Social Security

-> Medicare

1978

299

HANSARD 2 'Q. column 76-77.
11 February 1975.

285

Doctors/Dentists contracted out of Medical Schemes Act

*17. Dr. A. L. BORAINE asked the Minister of Health:

(1) How many doctors and dentists, respectively, (a) had contracted out under section 29 of the Medical Schemes Act as at 31 October 1974 and (b) have contracted out since that date;

(2) what percentage of the registered doctors and dentists, respectively, do not, in terms of notice given under section 29 of the Act, render services to members of medical schemes and their dependants according to the tariff of fees.

The MINISTER OF HEALTH:

(1) (a) Doctors: 1 362.
Dentists: 552.

(b) Doctors: 191.
Dentists: 26.

(2) Doctors: 12,2%.
Dentists: 30,4%.

As at 31 January 1975.

Warning over better jobs for Coloureds

Pay rise call to Minister

Labour Reporter

The Coloured Postal Employees Association made a direct appeal for equal pay to the Minister of Labour and of Posts and Telegraphs.

The call by Mr F M Luttig, the association's national secretary, followed the Minister's official opening of the association's biennial congress.

The theme of the congress is "equal pay for equal work."

Mr Luttig said he had learned from high authority that the productivity of Coloured post office workers did not lag behind that of other post office employees.

"We believe we have rendered sufficient proof of our loyalty, our aptitude and our sense of responsibility for the introduction of equal pay for the same work.

Mr Luttig also asked for his association to be given the opportunity to join in future pay negotiations, hinting at the formation of a federation of post office staff associations.

He thanked the Minister warmly for his interest

Labour Reporter

The narrowing wage gap could have serious inflationary consequences.

The warning came last night from the Minister of Labour and Posts and Telecommunications, Mr Viljoen.

He pointed out that the Government is "irrevocably" committed to a gradual narrowing of the wage gap, but added:

"If we do not succeed in balancing expenditure and production, we—all of us—will have to pay the price."

Not only the Post Office but the Government called for wholehearted co-operation, Mr Viljoen told the biennial congress of the Coloured Postal Employees Association in his opening address in Johannesburg.

Better news was Mr Viljoen's announcement that all Coloured employees of the Government, and of certain other institutions, could get a medical aid scheme similar to that for Whites.

"The Cabinet has already approved the scheme.

Mr Viljoen sketched advances made by Coloured telephone workers into technical fields previously reserved for Whites, gave details of progress made with training, and explained improvements imminent in leave for Coloured workers.

57 AT WORK

Senior Coloured workers handled certain facets of cable-jointing, mounting and line installation work.

At the end of June this year, there were already 57 trained telephone electricians in service, 108 apprenticeship telephone electricians and 28 technicians.

At present 50 offices were under the exclusive control of Coloured staff. A total of 69 Coloured supervisors had attended seminars on modern personnel management.

Improved arrangements would come into effect in January next year, providing equal leave privileges to those enjoyed by Whites.

In some cases leave had been increased from 24 to 36 days a year and sick leave from 60 days to 120 days in every three years.

(1) 285 (285)
2661

Medical aid is planned

Mercury 7/9/75

JOHANNESBURG — The Cabinet has approved the establishment of a medical aid scheme for Coloured civil servants, including Post Office workers and those employed by certain other institutions, the Minister of Posts and Telecommunications, Mr. M. Viljoen said here last night.

Opening the annual congress of the Coloured Postal Workers' Association the Minister said details were still being worked out. — (Sapa.)

Coloureds in PO to get medical aid

JOHANNESBURG — The Cabinet had approved the establishment of a medical aid scheme for Coloured civil servants, including post office workers and Coloured persons employed by certain other institutions, the Minister of Posts and Tele-communications, Mr. M. Viljoen, said here last night.

Opening the annual congress of the Coloured Postal Workers Association, the minister said details of the scheme were still being worked out.

The minister listed a number of improvements in service conditions for Coloured post office workers.

Since January of this year Coloured post office workers had been granted leave privileges on the same basis as enjoyed by white post office workers.

Vacation leave privileges for Coloured post office workers had in some cases been extended from 24 to 36 days a year and sick leave privileges from 60 to 120 days in a cycle of three years.

"The gradual narrowing of the wage gap, to which the Government is irrevocably pledged, could have a serious inflationary effect unless we succeed in compensating for the millions of rand of expenditure involved with higher production, not only in volume, but also in quality," he said.

The importance of the role of Coloured workers in the post office was shown that in five years the complement of Coloured post office workers had doubled, the figure having risen from 1 311 to 2 678, the minister said.

The activities of senior Coloured telephone workers had been extended to include technical work previously done by whites. — SAPA.

Social Sec - Medicare

Coloured medical aid plan

9/4/76
CAPE TIMES
295

Political Correspondent

A STATE-SUBSIDIZED medical aid scheme for Coloured people is to be established on June 1, the Minister of Coloured Relations, Mr Hennie Smit, announced yesterday.

The scheme is aimed mainly at State employees, but a spokesman for the Department of Coloured Relations confirmed yesterday that the private sector could apply for membership.

The Government has made R100 000 available for the scheme and membership contributions for its employees are to be subsidized by 60 percent.

According to the departmental spokesman, Coloured employees should benefit by the new scheme as they will no longer have to subsidize White claims which, it is said, are more common. Coloured people in Government employ are not prevented at present from joining the medical aid scheme existing for White civil servants.

Membership of the new scheme, which was established with the approval of the Cabinet, will be voluntary.

The mangement committee of the scheme will temporarily comprise representatives of employers in the public sector and be chaired by the chief education advisor in the department.

After the first annual general meeting, it is envisaged that both employers and employees will be represented on the committee.

285

MEDICAL AID PLAN WELCOME

ARGUS 9/4/76

THE Government's plan to establish a State-subsidised medical aid scheme for Coloured people was welcomed today by Coloured leaders.

The Minister for Coloured Relations, Mr H. Smit, announced yesterday that the Government has made R100 000 available for the introduction of the scheme.

The scheme will also be open to Coloured people in the private sector.

Dr Frank Quint, acting chairman of the Coloured Public Servants League of South Africa, said he welcomed the scheme under which membership contributions would be subsidised by 60 percent.

'This is something for which we have been fighting for a long time,' he said. 'Teachers and other Coloured public servants will benefit under the scheme.'

Mr Arthur Stanley, secretary of the South African Woodworkers' Union, said the move was 'a step in the right direction.'

'It is an extremely progressive step which will not only benefit State workers but also private companies and industrialists who are too small to launch medical schemes of their own. Many people will benefit,' he said.

Mr N. S. H. Kearns, president of the Coloured Ex-Servicemen's Legion, said he also welcomed the scheme as both public servants and the private sector would benefit.

285

Health aid for aged cut back

ARGUS 14/4/76

The Argus Correspondent

JOHANNESBURG. — The Department of Health has cut back its aids to the elderly and needy by 10 percent in an effort to keep within its budget.

The Deputy Secretary for Health, Dr James Gilliland, said this was an 'essential procedure' to enable the department to cut its coat according to its cloth.

'Within limited funds we are trying to treat the most deserving cases as priorities,' he said.

It was difficult, he said, to estimate how many people were affected by this as the cutback was being done on a regional basis throughout South Africa.

Dr Gilliland said the cutback was 'one of those very difficult, thankless things we are just forced to do.'

He said each application was dealt with on its merits and aids — such as spectacles, crutches, wheelchairs and dentures, among other medical aids — were given to priority cases.

'We try to be as sympathetic as possible and make certain the patient's health won't be affected.'

One of the things his department was trying to avoid was people using these aids for cosmetic purposes.

A number of old people wore dentures for this reason.

'As they get older their gums shrink and dentures are no use to them. They wear them to go to church and take them out when they eat.

'This is the sort of thing we want to avoid. A younger person who needs to chew his food well because he has a duodenal ulcer will get priority for a pair of dentures in a case like this,' Dr Gilliland said.

297

110·13

Hansard (897)

Medical schemes

(736) Mr. L. F. WOOD asked the Minister of Health:

(1) How many (a) White, (b) Coloured, (c) Indian and (d) Bantu beneficiaries were covered by (i) medical aid schemes, (ii) medical benefit schemes and (iii) exempted schemes as at 31 December 1975;

(2) how many (a) general practitioners, (b) medical specialists and (c) dentists were as at 31 December 1975 (i) prepared and (ii) not prepared to render services according to the tariff of fees;

(3) what is the (a) estimated and (b) actual additional amount which beneficiaries under such schemes were required to pay during the year ended 31 December 1975 as a result of (i) general practitioners, (ii) anaesthetists, (iii) specialist surgeons, (iv) radiologists, (v) pathologists and (vi) gynaecologists having contracted out of such schemes;

The MINISTER OF HEALTH:

(1) and (3) Since statistics for 1975 are to be submitted in terms of the Medical Schemes Act 1967, before 30 June 1976, figures for 1975 are not yet available.

		(i)	(ii)
(2)	(a)	9 524	956
	(b)	2 280	962
	(c)	1 239	813

297

3. HANSARD NO. 20

Medical Schemes Fund 1246

1007. Dr. E. L. FISHER asked the Minister of Health:

(1) What was the amount standing to the credit of the Medical Schemes Fund established in terms of section 11 of the Medical Schemes Act, 1967, as at 30 April 1976;

(2) (a) what is the amount of each payment made by the Central Council for Medical Schemes in terms of paragraph (i) of Regulation 7A since its publication under Government Notice R.908 of 30 May 1974 and (b) what is (i) the name of the institution to which each such payment was made and (ii) the date of each such payment;

(3) (a) what is the amount of each utilization in terms of paragraph (ii) of Regulation 7A by the Central Council for Medical Schemes out of the Medical Schemes Fund and (b) what in respect of each utilization is (i) the date on which the Fund was utilized and (ii) the type of the service in respect of which the amount was utilized.

(3) (a) R270,88.

(b) (i) 10 and 11 June 1974.

(ii) Defraying expenditure of conference of Medical Schemes organized by the Central Council for Medical Schemes.

1247 FRIDAY, 18

Compare your two lists of circ
restricted negotiate with the
your objective.

2. PLANNING THE PRESENTATION.

2.1 The MINISTER OF HEALTH:

(1) R214 348,23.

(2) (a) (b) (i)

R3 918 [illegible] 3/2/75

R1 052 [illegible] 3/2/75

2) Working or
think are

3) What do t
you want
your talk
short sentence.

4) Write your aim at the top of a clean sheet of paper.

The Body

5) Leave about six lines for the introduction. Write your three main points down leaving a few lines in between each.

6) Go through your list of ideas again. Underline those points that support your three main points.

7) Write two sub points under each main point.

8) At this stage you should refer to books, interview specialists, check figures and statistics, find quotations, apt examples or demonstrations.
Your talk should be an expression of your own ideas on the subject, backed by outside opinion.

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285

Medical plan for all sought

John Patten,
Political Correspondent

The United Party has thrown its support behind a plan to establish a countrywide voluntary contributory medical aid scheme open to all races.

Details of the plan were announced today by the UP's chief spokesman on health matters, Dr E L Fisher, MP, after a meeting in Johannesburg this week of the party's health group.

At the meeting, policy was expanded and elaborated.

Dr Fisher said today the contributory medical aid scheme would have the effect of eliminating the "means test" — which has long been the cause of complaints against Nationalist administration of hospitals.

OWN DOCTOR

Under the scheme, every patient would have the right to be treated by his own doctor. People going on pension would be allowed to continue their membership of the scheme.

"One thing must be made clear, we are not proposing a national health service. What we're planning is a voluntary service," Dr Fisher said.

Dr Fisher said mental health patients would be the responsibility of the State, with those mental patients that could be treated in provincial hospitals being treated there.

INDUSTRY

The UP was also proposing a streamlining of industrial health problems under the control of the Department of Health. Dr Fisher pointed out that at present industrial health was handled by the departments of Labour, Mines and Health separately, causing anomalies.

The UP also favoured a review of the whole of the Workmen's Compensation Act to make sure that people working at any particular job are fit to do those jobs.

Other UP health plans included allowing maternity benefits to be included in medical-aid schemes, proposals that the State take steps to expand family planning services, and support for ambulance services to be brought under the control of the provinces, which would then be empowered to delegate use of the services to local authorities.

285

A health plan for all

nm 31/7/76

Mercury Correspondent

PRETORIA — The Minister of Health, Dr. S. W. van der Merwe, last night said there was a growing awareness of the need for a national health policy applicable to all sections of the community.

Speaking at the congress of the International Society of Urology in Johannesburg, he said the fragmentation of medical services, inherited from the past, was clearly undesirable.

It led to duplication of services, high costs and an inevitable lack of efficiency.

What was needed was a team effort, involving all relevant authorities, for the benefit of all, irrespective of race, colour or creed.

The Minister said the Department of Health had embarked on a comprehensive health service for all groups, even in the remotest areas, embracing all facets of health - preventive, promotive, curative and rehabilitative.

Results had been encouraging but much remained to be done.

The speed with which an ideal comprehensive medical service could be instituted, however, depended on the availability of manpower and funds.

More facilities were being created for the training of White and Black doctors, dentists, paramedical staff and nurses.

Nurses were also being trained to help with anaesthetics, paediatrics, tuberculosis, and primary health care.

● See Editorial Opinion

Lab. Mirror - Sept. 76

Paid sick leave sought for all 'appies'

A call on the Government to amend the law to provide for paid sick leave for apprentices was made at Tucsa's annual conference.

A resolution submitted by the Transvaal Leather and Allied Workers Union, which was adopted unanimously by the conference, read:

'Conference expresses its serious concern over the fact that the Apprenticeship Act No. 37 of 1944 (as amended) does not provide for paid sick leave for apprentices, particularly in view of the fact that all workers other than apprentices are granted some degree of paid sick leave in terms of both the Factories Act, and the Shops and Offices Act.

'Conference calls upon the Minister of Labour to amend the Apprenticeship Act at the earliest opportunity, so as to provide for paid sick leave for apprentices, in conformity with the existing provisions of the Factories, and Shops and Offices Acts.'

Another resolution, from the National Union of Clothing Workers, which also received conference's unanimous support, expressed concern at the conditions of employment in some industries in the Border Areas.

It read:

'Whilst it is appreciated that the decentralisation of industry is important, inferior conditions of employment in some sectors of industry in the Border Areas is a cause of deep concern to the workers.

'Conditions of employment in metropolitan areas are largely established through negotiation between employers and workers, and Conference again emphasises the need for such established conditions of employment to be made applicable to all establishments which operate in Border Areas, thus preventing exploitation of the workers, and opportunities for unfair competition amongst employers engaged in similar activities.'

The Transvaal Leather and Allied Trades Industrial Union received conference's unanimous vote for a resolution calling for Industrial Council Agents to be appointed on a non-racial basis.

The resolution said:

'In view of the Department of Labour's extreme reluctance to designate Industrial Council Agents, regardless of race, with powers to operate in industries wherein the incidence of employers other than Whites is at a minimum, Conference instructs the N.E.C. to make suitable representations to the Minister of Labour, earnestly requesting that the present policy of the Department in this regard, be reviewed.

'Conference emphasises the need for agents to be appointed on a non-racial basis, due to the fact that the availability of suitable White Agents is declining, thus hampering the effective work of Industrial Councils.'

297

Black medical scheme planned

19/12/76

By ESMOND FRANK

S-E

A GROUP of doctors, members of Johannesburg's Black Medical Discussion Group, are planning to launch in the Transvaal the country's first black-organised and controlled medical aid scheme.

Initial finance, I understand, will be provided by a merchant bank.

The doctors hope subsequent finance will flow from contributions paid by black workers and their employers in labour-intensive industries as well as other industrialists who wish to provide full medical cover for their black employees.

The scheme, which the doctors have been planning for 15 years, will provide members with a full range of medical services.

Existing schemes for blacks are said to be inadequate since they do not make provision for private hospital or specialist services.

A sub-committee of the Black Medical Discussion Group has already investigated the feasibility of establishing a private hospital in Soweto. Building is likely to start as soon as a suitable site has been found.

In the meantime, the scheme — when it gets off the ground — plans to use private beds in provincial hospitals like Baragwanath and Thembisa.

Hansard 5 Q cols 499-500 25/2/77

297

Social pensioners

469. Mr. G. N. OLDFIELD asked the Minister of Health:

(a) How many applications were received from social pensioners for (i) spectacles, (ii) hearing aids, (iii) dentures, (iv) other medical aids during 1975 and 1976, respectively, and (b) how many applications were granted in each case.

The MINISTER OF HEALTH:

The Department does not treat social pensioners separately from other needy persons, and it is therefore not possible to furnish detailed information in this respect.

			1975	1976
(a)	Total number of Applications received:			
	(i)	.....	13 000	12 900
	(ii)	.....	1 282	910
	(iii)	.....	4 006	3 042
	(iv) (a)	Artificial Limbs	904	540
	(b)	Wheelchairs	1 429	1 578
(b)	Supplied:		1975	1976
	(i)	.....	13 000	5 899
	(ii)	.....	1 246	549
	(iii)	.....	3 455	1 735
	(iv) (a)	Artificial Limbs	494	312
	(b)	Wheelchairs	1 424	1 027

I also wish to point out that artificial limbs are being controlled and supplied by Provincial Hospitals on behalf of and at the expense of this Department. The figures shown for these items are not complete and will entail a detailed study of all the accounts received from the various and numerous Provincial Hospitals to give an accurate figure.

Hansard 8 col 653 - 654 15/3/77

(297)

Pensioners

625. Mr. G. N. Oldfield asked the Minister of Social Welfare and Pensions:

(1) how many White persons in receipt of (a) old age, (b) war veterans', (c) disability and (d) blind persons' pensions are at present receiving an attendant's allowance;

(2) (a) what is the present monthly amount of the allowance payable to such pensioners and (b) from what date was the present amount determined;

(3) whether consideration has been given to increasing the present amount paid; if so, with what result; if not, why not.

The MINISTER OF SOCIAL WELFARE AND PENSIONS:

(1) On 31 December 1976.

(a) 9 841.

(b) 1 498.

(c) 1 314.

(d) 76.

(2) (a) R10.

(b) 1 October 1965.

(3) All aspects of the social pension scheme are reviewed regularly. Improvements are effected as funds become available which, as the hon. member is aware, will not be known before the introduction of the main budget.

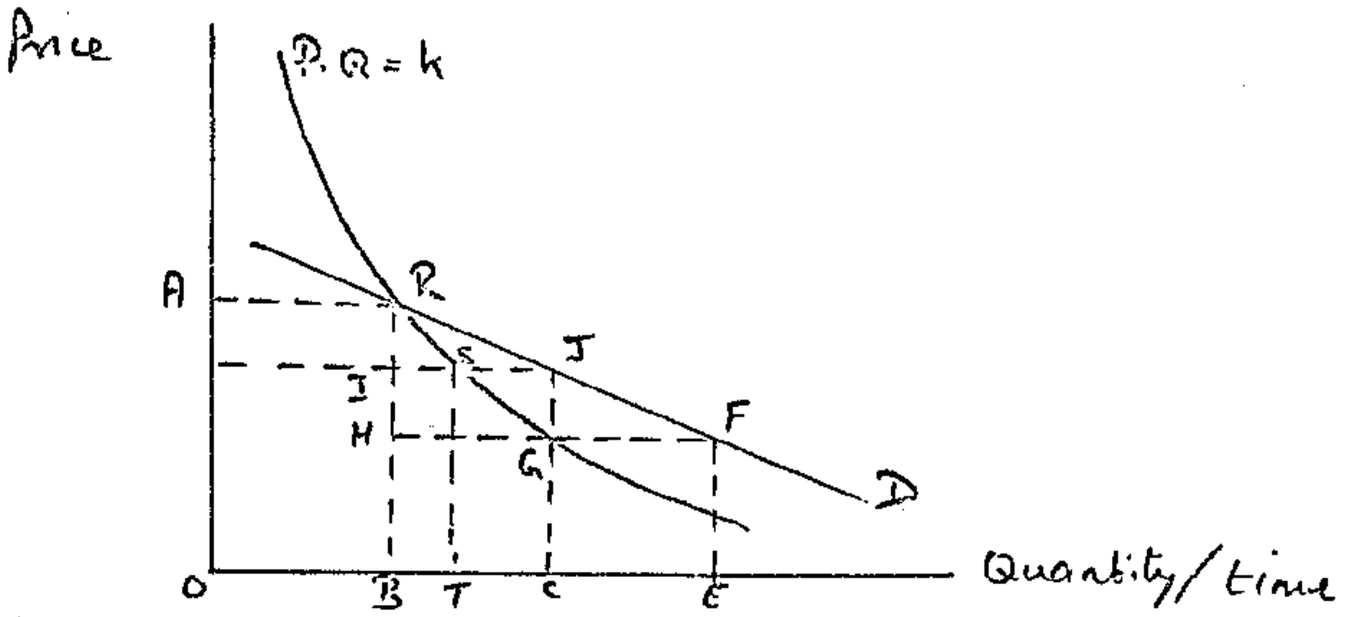
* * * * * * * * * *

12.

3. Write briefly on the causes of urbanisation.

(10 marks)

38. Consider the following diagram :



DD is the demand schedule for some agricultural good.
PQ = K is a rectangular hyperbole of unit elasticity.

Suppose the government aims to stabilise incomes at a value = K.

If in a certain year there was particularly good weather and output was OC rather than the expected level OB then, in order to stabilise farmers' incomes of K the government would have to -

1. Buy up HG = BC wheat.
2. Buy up JS = TC wheat.
3. Sell GF = CE wheat
4. Sell JS = TC wheat
5. Sell BC wheat.

39. Given the diagram abov ten year period if it started with no

1. The government sch e self financing.
2. The government's s be self financing depending on whet surpluses were equal to crop sho
3. The government wou vast surpluses.
4. It is theoretical incomes.
5. None of the above.

40. In the diagram below ar hyperbole and DD is the demand stabilisation in a bad year, where e expected OB, would require the

1. Sell JI wheat..
2. Sell LM = EC wheat
3. Buy LM = EC wheat
4. Buy GF = CB wheat
5. Sell GF = CB wheat

41. Given the diagram shov that over a ten year period, if it

1. The government sch self-financing.
2. The government wou heat.
3. The government's s e self-financing depending on crop ear.
4. The scheme whilst stabilising incomes would make prices paid by consumers more unstable.
5. None of the above.

(262) 17/3/71

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(3) No. Social pensions and allowances are, however, regularly reviewed in the light of the availability of funds.

(2) (a) R5,00 per month.
(b) 1 October 1965.

(1) (a) 89.
(b) 2.
(c) 86.
(d) 3.

The MINISTER OF INDIAN AFFAIRS:

(3) whether consideration has been given to increasing the present amount paid; if so, with what result; if not, why not.

(2) (a) what is the present monthly amount of the allowance payable to such pensioners and (b) from what date was the present amount determined;

(1) How many Indian persons in receipt of (a) old age, (b) war veterans', (c) disability and (d) blind persons' pension are at present receiving an attendant's allowance;

Minister of Indian Affairs:

(627) Mr. G. N. OLDFIELD asked the

Pensioners

RDM 20/4/77

Aid for crippled victims of riots

RDM 20/4/77

Staff Reporter

THE Cripple Care Association of the Transvaal is aiding and rehabilitating 21 victims of last year's Soweto unrest.

Many of the victims, whose ages range from 14 to 85, have spinal injuries Mrs Pam Herr, the secretary of the association said yesterday.

Plans are being made to supply them with wheelchairs and other aids.

However, a much-needed school for disabled Soweto children will have to wait for another year because of a lack of funds.

Mrs Herr said the Department of Bantu Education had approved the scheme, but funds were not available due to the present economic climate.

The school, to be named after the honorary president of the Cripple Care Association, Mr J C Merkin, was started in 1972 and its cost was initially estimated at R360 000.

"We are just going to have to cut corners. The building plans are being revised at the moment," Mrs Herr said.

The school will care for 100 day pupils and will offer courses in regular school subjects.

There will be special classes for handicapped pupils to teach them handiworks and help them to walk again.

Another black service provided by the association was the Orlando walking class in which mothers of handicapped children were taught how to exercise their children's limbs correctly.

These classes were cancelled because of the unrest, but have since been taken over by the Physiotherapy Department of the Baragwanath Hospital.

3/6

297

(297) Beeld: 28/8/77



SKOOLHOOF G. ENGELBRECHT — dit kan sy skool knou om ineens vyftig leerlinge te verloor..



BURGEMEESTER FRIKKIE STEYNBERG — „Geldelik onregverdigbaar? Maar Waverenhuis toon dan laasjaar R2 000 oorskot!"



WAVERENHUIS in die weegskaal — oor die lot van dié kindertehuis wat Tulbagh al 65 jaar op die hande dra, sal moontlik môre finaal beslis word.

Dorp veg vir sy kinders

Van Ons Kaapstadse Kantoor

MÔRE-AAND is zero-uur vir Waverenhuis op Tulbagh. Dan kan die hoofbestuur van die Afrikaanse Christelike Vrouevereniging van Kaapland finaal besluit oor die lot van dié herberg met sy 51 gekommitteerde kinders — uit gebroke of probleemhuise.

Daar is in der waarheid reeds op sluiting besluit, maar 'n aksiekomitee van die Tulbaghmense, onder voorsitterskap van mnr. Koos Theron van Erfdeel, het nog weer laaste vertoë tot die ACVV gerig, in die hoop dat die kinders tóg nog vir die gemeenskap — en sy skool — behou kan word.

Prof. Erika Theron se vader, wyle mnr. Gawie Theron, het nog die grond vir die tehuis geskenk en Tulbagh het die kinders van Waverenhuis soos sy eie aangeneem en dra hulle al vir 65 jaar op die hande.

Matrone H. S. Hugo wys na 'n kartondoos vol klere in die hoek van haar kantoor en beduie dis hoe dit week ná week gaan. Die mense bring net wanneer hulle meen dis nodig. Boere bring vrágte vrugte na die tehuis. „Man, die kinders kry hier meer as in die skoolkoshuis," sê mev. Hugo.

Tulbagh voel asof 'n stuk uit hom losgeskeur word as Waverenhis nou moet verdwyn. In dié klimaat word hartstogtelik gevra:

● Wat van die R37 000 wat ná 1969 se aardskudding deur die rampfonds geskenk is vir die herbou van Waverenhuis se beskadigde geboue? Die voorwaarde vir die destydse skenking was uitdruklik: Sit die geld in 'n trustfonds en herbou die plek binne twee jaar. Die kinders word egter nog gehuisves in opslaangeboue wat aan Gemeenskapsbou behoort.

Skool

● Wat word van die kinders? Net twee is nog nie in die skool nie. En Tulbagh se skool kan dalk onderwysers verloor as sy kindertal eensklaps met om en by 50 kinders daal.

Uit die ACVV-hoofbestuur kom dan antwoord dat die deel van die rampfondsbedrag wat nie vir noodsaaklike aanbou by die opslaanhuise gebruik is nie, uiteraard terugbetaal sal word; en dat dinge soos meubels wat die gemeenskap geskenk het, reeds deur 'n geswore waardeerder op Tulbagh gewaardeer is en aan die beheerkomitee van Waverenhuis vergoed sal word; of vir gebruik in die tehuis beskikbaar sal bly as 'n ander instansie — soos Tulbagh hoop — die tehuis oorneem. Die NG Kerk se Diens vir Barmhartigheid is hieroor genader, maar het nie sy weg oop gesien nie.

Die besluit om Waverenhuis te sluit, is nie maklik geneem nie. Toe die Sekretaris van Volkswelsyn ná die aardbewing van mening was dit sou beter wees om sulke kindertehuise liewer te skuif na stede waar 'n groter verskeidenheid van onderwysgeriewe bestaan, het die ACVV hom nog oorreed dat Waverenhuis tog nog 'n kans moet kry.

Intussen het navorsing geïnisieer deur die hoofbestuur se sekretaresse, dr. Hendrien Lambrechts, die wenslikheid beklemtoon dat kinders soos hierdie liefs in kleiner „gesinseenhede" as in groot onpersoonlike koshuise gehuisves moet word (soos nou in die nuwe Môreson-kompleks van die ACVV op George). Om so wat nou ook nog op Tulbagh te bou, is met vandag se boukoste geheel en al onmoontlik selfs vir so 'n flukse vrouevereniging. Hulle wurg nog aan Môreson.



MATRONE H. S. HUGO — „Man, die kinders kry hier by Waverenhuis meer as by die skoolkoshuis, só gul is Tulbagh se mense."

Kosgangers

Terselfdertyd het die ACVV, in die lig van al die halfvol of leë skoolkoshuise op plattelandse dorpe, met 'n baie geslaagde proefneming begin om kinders uit moeilike huise liewer soos gewone kosgangers soontoe te stuur. Maatskaplike werksters tref dan net die nodige vakansiereëlings vir hulle. Dan hoef minder gebou te word, en dit bespaar die kinders ook die traumatiese ervaring om in 'n kinderhof te verskyn en gekommitteer ofte wel amptelik uit hul ouerhuis uitgeplaas te word. Oor die honderd kinders is die laaste jare al op die manier 'n beter kans gegee.

Dis teen dié agtergrond dat 'n brief van die vereniging aan sy takke uitgestuur is om te sê dat die voortbestaan van Waverenhuis geldelik nie geregverdig kan word nie.

Geldelik nie geregverdig nie? Mnr. Frikkie Steynberg, burgemeester van Tulbagh en afgetrede onderwysman, kan dit maar nie kleinkry nie. Terwyl ander inrigtings reuseverliese toon, het Waverenhuis dan aan die einde van die boekjaar in Februarie 'n oorskot van om en by R2 000 gehad! Die plek is met die gemeenskap se hulp min of meer selfonderhoudend, voer hy aan.

Tulbagh se skoolhoof, mnr. G. Engelbrecht, sê hy weet nog nie hoe sluiting van Waverenhuis sy skool sou raak nie. Hy wil maar so min as moontlik sê. 'n Mens wil die ACVV nie antagoniseer terwyl die besluit nog hangende is nie, sê hy.

Daar's plek in die skoolkoshuis. Moontlik kan die standerdneges en matrieks daarin opgeneem word sodat hul skoolwerk nie te veel deur 'n sluiting ontwrig word nie.

● Waverenhuis se kinders kan een ding weet: hulle het in Tulbagh se hart ingekruip.

World War II disabled seek pension parity

~~278~~ 297

CAPE TIMES 29/8/77

Defence Reporter

PARITY — not charity. This is the rallying cry of a number of Capetonians who were severely disabled in World War II and who are embittered by recent pensions legislation which discriminates heavily against them in favour of soldiers wounded and disabled since mid-1975.

So great is the gap that a World War II veteran might well find himself drawing a basic pension which is less than one-third of that paid to a serviceman who suffered the same degree of disablement in, say, the Angolan campaign.

In some cases, particularly among black veterans, the gap is even greater.

Protests by various opposition members of Parliament since the discriminatory legislation was tabled and passed last year have not achieved any results. Neither has a lengthy interview between a group of local pensioners and the Deputy Minister for Social Welfare and Pensions, Mr Punt Janson.

Mr Janson stated the government view on May 10 this year, the last time the pensions disparity was raised in Parliament, when he told Dr Alex Boraine, PRP MP for Pinelands: "The necessary funds are not available."

Same answer

The South African Legion, an umbrella body which speaks on behalf of all military pensioners, received the same answer when it approached the government about the "generation gap", which affects more than 19 000 white, African and coloured ex-servicemen, almost all of whom were disabled while serving in the two world wars and Korea.

In the last budget, R9m was asked for pensions, widows' benefits and dependants' allowances resulting from World War II; R600 000 for World War I; and R8 000 for Korea.

Angry World War II disabled pensioners pointed out to me this week that the total amount payable to war-disabled pensioners is less than 3 pereent of the total of R324m paid out by the Department of Social Welfare

Soldiers 30 years and R91 apart

A CAPETONIAN who prefers to be known as "Mr B" joined a Cape Town infantry regiment in 1939, aged 22. He served in the Western Desert and then went on to Italy with the Sixth Division. While in Italy he lost his left leg and suffered multiple wounds when he stepped on a German mine (he does not like to talk about it, but he showed such gallantry that day that he was subsequently decorated with the Military Medal).

He spent a year in hospital, underwent 12 operations, and was then discharged with a 60 percent disability rating. Today he receives a pension which, with all allowances, totals R83,54 a month, and wears a corset which is supplied by the government. The reason for the corset is a hernia caused, so his doctor told him, by the extra daily physical exertion caused by his disability.

Mr B's resentment is compounded by a peculiarly unsettling encounter he had recently while shopping in a local supermarket. While thus engaged he met a young man in his early 20s who also had an artificial leg. As old soldiers will, they swopped stories. The young man told Mr B that he had lost his leg in Angola, had been classified as 50 percent disabled — a lower category than Mr B's — and was receiving a pension of R175 a month.

"He couldn't believe he was getting more than I was," Mr B recalls. "He thought I was putting him on."

Act 84 of 1976 all allowances have been consolidated and any future increases which may be granted will be calculated on the basis of these consolidated pensions.

Pensioners who had been disabled since July 1, 1975 were catered for by Act 84 of 1976, which provided for greatly increased pensions.

Treatment

All pensioners, whatever their vintage, were entitled to free hospital treatment and medication, as well as free appliances like artificial limbs, corsets and, in some cases, shoes.

The legion was satisfied with neither the pensions disparity nor the size of the gratuities, he added, but till now negotiations with the government had not been successful. However, the legion's pensions committee was still pursuing the matter.

"Why the hell should we be treated like this?" I was asked this week by a spokesman for the group which interviewed Mr Janson — a Rondebosch man who lost his left leg, right foot, and the hearing in his right ear when his tank was blown up by a German mine in Italy in 1944.

want your sympathy, I just want you to know. Have you ever thought of how a man without legs has to tackle the simple job of taking a bath in the morning?

"First of all you have to crawl to the bathroom. I have a friend who is even worse off than I am — he lost both legs. Do you know how he gets to the bathroom? He's got one of those wheeled platform things that mechanics use in garages when they want to slide in under a car. That's how he gets to the bathroom.

Retrenched

"Then, after he's got there, he has to lift himself in mainly with his arms. It takes strength and co-ordination.

"The thing is that he's 61 now. One of these days he won't be able to swing himself off the floor into his bath any more. The same applies to me. Of course, you might say that when I'm too feeble my wife could help me, but she's not getting any younger either. By rights I should have a specially-built bathroom — but I can't afford it and the government does not supply it."

In spite of his handicap — which cost him a year in

pension of R350 as well as the various allowances.

If Mr A was a coloured man the "generation gap" would be even greater; he would receive a minimum monthly pension of R57,12 before allowances — compared with R233 under the new dispensation. If he was an African he would receive a minimum of just R28 a month, compared with R175.

Survey

Mr A cannot see why two equally disabled men should receive different pensions simply because they were wounded in wars 30 years apart.

"If we were civil accident claimants," he says, "the minimum interest on the money awarded by any court for these injuries and disabilities would be at least 3½ times what we receive.

"My 21-year-old daughter-in-law receives R60 a month more salary than I get from my disability pension.

"A little survey I did on my own shows that practically all major disability pensioners' wives are working because they can't come out on the pensions."

Mr A points to recent increases in British war pensions and stresses the fact that disabled British pensioners can be supplied with a free automatic-gear car which is maintained by the state.

Some victory

"Most English-speaking or civilized countries maintain similar World War II disability pensions, including our defeated enemy, Germany. Some victory over tyranny!"

Mr A feels particularly strongly about the question of transport for disabled ex-servicemen. Because of his disability it is difficult for him to use public transport as he cannot walk long distances. This, he says, has brought great parking difficulties.

"In order to be able to function in my work I have paid out well over R1 000 in parking fines . . . we don't even get a disc from the City Council to show we're disabled and might have to park overtime because our cars are essential to us."

ARGUS 1/9/77

TABLE 21. NUM

3E IN THE CITY

AREA	3.A.R. MEN
1. Milnerton Munic (farm labourers Kilarney area) Stable 'boys' M	4,315
2. Bakoven to Port (domestics, car etc.)	own 1,719
3. Portwsood Road Gate (domestics takers, etc.)	
4. Toll Gate to Ne (includes Clare Athlone, Lands	
5. Kenilworth to H	
6. Retreat to Kalk	
7. Salt River Brid Paarden Island- Industries	
8. Fishhoek Munici	
9. Pinelands Munic	
10. Simonstown Muni	
11. Thornton	
12. Bergvleit	
13. Bishops Court	
14. Constantia	
15. Kirstenhof	
16. Ottery	
TOTAL	L 6,034

CITY COUNCIL TOTAL: 9,469

'Bonding' urged to retain SA doctors

The Argus Correspondent

JOHANNESBURG. — Bonding medical graduates immediately after qualification for 10 years' service in health care should be introduced to curb South Africa's alarming brain drain, a Wits University medical professor said in Johannesburg today.

Professor H. Seftel, Professor of African medicine at the University of the Witwatersrand, was speaking at a seminar at the university's medical school.

He said medical students were privileged people who were committed to serving community suffering. The community paid for the students to study at a medical school.

'I have no hesitation in calling for a system of bonding for graduate students to a period of 10 years' service in health care,' Professor Seftel added.

'Bonding graduate students might be the best way of selecting medical students who really cared,' he said.

Dr George Beaton, director of the division of continuing medical education at the university, said two surveys were conducted in 1973 and 1976 to find out how many Wits medical graduates had remained in South Africa.

The survey showed that about 46 percent of students who graduated between 1960 and 1973 had left South Africa and South West Africa.

Most had gone to the United States, Australia, New Zealand, Israel and Britain.

Since last December when the second survey was carried out, the brain drain had worsened.

(297)

25/9/77



Mrs Judith Wentzel . . . compelled to belong to a medical aid but excluded from maternity benefits.

25/9/77

Men only!

Ten years of medical aid payments, but no maternity grant for teacher Judith

By JILL MeILRAITH

SOUTH Africa's largest medical aid scheme, the Public Service Medical Aid Association, pays maternity benefits only to its male members.

A Pretoria teacher, Mrs Judith Wentzel, has discovered after a 10-year membership that she is not entitled to maternity benefits for the birth of her first child.

Mrs Wentzel, 31, said this week: "I'm furious about this. I have paid the same contribution as male members. Now I find that I'm not entitled to a cent."

Teachers are compelled to join the Public Service Medical Aid, which has more than 120 000 members in Government and provincial employ.

According to the rules of the scheme, women members can claim maternity benefits only if their husbands are "dependants".

To qualify as a dependant, a husband must be crippled or mentally retarded.

Mrs Wentzel's husband is neither but he has been financially dependent on her while studying full-time for the last three years.

Rules

"It seems that in the public service only men can claim maternity benefits. When I asked about this, the reply I got was, 'These are the rules'.

"I can't even leave the medical aid scheme — we have to be members to be employed as teachers at Government schools.

"I would like to see this provision changed, even if it is too late for me to benefit."

Mrs Wentzel has complained to the secretary of the medical aid scheme and to the Transvaal Teachers' Association.

The TTA is sympathetic and is taking up her case, along with a similar complaint by another member.

Medical Aid administrators say her case is exceptional. The rules, are made to cope with more common cases.

Provision

Mr John Ernstzen, chairman of the Representative Association of Medical Aid Schemes, said that most medical aid schemes had a similar clause excluding women from claiming maternity benefits.

"When a man is a member and there is a pregnancy in his family, his term of employment is not affected, but by law a woman must leave her job not later than four weeks before the expected birth of her child.

"Once she ceases to be a member, she is not entitled to benefits."

Some schemes get round this provision by giving a maternity grant to women leaving to have a baby.

"Even if a woman elects to have her husband and children as dependants on her scheme, and several schemes allow this, then she is still not entitled to claim maternity benefits."

Confinement was usually payable in respect of member's wives only, Mr Ernstzen said.

"There are also practical and financial reasons for this. Medical aid schemes try to keep costs to members and employers down yet still cover the most likely claims made by the majority of members.

Covered

"I am sorry for Mrs Wentzel and the few others in similar positions, but I do not think the rules are unfair. Hers is an exceptional case and most married woman having babies are covered by their husband's medical aid."

Mr Jack Ballard, secretary of the TTA, said that, while only a few women teachers had complained about their exclusion, the association would take up their cases.

The secretary of the Public Service Medical Aid Association, Mr John Davidson, refused to comment.

Government medical aid officials suggested that Mrs Wentzel take her case up formally with the medical aid disputes committee.

MEDICAL SCHEMES ACT NOW JUST A DEAD LETTER

Doctor-State clash is looming

STAR 25/11/77 (297)

Marais Malan
Science Editor

Unless extreme wisdom prevails, a stormy time in medical politics is in the offing with the possibility of open confrontation between the Government and the medical profession.

Until now the Medical Association of South Africa has merely made rumbling noises in its opposition to the Medical Schemes' Act.

Now it has irrevocably thrown it overboard by officially advising its members to contract out in protest against the latest tariff of fees laid down by the remuneration commission.

This means that the Act has become, theoretically, a dead letter. If all doctors contract out, they may charge all patients whatever they like, provided fees remain within the bounds of what is regarded as reasonable by the South African Medical and Dental Council.

UNSATISFACTORY

The Government has, of course, realised that the Act, in its present form, is unsatisfactory. Recently, the Minister of Health, Dr Schalk van der Merwe, said that a different method would have to be found of determining a tariff of fees for medical aid patients.

Since then, proposed amendments to the Act have been published. They do away with the remuneration commissions appointed to lay down a tariff and this function is to be transferred to the Medical and Dental Council.

But another amendment abolishes the right of doctors to contract out in terms of the Act.

While, in spite of their misgivings, they seem prepared to live with a Medical Council tariff, the removal of this right is placing the Government and the profession on a collision course.

In effect, doctors say, this provision introduces a form of socialised medicine in a time-honoured free enterprise system and further bedevil the traditional patient-doctor relationship.

PREDICAMENT

The Act, it is said, has already driven a wedge between doctor and patient by introducing a third party — the medical schemes.

But at least doctors could get out of it by contracting out. Enforce the tariff and doctor-patient relations can only deteriorate.

One cannot help sympathising with both Government and doctors in their predicament. The Medical Schemes Act was a sincere attempt on the part of the State to regularise private practice with the interests of both doctors and patients in mind.

It has not worked out that way. Unless a medical aid tariff can be enforced and doctors retain the right to contract out, the Act remains basically ineffectual.

SURVEY

If it is enforced, as the amendment seeks to do, the democratic right of doctors to run their practice as they see fit is taken away. This they will not accept.

But many doctors need the medical aid schemes, which ensure regular payment of accounts. So only about 2 000 of the 7 000 or so doctors in private practice have contracted out so far.

It is significant, though, that an independent survey has shown that most contracted-out doctors still charge their medical aid patients the preferential rates, which suggests that their opposition to the Act is not based entirely on financial considerations, but that ethics play a significant role.

Whether the Government should allow the present situation to reach a point of confrontation is debatable.

Enforcing medical tariffs will provide a better deal financially for the medical schemes and their patients and end, once and for all, the unseemly bickering that has followed each remuneration commission report.

RESENTMENT

On the other hand, it will leave in its wake a medical profession seething with resentment. This will do neither the patient nor professional medical standards any good.

The solution, as I see it, is for the Government to scrap the "no contracting out" clause in the new Bill, but to retain the provision whereby the Medical Council would fix the tariff.

Provided representation of the private medical sector is increased on the council — which seems a fair compromise — the chances are that a tariff may be worked out that will satisfy both doctors and medical schemes.

It is worth a try for a year or two anyway. The alternative, as embodied in the Bill, may lead to chaos.

Definitions of concepts, measurements, explanations.
Maree and deVos (1975), Simpkins (1976),

12. Migrant Labour in Southern Africa.
F. Wilson (1972b, 1976); C. van Onselen (1976);
J. Nattrass (1976).

13. Farm Labour in South Africa. History,
wages and working conditions, competition with Industry.
F. Wilson (1972), SALDRU Farm Labour Conference Papers.

F.M. 2/12/77 (297)

The doctors' dilemma

How to maintain earnings if they are forced to toe the line on medical aid tariffs

There are few relationships — business or otherwise — more personal than that between a doctor and his patient.

It is thus particularly unfortunate that the medical profession's blood pressure has been dangerously raised by the pronouncements of the latest remuneration commission, and by the contents of the draft bill to amend the Medical Schemes Act of 1967.

The federal council of the Medical Association (the doctors' and dentists' trade union) is so incensed that it has urged members to contract out of medical schemes. Normally that would allow doctors and dentists to charge what they pleased within reason, as adjudicated by the SA Medical and Dental Council, a government appointed body. However, they have been advised to retain the tariff format using a unit value of 90c instead of 80c. (The tariff format is a method of determining procedural values; ie treating a cold might be 10 units.)

Only doctors in private practice are affected by the dispute. At the end of December 1976, there were a total 13 946 doctors, 1 116 interns and 2 155 dentists on the medical register. No figures are available for the number of those in private practice but it is thought to be slightly more than half. In other words, somewhere between 8 000 and 10 000.

Three quarters of those in private practice had not contracted out, but the figure has almost certainly been reduced since the call to give notice by the federal council.

It is generally agreed that the remuneration commission method of establishing a medical tariff has proved unsatisfactory. Normally, but not necessarily, there are three year gaps between determinations. Inflation means that doctors' real income is falling and this leads to exaggerated claims.

Lack of co-operation

A further weakness was highlighted when the remuneration commission under the chairmanship of Mr Justice Erasmus reported in July. It expressed "displeasure" at an alleged lack of co-operation and noted that "the association can effectively paralyse the proceedings of a remuneration commission, mainly by neglecting to give relevant evidence. Under the present act, a remuneration commission can come to the correct and best conclusion only while it enjoys voluntary co operation."

The commission criticised the lack of information on income and expenditure of doctors and declared: "If the tariff suits them they remain contracted in, if not, they contract out and charge their own fees."

Instead of awarding an increase of a third, in line with the consumer price index, the commission raised tariffs by between 8% and 10%. For some procedures, tariffs were actually reduced by as much as 20%. For the doctors, that was insult and injury enough. But worse followed when a draft bill to amend the Medical Schemes Act was published in the Government Gazette on October 19.

That bill aims, among other things, to: repeal the competency of a medical practitioner or dentist to decide whether to render services in terms of the provisions of the act; abolish the remuneration commission; and give power to the Medical Schemes Council (appointed under the Medical Schemes Act of 1967) to determine a tariff of fees.

Bureaucratic control

Understandably, howls of anguish have arisen from the medical profession. Prof J N de Klerk, chairman of the federal council of the Medical Association, calls the measure "a further step along the road to bureaucratic control of private medical practice in South Africa". He, somewhat predictably, expects it to have "catastrophic" effects on the "methods and mores of medical practice".

Doctors resent the coercive nature of the proposals and what they call the "medical aid bureaucracy" they allege is being placed between doctor and patient. It is claimed that more doctors will emigrate.

Reacting to the call to contract out, John Ernstzen, chairman of the Representative Association of Medical Schemes, claims: "Schemes protect doctors by guaranteeing them direct payment. If there is a concerted contracting out, they will wait longer for their money and suffer bad debts."

Irrespective of the merits of the case, the whole matter has been handled with a considerable lack of finesse. This has raised temperatures unnecessarily. The issues are simple. If the doctors are to grant a discount by way of a preferential tariff in return for an assurance that they will be paid, they cannot reasonably be expected to do so on the basis of an unrealistic tariff, over which they have little control.

Throwing the decision on fees back on the Medical Schemes Council and doing



away with advisory committees and remuneration commissions does not appear to solve the problem of obtaining basic information on which to decide a tariff structure.

Perhaps there's a case for some permanent body of experts constantly at work examining medical costs, as much to keep doctors up to scratch (in terms of ensuring that they use the latest techniques and procedures) as to ensure that they receive fair payments.

Persuasion is always preferable to coercion and on this ground alone the arbitrary prohibition on contracting out is objectionable. If doctors were assured of a reasonable tariff there would be nothing to gain by contracting out and possibly quite a lot to lose. It is significant that, even in present circumstances, a high percentage of doctors remain contracted in, thus indicating that assurance of income is a real benefit.

It is arbitrarily a bad principle to suggest that any particular group of people should be required to accept a cut in their incomes. It is unjust to doctors who can, by reason of skill and experience, command a special premium for their services. The probable, and highly undesirable result of compulsion would be to encourage doctors to avoid treating medical aid patients.

However, doctors' financial grievances are not a popular cause. The arrogant approach of their official spokesmen in the past — to say nothing of their evident prosperity — ensures that they won't get much public sympathy, whether it's merited or not.

If one can't love the doctors though, one should at least care for the patients. Their interests require an accommodation between government and the medical profession. The stick won't work, let's see the carrot.

Minister defends medical draft Bill

THE Minister of Health, Dr S W van der Merwe, strongly defends the controversial draft Bill dealing with medical tariffs in a letter published in the latest issue of the South African Medical Journal.

Breaking official silence on the proposed legislation, Dr van der Merwe said the Bill, which will force doctors to charge medical aid tariffs without the right to contract out, was an 'honest endeavour, without any ulterior motive, to provide legislation for a contractual situation between the interested parties.'

The letter is an open letter to the chairman of the federal council of the Medical Association, Professor J N de Klerk.

MEMORANDUM

Dr van der Merwe was replying to an open letter from Professor de Klerk, addressed to him and published with a memorandum on the proposed legislation from the Medical Association on November 26 1977.

In the memorandum the Medical Association criticised the proposed legislation severely and advised the medical profession to contract out of the statutory tariff of the Medical Schemes Act, as determined by the latest remuneration committee.

DEADLOCK

The letter was widely interpreted as a deadlock between the medical profession and the State.

At a Press conference held in November, Professor de Klerk described the proposed legislation 'as a further step towards the socialisation of medical practice in this country and towards the bureaucratic control olf private practice.'

Dr van der Merwe wrote: 'The control of the Medical profession by the South African Medical and Dental Council has



The New Republic Party may only get two

FF1-7

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ALGEMENE KENNISGEWING

KENNISGEWING 136 VAN 1978

DEPARTEMENT VAN GESONDHEID

GEREGISTREERDE MEDIESE SKEMAS

Die Registrateur van Mediese Skemas maak ooreenkomstig artikel 16A van die Wet op Mediese Skemas, 1967 (Wet 72 van 1967), soos gewysig, bekend dat ondergemelde mediese skemas geregistreer is.

Skemas vrygestel kragtens artikel 3 is met 'n sterretjie (*) aangedui, met vermelding van die spesifieke vrystelling.

Hierdie lys vervang die lys wat in *Staatskoerant* 5405 van 18 Februarie 1977 gepubliseer is.

L.W.—Moenie name tussen hakies *tel* nie. Hulle *vertaalde* vorm verskyn *elders* in die lys.

GENERAL NOTICE

NOTICE 136 OF 1978

DEPARTMENT OF HEALTH

REGISTERED MEDICAL SCHEMES

The Registrar of Medical Schemes hereby notifies, in accordance with section 16A of the Medical Schemes Act, 1967 (Act 72 of 1967), as amended, that the undermentioned medical schemes have been registered.

Those marked with an asterisk (*) have been exempted in terms of section 3 as indicated.

This list replaces the list published in *Government Gazette* 5405 of 18 February 1977.

N.B.—Do not *count* names in brackets. Their *translated* form appears *elsewhere* in the list.

Naam van skema Name of scheme	X-Privaatsak/X-Private Bag Posbus/P.O. Box	Plek Place	Kode Code	Verwysingsno. Reference No.	Datum van registrasie Date of registration	Vrystelling van Regulasies/Wet Exemption from Regulations/Act
A.A. Mutual Medical Aid Society	9595	Johannesburg	2000	1001	11/8/71	—
Aberdare Africa Medical Aid Society	494	Port Elizabeth	6000	1002	20/11/70	—
Adcock-Ingram Medical Scheme	9391	Johannesburg	2000	1003	12/2/69	—
AECI Medical Aid Society	716	Johannesburg	2000	1005	11/2/71	—
African Cables Medical Benefit Fund	172	Vereeniging	1930	1004	9/6/70	—
A.G.S. van S.A. se Mediese Hulpfonds	197	Lyndhurst	2106	1442	1/8/74	—
Alabama Medical Plan	10314	Johannesburg	2000	1480	13/10/77	—
Alex. Aiken & Carter Medical Aid Society	61975	Marshalltown	2107	1009	24/11/70	—
*Amato Consolidated Industries Sick Benefit Society	9478	Johannesburg	2000	2010	3/11/67	Algeheel behalwe/Total except 6 & 9.
Ammosal Benefit Society	Mancorp Myn/Mine	Postmasburg	8420	2011	27/11/70	—
Anglo American Corporation Medical Aid Society	9761	Johannesburg	2000	1012	16/10/68	—
*Aranda Textile Mills Sick Benefit Society	9478	Johannesburg	2000	2013	15/12/67	Algeheel behalwe/Total except 6 & 9.
Architects' and Quantity Surveyors' Medical Aid Fund	56235	Pinegowrie	2123	1015	17/8/70	—
Argus Medical Aid Society	1014	Johannesburg	2000	1016	28/11/68	—
Argus Non-White Medical Aid Society	56	Kaapstad/Cape Town	8000	1262	24/8/70	—
Arthur Young Medical Aid Society	4807	Kaapstad/Cape Town	8000	1258	23/2/71	—
Associated Employers Medical Aid Society	958	Johannesburg	2000	1018	22/1/70	—
Associated Engineering Medical Aid Scheme/ . . . se Mediese Hulpskema	56235	Pinegowrie	2123	1428	8/10/72	—
B.A.B. Medical Aid Fund	25622	Denver	2027	1020	15/10/71	—
Bankmed	1242	Kaapstad/Cape Town	8000	1279	29/6/72	—
*Bay Passenger Transport Employees Medical Benefit Scheme	1069	Port Elizabeth	6000	2425	28/6/72	Artikel/Section 20 (c).

