiated five pilot projects in partnership with the private sector — most of which aim to attract private patients back to public hospitals — it has shirked from giving hospitals the full managerial and financial autonomy they need to slash costs and improve delivery.

The department received about 30 proposals from the private sector in response to media advertisements it placed late last year.

Half of the respondents were invited to make presentations to the department. One of them was Netcare. It is not clear who the other 14 groups that made presentation are.

Netcare has confirmed that it was among the 15 and claims that, given a chance, it can cut about R555m or 15% off the department's R3.7bn hospital budget. This, it says, can be done through better cost controls, working capital management, economies of scale, standardising operations, raising productivity and streamlining the administration.

Netcare ran its 36 hospitals with 606 beds at a cost of R1.3bn last year whereas Gauteng spent R1.2bn on the Johannesburg and Chris Hani Baragwanath hospitals alone. They have 4102 beds.

In its presentation to the department, Netcare revealed that by using similar management strategies it had shaved about R100m (on an annualised basis) off the operating costs of Clinic Holdings since purchasing the private hospital.

25% — a shift of R441m from public to private hospitals — between 1994 and 1995 (see graph)

"Only if hospitals are allowed to use the revenue generated from private patients to improve the local hospital environment and provide appropriate incentives to staff will we be able to retain the outstanding academics and improve the quality of care in academic centres," says Price.

The Gauteng Health Department's chief director, strategic management, Laetitia Rispel, admits that the hospitals are experiencing problems but says: "We believe in a strong public sector. We are not going to hand over management of public hospitals to the private sector, we prefer joint management and partnerships."

Despite Gauteng's inability to grasp the nettle, its five pilot projects are a step in the right direction.

One involves leasing empty public hospital wards to doctors to treat medical aid patients.

The hospital receives revenue from these patients who would otherwise have attended more costly private hospitals or, in all likelihood, paid a nominal charge along with the indigent. This is because public hospitals have inadequate billing systems.

Government estimates that public hospitals lose R1bn in fees from medical aid patients each year, either because the patients fail to disclose that they have medical aid or because the hospital is unable to bill them accordingly.

The concept was pioneered by the Uitenhage Independent Practitioners' Association (UIPA) which leased and upgraded an empty ward in the Uitenhage Provincial Hospital for private patients in April 1996. It netted almost R2m for the hospital in the first 12 months.

Two years later, the Gauteng health department is allowing GPs to lease empty beds in Sebokeng and Kapoong hospitals for private patients.

In another pilot project, the 9000 members of Transmed's State hospital plan in Gauteng will be billed slightly more than the standard public hospital fee which they have been charged until now.

The department has also invited private-sector proposals on ways to overhaul its emergency services, antiquated hospital IT systems and underperforming renal service. It may also outsource hospital laundry services.

"We're not handing over public hospitals to the private sector"

Clare Byers

FINANCIAL MAIL, JUNE 5, 1998 37
Crisis looms for Wynberg hospital

Service cuts as doctors axed

Doctors at Victoria Hospital in Wynberg have warned that the quality of service there will deteriorate further when the hospital loses five doctors' posts in the next three months.

Long queues and appointment delays will worsen - and it will be impossible to maintain the present standard of service.

The medical committee of the hospital said last night the hospital had steadily lost its ability to serve the area because of staff cuts over the years. Doctors and nurses were often the targets of disgruntled patients who found the delays and conditions hard to accept.

Victoria hospital is a referral hospital for the southern suburbs serving a population of between 300 000 and 400 000.

Alan Tooke, head of medicine at the hospital, said two doctors' posts had already been frozen and at least three more would be frozen - which would reduce the number of doctors from 21 to 16. In 1995 a crisis in the number of nurses had forced a reduction in the number of beds able to be staffed from 172 to 140.

In spite of few staff there had been a 50% rise in the number of admissions to the hospital for acute illness.

Because of a shortage of beds, patients were often discharged while they were still sick to make place for the next patient.

Freezing doctors posts would reduce the hospital's ability to offer specialised services. Already neurosurgery and thoracic surgery were not available at the hospital and from August neurology and ophthalmology services would not be available after hours. All patients needing these services would have to be referred to Groote Schuur Hospital - with its own staff and budgetary constraints.

The medical committee said it was aware of the financial situation in the Western Cape but that people had to know that the hospital was cutting its service.
Maladministration, poor security and lack of controls at three Gauteng hospitals have led to losses of about R65-million, according to a performance audit released by the Gauteng auditor-general yesterday.

The report focused mainly on aspects of administration of academic health centres at Chris Hani Baragwanath (CHB), Pretoria and Kalafong hospitals. Performance audits were completed from January last year to February this year.

Shortcomings highlighted in the report include inadequate funds for the replacement of equipment older than 10 years, long outstanding debt of R5.5-million at CHB and accumulative debt of R34-million at Pretoria. R8.1-million outstanding debts for treating patients from other hospitals at the three hospitals, and linen losses amounting to R3.5-million.

Furthermore, 62 abandoned children were accommodated for a total of 4,280 days at CHB at a cost of R24.4-million between 1993 and April 1997. The problem had since been addressed by the Department of Welfare and the children transferred to places of safety.

Three cases of alleged malpractice by medical personnel, in particular junior doctors at CHB, were not followed up.

When a patient underwent an operation on November 1, 1996, a gas mixture without oxygen was administered (according to a summary compiled by an anaesthetist), causing severe brain damage. In addition (according to a memorandum compiled by the chief of the department of anaesthesia), owing to a technical problem with the tracheostomy during a follow-up operation on November 26, the patient died.

According to a letter by the senior superintendent on November 4, 1996, a cervical fracture that had not been diagnosed had probably contributed to a patient's quadriplegia and death on October 20, 1996.

Another letter by the senior superintendent on November 5, 1996 revealed that the condition of a patient was not monitored after he had been admitted as a result of an accident, and he died on October 21.

CHB was also criticised for failing to timeously institute disciplinary procedures in all instances of misconduct. One case included a personnel member who had been jailed for six years following a charge of rape. He was not charged with misconduct, but granted a voluntary severance package of R74,000.

The report also highlighted the theft of medical stock. At CHB, stock to the value of R89,135 was stolen between May and December 1996, while stock amounting to R14,771 was stolen at Pretoria. Kalafong wrote off medicine worth R135,138 between 1996 and 1997.
Campaigners to save Valkenberg take heart

There has been a late surge of hope in the campaign to save Valkenberg Hospital, and the provincial health department is considering a proposal to keep a reduced service operating. Health Writer Judith Soal reports.

When the proposal to close Valkenberg Hospital was first mooted, the public responded with a resounding "No way!" But then the greater evil of closing Somerset Hospital raised its head and was firmly squashed, and the campaigners for Valkenberg began to lose steam.

It seemed certain that the hospital would close, except for the unit housing forensic patients — those accused of violent crimes and considered unfit to stand trial — which would remain open "in the short term." But there has been a late surge of resistance!

Brian Robertson, head of clinical services at Valkenberg, met the province's health chief Tom Sutcliffe recently and outlined his proposal to save the hospital without exceeding the health budget.

Robertson's proposal would allow the department to sell most of the Valkenberg land and reduce the services on the site, but to stop short of closure. He asks for 100 acute psychiatric beds to remain at Valkenberg alongside the forensic unit.

"It was the first time we'd been given an opportunity to discuss this proposal with the department," said Robertson. "They haven't accepted it, but at least they have listened."

Sutcliffe had this to say: "It's a very interesting proposal. We will go over it before the next cabinet meeting on Wednesday."

Campaigners for Valkenberg have taken heart.

"There may finally be some hope — however tentative. The issues at stake are those that dog all the health services: How to change from a system that focused almost entirely on treating mentally ill people in hospital (until recently the entire mental health budget for the province was spent on psychiatric institutions) to a system that tries to help more people before they get that sick. How do you do this without destroying the services that exist, where there just isn't enough money to go around?"

"They keep delaying the decision and changing their minds, we just don't know where we stand," said Jonathan Burns, a registrar at Valkenberg. He believes uncertainty has almost destroyed the hospital.

"There have been continual threats; then at the same time they offer voluntary severance packages, so of course people are taking them, rather than waiting to hear that they will be transferred somewhere they don't want to go."

Over 25% of the nursing staff have left the hospital in the last year. Twenty left at the end of May, and 32 are leaving this month.

Two of the eight psychiatrists have left, more are expected to go soon, and all have said they will leave if the hospital is closed. Many of the registrars say the same.

Once these people leave the public health service, they will not be able to return because of a clause in the voluntary severance agreement. As with the teachers, it is often the most experienced who go.

The health department — under pressure from the provincial government to stay within budget — does not have an enviable task. Although closing Valkenberg won't save much money this year, it hopes that running three psychiatric hospitals instead of four will free money for community services in the long run.

But mental health activists say this isn't good enough.

"Mental health is underserviced already, why cut where you are already short?" asks social worker Michelle De Benedicts.

"You know, Robben Island used to be a psychiatric institution before it housed the political prisoners. Now the political prisoners have been released and the country has changed, but very little has changed for the psychiatric patients. They are still the soft targets, the ones who always have to suffer when it comes to cuts."

Where to get help:

- The MRC's Anxiety and Stress Unit is offering free assessment and treatment to anyone who thinks they may have an anxiety disorder. These include post-traumatic stress disorder, social phobia, obsessive compulsive disorder and panic disorders. The unit can be contacted on 0800-600-411.

- The unit also runs a youth clinic at the University of the Western Cape, known as Bathurstige, for children who have experienced trauma.

- The Cape Support Group for Mental Health provides support to families and friends of people with schizophrenia. They can be contacted at 448-0760.

- The Depression and Anxiety Support group can be contacted on 0800-119283 or 0800-118392.
Patients upset by closure, officials blame protesters

GILLIAN EDWARDS spent a month in a locked ward at Valkenberg in 1987 and hasn't been back, except as an outpatient. She lives in Observatory and visits Valkenberg every three months.

"It's not pleasant being in a locked ward for psychotics, but Valkenberg got me right.

"All I need to stay right is five minutes with a doctor who knows me, every three months. Now they are proposing that we see a different psychiatrist every six months, and a sister in between at the day hospitals. That's not a service, I can't see how I will cope on that."

Noel Bates has been going to Valkenberg since he was 23. He is now 49. He has been an inpatient for the past four years, but has recovered enough to face the outside world.

"I'm leaving soon, but would like Valkenberg still to be there as a safety net, in case I need it again.

"I've had a lot of help, that's why I'm ready to leave. I really wish they wouldn't close it down."

Elaine Tshuka has been in and out of Valkenberg seven times.

"I go back every month for medication, I don't know how I'll get to the other places. It's easier for people in the townships to go there than to go to Lentegeur or Stikland, where there is no transport."

Edwards, Tshuka and Bates are part of the community that has grown around Valkenberg Hospital in Observatory. It's a community that has little resemblance to the stereotyped image of dangerous "mental" patients ready to kill anyone who crosses their paths. These people are unlikely to hurt anyone other than themselves.

They are friendly, interesting, sometimes slightly shy and often a little eccentric. They are also in crisis. The proposed closure of Valkenberg Hospital has shaken their already fragile worlds.

"People with mental health problems are particularly vulnerable, and all the uncertainty is very damaging for them," said social worker Michele De Benedictis of the rehabilitation centre Fountain House.

"We have seen so many people become unwell recently."

But the health department believes that the campaign to save Valkenberg has to take some responsibility for this disturbance.

"If patients were being reassured that services would continue rather than being taken out on protest, there would be less confusion and panic," said Greg McCarthy, head of the Western Cape mental health programme.

"These people are very insecure anyway; it's easy to use that insecurity to promote your own cause."

McCarthy's department knows that people who rely on Valkenberg will be hard-hit by the closure.

"We are trying to minimise the damage by opening services at Groote Schuur. Although we know the short-term view is bad, we have to plan for the future."
Groote Schuur

treatment tops

(Sept 16) 16

It has become the norm to knock the
country’s most famous hospitals.
Therefore we were alarmed when our
daughter had been admitted to the
respiratory intensive care unit at
Groote Schuur after a tour bus acci-
dent we were very apprehensive.

She was in the unit for a week dur-
ing which time she received absolute-
ly top-class treatment.

The care and concern shown by
the doctors and nursing staff could
not have been surpassed anywhere
and our only regret was that when
her condition improved she had to be
moved from the unit.

We would like to publicly express
our most sincere and heartfelt thanks
to the staff of C27. God bless you all.

The Stoner Family.
Milnerton
Mental illness the pauper of health budgets

MORE hospital beds in South Africa are filled by people with schizophrenia than any other illness — including heart disease, cancer and diabetes put together — although new treatments for the disease mean that long-term hospitalisation could often be avoided. Professionals say that although mental illness is costly to treat, it is more costly not to treat it.

"Research has shown that 20 to 40% of people attending community clinics have some sort of undiagnosed mental illness. Often this presents itself as a physical illness, because people have no other way of expressing their distress," said Liz Dartnell of the Wits Centre for Health Policy.

The World Health Organisation names depression as the leading cause of disability and includes five mental illnesses in the top 10 disabling disorders. In the United States, every third dollar spent on health is spent on anxiety disorders.

In South Africa, the mental health burden is thought to be even greater, although — as is typically the case in this Cinderella of medical fields — very little local research into mental illness exists. To rectify this, the Medical Research Council and the University of Stellenbosch have launched a research unit to focus on anxiety and stress disorders.

"Studies have shown that stress and anxiety disorders are the most common psychiatric disorders, yet there has been very little research in South Africa," said Dan Stein, the head of the new unit.

"Failure to diagnose and treat these disorders at a primary level contributes to enormous costs." Professionals say that South Africa has a high incidence of disorders like post-traumatic stress disorder because of our violent history. We also have a strong culture of substance abuse, with levels of risky drinking reaching 30% in some areas.

"We know that 25% of the population is affected by a mental illness at some point in their lives, and in South Africa this is probably higher," said Iage Vitos, director of the SA Federation for Mental Health.

"If this is not treated, the number of people who need hospitalisation will escalate."

The World Health Organisation recommends that 10% of a country's health budget be spent on mental health, yet South Africa spends less than half that. In some provinces it is as low as one percent.

The Western Cape has one of the better budgets, spending about eight percent on mental health, but most of this goes on psychiatric institutions which care for people once they have reached a crisis.

Unfortunately this isn't happening. More than half of schizophrenia relapse in the first year.

"Most of the patients come in too late for effective treatment," said Emley.
Privately funded hospice will ease plight of ailing Sowetans

Josey Bullner

A HOSPICE funded by the private sector with help from foreign governments was opened by Archbishop Desmond Tutu in Soweto this week.

The opening of the hospice, housed in 11 shipping containers refurbished and reconfigured at a cost of about R1m, marked 10 years of hard work by Soweto residents in their efforts to provide accessible health care for the terminally ill. The Gauteng health department will provide medicines for poor patients.

Tutu said that, in the light of disclosures to the truth commission in the past week about apartheid-era chemical and biological warfare programmes aimed at killing black people and making them ill, the hospice showed that “people are not all like that, there is compassion and caring”.

The hospice, which is situated at the Mofolo primary health clinic, employs two registered nurses to provide home care, day care for patients who are fit enough to leave home and counselling for patients and their families. Within a year, the hospice plans to hire an additional community nurse, a social worker and a 24-hour service in a nine-bed, in-patient unit.

Prof JP van Niekerk, chairman of the Hospice Association of SA, said more than 50 hospices in the country served 6,000 people a year, the majority of whom lived in disadvantaged areas. He said the number of patients was rising.

The biggest increase was coming from AIDS victims.

Nigel Unwin, chairman of the hospice association’s board of governors, said one in four Sowetans over the age of 60 was terminally ill with cancer. Many more were estimated to be HIV-positive or had full-blown AIDS.

Peter Buckland, director of the Hospice Association of the Witwatersrand, said the Corporate Outreach Trust contributed the R450,000 shipping containers, while McCarthy Motor Holdings donated two vehicles for staff use. The US and Japanese embassies and other donors contributed the balance for salaries, equipment, drugs and infrastructure.
Children's Hospital in need of R36m

To protect in the评论条形图, we're applying an
appropriate order and restoration to
children's hospital needs.

For more information, contact the hospital's
administration or visit their website.

The hospital needs financial assistance to
continue providing quality healthcare to its
patients. Your support will make a significant
difference in their operations.

Thank you for considering a donation.

[Contact Information]

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SA officials bade to jet in chemical warfare

Emergency forces are on standby to
respond to any potential incidents.

We encourage everyone to remain calm
and follow official guidance.

[Emergency Contact Information]
Tobacco helps Richemont hit profit

Tobacco Holden's international division spurred, says super

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STEMMING THE TIDE OF ACADEMICS' FLIGHT

But Nkosazana Zuma will take some convincing

The University of Cape Town has formed a partnership with SA's largest private hospital group, Netcare, and the listed German hospital group, Rhön-Klinikum, to build a R250m university hospital near Groote Schuur Hospital.

The 600-bed facility will focus on the provision of specialised care to ensure that such services — which are no longer adequately funded by the State — are not lost to the country.

The Oude Molen University Hospital, as it has provisionally been named, will be fully funded, equipped and managed by Netcare and Rhön-Klinikum. UCT will provide about 150 clinical personnel and share in the profits of the joint venture. Cosatu's investment arm Kopano Ke Mala — through its association with Netcare — will also be involved.

UCT hopes the new hospital will stem the flight of academics to the private sector by creating a First-World teaching and research platform — something Groote Schuur Hospital is unable to provide.

For the same reasons, Wits University is also seeking gain access to private tertiary hospital services. Both universities realise that if they are to continue to produce top-notch medical graduates, it will have to be in partnership with the private sector.

SA's academic hospitals have lost highly trained staff and private patients as a result of large and sustained budget cuts. They are swamped with trauma and communicable disease cases while some specialised services, academic programmes and wards are closing and research output is falling.

Groote Schuur Hospital has 1 734 beds but is only using 1 163 because of budget cuts. Of these, about 950 beds are devoted to tertiary care but the number is set to be slashed to 450.