Naam van skema Name of scheme	X-Privaat-sak/X-Private Bag Posbus/P.O. Box	Plek Place	Kode Code	Verwysings-no. Reference No.	Datum van registrasie Date of registration	Vrystelling van Regulasies Wet Exemption from Regulations Act
B.B.K. se Mediese Hulpskema/Medical Aid Scheme	56280	Pinegowrie	2123	1432	29/1/73	—
*Begrafnisfonds "Onder ons" (for English see: Funeral . . .)	3522	Johannesburg	2000	1151	21/12/67	Algeheel behalwe/ Total except 6 & 9.
Beland Medical Aid Society	7462	Johannesburg	2000	1021	1/8/69	—
*Belmed- Mediese Skema	45	Sanlamhof	7532	1473	14/2/77	Artikel/Section 17, 19A & 20B.
Bloemfontein Municipal Employees' Medical Aid Society (vir Afrikaans kyk: Mediese Hulpvereniging van die Bloemfonteinse . . .)	1765	Bloemfontein	9300	1022	30/9/69	—
Blue Circle Medical Aid Society	56038	Pinegowrie	2123	1264	21/7/69	—
Boart Medical Aid Society	9761	Johannesburg	2000	1024	14/10/68	—
*Bonmed- Mediese Skema	45	Sanlamhof	7532	1474	14/2/77	Artikel / Section 17, 19A & 20B.
Border Medical Plan	10314	Johannesburg	2000	1448	28/1/75	—
(Bouverenigings se Gesamentlike Mediese Hulpfonds) (for English see: Building . . .)	(61740)	(Marshalltown)	(2107)	(1030)	(1/12/70)	(—)
*BP Southern Africa Medical Aid Society	6006	Roggebaai	8012	1237	20/2/70	Artikel/Section 19A.
*Braitex Medical Benefit Society	5101	Johannesburg	2000	2451	23/4/75	Artikel/Section 20 (c).
Breyten Coalfields Medical Aid Society	141	Breyten	2330	1028	2/12/68	—
Building Societies Joint Medical Aid Fund (vir Afrikaans kyk: Bouverenigings . . .)	61740	Marshalltown	2107	1030	1/12/70	—
Bus Bodies Sick Benefit Society	4008	Port Elizabeth	6000	1032	4/3/70	—
Cape Asbestos Medical Aid Society	8644	Johannesburg	2000	1033	31/7/69	—
Cape Medical Plan (vir Afrikaans kyk: Kaapse . . .)	6183	Roggebaai	8012	1034	11/11/71	—
Cape Portland Medical Aid Society	1067	Kaapstad/Cape Town	8000	1035	24/2/69	—
*Cape Steel Sick Fund	2121	Kaapstad/Cape Town	8000	2036	5/1/68	Algeheel behalwe/ Total except 6 & 9.
*Cape Town Municipal Workers Association Medical Benefit Fund	49	Athlone	7760	2038	11/11/68	Algeheel behalwe/ Total except 6 & 9.
Capex Medical Aid Society	716	Johannesburg	2000	1471	8/2/77	—
*Castellion Medical Aid Society	90	Howard Place	7450	1450	26/3/75	Artikel/Section 20 (d) & (e).
C.D.A. Medical Aid Fund	671	Oos-Londen/East London	5200	1039	5/12/69	—
Chamber of Mines Medical Aid Society	809	Johannesburg	2000	1042	26/2/71	—
Chartered Accountants (S.A.) Medical Aid Fund	857	Johannesburg	2000	1043	6/8/71	—
Chrysler S.A. Medical Aid Society/ . . . se Mediese Hulpvereniging	411	Pretoria	0001	1045	1/2/68	—
City Council Employees' A.T.C. Benefit Society	31555	Braamfontein	2017	2046	12/11/71	—
C.N.A. Investments Medical Aid Fund	1033	Johannesburg	2000	1040	17/2/70	—
Commercial and Industrial Medical Aid Society (CIMAS)	958	Johannesburg	2000	1048	2/6/69	—
*Commercial Union Medical Aid Scheme	222	Johannesburg	2000	1050	11/6/70	Artikel/Section 17 & 19A.
Consolidated Employers' Medical Aid Society	716	Johannesburg	2000	1049	8/9/71	—
*Consolidated Frame Cotton Corporation (Pty) Ltd (Ladysmith Mills) Medical Benefit Society	317	Ladysmith	3370	2051	15/12/67	Algeheel behalwe/ Total except 6 & 9.
Consolidated Glass Works Medical Aid and Sick Benefit Society	562	Germiston	1400	1052	13/8/71	—
*Consolidated Textile Mills Medical Benefit Society (Durban)	12017	Jacobs	4026	2055	15/12/67	Algeheel behalwe/ Total except 6 & 9.
*Consolidated Textile Mills Medical Benefit Society (Huguenot)	6	Hugenoot/Huguenot	7645	2056	20/10/67	Algeheel behalwe/ Total except 6 & 9.
*Consolidated Textiles Medical Benefit Society (East London)	658	Oos-Londen / East London	5200	2054	15/12/67	Algeheel behalwe/ Total except 6 & 9.
*Contactor Medical Aid Society	Privaatsak/ Private Bag 62370	Suider-Paarl	7624	2057	6/3/68	Algeheel behalwe/ Total except 6 & 9.
Corner House Medical Aid Fund	1517	Marshalltown	2107	1058	21/1/70	—
Coronation Medical Aid Society	507	Durban	4000	1059	18/9/74	—
*Court Alfred No. 6039 of the Ancient Order of Foresters Benefit Society	10314	Pietermaritzburg	3200	1060	3/11/67	Algeheel behalwe/ Total except 6 & 9.
Crisis Medical Plan	81	Johannesburg	2000	1482	28/12/77	—
C.T. Medical Aid Society	10	Kaapstad/Cape Town	8000	1065	16/4/70	—
Datsun-Nissan Medical Aid Society/ . . . se Mediese Hulpvereniging	7706	Rosslyn	0200	1066	30/9/68	—
David Brown Employees Medical Aid Society	616	Johannesburg	2000	1067	12/6/70	—
De Beers Benefit Society	56234	Kimberley	8300	2068	29/5/69	—
Delfos Medical Aid Scheme	3400	Pinegowrie	2123	1415	17/8/71	—
*Dental and Optical Fund	290	Johannesburg	2000	1069	21/1/68	Algeheel behalwe/ Total except 6 & 9.
D.I.S.W. Medical Aid Society	48684	Benoni	1500	1070	4/11/70	—
D.K.K. of 1888 Medical Aid Scheme	38040	Roosevelt Park	2129	1465	30/8/76	—
Dormas Medical Aid Society	932	Booysens	2016	1072	12/12/69	—
D.R.G. Medical Aid Society	101	Kaapstad/Cape Town	8000	1263	16/3/70	—
East Asiatic Co. (S.A.) Ltd. Employees Medical Aid Society		Durban	4000	1075	16/4/71	—

Naam van skema Name of scheme	X-Privaat-sak/X-Private Bag Posbus/P.O. Box	Plek Place	Kode Code	Ver-wysings-no. Reference No.	Datum van registrasie Date of registration	Vrystelling van Regulasies/Wet Exemption from Regulations/Act
Eastern Province Newspapers Medical Aid Society	1117	Port Elizabeth.....	6000	1076	5/6/69	—
Erica Medical Aid Society.....	6052	Roggebaai.....	8012	1464	20/8/76	—
Escom Medical Aid Society (vir Afrikaans kyk: Evkom . . .)	1091	Johannesburg.....	2000	1346	12/2/71	—
E.T.C. Medical Benefit Society.....	121	Barberton.....	1300	2081	6/6/69	—
Everite Medical Aid Society/ . . . se Mediese Hulpvereniging	31166	Braamfontein.....	2017	1082	9/9/71	—
(Evkom se Mediese Hulpvereniging) (for English see: Escom . . .)	(1091)	(Johannesburg).....	(2000)	(1346)	(12/2/71)	(—)
Fedhandel se Mediese Hulpskema.....	56236	Pinegowrie.....	2123	1418	22/10/71	—
Federated Employers' Medical Aid Society	666	Johannesburg.....	2000	1083	21/5/70	—
Finmed Medical Aid Scheme/. . . se Mediese Hulpskema	56290	Pinegowrie.....	2123	1420	3/3/72	—
Ford Medical Aid Plan/ . . . se Mediese Hulpplan	—	1201 Oasim-Noord/ North, Havelock-straat / Street, Port Elizabeth	6001	1452	25/4/75	—
Fowler Group Medical Aid Society.....	28568	Sunnyside.....	0132	1467	21/9/76	—
Freight Services Medical Aid Society.....	716	Johannesburg.....	2000	1472	8/2/77	—
*Fruit and Vegetables Canning Workers' Medical Benefit Fund	2678	Kaapstad/Cape Town.	8000	2086	20/10/67	Algeheel behalwe/ Total except 6 & 9).
*(Funeral Fund "Onder Ons") (vir Afrikaans kyk: Begrafnis . . .)	(3522)	(Johannesburg).....	(2000)	(1151)	(21/12/67)	(Algeheel behalwe/ Total except 6 & 9).
Garlick Medical Aid Society.....	4642	Kaapstad/Cape Town.	8000	1417	15/9/71	—
Gemeenskaplike Munisipale Mediese Hulpfonds (Transvaal) (GMMH) (For English see: Joint . . .)	14145	Verwoerdburg.....	0140	1087	28/5/68	—
General Accident Medical Aid Society....	2755	Johannesburg.....	2000	1088	28/1/70	—
General Mining Group Medical Aid Society	7462	Johannesburg.....	2000	1089	3/12/69	—
General Motors South African (Pty) Ltd Medical Aid Plan	1137	Port Elizabeth.....	6000	1090	21/4/72	—
General Motors South African (Pty) Ltd Medical Benefit Scheme	1137	Port Elizabeth.....	6000	2421	21/4/72	—
Germiston Industries Medical Aid Society/ . . . Die Germistonse Nywerhede Mediese Hulpvereniging	680	Germiston.....	1400	1092	17/2/70	—
*Glass Industry Sick Benefit Fund.....	2221	Port Elizabeth.....	6000	2094	5/1/68	Algeheel behalwe/ Total except 6 & 9.
Goldbys Medical Benefit Fund.....	1172	Johannesburg.....	2000	1096	5/5/71	—
Gold Fields Medical Aid Society.....	1167	Johannesburg.....	2000	1098	14/5/70	—
Good Hope Medical Aid Society.....	7462	Johannesburg.....	2000	1466	7/9/76	—
Greatermans Medical Aid Society.....	5460	Johannesburg.....	2000	1099	25/4/69	—
Haggie Rand Medical Aid Scheme/ . . . se Mediese Hulpskema	56234	Pinegowrie.....	2123	1416	17/8/71	—
Helam Medical Aid Society.....	2	Mynkantoor / Mine Office, Swartruggens	2835	1100	1/3/71	—
*Helpmed Medical Scheme/ . . . Helpmed-Mediese Skema	45	Sanlamhof.....	7532	1413	1/7/71	Artikel / Section 17, 19A & 20B.
Hextex Medical Aid Society.....	48	Worcester.....	6850	1103	29/8/69	—
Highveld Medical Scheme.....	111	Witbank.....	1035	1177	28/12/72	—
Hoechst Medical Aid Society for Southern Africa	7706	Johannesburg.....	2000	1429	28/8/72	—
Homes Trust Medical Aid Society/ . . . . se Mediese Hulpvereniging	93	Kaapstad/Cape Town	8000	1105	28/10/70	—
H.T.L. Médical Scheme/ . . . . se Mediese Skema	93	Kaapstad/Cape Town	8000	1411	25/5/71	—
Huletts Medical Aid Fund.....	X-3	Glenashley.....	4022	1106	16/11/70	—
Hunt, Leuchars & Hepburn Ltd Medical Aid Society	716	Johannesburg.....	2000	1107	14/6/71	—
I.B.M. South Africa Medical Aid Society...	7462	Johannesburg.....	2000	1111	12/2/71	—
Ideal Medical Aid Scheme.....	31541	Braamfontein.....	2017	1461	31/3/76	—
I.C.S. Medical Aid Society/ . . . se Mediese Hulpskema	90	Howard Place.....	7450	1431	29/9/72	—
Impilo Medical Aid Society.....	7706	Johannesburg.....	2000	1475	1/4/77	—
Insbroke Medical Aid Society.....	8219	Johannesburg.....	2000	1109	18/11/68	—
Iscor Medical Benefit Fund (vir Afrikaans kyk: Yskor . . .)	2154	Pretoria.....	0001	2295	11/2/71	—
I.W.S. Medical Aid Society.....	716	Johannesburg.....	2000	1113	22/7/69	—
J.C.I. (Barberton) Medical Aid Society.....	17	Barberton.....	1300	1114	31/7/69	—
Johannesburg Chamber of Commerce Medical Aid Society (JCC) (vir Afrikaans kyk: Johannesburgse Kamer . . .)	7462	Johannesburg.....	2000	1115	17/7/69	—
(Johannesburgse Kamer van Koophandel se Mediese Hulpvereniging, Die) (for English see: Johannesburg Chamber . . .)	(7462)	(Johannesburg).....	(2000)	(1115)	(17/7/69)	(—)
Johannesburg Municipal Employees' Sick Benefit Society (vir Afrikaans kyk: Die Johannesburgse Siekehulpvereniging . . .)	2626	Johannesburg.....	2000	2116	10/3/72	—
(Johannesburgse Siekehulpvereniging vir Munisipale Werknemers, Die) (for English see: Johannesburg Municipal . . .)	(2626)	(Johannesburg).....	(2000)	(2116)	(10/3/72)	(—)

Naam van skema Name of scheme	X-Privaatsak/X-Private Bag Posbus/ P.O. Box	Plek Place	Kode Code	Verwysingsno. Reference No.	Datum van registrasie Date of registration	Vrystelling van Regulasies/Wet Exemption from Regulations/Act
[(Joint Municipal Medical Aid Fund (Transvaal)] (vir Afrikaans kyk: Gemeenskaplike . . .)	(14145)	(Verwoerdburg).....	(0140)	(1087)	(28/5/68)	(—)
(Kaapse Mediese Plan) (for English see: Cape Medical . . .)	(6183)	(Roggebaai).....	(8012)	(1034)	(11/11/71)	(—)
*Klerksdorp Mines Benefit Society (KDM) (vir Afrikaans kyk: Klerksdorpse . . .)	326	Klerksdorp.....	2570	2121	23/4/71	Reg. 15.
*(Klerksdorpse Mynbystandsvereniging, Die) (KDM) (for English see: Klerksdorp . . .)	(326)	(Klerksdorp).....	(2570)	(2121)	(23/4/71)	(Reg. 15.)
*Koopmed- Mediese Skema.....	33	Paarl.....	7620	1463	3/6/76	Reg. 9.
Krygmed.....	4659	Pretoria.....	0001	1434	2/4/73	—
K.W.B. Medical Aid Society.....	7706	Johannesburg.....	2000	1124	6/8/68	—
Legal and General Medical Aid Scheme...	4870	Johannesburg.....	2000	1125	8/10/71	—
*Leyland Sick Fund (voorheen/previously B.M.C. Sick Fund)	1536	Kaapstad/Cape Town	8000	2023	15/12/67	Algeheel behalwe/ Total except 6 & 9.
Local Authorities Medical Aid Fund (Cape) (LAMAF) (vir Afrikaans kyk: Mediese Hulpfonds . . .)	460	Kaapstad/Cape Town	8000	1145	10/1/68	—
*Loyal Alfred Lodge No. 5072 Friendly Society	—	Milstan, Maidstone-weg/Road, Heathfield	7800	2126	15/12/67	Algeheel behalwe/ Total except 6 & 9.
*Loyal Durban Lodge No. 5403.....	331	Durban.....	4000	1128	5/1/68	Algeheel behalwe/ Total except 6 & 9.
*Loyal Natal Unity Lodge No. 4443, I.O.O.F./M.U.F.S.	493	Pietermaritzburg.....	3200	1129	3/11/67	Algeheel behalwe/ Total except 6 & 9.
*Loyal Nil Desperandum Lodge No. 6054	—	87 Balfour St., Woodstock	7925	2438	11/3/74	Algeheel behalwe/ Total except 6 & 9.
M & Z Staff Sick Fund.....	239	Windhoek.....	9100	1132	24/3/70	—
Marley Medical Aid Society.....	6684	Johannesburg.....	2000	1134	2/9/70	—
Masonite Medical Aid Society.....	671	Durban.....	4000	1135	24/6/71	—
Massey-Ferguson-Safim Medical Aid Society	677	Vereeniging.....	1930	1136	21/5/70	—
*M.C.G. Medical Fund.....	2268	North End.....	6056	2155	15/12/67	Artikel/Section 20 1 (c).
M.C.I. Medical Scheme/ . . . se Mediese Skema	2268	North End.....	6056	2138	17/2/70	—
Meddent Medical Aid Society.....	9153	Johannesburg.....	2000	1139	27/10/67	—
Medicaid Medical Aid Society.....	9153	Johannesburg.....	2000	1140	6/2/68	—
*(Medical Aid Society of the Agricultural Unions) (vir Afrikaans kyk: Mediese hulpvereniging van die Landbou-Unies)	(54)	(Bloemfontein).....	(9300)	(1148)	(19/12/67)	(Reg. 6.)
Medical Aid Society of the Federation of Master Printers of S.A.	4465	Johannesburg.....	2000	1141	23/8/71	—
Medical Expenses Distribution Society (MEDS)	10178	Johannesburg.....	2000	1142	2/12/69	—
Medical Services Plan (MSP) (vir Afrikaans kyk: Plan . . .)	10314	Johannesburg.....	2000	1143	9/8/71	—
Medico.....	20	Pinelands.....	7430	1144	19/12/67	—
[Mediese Hulpfonds vir Plaaslike Owerhede (Kaap)] (for English see: Local . . .)	(460)	(Kaapstad/Cape Town)	(8000)	(1145)	(10/1/68)	(—)
Mediese Hulpskema van die N.G. Kerk van Transvaal	433	Pretoria.....	0001	1146	18/7/69	—
(Mediese Hulpvereniging van die Bloemfonteinse Munisipale Werknemers) (for English see: Bloemfontein . . .)	(1765)	(Bloemfontein).....	(9300)	(1022)	(30/9/69)	( )
*Mediese Hulpvereniging van die Landbou-Unies (for English see: Medical Aid Society of the Agricultural . . .)	54	Bloemfontein.....	9300	1148	19/12/67	Reg. 6.
Mediese Hulpvereniging van die Poskantoor (for English see: Post . . .)	303	Germiston.....	1400	1147	27/5/70	—
Mediese Hulpvereniging van Staatsamptenare (MHVS) (for English see: Public . . .)	26004	Arcadia.....	0007	1149	23/6/69	—
Mercantile & General (SA) Medical Aid Fund	2445	Kaapstad/Cape Town	8000	1152	5/8/70	—
*Messina Medical Benefit Society.....	X-620	Messina.....	0900	2153	4/9/69	Reg. 15.
Metal Box Medical Aid Society	7752	Johannesburg.....	2000	1154	1/2/71	—
(Middellandse Mediese Plan) (MMP) (for English see: Midland . . .)	(—)	(1201/6 Oasim-Noord Havelockstr., Port Elizabeth)	(6001)	(1156)	(3/12/70)	(—)
Midland Medical Plan (MMP) (vir Afrikaans kyk: Middellandse . . .)	—	1201/6 Oasim North, Havelock Street, Port Elizabeth	6001	1156	3/12/70	—
Mines Benefit Society (MBS) (vir Afrikaans kyk: Myn . . .)	23257	Joubert Park.....	2044	2158	3/2/71	—
Morcop Medical Aid Society.....	—	Dido Valley, Simonstown	7995	1161	6/8/71	—
Motomedic Society.....	5317	Johannesburg.....	2000	1290	14/6/72	—
Multimed Medical Scheme.....	62061	Marshalltown.....	2107	1483	19/1/78	—
Mumed 850 Plan.....	90	Howard Place.....	7450	1215	17/11/71	—
Municipal Medical Aid Scheme (Natal) (vir Afrikaans kyk: Munisipale . . .)	3472	Durban.....	4000	1162	5/8/69	—
[Munisipale Mediese Hulpskema (Natal)] (for English see: Municipal . . .)	(3472)	(Durban).....	(4000)	(1162)	(5/8/69)	(—)
Murray & Stewart Medical Aid Scheme....	56060	Pinegowrie.....	2123	1447	20/12/74	—
Mutual and Federal Medical Aid Fund....	90	Howard Place.....	7450	1208	10/6/71	—

Naam van skema Name of scheme	X-Privaatsak/X-Private Bag Posbus/ P.O. Box	Plek Place	Kode Code	Verwysingsno. Reference No.	Datum van registrasie Date of registration	Vrystelling van Regulasies/Wet Exemption from Regulations/Act
(Mynbystandvereniging) (for English see: Mines . . .)	(23257)	(Joubert Park).....	(2044)	(2158)	(3/2/71)	(—)
Namaqualand Medical Aid Society.....	66	Nababeep.....	8265	1460	12/1/76	—
(Nasionale Indiër- Mediese Skema) (NIMS) (for English see: National Indian . . .)	(56234)	(Pinegowrie).....	(2123)	(1453)	(18/12/75)	(—)
Natal Building Society Medical Aid Fund..	1744	Durban.....	4000	1164	8/6/70	—
Natal Coal Owners' (Durban Staff) Medical Aid Society	281	Durban.....	4000	1165	16/6/70	—
National Medical Plan (NMP) (voorheen/previously Natal Medical Plan)	2338	Durban.....	4000	1167	6/5/71	—
National Indian Medical Scheme (NIMS) (vir Afrikaans kyk: Nasionale Indiër-. . .)	2825	Durban.....	4000	1453	18/12/75	—
National Portland Medical Aid Society.....	21	Claremont.....	7735	1168	29/7/69	—
National Trading Medical Aid Society.....	2762	Johannesburg.....	2000	1169	20/11/69	—
N.B.C. Medical Aid Society.....	10423	Johannesburg.....	2000	1170	19/2/69	—
Nedmed Medical Aid Society.....	90	Howard Place.....	7450	1469	24/12/76	—
New Zealand Insurance Company (S.A.) Ltd Medical Aid Society	7706	Johannesburg.....	2000	1410	14/4/71	—
Nimax Medical Aid Society.....	1790	Durban.....	4000	1470	19/1/77	—
Nimed Medical Aid Society.....	1790	Durban.....	4000	1166	27/1/71	—
Ninham Shand Medical Aid Society.....	90	Howard Place.....	7450	1444	5/9/74	—
Northern Medical Aid Society.....	9263	Johannesburg.....	2000	1171	20/3/68	—
North Western Cape Medical Aid Society (voorheen/previously O'Okiep)	Pk./P.O.	Nababeep.....	8265	1459	22/10/75	—
N.T.E. Staff Medical Aid Fund.....	39	Pietermaritzburg.....	3200	1174	4/9/70	—
Number One Medical Aid Scheme.....	10314	Johannesburg.....	2000	1468	23/12/76	—
(O.F.S. Joint Municipal Medical Aid Fund) (vir Afrikaans kyk: O.V.S. . . .)	(1132)	(Kroonstad).....	(9500)	(1180)	(20/8/68)	(—)
O.K. Bazaars Medical Aid Society.....	4642	Kaapstad/Cape Town	8000	1176	10/2/70	—
Olifantsfontein Medical Aid Society.....	10	Olifantsfontein.....	1665	1178	26/4/72	—
Ommed Plan.....	90	Howard Place.....	7450	1476	5/5/77	—
Ore and Metal Medical Aid Society.....	3548	Johannesburg.....	2000	1181	18/9/70	—
O.V.S. Gemeenskaplike Munisipale Mediese Hulpfonds (for English see: O.F.S. . . .)	1132	Kroonstad.....	9500	1180	20/8/68	—
Parmed Medical Aid Scheme/ . . . Parmed-Mediese Hulpskema	56287	Pinegowrie.....	2123	1441	29/3/74	—
P.C.I. Non-White Medical Aid Society.....	1790	Durban.....	4000	1433	1/3/73	—
Pearl Medical Aid Scheme.....	3329	Johannesburg.....	2000	1183	26/1/70	—
Pep Medical Aid Society.....	76	Kuilsrivier.....	7580	1414	11/8/71	—
Perskor- Mediese Fonds.....	845	Johannesburg.....	2000	1007	3/6/70	—
Philips Medical Aid Society.....	7706	Johannesburg.....	2000	1184	14/7/70	—
Pietermaritzburg Chamber of Industries Medical Aid Society	1790	Durban.....	4000	1185	5/11/70	—
Pilkington Group European Medical Aid Society	111	Springs.....	1560	1186	20/11/70	—
*Pinetown Textile Mills Medical Benefit Society	203	Pinetown.....	3600	2187	20/10/67	Algeheel behalwe / Total except 6 & 9.
(Plan vir Mediese Dienste) (for English see: Medical Services . . .)	(10314)	(Johannesburg).....	(2000)	(1143)	(9/8/71)	(—)
Plate Glass Group Medical Aid Society....	7462	Johannesburg.....	2000	1437	23/11/73	—
Plessey (S.A.) Medical Aid Scheme.....	56150	Pinegowrie.....	2123	1423	23/6/72	—
Port Elizabeth Bus Workers Medical Aid Scheme	1069	Port Elizabeth.....	6000	1426	28/6/72	—
Port Elizabeth Tramway Employees' Medical Aid Scheme/ . . . Trenwerknemers se Mediese Hulpskema	1069	Port Elizabeth.....	6000	1190	13/5/67	—
(Post Office Medical Aid Society) (POMAS) (vir Afrikaans kyk: Mediese Hulpvereniging van die Poskantoor)	(303)	(Germiston).....	(1400)	(1147)	(27/5/70)	(—)
Powerlines Medical Aid Society.....	1989	Johannesburg.....	2000	1191	5/12/68	—
Pretoria Municipal Sick Fund/ . . . Die Pretoriase Munisipale Siekefonds	3497	Pretoria.....	0001	1242	28/1/70	—
Profmed.....	6268	Johannesburg.....	2000	1194	8/10/69	—
Pro Sano- Mediese Hulpskema/ . . . Medical Aid Scheme	56234	Pinegowrie.....	2123	1454	17/5/76	—
Protea Assurance Staff Medical Aid Society	646	Kaapstad/Cape Town	8000	1195	22/10/70	—
Protea Medical Aid Society.....	6052	Roggebaai.....	8012	1196	19/11/69	—
Prudential Medical Aid Scheme.....	1097	Johannesburg.....	2000	1197	20/2/69	—
(Public Service Medical Aid Association) (PSMAA) (vir Afrikaans kyk: Mediese Hulpvereniging van Staatsamptenare)	(26004)	(Arcadia).....	(0007)	(1149)	(23/6/69)	(—)
*Putco Staff Sick Fund/ . . .se Personeelsiekefonds	9571	Johannesburg.....	2000	1198	2/6/70	Artikel/Section 19 & 19A.
Radue's Staff Medical Aid Scheme.....	112	King William's Town	5600	1199	12/6/70	—
Rand Water Board Sick Fund (vir Afrikaans kyk: Rand-Waterraad se . . .)	1127	Johannesburg.....	2000	1201	24/10/69	—
(Rand-Waterraad se Siekefonds) (for English see: Rand Water . . .)	(1127)	(Johannesburg).....	(2000)	(1201)	(24/10/69)	(—)
Reed Corporation Medical Aid Society....	90	Howard Place.....	7450	1277	29/12/72	—
Reef Medical Aid Society.....	—	39 The Avenue, Krugersdorp - Noord / North	1740	1202	26/11/69	—

Naam van skema Name of scheme	X-Privaatsak/X-Private Bag Posbus/ P.O. Box	290 Plek Place	Kode Code	Verwysingsno. Reference No.	Datum van registrasie Date of registration	Vrystelling van Regulasies/Wet Exemption from Regulations/Act
Rembrandt Group Medical Aid Scheme/ Rembrandt-groep se Mediese Hulpskema	56300	Pinegowrie.....	2123	1430	18/9/72	—
Roberts Construction Medical Aid Scheme	56234	Pinegowrie.....	2123	1435	23/5/73	—
*Robertson se Algemene Hulpgenootskap...	1	Robertson.....	6705	2412	11/6/71	Algeheel behalwe / Total except 6 & 9.
Rondalia se Mediese Skema.....	2290	Pretoria.....	0001	1205	24/11/70	—
Rooiberg Mine Medical Aid Society.....	Privaatsak/ Private Bag	Rooiberg.....	0500	1206	12/6/70	—
Runstaff Medical Scheme.....	31082	Braamfontein.....	2017	1427	30/6/72	—
SAAN Medical Aid Society.....	1138	Johannesburg.....	2000	1130	6/5/70	—
(S.A.B.C. Medical Aid Scheme) (vir Afrikaans kyk: S.A.U.K. se . . .)	(56140)	(Pinegowrie).....	(2123)	(1424)	(23/6/72)	(—)
Safmarine Medical Aid Fund.....	27	Kaapstad/Cape Town	8000	1211	10/2/69	—
S.A.K.A.V. Medical Aid Fund/ . . . se Mediese Hulpfonds	33	Paarl.....	7620	1213	8/12/69	—
S.A. Mutual Life Assurance Society Staff Medical Aid Fund	66	Kaapstad/Cape Town	8000	1214	13/2/69	—
Santam se Onderlinge Mediese Hulpvereniging	653	Kaapstad/Cape Town	8000	1232	29/8/69	—
SAPPI Medical Aid Society.....	10246	Johannesburg.....	2000	1233	14/8/69	—
Sasol Medical Aid Fund/ . . . se Mediese Hulpfonds	80	Sasolburg.....	9570	1234	17/2/71	—
S.A.U.K. se Mediese Hulpskema (for English see: S.A.B.C. . . .)	56140	Pinegowrie.....	2123	1424	23/6/72	—
*Selfmed Medical Scheme/Selfmed- Mediese Skema	45	Sanlamhof.....	7532	1446	19/11/74	Artikel/Section 17, 19A & 20B.
Shell Southern Africa Medical Aid Society	6440	Roggebaai.....	8012	1455	30/6/75	—
Shoe Corporation Medical Aid Fund.....	7462	Johannesburg.....	2000	1238	18/2/69	—
Sick Benefit Fund for the Diamond Cutting Industry of South Africa	8304	Johannesburg.....	2000	2239	4/5/72	—
Sick Benefit Society D.C.I.S.A.....	4955	Johannesburg.....	2000	2240	18/8/71	—
Siekebystandfonds van die Nasionale Pers Bpk. (Kantoorpersoneel)	2271	Kaapstad/Cape Town	8000	1241	7/3/72	—
*Siemed Benefit Scheme.....	4583	Johannesburg.....	2000	2445	19/9/74	Artikel / Section 11; 26; 20(1)q; 25G(1)(b); 25G(2).
*Siemens Medical Aid Scheme.....	7462	Johannesburg.....	2000	1243	6/11/68	Artikel /Section 11; 26; 20(1)q; 25G(1)(b); 25G(2).
South African Breweries Ltd Medical Aid Society	90	Howard Place.....	7450	1209	1/9/70	—
South African Eagle Medical Aid Society...	61489	Marshalltown.....	2107	1210	18/6/71	—
*South African Teachers' Association Medical Aid Society (SATA)	—	5 Ellerslieweg/Road, Wynberg	7800	1235	21/12/67	Algeheel behalwe / Total except 6 & 9.
South Atlantic Corporation Medical Aid Society	1628	Kaapstad/Cape Town	8000	1248	5/6/70	—
Southern Medical Aid Society.....	—	P/a—C/o Southern Life Vereniging/ Association, Great Westerford, Rondebosch	7700	1249	8/5/72	—
South West Africa Company Medical Aid Society	2	Grootfontein.....	9245	1458	18/7/75	—
Springs Industrial Benefit Society (SIBS)...	554	Springs.....	1560	1250	29/1/70	—
Stability Medical Aid Society.....	5703	Johannesburg.....	2000	1251	19/1/68	—
Statutêre Organisasies se Mediese Skema (SOMS) (for English see: Statutory . . .)	X-363	Pretoria.....	0001	1252	11/8/71	—
(Statutory Organisations Medical Scheme) (SOMS) (vir Afrikaans kyk: Statutêre . . .)	(X-363)	(Pretoria).....	(0001)	(1252)	(11/8/71)	(—)
S.T.C. Black Medical Aid Scheme.....	9153	Johannesburg.....	2000	1449	31/1/75	—
Steeledale Group Medical Aid Scheme.....	1210	Johannesburg.....	2000	1253	7/8/68	—
Stewarts & Lloyds Medical Aid Society.....	74	Vereeniging.....	1930	1254	25/5/70	—
Stuttafords Medical Aid Society.....	69	Kaapstad/Cape Town	8000	1256	28/11/69	—
Sydmore Medical Aid Society.....	8853	Johannesburg.....	2000	1257	29/1/70	—
Tafelberg Medical Aid Society.....	6052	Roggebaai.....	8012	1260	26/8/70	—
Theron, Humphrey & Fick se Siekefonds...	62	Worcester.....	6850	1265	29/2/72	—
TMSA Medical Aid Society.....	56280	Pinegowrie.....	2123	1268	24/8/70	—
Tongaat Medical Benefit Scheme.....	5	Maidstone.....	4380	2267	11/11/71	—
*Topmed Medical Scheme/Topmed- Mediese Skema	45	Sanlamhof.....	7532	1422	24/4/72	Artikel / Section 17, 19A & 20B.
Traduna Medical Aid Fund.....	31811	Braamfontein.....	2017	1269	9/2/70	—
Tramway Employees' Medical Benefit Fund	115	Kaapstad/Cape Town	8000	2270	30/6/72	—
*Trawlermen's Sick Benefit and Benevolent Fund	2416	Kaapstad/Cape Town	8000	2271	20/10/67	Algeheel behalwe / Total except 6 & 9.
Tsumeb Corporation Medical Aid Society..	1313	Tsumeb.....	9260	1272	12/1/68	—
Tweefontein Colliery Employees' Benefit Society	Pk./P.O.	Coalville.....	2235	2273	8/12/69	—
Uitenhage Passenger Transport Employees' Sick Fund	225	Port Elizabeth.....	6000	2274	1/4/70	—
U.L.A. Medical Aid Society.....	785	Germiston.....	1400	1275	2/5/69	—
*Union Flour Mills Sick Fund.....	1010	Durban.....	4000	1276	12/2/71	Algeheel behalwe / Total except 6 & 9.

Naam van skema Name of scheme	X-Privaatsak/X-Private Bag Posbus/ P.O. Box	Plek Place	Kode Code	Verwysingsno. Reference No.	Datum van registrasie Date of registration	Vrystelling van Regulasies/Wet Exemption from Regulations/Act
Union Platinum Mine Medical Benefit Society/. . . se Mediese Bystandsvereniging	13	Swartklip.....	0370	2278	14/4/70	—
(United Bouvereniging se Mediese Hulpfonds) (for English see: United Building. .)	(7735)	(Johannesburg).....	(2000)	(1280)	(26/3/70)	(—)
*United Building Society Medical Aid Fund (vir Afrikaans kyk: United Bouvereniging . . .)	7735	Johannesburg.....	2000	1280	26/3/70	Artikel / Section 20 (1)(c); Ook/Also Reg. 6.
University of the Witwatersrand, Johannesburg, Staff Medical Aid Fund	—	Jan Smutslaan/Avenue, Johannesburg	2001	1282	18/5/71	—
Usco Medical Aid Society/ . . . se Mediese Hulpvereniging	48	Vereeniging.....	1930	1283	5/8/68	—
Vanderbijlpark Medical Benefit Fund/ . . .se Mediese Bystandsfonds	105	Vanderbijlpark.....	1900	2285	10/6/71	—
Verref Medical Aid Society.....	117	Vereeniging.....	1930	1286	3/2/70	—
Vryheid Coronation Medical and Benefit Club	Pk./P.O.	Hlobane.....	3145	2288	1/5/72	—
Witbank Coalfields Benefit Society.....	26	Witbank.....	1035	2291	30/4/69	—
Woolworths Medical Aid Society.....	4642	Kaapstad/Cape Town	8000	1293	12/12/69	—
Xhosa Development Corporation Medical Aid Scheme (vir Afrikaans kyk: Xhosa-Ontwikkelingskorporasie . . .)	779	East London.....	5200	1436	24/5/73	—
(Xhosa-Ontwikkelingskorporasie se Mediese Hulpskema) (for English see: Xhosa . . .)	(779)	(Oos-Londen).....	(5200)	(1436)	(24/5/73)	(—)
(Yskor se Mediese Bystandsfonds) (for English see: Iscor . . .)	(2154)	(Pretoria).....	(0001)	(2295)	(11/2/71)	(—)

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Hierdie publikasie word uitgegee as 'n geïllustreerde reeks, baie na die aard van Curtis se "Botanical Magazine". Die doel van die werk is om die skoonheid en variasie van vorm van die flora van Afrika aan die leser bekend te stel, om belangstelling in die studie en kweek van die inheemse plante op te wek, en om plantkunde in die algemeen te bevorder.

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GOEWERMENTSKENNISGEWING

DEPARTEMENT VAN GESONDHEID

No. R. 313 24 Februarie 1978

WET OP MEDIESE SKEMAS, 1967

Kragtens artikel 30 (10) van die Wet op Mediese Skemas, 1967 (Wet 72 van 1967), soos gewysig, wysig ek, Schalk van der Merwe, Minister van Gesondheid, hierby die geldetarief in artikel 1 (1) van genoemde Wet bedoel, deur die geldetarief wat op 1 November 1974 in Regeringskennisgewing R. 2010 gepubliseer is, met ingang van 1 Maart 1978 te vervang deur die volgende relatiewe-eenheidswaarde-staat en geldetarief vir tandheelkundige dienste:

RELATIEWE-EENHEIDSWAARDE-STAAT EN GELD-TARIEF VIR TANDHEELKUNDIGE DIENSTE

I. ALGEMENE REËLS

001. 'n Konsultasie sluit 'n ondersoek in. Geen verdere konsultasiegeld mag gehef word alvorens die behandelingsplan wat uit hierdie aanvanklike konsultasie voortspruit, afgehandel is nie. Hierdie reël is van toepassing slegs op tarieflitems 8101 en 8103.

002. Met uitsondering van dié gevalle waar die bedrag vasgestel word "volgens ooreenkoms", moet die bedrag vir die lewering van 'n diens wat nie in die tarieflys vermeld word nie, gebaseer word op die bedrag vir 'n vergelykbare diens wat wel daarin vermeld word.

003. Aangesien 'n lid van 'n mediese skema, en dus ook die waarborg van tandheelkundige gelde, onderworpe kan wees aan maksimum jaarlikse voordele, behoort 'n praktisyn met die betrokke skema in verbinding te tree indien hy in twyfel verkeer oor die bedrag van die voordele wat sodanige lede ter beskikking staan.

004. In uitsonderlike gevalle waar die tariefgeld buite verhouding laag is in vergelyking met die dienste werklik deur 'n tandarts gelewer, kan sodanige hoër geld gehef word as waaroor die tandarts en die skema onderling ooreenkom.

005. Behalwe in uitsonderlike gevalle, is die dienste van 'n spesialis beskikbaar slegs op aanbeveling van die tandarts of geneesheer wat die pasiënt behandel.

006. Indien 'n lid van 'n skema of 'n afhanklike van sodanige lid 'n afspraak gemaak het en daar nie vroegtydige stappe gedoen word ter kansellering daarvan nie, kan slegs die lid self vir die konsultasiegeld aanspreeklik gehou word.

007. "Die normale spreekure" is tussen 07h00 en 18h00 op weeksdae, en tussen 07h00 en 13h00 op Saterdae.

008. (a) Elke tandarts moet maandeliks 'n rekening lewer vir enige diens gedurende die betrokke maand gelewer, ongeag of die behandeling voltooi is al dan nie. Indien 'n rekening wat aan 'n lid van 'n mediese skema gelewer is, na een maand nog nie betaal is nie, kan die tweede maandelikse rekening regstreeks aan die betrokke mediese skema gestuur word. Ten einde betaling daarvan te verseker, moet die rekening regstreeks per aangetekende pos aan die betrokke skema gestuur word.

GOVERNMENT NOTICE

DEPARTMENT OF HEALTH

No. R. 313 24 February 1978

MEDICAL SCHEMES ACT, 1967

In terms of section 30 (10) of the Medical Schemes Act, 1967 (Act 72 of 1967), as amended, I, Schalk van der Merwe, Minister of Health, hereby amend, with effect from 1 March 1978, the tariff of fees referred to in section 1 (1) of the said Act by substituting the following relative unit value schedule and tariff of fees for dental services for the tariff of fees published on 1 November 1974 in Government Notice R. 2010:

RELATIVE UNIT VALUE SCHEDULE AND TARIFF OF FEES FOR DENTAL SERVICES

I. GENERAL RULES

001. A consultation shall include an examination. No furthe consultation fee is chargeable until the treatment plan resulting from this initial consultation has been discharged. This rule applies only to tariff items 8101 and 8103.

002. Except in those cases where the fee is determined "by arrangement", the fee for the rendering of a service which is not listed in the tariff of fees shall be based on the fee in respect of a comparable service that is listed therein.

003. Since a member of a medical scheme, and hence also the guarantee of dental fees, may be subject to maximum annual benefits, a practitioner should contact the scheme concerned if he is in doubt as to the amount of the benefits available to such member.

004. In exceptional cases where the tariff fee is disproportionately low in relation to the actual services rendered by a dental practitioner, such higher fee as may be mutually agreed upon between the dental practitioner and the scheme may be charged.

005. Save in exceptional cases the services of a specialist shall be available only on the recommendation of the dental or medical practitioner attending the patient.

006. If a member of a scheme or a dependant of such member has made an appointment and timely steps were not taken to cancel such appointment, only the member himself may be held liable for the consultation fee.

007. "Normal consulting hours" are between 07h00 and 18h00 on weekdays and between 07h00 and 13h00 on Saturdays.

008. (a) Every dentist shall render a monthly account for any service rendered during the month concerned, irrespective of whether or not the treatment has been completed. If payment of an account rendered to a member of a medical scheme is not received after one month, the second monthly account may be sent direct to the medical scheme concerned. In order to ensure payment thereof, the account shall be sent by registered post direct to the scheme concerned.

MEDICAL AID (299)

Shot in the arm FM 3/3/78

The medical aid system in SA is evolving into a shambles. Doctors everywhere are complaining that the fees which medical aid societies pay are inadequate — so they opt out of the statutory medical aid system and charge higher fees.

Medical aid society members are complaining that they have to pay the excess in the higher fees — so many just keep the doctor waiting for his money, even though they have been given a portion of the bill by their society.

Meanwhile government fumbles around, circulating draft legislation that proposes making it illegal for doctors to pull out of medical aid schemes — so the Medical Association promptly advises all doctors to opt out quickly.

This is not the scenario envisaged when the Snyman Commission of Enquiry into medical aid did its work, leading to the Medical Schemes Act of 1967.

The mistake was to fail to allow for inflation and the periodic and substantial increase in doctors' fees that would be occasioned by inflation. This is understandable — in 1967 in SA inflation was a remote concept.

There is no doubt that the medical aid law has done, and is doing, an immense amount of good; it provides the country with a controlled system of standardised medical benefits in return for standardised monthly payments; it provides for the transferability and continuity of these benefits into old age; and it prevents Parity-type disasters which leave people with subscriptions paid but benefits disappeared.

But the medical aid system is not doing today what it really should be doing — providing full cover for an eventuality, namely the doctor's fee, whatever it may be, in return for an actuarily calculated premium. In other words real medical *insurance*.

The need for such an insurance service is obvious. That's where Multicare comes in. This is a medical insurance plan offered by SA Underwriting Services (Pty), effectively underwritten by no less than Lloyds and right now being marketed in SA by Multimerit, an up-and-coming package insurance broking firm.

Multimerit MD Dave Kok says that in the course of selling ordinary cover his staff was finding a demand for full medical cover too. So he was looking around. And SA Underwriting director Noeline Gullan says her firm had been running a pilot medical insurance for nearly three years (called Compcare) and was ready to launch a wide sales campaign. So she was looking around. That's how Multimerit came to be selling SA Underwriting's scheme under the name Multicare.

Multicare claims its premiums are about the same order as the medical aid subscriptions, yet its benefits are wider and doctors fees are paid in full.

So why doesn't it come under the medical aid law? Because of a loophole. The law refers to "members" of schemes, Multicare does not have "members" but "policyholders."

It's a fine point but enough, it appears, to deter the Registrar of Medical Schemes from acting against Compcare and now Multicare.

Perhaps not for long. The Medical Schemes Amendment Bill which will probably be tabled this Session will change, if it is passed, the definition of "medical scheme" to mean a scheme obtaining its funds from membership fees, premiums or in any other way and providing medical benefits.

A case can be made for opposing that amendment. Why not allow free enterprise to offer a service at the same time as the statutory medical aids?

But a case can also be made for supporting it — provided the medical schemes laws are overhauled to clear up the mess.

SUNDAY TIMES, Business Times, March 12, 1978.

299

Medic aid law may halt new schemes

THE BILL presently before Parliament to amend the Medical Schemes Act will either outlaw the mushrooming number of insurance schemes offering full cover for medical expenses, or require them to cut their benefits and fall into line with the Act.

By NIGEL BRUCE

The expanded definitions of medical aid schemes and members will have this effect.

It appears, therefore, that unless some unexpected loophole is found, medical insurance schemes such as Compcare and Multicare, and many others that have come to the market recently or are planned, will have to revise radically their extensive and relatively cheap benefits.

It is this same Bill which has a controversial amendment to prevent doctors from opting out of medical aid tariffs and charging patients higher fees — an amendment which doctors believe the Minister of Health has indicated he might be prepared to modify.

However, insurance companies which provide these 100 per cent-benefit medical insurance schemes — and the brokers who sell them — believe their lobbying might also persuade the Minister to modify the Bill to allow the schemes to continue.

One reason is the rush there has been from the public and employers to buy this extensive cover; another that they plan to sell the cover to blacks; a third that they claim to have the support of organised medicine.

Undoubtedly there are weighty arguments both for and against allowing this new cover to be sold in its present form, and formidable entrenched interests are ranged on either side.

On the one hand are the powerful companies that administer non-profit making medical aid schemes in terms of the Act, and fear that additional competition will erode fees, which in some cases up till now have been particularly enriching.

On the other hand is organised medicine — doctors and hospitals — who believe their remunerations are being held artificially low by the provisions of the Medical Schemes Act.

For this reason some have opted out of the protective cover of the Act and charge fees above the stipulated tariffs — but related to a sort of usury limit agreed by their professional body.

A crucial influence is also that of government, which for social reasons is concerned that medical costs generally be held in check; that medical benefits be financed securely and equitably; and that the aged do not find themselves with limited cover — or more expensive cover — as their health deteriorates.

The authorities fear that if medical expenses are increasingly met in full by insurance companies, an important moderating influence on rising medical costs will be progressively eroded.

They have little confidence in the restraining influence of the "usury" ceiling agreed by the medical profession. Partly because it is set by the doctors themselves, and partly because it is easily circumvented by the unscrupulous practitioner.

For instance, a doctor has only to decide a condition being treated has "complications" and he virtually has carte blanche so far as fees are concerned.

These fears are certainly not without reason. It is not unknown for the commercial practices of organised medicine to fall short of the high ethical standards required within the various medical disciplines.

Moreover, some of the medical professions' arguments for higher fees have been shown to be of doubtful validity. For instance, doctors who have opted out of the official tariffs argue that they have done so to meet their own rising costs.

Yet University of the Witwatersrand economists have found that the average earnings of doctors, which outstrip those of all other professions, are little affected by their opting out.

This suggests that those who do so are more motivated by the possibility of working shorter hours for the same income. That may be justified on other grounds, but it has precious little to do with rising costs.

Furthermore, the findings of a study by the Organisation of Economic Co-operation and Development into medical spending in 12 countries up to 1974 suggests that the more spent on medicine doesn't necessarily lead to a rising standard of health. Instead, it does little other than increase the relative incomes of doctors and nurses.

In this regard it is worthwhile to recall that hypochondria is less a function of cheap medicine than of psychological disturbance.

Doubt can also be cast on what doctors claim to be their high incidence of bad debts. The Medical Schemes Act in effect guarantees the amounts owing to doctors who abide by the fee structure, though perhaps some are not aware of it.

Moreover, doctors who opt out of the tariff agreement obviously find that a higher income outstrips a deteriorating payments experience.

If bad debts were a real problem, doctors would years ago have encouraged the use of credit cards, because of the bank guarantee of payment they carry.

Nor can it be argued convincingly that higher doctors' incomes will encourage more entrants into the profession, ultimately to the public's benefit. For the medical profession, through the control it exercises over examination standards, is in a position to influence the numbers entering its ranks very effectively.

That the profession has not done this more extensively to its own advantage in the past is not to argue that it cannot happen. Rather it is a tribute to the many noble-minded doctors who put medicine above commerce.

Government, which is inherently suspicious of private enterprise, fears, too, that if medical cover is left to the free market, competition could create financial instability and lead to some schemes becoming insolvent. Rising premiums as the aged become less healthy and need cover most may occur, and some members may find, in consequence, that ultimately medical cover is beyond their means. If they are taken back into schemes they abandoned, they become an unfair burden.

Other amendments to the Bill will enable health officials to prevent medical aid administrations milking from medical aid schemes an administration fee, the size of which could approach avarice. The amendments will give the Registrar of Medical Aids wide searching powers into the affairs of these companies.

Be that as it may. The fact is that despite the Medical Schemes Act, medical costs have risen to the extent that medical f... members are finding that bills from opted-out doctors are met only to the extent of between 45 and 55 per cent by their schemes.

While this continues to occur, public preference for medical insurance plans that cover medical bills in full — whatever they might be, and whatever the eventual risks — will undoubtedly gain in strength.

This preference will find succour, too, in the claims (as yet unproven) of medical insurers that their superior efficiencies and ability to negotiate substantial discounts will, through the forces of supply and demand, keep rising medical fees in check.

There is no easy or complete solution to the vexing question of medical costs. All that can be said with certainty is that precipitate statutory action might serve no other purpose than to complicate the matter further. It is possible that the new medical insurance schemes do have an important role to play, maybe by providing supplementary benefits.

Clear thinking and a great deal of give and take is going to be needed, not least from organised medicine, before anything like a solution is reached. And organised medicine should never forget that it has most to lose if government were to resort to nationalisation.

Despite official protestations to the contrary, in a country such as ours where a high proportion of the means of production is already publicly owned, it would be naive for doctors to shrug off the possibility of growing support for nationalised medicine.

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21/3/78

RAND DAILY MAIL, T

Black workers on Reef get medical aid fund

A NEW medical aid fund, conceived by a group of black doctors on the Reef and aimed exclusively at black workers, has been established in Johannesburg.

The Sizwe Medical Fund has raised the R50 000 guarantee laid down by the Registrar of Medical Schemes and has so far signed up five employers with a total of 1 700 members.

Its projected membership after an initial 12 months is 50 000 at an average monthly contribution of R5,75 per member for his family.

The chairman of the Sizwe (the word means "nation" in Nguni languages) fund is prominent Johannesburg businessman, Mr Sam Motsuenyane.

"It is destined to become a viable business proposition," he told a Press conference in Johannesburg yesterday. "Contributions are small enough to allow a large number of people to participate."

The success of the scheme depends largely on the attitude of major employers of black labour. According to fund officials, a preliminary survey proved favourable. There is wide interest in the benefits available.

The fund is administered by Medscheme Administrators (Pty) Ltd, whose managing director is Mr Keith Hollis.

Mr Hollis said the average contribution of R5,75 less than a quarter of the average membership fees for whites — was made possible because there were less private facilities for blacks. — Sapa.

17. Is daar op die oomblik 'n tekort aan skeerders?

18. Dink u so 'n tekort sal in die toekoms ontwikkel? Indien wel, waarom?

Hoe gaan u hierdie tekort teenwerk?

(299)

Medical aid fund launched for Blacks

NM 21/3/78

JOHANNESBURG — A new medical aid fund, conceived by a group of Black doctors on the Reef and aimed exclusively at Black workers, has been established in Johannesburg.

The Sizwe Medical Fund has raised the R50 000 guarantee laid down by the Registrar of Medical Schemes and has so far signed up five employers with a total 1 700 members. Its projected membership after an initial 12 months is 50 000 at an average monthly contribution of R5,75 per member for his family.

The chairman of the Sizwe (the word means 'nation' in the Nguni language) is prominent Johannesburg businessman Mr. Sam Motsuenyane.

Attitude

"It is destined to become a viable business proposition," he told a Press conference here yesterday. "The contributions are small enough to allow a large number of people to participate in the scheme."

The success of the scheme depends largely on the attitude of major employers of Black labour. According to fund officials, a preliminary survey proved favourable and there is a wide interest in the benefits available.

Among the doctors on the board of directors are Dr. Ndumiso Mzamane of Katlehong, Dr. Harrison Motlana of Dube Village, Dr. Phaki Mokhesi of Sharpeville and Dr. Abner Tlakula of Tembisa. The fund is administered by Medscheme Administrators (Pty.) Ltd. whose managing director is Mr. Keith Hollis.

Contribution

Mr. Hollis said the average contribution of R5,75 — less than a quarter of the average membership fees for Whites — was made possible because there were less private facilities for Blacks and lower income groups made less use of sophisticated treatment procedures. Blacks were heavily dependent on State and provincial medical centres and were less inclined to visit private practitioners. — (Sapa.)

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Medical aid fund for blacks

21/3/78

JOHANNESBURG — A new medical aid fund, conceived by a group of black doctors on the Reef and aimed exclusively at black workers, has been established here.

The Sizwe Medical Fund has raised the R50 000 guarantee laid down by the Registrar of Medical Schemes and has signed up five employers with a total 1 700 members. Its projected membership after an initial 12 months is 50 000 at an average monthly contribution of R5,75 a member for his family.

The chairman of the Sizwe (the word means nation in the 'nguni language) is prominent Johannesburg businessman, Mr Sam Motsuenyane.

"It is destined to become a viable business proposition," he said yesterday. "The contributions are small enough to allow a large number of people to participate in the scheme."

Mr Hollis said the average contribution of R5,75 — less than a quarter of the average membership fees for whites — was made possible because there were less private facilities for blacks and lower income groups made less use of sophisticated treatment procedures. Blacks were heavily dependent on State and provincial medical centres, and were less inclined to visit private practitioners. — SAPA.

MEDICAL AID FM 24/3/78

Black initiative

(299)

The dream of Ntatho Motlana and several other prominent blacks came true in Johannesburg this week as the new Sizwe ("The Nation") Medical Fund for black workers was launched.

According to the fund's chairman, Sam Motsuenyane, the long-term goal is the education of blacks in preventive medical care, family security, and greater reliance on medical diagnosis and treatment. He adds: "The black man's problem in this country is that he always starts many ventures without the know-how. But we are entering this venture with hope."

Apart from Motlana, the other doctors who are directors of the scheme are Ndumiso Mzamane, Phaki Mokhesi, and Abner Tlakula. Advertising executive Madala Mphahlele is also one of the directors. For the first seven years the scheme will be administered by Medscheme Administrators Ltd (which currently runs 17 different schemes with a membership of 49 000). Beau Loots and Keith Hollis of Medscheme are the only whites on the Sizwe board.

Appealing to employers this week, Motsuenyane said: "The benefits from this scheme will not only flow to workers but to the black community. What employers should do is to see to the health of their black employees. We appeal to industry to support us."

The Sizwe scheme (which has been registered with the Registrar of Medical Schemes) already has five employers with 17 000 black workers on its books. And it hopes to have 50 000 members by the end of its first year, bringing in a total membership of 250 000 assuming each member has four dependants.

On contributions of R5,27 per month from each member, the scheme hopes to bring in monthly contributions of about R264 000.

The annual benefit for a single member is R300, for a member with one dependant R600, and for a member with more than one dependant, R750.

Dental benefits can run up to R80 per single member and R150 for members with dependants. The scheme will also cover 100% of the cost of basic accommodation in a hospital, 100% of theatre fees, and 100% of the cost of confinements.

As far as prescribed medicines are concerned, a single member is entitled to R50 a year, and a member with dependants up to R125.

The scheme is a contributory one. For example, a worker earning up to R34,62c a week (without dependants) will contribute 46 cents to the fund, while a member with one dependant will contribute 92c. A worker earning R92,32c a week will pay R1,15c if he has no dependants. A contributor with a monthly income of R401 and one dependant will contribute R10 in subscriptions.

Employers will be expected to contribute at least half the total fee per member.

● Motlana was unable to be present at the launching of the scheme. He has just entered his sixth month in detention without trial.

Financial Mail March 24 1978

Werkerbesonderhede (5)

16. Inkomste van gesin uit ander bronne

(sluit in lone van ander werkers op die plaas wat dieselfde afhanklikes het)

(a) Bron:

(b) Totale jaarlikse bedrag:

17. Aan kontrakarbeiders alleenlik:

(a) Oppervlakte van grond/vir verbouing (as werker sulke grond besit)

(b) Deel wat gewoonlik beplant word:

(c) Vee (as werker vee besit): Aantal bokke

(d) Beraamde deel van jaar waarvoor w kon lewe van die oes wat deur gesin ande bedrag terugge

(e)

Sick payouts

Bogus claims hit genuine

Labour Reporter

Genuine claimants of sick leave are suffering hardship as a result of delays in payment arising from a medical certificate packet on the Reef.

Hospital authorities have been asked to check every sick leave certificate after the discovery that every third certificate issued to clothing workers during the past three years was forged.

"This should be a simple process, but it causes unacceptable delays," said Mr Jimmy Thomas, secretary of the Industrial Council for the Transvaal Clothing Industry.

Out of 25 certificates submitted to Baragwanath Hospital, 15 had been returned with question marks 10 days later.

"I can't pay out on a question mark," said Mr Thomas. "And I don't believe that the hospital cannot certify a certificate as genuine or forged after 10 days."

But Mr Thomas disclosed that the racket had turned out much bigger than originally expected, with 400 out of the 1 200 claims for sick leave granted during the past three years shown to be fraudulent.

"This accounts for payments worth R25 000 — some of which went to people who were working during the periods for which they claimed sick leave," he said.

Most other sick funds on the Reef were bound to have been defrauded as well, since the racket was well known among workers, Mr Thomas said.

The medical superintendent of Baragwanath Hospital, Dr P J Beukes, said: "We've got no way of checking certificates from outside authorities."

He appealed to sick funds to accept only certificates issued by the hospital itself.

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28/3/78

Army pension move pledged

24/4/78

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Mercury Correspondent

PORT ELIZABETH — The South African Legion intends to petition members of Parliament and senators if high-level talks on improving war disablement pensions fail.

This was decided at the weekend in Port Elizabeth where the chairman of the Legion's pension committee, Mr. T. Mills, made a scathing attack on the Deputy Minister of Social Welfare and Pensions, Mr. T. N. H. Jansen, for failing to reply to a memorandum sent to him in December.

In an interview yesterday Mr. Mills said that the Legion was "terribly disappointed at the cavalier, or should I say callous, authoritarian treatment" of its urgent requests for better pensions.

He told the Legion's annual congress that nothing more than an acknowledgement of the memorandum was received from the Department of Social Welfare and Pensions.

It had been hoped that provision for better war disablement pensions would be made in this year's budget in response to the memorandum, but it was not.

A suggestion that MPs and senators be written to was held over pending the outsome of high level talks on June 30 between the Department of Defence and the new Minister of Social Welfare and Pensions, Mr. F. de Klerk.

Sick swindle

Star 7/5/78
(184)
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Thousands lost on fake medical forms

A WIDESPREAD racket involving fake medical certificates which cost sick funds many thousands of rands has been uncovered.

At least two people have already been prosecuted and given jail sentences. One, a provincial hospital worker, was sentenced to six months' imprisonment without the option of a fine for issuing a fake medical certificate. The worker who presented the certificate was sentenced to three months' imprisonment.

By Dick Usher

The prosecution arose when a worker in the tobacco industry presented a medical certificate covering a period he had been away from work.

Mr Hendrik van Reenen, secretary of the Industrial Council for the industry, said: "Unfortunately I knew the man was in jail at the time. When he was confronted with this he admitted he had bought the certificate."

An industrial council is a joint union/employer body through which wage agreements and agreements on other conditions are negotiated in terms of the Industrial Conciliation Act. Many councils also run benefit funds — including sick benefit funds — for workers in a particular industry.

The certificates, printed forms, are invalid unless issued by a doctor.

The racket, however, appears to be most widespread in the clothing industry.

Mr James Thomas, secretary of the Industrial Council for the Clothing Industry, said it had cost the council's sick fund at least R25 000 in benefits paid out on false medical certificates.

"That is what we have uncovered, but there may be more."

"Because the certificates were issued by provincial hospital employees we suspect that many other sick funds and employers have paid out benefits on the basis of false documents," he said.

Mr van Reenen said it was quite possible the racket had stopped following the prosecution.

"I told all my members legal action would be taken against anyone else who produced a fake certificate and I'm sure we will have no more trouble."

Sellers were apparently charging between R1,00 and R40,00 for the certificates — depending on the period they covered.

A short period of up to a week cost up to R3,00 while a certificate for 17 weeks — the maximum period of benefits for the clothing industry's medical benfit society — would cost about R40,00.

After production of a certificate the workers are paid sick benefits from the fund for the appropriate period.

Mr Thomas said any employer or sick fund could have paid out sick benefits on the basis of the fake

"It is very widespread as far as we can see. A large number of medical certificates on which we have paid out benefits in recent years have proved to be false.

"They were not issued by doctors but by staff, or relatives of staff, at provincial hospitals with access to the certificates."

The Garment Workers' Union has also discovered a racket involving bogus doctors who issue medical certificates.

Although not widespread an investigation showed a medical certificate issued to a woman by a "doctor" who had been treating her was valueless.

The address given by the man was occupied by a Soweto fish and chips shop. A doctor with the same name was no longer practising in Soweto but had been in Pretoria for four years.

A second doctor whose name was on the bottle of pills a worker had been [illegible] had been struck off the roll in 1970.

Paraplegics start 'cottage' industries



Paraplegic Mr Morgan Njolo works one of eight knitting machines donated by the public. The donations have made possible a knitting industry for unemployed paraplegics. Next to him is Mr Daniel Sokhulu.

By Karen Fredman

Self-help has enabled seven paraplegics in Soweto to supplement their meagre disability grants of R20 a month — and may eventually provide jobs for 400 paraplegics.

These seven men recently formed the Paraplegic Cottage Industries Committee. Their first project has been to start a knitting industry to provide jerseys for Soweto schools.

The project became possible when the public donated eight knitting machines after an appeal by the Cripple Care Association of the Transvaal, who then arranged a venue for the industry at the Sheltered Employment Centre in Orlando.

On June 7 the committee started its first contract of 109 jerseys for Putsekgani School in Ja-

JOBS, the Johannesburg Organisation to Boost Self-help for the unemployed, to pay the salary of a supervisor for three months.

JOBS has also been asked to train the supervisor in management techniques and to provide alternative markets for the knitters during the school holidays and in summer.

In addition JOBS has been asked to lend the group up to R200 until the money for jerseys already produced and not yet sold comes in.

The group also needs more knitting machines to expand its industry.

The paraplegics also plan to provide lessons for prospective hairdressers and are thinking of starting a patchwork industry. But they have appealed for other ideas to provide work for the 400 unemployed paraplegics known to live in Soweto.

The Minister said archi-
tects at the Department of
Community Development
were investigating the

20/7/78

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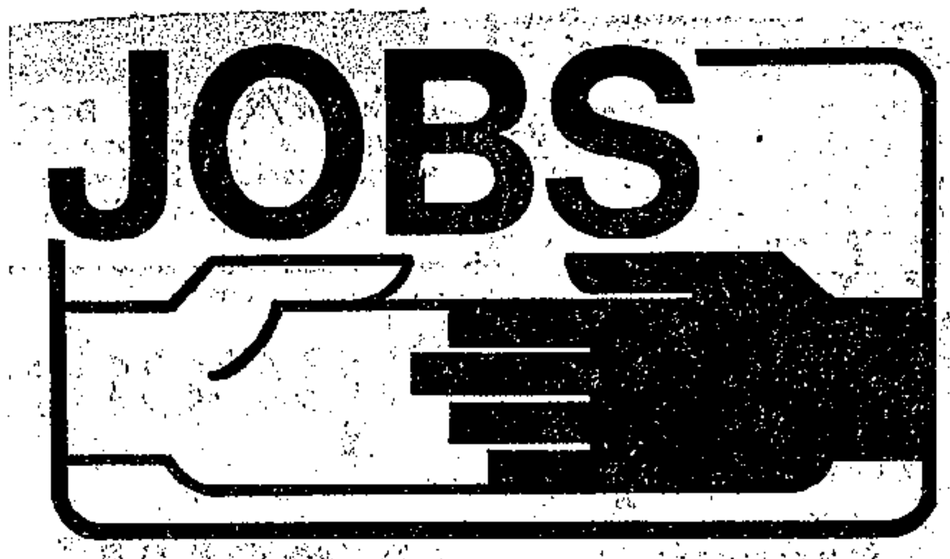

Workshop for handicapped

A self-help workshop where physically handicapped people can manufacture aids and devices for other handicapped is the dream of a team of occupational therapists at the Johannesburg Non-European Hospital.

Much of the equipment for the handicapped is being imported while it could be produced locally by handicapped people who battle to find work, said Mrs B G Coville, one of the therapists.

"We try to rehabilitate patients so that they will be able to resume normal working lives," she said.

"Many of those we discharge are willing and able to work but simply do not get jobs. It's hard enough for able-bodied people to find work these days."

With this in mind, Mrs Coville and her colleagues. Miss Denise Swain and Miss Corene Marcus, have set up an experimental workshop for three former patients.

But eventually they would like to set up a proper workshop outside the hospital to employ a large number of unemployed handicapped people.

They have contacted JOBS for advice on how this should be done.

The items they want to produce include lap boards which fit over wheelchairs, shoe horns with extended handles, dressing sticks and raised toilet seats.

They have moulds for the toilet seats but require firbeglass. Anybody who is able to help can do so through JOBS at the address given below.

★ ★ ★

Mrs Verby, a florist who closed her shop, offered JOBS two stools, a workbench and a partition.

★ ★ ★

Mrs Holloway has given JOBS two bags of scrap material.

★ ★ ★

JOBS urgently requires a vehicle, preferably a light truck or delivery van.

The co-ordinator of JOBS, Mr Iain McNeill, has been using his private car. But he is about to get an assistant who will be without transport.

His job will require frequent visits to self-help schemes and the conveyance of equipment and materials which have been donated to JOBS for self-help.

★ ★ ★

Donations, offers of assistance and requests for assistance should be sent to JOBS, PO Box 87459, Houghton, Johannesburg 2041 (Tel 41-5420 mornings only).

MEDICAL AID FM 21/7/78

None too healthy

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Medical Aid funds have had the biggest hammering of their lives, says the manager of one of SA's largest medical aid societies. The problems are multiple and in some cases well defined, but solutions are elusive.

Moreover, the medical profession is a powerful lobby, which is fast developing a shrill bark and toothy bite. Part of the problem undoubtedly lies in the rank ineffectualness of the Medical Aid movement in drawing attention to inconsistencies. To put it plainly, funds are loathe to incur the wrath of the profession. No fund manager canvassed by the *FM* was willing to be quoted, although most were vociferous privately.

During the past year a handful of funds managed to break even and some even came out with small surpluses, but the vast majority experienced wholesale "overutilisation" — the industry's term for an excess of expenditure over revenue. This ranged from only around R40 000 loss on a R10m income by one fund to R3m on subscription income of only [illegible] another.

Fund managers blame overutilisation on the medical profession as much as on members. As one regional manager of a fund, Ralph Stocker, puts it: "There's far too much overprescribing of exotic and expensive preparations instead of generic formulations." Others attribute overutilisation partly to a sharply higher incidence of unnecessary tests (particularly pathology tests) and to the ever rising expense of such tests in turn a cost function of more sophisticated equipment.

But the funds are also partly to blame, some managers admit. As one: "We're providing an apparently never-ending supply of money and no one is monitoring expenditure properly." He has a point. Medical insurance tends to discourage consumerism or comparative shopping by members and consequently costs are not carefully monitored.

Furthermore, medical aids claim they have been caught short by tariff increases and were not given sufficient notice to plan ahead. The imposition of GST on all medicines, drugs, hospital and dispensary fees, plus the possibility of a further 25% increase in prices of medicines within the next six months, will add further fuel to the fire.

All of which means funds must be due for hefty subscription increases. But this raises another question: are people prepared to finance continually rising health costs? At the moment most subscriptions are split equally between employer and employee. The employer's share constitutes a tax write-off. So employers wouldn't be overburdened by increases.

But this doesn't get to the root of the problem, nor is it a long-term solution.

Stocker sees as the only solution a system where the member pays the first R20 of any claim (which would entail a revision of the Act). Funds could then operate entirely on the 50% of the subscription contributed by the employer, he claims.

But other fund managers are sceptical. Such a scheme, they argue, could defeat the whole object of medical aid, which is to make funds available when needed and encourage a patient to seek treatment. Non payment of minor claims could lead people to delay being treated, which might prove harmful to public health (to say nothing of the patient) over the long run.

One manager suggests that SA should follow the example set in the US, which has been developing computerised profiles of doctors and dentists. These include such information as a code of claims, the average cost per claim according to code (which according to SA studies is known to vary widely from one practitioner to another) and so on. In this way funds should be able to keep a check on doctors' fees and on the actual service provided. "At the moment," says the source, "it's a case of 'hands off doctors'. What we need is a partnership deal between the funds, as the financiers, and the profession."

All sources agree that it's high time effective control was established over the pricing of pharmaceuticals and certain drugs. Price increases in these goods have far outstripped the consumer price index — even for drugs that have been on the market a long time with no research costs involved.

TURNING TABLES

In the table of building society results last week, the name of the 10th largest society should have read Provincial, not Prudential. The expense ratio given for Provincial included depreciation, which is shown separately by some societies. If this is excluded, Provincial's expense ratio would have been 1,64% (1977: 1,62%).

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REPUBLIC OF SOUTH AFRICA

GOVERNMENT GAZETTE

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GENERAL NOTICE

NOTICE 444 OF 1978

DEPARTMENT OF HEALTH

REGISTERED MEDICAL SCHEMES

The Registrar of Medical Schemes hereby notifies, in accordance with section 16A of the Medical Schemes Act, 1967 (Act 72 of 1967), as amended, that the undermentioned medical schemes have been registered.

Those marked with an asterisk (*) have been exempted in terms of section 3 as indicated.

This list replaces the list published in *Government Gazette* 5884 of 17 February 1978.

N.B.—Do not *count* names in brackets. Their *translated* form appears *elsewhere* in the list.

ALGEMENE KENNISGEWING

KENNISGEWING 444 VAN 1978

DEPARTEMENT VAN GESONDHEID

GEREGISTREERDE MEDIESE SKEMAS

Die Registrateur van Mediese Skemas maak ooreenkomstig artikel 16A van die Wet op Mediese Skemas, 1967 (Wet 72 van 1967), soos gewysig, bekend dat ondergemelde mediese skemas geregistreer is.

Skemas vrygestel kragtens artikel 3 is met 'n sterretjie (*) aangedui, met vermelding van die spesifieke vrystelling.

Hierdie lys vervang die lys wat in *Staatskoerant* 5884 van 17 Februarie 1978 gepubliseer is.

N.B.—Moenie name tussen hakies *tel* nie. Hulle *vertaalde* vorm verskyn *elders* in die lys.

Name of scheme Naam van skema	X-Private Bag X-Privaatsak P.O. Box Posbus	Place Plek	Code Kode	Reference No. Verwysing No.	Date of registration Datum van registrasie	Exemption from Regulations/Act Vrystelling van Regulasies/Wet
A						
A.A. Mutual Medical Aid Society	9976	Johannesburg	2000	1001	11/8/71	—
Aberdare African Medical Aid Society	491	Port Elizabeth	6000	1002	20/11/70	—
Adcock Ingram Medical Scheme	9956	Johannesburg	2000	1003	12/2/69	—
AECI Medical Aid Society	716	Johannesburg	2000	1005	11/2/71	—
African Cables Medical Benefit Fund	172	Vereeniging	1930	1004	9/6/70	—
A.G.S. Vaal Suid Vereniging Hospitaal	197	Lyndhurst	2106	1442	1/8/75	—
Alabama Medical Plan	10511	Johannesburg	2000	1480	13/10/77	—
Alex Aircraft Carrier Medical Aid Society	6195	Marshalltown	2107	1009	24/11/70	—
*Amalgamated Consolidated Industries Sick Benefit Society	9178	Johannesburg	2000	2010	3/11/67	Algeheel behalwe/ Total except 6 & 9.
Amasoal Benefit Society	Mancorp Mine Myn	Postmasburg	8420	2011	27/11/70	—
Anglo Alpha Group Medical Aid Society	7401	Johannesburg	2000	1487	28/3/78	—
Anglo American Corporation Medical Aid Society	9261	Johannesburg	2000	1012	16/10/68	—
*Arandis Textile Mills Sick Benefit Society	9478	Johannesburg	2000	2013	15/12/67	Algeheel behalwe/ Total except 6 & 9.
Architect Quantity Surveyors' Medical Aid Fund	56139	Pinegowrie	2123	1015	17/8/70	—
Argus Medical Aid Society	1014	Johannesburg	2000	1016	28/11/68	—
Argus Non-White Medical Aid Society	56	Cape Town/Kaapstad	8000	1262	24/8/70	—
Arthur Young Medical Aid Society	4807	Cape Town/Kaapstad	8000	1258	23/2/71	—
Associated Employers Medical Aid Society	7988	Johannesburg	2000	1018	22/1/70	—
Associated Engineering Medical Aid Scheme / Assoc Mediese Hulpskema	56235	Pinegowrie	2123	1428	8/10/72	—

Name of scheme Naam van skema	P. Private Bag X-Privaatsak P.O. Box Posbus	Place Plek	Code Kode	Reference No. Ver-wysing No.	Date of registration Datum van registrasie	Exemption from Regulations/Act Vrystelling van Regulasies/Wet
B						
B.A.B. Medical Aid Fund	56622	Denver	2027	1020	15/10/71	—
Bankmed	1242	Cape Town/Kaapstad	8000	1279	29/6/72	—
*Bay Passenger Transport Employees Medical Benefit Scheme	1069	Port Elizabeth	6000	2425	28/6/72	Section/Artikel 20 (c).
B.B.K. Medical Aid Scheme / ...se Mediese Hulpskema	56280	Pinegowrie	2123	1432	29/1/73	—
*Begrafnisfonds "Onder ons" (for English see: Funeral ...)	3522	Johannesburg	2000	1151	21/12/67	Total except/Algeheel behalwe 6 & 9.
Beland Medical Aid Society	7162	Johannesburg	2000	1021	1/8/69	—
*Belmed- Mediese Skema	45	Sanlamhof	7532	1473	14/2/77	Section/Artikel 17, 19A & 20B.
Black Mountain Medical Aid Scheme	X-18	Springbok	8240	1490	24/4/78	—
Bloemfontein Municipal Employees' Medical Aid Society (vir Afrikaans kyk: Mediese Hulpvereniging van die Bloemfonteinse ...)	1765	Bloemfontein	9300	1022	30/9/69	—
Blue Circle Medical Aid Society	56038	Pinegowrie	2123	1264	21/7/69	—
Boart Medical Aid Society	9761	Johannesburg	2000	1024	14/10/68	—
*Bonmed- Mediese Skema	45	Sanlamhof	7532	1474	14/2/77	Section / Artikel 17, 19A & 20B.
(Bouverenigings se Gesamentlike Mediese Hulpfonds) (for English see: Building ...)	(61740)	(Marshalltown)	(2107)	(1030)	(1/12/70)	(—)
*BP Southern Africa Medical Aid Society	6006	Roggebaai	8012	1237	20/2/70	Section/Artikel 19A.
*Braitex Medical Benefit Society	5101	Johannesburg	2000	2451	23/4/75	Section/Artikel 20 (c).
Breyten Coalfields Medical Aid Society	141	Breyten	2330	1028	2/12/68	—
Building Societies Joint Medical Aid Fund (vir Afrikaans kyk: Bouverenigings ...)	61740	Marshalltown	2107	1030	1/12/70	—
Bus Bodies Sick Benefit Society	4008	Port Elizabeth	6000	1032	4/3/70	—
C						
Cape Asbestos Medical Aid Society	8644	Johannesburg	2000	1033	31/7/69	—
Cape Medical Plan (vir Afrikaans kyk: Kaapse ...)	6183	Roggebaai	8012	1034	11/11/71	—
Cape Portland Medical Aid Society	1067	Cape Town/Kaapstad	8000	1035	24/2/69	—
*Cape Steel Sick Fund	2121	Cape Town/Kaapstad	8000	2036	5/1/68	Total except/Algeheel behalwe 6 & 9.
*Cape Town Municipal Workers Association Medical Benefit Fund	49	Athlone	7760	2038	11/11/68	Total except/Algeheel behalwe 6 & 9.
Capex Medical Aid Society	716	Johannesburg	2000	1471	8/2/77	—
C.D.A. Medical Aid Fund	671	East London/Oos-Londen	5200	1039	5/12/69	—
Chamber of Mines Medical Aid Society	809	Johannesburg	2000	1042	26/2/71	—
Chartered Accountants (S.A.) Medical Aid Fund	857	Johannesburg	2000	1043	6/8/71	—
City Council Employees' A.T.C. Benefit Society	31555	Braamfontein	2017	2046	12/11/71	—
C.N.A. Investments Medical Aid Fund	1033	Johannesburg	2000	1040	17/2/70	—
Commercial and Industrial Medical Aid Society (CIMAS)	958	Johannesburg	2000	1048	2/6/69	—
*Commercial Union Medical Aid Scheme	222	Johannesburg	2000	1050	11/6/70	Section/Artikel 17 & 19A.
Compcare Medical Scheme	9605	Johannesburg	2000	1491	1/6/78	—
Consolidated Employers' Medical Aid Society	716	Johannesburg	2000	1049	8/9/71	—
*Consolidated Frame Cotton Corporation (Pty) Ltd (Ladysmith Mills) Medical Benefit Society	317	Ladysmith	3370	2051	15/12/67	Total except/Algeheel behalwe 6 & 9.
Consolidated Glass Works Medical Aid and Sick Benefit Society	562	Germiston	1400	1052	13/8/71	—
*Consolidated Textile Mills Medical Benefit Society (Durban)	12017	Jacobs	4026	2055	15/12/67	Total except/Algeheel behalwe 6 & 9.
*Consolidated Textile Mills Medical Benefit Society (Huguenot)	6	Huguenot/Hugenoot	7645	2056	20/10/67	Total except/Algeheel behalwe 6 & 9.
*Consolidated Textiles Medical Benefit Society (East London)	658	East London / Oos-Londen	5200	2054	15/12/67	Total except/Algeheel behalwe 6 & 9.
*Contactor Medical Aid Society	Private Bag Privaatsak	Suider-Paarl	7624	2057	6/3/68	Total except/Algeheel behalwe 6 & 9.
Corner House Medical Aid Fund	62370	Marshalltown	2107	1058	21/1/70	—
Coronation Medical Aid Society	1517	Durban	4000	1059	18/9/74	—
*Court Alfred No. 6039 of the Ancient Order of Foresters Benefit Society	507	Pietermaritzburg	3200	1060	3/11/67	Total except/Algeheel behalwe 6 & 9.
C.T. Medical Aid Society	81	Cape Town/Kaapstad	8000	1065	16/4/70	—
D						
Datsun-Nissan Medical Aid Society/ ...se Mediese Hulpvereniging	10	Rosslyn	0200	1066	30/9/68	—
David Brown Employees Medical Aid Society	7706	Johannesburg	2000	1067	12/6/70	—
De Beers Benefit Society	616	Kimberley	8300	2068	29/5/69	—
Delfos Medical Aid Scheme	56234	Pinegowrie	2123	1415	17/8/71	—
*Dental and Optical Fund	3400	Johannesburg	2000	1069	21/1/68	Total except/Algeheel behalwe 6 & 9.
D.I.S.W. Medical Aid Society	290	Benoni	1500	1070	4/11/70	—

Name of scheme Naam van skema	X-Private Bag X-Privaatsak P.O. Box Posbus	Place Plek	Code Kode	Reference No. Verwysing No.	Date of registration Datum van registrasie	Exemption from Regulations/Act Vrystelling van Regulasies/Wet
D.K.K. of 1888 Medical Aid Scheme	48684	Roosevelt Park	2129	1465	30/8/76	—
Dormas Medical Aid Society	38040	Booysens	2016	1072	12/12/69	—
D.R.G. Medical Aid Society	922	Cape Town/Kaapstad	8000	1263	16/3/70	—
E						
Eastern Province Newspapers Medical Aid Society	1117	Port Elizabeth	6000	1076	5/6/69	—
Edgars Medical Aid Scheme	7462	Johannesburg	2000	1484	6/3/78	—
Erica Medical Aid Society	6082	Roggebaai	8012	1464	20/8/76	—
Escom Medical Aid Society (vir Afrikaans kyk: Evkom . . .)	1091	Johannesburg	2000	1346	12/2/71	
E.T.C. Medical Benefit Society	121	Barberton	1300	2081	6/6/69	—
Everite Medical Aid Society/ . . . se Mediese Hulpvereniging	31166	Braamfontein	2017	1082	9/9/71	—
(Evkom se Mediese Hulpvereniging) (for English see: Escom . . .)	(1091)	(Johannesburg)	(2000)	(1346)	(12/2/71)	(—)
F						
Fedhandel se Mediese Hulpskema	56236	Pinegowrie	2123	1418	22/10/71	—
Federated Employers' Medical Aid Society	666	Johannesburg	2000	1083	21/5/70	—
Finmed Medical Aid Scheme/ . . . se Mediese Hulpskema	56290	Pinegowrie	2123	1420	3/3/72	—
Ford Medical Aid Plan/ . . . se Mediese Hulpplan		1201 Oasim North/-Noord, Havelock Street/-straat, Port Elizabeth	6001	1452	25/4/75	—
Fowler Group Medical Aid Society	28568	Sunnyside	0132	1467	21/9/76	—
Freight Services Medical Aid Society	716	Johannesburg	2000	1472	8/2/77	—
*Fruit and Vegetables Canning Workers' Medical Benefit Fund	2678	Cape Town/Kaapstad	8000	2086	20/10/67	Total except/Algeheel behalwe 6 & 9.
*(Funeral Fund "Onder Ons") (vir Afrikaans kyk: Begrafnis . . .)	(3522)	(Johannesburg)	(2000)	(1151)	(21/12/67)	(Total except/Algeheel behalwe 6 & 9).
G						
Garlick Medical Aid Society	4642	Cape Town/Kaapstad	8000	1417	15/9/71	—
Gemeenskaplike Munisipale Mediese Hulpfonds (Transvaal) (GMMH) (for English see: Joint . . .)	14145	Verwoerdburg	0140	1087	28/5/68	—
General Accident Medical Aid Society	2755	Johannesburg	2000	1088	28/1/70	—
General Mining Group Medical Aid Society	7462	Johannesburg	2000	1089	3/12/69	—
General Motors South African (Pty) Ltd Medical Aid Plan	1137	Port Elizabeth	6000	1090	21/4/72	—
General Motors South African (Pty) Ltd Medical Benefit Scheme	1137	Port Elizabeth	6000	2421	21/4/72	—
Germiston Industries Medical Aid Society/ . . . Die Germistonse Nywerhede Mediese Hulpvereniging	680	Germiston	1400	1092	17/2/70	—
*Glass Industry Sick Benefit Fund	2221	Port Elizabeth	6000	2094	5/1/68	Total except/Algeheel behalwe 6 & 9.
Goldbys Medical Benefit Fund	1172	Johannesburg	2000	1096	5/5/71	—
Gold Fields Medical Aid Society	1167	Johannesburg	2000	1098	14/5/70	—
Good Hope Medical Aid Society	7462	Johannesburg	2000	1466	7/9/76	—
Greatermans Medical Aid Society	5460	Johannesburg	2000	1099	25/4/69	—
H						
Haggie Rand Medical Aid Scheme/ . . . se Mediese Hulpskema	56234	Pinegowrie	2123	1416	17/8/71	—
Helam Medical Aid Society	2	Mine Office/Mynkantoor, Swartruggens	2835	1100	1/3/71	—
*Helpmed Medical Scheme/ . . . Helpmed-Mediese Skema	45	Sanlamhof	7532	1413	1/7/71	Section / Artikel 17, 19A & 20B.
Hextex Medical Aid Society	48	Worcester	6850	1103	29/8/69	—
Highveld Medical Scheme	111	Witbank	1035	1177	28/12/72	—
Hoechst Medical Aid Society for Southern Africa	7706	Johannesburg	2000	1420	28/8/72	—
Homes Trust Medical Aid Society . . . se Mediese Hulpvereniging	93	Cape Town/Kaapstad	8000	1105	28/10/70	—
H.T.L. Medical Scheme/ . . . se Mediese Skema	93	Cape Town/Kaapstad	8000	1411	25/5/71	—
Huletts Medical Aid Fund	X-3	Glenashley	4022	1106	16/11/70	—
I						
I.B.M. South Africa Medical Aid Society	7462	Johannesburg	2000	1111	12/2/71	—
Ideal Medical Aid Scheme	31541	Braamfontein	2017	1461	31/3/76	—
I.C.S. Medical Aid Society/ . . . se Mediese Hulpskema	90	Howard Place	7450	1431	29/9/72	—
Impilo Medical Aid Society	7706	Johannesburg	2000	1475	1/4/77	—
Insbroke Medical Aid Society	8219	Johannesburg	2000	1109	18/11/68	—
Iscor Medical Benefit Fund (vir Afrikaans kyk: Yskor . . .)	2154	Pretoria	0001	2295	11/2/71	—

Name of scheme Naam van skema	X-Private Bag X Privaatsak P.O. Box Posbus	Place Plek	Code Kode	Reference No. Verwysing No.	Date of registration Datum van registrasie	Exemption from Regulations Act Vrystelling van Regulasies/Wet
J						
J.C.L. (Barberton) Medical Aid Society	17	Barberton	1300	1114	31/7/69	—
Johannesburg Chamber of Commerce Medical Aid Society (JCC) (vir Afrikaans kyk: Johannesburgse Kamer . . .)	7462	Johannesburg	2000	1115	17/7/69	
(Johannesburgse Kamer van Koophandel se Mediese Hulpvereniging, Die) (for English see: Johannesburg Chamber . . .)	(7462)	(Johannesburg)	(2000)	(1115)	(17/7/69)	(—)
Johannesburg Municipal Employees' Sick Benefit Society (vir Afrikaans kyk: Die Johannesburgse Siekehulpvereniging . . .)	2626	Johannesburg	2000	2116	10/3/72	—
(Johannesburgse Siekehulpvereniging vir Munisipale Werknemers, Die) (for English see: Johannesburg Municipal . . .)	(2626)	(Johannesburg)	(2000)	(2116)	(10/3/72)	(—)
[(Joint Municipal Medical Aid Fund (Transvaal)] (vir Afrikaans kyk: Gemeenskaplike . . .)	(14145)	(Verwoerdburg)	(0140)	(1087)	(28/5/68)	(—)
K						
(Kaapse Mediese Plan) (for English see: Cape Medical . . .)	(6183)	(Roggebaai)	(8012)	(1034)	(11/11/71)	(—)
*Klerksdorp Mines Benefit Society (KDM) (vir Afrikaans kyk: Klerksdorpse . . .)	326	Klerksdorp	2570	2121	23/4/71	Reg. 15.
*(Klerksdorpse Mynbystandsvereniging, Die) (KDM) (for English see: Klerksdorp . . .)	(326)	(Klerksdorp)	(2570)	(2121)	(23/4/71)	(Reg. 15.)
Kooöpmed- Mediese Skema	33	Paarl	7620	1463	3/6/76	—
Krygmed	4659	Pretoria	0001	1434	2/4/73	—
K.W.B. Medical Aid Society	7706	Johannesburg	2000	1124	6/8/68	—
L						
Legal and General Medical Aid Scheme	4870	Johannesburg	2000	1125	8/10/71	—
*Leyland Sick Fund (previously/voorheen B.M.C. Sick Fund)	1536	Cape Town/Kaapstad	8000	2023	15/12/67	Total except/Algeheel behalwe 6 & 9.
Local Authorities Medical Aid Fund (Cape) (LAMAF) (vir Afrikaans kyk: Mediese Hulpfonds . . .)	460	Cape Town/Kaapstad	8000	1145	10/1/68	—
*Loyal Alfred Lodge No. 5072 Friendly Society	—	Milstan, Maidstone Road/-weg, Heathfield	7800	2126	15/12/67	Total except/Algeheel behalwe 6 & 9.
*Loyal Durban Lodge No. 5403	331	Durban	4000	1128	5/1/68	Total except/Algeheel behalwe 6 & 9.
*Loyal Natal Unity Lodge No. 4443, I.O.O.F./M.U.F.S.	493	Pietermaritzburg	3200	1129	3/11/67	Total except/Algeheel behalwe 6 & 9.
*Loyal Nil Desperandum Lodge No. 6054		87 Balfour St., Woodstock	7925	2438	11/3/74	Total except/Algeheel behalwe 6 & 9.
M						
M & Z Staff Sick Fund	239	Windhoek	9100	1132	24/3/70	—
Marley Medical Aid Society	6684	Johannesburg	2000	1134	2/9/70	—
Massey-Ferguson-Safim Medical Aid Society	677	Vereeniging	1930	1136	21/5/70	—
*M.C.G. Medical Fund	2268	North End	6056	2155	15/12/67	Section/Artikel 20 (1) (c).
M.C.I. Medical Scheme/ . . . se Mediese Skema	2268	North End	6056	2138	17/2/70	—
Meddent Medical Aid Society	9153	Johannesburg	2000	1139	27/10/67	—
Medicaid Medical Aid Society	9153	Johannesburg	2000	1140	6/2/68	—
*(Medical Aid Society of the Agricultural Unions) (vir Afrikaans kyk: Mediese hulpvereniging van die Landbou-Unies)	(54)	(Bloemfontein)	(9300)	(1148)	(19/12/67)	(Reg. 5.)
Medical Aid Society of the Federation of Master Printers of S.A.	4465	Johannesburg	2000	1141	23/8/71	—
Medical Expenses Distribution Society (MEDS)	10178	Johannesburg	2000	1142	2/12/69	—
Medical Services Plan (MSP) (vir Afrikaans kyk: Plan . . .)	10314	Johannesburg	2000	1143	9/8/71	—
Medico	11352	Signal Hill/Vlaeberg	8018	1144	19/12/67	—
[Mediese Hulpfonds vir Plaaslike Owerhede (Kaap)] (for English see: Local . . .)	(460)	(Cape Town/Kaapstad)	(8000)	(1145)	(10/1/68)	(—)
Mediese Hulpskema van die N.G. Kerk van Transvaal	433	Pretoria	0001	1146	18/7/69	—
(Mediese Hulpvereniging van die Bloemfonteinse Munisipale Werknemers) (for English see: Bloemfontein . . .)	(1765)	(Bloemfontein)	(9300)	(1022)	(30/9/69)	(—)
*Mediese Hulpvereniging van die Landbou-Unies (for English see: Medical Aid Society of the Agricultural . . .)	54	Bloemfontein	9300	1148	19/12/67	Reg. 5.
Mediese Hulpvereniging van die Poskantoor (for English see: Post . . .)	303	Germiston	1400	1147	27/5/70	—
Mediese Hulpvereniging van Staatsamptenare (MHVS) (for English see: Public . . .)	26004	Arcadia	0007	1149	23/6/69	—
Mercantile & General (SA) Medical Aid Fund	2445	Cape Town/Kaapstad	8000	1152	5/8/70	—

Name of scheme Naam van skema	X-Private Bag X-Privaatsak P.O. Box Posbus	Place Plek	Code Kode	Reference No. Verwysings-no.	Date of registration Datum van registrasie	Exemption from Regulations/Act Vrystelling van Regulasies/Wet
*Messina Medical Benefit Society	X-620	Messina	0900	2153	4/9/69	Reg. 15.
Metal Box Medical Aid Society	7752	Johannesburg	2000	1154	1/2/71	—
(Middellandse Mediese Plan) (MMP) (for English see: Midland . . .)	(—)	(1201/6 Oasim-Noord Havelockstr., Port Elizabeth)	(6001)	(1156)	(3/12/70)	(—)
Midland Medical Plan (MMP) (vir Afrikaans kyk: Middellandse . . .)	—	1201/6 Oasim North, Havelock Street, Port Elizabeth	6001	1156	3/12/70	—
Mines Benefit Society (MBS) (vir Afrikaans kyk: Myn . . .)	23257	Joubert Park	2044	2158	3/2/71	—
Morcop Medical Aid Society	—	Dido Valley, Simonstown	7995	1161	6/8/71	—
Motomedic Society	5317	Johannesburg	2000	1290	14/6/72	—
Multimed Medical Scheme	62061	Marshalltown	2107	1483	19/1/78	—
Mumed 850 Plan	90	Howard Place	7450	1215	17/11/71	—
Municipal Medical Aid Scheme (Natal) (vir Afrikaans kyk: Munisipale . . .)	3472	Durban	4000	1162	5/8/69	—
[Munisipale Mediese Hulpskema (Natal)] (for English see: Municipal . . .)	(3472)	(Durban)	(4000)	(1162)	(5/8/69)	(—)
Murray & Stewart Medical Aid Scheme	56060	Pinegowrie	2123	1447	20/12/74	—
Mutual and Federal Medical Aid Fund	90	Howard Place	7450	1208	10/6/71	—
(Mynbystand Mediesregfonds) (for English see: Mines . . .)	(23257)	(Joubert Park)	(2044)	(2158)	(3/2/71)	(—)
N						
(Nasionale Indiër Mediese Skema) (NIMS) (for English see: National Indian . . .)	(56234)	(Pinegowrie)	(2123)	(1453)	(18/12/75)	(—)
Natal Building Society Medical Aid Fund	1744	Durban	4000	1164	8/6/70	—
Natal Coal Owners' (Persons Staff) Medical Aid Society	281	Durban	4000	1165	16/6/70	—
National Medical Plan (NMP) (previously/voorheen Natal Medical Plan)	2338	Durban	4000	1167	6/5/71	—
National Indian Medical Scheme (NIMS) (vir Afrikaans kyk: Nasionale Indiër- . . .)	2825	Durban	4000	1453	18/12/75	—
National Portland Medical Aid Society	21	Claremont	7735	1168	29/7/69	—
National Trading Medical Aid Society	2762	Johannesburg	2000	1169	20/11/69	—
N.B.C. Medical Aid Society	10423	Johannesburg	2000	1170	19/2/69	—
Nedmed Medical Aid Society	90	Howard Place	7450	1469	24/12/76	—
New Zealand Insurance Company (S.A.) Ltd Medical Aid Society	7706	Johannesburg	2000	1410	14/4/71	—
Nimax Medical Aid Society	1790	Durban	4000	1470	19/1/77	—
Nimed Medical Aid Society	1790	Durban	4000	1166	27/1/71	—
Nimham Shand Medical Aid Society	90	Howard Place	7450	1444	5/9/74	—
Northern Medical Aid Society	9263	Johannesburg	2000	1171	20/3/68	—
N.T.E. Staff Medical Aid Fund	39	Pietermaritzburg	3200	1174	4/9/70	—
Number One Medical Aid Scheme	10314	Johannesburg	2000	1468	23/12/76	—
O						
(O.F.S. Joint Municipal Medical Aid Fund) (vir Afrikaans kyk: O.V.S. . . .)	(1132)	(Kroonstad)	(9500)	(1180)	(20/8/68)	(—)
O.K. Bazaars Medical Aid Society	4642	Cape Town/Kaapstad	8000	1176	10/2/70	—
Olifantsfontein Medical Aid Society	10	Olifantsfontein	1665	1178	26/4/72	—
Ommed Plan	90	Howard Place	7450	1476	5/5/77	—
Ore and Metal Medical Aid Society	3548	Johannesburg	2000	1181	18/9/70	—
O.V.S. Gemeenskaplike Munisipale Mediese Hulpfonds (for English see: O.F.S. . . .)	1132	Kroonstad	9500	1180	20/8/68	—
P						
Parmed Medical Aid Scheme (. . .Parmed-Mediese Hulpskema	56287	Pinegowrie	2123	1441	29/3/74	—
P.C.L. Non-White Medical Aid Society	1790	Durban	4000	1433	1/3/73	—
Pep Medical Aid Society	76	Kuilsrivier	7580	1414	11/8/71	—
Perskor Mediese Fonds	845	Johannesburg	2000	1007	3/6/70	—
Philips Medical Aid Society	7706	Johannesburg	2000	1184	14/7/70	—
Pietermaritzburg Chamber of Industries Medical Aid Society	1790	Durban	4000	1185	5/11/70	—
Pilkington Group European Medical Aid Society	111	Springs	1560	1186	20/11/70	—
*Pinetown Textile Mills Medical Benefit Society	203	Pinetown	3600	2187	20/10/67	Total except/Algeheel behalwe 6 & 9.
(Plan vir Mediese Dienste) (for English see: Medical Services . . .)	(10314)	(Johannesburg)	(2000)	(1143)	(9/8/71)	(—)
Plate Glass Group Medical Aid Society	7462	Johannesburg	2000	1437	23/11/73	—
Plessey (S.A.) Medical Aid Scheme	56150	Pinegowrie	2123	1423	23/6/72	—
Port Elizabeth Bus Workers Medical Aid Scheme	1069	Port Elizabeth	6000	1426	28/6/72	—
Port Elizabeth Tramway Employees' Medical Aid Scheme . . . Tremwerknemers se Mediese Hulpskema	1069	Port Elizabeth	6000	1190	13/5/67	—
(Post Office Medical Aid Society) (POMAS) (vir Afrikaans kyk: Mediese Hulpvereniging van die Poskantoor)	(303)	(Germiston)	(1400)	(1147)	(27/5/70)	(—)
Powerlines Medical Aid Society	1989	Johannesburg	2000	1191	5/12/68	—
Premier Medical Plan	10314	Johannesburg	2000	1485	17/3/78	—

Name of Scheme / Naam van Skema	Trade Mark / Handelsmerk	Postal Address / Posadres	Place / Plek	Code / Kode	Reference No / Verwysing No.	Date of registration / Datum van registrasie	Exemption from Regulations/Act / Vrystelling van Regulasies/Wet
Pretoria Municipal Employees' Medical Aid Society		1497	Pretoria	0001	1242	28/1/70	—
Pretoria Municipal Employees' Medical Aid Society		6288	Johannesburg	2000	1194	8/10/69	—
Pretoria Municipal Employees' Medical Aid Society		844	Pretoria	7500	1454	17/5/76	—
Pretoria Municipal Employees' Medical Aid Society		646	Cape Town	8000	1195	22/10/70	—
Pretoria Municipal Employees' Medical Aid Society		6857	Roggebaai	8012	1196	19/11/69	—
Pretoria Municipal Employees' Medical Aid Society		1971	Johannesburg	2000	1197	20/2/69	—
Pretoria Municipal Employees' Medical Aid Society		(1971)	(Arcadia)	(0007)	(1149)	(25/6/69)	—
Provincial Hospital Board Staff Medical Aid Society			Johannesburg	2000	1198	2/6/70	Section/Artikel 19 & 19A.
Provincial Hospital Board Staff Medical Aid Society			King William's Town	5600	1199	12/6/70	—
Provincial Hospital Board Staff Medical Aid Society			Johannesburg	2000	1201	24/10/69	—
Provincial Hospital Board Staff Medical Aid Society			(Johannesburg)	(2000)	(1201)	(24/10/69)	—
Provincial Hospital Board Staff Medical Aid Society			Howard Place	7450	1277	29/12/72	—
Provincial Hospital Board Staff Medical Aid Society			39 The Avenue, Kruisfontein	1740	1202	26/11/69	—
Provincial Hospital Board Staff Medical Aid Society			-Noord / North				
Provincial Hospital Board Staff Medical Aid Society			Pinegowrie	2123	1430	18/9/72	—
Provincial Hospital Board Staff Medical Aid Society			Pinegowrie	2123	1435	23/5/73	—
Provincial Hospital Board Staff Medical Aid Society			Robertson	6705	2412	11/6/71	—
Provincial Hospital Board Staff Medical Aid Society			Rooiberg	0500	1206	12/6/70	Total except/Algeheel behalwe 6 & 9.
Provincial Hospital Board Staff Medical Aid Society			Braamfontein	2017	1427	30/6/72	—
Provincial Hospital Board Staff Medical Aid Society			Johannesburg	2000	1130	6/5/70	—
Provincial Hospital Board Staff Medical Aid Society			Johannesburg	2000	1450	26/3/75	—
Provincial Hospital Board Staff Medical Aid Society			(Pinegowrie)	(2123)	(1424)	(23/6/72)	Section/Artikel 20 (d) & (e).
Provincial Hospital Board Staff Medical Aid Society			Johannesburg	2000	1489	1/4/78	—
Provincial Hospital Board Staff Medical Aid Society			Johannesburg	2000	1488	1/4/78	—
Provincial Hospital Board Staff Medical Aid Society			Cape Town	8000	1211	10/2/69	—
Provincial Hospital Board Staff Medical Aid Society			Kaapstad	7620	1213	8/12/69	—
Provincial Hospital Board Staff Medical Aid Society			Cape Town	8000	1214	13/2/69	—
Provincial Hospital Board Staff Medical Aid Society			Kaapstad	8000	1232	29/8/69	—
Provincial Hospital Board Staff Medical Aid Society			Johannesburg	2000	1233	14/8/69	—
Provincial Hospital Board Staff Medical Aid Society			Sasolburg	9570	1234	17/2/71	—
Provincial Hospital Board Staff Medical Aid Society			Pinegowrie	2123	1424	23/6/72	—
Provincial Hospital Board Staff Medical Aid Society			Sanlamhof	7532	1446	19/11/74	—
Provincial Hospital Board Staff Medical Aid Society			Roggebaai	8012	1455	30/6/75	Section/Artikel 17, 19A & 20B.
Provincial Hospital Board Staff Medical Aid Society			Johannesburg	2000	1238	18/2/69	—
Provincial Hospital Board Staff Medical Aid Society			Johannesburg	2000	2239	4/5/72	—
Provincial Hospital Board Staff Medical Aid Society			Cape Town	2000	2240	18/8/71	—
Provincial Hospital Board Staff Medical Aid Society			Kaapstad	8000	1241	7/3/72	—
Provincial Hospital Board Staff Medical Aid Society			Johannesburg	2000	2445	19/9/74	—
Provincial Hospital Board Staff Medical Aid Society			Roodepoort	1709	1243	6/11/68	Section / Artikel 11; 26; 20(1)q; 25G(1)(b); 25G(2).
Provincial Hospital Board Staff Medical Aid Society			Randburg	2125	1486	17/3/78	—
Provincial Hospital Board Staff Medical Aid Society			Howard Place	7450	1209	1/9/70	Section / Artikel 11; 26; 20(1)q; 25G(1)(b); 25G(2).
Provincial Hospital Board Staff Medical Aid Society			Marshalltown	2107	1210	18/6/71	—
Provincial Hospital Board Staff Medical Aid Society			5 Fiberise Road/-weg, Wynberg	7800	1235	21/12/67	—
Provincial Hospital Board Staff Medical Aid Society			Cape Town	8000	1248	5/6/70	Total except/Algeheel behalwe 6 & 9.
Provincial Hospital Board Staff Medical Aid Society			Kaapstad	7700	1249	8/5/72	—
Provincial Hospital Board Staff Medical Aid Society			Die Plat Association/ Vereniging, Westford, Rondebosch				—
Provincial Hospital Board Staff Medical Aid Society			Groenkloof	9245	1458	18/7/75	—
Provincial Hospital Board Staff Medical Aid Society			Springs	1560	1250	29/1/70	—

2099

Name of scheme / Naam van skema	X-Private Bag / X Privaatsak / P.O. Box / Posbus	Place / Plek	Code / Kode	Reference No. / Verwysing No.	Date of registration / Datum van registrasie	Exemption from Regulations/Act / Vrystelling van Regulasies/Wet
Pretoria Municipal Sick Fund . . . . Die Pretoriase Munisipale Siekefonds	3497	Pretoria	0001	1242	28/1/70	—
Profmed	6268	Johannesburg	2000	1194	8/10/69	—
Pro Sano- Mediese Hulpskema . . . Medical Aid Scheme	484	Parow	7500	1454	17/5/76	—
Protea Assurance Staff Medical Aid Society	646	Cape Town/Kaapstad	8000	1195	22/10/70	—
Protea Medical Aid Society	6052	Roggebaai	8012	1196	19/11/69	—
Prudential Medical Aid Scheme	1097	Johannesburg	2000	1197	20/2/69	—
(Public Service Medical Aid Association) (PSMAA) (vir Afrikaans kyk: Mediese Hulpvereniging van Staatsamptenare)	(26003)	(Arcadia)	(0007)	(1149)	(23/6/69)	(—)
*Putco Staff Sick Fund . . . se Personeel-siekefonds	7571	Johannesburg	2000	1198	2/6/70	Section/Artikel 19 & 19A.
R						
Radue's Staff Medical Aid Scheme	112	King William's Town	5600	1199	12/6/70	—
Rand Water Board Sick Fund (vir Afrikaans kyk: Rand-Waterraad se . . .)	1127	Johannesburg	2000	1201	24/10/69	—
(Rand-Waterraad se Siekefonds) (for English see: Rand Water . . .)	(1127)	(Johannesburg)	(2000)	(1201)	(24/10/69)	(—)
Reed Corporation Medical Aid Society	90	Howard Place	7450	1277	29/12/72	—
Reef Medical Aid Society	—	39 The Avenue, Krugersdorp North / -Noord	1740	1202	26/11/69	—
Rembrandt Group Medical Aid Scheme/ Rembrandt-groep se Mediese Hulpskema	56300	Pinegowrie	2123	1430	18/9/72	—
Roberts Construction Medical Aid Scheme	56234	Pinegowrie	2123	1435	23/5/73	—
*Robertson se Algemene Hulpgenootskap	1	Robertson	6705	2412	11/6/71	Total except/Algeheel behalwe 6 & 9.
Rooiberg Mine Medical Aid Society	Private Bag/ Privaatsak 31082	Rooiberg	0500	1206	12/6/70	—
Runstaff Medical Scheme		Bramfontein	2017	1427	30/6/72	—
S						
SAAN Medical Aid Society	1138	Johannesburg	2000	1130	6/5/70	—
S.A.B. Castellion Medical Scheme	1099	Johannesburg	2000	1450	26/3/75	Section/Artikel 20 (d) & (e).
(S.A.B.C. Medical Aid Scheme) (vir Afrikaans kyk: S.A.U.K. se . . .)	(56140)	(Pinegowrie)	(2123)	(1424)	(23/6/72)	(—)
Sabre Medical Scheme	1099	Johannesburg	2000	1489	1/4/78	—
Sabstel Medical Scheme	1099	Johannesburg	2000	1488	1/4/78	—
Safmarine Medical Aid Fund	27	Cape Town Kaapstad	8000	1211	10/2/69	—
S.A.K.A.V. Medical Aid Fund . . . se Mediese Hulpfonds	33	Paarl	7620	1213	8/12/69	—
S.A. Mutual Life Assurance Society Staff Medical Aid Fund	66	Cape Town/Kaapstad	8000	1214	13/2/69	—
Santam se Onderlinge Mediese Hulpvereniging	653	Cape Town Kaapstad	8000	1232	29/8/69	—
SAPPI Medical Aid Society	10246	Johannesburg	2000	1233	14/8/69	—
Sasol Medical Aid Fund . . . se Mediese Hulpfonds	89	Sasolburg	9570	1234	17/2/71	—
S.A.U.K. se Mediese Hulpskema (for English see: S.A.B.C. . . .)	56140	Pinegowrie	2123	1424	23/6/72	—
*Selfmed Medical Scheme/Selfmed- Mediese Skema	45	Sanlamhof	7532	1446	19/11/74	Section/Artikel 17, 19A & 20B.
Shell Southern Africa Medical Aid Society	6440	Roggebaai	8012	1455	30/6/75	—
Shoe Corporation Medical Aid Fund	7462	Johannesburg	2000	1238	18/2/69	—
Sick Benefit Fund for the Diamond Cutting Industry of South Africa	8804	Johannesburg	2000	2239	4/5/72	—
Sick Benefit Society D.C.I.S.A.	4955	Johannesburg	2000	2240	18/8/71	—
Siekebystandfonds van die Nasionale Pers Bpk. (Kantoorpersoneel)	2271	Cape Town Kaapstad	8000	1241	7/3/72	—
*Siemed Benefit Scheme	4583	Johannesburg	2000	2445	19/9/74	Section / Artikel 11; 26; 20(1)q; 25G(1)(b); 25G(2).
*Siemens Medical Aid Scheme	7462	Johannesburg	2000	1243	6/11/68	Section / Artikel 11; 26; 20(1)q; 25G(1)(b); 25G(2).
Sizwe Medical Fund	51106	Randburg	2125	1486	17/3/78	—
South African Breweries Ltd Medical Aid Society	90	Howard Place	7450	1209	1/9/70	—
South African Eagle Medical Aid Society	61489	Marshalltown	2107	1210	18/6/71	—
*South African Teachers' Association Medical Aid Society (SATA)		5 Fellerstie Road/-weg, Wynberg	7800	1235	21/12/67	Total except/Algeheel behalwe 6 & 9.
South Atlantic Corporation Medical Aid Society	1628	Cape Town Kaapstad	8000	1248	5/6/70	—
Southern Medical Aid Society	—	C/o - P/a Southern Life Association/ Vereniging, Great Westerford, Rondebosch	7700	1249	8/5/72	—
South West Africa Company Medical Aid Society	2	Grootfontein	9245	1458	18/7/75	—
Springs Industrial Benefit Society (SIBS)	554	Springs	1560	1250	29/1/70	—

Name of scheme Naam van skema	X-Private Bag X-Privaatsak P.O. Box Posbus	Place Plek	Code Kode	Reference No. Verwysing-No.	Date of registration Datum van registrasie	Exemption from Regulations/Act Vrystelling van Regulasies/Wet
Stability Medical Aid Society	5703	Johannesburg	2000	1251	19/1/68	—
Statutêre Organisasies se Mediese Skema (SOMS) (for English see: Statutory . . .)	X-363	Pretoria	0001	1252	11/8/71	—
(Statutory Organisations Medical Scheme) (SOMS) (vir Afrikaans kyk: Statutêre . . .)	(X-363)	(Pretoria)	(0001)	(1252)	(11/8/71)	(—)
S.T.C. Black Medical Aid Scheme	9153	Johannesburg	2000	1449	31/1/75	—
Steeledale Group Medical Aid Scheme	1210	Johannesburg	2000	1253	7/8/68	—
Stewarts & Lloyds Medical Aid Society	74	Vereeniging	1930	1254	25/5/70	—
Stuttafords Medical Aid Society	69	Cape Town/Kaapstad	8000	1256	28/11/69	—
Sydmore Medical Aid Society	8853	Johannesburg	2000	1257	29/1/70	—
T						
Tafelberg Medical Aid Society	6052	Roggebaai	8012	1260	26/8/70	—
Theron, Humphrey & Fick se Siekefonds	62	Worcester	6850	1265	29/2/72	—
TMSA Medical Aid Society	56280	Pinegowrie	2123	1268	24/8/70	—
*Tongaat Medical Benefit Scheme	5	Maidstone	4380	2267	11/11/71	Section / Artikel 19A.
*Topmed Medical Scheme/Topmed- Mediese Skema	45	Sandanhot	7530	1422	24/4/72	Section / Artikel 17, 19A & 20B.
Traduna Medical Aid Fund	31811	Braamfontein	2017	1269	9/2/70	—
Tramway Employees' Medical Benefit Fund	115	Cape Town Kaapstad	8000	2270	30/6/72	—
*Trawlermen's Sick Benefit and Benevolent Fund	2416	Cape Town Kaapstad	8000	2271	20/10/67	Total except/Algeheel behalwe 6 & 9.
Tsumeb Corporation Medical Aid Society	1313	Tsumeb	9260	1272	12/1/68	—
U						
Uitenhage Passenger Transport Employees' Sick Fund	225	Port Elizabeth	6000	2274	1/4/70	—
U.L.A. Medical Aid Society	785	Germiston	1400	1275	2/5/69	—
*Union Flour Mills Sick Fund	1010	Durban	4000	1276	12/2/71	Total except/Algeheel behalwe 6 & 9.
Union Platinum Mine Medical Benefit Society/. . . se Mediese Bystandsvereniging	13	Swartklip	0370	2278	14/4/70	—
*(United Bouvereniging se Mediese Hulpfonds) (for English see: United Building. .)	(7735)	(Johannesburg)	(2000)	(1280)	(26/3/70)	[Section / Artikel 20 (1)(c); also/ook Reg. 5.]
*United Building Society Medical Aid Fund (vir Afrikaans kyk: United Bouvereniging . . .)	7735	Johannesburg	2000	1280	26/3/70	Section / Artikel 20 (1)(c); also/ook Reg. 5.
University of the Witwaterstand, Johannesburg, Staff Medical Aid Fund		Jan Smuts Avenue / -laan, Johannesburg	2001	1282	18/5/71	—
Usco Medical Aid Society/. . . se Mediese Hulpvereniging	48	Vereeniging	1930	1283	5/8/68	—
V						
Vanderbijlpark Medical Benefit Fund/. . . se Mediese Bystandsfonds	105	Vanderbijlpark	1900	2285	10/6/71	—
Vryheid Coronation Medical and Benefit Club	P.O./Pk.	Hlobane	3145	2288	1/5/72	—
W						
Witbank Coalfields Benefit Society	26	Witbank	1035	2291	30/4/69	—
Woolworths Medical Aid Society	6052	Roggebaai	8012	1293	12/12/69	—
X						
Xhosa Development Corporation Medical Aid Scheme (vir Afrikaans kyk: Xhosa-Ontwikkelingskorporasie . . .)	779	East London	5200	1436	24/5/73	—
(Xhosa-Ontwikkelingskorporasie se Mediese Hulpskema) (for English see: Xhosa . . .)	(779)	(Oos-Londen)	(5200)	(1436)	(24/5/73)	(—)
Y						
(Yskor se Mediese Bystandsfonds) (for English see: Iscor . . .)	(2154)	(Pretoria)	(0001)	(2295)	(11/2/71)	(—)

Buy National Savings Certificates

Koop Nasionale Spaarsertifikate

No. R. 2234 10 November 1978

RULES SPECIFYING THE ACTS OR OMISSIONS IN RESPECT OF WHICH THE CENTRAL COUNCIL FOR MEDICAL SCHEMES MAY TAKE DISCIPLINARY STEPS

The Minister of Health has, in terms of section 39A (2) of the Medical Schemes Act, 1967 (Act 72 of 1967), as amended, approved the following rules made by the Central Council for Medical Schemes in terms of section 39A (1) of that Act on the recommendation of the Representative Association of Medical Schemes:

1. A medical scheme shall conduct its affairs in such a manner that the highest ethical standards are maintained at all times and no medical scheme shall make any statement or perform any act which may bring discredit to the medical schemes movement or to another medical scheme: Provided that a scheme that reports an act or omission to the Council shall not be regarded as having contravened this clause.

2. SETTLEMENT OF ACCOUNTS.

2.1 Any payment by a medical scheme to a supplier of services shall be accompanied by a payment advice containing the following minimum details:

(i) The reference number (if any) of the supplier concerned;

(ii) the membership number, surname and initials of each member concerned;

(iii) the amount payable in respect of each member concerned;

(iv) for each member, the date of the service which is covered by the particular payment—it is sufficient to state the last date of service appearing on the individual account of the particular supplier; and

(v) in respect of each payment that is less than the amount charged on the supplier's account, the reason for such difference.

2.2 The frequency with which members are advised of the finalisation of their claims may be decided by each individual medical scheme: Provided that—

(i) each payment made direct to a member shall be accompanied by full details;

(ii) any scheme shall advise a member as soon as possible, but not later than the last day of the month following the month during which the claim was received from the member, if for any reason the claim is rejected and also if the full amount of any benefit is not paid out to the member; and

(iii) any scheme shall provide a member with sufficient details to enable the latter to complete his or her income tax return.

3. RECRUITING.

3.1 No medical scheme may, in respect of its own rules or those of any other scheme, including rules relating to contributions and benefits, make, or permit to be made on its behalf, any material misrepresentations or suppress, or permit to be suppressed on its behalf, any material fact for the purpose of inviting the participation of any prospective member or group of members.

No. R. 2234 10 November 1978

REËLS WAT DIE HANDELINGE OF VERSUIME UITEENSIT TEN OPSIGTE WAARVAN DIE SENTRALE RAAD VIR MEDIESE SKEMAS TUGSTAPPE KAN DOEN

Die Minister van Gesondheid het kragtens artikel 39A (2) van die Wet op Mediese Skemas, 1967 (Wet 72 van 1967), soos gewysig, sy goedkeuring geheg aan die volgende reëls wat die Sentrale Raad vir Mediese Skemas kragtens artikel 39A (1) van genoemde Wet op aanbeveling van die Verteenwoordigende Vereniging van Mediese Skemas uitgevaardig:

1. 'n Mediese skema moet sy sake doen op so 'n wyse dat die hoogste etiese standaarde te alle tye gehandhaaf word en 'n mediese skema mag geen verklaring doen of handeling verrig wat òf 'n ander mediese skema òf die mediese-skema-beweging kan benadeel nie: Met dien verstande dat 'n skema wat 'n handeling of versuim by die Raad aanmeld, nie, ten opsigte van sodanige handeling of versuim, beskou word as 'n oortreder van hierdie klousule nie.

2. VEREFFENING VAN REKENINGS.

2.1 'n Betaling deur 'n mediese skema aan 'n verskaffer van dienste moet vergesel gaan van 'n betalingsadvies wat ondergenoemde minimum besonderhede verstrek:

(i) die verwysingsnommer (as daar is) van die betrokke verskaffer;

(ii) die lidmaatskapnommer, van en voorletters van elke betrokke lid;

(iii) die grootte van die bedrag wat ten opsigte van elke betrokke lid betaalbaar is;

(iv) ten opsigte van elke lid, die datum van die diens wat deur die betrokke betaling gedek word—dit is voldoende om die jongste diensdatum te meld wat verskyn in die afsonderlike rekening van die betrokke verskaffer; en

(v) ten opsigte van elke betaling wat minder is as die bedrag wat in die verskaffer se rekening gehef word, die rede vir sodanige verskil.

2.2 Elke mediese skema kan self die frekwensie bepaal waarmee hy sy lede in kennis stel van die afhandeling van hulle eise: Met dien verstande dat—

(i) elke betaling wat regstreeks aan 'n lid gedoen word, vergesel moet gaan van die volledige besonderhede;

(ii) 'n skema 'n lid so gou moontlik, maar uiterlik op die laaste dag van die maand wat volg op die maand waarin hy 'n eis van die lid ontvang het, in kennis moet stel indien hy die eis om die een of ander rede verwerp en ook indien hy minder as die volle bedrag van 'n voordeel aan die lid uitbetaal; en

(iii) 'n skema voldoende besonderhede aan 'n lid moet verstrek om laasgenoemde daartoe in staat te stel om sy of haar inkomstebelastingopgawe in te vul.

3. WERWING.

3.1 Geen mediese skema mag met betrekking tot sy eie reglement of dié van 'n ander mediese skema, met inbegrip van reëls betreffende bydraes en voordele, enige wesentlike wanvoorstellings maak of enige wesentlike feit verswyg, of toelaat dat daar met betrekking daartoe namens hom sodanige wanvoorstelling of verswyging plaasvind, met die doel om 'n voornemende lid of groep voornemende lede tot lidmaatskap aan te lok nie.

3.2 No medical scheme may allow a fee to be charged over and above the normal contribution or entrance fee payable in terms of its registered rules for the purposes either of admitting any person or persons to membership or of allowing any person or persons to enjoy membership of that scheme.

3.3 No medical scheme or administrator of a medical scheme may pay or offer any inducement, in cash or otherwise, to any company, partnership or person as the result of the introduction of new members to such scheme: Provided, however, that a medical scheme may allow the earnings of any of its employees, and that an administrator of a medical scheme may allow the earnings of any of its full-time employees, to be linked to the introduction of new membership to a particular scheme.

4. ADMINISTRATIVE AND FINANCIAL CONTROLS

4.1 Any medical scheme shall ensure that it employs adequate measures to prevent duplicate payments of accounts.

4.2 Any medical scheme shall institute adequate procedures to ensure that each claim is paid correctly at the appropriate tariff.

4.3 Any medical scheme shall maintain adequate control of the contributions it charges and receives.

4.4 Any medical scheme shall ensure that members' records are correlated with claims records at all times and that claims are paid only for services rendered to members and dependants in good standing with the scheme.

4.5 Any medical scheme shall accurately record the date of receipt of each claim.

4.6 The administration of a medical scheme shall be such as to enable it to settle each account on or before the last day of the month following the month of receipt thereof, irrespective of whether such account was received from a member or from a supplier of services and irrespective of whether it has been partly or fully paid by the member: Provided that such account shall comply with the rules of the scheme and with the provisions of the Act and the regulations made thereunder.

5. PRESS STATEMENTS.

A member of the management committee of a medical scheme or an official of such scheme shall be guilty of improper conduct should he pretend to be speaking on behalf of the Representative Association of Medical Schemes unless he is specifically authorised to speak on behalf of the aforesaid Association.

6. TARIFF AGREEMENTS.

The benefits paid by a medical scheme may not be in excess of those determined in the tariff of fees as defined in the Medical Schemes Act or of any other tariff or fee determined by the Representative Association of Medical Schemes for a particular supplier of services.

7. NOTICE OF TERMINATION OF MEMBERSHIP.

Where an employer group wishes to terminate its membership of a scheme, such scheme may impose a period of notice not exceeding three (3) months in respect of such termination: Provided that a medical benefit scheme may with the written consent of the Representative Association of Medical Schemes,

3.2 Geen mediese skema mag toelaat dat hoër gelde as die normale bydrae of toetreegeld wat volgens sy geregistreerde reglement betaalbaar is, gehef word met die doel òf om 'n persoon of persone tot lidmaatskap van sodanige skema toe te laat òf om 'n persoon of persone daartoe in staat te stel om lidmaatskap van sodanige skema te geniet nie.

3.3 Geen mediese skema of administrateur van 'n mediese skema mag 'n voordeel, hetsy in kontant of andersins, aan 'n maatskappy, vennootskap of persoon betaal of aanbied ten gevolge van die toetrede van nuwe lede tot sodanige skema nie: Met dien verstande, egter, dat 'n mediese skema kan toelaat dat die verdienste van enige van sy werknemers, en dat 'n administrateur van 'n mediese skema kan toelaat dat die verdienste van enige van sy voltydse werknemers, gekoppel word aan die toetrede van nuwe lede tot 'n spesifieke skema.

4. ADMINISTRATIEWE EN FINANSIËLE BEHEER.

4.1 'n Mediese skema moet voldoende maatreëls tref om duplikaatbetalings van rekenings te voorkom.

4.2 'n Mediese skema moet gepaste prosedures instel om te verseker dat elke eis korrek teen die betrokke tarief betaal word.

4.3 'n Mediese skema moet voldoende beheer handhaaf oor die bydraes wat hy hef en ontvang.

4.4 'n Mediese skema moet toesien dat die besonderhede van sy lede deurentyd met die eise-besonderhede gekorreleer word en dat eise betaal word slegs vir dienste gelewer aan sodanige lede en afhanklikes van die skema as wat van goeie naam en faam is.

4.5 'n Mediese skema moet die ontvangsdatum van elke eis noukeurig aanteken.

4.6 'n Mediese skema moet sy administrasie só inrig dat hy elke rekening kan vereffen voor of op die laaste dag van die maand wat volg op die maand waarin hy sodanige rekening ontvang het, ongeag of sodanige rekening afkomstig is van 'n lid of van 'n verskaffer van dienste, en ongeag of dit reeds gedeeltelik of ten volle deur die lid betaal is: Met dien verstande dat sodanige rekening moet voldoen aan die vereistes van die reglement van die skema en aan die bepalings van die Wet en die regulasies daarkragtens uitgevaardig.

5. PERSVERKLARINGS.

'n Lid van die bestuurskomitee van 'n mediese skema of 'n beampte van sodanige skema maak hom skuldig aan onbehoorlike gedrag indien hy voorgee dat hy namens die Verteenwoordigende Vereniging van Mediese Skemas praat, tensy hy uitdruklik daartoe gemagtig is om namens voormelde Vereniging te praat.

6. TARIEFOOREENKOMSTE.

Die voordele wat 'n mediese skema betaal, mag hoogstens gelyk wees aan dié vasgestel in die geldetarief wat by die Wet op Mediese Skemas omskryf word of aan 'n ander tarief of geld wat die Verteenwoordigende Vereniging van Mediese Skemas vasgestel het vir 'n besondere verskaffer van dienste.

7. KENNISGEWING VAN BEËINDIGING VAN LIDMAATSKAP.

Indien 'n werkgewersgroep sy lidmaatskap van 'n skema wil beëindig, mag sodanige skema ten opsigte van sodanige beëindiging 'n kennistydperk van hoogstens drie (3) maande oplê: Met dien verstande dat 'n mediese bystandskema, met skriftelike toestemming van die Verteenwoordigende Vereniging van Mediese Skemas, 'n langer tydperk kan oplê: Met dien verstande

10/11/78

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imposed a longer period: Provided further that no such extended period may be in excess of six (6) months: Provided further that a scheme shall make provision in its registered rules for the validity of any such notice.

8. INFORMATION TO MEMBERS.

Where a scheme issues a summary of its rules to a member instead of a complete set of rules, that summary shall contain all such particulars as are necessary to inform the member of all his rights, in addition to full information regarding benefits, contributions and exclusions.

9. ADVERTISING.

No medical scheme may advertise its services in the press or otherwise in any manner that creates a false impression of the actual facts as at the date of the advertisement.

10. TRANSFER OF MEMBERSHIP.

Should a member of a medical scheme terminate his membership as a result of a change of employment and intends to join another medical scheme, the first-mentioned scheme shall on request provide a certificate of membership to him or to the latter scheme indicating the dates of admission and cessation of membership and the first-mentioned scheme shall also afford such other relevant information as may reasonably be required.