UCT medical school dean Emeritus Prof J P van Niekerk says the new hospital will complement rather than replace Groote Schuur Hospital. It is not intended to strip out the best staff, hi-tech equipment and tertiary services from Groote Schuur and to relocate them in a private facility free from State interference.

Health Minister Nkosazana Zuma will take some convincing, though Zuma, who has yet to be informed of the plan, placed a moratorium on the issuing of private hospital licences more than two years ago in the belief that government should decide the location of new private hospitals according to society's needs — a policy designed to discourage the flow of patients away from the public sector.

Van Niekerk says though the new hospital's emphasis will be on tertiary medicine, 450 beds will provide general care aimed at a large sector of the market not adequately catered for at present — those with jobs but no medical aid.

The hospital expects to charge fees below that of State hospitals — which average R225 per day in Gauteng — by mimicking the unique design and efficient management structure and administrative expertise of Rhön-Klinikum hospitals in Germany and specialising on a university hospital.

The centre of excellence is a plan of the proposed Oude Molen University Hospital.

The hospital is a free-standing hospital on land adjacent to the main private sector partner, the University of Cape Town, owned by the Groote Schuur Hospital. It will be managed by the private sector, a statement to the minister to ensure that the hospital will be a partner not a competitor.
FEWER SERVICES BUT ...

Valkenberg Hospital will be kept open

Valkenberg Hospital will not close, and that’s definite. The provincial authorities have bowed to public pressure to save the hospital.

They announced yesterday it would stay open with fewer services.

“We haven’t worked out all the details yet, but we intend to keep an outpatient unit and acute beds (for emergency patients) open on the Observatory side of Valkenberg,” said Linda Hering, the acting chief medical superintendent of psychiatric hospitals in the Western Cape.

“The other services will be transferred to other hospitals, which will mean that the land on the Pinelands side and most of the Observatory side will be available.”

The to-ing and fro-ing over Valkenberg has continued for years, with the department announcing it would close, then allowing a reprieve, then threatening closure again.

Hering said the latest announcement was not just another interim step.

“Valkenberg will go on into the next millennium,” she said. “We are relieved that a decision has finally been reached, the decision has been destructive for everyone.”

Former patients who rely on Valkenberg’s services were delighted by the news.

“My first reaction was such relief,” said Gill Edwards, a Valkenberg outpatient.

“You can’t go out into the world as a mentally ill person without proper medical back-up. I haven’t had problems as a schizophrenic, people treat me as an equal, but it’s on one condition: if I don’t feel well, I will go and seek help.

“They were threatening to destroy all that, but now I feel confident that my backup is safe.”

Brian Robertson, the head of clinical services at Valkenberg, was also relieved.

“At last the department is being sensible. We have always agreed it would be best to get rid of most of the land, but that it’s crucial to keep some services for those who depend on them.

“The other hospitals would never have been able to absorb all the patients from Valkenberg, and they seem to have realised that at last,” he said.

Money raised through the sale or leasing of the Valkenberg land will go into the general provincial revenue fund and will not be earmarked for health.

But the Western Cape’s health chief, Tom Sutcliffe, said his department was hoping to gain some benefits.

“We have recommended to the Works Department that the land on the Pinelands side of the site be alienated in return for the relocation and building of another forensic unit, probably at Lentegeur.”

SAVED: Valkenberg patients can now jump for joy.
Valkenberg to stay open, 2,000 health staff to lose jobs

After months of uncertainty about Cape Town's only academic hospital, health minister Aaron Motsoaledi announced in Parliament today that the hospital would remain open.

Motsoaledi said the proposed cuts would not go ahead.

"The Cape Town Health Department is not going to implement those recommendations," he told Parliament.

Motsoaledi said the cuts were contentious and would have affected the delivery of health services.

It was also not in line with the current government's policy of protecting the health sector.

The announcement comes a week after the hospital's services were threatened by the Department of Health.

Earlier this month, the department announced it was considering closing the hospital to make savings.

But this move was met with concern from medical professionals, residents and politicians.

Motsoaledi said the department would now move to implement the final plan for the future of the hospital.

The final plan for the Western Cape Hospital Unit in Cape Town is expected to be announced in the next three months.

"We will now move to implement the final plan for the Western Cape Hospital Unit," Motsoaledi said.

The hospital has been in existence since 1946 and has a record of providing care to thousands of patients.

In the announcement, Motsoaledi said the cuts were not permanent and the hospital would continue to provide the best care possible.

"The hospital will continue to provide the best care possible for patients," he said.

Valkenberg president Prof Anton Peiffer welcomed the decision.

"We are thrilled," he said.

Peiffer said the hospital was committed to continuing its work.

"We will continue to provide the best care possible," he said.

Meanwhile,摎on of the hospital's most popular services, the operating theatre, will now remain open.

The announcement comes as the hospital was named one of the best in the country by a leading medical journal.

The hospital has been a key player in the Cape Town health sector for many years.

It provides health care to thousands of patients every year.

The hospital has a strong track record in education and research.

It is home to many of the country's leading medical professionals.

The hospital has also played a key role in the development of new medical technologies.

Peiffer said the decision was a critical one for the hospital.

"This is a critical decision," he said.

"We are thrilled that the hospital will continue to provide the best care possible for patients," he said.
Marais ‘fuelled insecurity in health service’

Staff reduced but Valkenberg stays open

JENNY VIALL

Western Cape Health Minister Peter Marais has fuelled insecurity in health services in his few months as minister by announcing hospitals will close and then changing his decisions, says Ebrahim Rasool, leader of the ANC in the province.

Valkenberg hospital, originally planned for closure, is now to stay open, provincial finance minister Lampie Fick announced yesterday. To keep within budget 2148 staff will have to leave the health services through voluntary severance packages, retirement and resignations.

Since March, when the first business proposals were announced, there has been uncertainty about the closure of both Somerset and Valkenberg hospitals.

Following widespread criticism, over the possible closure of Somerset hospital Mr Marais announced last month that the hospital would stay open. At the time a revised business plan still proposed that Valkenberg be closed.

Both hospitals will now stay open but be reduced in size. Land at both sites will be sold or leased by the Department of Asset Management.

“It is unacceptable for a minister to make announcements before final decisions are made and then in the face of public pressure to make a U-turn,” said Mr Rasool.

“Mr Marais gives the signal that if you protest enough, he’ll change his mind. He has put the province in a permanent state of instability because he cannot rationally think through decisions and then reach a calm decision, which the fragile health department needs.”

He said a task team appointed to investigate mental health services had recommended that Valkenberg stay open.

“I don’t think he even read the task team report,” said Mr Rasool.

Mr Rasool, who was minister of health before Mr Marais, said he welcomed the announcement that Delft and Kraaifontein community health centres and a ward in Ceres hospital would be commissioned.

“However, I am worried that the final plan does not mention Delft clinic becoming a 24-hour clinic,” said Mr Rasool. It is needed as such and was intended as such in the original health plan.

“I’m also worried about the further erosion of staff numbers. It was my consistent contention and my fight in the cabinet that staff numbers should never be allowed to go below 27 600.

“This plan brings numbers to around 35 000. This is an enormous erosion of staff and I do not think the health system will be able to absorb it. It can only result in longer queues and more overworked staff at every facility.”

Mr Rasool said the announcement of the final health plan by Mr Fick, rather than Mr Marais, was clearly because the National Party government in the province had decided to keep sensitive matters away from Mr Marais and prevent further embarrassment and damage caused by his “shooting from the hip” about matters like Valkenberg and Somerset hospitals.

Armand de Roux, Mr Fick’s secretary, denied this, saying the announcement was drafted by both ministers. Mr Fick as finance minister was responsible for ensuring the plan would stay in budget.
Health official's question plans for R250m private hospital

Josey Ballenger

A PROPOSAL to build a private hospital near Groote Schuur Hospital, intended to “complement” the public hospital and reverse the trend of doctors leaving, has caused officials and health experts to question the University of Cape Town’s (UCT’s) commitment to improving the public sector.

Groote Schuur, known as an “academic” hospital because of its teaching and research relationship with UCT’s medical school, is regarded as one of SA’s finest medical institutions. However, it has suffered budget cutbacks and staff losses in recent years, prompting the UCT faculty to look at solutions to retain health professionals and tertiary care.

UCT has joined SA’s largest private hospital network, Netcare, and German hospital group Rhön-Klinikum, in discussions to build a R250m hospital to focus on specialised care. JP van Niekerk, the school’s dean emeritus, said the 600-bed facility would charge lower fees than either the public or private sector.

Prof Max Price, Wits University medical school dean, said SA would see “a number of different models of private academic hospitals” which would be better funded due to their use by private patients.

The Wits faculty is looking at leasing ward space in Johannesburg Hospital to absorb people from the public sector. “We believe this would relieve the state of a burden,” Price said.
40 die, in hands of poor surgeons
‘Doctors at Bara couldn’t give a damn’

Forty deaths to come under the spotlight at inquiry into former superintendent’s claims

BY ANSO THOM
Health Reporter

Former superintendent of Chris Hani Baragwanath Hospital, Dr Bernard "Bokkie" Rabinowitz, has accused his colleagues of "not giving a damn" about people dying at the hands of junior doctors performing surgery without supervision.

Rabinowitz, who worked at the hospital for more than 23 years, went public last week with claims that at least 40 patients had died at the hands of surgical staff at the hospital.

"I was driven to this (going public). It had become intolerable," said Rabinowitz, who will appear at a hastily convened special inquiry today and tomorrow.

Rabinowitz claimed that more than 40 patients died during surgery performed by inexperienced surgeons without the proper supervision.

"Those doctors at the hospital who are involved, or those who knew, don’t give a damn. I constantly notified (chief superintendent Chris) Van der Heever and (Dr Pieter) Van der Berg (director of hospital services at the Gauteng department of health), but they gave it no time and expressed no concern.

"Van der Heever tried to protect the surgeons," he said.

Rabinowitz said the inquiry was a damage control exercise, adding that he had insisted that Professor Taole Mokoena, head of surgery at Kalafong Hospital, head the panel.

Rabinowitz accused Van der Heever of removing him from his position as superintendent of surgery to protect the surgeons and to limit his access to data.

Van der Heever was not available for comment yesterday. Hospital spokesman Hester Vorster referred all queries to the department of health.

Rabinowitz said he would like to see the guilty surgeons disciplined and forced to resign.

"Disciplinary action must also be instituted against the administration, who are now literally being dragged to an inquiry, kicking and screaming," he said.

Rabinowitz said it was essential that senior people be present during surgery.

The hospital had about 70 surgeons at one time, with junior doctors “coming and going” while practising surgery unsupervised.

Cases of negligence Rabinowitz allegedly found included the death of a young girl after doctors allegedly directed a breathing tube to her stomach instead of into her lungs, and the death of an elderly woman who died after surgeons allegedly turned her away without detecting a hip fracture.
Probe into surgical negligence will finish today

Bonile Ngqiyaza

A PROBE into allegations that negligence and indifference among Chris Hani-Baragwanath Hospital's surgical staff resulted in about 40 deaths at the hospital got under way yesterday.

This came after the hospital's former superintendent, Dr Bernard Rabinowitz, accused his colleagues last week of an uncaring attitude, claiming that at least 40 patients had died as a result of junior doctors performing surgery without supervision.

Gauteng health spokesman Popo Maja said yesterday the probe, led by Tshele Mokoena, surgery head at Kalafong Hospital, would be completed today.

Maja said the probe's brief would be to establish the facts and to find out whether there was substance to the claims.

A decision on whether to appoint a commission of inquiry would be taken after Mokoena had handed his report.

Opposition parties expressed concern at the news yesterday, saying the claims could be just the tip of the iceberg because the hospital was, unlike rural hospitals, well placed and constantly under a spotlight.
Bara deaths: worry that doctors will close ranks

BY ANSO THOM
Health Reporter

Dr Bernard "Bokkie" Rabinowitz, former superintendent of Chris Hani Baragwanath Hospital, has expressed concern that "doctors will help doctors" while testifying at a panel looking into the deaths of patients, allegedly at the hands of inexperienced surgeons.

Rabinowitz has claimed that at least 40 patients died at the hospital, where he worked for more than 25 years, after being operated on by inexperienced young surgeons without proper supervision.

"The meeting was not quite what I had expected," Rabinowitz said yesterday shortly after being questioned by the panel.

"I was asked to list the cases and my concerns, and then I left. The surgeons who have been implicated were then called in to defend themselves.

"I didn't like it. I would have preferred a state inquiry, but this is how they have decided to do it," Rabinowitz said, adding he understood that an inquiry was still possible depending on the findings of the panel.

"I am concerned because doctors like to help doctors, but I guess that is the way it should be," he added.

The panel is chaired by Dr

Tacile Mkoena, head of surgery at Kalafong Hospital.

A senior physician at the hospital, who asked to remain anonymous, agreed with Rabinowitz's claims that many deaths at Chris Hani Baragwanath were related to negligence.

"A bad attitude does exist at the hospital. I think it's a case of racist attitudes die hard. There doesn't seem to be the same urgency with black patients as there would be at other hospitals. It's almost as if some surgeons rate black people's lives as cheaper than other races."

He added that young registrars, specialising in surgery, were merely using the hospital to gain practical experience before leaving for the more lucrative private hospitals.
Negligence alleged at other state hospitals

Bonile Ngqiyaza

The problem of patient deaths at surgical wards due to alleged indifference and negligence could develop into a full-blown crisis after medical personnel in the Northern and Mpumalanga provinces complained yesterday of similar occurrences.

A three-man team of doctors led by Kalafong hospital surgery head Tsele Mokoen on Monday started probing claims that at least 40 patients had died at the Chris Hani-Baragwanath hospital recently.

This came after the hospital's former superintendent, Dr Bernard Rabinowitz, went public last week with claims accusing senior personnel of an uncaring attitude, including allowing junior doctors in the hospital to perform surgery without supervision.

The Hospital Personnel Trade Union (Hospersa) yesterday handed over a memorandum to the provincial department of health, expressing concern that some of the files in the Chris Hani-Baragwanath case had disappeared. However, Mokoen said yesterday his team had received all 20 files that were "specifically" brought to the surgeon's attention and a report would be handed over to the department within the next three weeks.

He said members of the team had conducted interviews with the heads of the surgery, anaesthetic and nursing departments.

Hospersa expressed concern that the team's findings might not be acted on and requested that Gauteng premier Mathole Motshekga give the issue his personal attention.

The union also asked that all interested parties be updated continuously on the probe's progress and the team's findings.

Union spokesman Elize Richards said senior union officials would meet to discuss the possibility of approaching national government as the impression was that the provinces did not want to co-operate with the union.

She said the union had given the Gauteng health authorities until Friday to respond to the memorandum, hinting at mass mobilisation of the union's members if a resolution was not reached by then.

Richards said there was a general impression that the department was dragging its feet, as correspondence to the premier and health MEC Amos Masento since September 1996 had not been addressed.

She said that the union had also approached Public Protector Selby Baqwa.
Bara deaths spark an outcry

Public health service comes under the political scalpels

 Allegations of irregular deaths at Chris Hani Baragwanath Hospital in Soweto have sparked an outcry about the state of the public health service.

 Baragwanath was better equipped and supervised, and was less overcrowded and over-stressed than most other hospitals, Gauteng Democratic Party health spokesman Jack Bloom said yesterday.

 "There is no reason why Baragwanath should be the worst."

 What was happening at the hospital, the country's largest, was symptomatic of problems throughout the public health service, said Inkatha Freedom Party health spokesman Dr Ruth Robinowitz.

 Her husband and a former superintendent at Chris Hani Baragwanath, Dr Boikie Robinowitz, recently went public with his allegations that more than 40 patients had died there since 1996 because of lack of supervision during surgery by inexperienced doctors.

 This week, a three-person commission investigated his claims to establish whether a commission of inquiry should be set up.

 Hospital Personnel Trade Union of SA spokeswoman Elize Richards said various doctors from Northern Province and Mpumalanga had approached the union for help to uncover malpractices at state institutions.

 Both Bloom and Ruth Robinowitz were convinced that patients of hospitals in more rural areas were far worse off, not only because of poor medical care, but also because of a lack of staff and equipment.

 Bloom said he had received numerous complaints with horrific stories emanating from Nataalspruit, Oliver Tambo Memorial, Leroxeng and Far East Rand hospitals.

 A report by the Gauteng provincial service commission about alleged bed management at Nataalspruit Hospital is due to be completed within the next few weeks. The commission also investigated claims that a gynaecologist at Nataalspruit cut the urethras of women on whom he performed hysterectomies.

 In one case, a woman with thrombosis in her leg had to wait for treatment in a queue at Helen Joseph Hospital from 7pm on a Monday until 4am the following day. In another case, it was alleged that a patient's tongue was mistakenly cut out at a Gauteng hospital.

 An 81-year-old woman died recently after she reportedly fell from her bed at Bethal Hospital in Mpumalanga and was left on the floor for about seven hours.

 Relatives of an 84-year-old woman are considering legal steps because of her death last week after having been refused admittance at one Gauteng state hospital, and allegedly receiving little or no treatment at two others.

 Bloom said aggrieved state hospital patients or their relatives rarely had the money to pursue matters further. Furthermore, grievance procedures were very cumbersome and inaccessible.

 However, not every complaint indicated negligence. In many cases, hospitals were under such strain that they did not have the time to explain a patient's death to grieving relatives, Bloom said.

 Conservative Party health spokesman Dr Willie Snyman said reports about negligence and malpractice were so serious that the appointment of a judicial commission of inquiry was warranted.

 The national health department would comment later, a spokesman said. - Sapa
Surgery allegations ‘are not a vendetta’

Nomavenda Mathiane

FORMER Chris Hani-Baragwanath Hospital superintendent Dr Bernard “Bokkie” Rabinowitz said yesterday allegations that he had gone public about the deteriorating situation at the hospital because he had been passed over for promotion were “rubbish”.

Rabinowitz, who alleged that more than 40 patients had died at the hospital due to lack of supervision during surgery, said his detractors were failing to deal with the problem and instead chose to get “personal”.

He said for as long as he was chief surgeon at the hospital, there was only one case of negligence and the doctors concerned were disciplined.