11. REFERRALS.

The rules of a medical scheme shall, where they provide that a practitioner may refer a patient to a specific supplier of services, also provide that the supplier shall state the name of the referring practitioner on his account.

12. PRIVACY OF MEMBERS.

The officials and employees of a medical scheme shall regard as strictly confidential any information about the private affairs of members and their families which may come to their knowledge through their association with such scheme.

voorts dat sodanige verlengde tydperk nie ses (6) maande te bowe mag gaan nie: Met dien verstande voorts dat 'n skema in sy geregistreerde reglement voorsiening moet maak vir die geldigheid van sodanige kennisgewing.

8. INLIGTING AAN LEDE.

Indien 'n skema aan 'n lid 'n opsomming van sy reëls uitreik in plaas van 'n volledige stel reëls, moet sodanige opsomming, benewens die volledige inligting oor die voordele, bydraes en uitsluitings, al die besonderhede bevat wat nodig is om die lid op die hoogte te stel van al sy regte.

9. REKLAME.

'n Mediese skema mag nie sy dienste in die pers of elders adverteer op 'n wyse wat 'n valse indruk skep van die werklike feite soos op die datum van die advertensie nie.

10. OORDRAG VAN LIDMAATSKAP.

Indien 'n lid van 'n mediese skema sy lidmaatskap beëindig as gevolg van 'n verandering van werk, en indien hy voornemens is om hom by 'n ander mediese skema aan te sluit, moet eersgenoemde skema op aanvraag aan hom of aan laasgenoemde skema 'n sertifikaat van lidmaatskap voorsien wat die datums van toetrede en beëindiging van lidmaatskap aandui en moet eersgenoemde skema ook sodanige ander toepaslike inligting verskaf as wat redelikerwys verlang word.

11. VERWYSINGS.

Die reglement van 'n mediese skema moet, waar dit bepaal dat 'n praktisyn 'n pasient na 'n spesifieke verskaffer van dienste kan verwys, ook bepaal dat die verskaffer in sy rekening die naam van die verwysende praktisyn moet vermeld.

12. PRIVAATHEID VAN LEDE.

Die beamptes en werknemers van 'n mediese skema moet al die inligting wat hulle ten gevolge van hul verbintenis met sodanige skema te wete kom aangaande die private sake van lede en hul gesinne, beskou as streng vertroulik.

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SA invention breathes new life into infants

AFTER 14 years, a Johannesburg anaesthetist has finally won international recognition for a resuscitator he invented to save newborn babies dying from lack of oxygen.

The inventor of the hand-operated Samson resuscitator — he may not be named because of medical ethics — claims it is more effective than previous devices because it quickly forces air under pressure into the lungs. At the same time it expels the liquid which prevents the baby from breathing.

BY MIKE DENNEHY

"The lungs of a newborn child are collapsed and full of liquid, and before the child can breathe, this liquid must be removed," he explains.

"This can only be done with air forced into the lungs under high pressure. As far as can be established, this is the only resuscitator in the world that can inflate the lungs safely."

Research in Poland showed that many newborn infants died as a result of breathing problems. The lungs were ruptured because of over-inflation, or were not inflated at all.

"My device is revolutionary," says the proud inventor.

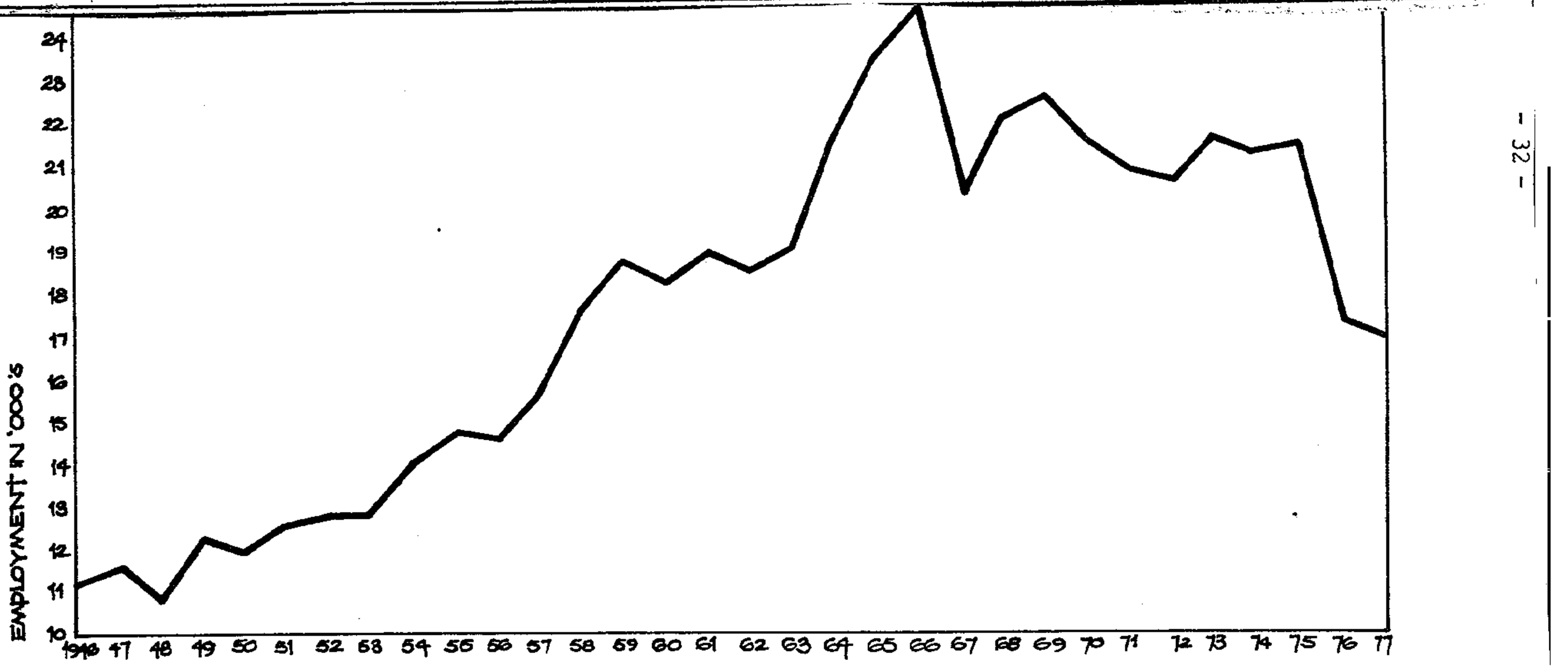
"It is small, plastic — and therefore disposable — easily operated, does not require medical training, and works on a simple principle.

This resuscitator, which is made in South Africa and is used in hospitals all over the country, is now receiving international recognition, and is manufactured in this country. It is used all over the world.

Resuscitation of an infant that has not yet taken its first breath is potentially dangerous. This danger is more pronounced in the case of a premature baby, because the lungs must first be cleared of fluid before gas exchange can take place.

The principle on which this resuscitator works is that air is driven into the lungs at high pressure to remove the liquid, and thus get the baby breathing.

It is vital that high pressures be used, but this must be done without injuring the lungs.



Social Security

→ Medicare 1979



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GENERAL NOTICE

NOTICE 54 OF 1979

DEPARTMENT OF HEALTH

REGISTERED MEDICAL SCHEMES

The Registrar of Medical Schemes hereby notifies, in accordance with section 16A of the Medical Schemes Act, 1967 (Act 72 of 1967), as amended, that the undermentioned medical schemes have been registered.

Those marked with an asterisk (*) have been exempted in terms of section 3 as indicated.

This list, as at 31 December 1978, replaces the list published in *Government Gazette* 6045 of 9 June 1978 and contains 254 schemes, of which 218 are Aid and 36 Benefit Schemes.

N.B.—Do not *count* names in brackets. Their *translated* form appears *elsewhere* in the list.

ALGEMENE KENNISGEWING

KENNISGEWING 54 VAN 1979

DEPARTEMENT VAN GESONDHEID

GEREGISTREERDE MEDIESE SKEMAS

Die Registrateur van Mediese Skemas maak ooreenkomstig artikel 16A van die Wet op Mediese Skemas, 1967 (Wet 72 van 1967), soos gewysig, bekend dat ondergemelde mediese skemas geregistreer is.

Skemas vrygestel kragtens artikel 3 is met 'n sterretjie (*) aangedui, met vermelding van die spesifieke vrystelling.

Hierdie lys, soos op 31 Desember 1978, vervang die lys wat in *Staatskoerant* 6045 van 9 Junie 1978 gepubliseer is en bevat 254 skemas, waarvan 218 Hulp- en 36 Bystandsskemas is.

L.W.—Moenie name tussen hakies *tel* nie. Hulle *vertaalde* vorm verskyn *elders* in die lys.

Name of scheme Naam van skema	X-Private Bag X-Privaatsak P.O. Box Posbus	Place Plek	Code Kode	Reference No. Verwysing No.	Date of registration Datum van registrasie	Exemption from Regulations/Act Vrystelling van Regulasies/Wet
A						
A.A. Mutual Medical Aid Society	9595	Johannesburg	2000	1001	11/8/71	—
Aberdare Africa Medical Aid Society	494	Port Elizabeth	6000	1002	20/11/70	—
Adcock-Ingram Medical Scheme	9391	Johannesburg	2000	1003	12/2/69	—
AECI Medical Aid Society	716	Johannesburg	2000	1005	11/2/71	—
African Cables Medical Benefit Fund	172	Vereeniging	1930	1004	9/6/70	—
A.G.S. van S.A. se Mediese Hulpfonds	197	Lyndhurst	2106	1442	1/8/74	—
Alabama Medical Plan	X-3011	Randburg	2125	1480	13/10/77	—
Alex. Aiken & Carter Medical Aid Society	61975	Marshalltown	2107	1009	24/11/70	—
Allcare Medical Aid Scheme	4757	Johannesburg	2000	1493	29/9/78	—
*Amato Consolidated Industries Sick Benefit Society	9478	Johannesburg	2000	2010	3/11/67	Section/Artikel 20 (1); also/ook Reg. 4.
Ammosal Benefit Society	Mancorp Mine/Myn	Postmasburg	8423	2011	27/11/70	—
Anglo-Alpha Group Medical Aid Society	7462	Johannesburg	2000	1487	28/3/78	—
Anglo American Corporation Medical Aid Society	9761	Johannesburg	2000	1012	16/10/68	—
*Aranda Textile Mills Sick Benefit Society	9478	Johannesburg	2000	2013	15/12/67	Section/Artikel 20 (1); also/ook Reg. 4
Architects' and Quantity Surveyors' Medical Aid Fund	56348	Pinegowrie	2123	1015	17/8/70	
Argus Medical Aid Society	1014	Johannesburg	2000	1016	28/11/68	—
Arthur Young Medical Aid Society	4807	Cape Town/Kaapstad	8000	1258	23/2/71	—
Associated Employers Medical Aid Society	7462	Johannesburg	2000	1018	22/1/70	—

Name of scheme Naam van skema	X-Private Bag X-Privaatsak P.O. Box Posbus	Place Plek	Code Kode	Reference No. Verwysing No.	Date of registration Datum van registrasie	Exemption from Regulations/Act Vrystelling van Regulasies/Wet
Associated Engineering Medical Aid Scheme/. . . se Mediese Hulpskema	56235	Pinegowrie.....	2123	1428	8/10/72	—
Azalea Medical Aid Society.....	1790	Durban.....	4000	1433	1/3/73	—
B						
B.A.B. Medical Aid Fund.....	25622	Denver.....	2027	1020	15/10/71	—
Bankmed.....	1242	Cape Town/Kaapstad	8000	1279	29/6/72	—
Bay Passenger Transport Employees Medical Benefit Scheme	1069	Port Elizabeth.....	6000	2425	28/6/72	—
B.B.K. se Mediese Hulpskema/. . . Medical Aid Scheme	56280	Pinegowrie.....	2123	1432	29/1/73	—
*Begrafnisfonds "Onder ons" (for English see: Funeral . . .)	3522	Johannesburg.....	2000	1151	21/12/67	Reg. 4.
Beland Medical Aid Society.....	7462	Johannesburg.....	2000	1021	1/8/69	—
*Belmed- Mediese Skema.....	45	Sanlamhof.....	7532	1473	14/2/77	Section/Artikel 17, 19A & 20B.
Black Mountain Medical Aid Scheme...	X-18	Springbok.....	8240	1490	24/4/78	—
Bloemfontein Municipal Employees' Medical Aid Society (vir Afrikaans kyk: Mediese Hulpvereniging van die Bloemfonteinse . . .)	1765	Bloemfontein.....	9300	1022	30/9/69	
Blue Circle Medical Aid Society.....	56038	Pinegowrie.....	2123	1264	21/7/69	—
Boart Medical Aid Society.....	9761	Johannesburg.....	2000	1024	14/10/68	—
*Bonmed- Mediese Skema.....	45	Sanlamhof.....	7532	1474	14/2/77	Section/Artikel 17, 19A & 20B.
(Bouverenigings se Gesamentlike Mediese Hulpfonds) (for English see: Building . . .)	(61740)	(Marshalltown).....	(2107)	(1030)	(1/12/70)	(—)
*BP Southern Africa Medical Aid Society	6006	Roggebaai.....	8012	1237	20/2/70	Section/Artikel 19 A.
*Braitex Medical Benefit Society.....	5101	Johannesburg.....	2000	2451	23/4/75	Section/Artikel 20 (1) (c).
Breyten Coalfields Medical Aid Society..	141	Breyten.....	2330	1028	2/12/68	—
Building Societies Joint Medical Aid Fund (vir Afrikaans kyk: Bouverenigings . . .)	61740	Marshalltown.....	2107	1030	1/12/70	—
Bus Bodies Sick Benefit Society.....	4008	Port Elizabeth.....	6000	1032	4/3/70	—
C						
Cape Asbestos Medical Aid Society.....	8644	Johannesburg.....	2000	1033	31/7/69	—
Cape Medical Plan (vir Afrikaans kyk: Kaapse . . .)	6183	Roggebaai.....	8012	1034	11/11/71	—
Cape Portland Medical Aid Society.....	1067	Cape Town/Kaapstad	8000	1035	24/2/69	—
*Cape Steel Sick Fund.....	2121	Cape Town/Kaapstad	8000	2036	5/1/68	Section/Artikel 20 (1); also/ook Reg. 4.
*Cape Town Municipal Workers Association Medical Benefit Fund	49	Athlone.....	7760	2038	11/11/68	Reg. 4.
Capex Medical Aid Society.....	716	Johannesburg.....	2000	1471	8/2/77	—
C.D.A. Medical Aid Fund.....	671	East London / Oos-Londen	5200	1039	5/12/69	—
Chamber of Mines Medical Aid Society	809	Johannesburg.....	2000	1042	26/2/71	—
Chartered Accountants (S.A.) Medical Aid Fund	857	Johannesburg.....	2000	1043	6/8/71	—
City Council Employees' A.T.C. Benefit Society	31555	Braamfontein.....	2017	2046	12/11/71	—
C.N.A. Investments Medical Aid Fund..	1033	Johannesburg.....	2000	1040	17/2/70	—
Commercial and Industrial Medical Aid Society (CIMAS)	958	Johannesburg.....	2000	1048	2/6/69	
*Commercial Union Medical Aid Scheme	222	Johannesburg.....	2000	1050	11/6/70	Section/Artikel 17 & 19A.
Compcare Medical Scheme.....	9605	Johannesburg.....	2000	1491	1/6/78	—
Consolidated Employers' Medical Aid Society	716	Johannesburg.....	2000	1049	8/9/71	—
Consolidated Glass Works Medical Aid and Sick Benefit Society	562	Germiston.....	1400	1052	13/8/71	—
*Contactor Medical Aid Society.....	Private Bag Privaatsak	Suider-Paarl.....	7624	2057	6/3/68	Section/Artikel 20 (1); also/ook Reg. 4.
Corner House Medical Aid Fund.....	62370	Marshalltown.....	2107	1058	21/1/70	—
Coronation Medical Aid Society.....	1517	Durban.....	4000	1059	18/9/74	—
*Court Alfred No. 6039 of the Ancient Order of Foresters Benefit Society	507	Pietermaritzburg....	3200	1060	3/11/67	Section/Artikel 20 (1); also/ook Reg. 4.
C.T. Medical Aid Society.....	81	Cape Town/Kaapstad	8000	1065	16/4/70	—
D						
Datsun-Nissan Medical Aid Society/. . . se Mediese Hulpvereniging	10	Rosslyn.....	0200	1066	30/9/68	—
David Brown Employees Medical Aid Society	7706	Johannesburg.....	2000	1067	12/6/70	—
De Beers Benefit Society.....	616	Kimberley.....	8300	2068	29/5/69	—

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Delfos Medical Aid Scheme	56234	Pinegowrie	2123	1415	17/8/71	—
*Dental and Optical Fund	3400	Johannesburg	2000	1069	21/1/68	Section/Artikel 20 (1); also/ook Reg. 4.
D.I.S.W. Medical Aid Society	290	Benoni	1500	1070	4/11/70	—
D.K.K. of 1888 Medical Plan	X-3011	Randburg	2125	1465	30/8/76	—
Dormas Medical Aid Society	38040	Booysens	2016	1072	12/12/69	—
D.R.G. Medical Aid Society	932	Cape Town/Kaapstad	8000	1263	16/3/70	—
E						
Eastern Province Newspapers Medical Aid Society	1117	Port Elizabeth	6000	1076	5/6/69	—
Edgars Medical Aid Scheme	7462	Johannesburg	2000	1484	6/3/78	—
Erica Medical Aid Society	6052	Roggebaai	8012	1464	20/8/76	—
Escom Medical Aid Society (vir Afrikaans kyk: Evkom . . .)	1091	Johannesburg	2000	1346	12/2/71	—
E.T.C. Medical Benefit Society	121	Barberton	1300	2081	6/6/69	—
Everite Medical Aid Society/. . . se Mediese Hulpvereniging	31166	Braamfontein	2017	1082	9/9/71	—
(Evkom se Mediese Hulpvereniging) (for English see: Escom . . .)	(1091)	(Johannesburg)	(2000)	(1346)	(12/2/71)	(—)
F						
Family Medicare	716	Johannesburg	2000	1494	20/10/78	—
Federated Employers' Medical Aid Society	9605	Johannesburg	2000	1083	21/5/70	—
Fedhandel se Mediese Hulpskema	56236	Pinegowrie	2123	1418	22/10/71	—
Finmed Medical Aid Scheme/. . . se Mediese Hulpskema	56290	Pinegowrie	2123	1420	3/3/72	—
Ford Medical Aid Plan/. . . se Mediese Hulpplan	—	1201 Oasim North/ Noord, Havelock Street/-straat, Port Elizabeth	6001	1452	25/4/75	—
Fowler Group Medical Aid Society	28568	Sunnyside	0132	1467	21/9/76	—
Freight Services Medical Aid Society	716	Johannesburg	2000	1472	8/2/77	—
*Fruit and Vegetables Canning Workers' Medical Benefit Fund	2678	Cape Town/Kaapstad	8000	2086	20/10/67	Section/Artikel 20 (1); also/ook Reg. 4.
*(Funeral Fund "Onder Ons") (vir Afrikaans kyk: Begrafnis . . .)	(3522)	(Johannesburg)	(2000)	(1151)	(21/12/67)	(Reg. 4.)
G						
Garlick Medical Aid Society	6052	Roggebaai	8012	1417	15/9/71	—
Gemeenskaplike Munisipale Mediese Hulpfonds (Transvaal) (GMMH) (for English see: Joint . . .)	14145	Vereeniging	0140	1087	28/5/68	—
General Accident Medical Aid Society	2756	Johannesburg	2000	1088	28/1/70	—
General Mining Group Medical Aid Society	7462	Johannesburg	2000	1089	3/12/69	—
General Motors South African (Pty) Ltd Medical Aid Plan	1137	Port Elizabeth	6000	1090	21/4/72	—
General Motors South African (Pty) Ltd Medical Benefit Scheme	1137	Port Elizabeth	6000	2421	21/4/72	—
Germiston Industries Medical Aid Society/. . . Die Germistonse Nywerhede Mediese Hulpvereniging	680	Germiston	1400	1092	17/2/70	—
*Glass Industry Sick Benefit Fund	2221	Port Elizabeth	6000	2094	5/1/68	Section/Artikel 20 (1); also/ook Reg. 4.
Goldbys Medical Benefit Fund	1172	Johannesburg	2000	1096	5/5/71	—
Gold Fields Medical Aid Society	1167	Johannesburg	2000	1098	14/5/70	—
Good Hope Medical Aid Society	7462	Johannesburg	2000	1466	7/9/76	—
Greatermans Medical Aid Society	5460	Johannesburg	2000	1099	25/4/69	—
H						
Haggie Rand Medical Aid Scheme/. . . se Mediese Hulpskema	56234	Pinegowrie	2123	1416	17/8/71	—
Helam Medical Aid Society	2	Mine Office / Mynkantoor, Swartruggens	2835	1100	1/3/71	—
*Helpmed-Mediese Skema/. . .Helpmed Medical Scheme	45	Sanlamhof	7532	1413	1/7/71	Section/Artikel 17, 19A & 20B.
Hextex Medical Aid Society	48	Worcester	6850	1103	29/8/69	—
Highveld Medical Scheme	111	Witbank	1035	1177	28/12/72	—
Hill Samuel Medical Aid Society	7106	Johannesburg	2000	1496	21/11/78	—
Hoechst Medical Aid Society for Southern Africa	7706	Johannesburg	2000	1429	28/8/72	—
Homes Trust se Mediese Skema	93	Cape Town/Kaapstad	8000	1105	28/10/70	—
Huletts Medical Aid Fund	X-3	Glenashley	4022	1106	16/11/70	—

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I						
I.B.M. South Africa Medical Aid Society	7462	Johannesburg.....	2000	1111	12/2/71	—
Ideal Medical Aid Scheme.....	31541	Braamfontein.....	2017	1461	31/3/76	—
I.C.S Medical Aid Society/. . . se Mediese Hulpskema	90	Howard Place.....	7450	1431	29/9/72	—
Impilo Medical Aid Society.....	7706	Johannesburg.....	2000	1475	1/4/77	—
Insbroke Medical Aid Society.....	8219	Johannesburg.....	2000	1109	18/11/68	—
Iscor Medical Benefit Fund (vir Afrikaans kyk: Yskor . . .)	2154	Pretoria.....	0001	2295	11/2/71	—
J						
J.C.I. (Barberton) Medical Aid Society..	17	Barberton.....	1300	1114	31/7/69	—
Johannesburg Chamber of Commerce Medical Aid Society (JCC) (vir Afrikaans kyk: Johannesburgse Kamer . . .)	7462	Johannesburg.....	2000	1115	17/7/69	—
(Johannesburgse Kamer van Koophandel se Mediese Hulpvereniging, Die) (for English see: Johannesburg Chamber . . .)	(7462)	(Johannesburg).....	(2000)	(1115)	(17/7/69)	(—)
Johannesburg Municipal Employees' Sick Benefit Society (vir Afrikaans kyk: Die Johannesburgse Siekehulpvereniging . . .)	2626	Johannesburg.....	2000	2116	10/3/72	—
(Johannesburgse Siekehulpvereniging vir Munisipale Werknemers, Die) (for English see: Johannesburg Municipal . . .)	(2626)	(Johannesburg).....	(2000)	(2116)	(10/3/72)	(—)
[(Joint Municipal Medical Aid Fund (Transvaal)] (vir Afrikaans kyk: Gemeenskaplike . . .)	(14145)	(Verwoerdburg).....	(0140)	(1087)	(28/5/68)	(—)
K						
(Kaapse Mediese Plan) (for English see: Cape Medical . . .)	(6183)	(Roggebaai).....	(8012)	(1034)	(11/11/71)	(—)
*Klerksdorp Mines Benefit Society (KDM) (vir Afrikaans kyk: Klerksdorpse . . .)	326	Klerksdorp.....	2570	2121	23/4/71	Reg. 15.
*(Klerksdorpse Mynbystandsvereniging, Die) (KDM) (for English see: Klerksdorp . . .)	(326)	(Klerksdorp).....	(2570)	(2121)	(23/4/71)	(Reg. 15.)
*Koöpmed- Mediese Skema.....	33	Paarl.....	7622	1463	3/6/76	Section/Artikel 20 (1) (q).
Krygmed.....	4659	Pretoria.....	0001	1434	2/4/73	—
K.W.B. Medical Aid Society.....	7706	Johannesburg.....	2000	1124	6/8/68	—
L						
Legal and General Medical Aid Scheme	4870	Johannesburg.....	2000	1125	8/10/71	—
*Leyland Sick Fund (previously/voorheen B.M.C. Sick Fund)	1556	Cape Town/Kaapstad	8000	2023	15/12/67	Section/Artikel 20 (1); also/ook Reg. 4.
Local Authorities Medical Aid Fund (Cape) (LAMAF) (vir Afrikaans kyk: Mediese Hulpfonds . . .)	460	Cape Town/Kaapstad	8000	1145	10/1/68	—
Lomed Medical Aid Society.....	9263	Johannesburg.....	2000	1492	22/6/78	—
*Loyal Alfred Lodge No. 5072 Friendly Society		Milstan, Maidstone Road/-weg, Heathfield	7800	2126	15/12/67	Section/Artikel 20 (1); also/ook Reg. 4.
*Loyal Durban Lodge No. 5403.....	331	Durban.....	4000	1128	5/1/68	Section/Artikel 20 (1); also/ook Reg. 4.
*Loyal Natal Unity Lodge No. 4443, I.O.O.F./M.U.F.S.	493	Pietermaritzburg....	3200	1129	3/11/67	Section/Artikel 20 (1); also/ook Reg. 4.
*Loyal Nil Desperandum Lodge No. 6054	—	87 Balfour St., Woodstock	7925	2438	11/3/74	Section/Artikel 20 (1); also/ook Reg. 4.
M						
M & Z Staff Sick Fund.....	239	Windhoek.....	9100	1132	24/3/70	—
Makro Medical Aid Society.....	7706	Johannesburg.....	2000	1495	20/10/78	—
Marley Medical Aid Society.....	6684	Johannesburg.....	2000	1134	2/9/70	—
Massey-Ferguson-Safim Medical Aid Society	677	Vereeniging.....	1930	1136	21/5/70	—
*M.C.G. Medical Fund.....	2268	North End.....	6056	2155	15/12/67	Section/Artikel 20 (1) (c).
M.C.I. Medical Scheme/. . . se Mediese Skema	2268	North End.....	6056	2138	17/2/70	—
Meddent Medical Aid Society.....	9153	Johannesburg.....	2000	1139	27/10/67	—
Medical Medical Aid Society.....	9153	Johannesburg.....	2000	1140	6/2/68	—
*(Medical Aid Society of the Agricultural Unions) (vir Afrikaans kyk: Mediese hulpvereniging van die Landbou-Unies)	(54)	(Bloemfontein).....	(9300)	(1148)	(19/12/67)	(Reg. 5.)

Name of scheme Naam van skema	X-Private Bag X-Privaatsak P.O. Box Posbus	Place Plek	Code Kode	Reference No. Verwysing No.	Date of registration Datum van registrasie	Exemption from Regulations/Act Vrystelling van Regulasies/Wet
Medical Aid Society of the Federation of Master Printers of S.A.	32496	Braamfontein	2017	1141	23/8/71	—
Medical Expenses Distribution Society (MEDS)	10178	Johannesburg	2000	1142	2/12/69	—
Medical Services Plan (MSP) (vir Afrikaans kyk: Plan . . .)	X-3011	Randburg	2125	1143	9/8/71	—
Medico	11352 (460)	Signal Hill/Vlaeberg (Cape Town/Kaapstad)	8015 (8000)	1144 (1145)	19/12/67 (10/1/68)	— (—)
[Mediese Hulpfonds vir Plaaslike Owerhede (Kaap)] (for English see: Local . . .)						
Mediese Hulpskema van die N.G. Kerk van Transvaal	433	Pretoria	0001	1146	18/7/69	—
(Mediese Hulpvereniging van die Bloemfonteinse Munisipale Werknemers) (for English see: Bloemfontein . . .)	(1765)	(Bloemfontein)	(9300)	(1022)	(30/9/69)	(—)
*Mediese Hulpvereniging van die Landbouunies (for English see: Medical Aid Society of the Agricultural . . .)	54	Bloemfontein	9300	1148	19/12/67	Reg. 5.
Mediese Hulpvereniging van die Poskantoor (for English see: Post . . .)	303	Germiston	1400	1147	27/5/70	—
Mediese Hulpvereniging van Staatsamptenare (MHVS) (for English see: Public . . .)	26004	Arcadia	0007	1149	23/6/69	—
Mercantile & General (SA) Medical Aid Fund	2445	Cape Town/Kaapstad	8000	1152	5/8/70	—
*Messina Medical Benefit Society	X-620	Messina	0900	2153	4/9/69	Reg. 15.
Metal Box Medical Aid Society	7752	Johannesburg	2000	1154	1/2/71	—
(Middellandse Mediese Plan) (MMP) (for English see: Midland . . .)	(—)	(1201/6 Oasis-Noord Havelockstr., Port Elizabeth)	(6001)	(1156)	(3/12/70)	(—)
Midland Medical Plan (MMP) (vir Afrikaans kyk: Middellandse . . .)	—	1201/6 Oasis North, Havelock Street, Port Elizabeth	6001	1156	3/12/70	—
Mines Benefit Society (MBS) (vir Afrikaans kyk: Myn . . .)	23257	Joubert Park	2044	2158	3/2/71	—
Moreop Medical Aid Society	—	Dido Valley, Simonstown	7995	1161	6/8/71	—
Motomedic Society	5317	Johannesburg	2000	1290	14/6/72	—
Multimed Medical Scheme	62061	Marshalltown	2107	1483	19/1/78	—
Mumed 850 Plan	90	Howard Place	7450	1215	17/11/71	—
Municipal Medical Aid Scheme (Natal) (vir Afrikaans kyk: Munisipale . . .)	3472	Durban	4000	1162	5/8/69	—
[Munisipale Mediese Hulpskema (Natal)] (for English see: Municipal . . .)	(3472)	(Durban)	(4000)	(1162)	(5/8/69)	(—)
Murray & Stewart Medical Aid Scheme	56060	Pinegowrie	2123	1447	20/12/74	—
Mutual and Federal Medical Aid Fund	90	Howard Place	7450	1208	10/6/71	—
(Mynbystandvereniging) (for English see: Mines . . .)	(23257)	(Joubert Park)	(2044)	(2158)	(3/2/71)	(—)
N						
Natal Building Society Medical Aid Fund	1744	Durban	4000	1164	8/6/70	—
Natal Coal Owners' (Durban Staff) Medical Aid Society	281	Durban	4000	1165	16/6/70	—
National Medical Plan (NMP) (previously/voorheen Natal Medical Plan)	2339	Durban	4000	1167	6/5/71	—
National Portland Medical Aid Society	21	Claremont	7735	1168	29/7/69	—
National Trading Medical Aid Society	2762	Johannesburg	2000	1169	20/11/69	—
N.B.C. Medical Aid Society	10423	Johannesburg	2000	1170	19/2/69	—
Nedmed Medical Aid Society	99	Howard Place	7450	1469	24/12/76	—
New Zealand Insurance Company (S.A.) Ltd Medical Aid Society	7706	Johannesburg	2000	1410	14/4/71	—
Nimax Medical Aid Society	1790	Durban	4000	1470	19/1/77	—
Nimed Medical Aid Society	1750	Durban	4000	1166	27/1/71	—
Nuham Shand Medical Aid Society	99	Howard Place	7450	1344	5/9/74	—
Northern Medical Aid Society	9262	Johannesburg	2000	1171	20/3/68	—
N.T.F. Staff Medical Aid Fund	30	Pietermaritzburg	3200	1174	4/9/70	—
Number One Medical Plan	51390	Randburg	2125	1468	23/12/76	—
O						
(O.F.S. Joint Municipal Medical Aid Fund) (vir Afrikaans kyk: O.V.S. . . .)	(1132)	(Kroonstad)	(9500)	(1190)	(20/8/68)	(—)
O.K. Bazaars Medical Aid Society	4642	Cape Town/Kaapstad	8000	1176	10/2/70	—
Olifantsfontein Medical Aid Society	10	Olifantsfontein	1665	1178	26/4/72	—
Onmed Plan	90	Howard Place	7450	1476	5/5/77	—
Ore and Metal Medical Aid Society	3548	Johannesburg	2000	1181	18/9/70	—
O.V.S. Gemeenskaplike Munisipale Mediese Hulpfonds (for English see: O.F.S. . . .)	113	Kroonstad	9500	1190	20/8/68	—
P						
Parmed Medical Aid Scheme/Parmed-Mediese Hulpskema	56287	Pinegowrie	2123	1431	29/3/74	—
Pep Medical Aid Society	76	Kuilsrivier	7580	1414	11/8/71	—

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Perskor- Mediese Fonds	845	Johannesburg	2000	1007	3/6/70	—
Philips Medical Aid Society	7706	Johannesburg	2000	1184	14/7/70	—
Pietermaritzburg Chamber of Industries Medical Aid Society	1790	Durban	4000	1185	5/11/70	—
Pilkington Group European Medical Aid Society	111	Springs	1560	1186	20/11/70	—
(Plan vir Mediese Dienste) (for English see: Medical Services . . .)	(X-3011)	(Randburg)	(2125)	(1143)	(9/8/71)	(—)
Plate Glass Group Medical Aid Society	7462	Johannesburg	2000	1437	23/11/73	—
Plessey (S.A.) Medical Aid Scheme	56150	Pinegowrie	2123	1423	23/6/72	—
Port Elizabeth Bus Workers Medical Aid Scheme	1069	Port Elizabeth	6000	1426	28/6/72	—
Port Elizabeth Tramway Employees' Medical Aid Scheme/. . . Tremwerknemers se Mediese Hulpskema	1069	Port Elizabeth	6000	1190	13/5/67	—
(Post Office Medical Aid Society) (POMAS) (vir Afrikaans kyk: Mediese Hulpvereniging van die Poskantoor)	(303)	(Germiston)	(1400)	(1147)	(27/5/70)	(—)
Powerlines Medical Aid Society	1989	Johannesburg	2000	1191	5/12/68	—
Premier Medical Plan	95	East London / Oos-Londen	5200	1485	17/3/78	—
Pretoria Municipal Sick Fund/. . . Die Pretoriase Munisipale Siekefonds	3497	Pretoria	0001	1242	28/1/70	—
Profmed	6268	Johannesburg	2000	1194	8/10/69	—
Pro Sano- Mediese Hulpskema/. . . Medical Aid Scheme	484	Parow	7500	1454	17/5/76	—
Protea Assurance Staff Medical Aid Society	646	Cape Town/Kaapstad	8000	1195	22/10/70	—
Protea Medical Aid Society	6052	Roggebaai	8012	1196	19/11/69	—
Prudential Medical Aid Scheme	1097	Johannesburg	2000	1197	20/2/69	—
(Public Service Medical Aid Association) (PSMAA) (vir Afrikaans kyk: Mediese Hulpvereniging van Staatsamptenare)	(26004)	(Arcadia)	(0007)	(1149)	(23/6/69)	(—)
*Putco Staff Sick Fund/. . . se Personeelsiekefonds	X-3	Wendywood	2144	1198	2/6/70	Section/Artikel 19 & 19A.
R						
Radue's Staff Medical Aid Scheme	112	King William's Town	5600	1199	12/6/70	—
Rand Water Board Sick Fund (vir Afrikaans kyk: Rand-Waterraad se . . .)	1127	Johannesburg	2000	1201	24/10/69	—
(Rand-Waterraad se Siekefonds) (for English see: Rand Water . . .)	(1127)	(Johannesburg)	(2000)	(1201)	(24/10/69)	(—)
Reed Corporation Medical Aid Society	90	Howard Place	7450	1277	29/12/72	—
Reef Medical Aid Society	—	39 The Avenue, Krugersdorp North/-Noord	1740	1202	26/11/69	—
Rembrandt-groep se Mediese Hulpskema/ Rembrandt Group Medical Aid Scheme	56300	Pinegowrie	2123	1430	18/9/72	—
Roberts Construction Medical Aid Scheme	56234	Pinegowrie	2123	1435	23/5/73	—
*Robertson se Algemene Hulpgenootskap	1	Robertson	6705	2412	11/6/71	Section/Artikel 19 & 20 (1); also/ook Reg. 4.
Rooiberg Mine Medical Aid Society	Private Bag/ Privaatsak	Rooiberg	0500	1206	12/6/70	—
Runstaff Medical Scheme	31082	Braamfontein	2017	1427	30/6/72	—
S						
SAAN Medical Aid Society	1138	Johannesburg	2000	1130	6/5/70	—
S.A.B. Castellion Medical Scheme	90	Howard Place	7450	1450	26/3/75	—
(S.A.B.C.) Medical Aid Scheme) (vir Afrikaans kyk: S.A.U.K. se . . .)	(56140)	(Pinegowrie)	(2123)	(1424)	(23/6/72)	(—)
Sabre Medical Scheme	90	Howard Place	7450	1489	1/4/78	—
Sabstel Medical Scheme	90	Howard Place	7450	1488	1/4/78	—
Safmarine Medical Aid Fund	27	Cape Town/Kaapstad	8000	1211	10/2/69	—
S.A.K.A.V. Medical Aid Fund/. . . se Mediese Hulpfonds	33	Paarl	7622	1213	8/12/69	—
S.A. Mutual Life Assurance Society Staff Medical Aid Fund	66	Cape Town/Kaapstad	8000	1214	13/2/69	—
Sanitas Medical Scheme	2825	Durban	4000	1453	18/12/75	—
Santam se Onderlinge Mediese Hulpvereniging	653	Cape Town/Kaapstad	8000	1232	29/8/69	—
SAPPI Medical Aid Society	10246	Johannesburg	2000	1233	14/8/69	—
Sasol se Mediese Hulpfonds/. . . Medical Aid Fund	80	Sasolburg	9570	1234	17/2/71	—
S.A.U.K. se Mediese Hulpskema (for English see: S.A.B.C. . . .)	56140	Pinegowrie	2123	1424	23/6/72	—
*Selfmed- Mediese Skema/Selfmed Medical Scheme	45	Sanlamhof	7532	1446	19/11/74	Section/Artikel 17, 19A & 20B.

Name of scheme Naam van skema	X-Private Bag X-Privaatsak P.O. Box Posbus	Place Plek	Code Kode	Reference No. Verwysing No.	Date of registration Datum van registrasie	Exemption from Regulations/Act Vrystelling van Regulasies/Wet
Shell Southern Africa Medical Aid Society	2231	Cape Town/Kaapstad	8000	1455	30/6/75	—
Shoe Corporation Medical Aid Fund	7462	Johannesburg	2000	1238	18/2/69	—
Sick Benefit Fund for the Diamond Cutting Industry of South Africa	8304	Johannesburg	2000	2239	4/5/72	—
Sick Benefit Society D.C.L.S.A.	4955	Johannesburg	2000	2240	18/8/71	—
*Siekebystandfonds van die Nasionale Pers Bpk. (Kantoorpersoneel)	2271	Cape Town/Kaapstad	8000	1241	7/3/72	Section/Artikel 20 (1) (c).
*Siemed Benefit Scheme	7462	Johannesburg	2000	2445	19/9/74	Section/Artikel 20 (1) (q); 25G (1) (b); 25G (2).
*Siemens Medical Aid Scheme	7462	Johannesburg	2000	1243	6/11/68	Section/Artikel 20 (1) (q); 25G (1) (b); 25G (2).
Sizwe Medical Fund	51106	Randburg	2125	1486	17/3/78	—
South African Breweries Ltd Medical Aid Society	90	Howard Place	7450	1209	1/9/70	—
South African Eagle Medical Aid Society	61489	Marshalltown	2107	1210	18/6/71	—
South African Teachers' Association Medical Aid Society (SATA)	-	5 Ellerslie Road/weg, Wynberg	7800	1235	21/12/67	—
South Atlantic Corporation Medical Aid Society	6624	Roggebaai	8012	1248	5/6/70	—
Southern Medical Aid Society	—	C/o– P/a Southern Life Association/ Vereniging, Great Westerford, Rondebosch	7700	1249	8/5/72	—
South West Africa Company Medical Aid Society	2	Grootfontein	9245	1458	18/7/75	—
Springs Industrial Benefit Society (SIBS)	554	Springs	1560	1250	29/1/70	—
Stability Medical Aid Society	5703	Johannesburg	2000	1251	19/1/68	—
Statutêre Organisasies se Mediese Skema (SOMS) (for English see: Statutory . . .)	X-363	Pretoria	0001	1252	11/8/71	—
(Statutory Organisations Medical Scheme) (SOMS) (vir Afrikaans kyk: Statutêre . . .)	(X-363)	(Pretoria)	(0001)	(1252)	(11/8/71)	(—)
S.T.C. Black Medical Aid Scheme	9153	Johannesburg	2000	1449	31/1/75	—
Steeledale Group Medical Aid Scheme	1210	Johannesburg	2000	1253	7/8/68	—
Stewarts & Lloyds Medical Aid Society	74	Vereeniging	1930	1254	25/5/70	—
Stuttafords Medical Aid Society	69	Cape Town/Kaapstad	8000	1256	28/11/69	—
Sydmore Medical Aid Society	8853	Johannesburg	2000	1257	29/1/70	—
T						
Tafelberg Medical Aid Society	6052	Roggebaai	8012	1260	26/8/70	—
Theron, Humphrey & Fick se Siekefonds	62	Worcester	6850	1265	29/2/72	—
TMSA Medical Aid Society	56280	Pinegowrie	2123	1268	24/8/70	—
*Tongaat Medical Benefit Scheme	5	Maidstone	4380	2267	11/11/71	Section/Artikel 19 A; also/ook Reg. 4 (2) (v).
*Topmed-Mediese Skema/Topmed Medical Scheme	45	Sanlamhof	7532	1422	24/4/72	Section/Artikel 17, 19A & 20B.
Traduna Medical Aid Fund	31811	Braamfontein	2017	1269	9/2/70	—
Tramway Employees' Medical Benefit Fund	115	Cape Town/Kaapstad	8000	2270	30/6/72	—
*Trawlermen's Sick Benefit and Benevolent Fund	2416	Cape Town/Kaapstad	8000	2271	20/10/67	Section/Artikel 20 (1); also/ook Reg. 4.
Tsumeb Corporation Medical Aid Society	1313	Tsumeb	9260	1272	12/1/68	—
U						
Uitenhage Passenger Transport Employees' Sick Fund	225	Port Elizabeth	6000	2274	1/4/70	—
U.L.A. Medical Aid Society	785	Germiston	1400	1275	2/5/69	—
*Union Flour Mills Sick Fund	1010	Durban	4000	1276	12/2/71	Total except/Algeheel behalwe 6 & 9.
Union Platinum Mine Medical Benefit Society/. . . se Mediese Bystandsvereniging	13	Swartklip	0370	2278	14/4/70	—
*(United Bouvereniging se Mediese Hulpfonds) (for English see: United Building . . .)	(7735)	(Johannesburg)	(2000)	(1280)	(26/3/70)	[Section/Artikel 20 (1) (c); also/ook Reg. 5.]
*United Building Society Medical Aid Fund (vir Afrikaans kyk: United Bouvereniging . . .)	7735	Johannesburg	2000	1280	26/3/70	Section/Artikel 20 (1) (c); also/ook Reg. 5.
*University of the Witwatersrand, Johannesburg, Staff Medical Aid Fund	—	Jan Smuts Avenue/-laan, Johannesburg	2001	1282	18/5/71	Reg. 5.
Usco Medical Aid Society/. . . se Mediese Hulpvereniging	48	Vereeniging	1930	1283	5/8/68	—

Name of scheme Naam van skema	Aggregate Reg No(s) of Scheme(s) Totale Reg No(s) van Skema(s)	Place Plek	Code Kode	Reference No. Verwysing No.	Date of registration Datum van registrasie	Exemption from Regulations/Act Vrystelling van Regulasies/Wet
V						
Vanderbijlpark Medical Benefit Fund/Vanderbijlpark Mediese Bystandsfonds	105	Vanderbijlpark	1900	2285	10/6/71	—
Vereeniging Coronation Medical and Benefit Club	P.O.'s/Pk	Hoboken	3145	2288	1/5/72	—
W						
Witbank Coalfields Benefit Society	26	Witbank	1035	2291	30/4/69	—
Woolworths Medical Aid Society	6952	Rosebank	8012	1293	12/12/69	—
X						
Xhosa Developmen Corporation Medical Aid Scheme (vir Afrikaans kyk Xhosa-Ontwikkelingskorporasie)	779	East London	5200	1436	24/5/73	—
(Xhosa-Ontwikkelingskorporasie se Mediese Hulpskema) (for English see Xhosa)	(779)	(Oos-Londen)	(5200)	(1436)	(24/5/73)	(—)
Y						
(Yskor se Mediese Bystandsfonds) (for English see Iscor)	(2158)	(Pretoria)	(0001)	(2295)	(11/2/71)	(—)

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6279—1

South African Railways and Harbours Sick Fund

136. Mr. N. B. WOOD asked the Minister of Transport:

(1) What was the amount of the subsidy paid to the South African Railways and Harbours Sick Fund during 1977-'78;

(2) (a) what amount was collected during that year in respect of the levy on prescriptions and (b) what was the Railway Administration's contribution;

(3) what was the number of (a) members and (b) dependants registered in respect of the Fund;

(4) whether any non-White employees are entitled to benefits; if so, how many (a) Coloureds, (b) Indians and (c) Blacks.

The MINISTER OF TRANSPORT:

(1) R16 891 335.

(2) (a) R1 368 225.

(b) R1 641 656.

(3) (a) 151 514.

(b) 225 582.

(4) Yes.

(a) 24 877.

(b) 1 904.

(c) 124 254.

Council bid to raise medical fees delayed

DURBAN — The South African Medical and Dental Council decided yesterday to cancel proposals for an interim increase in fees and to call a special sitting in August to discuss an increase.

Earlier the Representative Association of Medical Schemes (Rams) threatened to take the SA Medical Council to court if it went through with a 25 per cent fee hike recommendation payable by the medical schemes.

The proposed increase would have "the gravest economic impact" on the public, attorneys for the medical schemes said in papers tabled before the Medical Council meeting.

The tariff committee of the Medical Council recommended in February that the present tariff of 80c per unit payable by the medical schemes be increased to R1, an effective increase of 25 per cent, and gave the medical schemes two months to comment.

Rams claimed they were not given enough time to consider the proposed increases, and objected to the procedure adopted, which "is not one sanctioned by the legislation".

"We call upon the committee forthwith to indicate that it proposes to desist from any further action concerning a tariff of fees and that it will not purport to recommend any interim tariff to the council.

"If we do not have these assurances forthwith our clients propose to take legal action to set aside the proceedings thus far," attorneys for the medical schemes said.

The medical schemes also strongly objected that the tariff committee composition was "loaded in favour of the profession".

"The medical tariff committee is apparently comprised of eight persons, of whom only one is not a medical practitioner".

Rams said they were asked only to respond to an increase proposal after it was decided on, not whether there should be an increase at all. — SAPA.

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DISEASES OF BLOOD AND BLOOD-FORMING ORGANS

IV

	W		A		B		C	
	M	F	M	F	M	F	M	F
0–1	0,02	0,03	0,20	0,21	0,06	0,06	0,06	0,16
1–4	0,01	0,01	0,02	0,00	0,01	0,01	0,02	0,04
5–24	0,00	0,00	0,01	0,01	0,01	0,01	0,01	0,01
25–44	0,01	0,01	0,01	0,02	0,01	0,01	0,00	0,01
45–64	0,02	0,02	0,03	0,03	0,01	0,03	0,06	0,04
65+	0,11	0,11	0,13	0,15	0,03	0,03	0,13	0,15
ALL	0,01	0,02	0,02	0,02	0,01	0,01	0,02	0,03
NO.	30	34	7	7	23	21	21	31

1 JUNE 1979 Hansard 18 col 1002

Institutions subsidized by Department of Social Welfare and Pensions 799

849. Mr. J. W. E. WILEY asked the Minister of Social Welfare and Pensions:

(1)(a) What are the names of the institutions administered by a company [whose name has at Mr. Wiley's request been supplied to the Minister's Department for the purposes of his reply] subsidized by his Department and (b) how many patients are accommodated at each institution;

(2) what is the number of (a) medically qualified and (b) non-medically qualified staff members employed at each institution;

(3) whether pharmaceutical facilities are available at any of the institutions; if so, (a) at how many institutions and (b) what is the nature of these facilities.

The MINISTER OF SOCIAL WELFARE AND PENSIONS:

(1) (a) Struisbulthawe, Springs
Robinson, Krugersdorp
Portdene, Port Elizabeth
New Kings, Cape Town
The Department does not pay any subsidy to the company concerned. An all inclusive remunerative daily tariff per aged person is, however, payable in respect of the services rendered.

(b) Struisbulthawe 110
Robinson 84
Portdene 90
New Kings 104

(2)

	(a)	(b)
Struisbulthawe	10	49 (including 19 assistant nurses and 3 student nurses)
Robinson	3	35 (including 12 assistant nurses and 2 student nurses)
Portdene	9	46 (including 21 assistant nurses)
New Kings	8	46 (including 22 assistant nurses and 1 occupational therapist)

(3) No. Medicines are prescribed by the district surgeon concerned, who is responsible for the medical services at the institution. The medicines are obtained from local pharmacies on prescription.

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DISEASES OF THE CIRCULATORY SYSTEM

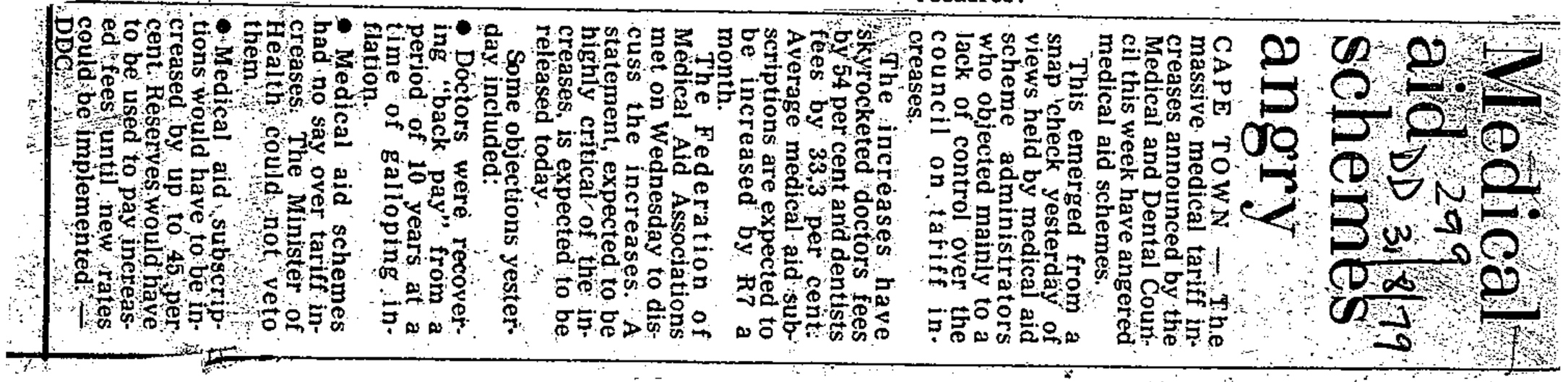
VII

	W		B	
	M	F	M	F
0–1	0,51	0,3	13	0,10
1–4	0,05	0,0	02	0,04
5–24	0,07	0,0	,11	0,13
25–44	1,09	0,4	,73	0,78
45–64	9,75	4,4	,61	5,01
65	42,19	32,9	,55	14,21
ALL	4,70	3,8	,14	1,20
NO.	9752	792	2390	1921

DISEASES OF THE RESPIRATORY SYSTEM

VIII

	W		A	
	M	F	M	F
0–1	2,90	2,22	7,81	4,85
1–4	0,22	0,28	0,90	0,69
5–24	0,05	0,06	0,17	0,11
25–44	0,20	0,12	0,37	0,33
45–64	1,46	0,92	3,33	1,85
65+	11,52	7,89	16,51	13,42
ALL	1,12	0,97	1,22	0,79
NO.	2336	2019	430	282



Medical aid schemes angry

CAPE TOWN — The massive medical tariff increases announced by the Medical and Dental Council this week have angered medical aid schemes.

This emerged from a snap check yesterday of views held by medical aid scheme administrators who objected mainly to a lack of control over the council on tariff increases.

The increases have skyrocketed doctors fees by 54 per cent and dentists fees by 33,3 per cent. Average medical aid subscriptions are expected to be increased by R7 a month.

The Federation of Medical Aid Associations met on Wednesday to discuss the increases. A statement, expected to be highly critical of the increases, is expected to be released today.

Some objections yesterday included:

● Doctors were recovering "back pay" from a period of 10 years at a time of galloping inflation.

● Medical aid schemes had no say over tariff increases. The Minister of Health could not veto them.

● Medical aid subscriptions would have to be increased by up to 45 per cent. Reserves would have to be used to pay increased fees until new rates could be implemented. — DDC

JAARVERSLAG

1978

SENTRUM VIR INTERGROEPSTUDIES

(Geregistreer as The Abe Bailey Institute of Inter-Racial Studies Limited
(Beperk deur Garansie))

Posadres:

Gedurende die eerste nege jaar van sy bestaan het die Sentrum vir Intergroepstudies gereeld 'n jaarverslag oor sy werksaamhede gepubliseer. Om die Sentrum se 10de verjaarsdag op 1 April 1978 te vier is die jaarverslag in 1977 vervang deur 'n Oorsig oor die Eerste Tien Jaar.

DIE OORSPRONG EN DOELSTELLINGS VAN DIE SENTRUM

Die Sentrum word grootliks gefinansier deur die Abe Bailey-Trust wat ingevolge die testament van Sir Abe Bailey gestig is. Dit is geregistreer as The Abe Bailey Institute of Inter-Racial Studies Limited (Beperk deur Garansie) - 'n maatskappy beperk deur garansie en sonder 'n aandele-kapitaal kragtens die Maatskappywet 1973 (Wet Nr. 61 van 1973).

Tucsa condemns doctors' pay demands

By Sieg Hannig, Labour Reporter

CAPE TOWN — The increases in tariffs demanded by the medical profession have been condemned unanimously by the annual conference of the Trade Union Council of South Africa (Tucsa).

It was incomprehensible that doctors' costs could have risen by 52,4 percent, Mr Norman Daniels, chairman of the Western Province area division of Tucsa, told the conference yesterday.

"Our members will, in actual fact, die," he stated. "They just haven't got the money to pay this extra cost. It's inigultous."

Mr Daniels objected to the medical profession having the final say in the determination of its own tariffs.

MR MALHERBE

Mr E "Lief" van Tonder, a past Tucsa president, said doctors should have to negotiate increases in tariffs as the trade unions had to negotiate pay increases with the people most affected by the increases.

Only a drastic amendment in legislation could prevent doctors getting the increases they demanded, he said.

Tucsa's new president, Mr Andre Malherbe, said the legislation which deprived medical aid schemes of a say in the fixing of doctor's tariffs had been passed only recently.

RPM TOO

Tucsa had protested to the Minister of Health about the increase which doctors demanded, as well as the increase in the cost of medicines.

Mr Ray Altman, of the white and coloured shop workers' unions, said his unions had protested to the relevant Ministers about resale price maintenance in medicines.

Recently published regulations compelled pharmacists to charge no less than 50 percent more than the manufacturers' cost of medicines, he said.

He considered this a direct contravention of the law against resale price maintenance.

STUFFED CABBAGE SALAD — May Bennett, Ridgeworth

1 fresh green medium size cabbage
onions
carrots
tomatoes
fresh
radis

Cut the centre from the cabbage, lea
form a bowl. Wash well. Chop onion
and pineapple. Cube tomatoes. Thin
leaves of the cabbage leaving the st
pineapple, tomatoes, sliced cabbage
in a bowl adding any juice from the
salt and black pepper to taste. Tos
into the cabbage "bowl". Garnish wi
bowl of mayonnaise for those who lik
roses, cut across the tops in a dout
iced water until the radishes open u

---oOo---

GERMAN POTATO SALAD

boiled potatoes
cooked bacon
mayonnaise
chopp
salt

Cube the potatoes while still hot.
with the potatoes, onion and mayonna
salt and pepper. Use hot or cold.

---oOo---

EGG SALAD — May Bennett, Ridgeworth

hard boiled eggs
salanaise
salt and pepper
paprika and parsley

Cut eggs in half and lay on a flat salad platter; cut side down. Pour over salanaise.

---oOo---

CHICKEN AND CUCUMBER SALAD — S. Drury, East London

1 cup cooked chicken, diced
4 T finely chopped walnuts
French dressing/mayonnaise
lettuce
1 cup cucumber, peeled and diced
1 cup cooked green peas

Marinade chicken, cucumber, nuts and peas with French dressing. Serve on lettuce with mayonnaise. Cover with greaseproof paper and refridgerate until ready for use.

French dressing:
Blend together 6 T salad oil and 2 T lemon juice.

---oOo---

SPRING GREEN SALAD — May Bennett, Ridgeworth

1 medium

Prof warns of SA socialist medicine

CAPE TOWN — If medical fees were brought under government control, South Africa would end up with "socialist medicine," a disaster for the medical profession, Professor J. N. de Klerk, chairman of the Federal Council of The South African Medical Association, has said.

In a newspaper interview published here yesterday, he said he was gravely concerned at threats made by the Minister of Health, Dr L. Munnik, following the recent 52 per cent rise in the statutory tariff for doctors contracted into medical schemes. There were dangers inherent in the idea of a minister wishing to have a right to veto.

"I can understand Dr Munnik's concern. He was presented with a fait accompli which has put him in a politically difficult situation."

However, it was one of the "cornerstones" of the medical and dental council's activities that it had always stood above politics and matters which could become political issues.

Dr Munnik's attitude could result in bureaucratic control of medicine in South Africa, which was the same as socialist medicine.

"The removal of the right of doctors to contract out would have the same effect."

Once a profession became dissatisfied with its remuneration, the profession's standard of ethics suffered.

He emphasised the recent increase in fees was not a rise in salaries. "It is irresponsible to suggest that doctors will make enormous profits."

"We are dealing with the income of self-employed professional people. A salaries individual has a pension scheme, housing loans and other fringe benefits which the self-employed professional lacks."

Prof De Klerk claimed 45 per cent of the 52 per cent increase would be ploughed back into the economy in the form of costs of running a practice.

The adjustment came after four years in which the medical profession had absorbed all increasing costs. The council had no choice. Doctors were entitled to a reasonable income.

It was also hoped the increases would encourage doctors who had contracted out of medical schemes to contract back in.

He was aware certain contracted-out doctors were charging fees way above the statutory tariff.

However, if a doctor charged exhorbitant fees a patient had recourse to the Medical Association, who would then inform the council. "We are willing to police our own members." — SAPA.

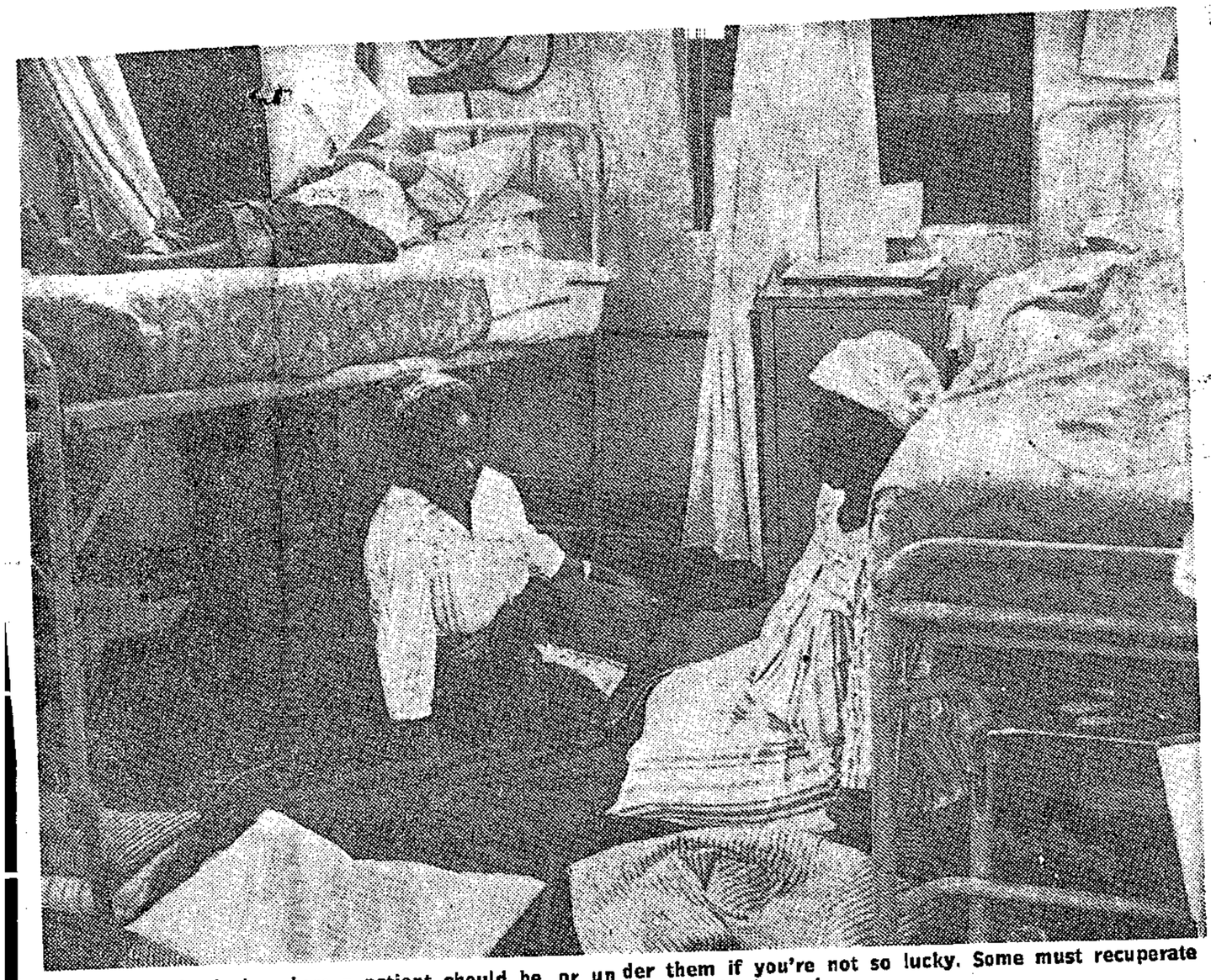
---oOo---

APPLE TUNA TOSS SALAD

1 medium head lettuce, torn in bite-size pieces (4 cups)
2 cups diced apple
1 11 oz can (1 1/3 cups) manderin orange sections, drained
1 6 1/2 or 7 oz can tuna, drained and broken in large chunks
1/3 cup coarsely chopped walnuts
1/2 cup mayonnaise or salad dressing
2 t soya sauce
1 t lemon juice

In a large salad bowl, combine lettuce, apple, orange sections, tuna and nuts; toss together. Combine mayonnaise, soya sauce and lemon juice; mix well. To serve, add dressing to salad; toss gently. Makes 4 - 6 servings.

---oOo---



On top of the beds, where a patient should be, or under them if you're not so lucky. Some must recuperate on the floor for weeks until discharged.

Despairing medic hits at hospital conditions

28/10/79
299

A despairing doctor yesterday condemned conditions for patients and staff at Baragwanath Hospital.

She alleged that in some wards 120 patients had to use two toilets and one bath. Males and females used the same toilets.

She said doctors had to work long hours, sometimes a 14-hour day.

She claimed that medical staff working at night were provided with a tray of tea at 10 pm. "But when we work until 2 am no further food is provided."

She said: "I can't blame any doctor for leaving this country. They're just trodden on."

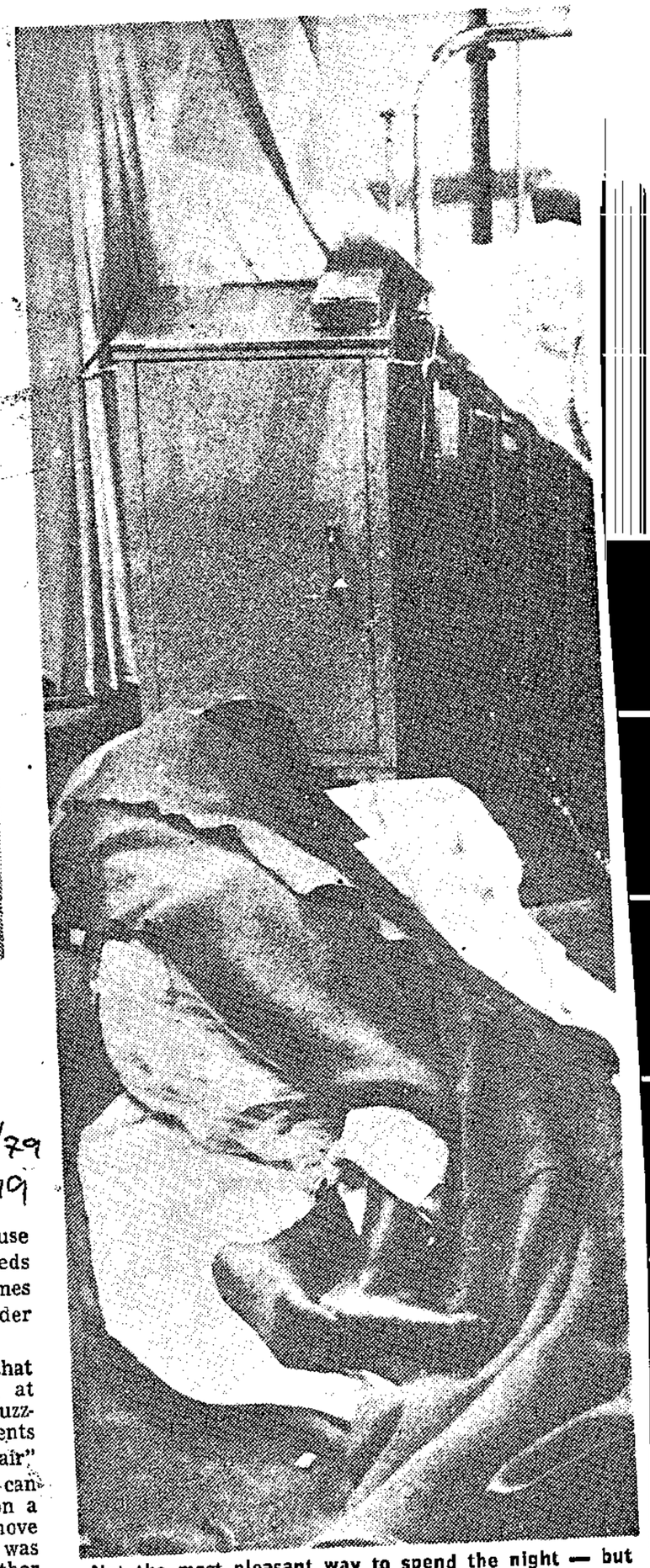
She claimed also that a shortage of competent nursing personnel meant doctors carried an extra burden. "You've just got to do everything yourself if you want it done," she said.

On the number of beds for patients at Baragwanath she said: "It's desperate. On one occasion in a very crowded ward I was attending a diabetic girl in pre-coma. She had to try and keep her balance on a chair because there was no bed available where I could examine her.

"Eventually I had to displace another sick patient to get her into a bed."

Other doctors have confirmed that this was not an isolated incident. They have claimed that because of a shortage of beds patients must sometimes sleep on the floor under beds.

One doctor said that when he first arrived at Baragwanath he was puzzled to see patients referred to as "chair" cases. "I asked: 'How can I examine a patient on a chair? I was told to move another patient out. I was horrified to see how other staff seemed to accept this'."



Not the most pleasant way to spend the night — but there is no alternative for this man.

[redacted]

26/10/79 299



The sick are referred to as "chair" cases when they do not have a bed — a situation that is present almost permanently and which has distressed doctors almost as muc as their patients.

Doctors at Bara warn: teaching ends if...

Star 26/10/79.

299

By Elizabeth Wilson and Lynda Loxton

Baragwanath doctors have warned that if the Transvaal provincial authorities do not act to improve facilities and increase staff at the hospital, its academic function may have to cease.

The hospital which serves the University of the Witwatersrand Medical School provides practical training for hundreds of students each year. Most of these are white.

The "ultimatum" is believed to have been issued by a delegation of doctors.

It is understood they presented their case to the Baragwanath Superintendent, Dr P J Beukes yesterday.

It follows allegations last week by a senior physician, Dr Roger Blackwood that the hospital was seriously short of personnel and was overcrowded.

Any move to stop teaching at the hospital would affect graduate and undergraduate students.

SAME ISSUES

It is understood details of the doctors' stand are being circulated at the hospital and will be included in a letter to the superintendent today.

Asked to comment on developments one Baragwanath doctor said:

"Most of us would have preferred to see this matter kept out of the Press. But the same issues have been dealt with privately in the past with no result.

"We therefore agree that matters should be brought into the open so that they may be rectified."

Doctors said Baragwanath played a vital role as a teaching hospital.

It had an "international reputation" as one of the leading academic hospitals in the country.

But, they said, the staff shortage had reached such a stage that doctors could not carry out teaching as well as medical duties. They had to make a choice. "If one must be sacrificed, it must be the teaching," said one doctor.

ULTIMATUM

When The Star tried to confirm the alleged "ultimatum" senior academic staff seemed reluctant to comment.

Professor P J P van Blerk appeared horrified at the possibility.

"It is a ridiculous suggestion," he snapped. "Baragwanath Hospital is an integral part of our teaching programme." He said he had heard of no move to sever academic links.

He admitted meeting the superintendent and Professor T H Bothwell on Wednesday. But what was discussed, he said, was "strictly private."

Professor D J du Plessis, Vice-Chancellor of the University, said he had just returned from Cape Town and had "not heard anything."

CONCERNED

Professor Leo Schamroth, head of the Department of Medicine said: "I very much regret I am not going to talk to the Press. I have no comment. I can only refer you to the superintendent."

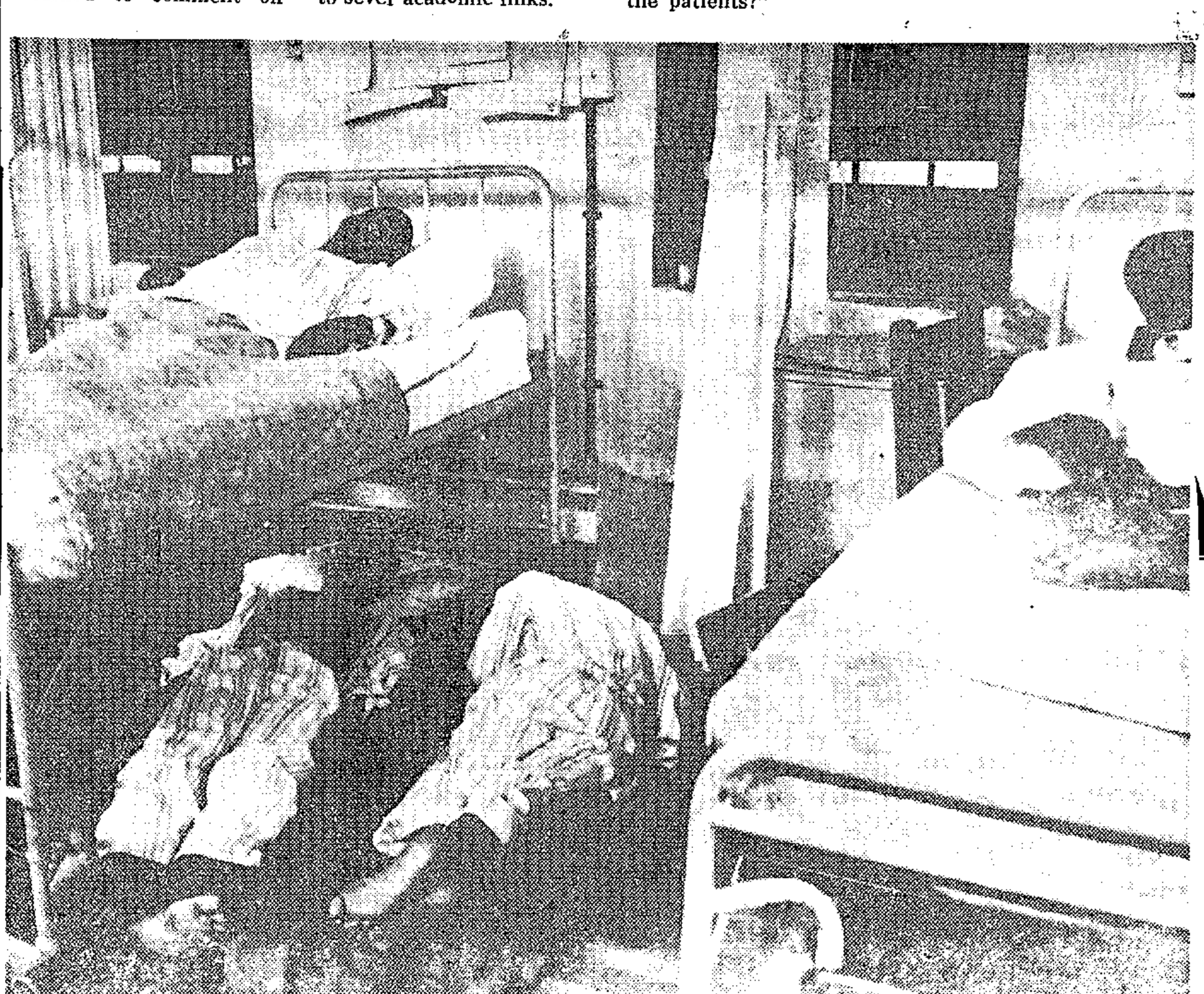
Professor H H Lawson said: "I don't discuss things that happen at Baragwanath."

Professor Lucy Wagstaff, while "interested and concerned" about the matter said: "Most staff at Baragwanath — even the superintendent — accept that Baragwanath needs moe staff. But it is a tricky situation. We jeopardise our position by talking to the Press."

Professor T H Bothwell said it was "difficult" for him to comment.

Another doctor at the hopital commented: "If teaching at this hospital stopped, it would be disastrous. Who would do the work? Who would see the patients?"

What is happening at the huge hospital? Frustrated doctors have begun to speak out against overcrowding which has placed sick men and women on the floor and under beds. They want better conditions for their patients and have called for action.

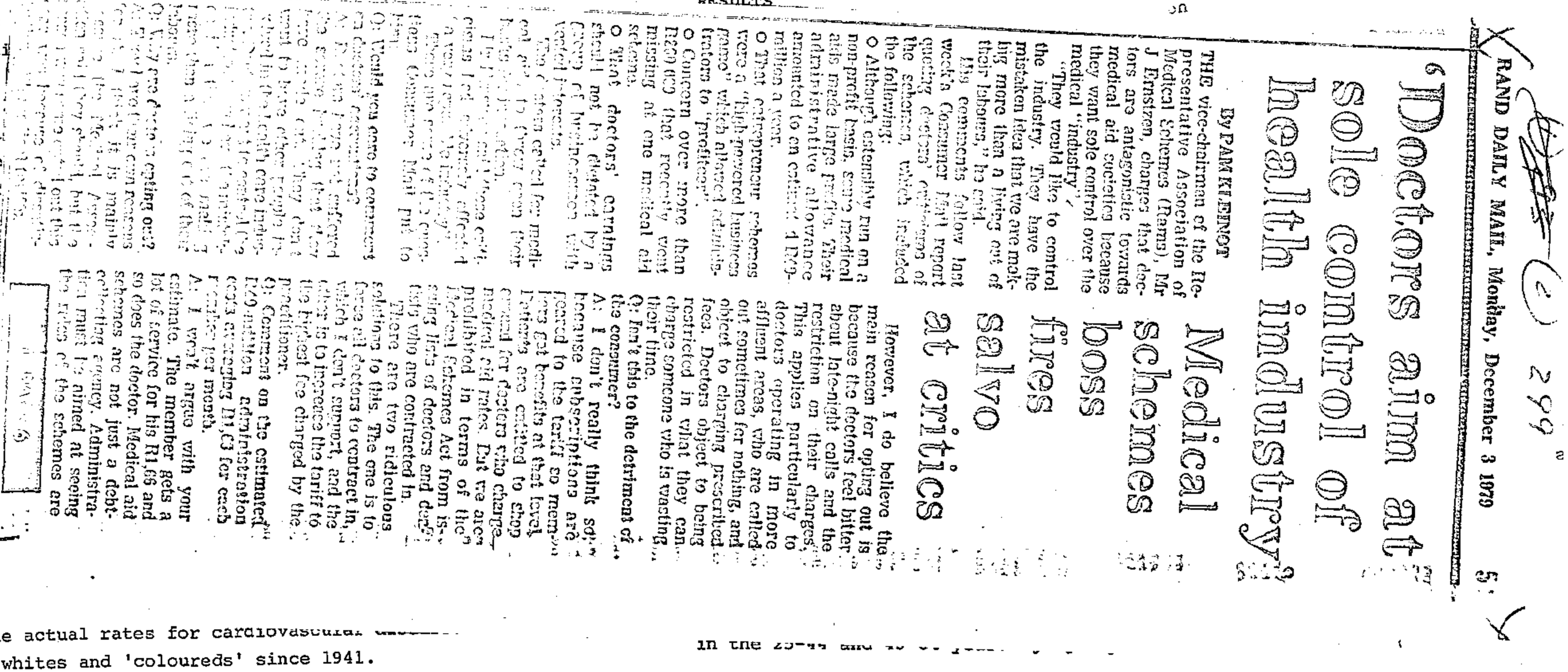


In beds — and under beds. Patients have to make do. The strain on staff and the sick is considerable.

(iv) Proportional Mortality, accounted for by specific conditions.

(v) Expectation of Life. This was calculated both at birth (e_o) and at 45 years of age (e_{45}) for both males and females. It expresses the average number of additional years an individual would be expected to live beyond birth and 45 years.

For Africans, the proportional mortality was the only index calculated.



RAND DAILY MAIL, Monday, December 3 1979

'Doctors aim at sole control of health industry'

Medical schemes boss flies salvo at critics

By PAM KLENOT

THE vice-chairman of the Representative Association of Medical Schemes (Rams), Mr J Ernstzen, charges that doctors are antagonistic towards medical aid societies because they want sole control over the medical "industry".

"They would like to control the industry. They have the mistaken idea that we are making more than a living out of their labours," he said.

His comments follow last week's Consumer Week report quoting doctors' criticisms of the schemes, which included the following:

O Although ostensibly run on a non-profit basis, some medical aids made large profits. Their administrative allowance amounted to an estimated R29-million a year.

O That entrepreneur schemes were a "high-powered business frame" which allowed administrators to "profiteer".

O Concern over more than R200 000 that recently went missing at one medical aid scheme.

O That doctors' earnings should not be dictated by a committee of businessmen with vested interests.

"The doctors control their own fees and do not dictate to the schemes. Their fees are negotiated with the schemes," Mr Ernstzen said.

Q: Would you care to comment on doctors' complaints?

A: I don't really think so, because subscriptions are geared to the tariff so members get benefits at that level. Patients are entitled to shop around for doctors who charge medical aid rates. But we are prohibited in terms of the Medical Schemes Act from issuing lists of doctors and dentists who are contracted in.

There are two ridiculous solutions to this. The one is to force all doctors to contract in, which I don't support, and the other is to increase the tariff to the highest fee charged by the practitioner.

Q: Comment on the estimated R40-million administration costs averaging R1,63 for each member per month.

A: I would argue with your estimate. The member gets a lot of service for his R1,66 and so does the doctor. Medical aid schemes are not just a debt-collecting agency. Administration must be aimed at seeing that the fees of the schemes are

by 1970, this figure had decreased to 15,7%, indicating that the whites had improved disproportionately to the 'coloureds'. Similarly, for children 1 to 4 years of age, during the period 1941 to 1970, the white mortality experience as a percentage of the 'coloureds' had decreased from 15,2% to 7,1%. It should be noted that the 0 year age specific death rates are higher than the corresponding IMRs. This is because the denominator for the former is the number of live births whilst for the latter it is the mid-year populations under one year of age.

Fig. 4 provides an [illegible] of the proportional contribution of selected causes of death to [illegible] and African communi[illegible]

During the period [illegible] of mortality which [illegible] Infectious disease[illegible] are increasingly r[illegible] 'coloureds' and Af[illegible] deaths caused by [illegible] mortality which i[illegible] whilst the 'colou[illegible] whites and Africa[illegible] Africans than it[illegible]

What is of parti[illegible] 'coloureds' is t[illegible] developed and th[illegible] Table II which [illegible] contributing to[illegible] form of cause s[illegible] though cardiova[illegible] small proportio[illegible] indicates that the actual rates for cardiovascular [illegible] similar for both whites and 'coloureds' since 1941.

Clearly, the broad diagnostic categories used in this analysis conceal a certain amount of information. However, because of the changes in disease classification which have taken place since 1929, it is not possible to examine the temporal changes of mortality rates in greater detail. Disease categories with rates greater than 5/1 000 appear in italics in Table II. It will be noted that the mortality experiences of the 'coloureds'

[illegible] in the 25-44 and 45-64 [illegible]

The imbalance between the age specific mortality rates of whites and 'coloureds' has improved or remained constant for persons between the ages of 5 and 64. However, for children less than 5 years of age, the gap between whites and 'coloureds' is widening. In 1941, white children under one year old experienced 28,0% of the mortality of 'coloured' children;

Medical aid chief hits back at doctors

strictly adhered to, which involves time, paperwork and money. It includes:

- The calculation of subscriptions and processing of members' particulars and claims.
- Preparing a subscription schedule for employers of their monthly payments.
- Providing members with information, dealing with queries and supplying them with annual tax certificates.

Q: Entrepreneur schemes are said to be competitive. How? Do some offer extra benefits?

A: They are basically competitive in terms of the service they offer. This includes the accuracy and speed with which settlements are made. We have to offer a high range of benefits. Some entrepreneur schemes go beyond the minimum benefits laid down in the Act and offer benefits for

From PAGE 5

homeopathy, chiropractice and remedial education. Most entrepreneur schemes pay for treatment for infertility, and contraception.

Doctors tend to confuse entrepreneur schemes with exempted schemes, which are not obliged to comply with minimum requirements.

Because of this we all get tarred with the same brush.

Q: Why do some doctors have to wait for up to three months before being paid?

A: Because of the tardiness of members in submitting their accounts.

Q: What are the reasons for the 25% reserve fund?

A: About five years ago, the registrar of medical aid schemes laid down that medical schemes should have a reserve of about 25% of the current year's claims to save them from bankruptcy. However, this is to be attained over several years, not taking a lump sum out of subscription income. We are not carrying a lot of money in our bank account. What we do have in our reserves is to protect us against losses.

According to 1978 figures, 91,6% of subscription money was paid out in benefits to members. Funds can't run on pure income expenditure. We have to budget in advance. There are going to be surpluses and deficits because of under- or over-budgeting.

Q: How many have attained the 25% reserve?

A: Few medical aid schemes have attained the 25% reserve, although at least two have got more than the required 25%. The reason why so few have attained it is because of the heavy run against the schemes in the last few years, particularly due to advances in medicine — for example, the Cat Scan, which is costly.

Q: Comment on the claims that medical aids make large profits, said to be as much as R1-million.

A: When they talk about the R1-million profit, it's the scheme's surplus, which it was fortunate to make in one year. This money will be used only for members' benefits.

Q: What happens to the interest on the 25% reserve?

A: The interest goes into the medical aid funds, which are ultimately used for members' benefits.

Q: How would you feel about a Government-introduced national health plan?

A: I believe this would be an adverse step. It would not be either in the public interest nor in the interest of the medical profession.

My basic objection is that it would turn doctors into public servants. It also doesn't fall in line with the free enterprise philosophy.

Govt to probe medical costs

By WILLIAM SAUNDERSON-MEYER
Pretoria Bureau

A COMMISSION of Inquiry would investigate all aspects of medical aid schemes, as part of a full inquiry into health services, the Minister of Health, Dr L A P A Munnik, said yesterday.

Mr J W Haak, former Minister of Economic Affairs, has been appointed chairman of the commission, which will issue an interim report on medical schemes within three months of its appointment.

Because the SA Medical and Dental Council had decided to review tariffs of fees for services, and the commission's report would not be ready for the next Parliamentary session, as an interim measure draft legislation on the present tariffs would be Gazetted today.

Dr Munnik said that he hoped the commission would be able to remove the unpleasantness that has accompanied the determination of tariffs.

The commission will make recommendations about the scope and costs of health services in both public and private sectors.

"This is with a view to rationalising services and making them more effective, as well as placing costs on a sound and firm basis," Dr Munnik said.

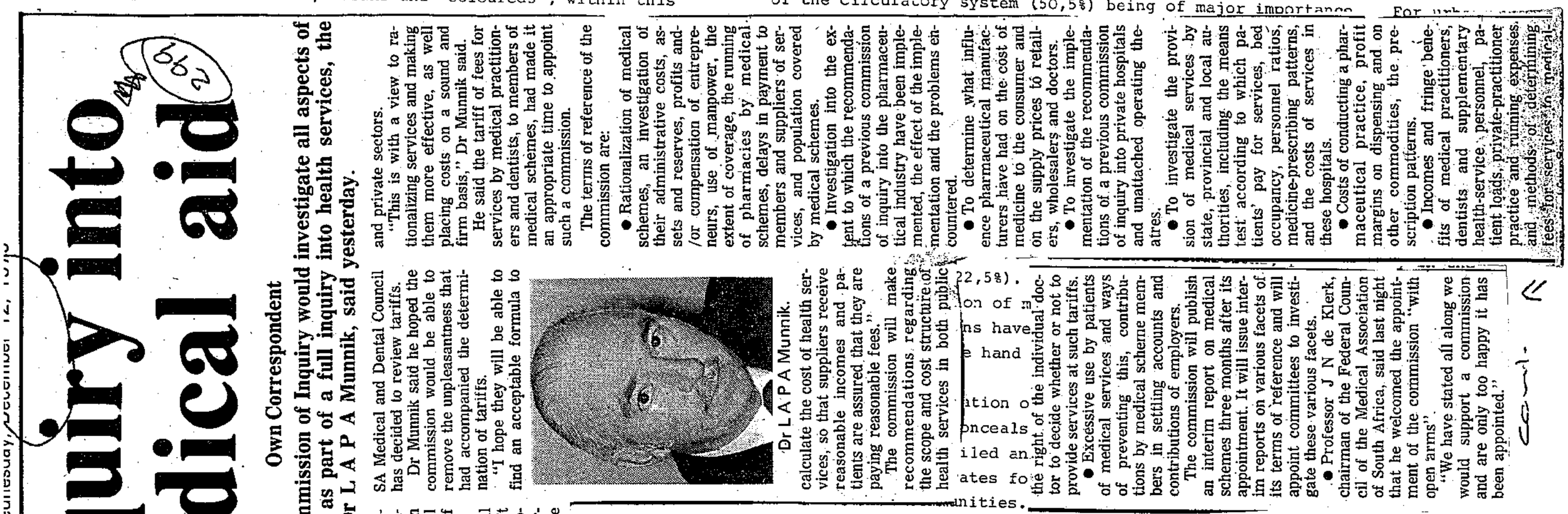
The commission will also investigate:

- How far the recommendations of a previous commission of inquiry into the pharmaceutical industry have been implemented;
- What influence pharmaceutical manufacturers have had on the cost of medicine to the consumer and on the supply prices to retailers, wholesalers and doctors;
- The implementation of the recommendations of a previous commission of inquiry into private hospitals and unattached operating theatres;
- The provision of medical services by State, Provincial and local authorities;
- The costs of conducting a pharmaceutical practice, profit margins on dispensing and on other commodities and prescription patterns, and
- The incomes and fringe benefits of doctors, dentists and other health service personnel, patient loads, private practices and their running expenses.

ortality rates greater than 5/1 000 appear in italics in Table I. For 11 of these major causes of mortality, the Asian and 'coloured' mortality ates exceed those of the whites.

owever, in this context, what requires emphasis is that by using the major isease classification a certain amount of detail is lost. For example, espite the fact that the overall rates for diseases of the circulatory ystem are comparable for whites, Asians and 'coloureds', within this

the South African population from all causes of death. The proportional contribution of the seventeen major disease categories of the International Classification of Disease (8th revision) to the overall mortality of the various communities is summarised in Fig. 5. The whites show a typical 'developed' country spectrum of mortality with Infectious and Parasitic Diseases being of minor importance (2,0%) and Neoplasms (15,6%) and Diseases of the Circulatory system (50,5%) being of major importance. For urb-



Inquiry into medical aid

Own Correspondent

PRETORIA. — A Commission of Inquiry would investigate all aspects of medical-aid schemes as part of a full inquiry into health services, the Minister of Health, Dr L A P A Munnik, said yesterday.

Mr J W Haak has been appointed chairman of the commission, which will issue an interim report on medical schemes within three months of its appointment.

As an interim measure, till the commission reports, draft legislation will be gazetted today concerning the present tariff of fees for services, as the SA Medical and Dental Council has decided to review tariffs.

Dr Munnik said he hoped the commission would be able to remove the unpleasantness that had accompanied the determination of tariffs.

"I hope they will be able to find an acceptable formula to

and private sectors.

"This is with a view to rationalizing services and making them more effective, as well placing costs on a sound and firm basis," Dr Munnik said.

He said the tariff of fees for services by medical practitioners and dentists, to members of medical schemes, had made it an appropriate time to appoint such a commission.

The terms of reference of the commission are:

● Rationalization of medical schemes, an investigation of their administrative costs, assets and reserves, profits and/or compensation of entrepreneurs, use of manpower, the extent of coverage, the running of pharmacies by medical schemes, delays in payment to members and suppliers of services, and population covered by medical schemes.

● Investigation into the extent to which the recommendations of a previous commission of inquiry into the pharmaceutical industry have been implemented, the effect of the implementation and the problems encountered.

● To determine what influence pharmaceutical manufacturers have had on the cost of medicine to the consumer and on the supply prices to retailers, wholesalers and doctors.

● To investigate the implementation of the recommendations of a previous commission of inquiry into private hospitals and unattached operating theatres.

● To investigate the provision of medical services by state, provincial and local authorities, including the means test according to which patients' pay for services, bed occupancy, personnel ratios, medicine-prescribing patterns, and the costs of services in these hospitals.

● Costs of conducting a pharmaceutical practice, profit margins on dispensing and on other commodities, the prescription patterns.

● Incomes and fringe benefits of medical practitioners, dentists and supplementary health-service personnel, patient loads, private-practitioner practice and running expenses, and methods of determining fees for services in medical-

Dr L A P A Munnik.

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Table I) may

g. 7 summarises the percentage improvement in the expectation of life birth subsequent to the total elimination of the mortality associated

If the mortality rates (Table I) are compared with the proportional mortalities for the seventeen major disease categories (Fig. 5), it will be noted that despite the relatively minor proportional contribution made by circulatory diseases in the 'coloured' community, the actual rates for these diseases are higher than those of the whites. The reason for this apparent inconsistency is that the mortality rates for Infectious and Parasitic Diseases are so high that they effectively swamp the proportional mortality of the Circulatory Diseases in the 'coloured' community. In the white community, the mortality rates for most causes of death are so low, the importance of the Circulatory diseases become disproportionately exaggerated.

Private patients to pay more

(98) (299) RDM 29/12/79

By ARNOLD GEYER

PRIVATE hospital patients face an average fee increase of 12,5% from January 1, 1980.

This considerable hike in hospital tariffs follows an agreement in Pretoria between representatives of medical aid schemes and private hospitals.

The new tariffs were published in yesterday's Government Gazette.

Mr J P H Steyn, registrar of medical services, said yesterday some tariffs had risen as much as 15%. Others had been left as they were.

The new fees for white private hospitals with fewer than 70 registered beds will be:

- R22 a day for surgical cases in a general ward;
- A maximum of R35 a day if a doctor prescribes a private ward — with a 10% discount if the patient's medical scheme undertakes to pay for it;
- R15 for the first 15 minutes and R7,50 for every 15 minutes thereafter in theatre, and
- R51,50 a day in basic fees for treatment in an intensive care unit.

The tariffs for private hospitals with more than 70 registered beds will be:

- R25 a day for surgical cases in a general ward;
- A maximum of R38 a day for private ward treatment — less a discount of 10 percent if the relevant medical scheme guarantees payment;
- R57,50 a day in basic fees for intensive care treatment.

Social Security

→ MEDICARE

1-1-80 → 31-12-80

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National health scheme denied

BY GERALD REILLY
Pretoria Bureau

THE Government has no intention of introducing a national health scheme, the Minister of Health, Dr L A P A Munnik, stressed in an interview from Cape Town yesterday.

However, the intention was to rationalise health services across a broad front following the report of the Medical and Hospitals Costs Commission, which had already started work under the chairmanship of a former Cabinet Minister, Mr Jan Haak.

Dr Munnik said he expected the full investigation to take about a year.

There would, however, be interim reports, and where necessary the recommendations in these reports would be implemented.

"For the first time we will have a complete and comprehensive report on the costs of illness in this country. We must ensure that it is within the financial capacity of all to get necessary hospital and medical attention," he said.

The aim of the investigation was to draw up a co-ordinated medical plan for the future. This did not mean nationalisation of health services.

It did not mean either that there would be interference with the private sectors' contribution to the national health.

Dr Munnik also indicated that legislation would go through Parliament this session to give the Minister the right to block the implementation of doctors fees, recommended by the South African Medical and Dental Council, if he considered these to be unreasonable.

Draft legislation had also been published preventing doctors from contracting out of the Medical Aid Act. This would mean that doctors would charge uniform fees.

Dr Munnik said after the big increase of 52% granted by the Medical Council there could be no reason why doctors wanted to opt out and set their own level of fees.

see GS 6827 See full text

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Vol. 175] PRETORIA, 25 JANUARIE / JANUARY 1980 [No. 6827

GENERAL NOTICE

NOTICE 60 OF 1980

DEPARTMENT OF HEALTH

REGISTERED MEDICAL SCHEMES

The Registrar of Medical Schemes hereby notifies, in accordance with section 16A of the Medical Schemes Act, 1967 (Act 72 of 1967); as amended, that the undermentioned medical schemes have been registered.

Those marked with an asterisk (*) have been exempted in terms of section 3 as indicated.

This list, as at 31 December 1979 replaces the list published in *Government Gazette* 6279 of 26 January 1979 and contains 251 schemes. of which 218 are Aid and 33 Benefit Schemes.

N.B.—Do not *count* names in brackets. Their *translated* form appears *elsewhere* in the list.

ALGEMENE KENNISGEWING

KENNISGEWING 60 VAN 1980

DEPARTEMENT VAN GESONDHEID

GEREGISTREERDE MEDIESE SKEMAS

Die Registrateur van Mediese Skemas maak ooreenkomstig artikel 16A van die Wet op Mediese Skemas, 1967 (Wet 72 van 1967), soos gewysig, bekend dat ondergemelde mediese skemas geregistreer is.

Skemas vrygestel kragtens artikel 3 is met 'n sterretjie (*) aangedui, met vermelding van die spesifieke vrystelling.

Hierdie lys, soos op 31 Desember 1979 vervang die lys wat in *Staatskoerant* 6279 van 26 Januarie 1979 gepubliseer is en bevat 251 skemas, waarvan 218 Hulp- en 33 Bystandsskemas is.

L.W.—Moenie name tussen hakies *tel* nie. Hulle *vertaalde* vorm verskyn *elders* in die lys.

Name of scheme Naam van skema	X-Private Bag X-Privaatsak P.O. Box Posbus	Place Plek	Code Kode	Reference No. Verwysing No.	Date of registration Datum van registrasie	Exemption from Regulations/Act Vrystelling van Regulasies/Wet
A						
A.A. Mutual Medical Aid Society.....	9595	Johannesburg.....	2000	1001	11/8/71	—
Aberdare Africa Medical Aid Society....	494	Port Elizabeth.....	6000	1002	20/11/70	—
Adcock-Ingram Medical Scheme.....	9391	Johannesburg.....	2000	1003	12/2/69	—
AECI Medical Aid Society.....	716	Johannesburg.....	2000	1005	11/2/71	—
African Cables Medical Benefit Fund....	172	Vereeniging.....	1930	1004	9/6/70	—
A.G.S. van S.A. se Mediese Hulpfonds...	89358	Lyndhurst.....	2106	1442	1/8/74	—
Alabama Medical Plan.....	51418	Randburg.....	2125	1480	13/10/77	—
Alex. Aiken & Carter Medical Aid Society	61975	Marshalltown.....	2107	1009	24/11/70	—
Allcare Medical Aid Scheme.....	7106	Johannesburg.....	2000	1496	21/11/78	—
Altech Group Medical Aid Society (was: STC Black)	9153	Johannesburg.....	2000	1449	31/1/75	—
*Amato Consolidated Industries Sick Benefit Society	9478	Johannesburg.....	2000	2010	3/11/67	Section/Artikel 20 (1); also/ook Reg. 4.
Ammosal Benefit Society.....	Mancorp Mine/Myn	Postmasburg.....	8423	2011	27/11/70	—
Anglo-Alpha Group Medical Aid Society	7462	Johannesburg.....	2000	1487	28/3/78	—
Anglo American Corporation Medical Aid Society	9761	Johannesburg.....	2000	1012	16/10/68	—
*Aranda Textile Mills Sick Benefit Society	9478	Johannesburg.....	2000	2013	15/12/67	Section/Artikel 20 (1); also/ook Reg. 4.

out-patient) at provincial hospitals for comparis
sion, she makes the following points:

(i) In general, more concern is shown for ski
difficult to replace, than for unskilled
is a skill and a race bias in the provisi

(ii) Medical aid schemes, and to a lesser exte
emphasise curative rather than preventi

(iii) The benefits extended by medical benefi
comprehensive than those extended by me

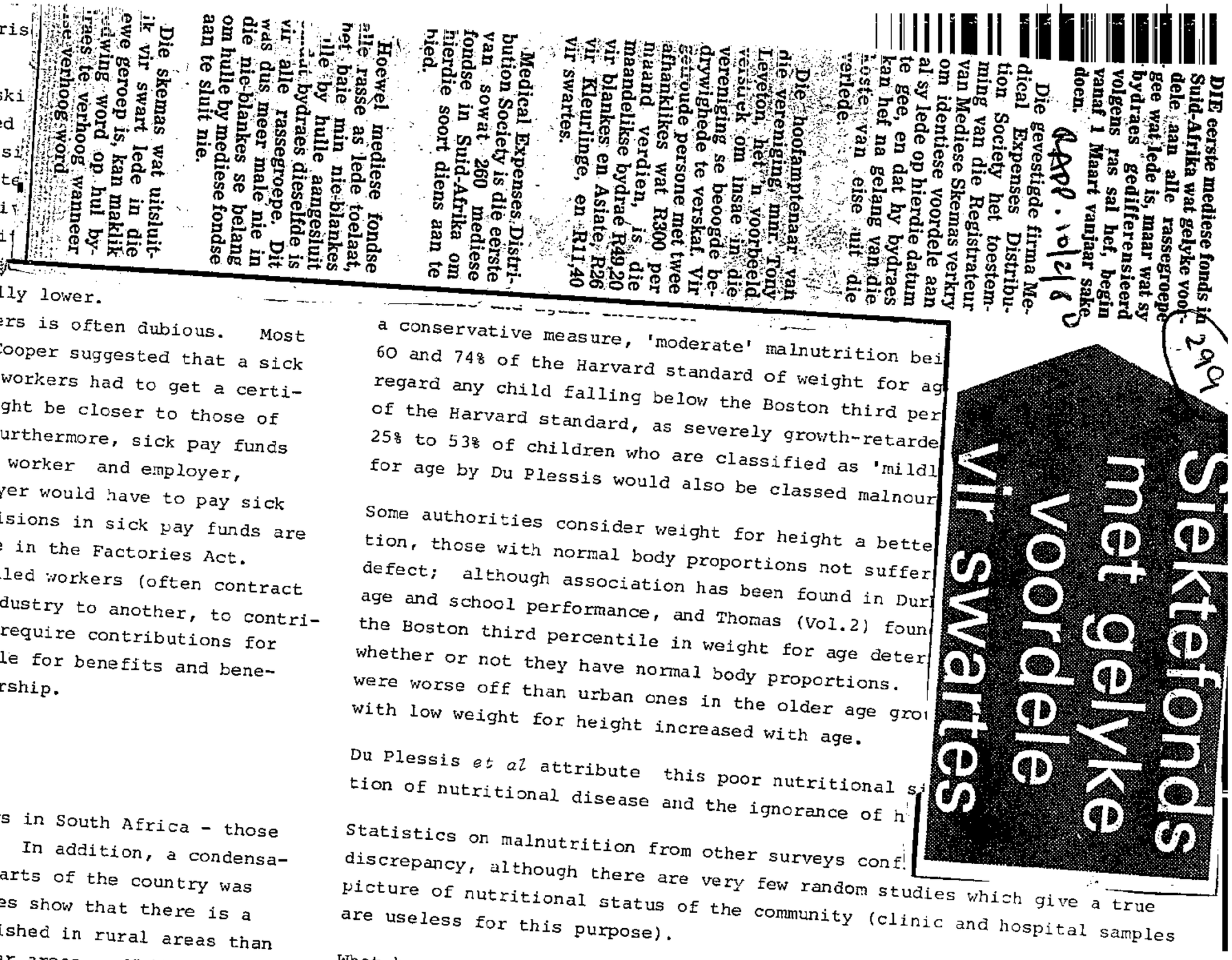
(iv) Contributions to the former are generally lower.

(v) The benefit of a sick pay fund to workers is often dubious. Most of the trade unionists interviewed by Cooper suggested that a sick pay fund increased employer control as workers had to get a certificate from a doctor whose interests might be closer to those of employers than to those of workers. Furthermore, sick pay funds are made up of equal contributions from worker and employer, while under the Factories Act the employer would have to pay sick pay in full, and the leave and pay provisions in sick pay funds are not always better for workers than those in the Factories Act.

(vi) It may not be in the interests of unskilled workers (often contract workers) who move frequently from one industry to another, to contribute to medical schemes. Most schemes require contributions for 13 to 16 weeks before a member is eligible for benefits and benefits often increase with length of membership.

6. NUTRITIONAL STATUS AND POLICY

Two papers dealt with nutritional status indicators in South Africa - those of Du Plessis *et al* (*30) and Neil White (Vol.2). In addition, a condensation of statistics on child nutrition in various parts of the country was provided as background and material. These studies show that there is a far greater proportion of children who are malnourished in rural areas than in urban ones, even among children in urban squatter areas. White shows that, using the arm circumference test, the proportion of malnourished children aged 1-5 years was 1,9% in Crossroads compared with 7,4% in Nqutu in KwaZulu, and he quotes other studies which find an incidence of 12% in Tsolo, Transkei, and 13,8% in the Muldersdrift farming area near Johannesburg. (The arm circumference method is an extremely conservative measure of malnutrition. In Tsolo, over 30% were malnourished by reference to the



a conservative measure, 'moderate' malnutrition bei
60 and 74% of the Harvard standard of weight for ag
regard any child falling below the Boston third per
of the Harvard standard, as severely growth-retarde
25% to 53% of children who are classified as 'mildl
for age by Du Plessis would also be classed malnour

Some authorities consider weight for height a bette
tion, those with normal body proportions not suffer
defect; although association has been found in Dur
age and school performance, and Thomas (Vol.2) foun
the Boston third percentile in weight for age deter
whether or not they have normal body proportions.
were worse off than urban ones in the older age gro
with low weight for height increased with age.

Du Plessis *et al* attribute this poor nutritional s
tion of nutritional disease and the ignorance of h

Statistics on malnutrition from other surveys conf
discrepancy, although there are very few random studies which give a true picture of nutritional status of the community (clinic and hospital samples are useless for this purpose).

What happens to children who are malnourished? In East London, Trudy Thomas (Vol.2) followed up a sample of children with mild malnutrition (below the third percentile but without clinical signs) who were not admitted to hospital but were treated as outpatients with supplementary food, advice and bus fares where necessary for follow-up, and found that 51% of them had died within 6 weeks. But hospitalisation too is often ineffective. 14% of children hospitalised died within 6 weeks of discharge. Hospitalisation with follow-up and milk after discharge offered the best chances of

MEDS injects medical aid cure for all

By STEPHEN ORPEN

HAILED by the inventors as South Africa's first truly non-racial medical aid plan, a scheme has been evolved by the 20-year-old Medical Expenses Distribution Society (MEDS) giving all plan members, whatever their race, the same benefits, but at a cost in line with their income.

Announced today, the plan has received official approval from the Registrar of Medical Schemes and will "go live" from Saturday, March 1.

The variable costs have been made possible by charging rates based on claims experience.

Principal officer, Tony Leveton, quotes the following examples of the monthly contribution which will be payable by a member earning R300 a month and with two dependents: whites and Asians R49,20; coloureds R26; blacks R11,40.

Without the new dispensation, all race groups would have paid the same R49,20 a month.

MEDS has 500 member companies employing 60 000 people.

It is the first among the country's 260-plus medical aid schemes known to have developed the new kind of scheme.

Mr Leveton explains that schemes developed exclusively for blacks could be forced to raise their contribution levels rapidly in response to rising claims experience.

With the overall funding in the MEDS plan, he claims "certain rises can be cushioned".

MEDS undertakes that at least 93% of its income will be available for the benefit of members.

These benefits are expected to top R11-million this year.

Medical aid boost for blacks

STAR 2/2/80

2 99

A concession by the Registrar of Medical Schemes has given the go-ahead to companies wanting to put all their staff on to one medical aid scheme.

The move is also expected to swell the number of blacks and coloureds of medical aid schemes and pave the way for more black patients to see doctors.

As from March 1, the Medical Expenses Distribution Society will give blacks and coloureds the same medical aid benefits as whites at a cost much more in line with their own incomes. The society has 500 member companies.

Each member's contribution will be based on his or her claims pattern, but all will get the same benefits.

In the past, medical aid schemes have been white orientated and companies were reluctant to put all their staff on to one scheme.

The law has stipulated that contributions and benefits must apply equally to all members, whatever their colour.

The society's research shows that the ratio of claims works out at whites and Indians 100, coloured 50 and blacks 20.

Medical scheme to cater for blacks

CAPE TIMES 12/2/80 299

Science Reporter

A MEDICAL AID concession which will give blacks and coloured people the same benefits as whites at a cost commensurate with their incomes will be launched on March 1.

The scheme, evolved by the 20-year-old Medical Expenses Distribution Society (MEDS), means that contributors will be charged according to their claims pattern. This will create the Republic's first 'truly non-racial scheme'', according to MEDS principal officer, Mr Tony Leveton.

In a statement issued yesterday, Mr Leveton said that over the years medical aid in the Republic had developed a white-oriented scale of contributions reflecting the claims whites make on a fund.

"Because the law says that contributions and benefits must apply equally to all members, other population groups have rarely joined the big, well-established medical aid schemes even though there was no racial bar on their membership," Mr Leveton said.

Computer analsis of claims had shown that for every 100 claims made by whites and Asians, there would be 50 from coloured people and 20 from blacks.

"Blacks, coloureds and their employers realized that they would have to contribute unduly heavily for the claims they made. In other words, black and coloured members were really subsidising the white and Asian members," Mr Leveton said.

As it was obviously unfair to charge a black member the same as his white counterpart when his claims occurred at only 20 percent of the white rate, it was necessary to charge a rate that was fair to all. This was found to be one based on the claims pattern.

With the new dispensation, companies could put their entire staff on the one scheme and offer them all identical benefits while charging rates in line with their level of claims.

MEDS, the first among the country's 260-odd medical aid schemes known to have developed the new idea, has 500 member companies employing some 60 000 people.

Equal medical aid benefits for blacks

JOHANNESBURG — Doctors are likely to see more and more blacks among patients in their waiting rooms.

A medical aid concession, which from March 1 will give blacks and Coloureds the same medical aid benefits as whites at a cost much more in line with their own incomes, is expected to swell the numbers of blacks and Coloureds on medical aid schemes.

At the same time, it's expected to open the way for more and more blacks and Coloureds to seek medical consultation in the same way whites do.

Mr Tony Leveton, principal officer of a medical aid society, whose scheme was the first to be granted the dispensation, said: "Their contributions will be based on their claims pattern, but they'll get benefits identical to everyone else's."

Because of its scale of operation, this society, a 20-year-old registered medical aid society with 500 member companies offering protection to 60 000 people, can keep costs down and undertake to make at least 93 per cent of income available for members' benefits.

This year, payouts are expected to top R11 million. Benefits available to members as soon as they join, include 100 per cent payment of medical bills at the recently increased tariff; no annual limit on medical attention; hospitalisation or conservative dental care; and for a family of three up to R750 a year for medicines, in addition to any used in a hospital. — DDC.

Examples of total contributions and benefits. (Most employers pay at least half of the monthly contribution, so the cost to the member is no higher than half of the amount quoted.)

Contribution per month:

Married member with two dependants, earning per month:

	R150	R300	R400	R600	R600+
White or Asian	R39,20	R49,20	R56,70	R63,80	R65,40
Coloured.....	R17,30	R26,00	R31,60	R36,70	R37,70
Black.....	R 7,60	R11,40	R13,90	R16,20	R16,60

Benefits applicable to all members, again taking example of member with two dependants:

Medicines: R750 a year in addition to any used in a hospital.

Opticians: R75 a year.
Doctors: no limit
Hospitals: no limit.
Conservative Dentistry: no limit.

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CHARLES SIMKINS

3. THE SPATIAL DISTRIBUTION OF MORTALITY AND ITS RELATION TO SOCIOECONOMIC INDICATORS IN SOUTH AFRICA IN 1970 [1]

1. INTRODUCTION

When trying to find health indicators for particular areas in South Africa, one is obliged to rely exclusively on mortality data as no comprehensive morbidity data are published. The incidence of mortality (deaths per annum) for Whites, coloured people and Asians is reported annually for each magisterial district in the country and for Africans in 33 magisterial districts, 31 of which jointly comprise the metropolitan areas.[2] Deaths are classified by cause; this classification has been considered by Dick and Bourne who conclude that

- Whites show a typical developed country spectrum of mortality with infectious and parasitic diseases being of minor importance and neoplasms (tumours/cancers) and diseases of the circulatory system being of major importance;
- Coloured people and urban Africans display an underdeveloped country profile in which infectious and parasitic diseases and respiratory diseases are important.

As a by-product, maps are produced showing the spatial distribution of mortality.

2. MORTALITY RATIOS BY RACE AND DISTRICT IN METROPOLITAN AREAS

Crude mortality rates (deaths per annum per thousand population) may vary across districts for no reason other than that the age distributions of the populations vary. To eliminate this source of variation, two sets of *mortality ratios* have been calculated for each race group in each district. These ratios have been calculated as follows

- Define EM_1 as the expected mortality if *White* age-specific death rates for South Africa as a whole are applied to the age distribution of the population for the race and district under consideration. (For the purposes of the calculation nine age-groups were considered: 0-4, 5-14, 15-24, 25-34, 35-44, 45-54, 55-64, 65-74 and 75+)
- Define EM_2 as the expected mortality if *own-race* age-specific death rates for South Africa as a whole (or in urban areas only in the case of Africans) are applied to the age-distribution of the population for the race and district under consideration



Blacks get new medical aid deal

Staff Reporter

A NEW concession, giving blacks and coloureds the same medical aid benefits as whites at a cost more in line with their incomes, will be introduced by a major medical aid society on March 1.

The move is expected to attract more blacks and coloureds to join medical aid schemes and to open the way for more blacks and coloureds to seek medical consultation.

Mr Tony Leveton, director of the Medical Expenses Distribution Society (Meds) — the first scheme to be granted the dispensation — said: "Their contributions will be based on their claims pattern, but they'll get benefits identical to everyone else's."

The Meds is a 20-year-old registered medical aid society with 500 member companies, offering cover to 60 000 people.

Mr Leveton said that with the introduction of the concession, South Africa now had its first truly non-racial medical aid scheme.

His group was given the go-ahead by the Registrar of Medical Aid Schemes to offer equal benefits to all, charging at rates based on claims experience.

This would solve what had until now been one of the most challenging problems for medical aid schemes, he said.

"Over the years, medical aid in this country had developed a white-oriented scale of contributions, reflecting the claims whites make on a fund.

"Because the law has stipulated that contributions and benefits must apply equally to all members, other population groups have rarely joined the big, well-established medical aid schemes, even though there was no racial bar on their membership.

"Blacks, coloureds and their employers realised they would have to contribute unduly heavily for the claims they made. In other words, black and coloured members were really subsidising the white and Asian members," Mr Leveton said.

With the new dispensation, companies could put all their staff on one scheme, offer them identical benefits, and yet charge a cheaper rate, in line with their level of claims.

This year Meds payouts were expected to be more than R11-million.

Mr Leveton said benefits available to members immediately they joined Meds would include:

- A 100% payment of their medical bills at the new tariffs.
- No annual limit on medical attention, hospitalisation or dental care.
- Up to R750 a year for medicines — in addition to medicines used in hospital treatment — for a family of three.

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are very small, the respective Spearman rank correlation co-efficients being 0,981, 1,000 and 0,942 respectively (all easily significant at the 1% level). This suggests

.cal services do, for the most part, satisfy the
' (there are no spillovers) and no economies
' clear that most aspects of the medical market
the private sector'. He admits a few exceptions -
ises and sanitation for example - where spillovers
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r medical care in general, he holds that subsidy
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pf redistribution on grounds of equity through
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e sufficiently defined and that any preference
nother is purely a matter of personal preference.

. participants felt unhappy about the fact that
d in the determination of policy, and Raine
point out that this is inevitable. A decision
location of medical care is also a value

.9 and Nattrass, Ch.10) that some people desire
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uld mean that there is still a case for subsidy
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Folb (Vol.2) indicate. Moreover, although
e, entry to the market as a seller is not free
d and therefore higher prices can be charged.[7]
n the number of students entering medical school
demic standards) and legal restrictions on the
and other workers may segment the market and

reduce the returns to substitute workers, keeping the demand for physicians' services and their price high. Archer (Ch.9) comments on the widespread concern over professional monopoly, with doctors behaving like a 'price-discriminating, wealth maximising cartel', (Cuyler 1971)--irrespective of whether they are salaried or operate on a free-for-service basis or receive income from capitation fees.

The defects of a market distribution of medical care, as seen by Nattrass and Archer, are:

(i) the intensity of individual preferences is not reflected except in relation to purchasing power;
(ii) the lack of information of the buyer which makes him unable to exercise discrimination among sellers;
(iii) the potential for the existence of restrictions on non-physician practitioners, whose explicit purpose is to protect the consumer from the effects of his ignorance, to serve also as barriers to entry to preserve high incomes for doctors;
(iv) benefits and costs often spill over to others not party to the transaction (the frequency of this is disputed by Rees), so society would benefit from the consumption of more health care than individuals would choose under market conditions;
(v) the tendency of costs to rise under insurance systems (not specific to private insurance); and
(vi) the absence of some desirable services from the market, notably preventative and rehabilitative services.

Interestingly, some of these arguments were mentioned by the 1944 Gluckman Commission on a National Health Service (reported by Kanis, Ch.8). The Commission argued that health care in South Africa should be related to needs rather than to supply and demand, that there was an over-emphasis on cure and lack of a comprehensive approach; and that externalities (e.g. loss of production) would make it worthwhile for the state to intervene to increase preventive measures. Various alternatives to the market are discussed. Rees is sceptical about all of them, and suggests that reliance on voluntary organisations to fill in the gaps (as in the collection of blood) is likely to be more effective than government provision. He recommends that only those aspects of medical care in inelastic demand (i.e. those least prone to 'moral hazard') should be subsidised or provided free: serious illnesses would qualify first.

No. R. 304
15 February 1980
AMENDMENT OF REGULATIONS MADE IN TERMS OF THE DISABILITY GRANTS ACT, 1968 (ACT 27 OF 1968)
Under section 15 of the Disability Grants Act, 1968 (Act 27 of 1968), read with Proclamation R. 275 of 1971 and Government Notice R. 2616 of 30 December 1977, I, Norman Stewart Middleton, Member of the Executive of the Coloured Persons Representative Council entrusted with Community Welfare and Pensions, hereby further amend, with effect from 1 October 1979,

No. R. 304
15 Februarie 1980
WYSIGING VAN REGULASIES UITGEVAARDIG KRAGTENS DIE WET OP ONGESKIKTHEIDS-TOELAES, 1968 (WET 27 VAN 1968)
Kragtens artikel 15 van die Wet op Ongeskiktheids-toelaes, 1968 (Wet 27 van 1968), gelees met Proklamasie R. 275 van 1971 en Goewermentskennisgewing R. 2616 van 30 Desember 1977, wysig ek, Norman Stewart Middleton, Lid van die Uitvoerende Bestuur vir die Verteenwoordigende Kleurlingraad aangewys vir Gemeenskapswelsyn en Pensioene, hierby, met ingang

MEDICAL LEGISLATION

A bitter pill

The Medical Association of South Africa (MASA) has called on the Minister of Health to reconsider draft legislation on amendments to the Medical, Dental and Supplementary Health Services Professions Act of 1974, and the Medical Schemes Act of 1967.

The objections are contained in an open letter to Dr Johan de Beer, Secretary for Health, published in the SA Medical Journal this week.

Feelings are running high among medics, who are at loggerheads with the Minister over the legislation. For one thing, the gazetting of the Bill is regarded as untimely. According to Professor Guy de Klerk, chairman of the Federal Council of MASA: "It was introduced over the festive season, the return date for objections being January 23. So there was little time to prepare objections."

Then again, the Bill was gazetted almost simultaneously with the appointment of a commission of enquiry under Jan Haak to investigate health services and health tariffs. De Klerk says bitterly: "The fact that the commission was announced at the same time as the Bill was introduced implies that the findings of the commission have been prejudged and its findings nullified."

De Beer disagrees. "The Bill does not pre-empt the commission's findings in any way, or its terms of reference — which are so broad as to cover the whole spectrum of health services."

The proposed legislation is a bitter pill for the profession. Against a background of public outcry over the 52% price hikes in medical bills effective from last November 1, the new legislation establishes the Minister's ultimate right to determine



Health secretary De Beer . . . socialism is not our policy

maximum tariffs for medical schemes and also for fees rendered by a practitioner to a member of a medical scheme. It also deprives doctors of the right to contract out of medical schemes.

Says de Klerk: "The Medical Association has gone on record and has implemented its stand that it should be left to *itself* to cope with those who abuse tariffs."

He argues: "The Bill sounds the death knell of proper doctor-patient relations in this country . . . in the long term the public will lose as the quality of medical services drops and a possible brain drain from both the country and the profession occurs."

In terms of the proposed legislation the Minister will have total control over the medical profession, which will in effect result in the socialisation of medicine, according to MASA.

De Beer rebuts this: "I have repeatedly publicly stated that it is not the government's policy to have a socialist health service for the population.

"In fact the greatest bulwark against any form of socialist practice is the fact that Parliament has passed a Bill by which medical schemes can be established. More than 80% of the white population belong to medical schemes and other groups are being encouraged to join. This is diametrically opposed to any form of socialist service because the public are taking responsibility for their own medical services, as opposed to the State. Socialist services only exist for the indigent."

MASA believes fee increases are well deserved and long overdue. To prove its point, the association commissioned Pretoria University economist Fritz Steyn to undertake a study of medical tariffs in relation to the consumer price index.

He found that "without any doubt the incomes of practitioners had been slowly eroding," and recommended that an increase of 60% be granted to doctors.

According to Steyn's calculation, the costs of medical practice increased from 1974 to 1978 by an average of 51% whereas the cpi rose by 75% from 1974 to 1979.

Therefore, says Steyn, "it is clear that the adaptation in gross income (tariffs) was totally inadequate to cover increases in practice costs and doctors' costs of living."