“In my time, we built Baragwanath to be the best hospital in the southern hemisphere,” Rabinowitz said. Since 1994, standards at Baragwanath had deteriorated and his attempts to get the chief superintendent Dr Chris van der Heever to act upon such matters had fallen on deaf ears.

Commenting later, Rabinowitz’s wife, Inkhata health spokesman Dr Ruth Rabinowitz, said her husband was too narrowly focused on Baragwanath. The entire state health system was in a shambles.

“The allegations and investigations at Baragwanath hospital should not be viewed in isolation. They are symptomatic of problems throughout the public health service,” she said.

Democratic Party health spokesman Jack Bloom echoed her sentiments, saying Baragwanath was better equipped than most hospitals and that there was no reason why it should be the worst hospital.

Baragwanath spokesman Hester Venter said she could not comment on whether Rabinowitz had informed the hospital superintendent about the problems at the hospital, saying the matter was now in the hands of the Gauteng health department.

Departmental spokesman Joan Collinge said the fact-finding mission into the hospital allegations, which is led by Professor Thapelo Mokoena, was expected to produce its report by the end of the month.

Women politicians will gather in Cape Town

Wyndham Hartley

CAPE TOWN — Twenty-three of the world’s most successful and powerful women politicians will gather in Cape Town next week to debate ways of making parliaments across the world more gender-sensitive institutions.

Nine of the 23, including the speaker of the National Assembly, Frene Ginwala, are presiding officers in their national parliaments. The remaining 14 are deputy presiding officers.

They include the president of the Bundestag in Germany, Rita Süssmuth; Swedish parliament speaker Birgitta Dahl; and Slovakian president Kirsi Gronsdahl of Norway.

Ginwala, said yesterday that the fifth international conference of women presiding over national parliaments would have as its main theme the transformation of the institutions and what measures could be taken to ensure women were not disadvantaged in political careers.

She said the issue went beyond simply electing quotas of women and that a handbook entitled Beyond Numbers would be launched during the conference.

The book, to which both she and former ANC MP Mavivi Mayakayaka-Manzini have contributed, has been produced at the Institute for Democracy and Electoral Assistance in Stockholm. It is designed to be a practical guide for women parliamentarians.

Invited to the conference as observers are President Nelson Mandela’s companion Graca Machel, and Zanele Mbeki, wife of Deputy President Thabo Mbeki.

Workshop
Surgery allegations ‘are not a vendetta’

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INSIDE OUR DYING HOSPITALS

- Man bleeds to death outside theatre
- Students scrub up to operate
- Hospital can't buy surgical gloves
- Patients wait 40 hours for surgery

THE ROT SETS IN: Patients await treatment at one of South Africa's state hospitals, where people are dying unnecessarily, say medical staff. Picture: HERBERT MABUZA
A man died of shock in the country's largest hospital as he waited for an operation in front of the doors of a theatre.

In the same hospital, another man waited a whole day for an operation on a gangrenous bowel. He had the surgery, but the length of time he waited caused complications that finally killed him.

This is the face of the country's major state hospitals that was revealed after a former superintendent at Chris Hani Baragwanath Hospital, Dr Bernard "Bokke" Rabinowitz, prompted an inquiry into 21 "preventable deaths" at the hospital.

Specialists, surgeons and doctors say patients in hospitals around South Africa are dying unnecessarily. And they say others are not receiving treatment to which they are entitled.

They blame a lack of funds and the soaring crime rate, which has left many of them dealing with numerous victims of violence.

At Edendale Hospital in KwaZulu-Natal, a girl who was involved in a car accident last week was unable to move her arms or her legs but could not have a scan to check for spinal injury as "the state cannot afford it", a doctor claimed.

Professor Roger Saadia, the chief of surgery at Chris Hani Baragwanath Hospital, said on Thursday that operating theatres at the hospital were grossly insufficient. "In any ward I have had two fatalities in the past two months that can be directly attributed to this.

"These were conditions at the hospitals this week:

- At Chris Hani-Baragwanath Hospital, six surgeons deliver service for 320 beds. In the past two years, more than 160 nursing sisters have left the hospital, spurred by generous retirement packages and better working conditions in the private sector or overseas.

The most visible effects have been fewer intensive-care beds available; fewer functioning operating theatres (with longer queues for patients in need of urgent and non-urgent operations); and poorer monitoring of critically ill patients in general surgical wards (with incidents of undetected complications and deaths).

- In the same hospital, doctors say they have access to five intensive care beds at a time, for 200 patients, and resuscitation equipment is antiquated.

- At Tygerberg Hospital in Western Cape, patients can wait up to 40 hours for surgery and those with breast cancer are being turned away because the radiotherapy machinery has broken down.

- At King Edward VIII Hospital in KwaZulu-Natal, there is often not enough staff to run two theatres.

- At Addington Hospital, students scrub for major cases because the hospital has lost six highly trained nurses in its surgical ward this year.

- At Edendale Hospital in Maritzburg there were no surgical gloves used in the theatre this week because the hospital could not afford them. Equipment that had been broken for more than three weeks could not be repaired or replaced.

In response to the number of deaths at Chris Hani Baragwanath Hospital, Saadia said: "The inquiry should find the allegations are misplaced. Those people could have been saved — by a better health system. Even a figure of 10 preventable deaths a year for a 320-bed surgical department is minute, and we state confidently that a greater number of preventable trauma deaths occur in my department out of the thousands of surgical operations performed each year. I am unable to give exact figures as we cannot afford the services of a full-time computer- literate doctor solely devoted to the collection and analysis of data."

Saadia said: "The unavailability of an ICU bed for a trauma victim who needs it means almost certain death. Three of the patients mentioned in Rabinowitz's report required ventilation; they were denied ICU access, and they died. "One figure alone can illustrate the magnitude of the emergency surgical load: over the past three years we have treated 2,500 victims of gunshot a year. This excludes victims of stabbing, assaults, road accidents and non-traumatic surgical emergencies. This is where we end up devoting our resources. And we're not having a civil war."

"We are hamstrung by finances," said Saadia. "In 1991 the people of Soweto were getting much better health care than they are now."

A surgeon at Tambo Memorial Hospital in Boksburg said: "It's easy to exhaust Bara's facilities because we are at the peripheral hospital for our priority trauma cases to Bara. Lack of facilities does play a big part. Our first-level trauma cases get referred at Johannesburg Hospital when it cannot cope, and Bara ends up with them."

Professor John Robs, the head of surgery at the University of Natal, said the number of preventable deaths had increased as trained surgical medical staff were emigrating or defecting to the private sector.

"Too many people are dying. Our nurses are superb, but there's been a massive depletion to the private sector and to countries like the United Arab Emirates and the US," he said.

Robs said King Edward VIII Hospital in Durban had excellent trauma facilities, but there was a shortage of trained staff to operate them. "I can't complain about the equipment at King Edward, but you can't put a bus driver in a Ferrari."

At Edendale Hospital, which caters for all emergency cases in the KwaZulu-Natal Midlands, a surgeon said: "The medical service is here is going down so rapidly, I just don't know what will happen."

Elize Richards, of the Hospital Personnel Trade Union of SA, which represents about 60,000 health care practitioners in the public and private sectors, said: "The standard of health care is down and the lives of patients are being compromised."

She said doctors in Northern Province and Mpuamana had come forward with the same problems since the Bara inquiry.

"The national department should establish better monitoring procedures in provinces."

"Only by having those can we safeguard patients' lives. "When free health care and abortion were introduced the necessary research was not done to see whether the system could cope. And patients have flooded the hospitals. These are wonderful concepts, but they need assessment and consultation. We do not have the necessary statistics to see what we are serving, and foreigners are flooding our health care system.

"The allegations made by Dr Rabinowitz and our calls for an investigation into conditions at the hospital are only the tip of the iceberg. These conditions prevail throughout Gauteng and we have received similar information from other provinces," said Richards.
Follow the stories of

WOODROW WILSON

SARA MONROE

ESTHER MAVIOLE

 Cyril M-large

 in other provinces

Bara, say doctors

And it isn’t just at

dead death
They are rallying their support behind Dr. Rabnowitz.

CPRESS NEWS

July 12, 1998

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I can’t remember whether I’ve killed one or one hundred.

High-powered las team investigating

4000 000 scandal hit squad offices

City Press
MEC pronounces Bara healthy after quick tour

BY ANSO THOM
Health Reporter

Gauteng Health MEC Mondli Gungubele whizzed through Chris Hani Baragwanath Hospital yesterday and, at the end of his 30-minute tour, pronounced the hospital healthier than it had been in the past.

After going through the casualty and surgical admissions wards, he praised the staff for working under immense pressure.

Gungubele met with hospital management before going through the hospital, where he spoke briefly to supervisors, nurses and patients.

He declined to comment in detail on claims by a former superintendent at the hospital, Dr Bernard Rabinowitz, that at least 40 patients had died at the hands of junior doctors.

Gungubele said he was satisfied with a preliminary investigation but added that a commission of inquiry would be appointed if necessary.

He said the majority of professionals were doing their best to make the hospital work, and added that media reports were causing the staff to be harassed by patients and the public.

The MEC also admitted that the department had received Rabinowitz’s allegations in 1995, but that he had failed to elaborate.

He also pointed to recent trends and various problems at the hospital and commended the staff for coping with a difficult situation.
Future of hospital site in your hands

Park plan proves popular

The main features of the land and who owns which portion of it

There are also a lot of people with an interest in the land, from developers who would like to see office parks, to those who would prefer there to be no further building. Most of the land is zoned for community facilities, or public open space. Its People Christian Missions would like to build a centre there but UCT has come up with a plan for a private teaching hospital. A working farm village where mentally ill and disabled people can live and work has also been suggested. Now that Valkenberg's future as a smaller psychiatric hospital has been decided, state land has come under the control of the province's Department of Asset Management. While it seems that the guy would like the land to be a park, what form that park takes and how to finance it have to be decided. It's valuable land, close to the city. It's also home to one of the city's four remaining nature reserves, the Raubenheimer Bird Sanctuary. The Vincent Pallotti wetlands are there, and more than 100 different species of birds, 30% of them terrestrial, nest there. It's rich in history: Zulu King Cetshwayo was imprisoned on the Oude Molen farm, where the first brick mill was completed in 1783, and there are few national monuments in the area, one of which is the original Valkenberg Manor House.

Cape Town has no large outdoor recreation areas and needs open areas as suburbs get more built up. The Valkenberg Confinement Alliance would like to see a therapeutic centre for the people of Cape Town, and an open place for people to jog and walk. The challenge is to come up with a plan that looks into account conflicting interests. The City of Cape Town has now began a public participation process to determine what should be done with the land.

Deseree Shepherd, who is co-ordinating the process, has asked any organization or individual with particular knowledge of the site to register with her as a stakeholder. She can be telephoned at 480 3039, or faxed at 418 8536, or e-mailed at desear@post.co.za.

A public meeting on the issue will be held later this month.
Doctors battle to cope with flood of ailing and bleeding

As the spotlight focused on Chris Hani Baragwanath hospital this week, Health Reporter Anso Thom spent time at the recently revamped medical admissions ward.

Tuesday, 9pm: The hospital should be in a mid-week lull, but the medical admissions ward is already resembling a train station and the number of patients waiting to be attended to continues to swell despite the efforts of doctors and nurses.

Sannah (17) starts shaking uncontrollably as Dr Sherwyn Romo approaches her. "Mamie, mamie," she calls, trying to attract the nurse's attention.

"It's okay," says Roman in a soft voice. "I just want to have a look."

Sannah's frail body is covered in bruises and scars. An old operation scar cuts through her chest. "She's very sick," says Roman as he leans over her, listening to her heartbeat.

On Tuesday, Sannah was one of more than 100 patients who passed through the medical admissions ward.

The red circle next to her name on the admittance list alerted Roman, a registrar and doctor at CHB for the past five years, that she needed to be treated urgently.

The others have to wait. Hours on end as three registrars and five interna battle to stay ahead while patients on trolleys continue to stream through the double doors of Ward 20, which was recently rebuilt with the assistance of a pharmaceutical company.

Nurses guide the trolleys like skilled drivers, parking patients between beds and in open spaces. But for the doctors, it's just another day at CHB.

Roman, like his colleagues, starts his day at 8am when he sees his patients from the previous night, who have since been transferred to wards.

By 10am he's at the admissions ward. If he wants to finish by midnight, he has to maintain a hectic pace while trying to spend enough time with a patient to make an accurate diagnosis. Mostly his diagnosis is purely clinical. X-rays are mostly non-existent.

But among all this chaos, much good prevails. Staff clearly treat patients in a sensitive manner and there is no obvious shortage of medication or equipment despite the huge demands.

"It is unfair to the patients and doctors that Bara has an open door policy. Hundreds arrive at casualty and are routed to us," says Roman.

The medical admissions ward deals with psychiatric cases and other medical problems such as tuberculosis, HIV/AIDS, hypertension, cardiology and most cases where the casualty department struggles to make snap diagnoses.

By 4pm, 60 patients had arrived, by 6pm the list had grown to 80 and so it continued until after 7pm when the list grew to more than 100.

"You try to check the list every hour and kind of calculate how much time you can spend with a patient. This open door policy is not good for the patient/doctor relationship," Roman reiterates. "The pressure expands all the time. I really think universities should set guidelines on how many patients a doctor should see."

By 9pm traces of exhaustion start to appear. Roman meets a colleague in the passageway.

"Have you caught up yet?" he asks. His colleague shakes his head. "We're losing the battle man," he smiles.

A registrar and intern take over all cases arriving at 10.30pm to allow those already on duty to try and finish by midnight.

"Sometimes I only finish at 3am," says an intern.

"Pilots are compelled to rest. But not us. We have to battle on," says a registrar.

An intern smokes outside the ward. "The way I feel now, I want to become a secretary."

"It helps that Bara is well equipped. I'm worried about community service in poorly equipped clinics next year. I can work under any circumstances or pressure as long as I have the proper resources."

As an intern leaves after a 16-hour shift, a colleague calls: "Close the gates as you leave."

But still the patients arrive.

Awesome facts and figures

<table>
<thead>
<tr>
<th>Number of approved beds</th>
<th>3,240</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total staff establishment</td>
<td>6,760</td>
</tr>
<tr>
<td>Employed nurses</td>
<td>3,362 posts (of which 1,227 are vacant)</td>
</tr>
<tr>
<td>Number of operations last year</td>
<td>49,169</td>
</tr>
<tr>
<td>Approved budget for 1998</td>
<td>R555 568-million</td>
</tr>
<tr>
<td>In patients treated last year</td>
<td>116,861</td>
</tr>
<tr>
<td>Out patients treated last year</td>
<td>429,444</td>
</tr>
<tr>
<td>Casualties last year</td>
<td>107,409</td>
</tr>
<tr>
<td>Deaths at the hospital last year</td>
<td>5,735</td>
</tr>
<tr>
<td>Meals</td>
<td>About 10,000 prepared every day</td>
</tr>
<tr>
<td>Latex gloves</td>
<td>2,500 pairs used every day</td>
</tr>
</tbody>
</table>

Deliveries (1997) 10,886

Gunshot wounds treated

| 1987 | 1,044 |
| 1988 | 696 |
| 1989 | 1,446 |
| 1990 | 2,210 |
| 1991 | 2,170 |
| 1992 | 2,539 |

(First 6 months) 1,374
Bara managing to cope despite crisis

Experts believe more money and more doctors and nurses is the only way conditions at the world's biggest hospital can be improved upon

By Alex Thawe
Health Reporter

Soweto's Chris Hani Baragwanath Hospital is ill, say doctors in the know. But the prognosis is not terminal although the symptoms are long working hours, huge patient loads and staff shortages. Their prescription is more nurses, more doctors and, ultimately, more money.

Now listed in the Guinness Book of Records as the world's biggest hospital, it was originally built by the British in 1861 as a convalescent facility for wounded Allied troops during the World War 2 and to cater for soldiers of the Middle East Command.

After the war the South African government bought the "Imperial Military Hospital" from Britain for the princely sum of £1 million, converting it to serve the rapidly growing population of Soweto.

Now the hospital is bursting at the seams. Its open door policy leading to patients flocking to the hospital not from as far afield as Botswana, Zimbabwe and Mozambique.

In the past 50 years the hospital has grown in size and stature, and now also serves as a referral hospital for many clinics in this country and surrounding African states.

In essence, the CHB is a microcosm of the greater South Africa, reflecting the stresses of the terrain's economic and political changes.

During times of political violence, CHB's trauma unit became an accurate barometer of the situation.

Nowadays, it has become a barometer of the escalating crime, with more than 50% of surgical cases being trauma-related. Last year 2,004 patients were treated for gunshot wounds alone.

In an effort to provide healthcare for even the most impoverished, patients pay for their treatment according to their income. But the needs of the community are great - only 13% belong to medical aid schemes and are therefore restricted to outpatient facilities.

As the hospital struggles to cover its costs, patients pay only a small percentage of what is needed: In 1995/6, patients paid only R8 million of the R257 million required to keep the hospital afloat at the time.

This year the hospital is operating on an approved budget of more than R257 million.

But, amid allegations that junior doctors are performing ununscreened surgery, leading to the deaths of at least 40 patients, there are renewed calls for more financial support.

Most doctors at the hospital agree that there are many cases of malpractice, but instead of blaming the hospital, they blame the system which has created the inequitable doctor/patient ratio.

"We work like dogs. It never stops. Work, work, work. It's quite possible to make a judgment error if you start working at 8am and you're still at it by midnight," said a doctor.

In the wake of allegations of incompetence, Mondli Gungubele, Gauteng Health MEC, met hospital management this week before touring the institution.

He declined to comment in detail on allegations by a former superintendent, Dr. Bernard Rebinowitz, that at least 40 patients had died at the hands of junior doctors since the end of 1995.

At face value I can say that I am not disappointed by the general attitude of the staff. I want to remind the media that we are investigating the allegations and that two senior doctors will not hold heed to a bill of inquiry," said Gungubele, adding that there had been an alarming increase in the number of people that come to the hospital. More than 50% of surgery cases were trauma related.

"The staff is not satisfactory, but we are interacting with clinicians to establish appropriate staffing ratios," he said. "I am proud of what the little staff are doing at this hospital with the capacity they have.