This unhappy situation is partly the outcome of many years of official interference in the bargaining process between doctors and medical schemes. It is unlikely to be resolved by regulatory legislation of this nature.

But the doctors themselves must also shoulder considerable blame. A professional association that regulates entry into the profession and stipulates uniform fees is effectively a cartel that severely limits the working of the market mechanism.

It is all very well for them to complain of interference now in doctor-patient relations. But what has their professional association done over 16 years to doctor-customer relations?

Sanmed payment

RDM 20/2/80

BENEFITS amounting to almost R17-million — equivalent to 93% of membership fees received — were paid to members of the various medical schemes of Sanmed, the medical-aid subsidiary of Sanlam, in the past financial year.

This is shown in Sanmed's annual report which shows that the organisation's schemes had a membership of 53 546 at the end of December last year — an increase of 8,8% over the corresponding figure for 1978.

Mr Herbert Peters, general manager of Sanlam, said: "With the surplus of R1 100 000 for the year, our reserves now stand at R6 500 000. These reserves represent approximately three months' income at current subscription rates and do not constitute a profit, but in fact are an essential cushion against fluctuations in claims experience."

Right money

POSSIBLE SOLUTION

re is no way of Instant Success in changing patterns tionships. They mature when based on trust and t. As people grow in confidence with one another, ess can be made. Perception is also sharpened. Both d the labourers have 'blind spots' which are mutually

ty is to be increased with the willing co-operation of armer needs to realise that labour needs information ake rational assessments on the various factors st farmers would find it very embarrassing to reveal ve incomes of himself and his labourers. Many labourers would find it difficult to understand the cost of production and expected returns in a given operation, especially when market prices are variable from season to season. Yet a direct link between work undertaken and income received makes sense.

Practical steps in bridging the gap between farmer and staff - Areas of discussion

1. What do the labourers consider a fair wage?
2. How would they define a fair day's work for a fair wage?
3. What hours of work would they choose? e.g. 8 or 9 hours: 2 hours off in midday in summer, and so on.
4. In a given operation should there be a direct link between work undertaken and income received? e.g. bonuses on crops marketed or income from animals, etc.
5. What are other priorities which concern labour? e.g. housing, electricity, water, etc.

CONCLUSION

1. Labour is an unrealised asset in the farming industry. At present it is often considered the most expensive farming 'cost', and used as a relatively inefficient 'mechanical' aid to farming.

GENERAL NEWS

Munnik wants cut in medaid premiums

Own Correspondent

CAPE TOWN — Medical aid schemes must be streamlined and amalgamated to reduce members' premiums, the Minister of Health Dr L A P A Munnik, told the annual meeting of the Federation of Medical Schemes today.

Dr Munnik said that if steps in this direction were not taken in "the foreseeable future" he would investigate the matter.

He would like to see fewer schemes so that each scheme had enough members to ensure a wide spreading of risk.

"Then it would be unnecessary for schemes to introduce all sorts of restrictions in order to keep costs low," he said.

With a large membership of different age groups, members' premiums could be much lower in contrast to the present situation with small schemes where one or two large claims resulted in expenditure exceeding income.

There were 35 schemes affiliated to the Federation of Medical Schemes, with a membership of 369 352. Employers reaped benefits by providing schemes because it ensured a loyal and satisfied workforce.

SUBSIDY

Dr Munnik said the employer's subsidy of a scheme was therefore a long-term investment in the health of his employees and he should subsidise their contributions on at least a "rand for rand" basis.

"The contributions of members have, in many cases, risen dramatically during the past four or five years and I find it worrying," said Dr Munnik.

The rise could be ascribed to factors such as improved benefits, rising medical tariffs, inflation, general price rises and the increased rate at which

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n to school at all. Unisa's

eas studied - 52 percent(11) is

esumably because the areas include

d major urban centres, where schools

TABLE 28

Distri according to schooling completed.

School	Number of workers	%
N	91	74,59
S	1	0,82
S	5	4,10
S	4	3,28
S	2	1,64
S	5	4,10
S	7	5,74
S	5	4,10
Higher	2	1,64
	122	100,00*
	8	

*Figures

ause of rounding off.

asked why they had not been to school,

(iv) Proportional Mortality, accounted for by specific conditions.

(v) Expectation of Life. This was calculated both at birth (e_o) and at 45 years of age (e_{45}) for both males and females. It expresses the average number of additional years an individual would be expected to l beyond birth and 45 years.

For Africans, the proportional mortality was the only index calculated.

RESULTS

, this figure had decreased to 15,7%, indicating that the whites had
l disproportionately to the 'coloureds'. Similarly, for children
years of age, during the period 1941 to 1970, the white mortality
ace as a percentage of the 'coloureds' had decreased from 15,2% to
It should be noted that the 0 year age specific death rates are
than the corresponding IMRs. This is because the denominator for
mer is the number of live births whilst for the latter it is the
populations under one year of age.

provides an indication of the proportional contribution of selected
of death to the overall mortality experience of the white, 'coloured'
rican communities.



MEDICAL AID

Tailored for blacks

Equalisation of fringe benefits is of increasing concern to those employers committed to improving the quality of life of blacks within their companies.

Many such employers will therefore welcome the registration of a new scheme launched by the Medical Distribution Society (MEDS), effective from March 1. The scheme offers equal medical benefits to all, though based on differential contribution.

With differential contributions, the problem of blacks paying the same, but claiming less than whites, and thus effectively subsidising the whites, is avoided.

Professor Guy de Klerk chairman of the Federal Council of MASA, explains: "There is a high incidence of coronary disease and cancer among whites as opposed to blacks, so if both are grouped into one scheme, blacks carry the can for whites."

Lower black claims

Dr Nthato Motlana, a spokesman for the governing board of Sizwe Medical Fund — a medical aid scheme exclusively for blacks, also based on differentiated claims patterns — maintains that the expected level of black claims will be 25% that of whites in monetary terms. In addition, even more important is the lack of comparable medical facilities for blacks.

At present, membership of medical aid schemes is virtually compulsory for whites, whereas for blacks it is generally voluntary. However, the administrators of Sizwe believe that "enrolment in a medical aid scheme is only the beginning. Only half the battle is won at this stage. As medical aid is a relatively new concept for them, the lower income groups are not aware of the advantages and usually require schooling in the concept of preventative medicine. As a result, Sizwe places a major emphasis on education and follow-up procedures."

Says Keith Hollis, MD of Medscheme Administrators, who administer Sizwe: "I believe that the medical aid system in this country is our answer to the National Health system in Britain, and every citizen has the right to participate in that system. However, to achieve this an enormous educational task is necessary."

Recent figures show 298 registered medical aid schemes in SA (89 whites only, 158 multiracial, and 51 blacks only). But some express doubts whether blacks actually benefit from membership. One medical source feels it might in fact be cheaper for blacks to use the services of provincial hospitals. For example, any black woman can have a confinement at Baragwanath for R5, but when she becomes a member of a scheme she is charged the maximum rate.

rdiovascular diseases are consistently responsible for a fairly
proportion of the overall mortality of the 'coloureds', Table I
tes that the actual rates for cardiovascular diseases have been fairly
r for both whites and 'coloureds' since 1941.

y, the broad diagnostic categories used in this analysis conceal a
n amount of information. However, because of the changes in disease
fication which have taken place since 1929, it is not possible to
e the temporal changes of mortality rates in greater detail. Dis-
categories with rates greater than 5/1 000 appear in italics in
II. It will be noted that the mortality experiences of the 'coloureds'

whites and the mortality rates for persons ove
the age of 65 years have shown a rising trend, it is of some concern tha
the mortality rates have also increased between 1960 and 1970 for 'colou
in the 25-44 and 45-64 years age groups.

The imbalance between the age specific mortality rates of whites and
'coloureds' has improved or remained constant for persons between the ag
of 5 and 64. However, for children less than 5 years of age, the gap
between whites and 'coloureds' is widening. In 1941, white children un
one year old experienced 28,0% of the mortality of 'coloured' children;

Munnik wants fewer aid schemes

ARGUS 29/2/80

299

Medical Reporter

MEDICAL aid schemes must be streamlined and amalgamated to reduce members' premiums, the Minister of Health, Dr L A P A Munnik, told the annual meeting of the Federation of Medical Schemes in Cape Town today.

Dr Munnik said that if steps were not taken in 'the foreseeable future' he would investigate the matter.

He would like to see fewer schemes so that each scheme had enough members to ensure a wide spreading of risk.

'Then it would be unneccessary for schemes to introduce all sorts of restrictions in order to keep costs low,' he said.

35 SCHEMES

With a large membership of different age groups members' premiums could be much lower. With small schemes, one or two large claims resulted in expenditure exceeding income.

There were 35 schemes affiliated to the Federation of Medical Schemes, with a membership of 369 352.

Members and their dependants were not the only ones to benefit from the schemes. Employers also reaped benefits because schemes ensured a loyal and satisfied workforce.

Dr Munnik said the employer's subsidy of a scheme was therefore a long-term investment and he should subsidise contributions on at least a 'rand for rand' basis.

'WORRYING'

'The contributions of members have, in many cases, risen dramatically during the past four or five years and I find it worrying,' Dr Munnik said.

The rise could be ascribed to factors such as improved benefits, rising medical tariffs, inflation, general price rises and the increased rate at which members made use of medical scheme services.

'The administrators of schemes should inform members how to make use of the scheme as frugally as possible.

He said the schemes were often accused of making enormous profits. Another accusation was that some schemes unnecessarily delayed paying out claims and doctors' accounts.

Dr Munnik said the system of medical schemes in South Africa had worked well.

'Accusations have been made that we are moving in the direction of a socialist nationalised health system. I sincerely hope that whatever steps we take now, and in future, will help to avoid such a system as I do not think our country can afford a socialist nationalised system,' he said.

He said that if costs could not be kept at a realistic level, pressure would be exerted by groups advocating a national health system, and this would require Government intervention.

Govt scalpel hangs over medical aids

CAPE TOWN. — The Minister of Health, Dr L A P A Munnik, warned yesterday that unless there were rapid moves to rationalise medical aid schemes in the foreseeable future, the Government might have to consider steps to bring about changes.

Opening the annual meeting of the Federation of Medical Aid Schemes in Cape Town, Dr Munnik said: "I would like to see considerably fewer schemes, so that each scheme would have enough members to ensure a broad distribution of risks.

"If this were done it would be unnecessary for schemes to lay down all sorts of limitations to keep down costs.

"With a large membership comprised of different age groups, membership fees could possibly be lower than in small schemes where one or two big claims result in payments exceeding income," he said.

"Efforts must therefore be made to link schemes which belong together, to the advantage of members. Movements in this direction have not been rapid enough in the past, and unless there is an improvement in the foreseeable future, I will have to review the situation and see what can be done to bring about a change."

Dr Munnik said he was concerned at the tremendous increase, in many cases, of membership fees in the past four or five years.

While he was aware that many of those increases were due to improved scheme benefits, rising tariffs, inflation and general price increases, there was another factor which had to be taken into account to explain the increased number of claims in recent years.

"Despite campaigns to accentuate the benefits of preventive medicine, there has been an increase in the number of claims submitted by individual members."

Dr Munnik suggested it might be necessary to tell scheme members how to use their benefits judiciously and sparingly. This would be up to the administrators of schemes.

"Better use of benefits could lead to a decrease in the number of claims and result in a stability of membership fees."

He said the administration costs of schemes would be dealt with in depth by the commission he had appointed.

"It is an aspect which has to be resolved once and for all, so that there can be no further accusations that millions of rands' profit is being made from members' contributions.

Dr Munnik asked schemes to try to identify problem areas to ensure that doctors' bills were paid as quickly as possible after claims had been submitted.

Accusations had been made that South Africa was moving in the direction of a "socialist nationalised health system", he said.

"I sincerely hope that whatever steps we take now and in the future will help to avoid such a system." — Sapa.

STAR 5/3/80

Doctors are contracting back into aid schemes

(299)

More doctors are contracting back into medical aid schemes following the estimated 52,45 percent increase in medical fees granted last November.

Dr Marais Viljoen, secretary general of the Medical Association, said in Pretoria today he had been reliably informed that the number of doctors contracting in was greater than that of doctors contracting out of medical aid schemes.

He had been told that between October, 1977, and April 1978, more than 2 000 doctors had contracted out. Last January, about 4 000 contracted out, but since then many more doctors had contracted back in.

Increasing numbers of doctors had contracted in following the increase in medical fees.

The Minister of Health, Dr L A P A Munnik, has drastically revised proposals which would have given him wide control over the medical profession.

Doctors were strongly opposed to moves which would have given the Minister powers to veto decisions of the Medical Council, including tariff determinations.

Dr Munnik announced in a statement last month that doctors and dentists would still be allowed to contract out. "Provision will, however, be made to withdraw the contracting right if, after consultation with the Medical Council, this is thought to be in the public interest."

In future, the Minister will only be able to change a tariff determination after consultation with the Medical Council.

The executive committee of the Federal Council of the Medical Association has twice stressed that doctors should not contract out for financial reasons.

Said Dr Viljoen: "It is encouraging that doctors are contracting in again. This shows they have no intention of abusing their rights." Some doctors who contracted out did so because they offered a special service or had long experience or had other medical qualifications.

Haak resigns from commission on health

CAPE TIMES 4/3/80 299

THE controversial former cabinet minister, Mr Jaa Haak, has resigned as the chairman of the commission of inquiry into health services because of "personal circumstances".

This was announced last night by the minister of health, Dr L A P A Munnik.

Dr Munnik said he had recommended various members of the commission including Mr Haak, who was appointed chairman.

"He informed me this morning that as a result of personal circumstances he would no longer be in a position to serve on the commission.

"I would like to express my deep regret that Mr Haak does not see his way clear to serve on the commission and express my appreciation for his positive attitude," Dr Munnik said.

The commission was appointed to investigate South Africa's health services with particular reference to doctors fees after Dr Munnik clashed with the Medical Association over the size of the increase in fees.

UPDATE MEDICAL AID

Women around the country are lobbying for an updating of antiquated medical aid scheme rules.

ARGUS 11/3/80 299

One woman, shocked to discover her medical aid scheme didn't pay for contraception, tried to argue the case. She was told with a wink; 'We pay for pain not pleasure.'

Few medical aid schemes pay for contraception or sterilisation for men or women, but committees are starting to reassess the rule, according to Mr I Schroeder, whose company administers 24 State and private medical aid schemes.

Somewhat illogically, some schemes pay neither for contraception nor maternity benefits for unmarried women on the grounds that they do not have to pay for treatment arising from 'misconduct.'

Mr Schroeder, who supports maternity benefits for single women, remarked: 'Who am I to judge someone's morals?' And a Cape Town gynaecologist who was only too happy to give an opinion said: 'Of course contraception should be paid for. The Medical Aid Schemes should realise that they'd save in the long run — they wouldn't have to pay for the repair of damage done by illegal abortions or for confinements. And of course single women should receive maternity benefits. Why should a woman be penalised because she decides she would rather live with her boyfriend rather than marry him.'



Cartoon adapted from the book I'm Training to be Tall and Blonde by Nicole Hollander, St Martin's.

The Reach for Recovery Group, who are concerned with women who have had surgery for cancer of the breast, is to make payment by medical aid schemes for prostheses and breast reconstruction surgery their major project this year.

Chairman of the group, Mrs V Croome said: 'Some schemes will pay for psychiatric treatment but they won't pay for something which, for a woman is a psychological necessity. We have a right to demand these things.'

Remarkably, there are rules still laid down that a married female employee may not claim benefits for her husband on her medical aid unless he is an invalid and cannot obtain employment or financial support. This means that a woman whose husband is a student, self employed or temporarily unemployed may not receive benefits for him. And she may not claim benefits for her children if they are eligible for any other scheme in some cases. This is one of those boomerang types of discrimination against women whereby the male ultimately is the loser.

A spokesman for one of the country's big schemes, who preferred not to be identified said: 'We're not women's libbers — we feel men are the breadwinners and unless he is not able to provide for his family, the wife should be on his scheme.'

In answer to the question of cosmetic surgery, he said: 'When it comes to something like breast reconstruction, the rules are there as guidelines and can be bent but if you pull open the floodgates by changing the rules

an ache in the woman's toe. Who am I to argue?'

There are 25 registered medical aid schemes in the country. They are all subject to the Medical Aid Act but:

- There is no law that prevents a woman bringing her husband and children on to her medical aid unless they belong to another scheme;
- There is no law preventing single women qualifying for maternity benefits;
- There is no law preventing payment of contraception, sterilisation or cosmetic surgery.

Mr H J J van Rensburg, chairman of the Federation of Medical Schemes which deals with about a million people, including dependents, says: 'It's up to each individual scheme as to whether they grant these benefits or not. If members wish to bring about a change in the rules they are free to make recommendations either by writing to the governing body or at the annual general meeting. As in any business with shareholders, the management will surely consider reasonable requests.'

Look at the constitution of your medical aid society and see if they offer what you feel you should be getting. If not approach your representative on the scheme who will probably have the power to make recommendations to the trustees and enlist the support of your colleagues.

- In America a South Dakota housewife last year filed a lawsuit against her medical aid scheme after it refused to pay her surgical claims for breast reconstruction after cancer surgery. The case was settled out of court with the medical aid scheme saying it had changed its policy to include payments for breast reconstruction after surgery. A spokesman said that those plans throughout the country that don't now cover breast reconstruction after cancer surgery are probably in the process of changing.

g.'

About contraception, he said: 'We do pay for contraception that has been medically prescribed for the simple reason that we've been quite embarrassed. When we query the GP who has prescribed contraception, we can be told that it's for

der the national health service in Britain. Most people choose to use HNS, but there are charities and other medical aid organisations which provide a service for those who do not want to have it done under the NHS or who need urgent attention and cannot afford to wait.

KERI SWIFT

Contraception

Railmen must shun doctor they prefer

STAR 15/3/80

270 299

White railway workers at three North Coast stations are angry at a new ruling that they should discontinue using the services of a local Indian doctor in Verulam and instead travel 30 km to 40 km to a white doctor at Umhlali.

About 30 workers from Ottawa, Verulam and Tongaat have made written representations to the Railways' sick fund board complaining about the new ruling.

DAY AND NIGHT

One of the workers said they had been attending the Indian doctor for more than four years and were very happy with him.

"We know him personally and regard him as a very good doctor. He is also available the whole day and at any part of the night.

"I don't see why we should now travel between 30 km and 40 km to see a doctor in Umhlali," he said.

He said most railway workers and their families from Ottawa and Verulam would be inconvenienced if they had to travel to Umhlali to visit the new doctor.

COST RISE

"If I have to go to Umhlali by car it will cost me almost R5 in petrol, and if I have to go by train I will have to take half-a-day off.

"Our Indian doctor is only a stone's throw away from our homes.

"The new railway ruling is all so unnecessary," he said.

Another worker said while the sick fund board had asked whites not to visit the Indian doctor any more, it still appointed him to attend to "non-whites."

A spokesman for the board in Durban confirmed it had received written complaints from its workers.

He agreed the white doctor had been appointed from December 1 1979 to attend white railway employees and the Indian doctor in Verulam to attend "non-whites."

It was the policy of the sick fund board and he could not comment on that, he said.

He said a committee had been appointed to visit the complainants on Tuesday to explain the policy and sort out their problems.

Since the implementation of the Medical Schemes Act, 1967, problems have arisen time and again with the determination of fees for services rendered to members and dependants of members of medical schemes. Initially the profession concerned and the schemes had to agree on a tariff of fees and when such agreement could not be achieved, a compensation commission under the chairmanship of a judge was decided upon. Subsequently problems arose in connection with the times at which compensation commissions were to determine such fees, and the Act was amended. After that complaints arose as to the constitution of the commission and the fact that two laymen on the compensation commission i.e. the judge and a member representing medical schemes, had to decide on the inherent value of one service in comparison with another within a profession, and once again the Act was amended to empower the profession concerned to determine these values, while the compensation commission only had to decide on a monetary value. This system, too, had to be modified, primarily because of the fact that a judge could no longer be made available as chairman of a compensation commission and also because the professions concerned were dissatisfied with the fees that had been determined.

After consultation with all the interested organizations it was then decided to entrust this function to the S.A. Medical and Dental Council. In this connection I must, in all honesty, say that there were misgivings. Medical schemes were not very happy because no specific provision was made in the Act that the schemes should have a direct say in the decisions on fees. Members of the council expressed misgivings, but could not suggest any alternative method and, with three dissenting votes, agreed to this function being entrusted to the council. The medical schemes would be reassured as far as their misgivings were concerned by pointing out that the council would be competent to appoint any person, including a person representing medical schemes, on the tariffs committee of the council. It was further envisaged that the council could appoint a body such as the Human Sciences Research Council or a Bureau for Economic Research at one of the universities to institute an inquiry and to provide the council with factual information.

...ad read a Third Time.

MEDICAL, DENTAL AND SUPPLEMENTARY HEALTH SERVICE PROFESSIONS AMENDMENT BILL

(Second Reading)

*The MINISTER OF HEALTH: Mr. Speaker, I move—

That the Bill be now read a Second Time.

he states in his amendment—I cannot quite understand the hon. member's attitude—

> This House, while welcoming certain provisions of the Medical, Dental and Supplementary Health Service Professions Amendment Bill, nevertheless declines to pass the Second Reading because the Bill changes drastically the effects of a determination relating to professional fees.

This does not affect the determination at all. The council still determines them. It uses its tariff committees. The only difference is that, when the council has decided upon a fee, the Minister will be handed the information, and if he agrees, the fee will be published immediately.

Mr. R. B. MILLER: [Inaudible.]

The MINISTER: That is not the determining of fees. That is the bringing into effect of the determination of fees. I want to appeal to the hon. member rather to withdraw his amendment.

*Do not let the amendment remain on the books. People will subsequently, when they see the amendment, laugh at the hon. member.

There is one more thing I want to point out to the hon. member, but I shall discuss this later during the discussion of the next Bill.

†That concerns the question of contracting in and out. The hon. member for Hillbrow, I think, has already made the point that that is not really relevant to this Bill. The hon. member for Durban North asked when representations were received from the Professional Board of Psychologists regarding the amendment to the Act. It was recommended by the board to the Medical Council sometime last year. The Board of Psychologists falls under the Medical Council. As far as I can remember, the department received the recommendation in about May 1979, i.e. early last year. All the recommendations embodied in the other clauses, which have not been discussed and do not seem to be any real problem, were actually received by way of the council. So we are putting them into effect because they had problems with certain aspects of the particular provisions.

There is one thing I would like to ask the hon. member for Durban North, and other members. I want to ask that the hon. members stop comparing doctors with plumbers. I think we are very sensitive about the whole issue. The number of jokes going around about the doctor and the plumber is getting a bit superfluous. The hon. member complained about his tap but for all practical reasons he could have fixed it himself, but the hon. member could not take his own advice out. That makes the medical profession a monopolistic profession. Anybody can try to fix an electric light—if one wants to bring electricians in as well—and one can fix one's own tap. [Interjections.] The hon. member for Bryanston raised another point by asking whether I should not alter the provision of the particular clause to read "shall" instead of "may". If I am left with no option it may be that the publication of the tariffs in the *Gazette* may be overdue and it is better that I perhaps published a raised tariff than a reduced one in the meantime. If I am bound by the clause that says that I shall do it then I cannot publish the new tariffs in the *Gazette*.

Mr. A. B. WIDMAN: But there will be a tariff in operation.

The MINISTER: Yes, but the reason for publishing a new tariff would be that the old one is azsolute. I obviously hope that the Medical Council will not come forward with a new tariff while the old one is still very effective. If a new tariff does come, but there is only a difference in respect of how much is should be raised, one does not want to have a long dissertation with the council. If it is stipulated that I must first refer it back to the council, then I cannot publish a tariff in the *Gazette* in the meantime.

*I want to thank all the hon. members who participated in the debate for their contributions. We have debated important legislation which I hope will ensure in future that we restore order in respect of medical tariffs, and that we are also able in this way to eliminate the dispute between the patient, the medical practitioner and the medical schemes in future.

Question put: That all the words after "That" stand part of the Question.

Question affirmed and amendment dropped (New Republic Party dissenting).

Bill read a Second Time.

MEDICAL SCHEMES AMENDMENT BILL

(Second Reading)

The MINISTER OF HEALTH: Mr. Speaker, I move—

That the Bill be now read a Second Time.

In the medical scheme set-up there is a definite contractual relationship, viz. the relationship between the member and the practitioner, the relationship between the member and the scheme, and the relationship between the scheme and the practitioner who is prepared to render services at the tariffs of fees laid down for members of medical schemes. The member and the practitioner derive benefit from the relationship in that the member is to a great extent assured against medical expenses, and the practitioner's payment for services is guaranteed. However, the definite relationship creates serious problems in regard to the mechanism that has to be created to determine the fees that would satisfy most practitioners and members of medical schemes. Various alternative methods for determining the tariffs have been adopted in the past. I do not wish to go into that any further at this stage, as the matter will be investigated by a commission.

The fact of the matter is that at present we have the situation that a person who renders services may decide whether or not he wishes to render services at the tariff of fees laid down. If such person does render services at the fees which have been determined, the member receives full benefits from the medical scheme. If the person does not render services at the tariff of fees laid down, the member's benefits decrease to 40% and even less of the account for the services. The question which immediately arises is whether it is worthwhile for such a member to remain a member of the medical scheme, particularly in the case where a member only avails himself of services sporadically. This aspect affects the young person in particular. A point could therefore be reached where it would no longer pay such a person to be a member of a medical scheme, and such a state of affairs could cause the entire medical scheme set-up to collapse.

If that were to happen, the State would have to provide services to people who cannot afford them for I doubt whether, under the present circumstances, many of these services would be within the financial means of persons with an average income unless they were contributors to a medical scheme.

The income of medical schemes consists of member's contributions and interest on investments. Reserve funds are limited to 50% of the annual income from member's contributions and these are compulsory to protect the interests of members in case a medical scheme were to be liquidated, and also to ensure the payment of accounts of contracted-in providers of services in such an event. In the case of employee's schemes, the member is subsidized by the employer. The amount of member's contributions determined in such a case depends upon the ability of the employee and the employer to pay and in the nature of things, they are limited. Consequently, the source of income of a medical scheme has a restrictive effect. So I wish to sound a serious warning that medical schemes are not geese that lay only golden eggs.

The medical profession, in particular, has levelled serious criticism and accusations at medical schemes in the past. With the appointment of the Commission of Inquiry into Health Services, every opportunity is now being afforded of proving claims and of rectifying shortcomings, and undesirable practices, if any. If people do not avail themselves of this opportunity to the full, nobody must be blamed if such criticism and accusations are ignored after the inquiry has been completed.

The question of contracting in and contracting out is a sore point with the professions. Certain practitioners charge the tariffs determined for members of medical schemes, but avail themselves of the right to contract out because they take pride in their independence as professional people and do not wish to be bound by stipulations made outside the profession to limit the exercise of their professional activities. Others, again, avail themselves of this right because they are of the opinion that the remuneration is insufficient.

As far as this matter is concerned, there are certain factors with particular disciplines, with the dental profession and at private hospitals, that do play a role. For that reason

National Health service 'not on' for South Africa

2-7-5
29/3/80
299

THE ASSEMBLY — It was not the policy of the government to create a socialised medical service, the Minister of Health, Dr Munnik said yesterday.

Replying to the second reading debate of the medical, dental and supplementary health service professions Amendmend Bill, he said he also did not seek confrontation with any profession or with medical schemes.

The sole aim of the Bill was to create harmony with regard to medical services and to satisfy the man on the street and the medical practitioner that they were both getting a fair deal.

If medical tariffs were too high for the ordinary man he was compelled to turn to the State for medical services and this in turn placed en unacceptable financial burden on the latter.

The Bill was not intended as State interference or the socialising of medical services but merely an attempt to keep tariffs within reasonable limits.

Dr Munnik said he was convinced that the Bill would also go a long way to prevent a dispute between general practitioners and medical schemes in future.

The sources of income of medical aid societies depended on how much employers and employees could contribute.

"I therefore want to issue a serious warning that medical schemes are not the goose that lays the golden eggs," he said.

The medical profession would get the opportunity to submit its criticism of medical aid societies to the commission of inquiry into health services.

If it did not fully utilise the opportunity, the medical profession should not blame anyone if further criticism and accusations against medical aid schemes were ignored.

The House rejected an amendment by the NRP declining to pass the second reading and the Bill was read a second time. — Sapa.

Munnik warns about medical aid schemes

HOUSE OF ASSEMBLY. — The collapse of medical aid societies would compel the State to provide health services to people even of the middle income group, the Minister of Health, Dr Lapa Munnik, said in the House yesterday.

Unless medical practitioners adhered to the established tariff of fees, benefits accruing to members of medical aid societies could drop sharply.

Dr Munnik, who was introducing the second reading debate of the Medical Schemes Amendment Bill, said a point could eventually be reached where it would no longer pay people to belong to medical aid societies.

"If that happenes, the State will have to provide the service to people who cannot afford it.

"I doubt whether many of the services will be within the financial ability of people with an average income."

For their income, medical aid societies depended on how much employers and employees contributed.

"I therefore want to issue a serious warning that medical schemes are not the goose that lays the golden eggs."

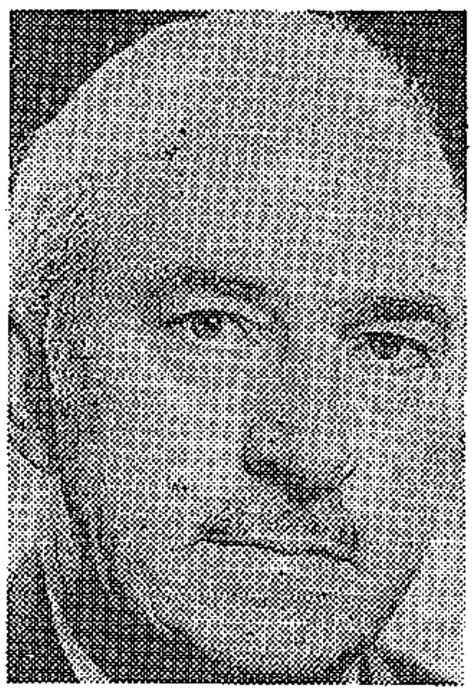
The medical profession would get the opportunity to submit its criticism of medical aid societies to the Commission of Inquiry into Health Services.

If it did not fully utilise the opportunity, the medical profession should not blame anyone if further criticism and accusations against medical aid schemes were ignored.

The question of opting in or out of medical aid societies was a tender issue with practitioners.

Many doctors prized their independence and opted out of medical schemes even though they were adhering to the established tariff of fees.

It had been decided not to abolish the right of practitioners to opt in or out of medical aid schemes.



DR LAPA MUNNIK
. . . stern warning

The Bill provided, however, that the right could be suspended by regulation, Dr Munnik said.

Mr Ron Miller (NRP Durban North) said the Minister would be empowered to compel medical practitioners to accept medical tariffs by suspending their rights to contract out.

The Bill, he said, constituted nationalisation of health services despite declared Government policy that it was opposed to a socialist system of health services.

The Bill, combined with the Medical, Dental and Supplementary Health Service Professions Amendment Bill, would have the joint effect of socialising health services.

In the latter Bill, the Minister had the right to determine tariffs and in the Medical Schemes Amendment Bill he would be empowered to take steps to prevent doctors who were dissatisfied with tariffs from contracting out.

"Then we have reached a turning point in South Africa."

The Minister, he said, had expressed his opposition to a nationalised health service, but the effect of the legislation would be to create precisely that.

"The only difference between South Africa and Britain would be that the doctors would not be in the employ of the Minister. They will remain self-employed in a nationalised health service."

The medical profession had been relieved when the Minister announced on February 15 that the powers he contemplated would extend to determining tariffs only as far as medical aid scheme tariffs were concerned.

"They correctly expected that the right to contract out would not be tampered with. But we're now entering into a completely new dispensation when the Minister takes powers to prevent doctors from contracting out should they be dissatisfied with the tariff determination.

"We are likely to destroy the fabric of one of the best medical and dental services in the world."

Whenever there was a disagreement over medical fees the system was blamed and steps taken to change it. The real problem was that the system actually worked well and, as was shown repeatedly, the tariff level was wrong.

In seeking acceptable tariffs, there had to be an alternative choice and this South Africa had. Every province provided one of the finest medical services available and one could have everything necessary, up to a cardiac transplant, for R50 or even free if one was poverty-stricken.

If fees were unacceptably high, a patient had the choice of leaving his private practitioner and going to a provincial hospital. There would, however, always be people who were prepared to pay extra for a private doctor's services.

The public had also been done a disservice by being panicked with publicised announcements that medical fees had gone up by 52%. "One has to look at the base line and when one realises that a service has gone up from R6 to R9, one obtains a proper perspective.

Just as the petrol price increases could not be dropped simply because of the public outcry, medical fees could not. The fact was that in both cases the increases were necessary. – Sapa.

'Means test should be revised'

THE ASSEMBLY. — The means tests at provincial hospitals should be revised to allow more people to make use of the excellent medical services provided at those hospitals, Mr Alf Widman (PFP Hillbrow), said in the House yesterday.

He was speaking during the second reading debate of the Medical, Dental and Supplementary Health Service Professions Amendment Bill.

The Bill, among other things, provides that medical fees determined by the South African Medical and Dental Council have to be approved by the Minister of Health.

Mr Widman said that a realistic tariff had to be found for medical services. If they were too low, many doctors would opt out of medical schemes.

UCT

Too many medical schemes — Mummik

Argus 1/5/80
(290)

Medical Reporter

SOUTH Africa had more than 300 medical schemes, and many of these could be amalgamated to the benefit of members according to the Minister of Health, Dr L A P A Mummik.

Dr Mummik told the South African Society of Insurance Medical Underwriters in Cape Town last night that health insurance had become possibly the fastest growing branch of the insurance industry.

TOTAL

A total of 4 155 518 South Africans were covered by registered or unregistered medical aid and medical benefit schemes.

Dr Mummik said he felt however, that there were too many schemes and many of them could be amalgamated to the advantage of members.

He said criticism was often levelled at the medical cover system by those who said that South Africa had 300 schemes for 25-million people while the United States had only two schemes for its population of more than 200-million.

AN ERROR

Dr Mummik said this was an error.

The US had two State-subsidised schemes for the poor and persons over 65, but a number of other schemes were run by assurance companies.

In South Africa the State also provided for the poor and aged.

Dr Mummik said people advocated a no-claim bonus system, but because illness was unpredictable the concept would be unfair to the 'underdog.'

Sick fund subs may go up again

STAR 9/5/80

Tariff increases of about 78 percent for white private medical aid patients at Transvaal Provincial Hospitals, could result in medical aid subscriptions rising even more.

Mr J D Ernstzen, vice chairman of the Representative Association of Medical Schemes, said today that medical aid subscriptions had increased by an average of 35 percent since November, when medical tariffs rose by an estimated 52,45 percent.

"This will mean a serious increase in our pay-out, that will vary from scheme to scheme," he said.

Medical aid administrators would have to look at the past history of their schemes to decide whether there should be subscription increases and how big the increases should be.

PFP members in the Transvaal Provincial Council have said the new hospital tariffs will mean that members' contributions to medical aid schemes would go up.

Some of the proposed increases are:

- Whites with medical aid and maternity cases admitted to provincial hospitals will now pay R25 instead of R14 a day.
- White medical aid members who have used up their medical aid benefits for the year will be admitted to provincial hospitals as ordinary patients. This tariff goes up from R6 to R8 a day.
- In-patients in low salary groups will pay no fees. But others in this group will pay between R2 and R6 a day.
- Patients who are not medical aid members and are admitted to provincial hospitals as private patients will pay between R10 and R20 a day. The fee was previously between R7 and R14 a day.

Even aid patients may pay R9 a day

By MARILYN ELLIOTT

MANY medical aid subscribers could pay up to R9 a day out of their own pockets for a stay in a Transvaal Provincial Hospital because of the 78% increase in tariffs for white private medical aid patients.

The increase, announced by the Administrator of the Transvaal, Mr Willem Cruywagen, in his maiden Budget in the Provincial Council, takes effect on July 1.

Yesterday, Mr John Davidson, manager of the largest registered medical aid scheme in South Africa, said that though he did not have full details of the increase, his firm, which handles medical aid for public servants, would have to consider whether it would increase maximum benefits for private medical aid patients.

"At present we pay out up to R16 a day for private patients. If the new tariff means an increase to R25, it is possible subscribers will have to pay the extra R9 until, and if, the management committee decides to increase the benefit.

"The hospital fees increase does not necessarily mean that subscriptions will go up. Of course, it is too early to say exactly what the impact will be. But it is obvious that public servants will have to pay the R9 difference until we decide what to do," said Mr Davidson.

Mr A M Leveton, chairman of a company which administers nine different medical schemes, said the hospital fee increase would inevitably affect subscriptions.

"Each medical aid scheme has to decide its own policy. We had expected a hospital fee increase, but not in the region of 78%.

"The system of increasing fees for those who have taken the trouble to protect themselves from sudden medical expenses, on the assumption that these people are 'unpoor', is a harsh one indeed. Since the increase in medical tariffs last November, medical aid subscriptions have risen from 30% to 40%. The new hospital tariff will probably mean a further increase in tariffs."

The vice-chairman of the Representative Association of Medical Schemes, Mr J D Ernstzen, said the new fees would "most certainly affect" subscription rates.

"Obviously, these increased rates will vary from scheme to scheme. In some cases, members will probably be asked to foot the bill for higher tariffs; in other cases subscriptions will increase."

Mr Ernstzen said that in cases where medical schemes shouldered much of the medical tariffs increases last November, they would now reconsider the position and have to ask for higher subscriptions.

Meanwhile, Sapa reports, the president of the Motor Industries Federation, Mr Theo Swart, said yesterday that the increase in vehicle licence fees in the Transvaal was "shocking".

Increases of up to 50% for car licences and 100% for motor-cycles would help to increase inflation, he said, and it was difficult to understand why drivers had been singled out to balance the province's accounts. The province's tax burden should have been spread more evenly.

The province should also have waited for the recommendations of the Browne Committee, appointed by the Minister of Finance, Senator Owen Horwood, to find ways and means to raise revenue for local authorities which would also alleviate the position.

He appealed to Administrators of other provinces not to follow the transvaal's example.

12/05/80 ARGUS

Sterilisation — medical aid benefit urged

(299)

Medical Reporter

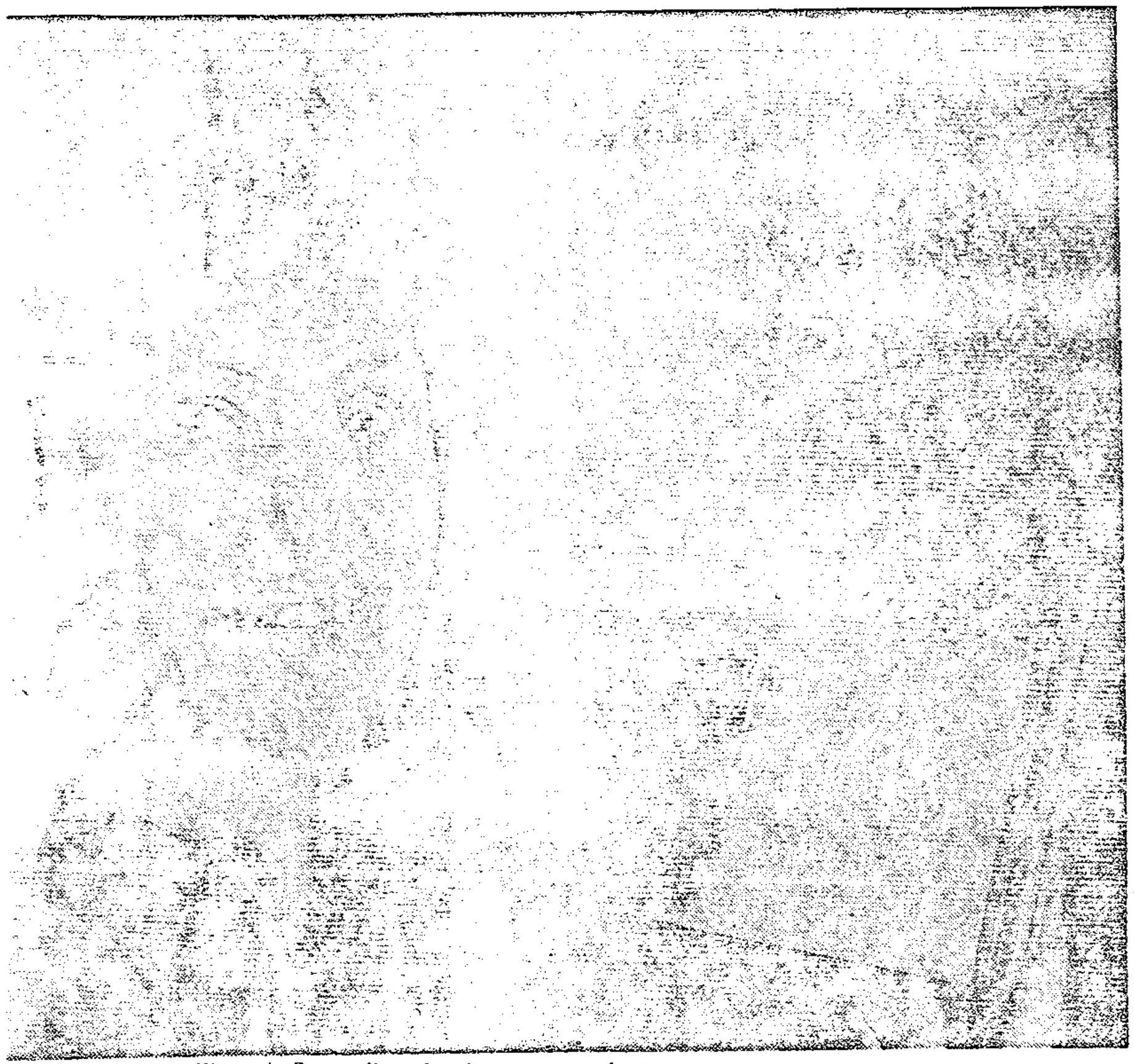
THE Cape Association for Voluntary Sterilisation (AVS) has expressed the hope that all medical aid schemes will come to regard voluntary sterilisation as an important preventive health measure and automatically include benefits for the procedure.

In the latest issue of the South African Medical Journal the CAVS honorary secretary, Mr E P Woodrow, said that encouraging patients to have the operation by including it as a benefit would save on illnesses, unplanned pregnancies, confinements and children's ailments.

CAVS recently completed a survey on attitudes of medical schemes towards including voluntary sterilisation as a benefit.

The results showed 65 percent of 51 of the largest schemes already offered benefits for the operation. Eight allowed benefits only when there were medical reasons for the operation and nine offered no benefits at all.

Some of the schemes not offering full benefits said they might consider a 'less conservative' policy in the future.



Sue Garbett, Star Women's Page editor, has been presented with the Medical Association of South Africa's award for excellence in medical reporting for 1979. Mrs Garbett was presented with a plaque by the president of the association, Dr H D Chomse, at the annual meeting of the association. Mrs Garbett's series of articles on artificial insemination, adoption and infertility, published in The Star last August, won her the award.

National health service for all races supported

STAR 14/5/80 (299)

By Bob Kennaugh, Science Correspondent

Support has been given to a call for a comprehensive, consolidated and streamlined health services system for all the peoples of South Africa.

The call for health to be tackled on a national basis no matter what sociological or ethnic boundaries there might be was made by the president of the medical association of South Africa, Dr H D Chomse, in his inaugural address to the association this week.

He said there could be no social contentment without health and on this the stability of the State was dependent.

MUCH MORE

Emphasising that much had been done to check the spread of Third World diseases — malnutrition, gastro-enteritis, rickets and others — in black urban areas, including Soweto, two leading medical men said much more could still be done to help the underprivileged.

Dr Chris van den Heever, acting superintendent of Baragwanath Hospital, one of the biggest hospitals in the southern hemisphere, and Professor H Stein, assistant dean of the medical school at the University of the Witwatersrand and a professor of paediatrics, agreed that South Africa's health services should be streamlined.

Professor Stein said: "Much more money and the services of skilled manpower should be ploughed into health services for the poor.

IMPROVEMENTS

"This is already happening — but we need to do more. We must prevent the spread of disease and improve socio-economic conditions for all our people."

There had been significant improvements in checking the spread of preventable disease in children — but more could still be done.

There was a critical need for more doctors in the homelands and more general practitioners in Soweto, they said.

Dr van den Heever said: "We need more hospitals and clinics in Soweto, a complex with more than a million people.

"There are only about 18 general practitioners in private practice in Soweto. We need thousands more. This would help to take some of the pressure off Baragwanath."

Dr van den Heever called for a co-ordinated and integrated health service in which there would be interdependence between provincial, local and peri-urban authorities.

The spirit of the Health Act of 1977 was that there should be a move towards integration and consolidation of services, he said.

"There is still fragmentation. But we are moving towards a more integrated approach," he said.

Probe medical aid first, inquiry urged

CAPE TOWN. — The Minister of Health, Dr L A P A Munnik, yesterday urged the Commission of Inquiry into Health Services to give priority to aspects relating to medical aid societies in South Africa.

There were well over 200 medical aid schemes with divergent rules and regulations for payment.

"The commission will have to consider whether there is room for so many schemes in a small country such as South Africa," Dr Munnik said at the opening of the commission's first meeting.

The Government was concerned at the situation and it would be grateful if the commission submitted an interim report within three months.

The commission had as its terms of reference to inquire into the entire question of supplying a health service in both the public sector and the private sector.

Dr Munnik said the commission would attend to, among other things, methods to determine doctors' tariffs so as to avoid the "melee" (gemaal) of the last fixing.

Dissension about doctors fees was detrimental to the medical profession, which was detrimental to the provision of services.

The chairman of the commission, Dr Gerald Browne, said the commission had received a letter from the Medical Association of South Africa in which it offered its full co-operation

Medical aids in dark on cost hike

(299) ~~295~~

(DM 30/6/60.

Staff Reporter

AFTER the 10% hike in private hospital ward and theatre fees agreed last week, several medical aid schemes still do not know whether they will increase their contribution scales — because they have not yet been officially informed.

The increase was negotiated on Thursday at a meeting of the Representative Association of Private Hospitals and the Representative Association of Medical Schemes.

The 10% increase in private hospital theatre and ward tariffs means that from July 1 a bed in a general ward will cost R27,50 a day, and theatre fees will range from R70 and R88.

Of six medical aid schemes approached by the Rand Daily Mail, only two had been officially notified of the increase — Anglo American Corporation Medical Aid and OK Bazaars Medical Aid.

Spokesmen for the other four had either not heard about the increase or had only read about it in Friday's "Mail".

A spokesman for the Anglo American scheme said they had been informed of the increase by RAMS.

He said members' contributions would not increase. The scheme would increase its contribution by R1 a month for each of its 10 000 members.

At the moment, the Anglo American medical aid scheme pays the full tariff for ward and theatre fees, and apparently will continue to do so after July 1.

A spokesman for the OK Bazaars Medical Aid Scheme refused to comment and would not disclose the amount the scheme paid out to members for ward and theatre fees.

A spokesman for the South African Associated Newspapers Medical Aid scheme said they had received no official notification of the increase.

A spokesman said the last increase in medical aid subscriptions had been on January 1, when medical tariffs increased. She did not know whether they would be increased again this year.

The Argus Medical Aid Scheme had not been informed of the 10% increase and did not know whether contributions would have to be increased.

A spokesman for NBC Medical Aid had not heard about the increase. At the moment, NBC covers the previous tariff of R25 a day for a bed in a general ward and 100% of theatre fees.

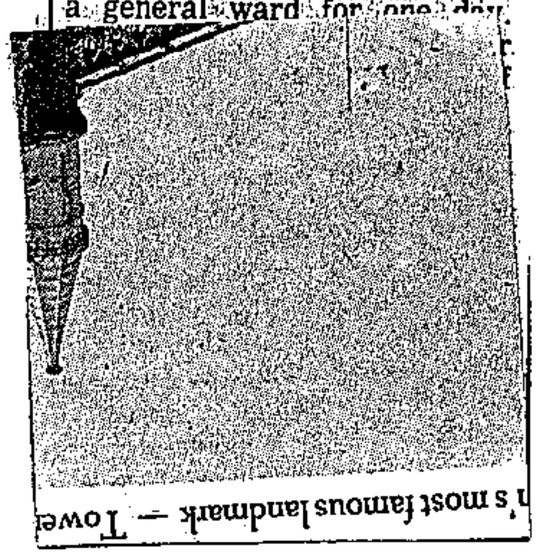
The spokesman was unsure whether NBC rates would increase.

South African Breweries Medical Aid had read of the 10% increase in the 'Mail', but had not been officially informed. At present the scheme pays all theatre fees and R20 a day for general ward fees.

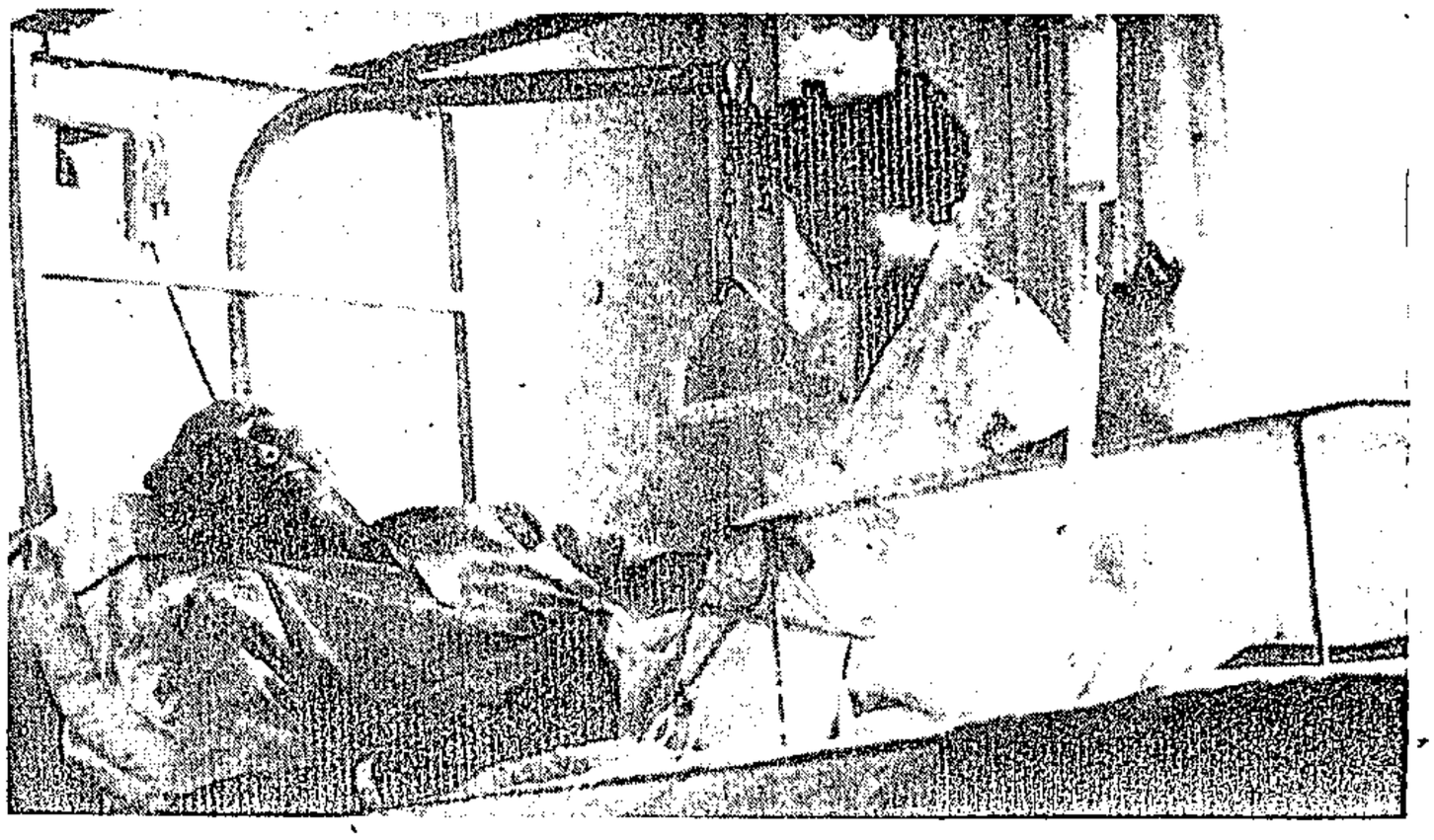
A spokesman said the new increase would cost the scheme an estimated R6 000 a year more, but he did not know whether contribution rates would be increased. The SAB scheme's last increase was 32%, on January 1.

A calculation involving three routine operations — not allowing for theatre complications — compares the average cost of ward and theatre fees, at present and from July 1.

• A tonsillectomy — the patient would be in theatre for about half-an-hour and would stay in a general ward for one day.



's most famous landmark — Towe



Hospital costs . . . rises on the way

MEDICAL AID

Tariffs to rise

FM 4/7/80

Contrary to some newspaper reports, the 10% hike in private hospital ward and theatre fees has not yet been implemented. In terms of the Medical Schemes Act, the increase has to be approved by Health Minister Lapa Munnik, and as he is presently on holiday, his consent has not yet been given.

The decision to ask the Minister to approve a tariffs rise was taken last week at a meeting of the Representative Association of Private Hospitals and the Representative Association of Medical Schemes (Rams). The disclosure was made public in the form of an official press release. Suggestions, therefore, that medical aid societies were not informed of the proposed increase are misleading as the meeting's decision was communicated to all societies and the public as quickly as possible.

Rams vice-chairman John Erntzen tells the *FM* the proposed rise is necessary in order to pay hospital salary scales to nurses commensurate with provincial scales.

Erntzen says the medical aid societies face constant increases in medical costs. Moreover, dental technicians' tariffs went up by 25% on July 1, provincial tariffs have risen by as much as 78% and in the present 'flu epidemic, the societies could face an avalanche of claims. Consequently, Erntzen warns that the "societies might have to adjust their members' contributions before the year-end."

The societies are also under pressure from the provincial authorities, some of whom display antipathy to private medicine. One proposal presently being hawked round is that medical aid patients in provincial hospitals should pay R25 per day in charges. Erntzen points out this is "absolutely reprehensible" as the working man who has a job and is on medical aid will be penalised for the benefit of the person who has taken out no health insurance of his own.

Another unacceptable provincial plan is to charge black medical aid patients the full medical aid rate, even though white patients can get reductions. Province's motives for this are unclear but Erntzen attributes it to "province grabbing whatever money it can."

Erntzen feels allegations that private hospitals "rip-off" their patients are not justified. Many of the charges the hospitals levy stem from the high cost of medical materials. And people who are unhappy with the size of bills can always query them. "In my experience," says Erntzen, "the private hospitals always pass credit if overcharging should be discovered."

Bosses are asked: pay workers' medicines

A JOINT committee of the Medical Association of South Africa and the South African Pharmaceutical Society yesterday asked employers to help low-income workers who can't afford vitally-needed medicines when they have been injured.

A statement issued in Pretoria said: "The associations have asked employers to provide company orders to accompany Workmen's Compensation Act prescriptions, accepting responsibility for payment. Accounts for prescriptions would then be sent directly to the employer, who would then claim the amount back from the WCA Accident Fund."

A Masa spokesman said: "Some workmen incur considerable financial hardship after injury. This usually affects those in the lower-income groups.

"The main financial problems include not only loss of salary, but also that he must pay for his own medicines before, and even after, the Workmen's Compensation has accepted his claim. Obviously, the workman deprived of his income — and often without savings — is unable to purchase the drugs he needs."

At present, employers sometimes help, and often the doctor supplies drugs from his own stock, but no proper system has been set up to handle the problem.

"In less than 2% of WCA claims is liability by the scheme not accepted, so the MASA believes few employers would be risking loss by underwriting the cost of medicines in these needy cases." — Sapa.

Medical fees may go up — again

RDM 19/7/80.

299

Staff Reporter

DOCTORS' fees could be increased again later this year, according to medical sources in Pretoria.

The chairman of the Federal Council of the Medical Association of South Africa, Professor Guy de Klerk, said an investigation was under way into the effects of the current inflation rate of more than 14% on doctors' earnings.

Depending on the result of the investigation, representations could be made to the tariff committee of the South African Medical and Dental Council.

Last October fees were raised by a massive 52,45%.

The increases caused a public outcry. The Minister of Health tried to intervene. He asked the council to review the big increase but had no success, and the increase came into operation on November 9 last year.

Doctors claimed that the increases merely compensated them for the backlog which had built up over a number of years' inadequate compensation for costs of running practices and in general living costs.

Later a request from the Medical Council to be relieved of the responsibility of fixing fees was turned down. Legislation, however, was amended to give the Minister the final say in any rise in doctors' fees.

Earlier this year a commission was appointed to inquire into health matters. One of its terms of reference is to determine where the responsibility for fee fixing should lie.

The vice-president of the Representative Association of Medical Aid Schemes (RAMS), Mr J Ernstzen, said yesterday that RAMS still considered the 52,45% increase to be greatly excessive.

The forecast made by RAMS that the increase would mean an additional average income for doctors of R12 000 a year had been borne out by claims on medical aid funds since last November, he added.

PE doctors plan to boycott group fund

Own Correspondent

PORT ELIZABETH — Port Elizabeth doctors have unanimously decided to resign en masse from the panel of the Midland Chamber Group Fund (MCG), a medical benefit scheme, unless they are paid the same fees as those granted for other medical aid societies.

This was reliably learnt after an urgent meeting held on Thursday night by the Cape Midlands branch of the Medical Association of South Africa (Masa).

Approached afterwards, the branch chairman, Dr Angus Hofmeyr, said he was not prepared to comment.

He said he would make a statement later next week after he had informed "certain groups" with which he would hold talks.

A doctor, who did not wish to be named, said that a resolution to resign from the panel of the MCG fund — a medical benefit scheme used by many companies and administered by the Midland Chamber of Industries — was passed by the 28 doctors at the meeting.

"It was unanimous," he said.

The meeting was called to discuss the low fees paid to MCG panel doctors in Port Elizabeth and Uitenhage.

A doctor, who is not on the MCG Fund panel, said it had been discovered that some of his colleagues were being paid less than a third of the gazetted tariff for medical aid societies.

To make it worth their while, they had to see about 16 patients an hour, compared to the four or six seen by doctors whose patients belonged to medical aids.

One source said that medical benefit patients ultimately suffered through what he called "sausage machine practices".

He said as a result of "discriminatory fees" paid to black doctors on the panel, the profession was losing many of them to other centres — something which Port Elizabeth could not afford.

"Virtually all the MCG doctors here are black," he said.

It is believed that some of them receive as little as R3,10 per patient, compared to the R6,60 paid by medical aids.

On October 1, Ford Motor Company in Port Elizabeth switched 2 600 black hourly paid workers from its medical aid scheme to the MCG fund.

The company's personnel services manager, Mr A Nel, said in an interview then that this was because of last year's negotiations by the hourly paid workers for cheaper medical benefits.

Medical aid chiefs dubious on fee rise

By GERALD REILLY
Pretoria Bureau

MEDICAL aid fund chiefs feel it is not at all certain that the Minister of Health, Dr L A P A Munnik, will agree to a new 10% rise in doctors' fees.

They said yesterday that the funds had calculated that if the tariff rise demanded by the SA Medical and Dental Council is approved, it will mean doctor's fees will have risen by more than 65% in just over a year.

This was calculated on a base of 100 set before the last fee rise.

Meanwhile, Dr Munnik said in Pretoria yesterday he could not state at this stage whether or not he would agree to the demand.

He said he would have the claim investigated by his department and by the Prime Minister's Economic Advisory Council.

"They will advise me on whether the motivation of the SAMDC for its recommended fee hike is sound on economic and financial grounds."

Last year the SAMDC — which then had full powers to fix the level of fees — rejected an appeal by Dr Munnik to review and reduce the huge 52,45% fee rise which came into operation last November.

An amendment to the legislation passed during the last parliamentary session has given the final say on medical fee disputes to the responsible Minister.