"The hospital's successes are rooted in the Government's new primary health care system, which has already alleviated the patient load. Last year the hospital delivered 10,000 babies in comparison to previous years when more than 30,000 were born at the hospital in one year.

"The clinics have taken many maternity cases away and we only deal with referrals," said hospital spokesman Hunter Water.

In the hospital's yearbook, Dr. Chris van den Heever, chief superintendent, recalled that a visit to July 1995 by President Mandela to an old friend at CHB had had positive results.

Van den Heever pointed out that, since Mandela's visit, work had begun on improving the antiquated sewage and water reticulation system and plans were approved for a new kitchen. Planning is also going ahead for a major upgrading of the main theatre block, a new outpatient block and an emergency medical centre.

"With the restructuring nearing its end, we look forward to doing what we do best - treat patients," Van den Heever concluded.
Availability of drugs could be retarded

New cartel 'could kill pharmacies'

ADELE SHIVELY

Johannesburg — Pharmcare, the healthcare company, and five top multinational pharmaceutical companies were poised to cause a realignment of the pharmaceutical industry with a deal aimed at bypassing wholesalers, they revealed last week.

News of the deal, called Project Nasa, caused concern among pharmacists, who were worried that the removal of wholesalers from the drugs distribution loop could prove to be lethal for retail pharmacists. It could also retard the availability of drugs to the consumer, they said.

But an analyst said Project Nasa could save distribution channels which were vying on bankruptcy because of cut-throat competition among distributors.

He also said it would decrease competition in drugs distribution, leading to a slight increase in costs which would probably be passed on to the consumer.

John Bartlett, the project's spokesman, said pressure from managed healthcare and the government to contain costs had spurred the formation of the company. International management consultants are already working on Project Nasa.

It would be the second such deal in the industry, following on the heels of International Health Care Distributors (IHCD), which distributes goods directly to end-users and is jointly owned by nine international pharmaceutical manufacturers.

Nasa's multinational partners include Glaxo Wellcome, Janssen-Cilag, Pfizer, SmithKline Beecham, Warner Lambert and Pharmcare, which is part of the SA Druggists group. No formal agreement has been reached.

Val Beaumont, the chairman of Southern Gauteng Pharmaceutical Society, voiced concern about the implications of the deal: "If you kill the wholesaler, the retail pharmacist will be close behind."

"Experience has shown through IHCD that margins for pharmacists fell dramatically. We already give medical aids a rebate. We cannot afford any further cost-cutting exercises."

Nasa said it was formed in response to uncertainty within the traditional South African distribution channels to streamline distribution; limit fraud and grey market transactions; and meet government demands for transparency in distribution costs.

Grey market trading of pharmaceuticals in South Africa was believed to be in excess of R500 million last year.

"It looks like we will have about 25 percent of market share," said Bartlett, referring to the combined market penetration of the companies. Bartlett estimated the total amount of pharmaceutical goods traded a year to be about R4 billion.

Products to be distributed through the company include prescription medicines, generic medicines, over-the-counter and consumer products.

"The time of the wholesaler is basically over," said an analyst.

Adcock Ingram, for example, had closed down its distribution division, which had been operating at a loss, the analyst said.
Phelophepa, train of hope

WENDY LOPATIN

The world's first health train and eye clinic is a godsend to rural people.

EVERY weekday for nine months of the year, Lillian Cingo - nurse, midwife, psychologist, earth mother and manager of Phelophepa, the world's first health train - awakens her staff at dawn with her special morning call in many languages. The train delivers an affordable, accessible, mobile primary health care service, to supplement and support existing facilities in the rural communities of South Africa.

Phelophepa, "good clean health" in Tswana and Sotho, originated in 1993 as a joint Transnet/Rand Afrikaans University two-coach mobile eye clinic, the brainchild of Professor Jannie Fenietsa, nurtured by Lyndette Coetsee of Transnet, now senior manager of the project.

Now the 16-coach train has a multi-professional, multicultural staff of 10 professionals, and 40 final-year and postgraduate students from colleges and universities throughout South Africa, working on two-week rotation. There is great competition for student placement and some have returned after qualifying to join the full-time staff.

The train visits isolated and impoverished areas where there are either no health clinics or a critical lack of facilities. It supports existing services through referral to local clinics, hospitals and doctors and facilitates the establishment of permanent clinics in towns visited - such as Venlum, KwaZulu-Natal.

There is cooperation with the Health Department and last year Nicazarza Zuma, Minister of Health, visited the train at Malmsbury and voiced her enthusiasm and support for the programme.

South Africa's vast rail infrastructure helps Phelophepa's mission. Some 15 000 km of railway track is covered annually about 37 trips in 8/10 months. Since 1994, 166 350 patients have been treated, 66 000 children screened and 1 200 community volunteers educated in the train's education clinics.

Transnet has invested R41 million to fund Phelophepa. The "train of hope" spends five weekdays at each stop, traveling to its next destination at weekends. One third of expenses is recovered through patient income - RX for prescriptions and basic spectacles, plus donations. Transnet makes up the deficit. A drug company supplies all generic medicines, another provides educational materials and some of the professional- posted are sponsored.

Speaking to me of her multicultural staff, Lillian Cingo said: "They can learn from each other, working as a team and capitalising on differences.

"She calls them her 'little rainbow nation'. Because of the cramped accommodation, long hours worked and sometimes so many traumatic situations, Cingo supports her staff by facilitating regular sensitivity meetings.

"The warm and competent person of great energy studying nursing in South Africa before moving to Britain in 1966, specialising in neurological nursing and later gaining her master's degree in counselling psychology.

"She returned to South Africa in 1994 to manage Phelophepa. "I am a special child of rural people," she told me. "Whatever government is in power, the rural people will always be the most in need. They ask for basics with such dignity."

In February, Veronica joined other distinguished guests - Leah Tutu, Joyce Sokene of the Truth and Reconciliation Commission and Nomhle Sodile, wife of the Eastern Cape premier - and Phelophepa supporters in Stuttgart.

"The train carries the message of hope," the professor told me, "giving back not only sight, but also quality of life. Prevention through lifestyle education is so important, making local communities more aware."

Leah Tutu and Sodile recognised the great need for more rural health care and additional health care trains. Sokene highlighted the potential for counselling work with trauma victims of violence in areas such as KwaZulu-Natal.

A mobile triage unit visits towns before the train arrives, linking with local health authorities, hospitals, magistrate's courts, clinics, police and shopkeepers. News is spread to the local population.

Often health department co-ordinators liaison with Phelophepa. School outreach programmes are organised, concentrating on dental health. Local labour is recruited such as cleaners, interpreters and cashiers. In some towns recreational facilities such as braais are laid on for train staff.

I spent three days visiting the train, and also accompanied staff to local rural schools. I was moved by their passion and dedication which has helped to change the lives of so many people. Some have received medical care for the first time. The resident dentist, Emile Prince, spoke passionately, saying the three most important aspects of his work were "education, education, education".

He trains his students never to extract a tooth unless they can teach the patient how to save the next one.

Patients, hundreds of them unemployed and from areas of great poverty, who make the 30 km to the train. Some sleep out in the open to ensure they will be there when the clinics open. Sometimes farmers transport their workers and families in trucks.

The train has eye, dental, health and education clinics. It accommodates 50 staff, a laundry, a power-generating coach and communications network and a pharmacy. The dental clinic, with six surgeries, is equipped to perform cleaning, extractions, restorative work and X-rays.

The highly sophisticated and well-equipped eye clinic also has a workshop that prepares spectacles for long and short-sightedness. An elderly woman, who had just been given her first pair of spectacles, told me through an interpreter of her great joy on being able to see her grandchildren for the first time.

Colin Boucher manages the catering department, serving 180 meals a day. He is married but, like other married staff, sees his wife only twice a month.

His dedication is illustrated by his comment that if the Blue Train pulled up alongside and offered him twice the pay for his skills, he would choose to stay on Phelophepa.

The focus of the health clinic, managed by community nurse Maggie Nikitinac, is education, giving special attention to mother and baby care, nutrition, guidance and economical use of water.

Patients are supplied with seeds and taught seed cultivation. Nurses screen all patients. Some common ailments are respiratory such as TB and bronchitis, skin problems, bilharzia, sexually transmitted diseases and urinary infections. Chronic ailments such as blood pressure and diabetes are referred to local clinics for follow-ups. Aids is widespread in rural South Africa and rapid HIV tests are carried out, but there is no repeat assessment because of shortage of time.

The psychology clinic, which conducts workshops in the local communities and schools, forms support groups and puts local people in touch with the closest professional help. Recent workshops concentrated on conflict resolution, HIV and AIDS, sexuality, parenting skills and stress management - all services being free. The education clinic offers structured five-day courses for 21 community volunteers, covering environmental and personal hygiene, diseases, nutrition, family health and first aid, and promotes empowerment of the communities.

One of the most moving comments I heard was from a Transnet security guard who drives the coaches and escort staff and students to the outgoing schools.

"I'm not just a security guard, but part of a family, helping to do something really worthwhile for the new South Africa."

■ Wendy Lopatin, formerly chief librarian of the Cape Times, is editor of *In AYP Healthcare, a large UK publishing company*.
Women beat cancer crisis once—
R5-m can make it happen again

DI CAELER
Social Writer

Dee Krauss, Funeka Xamlashe and
Zahrah Damonse have Groote Schuur
hospital’s cancer unit to thank for
their lives. Now, unless Cape Town
rising to the challenge of ensuring the
unit’s future, other women may not be
so lucky.
In 1990 women made it happen when
they raised R1-million in just three weeks
for hi-tech equipment for the unit.
Today the Cape Argus resuscitates its
Women Can Make It Happen campaign,
this time with a target of R5-million in
three months.
The money will buy Groote Schuur a
replacement for a cancer treatment
machine—a linear accelerator or Linac—
that is the oldest still operating anywhere
in the world.
In spite of its age, the machine is used to
treat between 50 and 35 people a day, five
days a week.
If it were to finally break down, thou-
sands of lives would be compromised, par-
ticularly since 85% of Peninsula residents
have no medical aid and do not have the
choice of shopping around for treatment.
And these will not be the lives of some
unknown people somewhere out there; the
cancer unit at Groote Schuur is everyone’s
business. Latest statistics from the Cancer
Association of South Africa are that one in
four people will suffer from cancer in some
form, and that one in five women will get
some form of cancer.
Women like Dee Krauss, Funeka Xaml-
ashe and Zahrah Damonse know what it is
like to be a statistic. But they also know all
about the high standards of treatment, con-
cern and even friendship they got at Groote
Schuur’s cancer unit, all of which they say
combined to ensure the quality of life they
enjoy today.
All three women suffered breast cancer,
but thanks to treatment on the ageing
Linac, all avoided mastectomies that would
have disfigured them. They have all been
clear of cancer for several years.
Ms Krauss—a former top model as Dee
Gardiner in the 1960s and 1970s and now a
property consultant in Plumstead—was liv-
ing alone and had no medical aid when she
found a lump in her breast in January 1995.
As a former nurse, she noticed a puckering
in her breast and knew immediately some-
thing was wrong.
When a private doctor drew fluid off the
lump and said it was not cancerous, she
told him she had no medical aid and could
not afford to have an operation to remove
the lump. That was when she was referred
to Groote Schuur.
And at the hospital a needle biopsy to
test the tissue found the lump was indeed
cancerous.
“A week later I went in for the operation
to remove the lump. Then followed
chemotherapy, during which I lost all my
hair, and a series of radiation treatments
on the Linac.”
She said staff at the unit were “just the
most amazing people in the world:
“It wasn’t just with me—they are
absolutely wonderful with every single
patient.”
Mrs Krauss said that although it was
really a matter of life and death and that

To page 3

Survivors: Zahrah Damonse, top, Funeka Xamlashe,
left, and Dee Krauss have new leases on life

Cape Argus
Women Can Make It Happen
Groote Schuur Cancer Unit Appeal
In association with Pink ‘n’ Pay

R570 000

That’s what you can win in the
Weekend Argus Charity Jackpot
this weekend. Get Saturday
Argus and Sunday Argus to find
out how you can help the
Women Can Make It Happen
Appeal just by sending in your
jackpot entry

Cover-up feared in health probe

By ZOLILE NQAYI

FEARS of a cover-up have surfaced around the probe into alleged malpractice at public hospitals after files were removed from the home of a doctor involved in the exposé.

The doctor, based in the Northern Province, was confronted by the police in his home and told to hand over the files— which he intended to make public.

The files contain information regarding an investigation into culpable homicide which resulted from alleged malpractice at a public health institute.

The Hospital Personnel Union of South Africa (Hospersa), which is backing the probe into malpractice, this week refused to identify the doctor— but disclosed that he had been transferred from Gauteng to Mpuulanga and then to the Northern Province after exposing malpractices in each province.

When he spoke out in the Northern Province he was dismissed from his job. According to Hospersa organiser Elize Richards, the files were taken back from the police because they had failed to make any progress in investigating the culpable homicide charge. Hospersa took the files to supply proof of claims that medical services were collapsing in almost all provinces.

Former senior superintendent of the Chris Hani Baragwanath Hospital in Soweto, Dr Barney Rabinowitz, has added fuel to cover-up claims with his dismissal of the recently launched commission of inquiry investigating his allegations concerning the hospital.

Rabinowitz fired the first salvo against the medical authorities three weeks ago when he made shocking allegations that at least 40 people had died “unnecessarily” at the hospital because of either negligence or inexperience.

The commission’s report is to be released this week.

Rabinowitz said the investigations would not come up with anything credible as it was only aimed at covering up for the Gauteng Health Department.

He told City Press a commission could only work if it was completely independent. All the commissioners investigating his allegations could not be expected to be impartial as they were all in the employ of the Gauteng Health Department, he said.

Rabinowitz said he was ousted from Baragwanath because he had rocked the boat and not because he was too old (the official reason for terminating his employment). He showed City Press a list of at least 200 surgeons who are 60 or older and are still employed at the hospital. Some are well into their 70s.

“I asked questions which were too uncomfortable to some people in authority. Some say I am a bitter old man. Yes, I am bitter— not because my employment was terminated, but because of what is happening at this hospital,” he said.

“I started asking questions about the deaths while I was still a senior superintendent at the hospital. I went to the media when I realised there was a major cover-up of what was happening at Baragwanath. I am bitter because people are getting away with murder and those in authority are trying to conceal that which is indefensible.”
Audits of all senior Cauntry health boards were not productive.

Regulations at National health lead to wider investigation by commission.

Hospital posts to be conducted.

(98) November 3/1/98

By Assia Khan
Train strike off after agreement

By Mzwakhe Hlangani

A potentially crippling nationwide strike planned for tomorrow was averted last night when six trade unions representing about 10 000 workers and management of Metrorail reached a last-minute agreement over wage increases.

Only one union, the SA Footplate Association (Safa), with a membership of only 1 700, including train drivers, technical workers and train guards, rejected Metrorail’s final offer.

Safa spokesman Mr Chris de Vos said the union’s demands were not met and it would report back to its members for a new mandate.

The deal followed lengthy talks in Johannesburg yesterday between the SA Railways and Harbours Workers Union, the Black Allied Workers Union and the Technical Allied Workers Union (Tatu) in a bid to resolve the wage dispute.

The signatories said social commitment was the major criterion for reaching consensus among all the parties since the strike would affect the poor communities more than it would Metrorail’s management.

Metrorail’s executive human resources director Mr Mark Ganstein-Bein pointed out that the deadlock negotiations were reopened after chief executive officer Mr Z Jakavula and Shahvui general secretary Mr Derrick Smoko had started informal talks with the aim of “putting out the flames that could be caused by the strike.”

He said the doors would be left open for Safa to join the fold as it had reneged in the final minutes.

If the union decided to go on with the strike, minimal disruption could be expected as bases had been hired in anticipation of the strike by some train drivers.

The terms of agreement include a 7.5 percent increase backdated to March 16 1998 and 3.5 percent to be effective from November 16 1998. There would be a further 5 percent from March 16 next year.

Both parties agreed to negotiate a deal on profit-sharing among the workers.

Hospital sets quotas

By McKeel Kotlolo

A CRISIS is gripping the Pretoria Academic Hospital, one of the capital’s busiest hospitals, following an acute shortage of pharmacists caused by resignations.

As a result, hospital management has introduced a temporary quota system with a maximum of 150 outpatient patients accepted each day.

Dr Julius Kunzmann, the Pretoria hospital’s director, said yesterday such situations occurred from time to time when pharmacists left to join the private sector which offers lucrative salaries.

Although the Pretoria Academic Hospital has managed to cope with the situation in the past, the recent departure of four pharmacists in a short period had dealt the institution a serious blow, he said.

Kunzmann said the issue of improving hospital salaries was out of their control since it was negotiated at the national level.

The hospital’s chief medical superintendent, Dr Zola Njongwe, said the new quota system came into effect on Monday in an attempt to ease the pharmacy’s load.

She said the hospital had 32 approved pharmacist posts, but only nine were filled. “Of the remaining nine, three have resigned their posts and would be leaving us at the end of the month,” Njongwe added.

The departure on maternity leave at the end of this week of one of the remaining six pharmacists would worsen the situation.

She appealed to residents, in particular those from the eastern and central suburbs of Pretoria, to take note of the limited number of patients to be admitted a day at the general outpatients clinic.

Njongwe appealed to qualified pharmacists “who are able and willing to assist us on a full-time or sessional basis (with remuneration)” to urgently contact Mrs A Engelbrecht on telephone number (012) 354-2235.
Underqualified staff "a time bomb" at hospitals

Josey Ballenge (98) BD [8/98]

A "LOOMING time bomb" is developing, with 800 staff members in Gauteng hospitals doing work beyond their qualifications or job descriptions, the Democratic Party (DP) said last week.

The DP said it was important to highlight the difficulties hospitals faced with the moratorium on hiring staff.

Answering a DP question in the Gauteng legislature, health MEC Mondli Gungubele said a departmental survey revealed about 800 cases of "misappropriation" — defined as people carrying out functions not applicable to their posts.

The results revealed that Chris Hani Baragwanath had 179 staffers who were wrongly placed, Johannesburg Hospital had 52, Tembisa 48, South Rand 37, Nataliispruit 30 and Pretoria Academic Hospital 26.

Gungubele acknowledged that this "might lead to labour unrest ... cases of unfair labour practice being instituted against the department, (or create) a legitimate expectation of inappropriate personnel being absorbed into higher posts".

"DP health spokesman Jack Bloom said "messengers" earning R25,256 a year are acting unofficially as grade one administrative clerks — a post with a R29,618 salary. If the moratorium is lifted the appointments will have to be regularised, which means advertising and possibly finding the messenger unqualified. This could lead to a dispute."

Gungubele said the primary problem was the moratorium on filling vacancies imposed by the Cabinet in 1994, and the lack of funds for exceptions.

"The department is trying to stamp out misappropriations, but I cannot blame the hospitals because they couldn't function otherwise," Bloom said.

Gungubele's spokesman, Popo Maja, said unions officials were involved to "try to rectify" the situation.
Crime cripples clinic for mums

Doctors stay away as attacks put Guguletu unit's staff at risk

JANET HEARD
ST(CM)16/8/98

The maternity clinic in Guguletu has become a no-go area for doctors and medical students because of crime.

The medical faculty at the University of Cape Town suspended its services and teaching activities at the maternity obstetrics unit more than two weeks ago because the safety of doctors and students could no longer be guaranteed.

In the past month, students travelling to the clinic in Guguletu have been held up at gunpoint, but have managed to get away unharmful.

The driver of a Groote Schuur van was hijacked.

In June, a man driving his pregnant wife to the clinic had been stabbed at the front gate and a cellphone had been stolen from another on the premises, said supervising matron Olga Lenga.

This week, the 42 staff members at the clinic held a crisis meeting at which they called on the community to help put an end to the alarming rise in crime and take steps to make it safer for doctors, students, staff and patients.

"The clinic won't be able to function longer than a couple of weeks without the medical back-up of paediatricians, gynaecologists and students," said Lenga.

The sister in charge of the clinic, Mary-Ann Mamatsiare, said antenatal care was at greatest risk.

Doctors were vital for checking on high-risk pregnancies. If there was any sign of danger to a woman's health, they referred her to a hospital, Mamatsiare said.

The 24-hour clinic delivers up to 12 babies a day and serves a wide area that includes Brown's Farm, Langa and Old and New Crossroads.

Negotiations are under way to resolve the crisis and the Guguletu policing forum has offered to escort doctors and students.

At the meeting, Dr Ruth Rabinowitz, the Inkatha Freedom Party's spokesman on health, said doctors had lost confidence in the police's ability to deal with crime. "We have a clinic with dedicated staff, but it cannot function properly because of the breakdown in law and order."

Dr Greg Petro, a gynaecologist who supervises medical staff and students at the clinic, emphasised the potential repercussions of the suspension of services.

"The clinic can operate for a few weeks, but not much longer, without medical personnel."

An effect was that more mothers and newborn babies were being referred to Groote Schuur and Mowbray hospitals, overloading staff at these hospitals.

Petro paid tribute to the dedicated midwives at the Guguletu clinic and said that he hoped conditions would be made safer for doctors and students "as soon as possible" so UCT could reverse its decision.
适当平衡，提供良好服务，以支持社会的健康需求。这包括了通过建立和完善公共卫生系统和医疗设施，提供健康教育和健康促进等服务。为了实现这一目标，需要政府、医疗机构和社会各界的共同努力，通过政策制定、资金投入和公众参与，共同推动医疗卫生服务的发展。
Babies’ Lives Endangered

Red Cross Hospital runs out of oxygen

A TINY baby may die and many other lives were endangered after Red Cross Children’s Hospital ran out of oxygen last week — apparently because the person responsible for checking supplies has left. Health Writer JUDITH SOAL reports.

OXYGEN is as vital to the running of a hospital as is blood — perhaps more so because it is needed by more people. Last Thursday, Red Cross Children’s Hospital ran out of oxygen and now a two-week-old baby is struggling for its life while the health of at least two other children has deteriorated.

Operations scheduled for Friday were cancelled. An emergency delivery restored supplies within about six hours, but as the hospital was investigating how the tank of liquid oxygen had been allowed to run dry, another oxygen scare yesterday had staff switching off all but essential supplies. Operations were again cancelled.

Doctors have no doubt that last week’s crisis endangered children’s lives.

Registrar Liesl Hendricks said the children who were too young or unable to speak had suffered the most. “They just lay there. They knew something was wrong, but they couldn’t tell anyone.”

Paediatric specialist Louis Reynolds said it was a “miracle” that no one had died. “It’s like an earthquake. You rely on the earth to be there and then suddenly it’s not. It’s the same with oxygen. It’s crucial to what we do.”

The baby, who has not been named, did not respond to his first dialysis treatment. “He will have more dialysis tomorrow but if he doesn’t respond, he will die. He’s not doing well,” Lorenson said.

Hendricks said several children had suffered serious consequences. “There was one child with critical pneumonia and another with renal (kidney) failure whose conditions have worsened. There are lots of children whose health has suffered. Although we can’t say it is directly related to the oxygen, it certainly appears so.”

The hospital cancelled operations again yesterday after a problem with the oxygen supply. “We had a warning that we were running out of oxygen,” said Hendricks. “Apparently there is something wrong with the pipes, but no one seems to know.

“We have been running around making sure there are enough cylinders and switching off oxygen where it is not absolutely necessary.”

Hospital authorities were reluctant to comment on the incident.

“We are still busy investigating,” said hospital secretary Lennie du Preez. “We are not sure if it was a technical problem from the firm’s side or on the hospital’s side.”

He denied that there had been another oxygen crisis yesterday.

“It was nothing major and everything has been sorted out satisfactorily,” he said. “It wasn’t actually necessary to cancel theatre.”

Red Cross staff say the person who was supposed to check the level of oxygen in the tank had accepted a voluntary severance package and no one had been given responsibility for this task. Du Preez could not confirm this.

Alan MacMahon, chief executive officer of the three academic hospitals, Red Cross, Tygerberg and Groote Schuur, said the crisis was not related to budget cuts.

“Obviously we would rather break the budget than run out of oxygen. This is not a budget problem, but a managerial one.”

Red Cross medical superintendent Shahid Hashim was unavailable for comment.
Bara hospital report damns doctors, nurses

BY ALDO THOM
Health reporter

A commission of inquiry has been appointed after a task team investigating alleged irregular deaths at Chris Hani Baragwanath Hospital found there was a lack of supervision and a breakdown in nursing at the hospital.

The task team was established about two months ago, after Dr Bernard Rabinowitz, a former medical superintendent at the Soweto hospital, claimed that at least 40 patients had died at the hands of junior doctors performing surgery without supervision since 1986.

Professor Tsole Mokoena, head of the three-man commission, said yesterday the overall impression was that the majority of the 31 deaths brought before the commission by Rabinowitz would have occurred anywhere else and under any type of care.

Mokoena added that two cases had died "unexpectedly and inexplicably", and that it had not been possible to obtain postmortem results. He did not elaborate on these two cases.

Mokoena said the allegation by Rabinowitz that senior supervision had been less than adequate was legitimate.

"Close supervision by senior consultants was not always robust enough nor well structured. This allowed 'junior' doctors to make and execute decisions which ought to be referred to 'seniors'," he said.

One of the most damning findings in the report was a breakdown of effective nursing with no effective communication between doctors and nurses. This was blamed partly on a severe shortage of nurses, but it was also pointed out that "the degree of lack of nursing is out of proportion to the nursing personnel shortage".

Mokoena said there were insufficient beds in the intensive care units, with post-operative care carried out in the general wards without adequate nursing or equipment.

It appeared that management either did not take that seriously enough or did not push hard enough with the Health Department to have the problems rectified, or the department did not heed the complaints, Mokoena said.

He added that besides Rabinowitz, senior administrative and nursing staff members had submitted representations regarding the various problems to management.

Rabinowitz described the statement that the majority of deaths were unavoidable as "absolute rubbish".

Gauteng Health MEC Mondli Gungubele said the follow-up investigation would focus specifically on how the system failed desperately ill patients.

Dec 18/8/98
Bara findings 'drivel', says Rabinowitz

A former Chris Hani Baragwanath Hospital superintendent Dr Bokke Rabinowitz said yesterday that some of the findings of a commission investigating his claims of irregular deaths at the hospital were "absolute drivel".

"People do not die because of bad management, they die because of bad doctoring," Rabinowitz said.

The investigation stemmed from Rabinowitz's claims last month that more than 40 patients had died at the hospital since 1996 because of insufficient supervision during surgery by junior doctors.

A commission was then instituted to investigate 21 patient deaths at the hospital.

The chairman of the three-man commission, Professor Taole Mokoena, told a press conference yesterday that the majority of 21 patients investigated would have died in any institution under any type of care.

However, Mokoena pointed out serious problems at the hospital, including a breakdown in nursing and a lack of communication between health professionals.

"It appears that senior professional staff and hospital administrators failed to press the case for provision of adequate facilities with the provincial authorities, or their pleas went unheeded. They allowed morale and professional diligence to deteriorate among junior staff, especially nurses."

The commission found close supervision by senior consultants was not always robust enough, nor well structured. "This allowed junior doctors, mainly because of inexperience, to make and execute decisions which they ought to have deferred to seniors."

The commission also found that procedures for post-operative care and the handover of critically ill patients from junior doctors was not sufficiently structured or enforced.

"In some cases that could have led to the death of patients," Mokoena said.

The panel also found that the physical facilities for the management of critically ill surgical patients, such as intensive care monitoring facilities, were inadequate.

"Post-operative care of critically ill patients was carried out in the general ward or in the anaesthetic recovery room without adequate medical oversight or nursing procedures."

Mokoena said there was no evidence that any particular doctor needed to be referred to the South African Health Professionals Council for possible disciplinary action.

Disciplinary action

Gauteng health MEC Mr Mondli Gungubele said the commission's report would be submitted to the relevant medical and nursing councils to decide whether any disciplinary action was necessary.

A follow-up investigation would be instituted to focus on how the system had failed desperately ill surgery patients.

Gungubele said the hospital performed an almost heroic task daily. Yet it was clear from the report that there were failures in basic healthcare practice at the hospital.

Asked whether similar investigations would be instituted at other Gauteng hospitals about which complaints had been received, Gungubele said the Chris Hani Baragwanath Hospital was the first priority.

If similar conditions prevailed at other hospitals, they would also warrant investigation. Sapa.
Forests bill ‘puts R300m and 23 000 jobs at risk’

Wyndham Hartley

CAPE TOWN — Almost R300m in turnover and 23 000 jobs would be at risk if the National Forests Bill was implemented in its present form, Eastern Cape sawmillers told a parliamentary committee yesterday.

In a tough rejection of the changes to conditions of contract contained in the bill, sawmills from across the country said if the contract period was reduced to three years from the present five, confidence in the industry would diminish and further investment in the rural areas would be discouraged.

The sawmills hold contracts to purchase the harvest from state forests and the bill proposes to change the terms of these contracts.

The parliamentary agriculture, water affairs and forestry committee was also told that if state-owned forestry operations were privatised it would be important to prohibit the buyers from exporting the logs as this could be disastrous for the timber industry.

Christopher Rance, representing Rance Timber and four other companies, warned that the depreciation of the rand had made the export price of logs high in rand terms, making it more affordable to export logs than to process them locally.

Rance said if the licence period was reduced to three years the successful bidder for a state forest could cancel all contracts, wait three years and then export all the timber.

Rance said: “The state might get a higher initial sale price but the economy and the job market will lose much more.”

He said there was nothing in the new legislation that prevented this from happening.

Nthato Motlana, executive director of Madiba Mills inMpumalanga, called for the clause reducing the licence period to three years to be scrapped.

“What we as new entrants to the industry need most is opportunity and the confidence of the providers of capital. Section 28, if ever became law in this form, will hurt confidence in the industry and in us. Without security of tenure it will become too risky to support sawmills financially or to rely on them for stable supplies,” he said.

Motlana said the intended privatisation of the SA Forests Company and other state forests was a way to give formerly disadvantaged newcomers to the industry a start.

Solly Tucker, from York Timber, said section 28 of the bill empowered the minister to deprive people of their contractual rights without compensation and that this violated the constitution.

He said the clause also offended “the spirit if not the letter of the bill of rights”.

The legislation seeks to rectify the discriminatory allocation of forest resources of the past either for recreation or for commercial exploitation.

It also seeks to resolve the anomaly that, at the moment, makes the state a participant and regulator of the industry at the same time.

DP critical of discipline at hospitals

Josey Bellenger

THERE was an alarming breakdown in discipline in Gauteng hospitals, with a low incidence of action taken against guilty parties, Democratic Party MPL Jack Bloom said yesterday.

Health MEC Mondi Gungubele told the Gauteng legislature that 214 disciplinary cases were handled last year and 58 formal charges laid against officials.

Forty-one of these officials were found guilty on various charges, including 22 cases of fraud and theft.

But Bloom said the figures were “extremely low in view of the widespread theft in hospitals and public complaints of indiscipline”. Disciplinary procedures were “so slow” that six employees were still employed despite being convicted in court.
Semi-private state hospitals proposed

PUBLIC-private partnerships at state hospitals could become more mainstream and make the institutions more alluring to private patients when a national framework was ironed out, Tom Sutcliffe, head of the Western Cape's health department, said this week.

Sutcliffe said provincial departments were considering a framework drafted by the Western Cape earlier this month to develop guidelines for partially "privatising" public hospitals.

Sutcliffe said the need for the guidelines arose after proposals were tabled at Tygerberg Hospital in the Western Cape and Uitenhage in the Eastern Cape to lease unused wards to private practitioners. The argument for the guidelines was that professionals would not be easily tempted to move from one hospital to another in search of better working conditions, if a national framework was adopted and the practice became widespread.

Sutcliffe said calls for public-private partnerships posed some "interesting pros and cons". One positive aspect was that the public sector would receive revenue from private beds and a more varied patient profile and spectrum of disease, which would be useful for teaching purposes.

The ultimate aim was for public hospitals to compete for private patients. "Right now, the perception of public facilities is not good and that must be changed. We have a high level of skilled sources — as good as, if not better than, the private sector — plus resources that are nonexistent (in the latter)."

Provincial departments' heads are due to report back on the draft framework and consolidate a position at a meeting next month. The framework would ultimately have to be approved by Health Minister Nkosazana Zuma and provincial MECs.

Sutcliffe said he had "reason to believe they are open-minded," but authorities had to be assured there would be "checks and balances" and that "indigent patients' care would not be sacrificed or compromised."
'Home of shame' investigated

LAURICE TAITZ

ST 29/8/98

POLICE are investigating complaints of assault and neglect at South Africa's largest state home for the mentally handicapped.
The complaints came to light after a nurse was charged with assaulting two minor patients, aged 15 and 17, at the 1100 bed Witrand Hospital in Potchefstroom in the North West.
Some of the accusations levelled against the hospital are that:
- On one visit parents found their 15-year-old son tied to a chair in the TV room;
- A mother of a 41-year-old woman found her wearing no underwear and weighing 39kg. She took her home, yet a month later received a letter from the hospital saying her daughter was making good progress; and
- The parents of one patient said they found her body covered in bruises.
The parents of one of the boys who was allegedly assaulted on July 4 — a 15-year-old who has a mental age of three — further charged that their son's assault was covered up.
They said they were only alerted to the fact that something was wrong one week after the incident when their son ran away.
The boy was found 14 hours later.
The mother was told he had climbed through a window and over a razor-wire fence into the neighbouring army base. He was found in an army truck, naked and bleeding.
"The man who found him followed a trail of blood. My son's clothes were still stuck in the razor wire," she said.
The teenager received 62 stitches for his injuries.
Soon after the incident, the parents met with hospital management to discuss their son's condition and a programme of activities for him.
"They never mentioned the assault during the meeting. I heard about it the following day," said the mother.
"My son is a lovable, beautiful kid. In the past I have seen marks on his body that I have not been happy about. But I was told he got into fights with other kids. I worry that he may have been assaulted before."
Although provincial policy is that relatives must be informed of any injury to a patient at the hospital, Michael Siebert, the hospital secretary, said the assault case was a police matter and it was not the hospital's duty to inform the parents.
Witrand has been described by doctors as "the last stop". It "gets patients other people cannot manage."
George Sekoele, 35, the nurse charged with the assault, appeared in the Potchefstroom magistrate's court last month. He was released on bail of R400 and is due to appear again on August 31.
This week, Captain Louis Jacobs, the Potchefstroom police media liaison officer, said the hospital had been unco-operative in the investigation and had not complied with a request to transfer Sekoele to another institution.
Responding to the other allegations, Siebert and Annetjie de Bruin, the nursing head matron at the hospital, said many of the problems at Witrand were the result of staff opposition to transformation — the institution's attempt to bring the hospital in line with government policies.
"The impact on staff has been severe and we have experienced a lot of turbulence during this process," Siebert said.
End of an era for orthopaedic hospital

Goodbye, Princess Alice

CARE NEWS MONDAY AUGUST 14 1998

10 NEWS
Hospitals owed R42-m

By Joshua Raboroko

PATIENTS still owed three Gauteng hospitals R42 million despite legal action to recover the money, an audited report tabled in the Gauteng provincial legislature said.

The auditor-general's report on the performance audit at the Gauteng hospitals administration said that Pretoria Academic Hospital was owed R34 million while Chris Hani Baragwanath Hospital was owed R5.5 million at the end of January last year.

The report said although 76.8 percent of the debtors' account at Chris Hani Baragwanath Hospital, which amounted to R5.5 million in January 1997, had been outstanding for a long time, no legal action had been taken for its recovery.

The accumulative debt of R34 million in October 1996 had not been effectively retrieved by Pretoria since 1991, the report said.

Kafafong Hospital was owed R3.2 million. Money has also not been recovered from patients from other countries. Nobody may be refused treatment but in most cases addresses cannot be verified.

Treatment of patients from other provinces had cost the Chris Hani Baragwanath Hospital R87 230 between October 1996 and January 1997.

The cost to Pretoria Academic Hospital between April and October 1996 had been R1 million and to Kafafong Hospital R7 million.