Supporting the view that Dr Munnik may reject the SAMDC recommendation is the fact that the Minister obviously believed last year's huge fee rise excessive.

This being so, it is reasoned, he would have similar views about an accumulated fee rise of more than 65% in just over a year.

Meanwhile, medical aids fear the effective rise in doctors' charges could be greater than the actual 9,9% asked for.

One prominent board member of a large fund said that if the number of units used to assess fee levels for various treatments were increased, the increase in some categories could be well over 10%.

He added that if the 9,9% was approved, subscriptions to medical aid funds would have to be raised by about 5%.

Doctors' fees make up about 50% of all medical aid payouts.

Meanwhile, it was pointed out, the cost of illness in the Transvaal has increased at an unprecedented rate during the past 12 months.

This includes higher private and provincial hospital tariffs and sharply rising dispensary fees and medicine prices.

The president of the Garment Workers' Union of SA, Senator Anna Scheepers, warned yesterday that if doctors were permitted to keep on raising their fees it would eventually destroy the medical aid system, and she called for a national Government-administered contributory aid scheme.

299 RDM 17/10/80

Planned medical fees rise regarded as fair

By MARIKA SBOROS

MAJOR companies and medical aid schemes regarded the proposed new rise in medical tariffs as reasonable, the managing director of one of the country's largest medical aid scheme administration companies, said yesterday.

Mr Keith Hollis was commenting on the announcement that the South African Medical and Dental Council had recommended an increase of 9,9% in doctors' fees to the Minister of Health, Dr L A P A Munnik.

Mr Hollis said some schemes would be increasing contributions by about 5% to cover the new increase, but that this would depend on individual schemes and their particular funding.

"We were expecting a higher increase," Mr Hollis said.

"We administer 25 different medical schemes for more than 750 companies.

"We have canvassed major companies that are doing the paying and the general feeling is that they regard the increases as very reasonable."

Doctors' fees have been too low over the past ten years and have not kept up with increased practice costs and inflation, Mr Hollis said.

Last year's increase of 52%, though substantial, was necessary because it brought rates charged by doctors who worked within medical aid schemes in line with fees of doctors who had contracted out.

"Last year's adjustment narrowed the gap which was carried by the member of a medical aid. The fact that there was this gap indicated that there was a statutory tariff that was trailing," he said.

Medical aid contributions cost the average family R50 a month for full coverage, of which the employer usually paid half, Mr Hollis explained.

The increase in doctors' fees would mean an increase of R1,25 a month for the average family man.

Last year, the SAMDC — which then had full powers to fix the level of fees — rejected an appeal by Dr Munnik to review and reduce the huge increase which came into effect in November.

An amendment to the legislation passed during the last parliamentary session gave the final say on medical tariffs to the Minister of Health.

Minister asked to veto doctors' fee rise

Rams 18/10/80

Pretoria Bureau

THE Representative Association of Medical Schemes (Rams) has asked the Minister of Health, Dr L A F A Munnik, to veto the SA Medical and Dental Council's recommendation that doctors fees be raised by 10%.

Rams represents the country's 250 medical aid funds with a total of nearly four million beneficiaries.

The vice-chairman of Rams, Mr J Ernstzen, said yesterday the Rams executive, after a meeting in Johannesburg earlier in the week, could find no justification for the council's recommendation.

"Even although the percentage asked for might seem low, it should not be forgotten it is a percentage on top of the excessive 52,45% last November."

Mr Ernstzen said last year's increase, combined with the recommended 10% rise this year, would mean a hike of more than 67% in just over a year.

Earlier this week the Minister said that before making a decision on the council's recommendation, he would get the advice of the Prime Minister's Economic Advisory Council and of his department.

Mr Ernstzen said a fee hike of 10% would mean an increase of about 5% in members' fund subscriptions.

He said there had been other steep increases in the cost of being ill, including higher private and provincial hospital charges, higher dispensary fees, and the "alarming" rate at which medicines were escalating in price.

In 1979, for instance, the costs of medicines for each member worked out to R7,91. So far this year the average amount spent on medicines for each member was R6,80, Mr Ernstzen said.

The Progressive Federal Party's spokesman on health, Mr Horace van Rensburg, said it was unfortunate the medical profession had asked for another 10% fee rise after last year's increase of 52,45%.

In isolation, 10% could be justified, but 10% on top of last year's rise could only cause "alarm and suspicion" in the public mind.

"The public feels defenceless in the face of all escalating prices, but when it comes to medical services they feel particularly resentful."

Mr Van Rensburg said the image of the medical profession had been harmed after last year's huge fee increase. The latest recommendation of the council could have done nothing to restore the damage.

The disabled:

NM 27/10/80

(299)

They do not seek pity

NEXT YEAR is International Year of the Disabled. To make it a year of impact, the Durban Branch of the National Council Of Women (NCW) convened a meeting of organisations involved with the disabled in an attempt to combine efforts to give the public a new awareness of their plight.

A co-ordinating committee was formed, the Co-ordinating Committee for the International Year of the Disabled, chaired by Bobby Bonfield, President of the Durban Branch of the NCW. The committee will meet monthly to arrange projects for next year.

'Having been in close contact with the disabled for years, I feel that they are too often pitied,' commented Bobby.

Much to offer

'People generally think of what they can give or do to compensate for the disadvantages suffered by the disabled. Seldom do we realise what a lot they have to offer. Disability seems to make people so much more aware of the worth of life.'

As a member of Cripple Care, Bobby has been in close contact with disabled children in particular for more than seven years and has often been surprised by their wonderful sense of humour. 'I think it could be a result of the fact that they are forced to explore themselves more — there are fewer distractions.'

One of the ambitions of the 12-strong committee is to see more communication between disabled and other children. Organising sport events and outings for disabled and other children together is a high priority on the agenda for 1981.

'Because of the attitude of grownups, children also tend to think they should now and again put up with the disabled out of gratitude for their own good fortune in having the use of all their limbs and senses. We want to make them realise that the disabled can add to their fun, can be a stimulating and exciting experience and not something to be endured because it is virtuous. Only through experience will they form their own opinions.'

Normal children are often intrigued by the way disabled children utilized the use of their remaining limbs to compensate for the ones they have lost the use of. Because children are so impressionable changing their attitudes will possibly achieve a lasting change of attitude.

At the general meeting a co-ordinating executive committee of 12 representatives was elected and various subcommittees were formed to concentrate on different areas such as medical and paramedical services, employment, accesibility, recreation and research.

'We want practical changes, not just symposiums,' said Bobby. 'In the greater Durban area there is, for example, a very urgent need for a multi-racial multi-disability accessment centre. We need a spinal unit.

Accessibility

'We have to make public buildings and facilities accessible to disabled people and at the moment they have no access to the City Hall with its library and art gallery.

'The ideal situation would be when all buildings are designed to include disabled people. Steps are not the only problem — lift buttons are often too high, entrances too narrow. The aim is to convince the municpality of the necessity to introduce building regulations to compel builders to apply certain basic requirements that would make buildings accessible to the disabled.

Activity

'More disabled people will get the opportunity to be economically active if employers can be made aware of the advantages of employing them. Apart from valuable characteristics such as stability, maturity and determination, disabled people are usually physically much more capable than employers realise. Many of them are academically qualified people with active minds, who needs challenging jobs as an incentive to be productive.

'Another problem area is that many disabled people are unaware of existing services and grants. With this in mind the NCW plans to publish a book in 1981 which will depict with a humane approach the facilities at present available to the disabled in and around Durban.

Among the other events planned for 1981 is a film festival, not featuring documentaries but feature films on disabled people, like *The Raging Moon*, *Coming Home* and *Window to the Sky*.

A pictorial and factual exhibition will also be held displaying among other things the crafts and art of disabled people. The aim is to confront the public with the reality of the disabled and erase the misconception that they are to be pitied. **Erina Botha.**

PHARMACY FJM 7/11/80 299

Computer mess

The southern Transvaal branch of the Pharmaceutical Society of SA (PSSA) and its wholly-owned subsidiary, the TPS Mutual Trust (TPSMT), have come under criticism from many of the 1 200 southern Transvaal chemists over delays in medical scheme payment redistribution and the amount of administrative work necessary to comply with TPSMT regulations.

Wendywood chemist Basil Bennett, for one, is indignant. "Why should I have to belong to the Pharmaceutical Society, and then have them take so long to pay me my money? I'm bloody annoyed."

The southern Transvaal branch is enfranchised by the PSSA, the trade association of the country's approximately 2 000 chemists. There are four regional PSSA branches operating a "checking service" to compile prescriptions submitted by individual chemists for payment by the estimated 100 medical schemes the PSSA has contracted to handle their bookkeeping.

The TPS Mutual Trust is a "checking service," handling about 300 000 prescriptions a month, including all of the government-sponsored medical programmes.

It is estimated that the various medical schemes cover over 2m SA workers and their dependants.

Bennett claims that he has had to wait from four to eight months to get paid by the TPS Mutual Trust, forcing him to carry about R4 000 a month in credit overdrafts. He says he once had credit outstanding of R27 000. "And by the time I finally do get paid," Bennett says, "I don't get 100 cents in the rand. I figure that with the discounts, brokers' fees and the cost of the credit, I'm losing about 20%. We're financing their operations."

A survey of the three other payment offices revealed that the normal lag is between 30 and 45 days. One branch, the eastern Cape office located in Port Elizabeth, advances its chemists the money before the medical schemes actually pay them, for which they charge a 1% fee.

David Boyce, chairman of the southern Transvaal PSSA branch and a director of the TPS Mutual Trust, concedes that the group has been aware of the problems. "We recognise that the service to the chemists has been far below what we should be offering them. It's basically due to our failure to cope with the changes brought on with computerisation of the process. We also had a complete breakdown in the system last winter for about three weeks. That really hurt us."

The switch to a completely computerised bookkeeping system, which began 18 months ago, caught the TPS Mutual Trust staff unprepared, Boyce says. "We've come to grips with the problems now," he insists. "But we've spent since last June trying methodically to restructure the company. What happened was we did not properly assess our staff requirements."

Bill Bannatyne, a member of the PSSA executive committee, insists that the group is "over the hump" of its difficulties. "People are just scared of computers and of change. But you have to remember that it's a very complex programme. Each medical scheme that we contract with has their own individual programme operating, so we can't really condense the workload."

Meanwhile, the TPSMT held a meeting for the Vaal Triangle area chemists on September 23 to explain the problems and ask for patience while the system caught up with the delayed prescriptions. Bennett did not attend. "We've had all this hot air for 30 years," he fumes. "And I'm tired of it."

Black health services to benefit from new scheme

Pretoria Bureau

BLACK health services would benefit greatly from the new Health scheme announced recently, Dr Johan de Beer, director-general of Health, Social Welfare and Pensions, said yesterday.

Commenting on the plan, announced this week by the Minister of Health, Dr L A P A Munnik, Dr De Beer said the new service would be introduced in areas such as Soweto and Mamelodi "according to the needs of the community".

"Technical assistance will also be given to black states through the Regional Health Organisation of South Africa (Rhosa) so that health services there can be co-ordinated," he said.

Resettlement areas, such as Thornhill in the Transkei, came under the jurisdiction of the "self-ruled" black states, Dr De Beer said.

The new plan, in which the emphasis would be placed on preventive measures, would benefit the whole population and therefore such services would also be rendered in black urban areas, he said.

Although it was not possible to estimate the cost of the new scheme, it would lead to savings in the long run because it was a comprehensive and preventive service.

"The planned community health centre buildings would be far cheaper than a hospital. Smaller centres might be created later according to the needs of the particular community," he said.

The centres differed from existing clinics because, whereas ill people would go to a clinic, the new centres would include wider services.

The centres would be run mainly by nurses under the supervision of a doctor. "The nature of the work will stimulate their interest and the nurses are already well trained," Dr De Beer said.

Public health spot fines

299
22/11/80

EAST LONDON — Peace officers appointed in terms of the Criminal Procedures Act, may now issue spot fines to anyone contravening public health by-laws, said the Medical Officer of Health, Dr J. R. van Heerden.

All officials in the cleansing section of the Health Department have passed a peace officers' course qualifying them to issue these fines and to make arrests. When the books of spot fine tickets become available, possibly next week, fines approved by the senior public prosecutor may be issued for offences in terms of the Health Departemt's cleansing regulations.

Offences which carry fines include the illegal dumping of refuse, R50, failure to store rubbish in an approved manner, R50, allowing a conservancy tank to overflow, R50, and failure to pay the prescribed charge for refuse services, R10.

Plans to implement spot fines for the contravention of other municipal health by-laws were being considered, said the Chief Health Inspector, Mr R. N. Kriel.

Until now the implementation of charges for offences in places where food was sold or prepared had been a laborious process, wasting the officials' time and council money.

The introduction of spot fines would be a positive step, he said. — DDR

Social Security

→ MEDICARE

28 Aug 81 – 9 Dec 81

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GENERAL NOTICE

NOTICE 656 OF 1981

DEPARTMENT OF HEALTH, WELFARE AND PENSIONS

THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

NOTICE CONCERNING THE TARIFF OF FEES FOR SERVICES RENDERED BY MEDICAL PRACTITIONERS TO MEMBERS OF REGISTERED MEDICAL SCHEMES

In terms of section 53A (4) of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974), as amended, I, Nicolaas Marthinus Prinsloo, Registrar of the South African Medical and Dental Council, hereby publish the tariff of fees set out in the Schedule hereto for services rendered by medical practitioners to members and dependants of members of registered medical schemes, determined by the Council in terms of section 53A (5) of the said Act and approved by the Minister of Health, Welfare and Pensions, in substitution of the tariff of fees published under General Notice 878 of 1979. The said tariff shall be binding with effect from 1 September 1981 on medical practitioners who, in terms of section 29 (1) of the Medical Schemes Act, 1967 (Act 72 of 1967), render services to members and dependants of members of medical schemes.

ALGEMENE KENNISGEWING

KENNISGEWING 656 VAN 1981

DEPARTEMENT VAN GESONDHEID, WELSYN EN PENSIOENE

DIE SUID-AFRIKAANSE GENEESKUNDIGE EN TANDHEELKUNDIGE RAAD

KENNISGEWING INSAKE GELDETARIEF TEN OPSIGTE VAN DIENSTE GELEWER DEUR GENEESHERE AAN LEDE VAN GEREGISTREERDE MEDIESE SKEMAS

Kragtens artikel 53A (4) van die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1974 (Wet 56 van 1974), soos gewysig, publiseer ek, Nicolaas Marthinus Prinsloo, Registrateur van die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad, hierby die geldetarief in die Bylae hiervan uiteengesit, vir dienste gelewer deur geneeshere aan lede en afhanklikes van lede van geregistreerde mediese skemas, deur die Raad bepaal en deur die Minister van Gesondheid, Welsyn en Pensioene goedgekeur, ter vervanging van die geldetarief gepubliseer by Algemene Kennisgewing 878 van 1979. Die genoemde tarief sal met ingang 1 September 1981 bindend wees vir geneeshere wat ingevolge artikel 29 (1) van die Wet op Mediese Skemas, 1967 (Wet 72 van 1967), dienste aan lede en afhanklikes van lede van mediese skemas lewer.

SCHEDULE/BYLAE

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Misconduct clause 'too wide'

THE Indians Education Amendment Bill, providing for a medical aid scheme for Indian teachers, was read a second time yesterday in the Assembly.

The second reading was opposed by the official Opposition who said the Bill contained a 'far-reaching and too broad a description of misconduct.'

The Bill provides that any contravention of any provision of the scheme would be misconduct and could lead to the dismissal of the teacher in question.

Mr Ray Swart (PFP, Musgrave) said that this was totally out of proportion to some of the possible transgressions such as omissions which could take place unintentionally or without any intent to defraud the scheme. — Sapa.

Medical aid for teachers

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Unless otherwise stated, all political reports in The Star by P Sullivan, T. R. Duff, A H G Wentzel, G R Linscott, F S Esterhuysen, L Parker and L H Marshall. Cartoons by A Berry, D Fedler, L Jackson, J Leyden and G Muller. Headlines and posters by Johan de Villiers. Political comment by H W Tyson. All of 47 Sauer Street, Johannesburg.

CT 3/2/8

(299)

Description 'too broad'

HOUSE OF ASSEMBLY. — The Indian Education Amendment Bill, providing for a medical aid scheme for Indian teachers, was read a second time yesterday.

The second reading was opposed by the official opposition which said that the bill contained a "far-reaching and too broad a description of misconduct".

It provides that any contravention of any provision of the scheme would be misconduct and could lead to the dismissal of the teacher in question.

Mr Ray Swart (PFP Musgrave) said that this was totally out of proportion to some of the possible transgressions, such as omissions, which could take place unintentionally or without intent to defraud the scheme.

He was supported by Mr Nic Olivier, who in his first speech on returning to parliament, said that the House should know what possible contraventions faced a teacher before approving punishments which could lead to heavy fines and dismissal.

He said these punishments did not exist for other teachers, and Indian teachers would not be interested in whether they existed for civil servants.

Mr Badenhorst denied this and said the provision brought Indian teachers into line with all other teachers, although he was not sure of the situation regarding coloured teachers. — Sapa

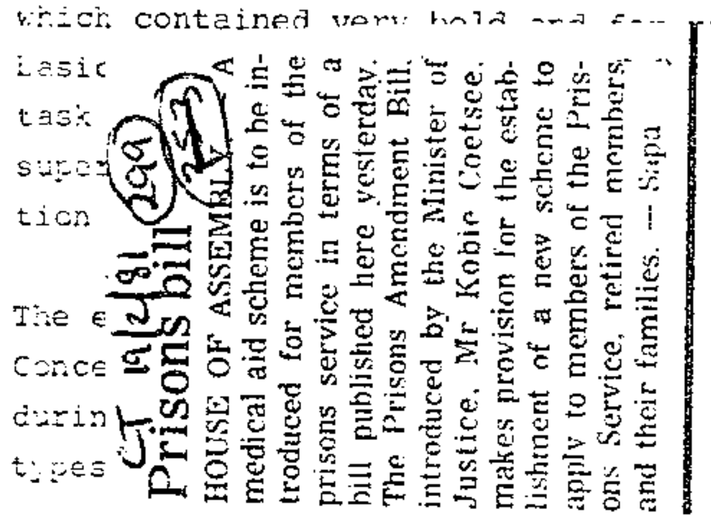
into the whole South African health scene, which occupied them for two years During a tour of 3½ months, the Commission visited various centres and institutions in South Africa.

More than 1 000 witnesses testified and 505 memoranda were handed over. The Commission was authorised: 'to enquire into, to report and advise upon'

(1) The provision of an organised National Health Service in conformity with the modern conception of 'health', which will ensure adequate medical, dental, nursing and hospital services for all sections of the people of the Union of South Africa.

(2) The administrative, legislative and financial measures which would be necessary in order to provide the Union of South Africa with such a National Health Service.

Finally, in 1944, the Commission tabled their Report of more than 200 pages, which contained very bold and far-reaching proposals. In their summary of



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n states clearly: "The Commission's suggestions for the improvement of a s already laid, but for the reconstruc-

n Part I, chapter III: 'The Modern o have lost nothing of its actuality ery comprehensive account of the various necessary.

In this chapter, a fundamental distinction is made between personal health services, which deal with persons and non-personal health services, which deal with things. Personal health services were divided into promotive, preventive, curative and rehabilitative services.

The great value of promotive and preventive health factors was stressed in maintaining the health of the individual and his community. Under promotive health services, the importance of adequate wages, nutrition, general education, etc., is mentioned. Periodic medical examinations, antenatal care, infant welfare clinics, immunisations, health education, school and workers' health services, are listed under preventive services.

The Commission also realised the tremendous importance of a proper relationship between promotive, preventive, curative and rehabilitative services:

> "Today in short, advanced medical thought everywhere has come to realise that there should be no sharp division, even in administration and still less in presentation to the people, between promotive, preventive, curative and rehabilitative health services. All should be integrated in a comprehensive planned health service. Such a service would aim to secure not only the absence of disease, but also the maximum degree of physiological and mental efficiency".

The chapter ends with the following vision:

> "The ultimate aim of our recommendations is to bring these services within reach of all sections of the population, according to their need, and without regard to race, colour, means or station in life".

Part II of the Report of the Commission contained a detailed survey of the health needs of the population of South Africa and to what extent these needs were met by the existing health services. The Commission observed that from 1919 onwards, there were three different kinds of public authorities, which dealt with health services: local authorities, Provincial Councils and the Department of Public Health.

Their conclusions at the end of this survey about existing health services were very straight-forward:

> "The services are NOT 'organised on a national basis' - they are disjointed and haphazard, provincial and parochial.
>
> The services are NOT 'in conformity with modern conception of Health - for they are mainly directed not to promotion and safeguarding of health, but to the cure of ill health.
>
> The services are NOT 'available to all sections of the people of the Union of South Africa ' - they are distributed mainly among the wealthier sections who, on account of their economic potentialities should need them least: and are but poorly supplied to the underprivileged sections who require them most.
>
> Moreover, existing 'administrative, legislative and financial measures' are NOT adequate to provide, by any mere process of expansion a national health service of the range and quality demanded by our terms of reference".

Part III of the Commission's Report dealt with the fundamental question of whether a National Health Service would be the best solution for the health needs of the people. The answer of the Commission was affirmative in order to ensure unified direction, a redistribution of health resources and to make the best use of the limited economic resources available.

It was realised that massive ill health means decreased economic productivity and an increased expenditure on curative health services. The Commission

REPUBLIC OF SOUTH AFRICA

GOVERNMENT GAZETTE

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Vol. 188] PRETORIA, 13 FEBRUARY FEBRUARIE 1981 [No. 7404

GENERAL NOTICE

NOTICE 129 OF 1981

DEPARTMENT OF HEALTH

REGISTERED MEDICAL SCHEMES

The Registrar of Medical Schemes hereby notifies, in accordance with section 16A of the Medical Schemes Act, 1967 (Act 72 of 1967), as amended, that the undermentioned medical schemes have been registered.

Those marked with an asterisk (*) have been exempted in terms of section 3 as indicated.

This list, as at 31 December 1980 replaces the list published in *Government Gazette* 6827 of 25 January 1980 and contains 241 schemes, of which 211 are Aid and 30 Benefit Schemes.

N.B.—Do not *count* names in brackets. Their *translated* form appears *elsewhere* in the list.

ALGEMENE KENNISGEWING

KENNISGEWING 129 VAN 1981

DEPARTEMENT VAN GESONDHEID

GEREGISTREERDE MEDIESE SKEMAS

Die Registrateur van Mediese Skemas maak ooreenkomstig artikel 16A van die Wet op Mediese Skemas, 1967 (Wet 72 van 1967), soos gewysig, bekend dat ondergemelde mediese skemas geregistreer is.

Skemas vrygestel'kragtens artikel 3 is met 'n sterretjie (*) aangedui, met vermelding van die spesifieke vrystelling.

Hierdie lys, soos op 31 Desember 1980 vervang die lys wat in *Staatskoerant* 6827 van 25 Januarie 1980 gepubliseer is en bevat 241 skemas, waarvan 211 Hulp en 30 Bystandsskemas is.

L.W.—Moenie name tussen hakies *tel* nie. Hulle *vertaalde* vorm verskyn *elders* in die lys.

Name of scheme Naam van skema	X-Private Bag X-Privaatsak P.O. Box Posbus	Place Plek	Code Kode	Reference No. Verwysing No.	Date of registration Datum van registrasie	Exemption from Regulations/Act Vrystelling van Regulasies/Wet
A						
AAC Mines Medical Benefit Society	716	Johannesburg	2000	2503	5/2/80	—
A.A. Mutual Medical Aid Society	9595	Johannesburg	2000	1001	11/8/71	—
Aberdare Africa Medical Aid Society	494	Port Elizabeth	6000	1002	20/11/70	—
Adcock-Ingram Medical Scheme	9391	Johannesburg	2000	1003	12/2/69	—
AECI Medical Aid Society	716	Johannesburg	2000	1005	11/2/71	—
African Cables Medical Benefit Fund	172	Vereeniging	1930	1004	9/6/70	—
A.G.S. van S.A. se Mediese Hulpfonds	89358	Lyndhurst	2106	1442	1/8/74	—
Alabama Medical Plan	51418	Randburg	2125	1480	13/10/77	—
Alex. Aiken & Carter Medical Aid Society	61975	Marshalltown	2107	1009	24/11/70	—
Allcare Medical Aid Scheme	7106	Johannesburg	2000	1496	21/11/78	—
Altech Group Medical Aid Society	9153	Johannesburg	2000	1449	31/1/75	—
Ammosal Benefit Society	Mancorp Mine/Myn	Postmasburg	8423	2011	27/11/70	—
Anglo-Alpha Group Medical Aid Society	7462	Johannesburg	2000	1487	28/3/78	—
Anglo American Corporation Medical Aid Society	9761	Johannesburg	2000	1012	16/10/68	—
*Aranda Textile Mills Sick Benefit Society	9478	Johannesburg	2000	2013	15/12/67	Section/Artikel 20 (1); also/ook Reg. 4.
Architects' and Quantity Surveyors' Medical Aid Fund	56348	Pinegowrie	2123	1015	17/8/70	—
Argus Medical Aid Society	1014	Johannesburg	2000	1016	28/11/68	—
Arthur Young Medical Aid Society	4807	Cape Town/Kaapstad	8000	1258	23/2/71	—

TABLE 13

Distribution of workers according to number of small stock units allowed

(1 horse/donkey/cow = 6 goats/sheep = 6 small stock units)

Number of units	Number of workers	Cumulative %
0 - 10,00	6	11,54
10,01 - 20,00	25	59,62
20,01 - 30,00	9	76,92
30,01 - 40,00	5	86,54
40,01 - 50,00	6	98,08
> 50	1	100,00
total	52	

A more detailed breakdown is given below:

Grazing: D

Goats:

107 wo

12

1

1

3

1

4

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Sheep:

120 wo

3

2

2

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One w

Horse

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6

7

1

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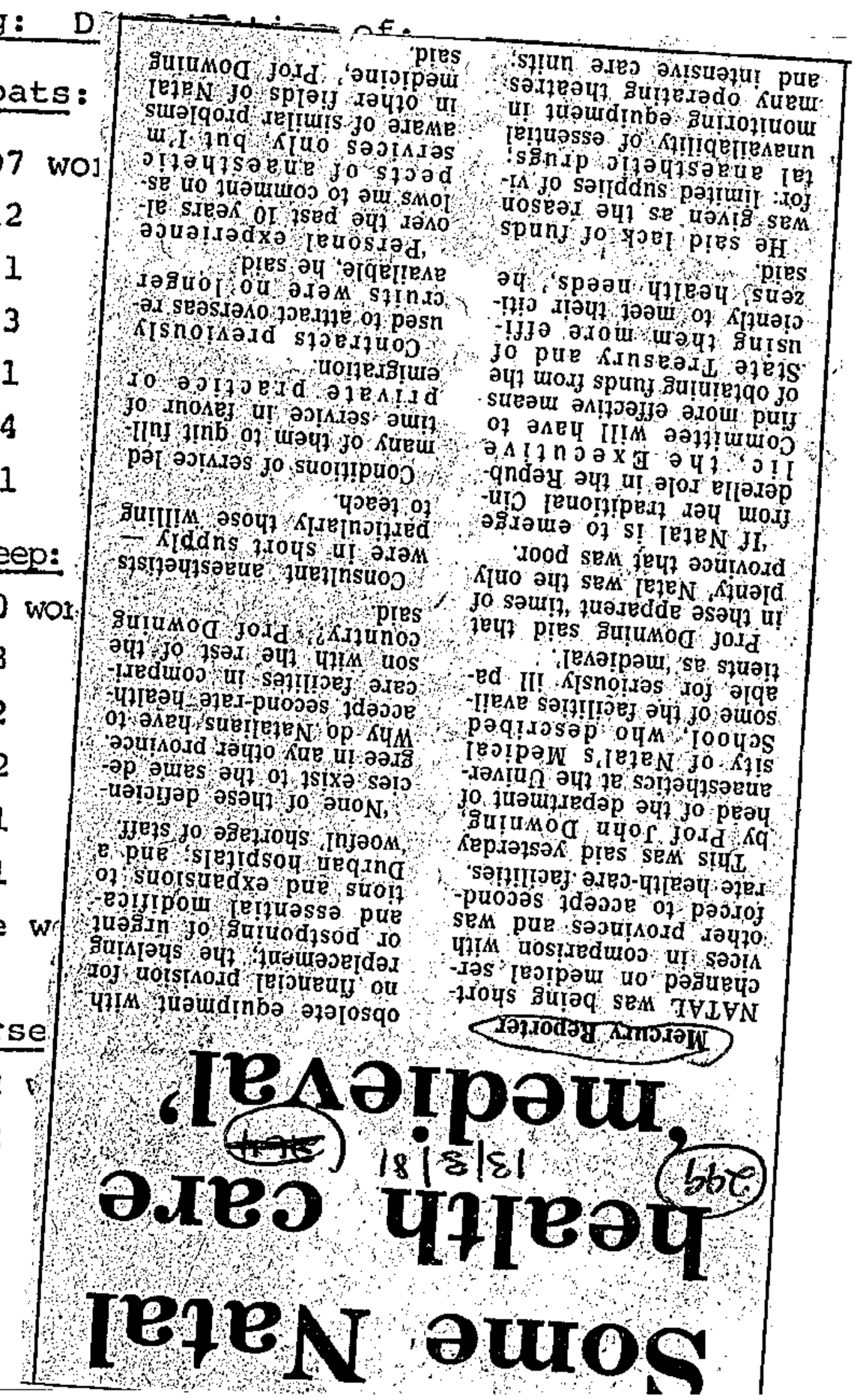

Some Natal health care 'medieval'

Mercury Reporter

NATAL was being shortchanged on medical services in comparison with other provinces and was forced to accept second-rate health-care facilities, this was said yesterday by Prof John Downing, head of the department of anaesthetics at the University of Natal's Medical School, who described some of the facilities available for seriously ill patients as 'medieval'.

Prof Downing said that in these apparent 'times of plenty' Natal was the only province that was poor.

'If Natal is to emerge from her traditional Cinderella role in the Republic, the Executive Committee will have to find more effective means of obtaining funds from the State Treasury and of using them more efficiently to meet their citizens' health needs,' he said.

He said lack of funds was given as the reason for: limited supplies of vital anaesthetic drugs; unavailability of essential monitoring equipment in many operating theatres and intensive care units; obsolete equipment with no financial provision for replacement, the shelving or postponing of urgent and essential modifications and expansions to Durban hospitals; and a 'woeful' shortage of staff.

'None of these deficiencies exist to the same degree in any other province. Why do Natalians have to accept second-rate health-care facilities in comparison with the rest of the country?' Prof Downing said.

Consultant anaesthetists were in short supply — particularly those willing to teach.

Conditions of service led many of them to quit full-time service in favour of private practice or emigration.

Contracts previously used to attract overseas recruits were no longer available, he said.

'Personal experience over the past 10 years allows me to comment on aspects of anaesthetic services only, but I'm aware of similar problems in other fields of Natal medicine,' Prof Downing said.

24/03/81

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GOEWERMENTSKENNISGEWINGS

DEPARTEMENT VAN GESONDHEID, WELSYN EN PENSIOENE

No. R. 635

27 Maart 1981

WET OP MEDIESE SKEMAS, 1967

Kragtens artikel 30 (3) van die Wet op Mediese Skemas, 1967 (Wet 72 van 1967), soos gewysig, kondig ek, Joseph Petrus Hermanus Steyn, Registrateur van Mediese Skemas, hierby die geldetarief in artikel 1 (1) nie, word hy by die toepassing van hierdie Proklamasie geag 7½ jaar pensioengewende diens tot sy krediet te hê.

GOVERNMENT NOTICES

DEPARTMENT OF HEALTH, WELFARE AND PENSIONS

No. R. 635 gls 7576

27 March 1981

MEDICAL SCHEMES ACT, 1967

In terms of section 30 (3) of the Medical Schemes Act, 1967 (Act 72 of 1967), as amended, I, Joseph Petrus Hermanus Steyn, Registrar of Medical Schemes, is not reappointed for a further period, for the purposes of this Proclamation he shall be deemed to have 7½ years of pensionable service to his credit.

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Vol. 189] PRETORIA, 31 MAART / MARCH 1981 [No. 7522

GOEWERMENTSKENNISGEWING

SUID-AFRIKAANSE POLISIE

No. R. 685 — 31 Maart 1981

Dit het die Staatspresident behaag om kragtens artikel 33 van die Polisiewet, 1958 (Wet 7 van 1958), sy goedkeuring te heg aan onderstaande wysiging van die Regulasies vir die Suid-Afrikaanse Polisie, gepubliseer by Goewermentskennisgewing R. 203 in *Buitengewone Staatskoerant* 719 (*Regulasiekoerant* 299) van 14 Februarie 1964, soos later gewysig:

Vervang regulasies 30, 31, 32, 33, 33A, 33B en 34 deur die volgende:

GENEESKUNDIGE, TANDHEELKUNDIGE EN HOSPITAALBEHANDELING EN AANVULLENDE GESONDHEIDSDIENSTE

30. (1) *Instelling van 'n mediese skema.*—Met ingang van 1 April 1981 word die Suid-Afrikaanse Polisie se Mediese Skema (hierna die Skema genoem) ingestel om, behoudens die bepalings van hierdie regulasie en regulasies 31 en 32, geneeskundige, tandheelkundige en hospitaalbehandeling en aanvullende gesondheidsdienste, (met inbegrip van medisyne, verbandmiddels, geneeskundige geriewe, hulpmiddels en toestelle, en vervoer tydens ongesteldheid) aan lede en hul afhanklikes, op staatskoste te voorsien: Met dien verstande dat—

(a) 'n lid een tiende van die koste vir geneeskundige en tandheelkundige behandeling en aanvullende gesondheidsdienste moet betaal, bereken volgens die geldtarief of 'n goedgekeurde tarief, welke behandeling en dienste deur persone gelewer moet word wat by die Suid-Afrikaanse Mediese en Tandheelkundige Raad geregistreer is; en

(b) die Kommissaris sodanige voorskrifte, reëls en voorwaardes, wat hy vir die doeltreffende administrasie of die verwesenliking van die oogmerke van die Skema nodig of dienstig ag, kan bepaal met betrekking tot 'n bepaalde lid of lede of enige kategorie van lede en welke voorskrifte, reëls en voorwaardes op al sodanige lede van die Skema bindend is.

(2) *Woordomskrywing.*—Vir die toepassing van hierdie regulasie en tensy uit die samehang anders blyk, beteken—

(a) "lid"—

(i) 'n dienende lid van die Mag;

GOVERNMENT NOTICE

SOUTH AFRICAN POLICE

No. R. 685 — 31 March 1981

The State President has been pleased, under section 33 of the Police Act, 1958 (Act 7 of 1958), to approve the following amendments to the Regulations for the South African Police, as published under Government Notice R. 203 in *Government Gazette Extraordinary* 719 (*Regulation Gazette* 299) of 14 February 1964, and subsequently amended.

Substitute the following for regulations 30, 31, 32, 33, 33A, 33B and 34:

MEDICAL, DENTAL AND HOSPITAL TREATMENT AND SUPPLEMENTARY HEALTH SERVICES

30. (1) *Establishment of a medical scheme.*—With effect from 1 April 1981 the South African Police Medical Scheme (hereinafter referred to as the Scheme) shall, subject to the provisions of this regulation and regulations 31 and 32, be established to provide medical, dental and hospital treatment and supplementary health services (including drugs, dressings, medical comforts, aids and appliances, and transportation in the case of indisposition) for members and their dependants at public expense: Provided that—

(a) a member shall pay one-tenth of the cost of medical and dental treatment and supplementary health services, calculated in accordance with the tariff of fees or an approved tariff, and such treatment and services shall be given and rendered by persons registered with the South African Medical and Dental Council; and

(b) the Commissioner may frame such regulations, rules and conditions with regard to a particular member or members or any category of members as he may deem necessary or expedient for efficient administration or the achievement of the objects of the Scheme, and such regulations, rules and conditions shall be binding upon all such members of the Scheme.

(2) *Definitions.*—For the purposes of this regulation, and unless inconsistent with the context—

(a) "member" means—

(i) a serving member of the Force;

299 See GG 7522 for full text

STAR 1/5/81

299

Move to increase prescription tariffs

Consumer Reporter

The South African Pharmacy Board has approved a 20c an item increase in the dispensing tariff for prescription medicines.

The increase, which is subject to confirmation by the Minister of Health, is expected to be introduced before the end of the year.

The higher tariff will bring the dispensing fee from 90c to R1,10 for each item on the prescription.

The dispensing fee was increased from 50c to 90c in 1979.

The new fee, coupled with the recent 15 percent increase in private hospital tariffs will place a burden on medical aid societies, and members' contributions may have to be increased.

Mr Glen Wigzell, secretary of the Johannesburg branch of the Argus Medical Aid Society, said medical aid schemes would probably wait to see if fees of doctors, dentists and physiotherapists were increased before deciding on higher contributions.

"If medical and dental tariff increases are substantial, serious thought will have to be given to raising medical aid contributions at the beginning of next year," he said.

High doctors' fees will hit medical aid schemes

Pretoria Bureau

THE rocketing cost of being ill in South Africa is placing a severe strain on the resources of the country's more than 250 medical aid schemes.

And the strain is expected to intensify when the proposed 10% increase in doctors' fees is announced soon by the Minister of Health, Dr L A P A Munnik.

Transvaal hospital fees are also expected to go up later this year or early next year.

The fees were last raised in July last year when they went up from R14 a day to R20 for a private-paying patient, and to R25 a day for medical aid scheme members.

Natal's MEC in charge of hospitals, Dr Fred Clark, announced last week that Natal provincial hospital fees would be raised by 50% from October 1.

Earlier this year private hospital fees were raised. It was the third rise in 18 months, according to the registrar of medical schemes, Mr J P H Steyn.

Aggravating the costs of illness is the continuing rise in the price of medicines and drugs.

The chairman of the Representative Association of Medical Schemes, Mr J D Ernstzen, said the association was waiting to see whether Dr Munnik would authorise another rise in doctors' and dentists' fees.

He said the association's 250 affiliated medical aid schemes paid out about R600-million a year in aid, of which 40% went to doctors.

Mr Ernstzen said payments from the schemes for medicines had increased by 17,5% last year compared with 1979.

He said a 5% or 6% rise in costs would force many of the 250 schemes to review members' subscriptions.

It was learnt in Pretoria yesterday that the Department of Health was still studying the medical and dental councils' recommendation that doctors' fees be raised by 10% and dentists by 25%.

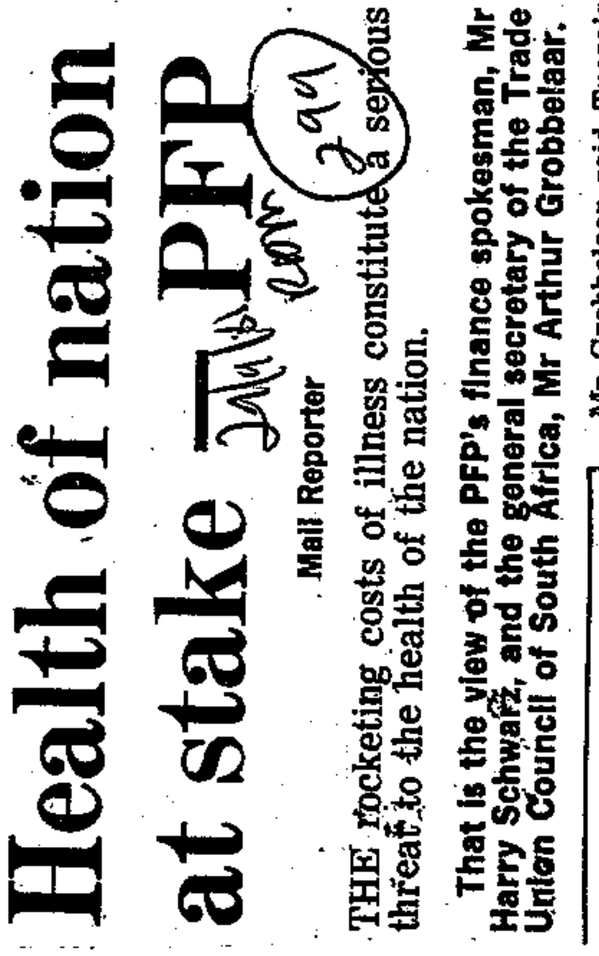
UNIVERSITY OF CAPE TOWN

DEPARTMENT OF ACCOUNTING

TAXATION AND ESTATE DUTY II - 1981

COURSE OUTLINE/READING LIST - 3rd & 4th QUARTER

LECTURE DATE	LECTURE NO.	TOPIC	THE INCOME TAX ACT	MEYEROWITZ	ILLUSTRATIVE EXAMPLES	TUTORIALS
31 August	20	Tax Planning for Asset Acquisitions	ss.1 'gross income' definition paras.(g).(h):	513 - 524, 765 - 786, 534 - 537, 1423 - 1426	-	T.1319 T.1409 T.1411



Health of nation at stake

PFP

Mail Reporter

THE rocketing costs of illness constitute a serious threat to the health of the nation.

That is the view of the PFP's finance spokesman, Mr Harry Schwarz, and the general secretary of the Trade Union Council of South Africa, Mr Arthur Grobbelaar.

Mr Grobbelaar said Tucsa's annual congress later this month was expected to demand a public inquiry into the costs of medicines to reassure the people of South Africa that their misfortune was not being exploited.

Mr Grobbelaar said the resolution called for:

- Amendments to the Medical Schemes Act to require all doctors to treat medical aid patients at prescribed tariffs;
- Provincial administrations to improve hospital services, by improved hospital salaries to ensure adequate staffing.

"Not only were lower paid workers unable to afford adequate medical treatment, but medical schemes would be forced to raise fees to a level beyond the reach of the average worker," Mr Grobbelaar said.

Mr Schwarz said the Government's inability to control inflation was undermining national health.

Ombudsman Eugene Roelofse said the consumer was being hit at every turn.

"The Government must look at profit margins, which in many instances are too great, and act against organisations which are clearly ripping off the public," Mr Roelofse said.

		Business Acquisitions - partnerships and joint ventures (briefly) - acquiring assets and liabilities - acquiring shares - interest payable on acquisition	22,22A,24A,103(1),103(2)	The relevant paras. in Chapters 9,11, 12 and 26	-	16.10 T.1051 (b) and (c) T.1401
		REVISION				T.1424,T.1425 T.1431,T.1432 T.1525, 14.5 16.7,16.9
		EXAMINATION - OCTOBER 1981				

N.B. THE TUTORIALS REFER TO 'QUESTIONS ON S.A. INCOME TAX 1980' AND THE SOLUTIONS ARE PREPARED ON THE BASIS THAT THE QUESTIONS ARE UPDATED BY ONE YEAR.

N. McKenny 12/11/84 (299)

Medical aid blues

Finance Reporter

THERE are nearly two million subscription-paying members of medical aid schemes in South Africa, and they are not very happy people.

Medical aid tariffs have been increasing regularly throughout the year and many healthy South Africans feel that the large subscriptions they pay, from which they hardly ever make a major claim, are subsidising the medical bills of the sick and aged.

In a way they are. Subscriptions from those who do not claim from the medical aid, go into the communal kitty to pay for the accounts of those who have claimed.

'People think that each member has his own account from which he pays for his own claims. But the system doesn't work like that,' said Mr Andrew Jackson, Natal manager of Medscheme.

Medical aid tariffs are controlled by legislation, and companies are allowed to charge 10 percent to cover administration costs.

So how can subscriptions be reduced, while still retaining an adequate medical aid system?

There are a number of ways this could be achieved, but current legislation prevents any of them from being implemented. And the medical aid industry itself is not sure which method would be best.

Cost containment takes place in various ways. The company itself could introduce stricter management of funds, patients could be given the option of less expensive treatment and the subscribers can be educated in health maintainance.

Education

'It is universally recognised that it is a good idea to encourage less usage of the scheme,' said Mr Jackson, but this is usually achieved through the education of the society's members.

Mr John Ernstzen, chairman of the Representative Association of Medical Aid Schemes (RAMS), noted that if subscriptions were reduced, benefits would also have to be reduced, and that would not help anyone.

One alternative would be to regard medical expenses in the same light as car repairs.

That is to give the member the option of paying a percentage of each claim.

One company which does operate what is called a dis-incentive scheme pays the full amount of the claim, as is called for by law, and then 20 percent of the account is reclaimed from the member.

A spokesman for this company said that because of this system, they did not pay out as much as other firms in claims, and subsequently their tariffs were less.

However Mr Ernstzen noted that recovery of funds from members could be difficult because people change their places of employment and are difficult to trace.

'Medical aid is not an insurance, we do not make profits like insurance companies. The word is 'aid'; we help people to pay their medical accounts,' said Mr Arnold Rossouw, a director of the Price Forbes Federale Group.

But Mr Jackson noted that medical aids are a kind of insurance too, because as we grow older we need more medical attention. Also we are covering ourselves in case we do have a major claim at some stage.

'It's amazing how people's attitudes change when they do get a big claim,' Mr Ernstzen said.

Mr Jackson agreed that there should be some incentive for those who don't claim, but said that the problem lay with those people who overclaim.

Problems

Refunding a certain proportion of the subscription of a member who does not make excessive claims also raises problems.

'That sort of 'no claim bonus'would be an ideal situation. It has been mooted in international forums, but the practicalities for administering it would be vast,' said Mr Jackson.

'A no claim bonus to encourage people not to claim unnecessarily would have to be considerable and would not be allowed under the present legislation,' Mr Ernstzen said.

Mr Jackson said that for a dis-incentive scheme to be really effective it should operate at the point of benefit.

Dis-incentive schemes have the advantage of making the scheme less used, but they involve extra administration and bad debts write-offs.

'They also tend to hurt the poor more than the wealthy,' he said.

Mr Ernstzen also drew attention to the problems that could be encountered if dis-incentives were too successful, and people were discouraged from going to doctors.

'Serious problems could arise if people did not seek medical attention as soon as possible,' he said.

A possibility that hasn't been seriously looked at yet is risk management. The member could select his own risk like he does with his insurance.

'Those people who would be prepared to cover themselves for calamities only would probably be professional people only.

'But the vast majority prefer enforced budgeting for medical expenses. They like to know that they're covered for all expenses, no matter what happens. So the present system is best,' said Mr Ernstzen.

According to Mr Jackson, South African schemes cost less than other systems and the medical service is better and cheaper than in many other countries.

'If the law was changed, packages would be able to be developed for different people according to their needs, instead of the same scheme operating right across the board,' said the spokesman for one medical aid society.

Mr Ernstzen said that he hoped that medical aid schemes would eventually be able to tailor schemes to suit the different classes of the population.

But he warned that changes in the system would need to be carefully considered. 'What would appeal to some, would be harmful to others,' he said.

Mr Erntzen sees the main problem facing the South African medical aid industry in the inflexibility of the setting of fees and benefits. 'The free market system cannot work in this situation,' he said.

But he said that in a situation such as exists in the US, where there is maximum choice and maximum competition, with numerous companies offering different schemes, costs could be raised.

Warning

Members of any particular scheme would all be covered for a particular claim, so this could lead to a situation where claims total more than subscriptions, as there are no healthy people subsidising claims.

Mr Ernstzen warned that this could also lead to people buying the wrong covers.

At present there is a Government commission of inquiry investigating all matters relating to costs of medical schemes.

Although the Brown Commission is not expected to report for a number of years yet, Mr Ernstzen said he hoped that its report would allow for greater flexibility of schemes.

He also said one of the greatest demands on schemes is the costs of medicines. 'This is an area requiring immediate attention.'

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APPENDIX A

EXAMPLES OF RUN STREAMS

The following are sample run streams that vary in complexity due to the program[illegible] These pertain to the FORTRAN, COBOL, Assembl[illegible]rocessors. These examples are intended to illustr[illegible]nt formats and are not intended to illustrate the mo[illegible]sted system usage.

EXAMPLE

[illegible]234,PROJFLD

[illegible]nguage Statements

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EXAMPLE

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MRS M RAATH has won her battle with the SA Typographical Union's medical aid.

Mrs Raath joined the union in July last year. For pre-natal care, she was told, she could claim up to R150, but had to be a member of the medical aid for six months first.

She began sending in accounts for her pre-natal care in February, but they had still not been paid by June.

Then, in July, in response to numerous inquiries, she was sent a medical aid enrolment form to sign, which she had done when she joined.

YEAR

She then approached the Cape Town office, where she was assured that the accounts would be paid by the time she stopped work in September. They were not.

Instead, she received a letter saying her accounts would not be paid as, to qualify for the payment of pre-natal care, she had to be a member for a full year, **and not six** months.

This was the last straw. Had she known this, she said, she would have had her pre-natal care as a hospital patient, which would have cost her nothing. She was now saddled with accounts for an astronomical amount which she could not pay.

She then approached the Cape Town branch again. This time, she said, the regional secretary-organiser, Mr M Deysel, admitted they were at fault but said he could do nothing about it.

ACTION: In reply to a letter from us, Mr Deysel said it would 'take pages' to explain what had happened.

★

His office HAD mis-informed Mrs Raath, he said, but his head office had nevertheless agreed in September to pay her expenses. At that stage, he said, Mrs Raath had undertaken to contact head office herself, and had not been in contact with him again.

"Since receiving Argus Action's letter, I have contacted her and she will let me have the accounts. I believe the matter is now cleared up," he said.

Typographical Union pays for mistake

Argus 2/12/81

299

CAPE Times 9/12/81

R400m health budget

Staff Reporter

THE cost of providing health care by the Cape Provincial Administration has escalated by 399 percent in the past nine years and for the year ending in March 1982, the CPA has budgeted an excess of R400 million.

These statistics were revealed by the Administrator, Mr Gene Louw, at the official opening of the amenities building of the University of Cape Town's medical faculty.

"It has become apparent that the major portion of the expenditure arises from the highly-sophisticated services rendered in our teaching hospitals."

The hospitals department had had to do a rethink on the services rendered, he said.

"From this it has become clear that due to lack of preventive treatment and late diagnosis many illnesses reach an advanced stage where hospitalization and sophisticated treatment are the only answer."

He said the establishment of community health care centres and the long-term impact of the 1979 Health Year had gone a long way to take the pressure off hospital bed occupation.

SOCIAL SECURITY — MEDICARE

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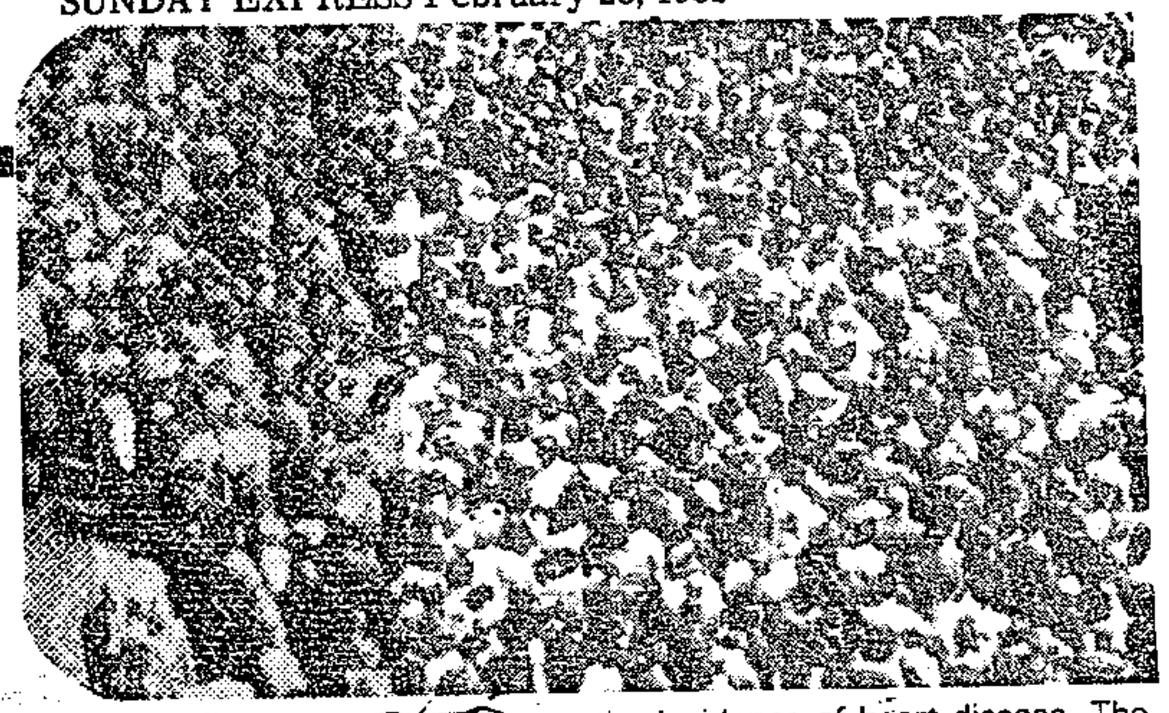
1982 — FEB. — NOV AND
1983 — FEB — NOV.



● This picture graphically illustrates the incidence of heart disease. The represents the 20% of South Africans who will be killed by

The medical killing us, s

CATHY KENTRIDGE finds that mer

HEART disease deaths account for 20% of the annual toll in South Africa — yet cardiac specialists claim they are being forced out of business by medical aid societies.

Although members of these schemes apparently have the choice of treatment at either a provincial or a private hospital, Sunday Express investigations have revealed that most societies will only pay provincial hospital rates.

But, especially in the Transvaal, private doctors are not allowed to operate at provincial hospitals.

Specialists said few people could afford to foot the bill themselves for open-heart surgery in a private hospital — between R4 000 and R8 000 — and that this meant patients were being deprived of the choice of where and by whom they could be treated.

It also meant, they said, that highly-trained surgeons in private practice were being deprived of the opportunity to exercise their skills.

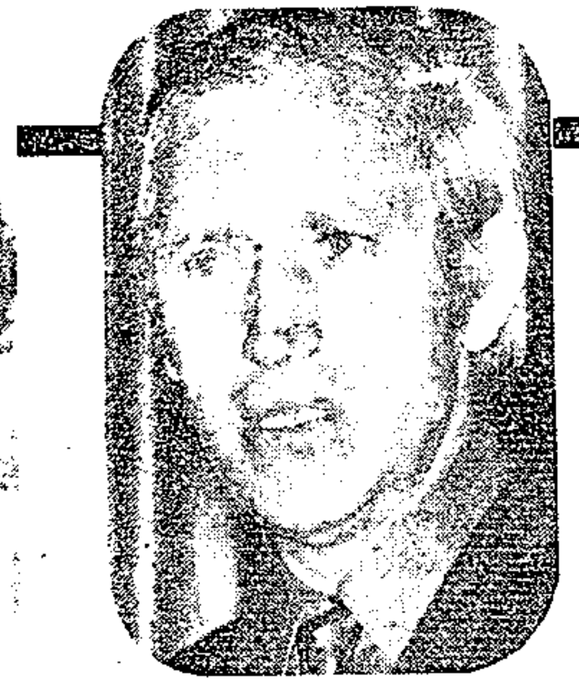
The fear expressed b many cardiac surgeons an cardiologists is that the fu ture of cardiac surgery i South Africa is being place in jeopardy, because the are not being motivated t undertake the four-year spe cialisation course.

An eminent cardio-tho racic surgeon told the Sun day Express that provincia hospitals could not even ab sorb the number of cardia surgeons they trained.

"In a way these young doc tors are caught in a vicious circle. They don't know which direction their ca-



● Dr Ali Bacher
... happy after local op



● Dr Marius Barnard
... blacks susceptible

schemes are art experts

et a fair return on subscriptions

ospital, including the oper-tion, cost my medical aid cheme R175. In the US it ould have cost me between 30 000 and R50 000."

Mr Tony Factor, of dis-ount stores fame, also had is open-heart surgery per-ormed at the J G Strijdom.

"I had no choice in the tter as I was unconscious

Johannesburg scheme who said: "By limiting our payments to provincial rates for major surgery such as open-heart, we are in fact benefitting all our subscribers in the long run.

"By not paying out too much to any one person, we do not drain the pool for others. We will however

to derive benefit from their scheme, the scheme 'cops out' and lets the province — that is the taxpayer — foot the bill."

He feels that it is only the patient or subscriber to medical aid schemes who can really bring any pressure to bear — by boycotting the schemes if necessary to

SOLUTION TO: GL5

(1) Premiums Treated as Business Expense

01, Jan 1:	Insurance Expense	300	
	Bank		300
	being payment of premium		
Dec 31:	Income Statement	300	
	Insurance Expense		300
	being closing entry		
Years 02 and 03 - same as 01			
04, Jan 1:	Insurance Expense	300	
	Bank		300
Jan 2:	Debtor (Insurance Company)	24 000	
	Income from Life Policy		24 000
	being accrual of proceeds receivable		
Jan 2:	Income from Life Policy	24 000	
	Income Statement		24 000

(2) Premi

01, :

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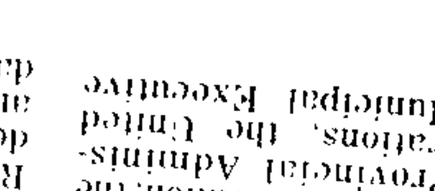


of 60 percent by the employer. The first management committee would consist of representatives nominated by the Department of Post and Telecommunications, Education, Finance, Education and Training, Co-operation and Development, the Commission for Administration, the Provincial Administrations, the United Municipal Executive

(Contributions would be subsidised at a rate

The new scheme, Bonitas Medical Fund, whose initial membership is expected to exceed 20 000 after the first 12 months, would be administratively run by Med Scheme Administrators (Pty) Ltd.

300

24 000

Mr H H Dlamlenze, secretary-general of the African Teacher's Association of South Africa (Atasa) at a news conference held in Pretoria.

Mr G van der Walt, deputy director-general of the department, presented a cheque to

300

THE Department of Co-operation and Development yesterday donated the sum of R100 000 for the immediate launching of a medical aid for black employees in the public service.

300

Medicaid for black gov't employees

Members will elect their own representatives at the first annual meeting. Mr Dlamlenze, who is also coamunizer of the fund, said the scheme will provide, "a very necessary service to our people and will be welcomed by all those employed by the State".

Membership of the scheme is voluntary and contributions will vary from R1,60 to R9,60 per month depending on salary and number of dependants.

ed/ .....

Grant to aid retarded

(299) BY MONK NKOMO 5/3/82 Sowetan

THE level of civilisation in any community is measured by the manner in which they can ably look after the crippled, aged and retarded members of their society, according to Mr Z Z Mashao, president of the Atteridgeville/Saulsville Chamber of Commerce and Industries.

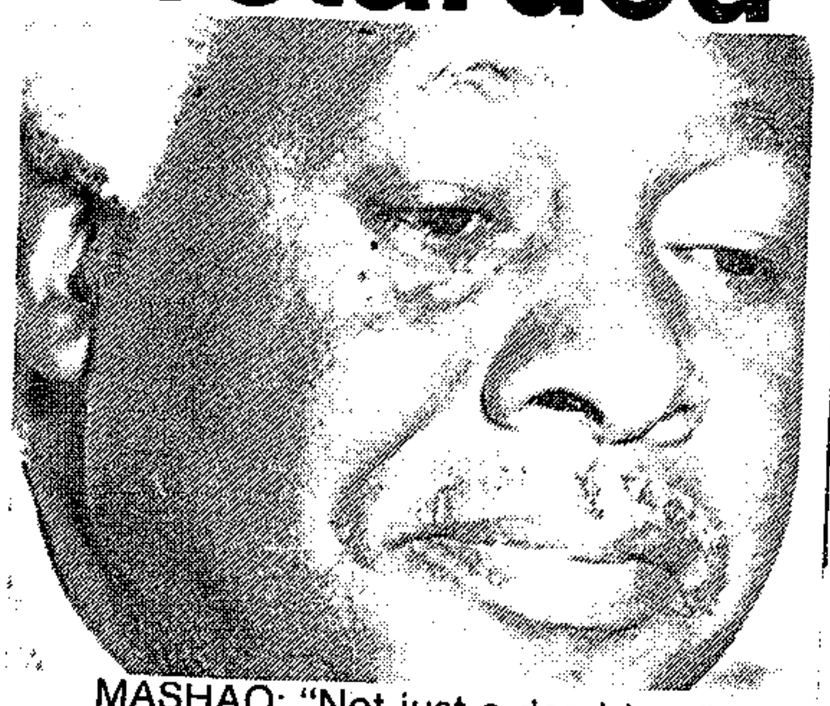
He was speaking at a presentation ceremony at which his chamber donated R500, and a City Furnisher store R100, to the local Zodwa Day Care and Training Centre for retarded children.