A total of 62 children had been accommodated for 4,290 days at a cost of R2.4 million from the 1993-94 financial year to last year. Abandoned children requiring no medical attention had been accommodated at Chris Hani Baragwanath Hospital and had not been transferred to places of safety.

Community's needs at the outpatient section of Mamelodi had not been optimally addressed. From April 7 to 17 a daily average of 85 patients had been turned away.
Hospitals move to ease workload
Budget cuts paralyse security at hospital

Call the shots where gangsters

September 26, 1998

Sunday Times II

Andrew Ugres, WS
South Africa's cash-strapped hospitals can no longer afford to keep premature infants alive.

The babies who are born to die.
Mamelodi Hospital bursting at the seams

By STEVE DLAMINI

Calls to upgrade Mamelodi Hospital in Pretoria to a regional hospital seem to have fallen on deaf ears.

Donny Makoala, secretary of Mamelodi Civic Organisations, claimed an agreement to improve the hospital and its working facilities was reached with the Gauteng Department of Health and the hospital’s senior staff.

But the hospital’s matron Stella Sebati said it would probably take longer than seven years to convert the hospital into a regional hospital because of budget constraints.

The health department could not be reached for comment, but it recently made plans for the hospital to be converted into a regional hospital, without specifying when.

The hospital needs to be upgraded to supply a more effective health service for the community it serves and to eliminate the queues in which patients have to wait for hours to receive attention.

Even though the casualty unit will be upgraded next month and 10 extra consulting rooms will be built, the community fears this will not sufficiently improve the facilities.

“The position will largely be the same. The hospital is too small to serve the entire Mamelodi community with a population of more than 800 000,” Makoala said, adding that the hospital also catered for people as far away as the Cullinan and Mpumalanga areas.

The hospital’s acting superintendent, Dr Julia Blitz, confirmed the hospital was experiencing a number of problems but said the matter was receiving the department’s attention.

The hospital, with a staff of 131 nurses and 18 doctors, has two wards totalling 90 beds, and has to attend to more than 600 outpatients a day.

“The beds are used for people hospitalised for five days or less. Patients who sustain serious gun and knife wounds are transferred to Klaafong Hospital in Atteridgeville or the Pretoria Academic Hospital,” Dr Blitz said.

The hospital also did not have facilities to test blood, she said.
Air ambulance to die tonight

Angie Schutt's ambulance service, which transports 500 patients a year, is to be axed due to a shortage of funds.

Photo of a man in a stretcher, possibly related to the article content.
Lifeline thrown to air-ambulance service

BY ANSO THOM
Health Reporter

At least four major businesses have offered to help keep Gauteng's 24-hour Flight for Life service alive by footing the R5-million needed to keep the two helicopters in the air.

The province's air-ambulance service was axed at midnight last night by the department of health - but Europ Assistance is to keep the lifeline open by using a small helicopter during the day. Other companies have also offered assistance.

Popo Maja, spokesperson for Gauteng Health MEC Mondli Gungubele, confirmed yesterday that the province would not be in a position to renew the contract. "We don't have the funds to do that."

Ian Cornish, the managing director of Europ Assistance, which has been operating the service from the Johannesburg and Pretoria Academic Hospitals since 1995, confirmed that at least three big businesses had approached the company with offers to help meet costs.

Cornish said that, although they had received no directive from the department of health as to what should happen by the time the extension expired, they had taken a decision to keep a small helicopter in the air during the day.

Cornish also disclosed that Europ Assistance had approached the Government with a proposal to become a co-sponsor: "I sent a proposal yesterday to sponsor the service with a fixed amount of R2,5-million a year, which would allow us to continue servicing non-paying patients. We guaranteed that we would find the sponsors to make up the rest."

He would not reveal who the interested sponsors were, but indications were that the SABC and Telkom had or were planning to approach the company.

He said Netcare, John Rolfe and Europ Assistance would foot the bill for the next few days until a solution had been found. "We won't be able to run a 24-hour service anymore," he confirmed.

Dr Pieter van den Berg, director at the Gauteng department of health, said the department was willing to negotiate with Europ Assistance on the co-sponsor proposal.
Lack of planning led hospitals’ problems

CAPE TOWN — Inadequate financial management and lack of planning affecting two KwaZulu-Natal hospitals — King Edward and Wentworth — were cited by the auditor-general’s office in a report tabled in Parliament yesterday.

It said an amount of R281m had been allocated by the provincial administration to King Edward during the 1997/98 financial year, about 14% lower than the expenditure of R312m for the 1996/97 financial year.

However, the budget had already been overspent by nearly R26m by January 31 this year. An amount of R32m had been allocated to Wentworth for 1997/98 financial year, about 3% lower than the expenditure of R35m for the 1996/97 financial year. However, the budget was already overspent by nearly R11m by January 31 this year.

The report said although every effort was made to control the budgeting process to the actual needs of hospitals, allocations were not made accordingly.

Although a strategic plan was developed and documented by the provincial health department during June last year, its contents were not adequately communicated to and monitored by relevant role players.

The need for additional staff was not addressed on time, the report said. This had contributed to staff not being used according to their qualifications and skills, as well as a loss of potential income.

Monthly service accounts were not always paid on time, and as a result at least R39 476 interest on overdue telephone, water and electricity accounts was incurred. The collection of outstanding patient fees at Wentworth was not adequately addressed. This had led to revenue being forfeited. — Sapa.
Threat of Cuts to Medical Services

(86)
First traditional hospital opens in Manipal

The medical and research facilities of the hospital will be complemented by traditional Chinese medicine for a more holistic approach to patient care.

Intensive treatment

The hospital will offer a range of traditional therapies, including acupuncture, herbal medicine, and massage, alongside conventional treatments. This holistic approach is designed to improve patient outcomes and enhance the overall experience.

Medical advisory board

A board of medical experts will oversee the development and implementation of the hospital's integrated care model, ensuring a high standard of service.

By Sherman Wong

(Asianews 6/10/06)
Doctors must decide which babies will die

PRISCILLA SINGH

An urgent appeal for public donations has been made by the Groote Schuur Newborn Medicine Unit, which loses two to three babies a week because of a critical cash shortfall.

At times, painful decisions like taking babies off ventilators and allowing them to die are part of the normal duties in the unit. A lack of resources and money has forced this situation, coupled with the fact that equipment in the unit is more than 30 years old and broken and obsolete machines are not replaced, doctors say.

The plight of the babies has been highlighted by three senior doctors who are forced to deal with the unfair reality of making life and death decisions every day.

Dave Woods, who heads the unit, said yesterday that they were “totally strangled as far as resources are concerned”.

“Care is determined by budget and not by need. We sometimes put two babies at a time in an incubator and then we have to make the difficult decision to take very underweight babies off ventilators because it is too expensive.”

A three-month survey at the unit indicated that 482 infants were cared for; of these 33 weighed less than 1kg at birth while the remaining 449 weighed 1kg or more. Survival rates in the two groups were 60% and 98.4%, respectively.

The 33 low-weight infants accounted for 31.2% of the total expenditure. The financial cost to the state per survivor was 10 times higher for this group compared to the heavier babies.

Very small infants therefore, have a reduced rate of survival and take up a large slice of the funding available and also need a lot of nursing time.

Over the past two years the nursing staff has been cut by more than half and specialists from six to two. The unit was equipped to accommodate 60 low-weight babies, but a room with 10 incubators now stands empty because of the staff and finance crunch.

One of the strategies that have been implemented is the “Kangaroo Mother Care” facility, where mothers act as incubators, keeping the babies close to their bosoms at all times to ensure warmth.

Woods said the most difficult fact to deal with was that babies under 1kg will not be ventilated unless under very extreme circumstances.

“The way our budget is structured, it is a lot cheaper if we had to let babies die. It sounds harsh and inhumane, but unfortunately this is the reality,” Woods said.

To pledge donations, call Dave Woods on (021) 494-5022 or (021) 488-4728.
Which babies will die.

Doctors must decide.
Gauteng 'dragging heels on health partnerships'

Prasa Pillay  
20/16/18/98

The Democratic Party (DP) yesterday criticised the Gauteng health department for "dragging its heels" on private/public partnerships in health institutions and attributed this to "ideological reasons and administrative incapacity."

DP Gauteng health spokesman Jack Bloom said private/public partnerships would bring badly needed income to sustain Johannesburg Hospital. He was concerned Wits University's proposal for the private use of 200 beds at Johannesburg Hospital had been stalled for years.

"It is vital that we have faster movement in this area, as it is an opportunity to generate income desperately needed to halt the alarming decline in medical standards at Johannesburg Hospital," said Bloom.

In a written response to questions by the DP, Gauteng health MEC Mondli Gungubele said the department was conducting a detailed audit of underused space in all Gauteng's hospitals. Spare capacity at public hospitals could be used for partnerships either in specific clinical departments or in a hospital as a whole.

"The department is exploring various options including partnerships with the universities," Gungubele said.

Before entering any partnership, the department needed to give full consideration to the impact of the proposal on equity, efficiency, quality of care and whether it addressed the need for services. The department also had to consult staff and unions at the institutions to ensure partnerships did not have a negative impact on the public sector.
Foreign doctors get the needle

They're doing a great job but get little recognition or reward

By Charlene Smith

When is a South African not a full South African? When he or she is a doctor who qualified abroad, emigrated to this country and became a citizen.

While their SA-born counterparts leave the country in droves for hospitals or private practices overseas, foreign-born and trained doctors who live in South Africa, even if they are citizens, are forced to work the rest of their lives in under-resourced, poorly paid, overloaded government hospitals.

At Germiston Hospital (formerly known as Willem Cruywagen Hospital), all the doctors are foreign. The superintendent is a Bulgarian, and all the remaining staff are foreign trained (although most have taken out South African citizenship). A single South African paediatrics consultant comes in two to three times a week to help an overstaffed woman doctor who is in charge of the paediatrics, gynaecological and obstetrics wards.

No unions

A look at her case load gives an idea of what foreign doctors do for this country. She is a Bulgarian who qualified in 1990. She came to SA in 1992. She has 35 South African exams and completed a year of internship here (despite having already done all that in Bulgaria).

In her typical 8am to 4pm working day she cares for an average of 15 patients in the paediatrics ward, 30 antenatal patients and 10 patients in the gynaecological ward, monitors about 10 women in labour, delivers at least 10 babies and performs two to five caesareans.

A doctor like her earns, after tax, around R4,600 a month. Senior doctors in South African hospitals gross R6,000 a month. Nearly all work overtime to increase their earnings, and earn around R30 an hour for overtime work.

There is probably not a union in the country that would accept such rates, but doctors are not allowed to be unionised.

There is a furor in medical circles at present because foreign doctors, the Department of Home Affairs, the SA Interim Medical and Dental Council, and even, initially, Dr Nkosazana Zuma's own Health Department claimed she had instructed Home Affairs not to renew the work and residence permits of about 1,300 foreign doctors. However, after persistent Saturday Star inquiries, Zuma denied this.

If foreign doctors leave, in their place will be community service doctors - who have just qualified or are about to qualify. But even with those doctors, SA's understaffed, under-resourced hospital system cannot cope, as Mpumalanga Premier Mathews Phosa found after being involved in a car accident.

Phosa said that when he arrived at a government hospital after the accident, "There was not even a stretcher to carry me. Many hospitals don't have enough staff or medical equipment."

But while the system may be inadequate, the doctors are not. Mark Joubert, who was shot in his lower back, was taken to Germiston Hospital. Dr Valentin Jordanov, the hospital's acting superintendent, and who was a specialist general and thoracic surgeon in Bulgaria, operated on him. Joubert believes he would have died if not for the help of Jordanov and his team.

Jordanov wrote to President Nelson Mandela in July this year querying legislation that would not allow him full registration (which would put him on a higher-paying specialist scale at his hospital). His letter was referred to the minister of health who referred it to her director-general, who wrote back a letter headed Application for Employment, essentially saying his failure to adopt a new regulation to write a South African exam for final-year medical students excluded him from full registration.

However, Dr Vesselin Milkov, who was a specialist nephrologist in Bulgaria with 22 years' experience, has applied to write the exam. He is one of two qualified nephrologists at Chris Hani Baragwanath Hospital; the other is Cypriot.

But with a month to go, Medunsa has failed to send him details of the exam.

The situation is rendered ridiculous because Milkov, an SA citizen, trains South African students and registrars. Many of those he has trained have left the country. But present regulations mean he cannot legally write prescriptions, he has to ask SA-born junior doctors to do that for him. "I love South Africa and this hospital, but because I am foreign trained, I will never rise higher, I can never be a specialist and get the pay benefits of that."

Dr Marija du Plooy, a registrar at Chris Hani Baragwanath, and a South African-born doctor, says: "In South Africa we come from a background of discrimination and yet we are continuing that with foreign-trained doctors. Health services have dropped. There are two to four sisters per ward caring for 60 patients. The more patients you deal with, the more likely it is that mistakes will be made."

Solution

But Milkov, who was part of a delegation of foreign doctors to the Human Rights Commission last year with their plea for equality, has a possible solution.

"If doctors come to this country there is no reason why they should not work in government hospitals for two or three years. But, if they make a commitment to this country and become citizens, they should have the rights of citizens. There is no reason why the government should not have categories of doctors who are only contract workers and who may have contracts for no more than, say, four years, with an option to extend for two or three years."

Members of the SA Foreign Qualified Doctors Association are so incensed that they have established a "fighting fund" to pay for their legal battles against the minister of health. They plan to meet next weekend to discuss strategies. One doctor said: "I am getting tired of this humiliation. Maybe I should do what the South African-born doctors do and just leave the country too."
Valkenberg 'abuses' probed

BOBBY JORDAN (88) 98
STC(EM) 18 10 98

The Human Rights Commission is investigating reports of improper conduct by staff at Valkenberg Psychiatric Hospital.

This follows the death of a 39-year-old patient — admitted to nearby Conrado Hospital with a chest infection — and the alleged sexual abuse of a male patient.

The commission’s legal officer, Paranaaz Verlava, said it was waiting for a response from the Cape Town hospital before deciding on the next step.

According to a report, many inmates raised concerns about the sudden death of Joseph Damon on August 18.

"From the evidence there could have been some negligence on the part of those responsible for treating Damon," the report said. The hospital is also investigating an allegation that one of its staff assaulted and sexually abused a patient earlier this year.

Valkenberg medical superintendent Dr Garvin MacKay this week confirmed that the hospital had launched an internal investigation into the sexual abuse case and had reported the matter to the police. He said the hospital had to deal with many allegations against staff members but most had proved to be false.

"There will also be a thorough internal investigation," MacKay said.
Ambulance crisis as 50 quit service

Cape Town's emergency rescue service has been plunged into a crisis after the shock resignation of 50 ambulance staff members, including a top executive and the first black person to be appointed to a senior officer's post.

Uncertainty over who will run the ambulance service in future, as well as a change to the rules of the Cape Town municipality's pension fund, appears to have prompted the resignations.

The exodus of about 17% of the city's 291 ambulance staff members comes after months of uncertainty for the service which is funded by provincial government but run on an agency basis by the Cape Town municipality.

Cape Town has signalled that the service should be taken over by provincial government, and staff are uncertain what the implications are for their pay scales and other benefits should this happen. The pension fund change has allowed staff to take out lump sums.

Some personnel left at the end of last month, others at the end of this month and a number indicated they were planning to go at the end of November.

Among them was ambulance station control room officer John Bester, 51, who has opted for early retirement after directing emergency personnel and emergency vehicles for 23 years in his 31-year career at the city council.

Mr Bester was a legend in his time at the helm of the control room.

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Time to go: John Bester, 51, the 'first senior officer of colour' of the Cape Ambulance and Rescue Service, has quit.
CHRISTMAS 1997 at the Wesfleur Hospital in the apartheid-created town of Atlantis on the West Coast. The staff had been holding a Christmas Eve party at the end of another long year serving the people of the town and its surrounds in Mamre, Pella and the informal settlement of Witsands nearby.

"We started the evening so well," recalls Des Stumpf, the doctor in charge of the ailing hospital's outpatient section.

"We had a sound system, we were singing carols, dancing in dressing gowns... then all hell broke loose.

By the end of his shift, Stumpf and his handful of dedicated staff had treated more than 100 stabbing cases. One involved a young woman who had stabbed her father to death in a domestic squabble.

The usually good-natured doctor drove home in tears. "God, please help Atlantis," he prayed.

Depending on who is being interviewed, the unemployment rate in the town is put at 40-50%.

The ranks of the unemployed will be swelled by nearly 700 by the end of the year due to job cuts at the Atlantis Diesel Engines company, situated in the areas industrial hub.

Everyone agrees that the jobless figure is frightfully high for a town with a population of 100,000.

With both parents at work, there is little or no adult supervision in the home to ensure children attend school.

Many of Atlantis' inhabitants have been forced to turn to alternative ways of earning an income, such as traveling to Cape Town and other centres for work, or establishing informal businesses, including wholesale shebeening, in the town itself.

An average of eight Atlantis residents are dependent on the salary of one working person.

Forty percent of Atlantis' working residents are employed outside the town. They have to wake up as early as 4am for the daily journey that will cost them an average of R300 per month — a huge chunk considering that most earn about R1,000 a month for mental jobs in factories and as domestic servants.

Staff and budgetary cuts have further shaven capability down to the bone.

Speculation is rife that the needs of Atlantis are deliberately being ignored because its inhabitants voted for the National Party in the 1994 elections.

"Not white enough and not black enough," is a saying often heard when residents struggle to make sense of the new dispensation.

The prospect of the hospital acquiring urgently needed equipment and additional staff is bleak.

In its 1997 annual report, the hospital says that it presently provides a busy outpatient service which is divided into general and chronic sections, 24-hour cardiac and 24-hour intensive care services.

It notes that the hospital's philosophy of primary health care adopted by the new government, which has over the last two years been a reduction in staff by 15% and a loss of service in terms of the hospital's 25-bed ward and theatre, both of which are not operating due to staff shortages and despite a net increase in the patient workload of 40%.

The voluntary service package has removed many experienced staff in all departments. In many instances they have not been replaced.

"Where they have, relatively inexperienced staff have joined," says the report.

"These have not been adequately indoctrinated due to service pressures and have required extra supervision, creating increased work and decreased morale.

"Many nurses perform duties beyond their scope of practice. Staff members were medically boarded during the week and another was sacrificed for medical board by the end of the year. A few simply resigned.

"From the Cape Times visited the hospital, staff said they were discouraged from taking the refresher course; management, on the other hand, pointed to the scarcity of staff and asked for help from the medical board.

"In every instance management has made strenuous efforts to fill the vacant posts," the report notes. "The rules and procedures for filling positions are changed frequently to suit the needs of the patient; the recruitment of additional staff if the hospital continues to the present rate.

"This culminated in the "Friday 13 June" cancellation of all vacant posts, in which posts which had been advertised for but not yet filled were abolished.

"Equipment is also sorely needed.

"It is this desperate scenario that drove Stumpf to contact the Lions Club of Groote Schuur to help lift the hospital out of its quagmire.

"With its motto "We serve", the objective of the Lions club internationally is to promote good citizenship, encouraging service-minded people to serve their community.

"At a meeting with the Lions Club of Groote Schuur when they were in operation Bright Star, they showed them facts and figures and provided spectacles for needy residents, providing a R30 subsidy towards the R80 cost, R20 of which is provided by the patient.

"Through that contact I asked them if they could please have a look at the hospital and assist.

"In 1997 alone, the Lions Club has provided R300,000 worth of services.

Outgoing Lions Groote Schuur president Alan van Wulven and fellow Lion Ingelis de Klerk travelled to the hospital one night to experience its predicament first hand.

"I got a phone call from Des (Stumpf) saying, "Help, our hospital is in trouble, can you do anything?"

"When we got there, we found him to be the only doctor working in this massive hospital. One thing he said to us was, "We saw an opportunity where we could possibly help."

PUTTING DEED TO THE WORD: Lions Club members Richard Hayman (second from left) and outgoing Lions Club Groote Schuur president Alan van Wulven (third from left) help to load a crate of tomatoes into a bakkie headed for Rainbow Educare Centre in Guguletu. With them are (from left) driver Solani Femela, Pietro van Heerden, Mwolwle Moko and Bascoy Mthetho, 13. The Lions food project has been operating for approximately 27 years and is currently annually providing foodstuffs to over 1.2 million people. It operates in the southern suburbs and northern suburbs. Recipients include churches, schools, church groups, soup kitchens, homes and institutions serving underprivileged and needy communities.

PITURE: GARTh STEAD
hospital struggles for life

Casualty and 24-hour maternity services. It notes that in terms of the principles of primary health care adopted by the new government, there has been little change since the last two years. The hospital's 22-bed ward and theatre, both of which are not operating due to staff shortages and despite a net increase in the patient workload of 40%.

The voluntary service package has removed a number of experienced staff in all other departments, and many positions have not been replaced.

"Where they have, relatively inexperienced staff have joined," says the report. "These have not been adequately inducted due to service pressures and so have required extra supervision, creating increased work and decreased morale."

Many nurses perform duties beyond their scope of practice. Four staff members were medically不适 due to the stress of working on the ward and another swallows medical boarding by the end of the year. A few simply resigned.

When the Cape Times visited the hospital, staff voiced concerns of bullying. Four staff members were medically不适, and another another swallows medical boarding by the end of the year. A few simply resigned.

"In every instance management has been aware of attempts to fill the vacant posts," the report notes. "The rules and procedures for filling posts changed frequently throughout the year, thwarting these efforts."

This culminated in the "Friday 13 June" cancellation of all vacant posts, in which posts which had been hand-taken for but not yet filled. Many positions will be abolished.

Equipment is also sorely needed. It is three scenes that drove Stumpf to the Lions service organisation to help lift the hospital out of its current plight.

With its motto "We serve", the objective of the Lions Internationally is to promote good government and good citizenship, encouraging service-minded people to serve their community.

Stumpf first came into contact with the Lions Club of George hours when they were involved in Operation Blind Sight, which facilitated eye tests and provided spectacles for the residents, providing a R20 subsidy towards the R50 cost, or which is provided by the patient.

"When enough that contact I asked them if they could please have a look at the hospital," Stumpf said.

Clive Fox, a retired general hospital patient and Lions Club of George member, went along to the hospital one night to experience the predicament first-hand.

"I got a phone call from Des (Stumpf)," says Van Vuuren. "It was really spicy... I said, Help, our hospital is in trouble, can you do anything?"

"When we got there, we found him to be the only doctor working in this massive hospital. One thing led to another."

"We saw an opportunity where we could possibly help."

Only limited assistance has so far been possible, such as trying to bring in the services of the Lions' Medics Alert campaign to the hospital as well as providing blankets, but says Van Vuuren, the hospital's needs are "far bigger than just what our club can manage."

"My feeling is that even if all Lions put their money into the hospital it will never fill the gap. It is a massive project, so if we can do just a little bit to help, well, we're there."

Committees are being set up to tackle the project and fund-raising is being planned for the near future.

Stumpf has also been asked to draw up a wish list so that the organisation can get cracking on the hospital's needs.

Stumpf said Van Vuuren: "Your health is your most important asset, so many of the Lions projects revolve around the principle of providing service that will help practically."

His colleague and Goodwood Lions president Jeanie van Vuuren has been doing international fund-raising and promotion projects for 10 years with Lions organisations all over the world.

Through his efforts, the wish list has been included in an aid application and sent overseas. Fox hopes that he will be able to persuade two American relief agencies to repeat the success they scored last year in supplying medical equipment to the Border Institute of Health in London.

"It was of considerable value and two Lions clubs picked up the cost of bringing in the equipment. It went primarily to clinics in the Border area; tens of thousands of people have been assisted by that equipment."

Both relief organisations have now been asked if they would be willing to supply the equipment necessary to meet Westfuels needs.

In both cases, some funding will be required locally and free clearance and shipping costs will have to be arranged. The success of the project, however, depends on the availability of equipment.

"We are just one of many applications they get and they must now determine whether they are a position to help us. But we will have to come up with some kind of sponsorship, contribution ourselves of employment you can think of, to become all-powerful because the team can work wonders."

"One I belong to an association... I can become all-powerful because the team can work wonders."

Fox said the advantage of involving an organisation like Lions is that it is an international association with many contacts worldwide.

"The point is that as an individual there's a limit to what I can do, but once I belong to an association where its members cover every conceivable form of employment you can think of, I could become all-powerful because the team can work wonders."

Jeanie van Vuuren, spokesperson for the Lions' 648-member Cape Town district, which reaches as far as Brackenfell, says that with the Westfuels appeal it was realised that "we have to do something about the hospital service in general."

"The point is that the government doesn't have the funds, so that's why we as a service organisation are taking a more serious interest in Westfuels. We want to develop a long-term involvement with the hospital."

For his part Stumpf and his dedicated staff, immensely grateful for the Lions efforts, are trying to organise a fund-raising event, with a government dignitary as guest, at which memorabilia of sporting greats will be auctioned.

"My appeal is that we obviously need the funds. When you ask for manpower, the manner in which you get it is not sustainable."

"People from their altruistic motivations say 'yes we'll help' but we can't work out somewhere where they can be permanently engaged all the time."

"And, what's more, the community of Atlantis is traumatised."

"It's enough for them; just trying to survive on their own. They've got no money for things like fund-raising, so it's like a losing battle you fight in the end."

"With the funds we can at least get the equipment that we require."

"The most immediate priority, however, is to ensure the 25-bed ward, closed for a long while now, is opened. Stumpf and his staff are confident they will be able to demonstrate the authorities that they are able to run it economically by reducing the unnecessary R600 000-1 000 000 a year it costs to keep patients at this compromised hospital."

"Asked what he most wanted other Capetonians to know about Atlantis, Stumpf said without hesitation: 'That there's a disaster here in this town; it's an explosion just waiting to happen.'"

He added the features of the town are directly related to the state of its industry. "And if it's shrinking at the rate that it is, how are these people going to live?"

"There was a plan to help boost the Westfuels relief effort should contact:

Alan van Vuuren on (021) 930-4046 (ah); Jeanie van Vuuren on (083) 305-0424; or Clive Fox on (021) 539-1440 (home and business)."
Hospital union in conflict after walkout.

Renee Grawitzky

The Hospital Personnel Trade Union of SA faces a possible split after five of nine regions walked out of its national congress on the weekend amid claims of racism and a leadership battle.

Union sources said the congress was disrupted after a vote of no confidence was taken against the current union leadership. The leadership disputed this and said the congress was disrupted by four, mainly black, regions which had lost a vote by a wide margin.

"This minority faction originates from the Lebowa Action Committee and favours radicalism."

The sources said tensions had been building up ahead of the congress after the union's former vice-president, David Tshela, was forced to resign. He had gained support from the four mainly black regions.

The union said the four regions had tried to create the erroneous impression the leadership was still white.

The union said the congress was forced to close after the five regions walked out as the constitution required that a quorum include six regions. The union will have to reconvene a congress within eight weeks.
Ambulances: red lights flash

Last day for chief, No 2

The crisis in Cape Town's ambulance service has deepened.

Yesterday its chief, Greg Pillay, and his deputy, Cyril Leeuwendaal, left the service, but staff learnt with dismay that no one had been appointed to replace them.

Mr Pillay is to become the City's disaster manager on Monday and Mr Leeuwendaal had hoped for early retirement, along with about 50 colleagues.

Uncertainty over who will run the service in future and a change in the rules of the Cape Town municipal pension fund appear to have prompted the resignations.

But last night, director of the city's uniformed services Alan Dolby announced that Mr Pillay had been asked to carry on at the helm of the ambulance service until a replacement was found.

"Obviously Mr Pillay will not be entirely withdrawn from the service and will be working closely with staff in his new portfolio," said Mr Dolby.

Yesterday Mr Pillay told a farewell reception for 30 staff that the exodus would leave a void that would be difficult to fill.

"Emergency medical services is a distinct discipline with specialist training and development. Experience and expertise cannot be attained overnight. We are worried that so many trained personnel are leaving at once.

"Notwithstanding these circumstances, I wish to thank all these people for their many faithful years of dedicated service and devotion in caring for and transporting the sick and injured, the core function of this organisation."

He handed long service certificates to staff and plaques to personnel with more than 20 years service.

Staff said they were concerned about the simultaneous departure of both senior executives. One said, "It's like a ship at sea losing its captain and first mate in a storm."

Embellished staff say Cape Town is bleeding for a crisis in the busy summer season.

The ambulance service in greater Cape Town was already stretched because of insufficient staff.

Already the service was being run on shifts and overtime and the system suffered when staff declined to work extra time or were off sick.

On some days the standard 24 vehicle fleet was reduced to 20, 16 or even 15 ambulances to serve the entire city.

Answering questions, Mr Pillay told staff that 33 members had resigned and 41 new people appointed, 15 of whom had not had any emergency service training.

He emphasised that ambulance and rescue personnel were resigning to take advantage of the new pension deal.

He confirmed the section hardest hit by resignations was the ambulance service.

Metro emergency services founder and former chief Allan MacMahon said he believed the city's metropolitan ambulance division was the best in the country.

He believed that a privatised ambulance service would not work because profit would be a priority and many people could not afford to pay for ambulances.
Health dept 'will recover money'

By Charity Bhengu

The Gauteng health department, which is owed R4,25 million by foreign governments for the treatment of their patients in state hospitals, said yesterday the debt would be recovered within the next month.

Department chief director Dr Trevor Frankish said contrary to the impression created by the media, the matter of the outstanding amount did not constitute a crisis.

"No cognisance seems to have been taken of the millions of rands already paid by those foreign governments for services rendered over many years," Frankish said.

Over two years about 871 foreign patients were treated at Chris Hani Baragwanath, Johannesburg, Ga-rankuwa and Pretoria Academic hospital, by arrangement with foreign governments at a total of R9,6 million.

Kenya still owes R746,000 and Botswana R1,5 million. Mozambique, Zambia and Angola owe about R475,000 each.

Swaziland owes R310,000 and the Democratic Republic of Congo owes R277,000.

Democratic Party Gauteng health spokesman Mr Jack Bloom said every effort should be made to recover the outstanding amounts.

"There is no reason why such patients should not be treated in the private sector," Bloom said.

Gauteng health spokesman Mr Popo Maja said the DP was not interested in the humanitarian aspect of health but only in profit making.

"It is in extreme bad taste for the DP to suggest that foreign patients should be sent to private hospitals when they lack necessary resources and expertise," Maja said.

He said that a policy that stipulates that costs be paid in full by foreign governments before patients were admitted "would be enforcing on non-emergency cases only".

"The policy had always been there but for humanitarian reasons we could not turn people away because they had no money," he said.

Pan Africanist Congress spokesman Mr Ngila Muedane said human life was more important than money.

"It is a Western mentality to turn people away because they have no money," Muedane said.

African National Congress spokesman Mr Thabo Masebe said: "Even if the hospitals were crowded, it would be insensitive to turn foreign patients away."
List drawn up to ensure public hospitals stock basic drugs

Star 4/12/98

A list of cheaper, alternative drugs that all public hospitals and clinics are obliged to keep in stock was launched by Health Minister Nkosazana Zuma in Pretoria yesterday.

"The list was drawn up with a view to ensuring the availability of medicines to the majority of South Africans at affordable prices," she said in Pretoria.

"Drugs that are on the list will always have to be in public clinics and hospitals, but drugs that have not been listed will not be banned from the country," Zuma said.

The Essential Drug List (EDL) names 693 medicines which can be used to treat most of South Africa's common health problems, according to EDL committee chairperson Patrick Mokhobo.

A statement released at the launch said the list was drawn up based on World Health Organisation guidelines.

Drugs included on the list were those found to be the cheapest, the best researched, and those produced by the most reliable local manufacturers.

Mokhobo said the list would be updated regularly in response to new diseases. Zuma said there was a huge market for South African-made drugs because they were cheaper but still of a high quality - Sapa
Equipment ‘could endanger patients’

Pearl Sebolao 04/12/98 (98)

AN ARRAY of condemned and defective hospital equipment that could pose a danger to patients and staff was still in use in Gauteng hospitals, the provincial health department has admitted.

It would cost the province an estimated R24m to replace the condemned equipment — which includes ventilators, dialysis machines, x-ray systems and monitors — which are an electrical hazard, the department said in response to questions from the Democratic Party (DP) in the legislature.

The Pretoria Academic Hospital was the worst affected, with 11 pieces of defective equipment that needed to be replaced at a total cost of R9m. Kalafong and Aranikwa hospitals need R8m and R6m respectively for new equipment.

Other affected hospitals were Johannesburg and Yusuf Dadoo, near Krugersdorp.

DP health spokesman Jack Bloom said the use of some of the substandard equipment could lead to patient fatalities. “It is absolutely shocking that condemned equipment that is a danger to staff and patients is still in use,” Bloom said.

He called on the provincial health department to institute urgent steps to rectify the situation. He suggested this be done through leasing arrangements or partnerships with the private sector.

Gauteng health spokesman Popo Maja said the department could not readily replace the worn-out equipment as it was subject to financial constraints.

Maja said that funds that had been earmarked for capital expenditure had been frozen and redirected to other projects, such as services. However, the department had already instituted “a thorough situational analysis as far as equipment is concerned and critical areas will be attended to as the situation develops”.

He said the department would concentrate on the replacement of equipment which was crucial to the running of the hospitals.
Bara probe reveals poor management

By Charity Bhengu

GAUTENG health MEC Mr Mondli Gungubele conceded at the weekend that there were problems at the Chris Hani Baragwanath Hospital regarding the supervision of junior staff.

This follows claims by former senior superintendent Dr Bokkie Rabinowitz that 21 patients may have died because junior doctors were unsupervised during surgery.

"To a certain degree there is a basis for concern about the problem of consultation with and supervision of junior staff," Gungubele said. "But we are careful about how this may have contributed to the death of each patient. We would prefer the relevant medical councils to decide on that."

The matter has been referred to the Medical and Dental Council for independent scrutiny.

"It is my intention that all necessary actions be taken, be it against the institution or against individuals."

In July, Sowetan reported on claims by Rabinowitz about deaths due to negligence at the hospital.

**Investigating the claims**

A committee under the chairmanship of Professor Thole Mokoena investigated the claims. The findings have not yet been made public.

Gungubele spent two days last week investigating the hospital's administration and management systems.

Addressing a press briefing on Friday he said: "The hospital's management leaves much to be desired."

Gungubele said there was serious cause for concern about sub-standard medical care and the failure and absence of senior surgical supervision.

Gauteng health spokesperson Mr Popo Maja said only 25 percent of Rabinowitz' claims were true. The rest were unfounded.

"In as far as the breakdown of communication between doctors and nurses is concerned there was a case. But this was not disclosed by Dr Rabinowitz anyway."

Regarding poor administration and management of patients, Gungubele believed Rabinowitz had a case.

Gungubele said the disclosure had made them realise that the hospital's management needed to be revolutionised.

"I am not opposed to whistleblowing but I will not allow people to talk about untested things," he said.
Bara’s state of management ‘is shocking’

By Charity Bhengu

TOURING Chris Hani Baragwanath Hospital in Soweto last week was like running a marathon, said Gauteng health MEC Mr Mondli Gungubele at a media briefing afterwards.

Before addressing the media, Gungubele slumped into a chair and said media reports about people dying at the hospital prompted him to “get into the works of this hospital”.

He spent time at Bara and Johannesburg hospitals after reading a report in a weekend newspaper about two infants who allegedly died because of negligence.

He was also perturbed by Sowetan’s report that 21 people allegedly died because junior doctors were not supervised during surgery at Bara.

“Yet this is not only about Bara; but about the overall management of our entire health system,” Gungubele said.

Before he visited Bara, he also went to Soweto and the Far East Rand hospitals. “All the hospitals I visited leave much to be desired when it comes to management,” he said.

‘Disappointed’

Gungubele said the main purpose of visiting Bara – a 3 400-bed hospital which admits about 275 000 people a year – was to check the systems, regulations and controls in place at the hospital.

Accompanied by a task team, Gungubele interviewed the staff nurses, doctors, staff in allied professions, trade union officials and members of management for two days.

“I was disappointed by obvious problems such as chaos in the laundry department and bad management. There is no system for laundry in this hospital and this impacts badly on the dignity of patients.”

Patients who did not bring their own bed linen to the hospital were reduced to sleeping on plastic mattress covers, he said.

“I will send the acting deputy director-general in charge of administration, Ms Letitia Rispel, to check on the laundry.”

He said that he expected a report in a week’s time on “why this has been allowed to happen and what will be done to turn it around”.

But, despite the negative aspects of the hospital, Gungubele pointed out that there was a significant number of dedicated staff at Bara. “Without them, the worst could happen. The danger is that good doctors, nurses and technicians will lose morale because of poor management.”

Once he receives the findings of the report on Bara, Gungubele plans to invoke Section 17 of the Public Services Act to determine whether some staff members were incapable of carrying out their duties.

In terms of Section 10 of the Act, if officials were found to be unfit or incapable of doing their work efficiently, they could face being transferred, dismissed or reduced in salary.

“We are not talking only of inefficient systems; we are talking about individuals as well. I have found that some officials in management have been negligent.”

Common complaints

Linked to the management system, one of the most common complaints was staff were their workload. This was a legitimate concern, Gungubele said, with two nurses sometimes attending to 50 to 60 patients a shift.

“The problem is probably magnified by bad management and should be addressed in conjunction with an effort to improve their workload.” However, he did admit the huge impact of staff cuts on the hospital.

Another problem he found at Bara was a lack of communication between nurses and doctors.

“It is a deep-seated problem clouded by the legacy of apartheid, which granted white doctors supremacy over black nurses.”

He argued that the minimum safety of patients could only be guaranteed if nurses and doctors applied a multi-disciplinary approach, which respected each other’s professional autonomy.

“For us to consciously allow the breakdown of doctor-nurse communication is criminal. Only a complementary principle will succeed.”

He announced that plans would be developed to manage hospitals. Among these would be an amendment to the province’s hiring procedures.

Hospital superintendents under the new plans would no longer require a primary background in medicine but would be selected for their management skills.

“We cannot allow Bara to control an annual budget of R500 million without conventional management structures.”

Gungubele will visit Tembisa Hospital next week...
Strikes at Netcare likely to 'escalate'  

Adel Shevel

Johannesburg — Strikes at Netcare, South Africa's largest private hospital group, would "escalate next week when we continue the pressure", Albert Wöcke, the assistant general secretary at the Hospital Personnel Union of South Africa (Hospersa), said yesterday.

But discrepancies abounded as Peter Warrener, Netcare's human resources director, said what was touted as a national strike ended up being "isolated events", with only 15 administrative staff taking an active role.

The dispute revolved around yearly wage increases. Netcare had put forward an increase of 8.5 percent, while union members were demanding a 9.5 percent rise.

"We believe the offer is good given the economic climate," Warrener said.

Wöcke said the action had been boiling for the past three years. Yesterday it ranged from a series of short work stoppages such as "grasshopper strikes" to go-slows to general disobedience.

Wöcke said the union had to build confidence of members, some of whom had been intimidated.

Warrener said the dispute could not extend to other hospitals because the union represented administrative staff of only seven of the 38 hospitals within the group.

The union claimed they had been "recruiting like mad", and sympathy had been expressed from the nursing staff in one of the hospitals.

Wöcke said 300 union members had been involved nationally through six hospitals in four provinces.

"The irony is that the union negotiated with us recently over the same increase with regard to the nursing staff, which they settled," Warrener said.

Wöcke said the increases in this regard included an adjustment in the nurses' minimum salaries.

"This was not the case with regard to the administrative staff, who have been given a raw deal," Wöcke said.

"The effect has been minimal, and there has been no negative effect on any of the hospitals," Warrener said.

Although Wöcke said replacement labour had been taken on board, this was refuted by Netcare.

Hospersa is the biggest union in Netcare, with about 5,000 members. It represents about 76,000 hospital staff, mainly within the public services sector.

Netcare closed up 1c at 72c on the JSE yesterday.
DAVID MARCUS GORE, a British doctor, describes the horror of work at Chris Hani Baragwanath Hospital in South Africa.

Descending into the Circle of Hell

Chris Hani Baragwanath Hospital is the biggest in the world, with 3,200 beds. It is known in South Africa as the "circle of hell." The hospital is infamous for being a rough place to work.

In the white northern suburbs of Johannesburg the beleaguered citizen is flourished by stories of Bara and violence in Soweto. It's like their worst nightmare - the barbarism of the gate.

Black people tend to be more reflective. Soweto has a central role in the black South African psyche as the apogee of the struggle, the anvil on which the nation was forged. But tales of my job at the hospital would provoke much speculation about problems facing the new South Africa - crime, violence, ignorance, alcoholism and unemployment.

The main surgical action in Bara is in the "pit," the surgical casualty department. Structurally it is falling apart at the seams and when busy it's a special circle of hell. Interns and registrars wheel around, tending to the great unwashed. Gunshot wounds and other assaults are the stock-in-trade.

The wounded are brought in by ambulance, minibus taxi or private car and laid on ancient red trolleys. If they are badly injured a red "urgent" sticker is slapped on their foreheads lest we forget about them. If they are really bad they are wheeled at speed into the resuscitation room en route to the theatre or the mortuary. "Resusc" can get very exciting on a Saturday night or any day near the end of the month, when salaries are paid and liquor flows freely in the townships. It's not a place for the faint-hearted.

I suppose many people's images of trauma in hospital are shaped by the American television series ER. The surgical pit at Bara has all the excitement of ER but batters in its down when it comes to numbers and greatness. Moreover, the recurring theme of ER is one of care and commitment. The recurring theme in the Bara pit is one of weariness, cynicism and indifference. Compassion is absent.

I had been told about the horrific injuries but I was unprepared for this. The black community here may be teachable. After their young and old, and demonstrate precious little concern about each other's physical suffering.

At first I was amazed at how the patients can suffer: rarely do they gripe and often never complain. They would be unwise to try for sympathy. The nursing staff, wholly black, does not tolerate whingers. Those are tough people.

Privacy and dignity are in short supply. Patients are exposed where they lie. Communication skills, now fashionable in medical schools, take on a new meaning when you are faced with patients who are uncomfortable speaking anything other than Zulu or Sotho and who associate interrogation by a white official with the police. Inevitably the finer points of the doctor-patient relationship are lost.

"Yebo baba! Is it painful? Kutshhlang'u kuthu? My friend, we must put you to sleep and cut you, from here to here."

The patient is too spaced out to see a consent form, but their signed thumb is applied to the sheet of paper anyway.

Advice given to a reluctant patient is blunt: "Baba, without the operation you die. Understand? If you don't want the operation you have to go home right now." Sometimes it all goes too much and tempers fray. For example, Easter Sunday was bedlam: three patients had died on the operating table by six o'clock that evening. One of my senior colleagues would lay into the gunshot victims as they were wheeled in: "Did you get that going to church, baba? Did you have a nice Easter, my friend?"

The most abject cases are those shot in the head. The patients are brought in comatose; we intubate them with a tube in their airway and leave them to die. There's nothing to be done. The neurosurgeons don't even bother coming to see them.

Gunshot wounds to neck, chest or abdomen are often much more challenging. There's nothing quite like a badly injured patient to concentrate the mind. Patients with stab wounds to the heart occasionally need to have their chests opened by a surgeon and then in a ghoulish orgy of blood and chaos. Ahh, stab wounds are old hat in Soweto: any self-respecting suicidal carries a gun nowadays.

The "slam" trauma of road-traffic accidents is much in evidence as well. People continually wander into the path of the ubiquitous minibuses taxis. Perhaps it's because there aren't many footpaths in the townships, just dirt roads.

I came to hate these with their faces and limbs as they hours spent on them to cut, splintering limbs, concussive blood, placing chest-X-rays from surgery and arranging beds across Gunshot abdomens comparison: you wont a gunshot wound in the theatre, gas always a hit, open him look. With 1/6 of the... HIV positive, one has to where one puts one's exculpates. The smell of liquor on the ambient aroma when pumping. These black b...
Focus 1

Saturday Argus
December 11/13 1998

Ior, describes the horror of working in the world's largest hospital... into the Bara pit

Graveshame. Advice given to patients is blunt: 'If you don't want an operation, go home now.'

Gunshot wounds to neck, chest or abdomen are often much more challenging. There's nothing quite like a badly injured patient to concentrate the mind. Patients with stab wounds to the heart occasionally need to have their chests opened by a surgeon there and then in a ghoulish orgy of blood and chaos. Also, stab wounds are old hat in Soweto: any self-respecting taxis carries a gun nowadays.

The blunt trauma of road traffic accidents is much in evidence as well. People continually wander into the path of the ubiquitous minibus taxis. Perhaps it's because there aren't many footpaths in the townships, just dirt roads.

I came to hate these hapless wretches with their smashed faces and limbs as they would need hours spent on them to sort them out, splintering bones, cross-fetching blood, placing chest drains, requesting X-rays from x-ray radiographers and arranging brain scans.

Gunshot abdomens were easy by comparison: you would simply take the victim to theatre, gas him (it's always him), open him and have a look. 90% of the patients being HIV positive, one has to be careful where one puts one's needles and scalpels.

The smell of urine on breath is the ambient aroma when the pit is pumping. These black bikies can certainly drink and fight - I thought the Irish were good at it until I came here. All sorts of misery has alcohol at its root. Imprisoned on my mind is the sight of the drunk who fell asleep on a railway line and had both legs severed at the knee. When the ambulance fetched him he still had his bottle of Kulpdrift brandy in his hand. He made it, but what a nightmarish hangover he had.

It took me two months until I really started to get a grip on what Buma was really all about and what people's expectations actually were. Never have I worked in such a hostile and unpleasant atmosphere. Relationships with medical colleagues from other specialties are strained or nonexistent. The surgical registrars generally hail from countries whose public health services are even rougher than that of South Africa.

Nearly all my colleagues imagined the British National Health Service to be a land promised. About one third of the surgeons come from Bangladesh and Pakistan, one third from the rest of Africa and the rest from here and there, including quite a few from eastern Europe and a small number of voyeurs, like myself, from western Europe.

On the other hand, the anaesthetist department is wholly white and wholly South African. These white supremacists view us as the flotsam and jetsam of the world of surgery, and despite the colour of my skin I was treated with that same brush.

Anaesthetists and surgeons have differences of opinion all over the world, but here the appealing rapport was truly a wonder to experience. It was as if we worked in different dimensions: we would get through a three-hour operation without the slightest social malaise.

I found working with the nursing staff in the pit and on the wards quite difficult at first because a lot of them don't work very hard. It is a paradox of the hospital that one can get a state-of-the-art cast scan, but patients can only quietly expire for want of basic nursing observation at night-time.

There's a favourite northern suburb joke to which tourists are subjected: what's the difference between a tourist and a racist? The answer, inevitably, is two words: Twisted as this might sound, as I worked with some black nurses who ignored me and manifestly couldn't care less about their charges, and as I dealt with a suffocated, mutilated and violent clientele, I wasn't far off illustrating that cliché myself. I was only through meeting some splendid doctors from the rest of Africa, working with the odd diamond of a nurse and seeking through to the basic humanity of the patient that I escaped that label for the time being.

It is said that life is cheap in Africa. As a generalisation this is nonsense, but it doesn't mean that life isn't at a premium in Soweto.

Did I become brutalised by the carnage? A little. Did I enjoy my spell at Buma? Yes, I did, but it wasn't all plain sailing. Would I recommend it to someone? Yes, but not blindly.

Certainly it was the most memorable year of practice I have ever had. Hospitals come and go, but it will be a long time before I forget the smell of the Bara pit on a Saturday night.
Law will allow for hospitals overhaul

Pearl Sebolao

NEW legislation aimed at revamping the management systems in Gauteng hospitals would be tabled in the provincial legislature early next year, Gauteng health MEC Mondli Gungubele said this week.

According to the proposed legislation, hospital superintendents would no longer be required to have a primary background in medicine, but would be selected for their management skills.

"Medical background has little to do with the running of hospitals. It is about the economics of the hospital — the management of human and financial resources," Gungubele said.

He said the need to develop management capacity remained a serious challenge for the department.

The department employed 48 000 people and had a budget of more than R5bn.

Gungubele, who recently toured Gauteng hospitals to assess management practices and standards of care, said that management at most of the hospitals "left a lot to be desired".

"I threatened to invoke section 18 of the Public Service Act which made provision for officials to be transferred or even discharged from the public service if they were found to be unfit or incapable of carrying out their duties efficiently.

Asked whether the new law would mean large-scale replacements of superintendents, Gungubele said the health department could have created "a new post of CEO over and above the ones we have now". Alternatively, CEOs would be appointed as positions became vacant. He did not, however, rule out the possibility of replacements.

The department also planned to prioritise the creation of new hospital boards during the next six months to ensure accountability to the communities they served. Two hundred new board members would be confirmed by the end of January.

The department also wanted to fast-track the creation of the district health system and to consolidate the promotion of HIV/AIDS awareness. It would hold breakfast meetings to get support from sports clubs, artists, and nightclub and brothel owners.
is admitted to hospital

the department

medical

minister of health sees the effects of her cutbacks when her brother

zuma gets taste of her own
The last time the floors shined was 10 years ago.

Up Barra Eyresore

Somato club cleans
Guts and loathing in the pit of agony

DAVID MARCUS GORE, a surgeon who returned home to Belfast, Northern Ireland, recently after a stint at Baragwanath, describes the horror of working in the world's largest hospital.

"Baba, without the operation you die. Understand? You don't want the operation youhabit kaya [go home] right now." Sometimes it all gets too much and tensions fray. Easter was bedlam: three patients had died on the operating table by 6am. One of my senior colleagues would lay into the gunshot victims as they were wheeled in. "Did you get that going to church, babay? Did you have a nice Easter, my friend?"

The most abject cases are those who’ve been shot in the head... the neurosurgeons don’t even bother coming to see them.

Gunshot wounds to the neck, chest or abdomen are often much more challenging. There’s nothing quiet like a badly injured patient to concentrate the mind. Patients with stab wounds to the heart occasionally need to have their chests opened by a surgeon there and then to a goushing orly of blood and chaos. Abscess, stab wounds are old hat in any self-respecting hospital nowadays. The “blunt” trauma of road accidents is much in evidence as well. I doubt there was ever a Green Cross Code here: people continually wander into the paths of the ubiquitous minibus taxis. Perhaps it’s because there aren’t many footpaths in the townships.

I came to hate these helpless wrecks with their smashed-up faces and limbs as they would hours spent on them to sort them out, splinting limbs, cross-matching blood, placing chest drains, requesting X-rays from the radiographers and arranging bed space.

The rest from here including quite a few Europeans and Africans, like western Europe. On the other hand the rest is white and wholly white. These patients viewed us as the “hittus of the world and despite the fact that I was tattered by brush. Anaesthesiologists have different opinions around the world on the tremendous thing that took me two months until I started to get a grip on what Bara was really all about and what the patients’ expectations actually were. Never have I worked in such a hostile and unpleasant place. Relationships with medical colleagues from other specialties are strained or non-existent. The surgical registers generalist have cut public health services are even rougher than that of South Africa. Nearly all my colleagues imagine the British National Health Service to be a sheltered promised land. About one third of the surgeons like the rest from these countries have been right about what the rest from here including quite a few Europeans and Africans, like western Europe. On the other hand the rest is white and wholly white. These patients viewed us as the “hittus of the world and despite the fact that I was tattered by brush. Anaesthesiologists have different opinions around the world on the tremendous thing that took me two months until I started to get a grip on what Bara was really all about and what the patients’ expectations actually were. Never have I worked in such a hostile and unpleasant place. Relationships with medical colleagues from other specialties are strained or non-existent. The surgical registers generalist have cut public health services are even rougher than that of South Africa. Nearly all my colleagues imagine the British National Health Service to be a sheltered promised land. About one third of the surgeons like the rest from these countries have been right about what
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Twisted as this might sound, as I worked with some black nurses who ignored me and manifestly couldn’t care less about their charges, and as I dealt with a sullen, mute and violent clientele, I wasn’t far off illustrating that cliché myself. It was only through meeting some splendid doctors from the rest of Africa, working with the odd diamond of a nurse and seeing through to the basic humanity of the patients that I escaped that fate (I think).

It is said that life is cheap in Africa. As a generalisation this is untrue, but there’s no doubt that life isn’t at a premium in Soweto. Did I enjoy my spell at Bara? Yes, I did, but it wasn’t all plain sailing. Would I recommend it to another? Yes, but not blithely. Certainly it was the most memorable year of practice I have ever had. Hospitals come and go but it will be a long time before I forget the smell of the Bara pit on a Saturday night.

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Zuma visit sparks hospitals probe

Durban — All major hospitals in KwaZulu Natal would be investigated to ensure service was delivered properly, provincial health superintendent-general Ronald Green Thompson said here.

He was speaking at a press conference yesterday after a complaint by Health Minister Nkosazana Zuma about the delay of treatment of patients at Addington Hospital in Durban.

Dr Zuma discovered the discrepancy when her younger brother, Malusi Dlamini, was admitted to the hospital two weeks ago after an epileptic fit.

Dr Zuma claimed there were many patients at the casualty section on the evening when her brother was admitted and that there was only one doctor to attend to them.

"There was only one doctor on that night."

"I want to know why a major hospital in Durban has one doctor on duty at the casualty section at a weekend," she said.

She alleged that some patients told her they had waited for long hours to get treatment.

She added that a meeting with Dr Green-Thompson and hospital management was held to discuss the matter and that an investigation into problems was launched.

Dr Green-Thompson said the investigations would assist in identifying problems in the hospitals and if there was a delay of treatment as a result of shortage of doctors alternative arrangements would be made.

Dr Zuma denied weekend reports that she abused her position by demanding preferential treatment for her brother.

"As a minister I have a right to ask if our people are not receiving proper treatment.

"I want to make it clear that I did not abuse my position and I did not demand preferential treatment for my brother," she said.

Dr Zuma said she would take legal action against newspapers and anyone who alleged otherwise. — Sapa