The ceremony was held at the Mphebatho Hotel on Wednesday evening.

"For many years these unfortunate children, who happen to be born black and retarded, have been completely ignored by the community. They are allowed to roam the streets, uncared for, derided and scorned by other children", said Mr Mashao.

The training centre, which has 52 registered pupils, has its temporary premises at the Methodist Church hall. The hall, according to Ms M A Mashilo, a social worker, is not able to accomodate the services that must be rendered to the children whose ages vary between three to twenty one years of age. "The hall is being used as a kitchen, a nursery room, a classroom for teaching, a sleeping room and an office for a social worker", said Ms Mashilo in her recent report submitted to the local community council.

Mr Mashao who is also a senior member of the local community council said businessmen should realise that, "extravagant wealth cannot co-exist side by side with object poverty, deprivation and lack of social facilities".



MASHAO: "Not just a dead-loss"

He said: "Contributions by businessmen to worthy causes in the community should therefore not be regarded as a dead loss on the balance sheet, but as a profitable investment in good relations and in the continued existence of the free-enterprise system as we know it.

"An uncaring community rejects these children, and looks down upon them as though there condition is a fault of their own. Because of their parental love, parents may look after their immediate needs, but what happens when the parents die? They become an unwanted burden on the shoulder of their relatives, and end up as hobos who are unable to do anything for themselves."

He urged the community to help in contributions for the erection of a suitable training centre.

Abalone Industry

*13. Mr. P. A. MYBURGH asked the Minister of Agriculture and Fisheries:

Whether the Government has appointed a commission of inquiry into the abalone industry; if so, (a) when was the commission appointed, (b) what are its terms of reference, (c) who (i) is the chairman and (ii) are the members of the commission and (d) when is it due to report?

†The MINISTER OF AGRICULTURE AND FISHERIES:

No.

Mental health services

*14. Dr. M. S. BARNARD asked the Minister of Health and Welfare:

Whether his Department subsidized mental health services in Port Elizabeth in 1981; if so, (a) to what extent, and (b) for what purposes were subsidies allocated?

The MINISTER OF HEALTH AND WELFARE:

No; (a) and (b) fall away.

Mental health services

*15. Dr. M. S. BARNARD asked the Minister of Internal Affairs:

Whether his Department subsidized mental health services in Port Elizabeth in 1981; if so, (a) to what extent, and (b) for what purposes were subsidies allocated?

†The MINISTER OF INTERNAL AFFAIRS:

Yes.

(a) R86 172 for the financial year 1981-'82.

(b) A subsidy of R11 472 to the Port Elizabeth Mental Health Society in respect of the salary of one post of social worker; and a subsidy of R74 700 to the Happydale Training Centre in respect of salaries of staff, maintenance grants, transport costs, educational aids and general expenses.

Survey assesses the needs of the deaf

(299) Sowetan 14/4/82

THERE are insufficient welfare services being offered to deaf people in the major townships of the East Rand.

This emerged from a survey conducted last month, under the auspices of the South African National Council for the Deaf, on the needs and resources of the deaf in the area.

The aim of the survey, according to Miss Khosi Mthembu, a social worker with the council, was to assess the number of deaf people staying in those areas and the exact nature of problems experienced by them.

It was also geared at studying the community and welfare services that exist in order to enhance the integration of deaf people with the hearing community.

The areas covered were Thembisa, Kwa-Thema, Tsakane, Vosloorus, Daveyton, Wattville and Katlehong.

Findings were broken up into five sections, namely; identifying particulars of the deaf, type of hearing loss, number of deaf people, nature of problems they experience and the extent of community services available to them.

In each of these sections 40 people were interviewed, percentages obtained and rounded-off.

Of the people interviewed, the majority of the sample — 29 (73%) — are totally deaf and the remaining 11 (28%) are partially deaf.

On the question of the practical nature of the problem experienced by them, the sample revealed that 32 (80%) had problems with communication, while 11 (28%) had problems with documentation. Only 7 (18%) had problems with accommodation.

When asked to describe the methods of communication with which they encountered the most problems, 24 (75%) said they had difficulty with speech while another 12 (38%) experienced problems with lip-reading and the remaining 14 (44%) with writing.

Of the 21 respondents asked to comment on problems encountered in their work situation, 7 (33%) stated that they had communication problems while 11(52%) said they had difficulty regarding salary, hours of service and the type of work they were doing.

As regards other community services, schools and hostels for the deaf, vocational guidance, driving schools, speech therapists, church services and legal interpreters in court were also mentioned as being available.

It also emerged that there was a lack of material being directed at deaf blacks to provide vide the additional necessary information about their handicap.



DEAF: Learning to use hearing aids.

As a result of these findings Miss Mthembu and her team have strongly recommended that:

- Special emphasis be placed on communication skills to equip the deaf to communicate with hearing people.
- Courses for parents of the deaf and other community members should be provided on communicative skills, particularly sign-language, which would equip them to communicate more satisfactorily with the deaf.
- Social work, particularly case work, should be implemented as a follow-up to the survey.
- The National Council for the deaf should embark on establishing community services and local societies for the deaf, and both the deaf and their families should be encountered to use existing facilities.
- Publicity to enlighten the public about deafness and programmes to inform the deaf through pamphlets, talks and group work should be made available.

Introductory Offer!
available from April 1st

299



Talking "total communication" to three former pupils of the Delabat School for the Deaf at a meeting in Port Elizabeth is the principal of the school and chairman of the National Council for the Deaf, Dr J H HAMILTON (right). With him are (from the left) Mr ROBERT GOODYEAR, Mr JOSUA dU PREEZ and Mr J P VAN ROOYEN. "Total communication" is defined as combined lip reading, sign language, speech and body language — a mode of communication for the deaf rapidly being adopted in the Western world.

New fields for deaf with widened school facilities

By SALLY KERNOHAN

SOUTH AFRICA's deaf — commonly called the "twilight people" — face a brighter future following the introduction of secondary educational facilities at Worcester.

In an exclusive interview with the Weekend Post, Dr J H Hamilton, chairman of the National Council for the Deaf and principal of Delabat School for the Deaf in Worcestor, said this brand-new facility had only opened its doors this week.

"Our school facilities have always been adequate, but once a deaf person got to school-leaving age, his chances of further advancement were nil," said Dr Hamilton.

"Up to a month ago, there was no secondary training available," he said.

"But, through the new approach towards early identification, differentiated systems of education, the advancement of educational aids, television and creating post-secondary training facilities, a better future is promised to the deaf in South Africa."

Dr Hamilton said the new advanced technical training centre was a branch attached to the Technical College at Worcestor.

For men it offered courses in most technical subjects up to NTC 3 level.

"For the girls we are introducing courses in hairdressing, typing and commercial courses."

Dr Hamilton said the biggest problem facing deaf people was not their hearing loss.

"But if the deafness is at the pre-lingual stage, the loss of actual sound causes a retardation or no development of language.

"The language problem is the biggest one facing them. For without language, they cannot learn and, in turn, have an educational problem."

Dr Hamilton said the council was doing extensive research into all aspects of language systems.

"Up to now there have been different sign languages in South Africa. We now want to teach an oral language as a sort of universal vernacular so the various groups can communicate more easily with each other."

He said television had opened up a whole new world to the deaf.

Television was the only recreational facility the deaf had, but, because he couldn't hear, Dr Hamilton would like to see sub-titles introduced to the box.

"For instance they see unrest in Northern Ireland. But because they can't hear, they think it's in South Africa."

Community participation was also vitally important, said Dr Hamilton

"Sport is a deaf person's biggest outlet.

"But they have no clubs of their own and are not members of clubs.

"The community should reach out to the deaf and involve them — especially in indoor games.

"Just because a man is deaf does not mean he may not become a badminton champion," said Dr Hamilton.

Medical aid 'attacked by doctors'

Mercury Reporter

DOCTORS have accused the National Medical Plan scheme of exercising control over treatments administered by private doctors in an attempt to cut down costs and work loads.

A local general practitioner, who cannot be named for professional reasons, threatened yesterday to withdraw from the National Medical Plan scheme because he was 'tired of being dictated to from laymen on how to treat patients'.

The doctor said he had experienced cases where a patient had been admitted to hospital with chest pains and where he had ordered cardiograph treatment for three days.

The medical aid scheme had questioned the treatment and determined that only one day under treatment was sufficient.

'Medical Plan is deliberately trying to cut down on our work load,' said the doctor. 'Excuses are always given that they are acting in the patient's interests.'

He said he had been 'cleared' by the Medical Association in Pretoria who had investigated his complaints and confirmed he was not charging patients for unnecessary and expensive treatments.

He added it appeared that National Medical Plan was following American trends where patients were often given unnecessary tests 'which cost a fortune'.

'Blows'

A specialist, who cannot be named, confirmed he had also 'come to blows with the National Medical Plan scheme'.

He said he had been accused of 'overtreating' patients admitted to hospitals with serious complaints and who had had to undergo operations.

The secretary-general of the Medical Association in Pretoria, Dr C E Viljoen, said yesterday although he had not studied the complaints in great detail, he could assure doctors that such attitudes would not be tolerated.

'I cannot believe that the Medical Association would condone either doctors overtreating patients or the malfunctioning of medical aid schemes,' said Dr Viljoen.

The general manager of the National Medical Plan, Mr R H Basson, said his company, as all other medical aid companies, were 'only trying to act in the interests of their members'.

'We are a trust fund,' said Mr Basson. 'Although I am not a doctor we have a committee of doctors who may be approached with any problems.'

DEPARTEMENT VAN GESONDHEID EN WELSYN

No. R. 1013 28 Mei 1982

WET OP MEDIESE SKEMAS, 1967

Kragtens artikel 30 (3) van die Wet op Mediese Skemas, 1967 (Wet 72 van 1967), soos gewysig, kondig ek, Joseph Petrus Hermanus Steyn, Registrateur van Mediese Skemas, hierby die geldetarief in artikel 1 (1) van genoemde Wet bedoel, soos volg af:

GELDETARIEF TEN OPSIGTE VAN PRIVATE HOSPITALE

1. Die tarief wat in Bylae A hiervan uiteengesit is, geld ten opsigte van private hospitale vir Blankes met hoogstens 70 geregistreerde beddens.

2. Die tarief wat in Bylae B hiervan uiteengesit is, geld ten opsigte van private hospitale vir Blankes met meer as 70 geregistreerde beddens.

3. Die tarief wat in Bylae C hiervan uiteengesit is, geld vir beide sodanige kategorieë hospitale.

4. Die tarief sluit algemene verkoopbelasting in, behalwe op items met betrekking tot medisyne, verdowingsmiddels en verbandgoed.

5. 'n Komitee van vyf lede, van wie die Verteenwoordigende Vereniging van Mediese Skemas drie benoem en die Verteenwoordigende Vereniging van Private Hospitale twee benoem, word saamgestel om aansoeke van private hospitale met minstens 61 geregistreerde beddens vir Blankes, om by die toepassing van die tarief in Bylae B geag te word hospitale te wees wat meer as 70 sodanige beddens het, te oorweeg. Bedoelde komitee bepaal die prosedure wat by die aanhoor van sodanige aansoeke gevolg moet word, en die beslissing van bedoelde komitee is afdoende.

6. Hierdie tarief is ter vervanging van die tarief wat by Goewermentskennisgewing R. 558 van 26 Maart 1982 gepubliseer is en tree in werking op 1 Junie 1982.

BYLAE A

Saalgelde

Hospitale moet die presiese tyd van toelating en ontslag op alle rekenings aandui.

Saalgelde word gehef teen die volle daaglikse tarief indien toelating vóór 12h00 geskied en teen die helfte van die daaglikse tarief indien toelating ná 12h00 geskied. Saalgelde word gehef teen die helfte van die daaglikse tarief indien ontslag vóór 12h00 geskied en teen die volle daaglikse tarief indien ontslag ná 12h00 geskied: Met dien verstande dat die minimum bedrag wat gevra word, gelyk is aan die tarief vir een volle dag.

	Algemene saal	R
57001	Chirurgiese gevalle, per dag	37,50
57002	Toraks-chirurgiese gevalle, per dag	39,00
57003	Neurochirurgiese gevalle, per dag	39,00
57004	Mediese en neurologiese gevalle, per dag	39,00

57020 *Privaatsaal*

Indien 'n geneesheer verblyf in 'n privaatsaal om mediese redes voorskryf, word gelde vir sodanige verblyf gehef teen die heersende privaatsaal tarief, wat in geen geval R61 per dag mag oorskry nie, min 10 persent korting.

Hospitale moet 'n gedetailleerde sertifikaat aangaande die noodsaaklikheid vir privaatsaalverblyf van die behandelende dokter verkry en sodanige sertifikaat saam met die rekening aan die betrokke skema stuur.

57021 *Privaatsaal op lid se versoek*

Waar 'n skema onderneem om betaling vir privaatsaalverblyf *wat op die uitdruklike versoek van die lid verskaf word*, te waarborg, is die skema geregtig op 'n 10 persent korting op die *heersende privaatsaaltarief van toepassing op daardie besondere hospitaal*.

DEPARTMENT OF HEALTH AND WELFARE

No. R. 1013 28 May 1982

MEDICAL SCHEMES ACT, 1967

In terms of section 30 (3) of the Medical Schemes Act, 1967 (Act 72 of 1967), as amended, I, Joseph Petrus Hermanus Steyn, Registrar of Medical Schemes, hereby publish the following tariff of fees, as referred to in section 1 (1) of the said Act:

TARIFF OF FEES IN RESPECT OF PRIVATE HOSPITALS

1. The tariff set out in Annexure A hereto shall apply in respect of private hospitals with no more than 70 registered beds for Whites.

2. The tariff set out in Annexure B hereto shall apply in respect of private hospitals with more than 70 registered beds for Whites.

3. The tariff set out in Annexure C hereto shall apply in respect of both categories of such hospitals.

4. The tariff shall include general sales tax except on items in relation to medicines, drugs and dressings.

5. A committee of five members shall be established, and shall consist of three members nominated by the Representative Association of Medical Schemes and two members nominated by the Representative Association of Private Hospitals, to consider any applications from private hospitals having no fewer than 61 registered beds for Whites to be regarded for the purposes of the tariff in Annexure B as if they were hospitals with more than 70 such beds. The procedure for hearing such applications shall be laid down by the said committee and the decision of the said committee shall be final.

6. This tariff is substituted for the tariff published in Government Notice R. 558 of 26 March 1982 and shall come into effect on 1 June 1982.

ANNEXURE A

Ward fees

Hospitals shall indicate the exact times of admission and discharge on all accounts.

Ward fees shall be charged at the full daily rate if admission takes place before 12h00 and at half the daily rate if admission takes place after 12h00. Ward fees shall be charged at half the daily rate if discharge takes place before 12h00 and at the full daily rate if discharge takes place after 12h00: Provided that the minimum amount charged shall be equal to the tariff for one full day.

	General ward	R
57001	Surgical cases, per day	37,50
57002	Thoracic cases (surgical), per day	39,00
57003	Neurosurgical cases, per day	39,00
57004	Medical and neurological cases, per day	39,00

57020 *Private ward*

If accommodation in a private ward has been prescribed by a medical practitioner for medical reasons, fees for such accommodation shall be charged at the prevailing private ward rate, which shall in no case exceed R61 per day, less a discount of 10 per cent.

Hospitals shall obtain a detailed certificate as to the necessity for accommodation in a private ward from the attendant practitioner and such certificate shall be forwarded to the relevant scheme together with the account.

57021 *Private ward at request of member*

Where a scheme undertakes to guarantee payment for accommodation in a private ward, supplied *at the specific request of the member*, the scheme shall be entitled to a 10 per cent discount on the *prevailing private ward rate applicable at that particular hospital*.

UNIONS OPERATING I

Unions have been c
of All Economic Ac
general workers un

AGRICULTURE, FORES

Black Allied Worker
Farmworkers Union
Food and Canning Wc
National Certified
Orange-Vaal General
Trawler and Line Fi

MINING AND QUARRYIN

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Amalgamated Society
Black Allied Worker
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Mine Coloured Staff
Mine Surface Officia
Mine Workers Union
S.A. Boilermakers, I
S.A. Electrical Work
S.A. Engine Drivers,
S.A. Technical Offici
Underground Officials

MANUFACTURING

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General Workers Union
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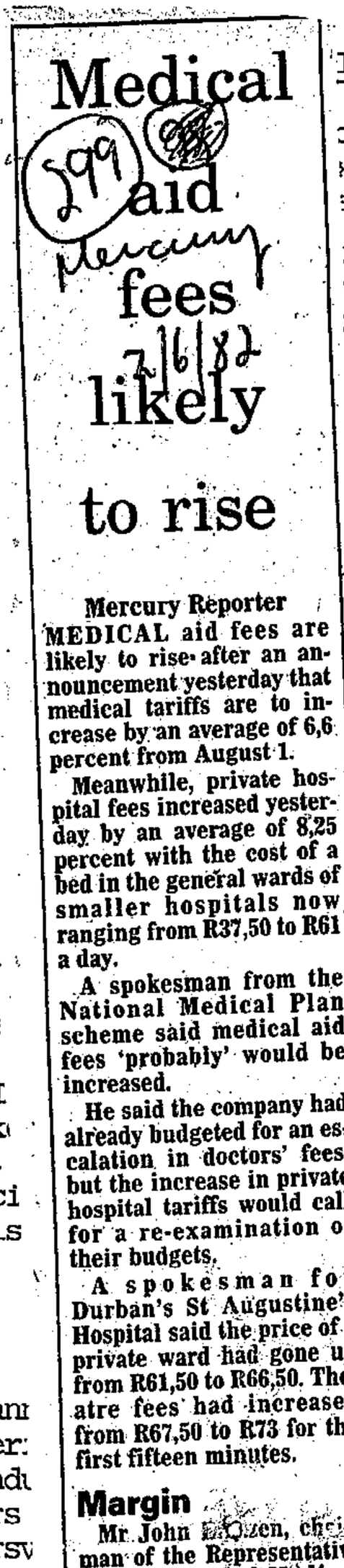

Medical aid fees likely to rise

Mercury Reporter

MEDICAL aid fees are likely to rise after an announcement yesterday that medical tariffs are to increase by an average of 6,6 percent from August 1.

Meanwhile, private hospital fees increased yesterday by an average of 8,25 percent with the cost of a bed in the general wards of smaller hospitals now ranging from R37,50 to R61 a day.

A spokesman from the National Medical Plan scheme said medical aid fees 'probably' would be increased.

He said the company had already budgeted for an escalation in doctors' fees, but the increase in private hospital tariffs would call for a re-examination of their budgets.

A spokesman for Durban's St Augustine's Hospital said the price of a private ward had gone up from R61,50 to R66,50. Theatre fees had increased from R67,50 to R73 for the first fifteen minutes.

Margin

Mr John [illegible]zen, chairman of the Representative Association of Medical Schemes said medical aid subscriptions might rise but it 'depends on each scheme's financial position at the moment'.

He said it was hoped schemes which had increased subscriptions recently had allowed a sufficient margin to carry the rises in nurses' salaries and doctors' and private nursing home fees.

A spokesman for the South African Medical and Dental Council said the council had been informed yesterday that the application for the increases had been approved by the Minister of Health, Dr L A P A Munnik.

ING TO INDUSTRIAL CLASSIFICATION

o the Standard Industrial Classification
xtent of the operation of the following
ablished:

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Sizwe medical fund makes progress

9/6/82

299

Sowetan

By SELLO RABOTHATA

THE SIZWE Medical Fund is four years old and significant progress has been made with extending membership of the scheme and introducing its benefits to black employees throughout the Republic, the Medscheme Administrators have announced.

The fund, which was originally conceived by a group of well known black doctors and which caters exclusively for blacks, presently has a contributing membership amounting to 5 741 with 14 847 dependants. Membership to the fund is only available through employer participation and 56 companies are participating at present.

In the first eight month financial period which ended in 1978, the fund is reported to have paid out R13 000 in benefits. In the financial year which ended in December 1981, the value of benefits paid out to members had jumped to R794 000. Total benefits paid out since inception now exceed R1 500 000; a clear indication that the fund is fulfilling an important need for its members.

Sizwe, which means "nation", has been created out of the realisation that medical, dental, hospital and para-medical services for blacks, as they exist, do not meet the growing medical needs of the black population.

Audited accounts at the end of last year showed reserves of R256 000, which is a per member reserve of R49.

Contributions from members range from R2,35 to R15,30 per month, the same amount as that paid in by the employers.

To assist employers in the promotion of the fund among black employees, a unique audio visual programme has been designed and produced which explains the aims of the fund and the steps involved in taking out membership. The audio visual offers a straight forward, clear-cut way for employers to pass on the facts about the fund to their black employees.

An optional funeral benefit is available as part of the fund's package deal.

Advantages for the employer include reduced absenteeism through ill-health, less loss of time through travelling and the use of State services and the potential of improved health for both the employee and his family; all leading to an improvement in productivity and the increased well-being of employees.



AT WORK: Dr Nthato Motlana (in safari suit) with members of the Siz... Medical Fund management committee considering financial results.

(299) Hansard Q. 61. 1044 - 1045 11/6/82

Black unmarried mothers: allowance

736. Mr. P. R. C. ROGERS asked the Minister of Co-operation and Development:

(1) Whether an allowance is paid to Black unmarried mothers for each illegitimate child; if so, (a) what is the amount of the allowance and (b) in terms of what statutory provision is it paid;

(2) whether any additional allowances or amounts are paid to such mothers; if so, what allowances or amounts;

(3) what was the total amount paid in such allowances and amounts in the latest specified two financial years for which figures are available?

The MINISTER OF CO-OPERATION AND DEVELOPMENT:

(1) and (2) The Department of Co-operation and Development does not pay a specific allowance to Black unmarried mothers. Persons eligible for a grant and the conditions for maintenance

grants are set out in the Regulations promulgated in terms of the Childrens Act, 1960 (Act 33 of 1960).

(3) The information asked for is not available as it forms an integral part of payments made to guardians and foster parents.

Caring for Soweto's forgotten people . . .

(299) Star 16/6/82



Mr Mike du Toit, co-ordinator of Shap, discusses the plans for the employment work centre for Soweto's paraplegics with the organisation's chairman, Mr Friday Mavuso. Looking on is voluntary worker Mr Ephram Nxumalo.

By Elaine Reyneke

Ambitious plans are under way to boost training and employment opportunities for Soweto's paraplegics.

The gallant steps have been initiated by the Self Help Association of Paraplegics (Soweto), (Shap), a body formed nine months ago to investigate the needs of the township's "forgotten people."

Topping the body's priority list is a well-equipped work centre costing an estimated R400 000. The centre will provide employment for 50 paraplegics, most of whom will be involved in assembly contracts for local industries.

The centre, to be built in White City, Jabavu, where a suitable site has been found, will also serve as a foundation for Shap's rehabilitation programmes.

Over the past few months the organisation has traced about 400 paraplegics living in the township and has made a concerted bid to assess the skills and potential of these people as viable members of the country's work force.

Prior to Shap's drive to uplift the training and employment opportunities for these people "many paraplegics in the townships were virtually prisoners in their own homes because of the inadequate facilities provided for them," according to chairman Mr Friday Mavuso.

Already the investigations by Shap into the plight of Soweto's paraplegics have revealed several alarming trends. About 60 percent are disabled as a result of assault. About 70 percent are unemployed, while about 62 percent have an educational level of Std 5 or below.

The investigations have also revealed that about 85 percent of the township's paraplegics are motivated to receive training and to take up full time employment.

These figures were released in a report compiled by Shap's co-ordinator, Mr Mike du Toit, who plans to fight and eliminate the prejudice and problems which have, over the years, succeeded in excluding the paraplegic from participating fully in the open labour market.

According to Mr du Toit a major problem facing paraplegics in the past was the severe lack of employment opportunities and suitable transport facilities. Another obstacle facing black paraplegics, he said, was the small State disability grants of about R50 a month.

He also pointed out that it was generally recognised that the handicapping effects of a physical disability may be significantly exaggerated by socio-economic factors such as poverty, low levels of education and consequent lack of opportunity.

He believed that by the simple achievement of gainful employment and the consequent self-respect and income derived, the paraplegic "is in a stronger position to solve for himself other typical problems encountered, for example housing, transport, the lack of physical aids and family rejection."

In recent months several significant breakthroughs have been achieved for black paraplegics in the open labour market and Mr du Toit attributed this success to the initiative shown by Shap.

In February six men began work as welders at a Chamdor factory in Krugersdorp. Shap has organised their daily transport needs and, according to Mr du Toit, the men's employers are "delighted with their progress and are already talking of taking on more paraplegics in the near future."

Shap has also secured a contract with one of the country's major electrical appliance manufacturers on an experimental basis. Training has already commenced and, once trained, paraplegics will be involved in the assembly of fluorescent light fittings which are currently being imported from Italy.

"This project is seen to be of great value in terms of a pilot project. It will not only afford Shap the ideal opportunity to gain experience, but will also enhance Shap's credibility with a potentially excellent source of future assembly contracts," said Mr du Toit.

Life, however, will not be all work, says Mr du Toit, pointing out that concerted efforts are also being made to boost the recreational needs of paraplegics.

The organisation playing a major role in the initiation of a steering committee, under the chairmanship of Mr Menzo Barrish, chairman of the South African Sports Association for the Physically Disabled, to establish a sports centre for which land has already been approved.

Within six months facilities for basketball, table tennis and bowls will be available. Plans are also afoot to provide other sporting facilities.

Mr du Toit contended that support for the achievement of Shap's objectives would constitute a meaningful contribution to the quality of life of a great number of Soweto paraplegics.

"In the nine months of Shap's existence, a period actually earmarked only for investigation, no less than 30 paraplegics, previously inactive, have been placed in training and /or productive employment," said Mr du Toit, who said he believed that the body's preoccupation with the employment issue "can only result in greater independence for its members, thereby lessening the financial burden of the State and the community in the long term."



Life will not be all work . . . land has already been approved for a sports centre in Soweto.

Boost for paraplegics

(299) Sowetan 16/6/82

By WILLIE BOKALA

AFTER months of tiring work and dedication, a self-help group of paraplegics from Soweto has realised what, in the long run, may turn out to be an established project that will help phase out problems presently facing black paraplegics.

Quinton Hazell Superite's automotive division in Chamdor, Luipaardsvlei, in a move to assist the paraplegics, has employed six members of the Self-help Association of Paraplegics (Shap).

Although there are numerous problems facing these people on wheels, the firm believes that the employment of paraplegics will help fulfil their financial needs and instill a sense of security and acceptability in the community.

At a Press conference held this week to introduce the employment project, Mr Anthony Dixan-Seage, chief executive of the QHS automotive division, said paraplegics needed to be shown that they were accepted as members of the community.

"The lesson we have learnt from the men we are now employing is that there is no reason why they cannot be taken into normal industry to work like physically able people."

Prefab puzzle will be new school for blind

By NOREEN SUTCLIFFE

WHILE Round Tablers sort out a jigsaw puzzle with a difference, blind workers are finding the winter winds just that much harder to bear.

The jigsaw puzzle with a difference was unravelled recently when members of Round Table sorted out what will eventually turn into a new school for blind children in New Brighton.

Mr Hennie Ordel, chairman of Round Table 142 (PE West) told Weekend Post the Port Elizabeth Society for the Blind had obtained a pre-fab building which was literally in pieces.

This they hoped to use for the building to house the blind children and, because it was such a worthwhile project, his Table had decided to go ahead with "what I can only describe as a jigsaw puzzle".

"At the moment, the parts of the prefab are housed in the Lindsay Road premises of the society. This was our second work party and we had a lot of sorting to do.

"My table has set aside a sum of about R1 000 for this project which can be used for replacing necessary parts and for throwing the cement slab needed for the building.

"We feel it is such a worthy project that if we find we need more money, I am sure we will find it.

"We also have to allow for the transport of the prefab to the site set aside in New Brighton.".

The new school is to be sited in Enthembeni and already plans for the structure have been approved by the Community Council.

The first four pupils have been enrolled.

But while the tablers unravel the jigsaw puzzle to get the structure ready, workers at the society's Mount Road workshop are feeling the cold.

Mr Charles Norman, a voluntary worker, told Weekend Post many of the blind workers suffered from arthritis and rheumatism, as well as bronchitis and asthma.

"I gave up my profession as a hairdresser to do voluntary work with the blind. I find it so rewarding although I suppose one could say I am still involved with 'hairdressing' as I singe the cane and trim it for the workers.

"But I am depressed by the fact that, despite the wonderful opportunities given to these people, the funds cannot stretch to providing some form of floor covering.

"Money is tight and, without the help of the society, these people would be without work.

"Many of them are at the age when they feel the cold dreadfully. Isn't there anybody who would be prepared to give us some type of floor covering for them when they sit on the floor and weave?

"Old rubber belting or any type of rubberised covering, or carpeting, would be fine and make the workers' lives so much more comfortable," said Mr Norman.

Mr Denis Glendining, manager of the PE Society for the Blind, said Mr Norman was an indefatigable worker for his society and his quest for some floor covering was supported by the society.

"Talking about floor covering, it is going to be the same plea for the new school for the blind children in New Brighton.

"Round Tablers have undertaken to put up this structure which will have a concrete slab as a floor, but we will need help to cover this as well."

Mr Glendining told Weekend Post support from service organisations would again be necessary for the society's projects to serve, not only the Eastern Cape Region, but also disabled blacks from elsewhere in the Republic on the subsidised basis of R160 per pupil per annum.

He pointed out some of the setbacks the society suffered last year.

They had to write off large sums of money for home rentals and boarding fees for blind persons caught up in the vicious spiral of rising prices.

The society also paid out amounts to avoid ejection of blind people by local authorities for arrears arising out of municipal rent increases.

Also compulsory monthly rental payments in advance replaced weekly rentals, for which funds had to be provided.

A further hazard of blindness was that workers mislaid and accidently lost their bus tickets. Many journeys paid for were never used.

"Until our city falls in line with other centres providing free travel, our society must carry the financial burden.

"State subsidies or other assistance is available to us through local authorities from whom we must now await further response," he said.

Handicapped kids may lose out

A SCHOOL for heavily handicapped kindergarten children in Port Elizabeth could be forced to close because it has to vacate its premises.

The welfare committee that runs the Aurora Nursery School for Handicapped Children has been told it has to vacate the premises in Harrower Road as soon as it finds alternative accommodation.

The child welfare organisation which owns the building needs the former creche for its own use.

Mrs Joan Goosen, chairman of the Aurora committee, said this week that her committee hoped to build a

By PETER MALHERBE

school but that their fund-raising drive had netted only R20 000.

Struggling

A new school would cost about R100 000.

"We will do anything to keep the school going, but we are struggling at the moment."

She said that when she had talked of closure, parents had reacted with great dismay.

"While the schooling is good for the development of the child, it also makes it easier for their families to cope," said Mrs Goosen.

The Aurora school is the only nursery school for handicapped children in Port Elizabeth.

At present the school has 17 students, including a few older children who cannot be accepted at schools for the handicapped in the city.

"They accept only students who are classified as 'trainable', so we keep them on here," said Mrs Goosen.

Where the disabled learn to cope



NO EFFORT SPARED: Veronica Modise has learnt to write beautifully.

THE THIN little body of Veronica Modise bends sideways and with a pen gripped firmly between her toes, she writes in her notebook - the writing is so beautiful it could match that of any other pupil at the Queens College.

When she inserts a key into a keyhole to open or lock a door you won't believe your eyes.

By ITSENG MOGOROSI

Veronica is just one of the 100 pupils at the J C Merkin School for the Disabled in White City Jabavu, Soweto.

The little girl and her colleagues may be different — that is, physcially — from any other schoolkids in the vast area that forms these South-Western townships of Johannesburg, but the form of education is no different from what other kids are taught at day school.

One teacher at the school said: "They are quite receptive. In fact some of them have very high IQ's."

Recently, the school participated in a series of sport competitions held in Pretoria. They brought back three gold and three silver medals. Swimming will be introduced in the near future.

The school caters specifically for such children. It was named after Mr J C Merkin, a former chairman of the Cripple Care Association. The school is subsidised by the Department of Education and Training.

Progress has been fairly rapid since the school was opened in 1980 but Mr J M Bernadie, the principal, feels that the staff isn't kept busy enough: "We need more students and we are not getting enough applications. We are building additional classes which will accommodate about 60 more students."

For further information write to J C Merkin, PO Box 82424, Southdale 2135, or call 984-1187.

NEWS

Disabled get R1-m boost from State

By Elaine Reyneke

The Government has given R1 million towards the cost of a multiracial sports complex for the physically disabled in Soweto.

The full estimated cost of the complex — in Dube — is R3,5 million.

The Government grant was announced this week by Mr Menzo Barrish, chairman of the steering committee spearheading the development.

He said it would give the project a "flying start."

Since it was formed five months ago, the steering committee — comprising three organisations concerned with improving the plight of the physically disabled — has defined the facilities needed.

ALL RACES

The organisations represented on the committee are the National Association for Blind Bowlers, the South African Sports Association for the Physically Disabled, and the Self-Help Association of Paraplegics, Soweto (Shap).

To be built to international standards, the complex will meet the needs of Soweto's disabled — estimated at 1 000 after a survey last year.

Though catering primarily for the physically disabled, the facilities will also be available to the able-bodied.

FUNDS DRIVE

Despite being in Soweto, the centre will be open to all people, irrespective of race, colour or creed said Mr Barrish.

"Development of the complex will be in line with the policy of the South African Sports Association for the Physically Disabled, which has always been non-racial," he said.

The type of complex should involve the State, local and provincial authorities and major private companies, he added.

A plan for the development has been prepared and the steering committee is undertaking an extensive fund-raising drive, calling on authorities and leading companies to "examine the possibilities of sponsoring the scheme."

Building is expected to be completed by January 1984 but field events will begin before that because tenders for sports facilities have already been accepted.

Commenting on the committee's first major success, Mr David Thebahali, the Mayor of Soweto, said a development of the project's magnitude was important because it boosted man's awareness of the basic needs of others.

ARCHERY

He called on the private sector to match the State's contribution towards the project.

The complex will include:

- Outdoor basketball and volleyball courts.
- Bowling green.
- Archery range
- 400 metre Tartan track
- Field events area for javelin, discus and shotput.
- Two-court sports htall for basketball, volleyball, weightlifting, table tennis, badminton, fencing and movement classes.
- Six activity rooms for teaching handicrafts, as well as for physiotherapy and occupational therapy.
- Halls for conferences, meetings, exhibitions, crafts and hobbies, a day clinic, film shows, examination centre, Scouts, Guides and social functions.
- A 30-metre indoor heated swimming pool.



Sweden subjects tourists to a fine distinction

Own Correspondent

STOCKHOLM — Dozens of tourists in Sweden have been arrested as foreign spies and fined a regulation R37 on the spot by over-zealous national servicemen.

The tourists have been "caught" in the sensitive Karlskrona area, where a W-137 Soviet submarine was stranded on the rocks outside the top-secret naval base.

Now the town's tourist bureau executive, Mr Sonny Nilsson — trying to cope with tourist complaints — has protested against the 35 military policemen with guard dogs who have been drafted into the area to hold non-Swedes at bay.

He told the Home Office in Stockholm: "Spies don't come in sailing boats or in holiday caravans."

The area has become popular with tourists since the Soviet sub incident last year and the two-week drama which was highlighted on television.

Saturday Star

Welc hom: boys

FALKLANDS OR BUST — the motto with which the British Fleet set out to recapture the islands. There was something of the same spirit as their homecoming ships steered into Southamp-

ton harbour The boys had got Falklands statuesque joyous la condition t welcome in



the city to beautify Johannesburg
Interbreeding. Picture: GREG ENGLISH

l rule, OK!

sands of pigeons hanging about, they haven't declared open season yet.

"A few years ago they discussed the possibility to putting the pigeons on the pill," one City Health doctor said. "They were going to spread birth control pellets around to try to cut down future pigeon population explosions."

Luckily for all these young birds strutting around our parks today, the idea was shelved because the birds' chemist bills would be exorbitant — the birth control drug costs too much.

Martin Botha, who lives in a downtown hotel, has issued a challenge to pigeon fanciers all over the country to release some of their charges and bring more natural beauty to the cities of South Africa.

"I want a new generation of city pigeon," he said.

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Pik queries US 'secret document'

Pretoria Bureau

THE SA ambassador in Washington has been told to find out from the US State Department if a document, claiming that South Africa conceals certain terrorist attacks, exists.

The Minister of Foreign Affairs, Mr Pik Botha, last night said Press reports indicated the State Department had such a "secret document".

"It will surprise me if the report is correct because it

said.

It said the Queen had pressed an alarm bell by the

after climbing a fence into the Palace grounds and first entering a room on the

day after admitting an affair with a male prostitute. — UPI.

Medical aid scheme fees to rise 'substantially'

By GERALD REILLY
Pretoria Bureau

SOUTH Africa's financially stressed 200 medical aid schemes will have to increase members' subscriptions substantially before the end of the year, the president of the Representative Association of Medical Aid Schemes, Mr J Erntszen, said yesterday.

Some had already raised their fees to meet the alarming increases in the cost of treatment, he said.

This year alone private hospital fees had risen twice — by 15% on April 1 and again by 8,25% on June 1, provincial hospital fees had been increased; doctors' fees would go up by more than 6% from August 1; and from February 1 dentists' fees rose by 25% and physiotherapists' fees by 50%.

Dispensary fees had been increased by 32% and the costs of medicines and drugs were constantly rising.

And according to a spokesman for the South African Medical and Dental Council the council's tariffs' committee will meet in September to formulate new demands for another increase in doctors' fees.

Mr Erntszen said doctors were grossly over-remunerated for certain procedures, and the medical aid schemes were powerless to intervene.

The average member of medical aid schemes was unaware of the high costs of illness because he was financially shielded by the funds.

He stressed the funds should be freed from the burden of direct payments to doctors and for other medical and hospital services.

"Only when members are made to actually pay the acounts will they become aware of the high costs involved."

Mr Erntszen said that of the R600-million a year the funds spent in paying members' accounts, about R240-million went to doctors. The funds themselves should therefore set the maximum fees they were prepared to pay for medical services.

"It makes no economic sense that the organisations who pay the piper have no say in the level of charges which can be made by doctors and others rendering medical services," Mr Erntszen said.

THE Editor and Staff of the Rand Daily Mail wish all its Muslim readers a happy Eid.



Govt's huge orders boost cost of drugs

299 96 259 267 E. Post 24/7/83

By SALLY KERNOHAN

BLAME for the soaring price of drugs in retail chemist shops was this week laid at the door of the Government, which secures such an advantage with its huge bulk orders that it does not contribute a "fair share" towards the manufacturing costs.

This was stated by the Cape Midlands branch of the Pharmaceutical Society of South Africa, and the view was endorsed by manufacturers themselves.

The State buys 60% of all medicines produced in South Africa and in this way is able to secure tenders on extremely favourable terms.

This situation came to light when a Port Elizabeth doctor drew Weekend Post's attention to a prescription which had been presented to a Railways dispensary, and later taken for a comparison of prices to an ordinary retail chemist.

The cost at one of three local Railway dispensaries was R36,18. The patient — a member of the Railways Transmed Medical Aid Scheme — was liable only for a percentage not payable immediately to the dispensary.

At a retail chemist, the cost would have been more than three times higher — about R120, which the patient would have had to pay in full to the chemist before claiming her share back from the medical aid scheme.

To confirm this surprisingly large disparity, Weekend Post took the same prescription to three other chemists.

One gave the cost at R124,14 and the other two both quoted R112.84. The difference of R11.30 was put down to price increases on new stock.

Weekend Post took these figures to the chairman of the Cape Midlands branch of the Pharmaceutical Society, Mr C Hurter, to find out why there should be such a tremendous variation in the prices, and why costs of drugs should be so high.

Mr Hurter said he was only too well aware of the tremendous variation in the prices and explained: "There is no comparison between prices paid by the ordinary distributionary sector — that is, the retail pharmacist — and the State, semi-State, and in fact the dispensing doctor.

"The State is, in fact, buying 60% of the medicines from the manufacturers in South Africa and in reality paying far less than purchasers of the remaining 40% — because of its tender system in the drugs market."

Because of this, Mr Hurter said, the society was looking at a different way of distribution in which private enterprise would carry the entire burden of the costs. There would be open competition with no protected areas.

"The society is busy on an extensive survey which leads us to believe that the private sector could establish health-care centres which would be scaled to the needs and the incomes of the groups that it would serve.

"At present the private sector is carrying the overheads in the drug manufacturing industry," he said, "and the

● Turn to Page 3

Big bulk orders by Govt blamed for soaring price of drugs

● From Page 1

State and semi-State organisations such as the Railways are not sharing sufficiently because of their tender system.

"To equalise it, the State should drop the tender system and buy their drugs at standard factory costs."

Mr Hurter added that the State already had a strict mechanism to control prices and to ensure there was no profiteering.

He said the present system of medical aid schemes had made patients and medical advisers unaware of prices. The concept of health-care centres would tighten up the number of visits people would make, and discourage wasted time and money which the medical aid system encouraged.

He explained that the centres would consist of doctors, nurses, pharmacies and all other allied services, like dental and eye care.

"The society is making positive efforts to establish these," he said.

The time had come to change the entire system of medical aid care throughout South Africa, from one based on insurance principles to a completely different concept.

Manufacturers confirmed the society's view that the Government was not contributing its fair share to production costs, but did not want to be quoted by name.

A spokesman for one of the leading manufacturers said: "The industry basically supports the private enterprise system and believes that the retail pharmacy can play a much larger part in the distribution of medicine to the community," he said.

If this happened, it was likely that medicines would reach the consumer at lower prices.

Civil pensioners can join medical aid fund free

299

Sunday Post 30/7/82

PRETORIA — The Government has decided to give substantial aid to civil pensioners who in the past could not afford an official medical aid scheme, the Minister of Health and Welfare, Dr L A P A Munnik, said.

"It has been arranged with the Public Service Medical Aid Association that a civil pensioner who, prior to April 1, 1982, received a civil pension administered by the Department of Health and Welfare and is still in receipt thereof and who, on March 31, 1982, or any date thereafter, was not, or is not a member of an officially prescribed medical scheme, can obtain membership of the association," he said.

"Such members' subscription fees will be paid in full by the Government," said Dr Munnik.

"Membership counts with effect from the date on which a valid application is received by the association, but, in any case, not earlier than October 1, 1982," Dr Munnik said.

Application forms to join the PSMAA are obtainable at most, but not all, branches of the Post Office in the Republic. — Sapa

Semi-blind men help with project



Two semi-blind men, Mr MARTIN PETER (left) and Mr EDWARD GAZI, help to put on the roof of the new school for the blind in New Brighton.

Work with hands 'makes job easy'

By GILLIAN McAINSH

TWO semi-blind men were helping to roof a unique school for the blind in New Brighton today.

Mr Martin Peter and Mr Edward Gazi, who work for the Port Elizabeth Society for the Blind, both have to wear strong glasses which enable them to see about 20 metres in front of them.

"It's easy to work because we use our hands most of the time, and we can feel the things we use," said Mr Gazi.

"We must do something for our physical well-being," said Mr Peter.

The school will cater for blind black children, and be the first of its kind in South Africa. At present there are only schools for white or coloured children.

Mr Denis Glendining, a member of the welfare committee for the Port Elizabeth Society for the Blind, said the Aggrey Street school was needed as there were no facilities for blind black children in this country.

"We hope this will act as a lever to the Government to build a proper blind school for black children, which would be partially subsidised by the Mfsane Trust," he said.

"It's a big project, as it would have to cater for all the blind black children in South Africa."

He said the society encouraged blind and partially blind people to work on projects like this one: "It's part of their therapy to adopt a realistic approach to life and to show a commitment to other people as well."

Although the Round Tablers and men from the Blind Society have only worked for 12 hours (four Saturday mornings) they have laid the foundations, erected the asbestos sheet walls and put in window frames.

Most of the parts have been donated by a building company which had dismantled an existing house on the site. The Round Tablers bought the window frames and the cement for the floor.

The Round Table chairman, Mr Hennie Ordel, said he expected the two-roomed building to be completed within three weeks.

"It's been a lot of fun and the cost has been minimal so far," he said. "It started from nothing and we've had a lot of assistance from the blind people themselves."

MAN SHOT BY POLICE USES HIS STATE PAYOUT TO AID OTHERS

Cripple refuses to go hungry — and starts a crusade

EIGHT YEARS ago Soweto businessman Mr Friday Mavuso was mistakenly shot — and crippled — by police.

A year ago he took a substantial amount paid to him by the Minister of Police and put it towards helping other cripples.

Mr Mavuso and a group of friends formed SHAPS — the Soweto Self-Help Association of Paraplegics.

Today it is probably the fastest-growing and most active group of its type in Soweto, manned and run by a tight-knit band of courageous people, nearly all of them cripples.

For four years after the accident that robbed him of the use of his legs, Mr Mavuso was in hospital.

"I saw my fellow paraplegic patients getting discharged healthy — and coming back a month later thin and with bladder problems or bed sores.

"They were always hungry. The disability grant of R40 a month was never enough to pay rent, food, transport and other costs. Some said they had lost their house, or wife or family."

By CHARLENE BELTRAMO

Mr Mavuso started raising funds in the hospital to help discharged paraplegics. This was stopped by the hospital authorities, who didn't approve of business activities on the premises.

Undaunted, Mr Mavuso kept devising plans to help fellow paraplegics.

Soweto has about 500 paraplegics, the largest concentration of cripples in South Africa.

The major cause is assault. While 65% of white paraplegia is caused by car accidents, in Soweto the same percentage is caused by assault with knives, bicycle spokes or guns.

Paraplegics have an abnormally high mortality rate, mainly because they have no sensation in their lower limbs. They develop pressure sores easily, and because they have no control over their bladder or bowels, infection leading to kidney failure and death is common.

SHAPS found that most paraplegics were not told by hospitals how their condition would change their bodily functions. It has now trained two paraplegics to lecture other cripples on health care.

But the high death rate among wheelchair victims is caused by a far sadder aspect. Semi-helpless people in wheelchairs are not very welcome in the small overcrowded houses of Soweto.

SHAPS co-ordinator Mr Mike du Toit, himself the victim of a spinal injury 11 years ago, explained: "Wheelchairs take up a lot of space, particularly if 12 to 20 people are crammed into the house.

"Paraplegics have a problem getting around. Taxis don't stop because wheelchairs scratch cars, and because it's a problem lifting people into them."

Their comparative helplessness leads to exploitation. If taxis do carry them, they are usually overcharged.

Most paraplegics lose their houses — if they have one — once they are disabled, and have to become lodgers. They are charged exorbitant rents: R60 or more a month for a little space that usually costs about R30.

SHAPS is changing much of that. It has found employment for some members — as watchmakers, welders, glasscutters, and doing light assembly work.

The organisation is planning a R3 500 000 sports centre in Dube, destined to be the biggest and best of its kind in Africa. The Government has already given it a R1-million grant, and R15 000 came from an unexpected source.

The determined group is now battling to raise not only R2 500 000 more for the centre, but R450 000 for a work and recreation centre.

The members' determination to avoid charity and help themselves has seen the 200 crippled members raise R168 000 in a year.

But they don't want charity. They want a chance to liberate themselves and others from the stigma and loneliness of being wheelchair victims . . .



● Friday Mavuso and Mike du Toit fighting the most noble liberation struggle of all — freedom from charity and the chains of a wheelchair. Picture by PIERRE OOSTHUYSEN

Social worker shortage

Sowetan 15/9/87 297

THE SERIOUS shortage of manpower in the social-work field indicated a bleak future for the profession, an annual general meeting of the Johannesburg Child Welfare Society was told yesterday.

The society's ex-chairman, Mr J Flemming, said in his report that universities throughout the country had this year reported a 50 percent drop in the number of students entering the profession.

He said most social workers were joining the industry, which offered better salaries. This critical shortage of social workers boded ill for the future of the profession and that of the society.

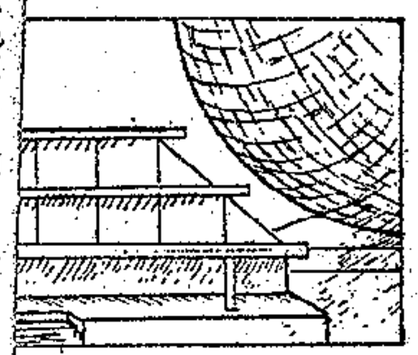
Professor Ceciel Muller, of the University of the Witwatersrand, said the university had reduced the present four-year social science degree course by one year to meet the increasing demand for the social workers.

"Students will now do the degree full-time for three years and fourth year part-time.

proposed new Rand Show grounds on Crown Mines land would be an obvious part of the centenary.

Omitted too is Mr Nigel Mandy, dynamic chairman of the private enterprise group, the Central Business District Association, committed to revamping the central city.

Two years ago both CARE and the Central Business District Association called for a start to be made to create something in the city that would be internationally eye-catching and functional. It cause it offered an oppor-



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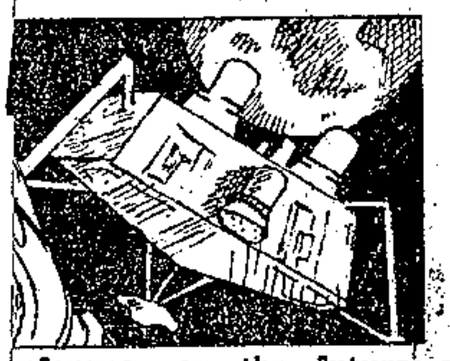

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and Development has approved subsidisation of protective workshops, no funds were allocated for the current year.

In the meantime, because the need is so urgent, the garages at Pumla and Pumelela are being turned into temporary workshops, each employing 10 to 15 people.

The society feels there are many reasons why this scheme should be started immediately.

By transferring older children to the temporary workshops now, their places in the training centres can be offered to children on the waiting list while they are young enough to be trained effectively.

Over R20 000 is required to fund the two workshops. This includes expenditure on equipment, furniture, materials, staff salaries and R20 a month for each of the handicapped workers.

It is hoped that after the first year the Department of Co-operation and Development will provide a subsidy, and the costs incurred

additional R80 000 will be required for equipment, and staff salaries and materials for the first year will be about R50 000.

The workshop could be self-supporting after three years.

The Mental Health Society is now planning a campaign to raise R380 000 and hopes the building will be completed by 1984.

Although the Department of Co-operation and Development has approved subsidisation

Society aims to start workshops for intellectually s in Soweto.

Workshops the key to a ier life

EDUCATION

16 The Star Wednesday September 22 1982

292

D-Dispatch 29/8/82

Masa inquiry into false certificates

EAST LONDON — False medical certificates, giving employees paid leave under the guise of sick leave, are being investigated by the branch of the Medical Association of South Africa (Masa) here.

A questionnaire is being circulated to city businesses and industries in an effort to determine the extent of false sick certificates being given to employers by employees.

The Masa official in charge of the investigation, Dr P. A. Matthews, said yesterday it was decided to launch the survey after the association received two letters of complaint.

"We want to see if the complaints are justified, if they are isolated cases or if they are part of a much larger problem," he said.

Dr Matthews said the study, depending on the statistical returns from the questionnaires, could prove useful, not only to local doctors and businessmen, but to the medical profession and business community throughout the country.

"East London is a nice study model, and we hope we will be able to extrapolate the survey results for other centres, especially for areas similar to ours," he said.

Dr Matthews said that East London had a large, transient, urban population with strong rural links.

"It will be interesting to see if there is any significant statistical relation between certain periods of the year and the number of medical certificates issued.

"There is, for example, evidence that in Transkei the number of certificates issued increases when it comes to ploughing time."

He said that if it was found that certain medical practitioners "were not playing the game" and were issuing sick leave certificates without examining the patient, the association would take action.

"We have a responsibility to try to isolate such problems and we have a duty to the people we serve," he said.

The questionnaire sent to businesses and industries asks, among other questions, the approximate number of sick leave certificates presented monthly, what percentage are considered false, if false sick leave certificates are considered a real problem, if a large number of supposed false certificates come from any specific doctor or doctors and if there was any particular variation to the incidence of false certificates, such as seasonal or after bonuses.

The form also calls for suggestions on ways and means of combating the problem and whether a meeting between commerce and industry with the local Masa branch to discuss the issue would be useful.

All the information returned on the questionnaire, said Dr Matthews, would be strictly confidential. He also asked if the questionnaires could be returned as soon as possible.

Commenting on the survey, the president of the Border Chamber of Industries, Mr Dave Saunders, said the issue of false sick leave certificates was "periodically seen to be a plague which then dies down."

Mr Saunders said the chamber had not discussed the issue "certainly not during the past 12 months."

The secretary of the East London Chamber of Commerce, Mr Jock Allison, also said the issue had not been discussed by the chamber. — DDR

Tabba—a victory for the black blind

By Barry Ronge

When the Transvaal Association for Black Blind Adults (Tabba) holds its first conference tomorrow it will mark an important victory for a few people whose struggle against their disability led directly to the establishment of Tabba.

The organising secretary of the conference is Ruth Machobane, who says that the association was born from a sense of deep frustration which centred on the education of the black blind, and their preparation for the open job market.

"There are only two schools for the blind in the Transvaal," says Mrs Machobane, "one in Pietersburg and the other in the Middelburg area. Getting blind children into these schools presents several problems.

"For example," she continues, "Xhosa-speaking children can go only to a Xhosa school in the Transkei, and Zulus can go only to Empangeni in Natal, so the children inevitably have to leave home and be separated from their parents, which is emotionally difficult and financially taxing as well.

"What is more, the schools are very full, and they do not accept children after the age of 12. Now many children are entered on the waiting list at a very early age, but because the schools are so full they may not get accepted before they are 12, which means they never get any form of education," says Mrs Machobane.



NEW HOPE FOR THE BLACK BLIND — Mrs Ruth Machobane (left) and Mr Jimmy Mojapelo, who worked for the establishment of the Transvaal Association for Blind Black Adults.

"But even for those who do go to school and complete a matric," she says, "there are great problems, for the only work they can get is in the sheltered workshops.

"To have to go back to basket-weaving all day after you have struggled to get a complete education," she says, "is very frustrating for the blind. I experienced this myself along with the other blind people of my age, and we felt that we must do something ourselves to change this situation."

The impetus came when, after having worked for five years as a secretary, she went back to a school for the blind to sit for an examination. "All the children I met there were filled with a great fear of their future, and there was also anger," she says.

"They could not see why they should trouble themselves with education if they were never going to find anything but sheltered employment."

In 1978 Ruth Machobane and a colleague James Mojapelo sat down together to write the constitution for Tabba, for they felt a most urgent need for some organisation in Soweto to work in the townshp for school-leavers and the adult blind.

She points out the Transvaal Society for Blind Blacks is now located in Garankuwa, and is somewhat removed from the immediate problem.

After five years of hard work and careful negotiation with the National Council for the Blind, its revised constitution was accepted, and in 1979 Ruth Machobane was one of the first blacks ever invited to attend a National Council for the Blind conference.

Since then it has been working to establish the size of the community of the blind in Soweto, to deal with its problems, and to act as a liaison with other welfare agencies.

It has obtained a fund-raising number, and has now eventually found permanent office premises from which all its work can be co-ordinated.

Its need for funds is desperate, and the scale of their operations still small, but as Ruth Machobane says, "we are having this conference because we feel we now have something constructive to say to the world."

Tabba is a symbol of dedication and concern, hard won by people who, as blind blacks, have immense obstacles to overcome as they struggle for the right to make a living for themselves.

The association has, in the face of its obstacles, declared its intention "to survive in fine and foul weather, to integrate into our society and claim blind black, are part of the community, and entitled to share all resources together.

● Telephone Johannesburg 944-3808 for further details.

Seven years for false claims

Court Reporter

A 63-YEAR-OLD man, Rangasamy Naidoo, who assisted an employee of the Department of Manpower to obtain money fraudulently by making fictitious sick-benefit claims, was sentenced to seven years' jail by Mr N S Main in the Durban Regional Court yesterday.

Half of the sentence was suspended for five years.

Naidoo pleaded guilty. He told the Court he had been approached by a man who worked in the offices of the Department of Manpower. He had been offered a share of the proceeds if he would assist in presenting fictitious claims.

He told the Court that between May 1981 and July this year he had presented six fictitious claims for sick-benefits for a total amount of more than R10 600.

He had received the money which he had handed over to the other man.

Naidoo told the Court he had received only R600 as his share of the proceeds.

He said he had been out of work for several years.

Centre planned for blind

(299) Soweten 15/10/82

By ELLIOT TSHINGWALA

IDLENESS and boredom for blind people in Soweto will become a thing of the past when the R100 000 centre planned for them is built in Dube in the near future.

This was disclosed by Ms Ruth Machobane, the organising secretary of the newly-formed Transvaal Association for Blind Black Adults (Tabba) which held its first seminar at the Soweto Teachers Training College at the weekend.

Mr Machobane, blind herself and a well-known community worker among the blind, said the centre will consist mainly of workshops and will be built next to Duba-Duba shopping centre.

Tabba boasts among its members community workers, a tribal chief, a journalist and a show businessman, all blind, and already runs a small centre at the Dutch Reformed Church in Pimville.

According to Ms Machobane, they have a large balcony which they use for recreation activities and a small office for their administrative duties. A social worker will soon join the group.

Blind people, who had lost all hope of leading an active life, are gathering at the centre to spend their afternoons playing dominoes, chatting and practicing drama or a bit of music instrument practice.

The two day seminar at the training college was also attended by the deputy "mayor" of the Soweto Council, Mr Tolica Makhaya, who made a first donation of R20. He said he was happy to associate himself with an organisation of such "industrious" personalities.

Another speaker, Mr J J Krüger, the vice chairman of the National Council for the Blind, called on Tabba members to intergrate with the people of Soweto.

He urged Tabba members to make themselves useful to the community in which they live.

The seminar ended on Sunday afternoon with a play reviewing the plight of the blind by the blind themselves. It showed how a blind woman, already handicapped by her blindness, was deserted by her husband and relatives until she came to Tabba.



JIMMY MOJAPELO: Speaking at the seminar last weekend.

Aid schemes: Medical fee hike excessive

Own Correspondent

JOHANNESBURG. — The Representative Association of Medical Schemes (Rams) is to ask the Minister of Health, Dr N A K van der Merwe to modify the "excessive" tariff increases being demanded by doctors and dentists.

The chairman of Rams, Mr J D Ernstzen, said yesterday that the increases approved by the SA Medical and Dental Council — 17,8 percent for doctors and 30 percent for dentists — could raise the total payouts from the country's 250 medical schemes to R800-million a year.

"All funds are under great financial pressure and if these new increases are granted by the minister, then substantial increases in members' subscriptions are unavoidable," Mr Ernstzen warned.

'Demands excessive'

Rams considered the increases demanded excessive because of the series of tariff increases granted doctors and dentists in the past few years.

Other medical aid sources pointed out that other costs associated with illness had also risen steeply recently. Costs included higher hospital fees.

Since November 1979, doctors' fees had risen by nearly 70 percent.

In Pretoria yesterday, a spokesman for the Medical Association of South Africa said practice costs had increased by about 20 percent in the past 12 months.

Council introduces medical aid

By Mzikayise Edom

THE Boksburg Town Council has introduced a medical aid scheme for its more than 1 000 black and coloured employees.

Mr J J Mare, the director of Management Services told The SOWETAN this scheme would affect at least 1 040 black workers and about 50 coloured workers when it is implemented.

The move was prompted by the director of local Government who informed the council that it was possible for blacks to join the Government-sponsored medical schemes, "Bonitas" for blacks and Pro Sana for coloureds.

Black municipal workers are not provided for on the Joint Medical Aid Fund, which caters mainly for white employees.

Medical aid schemes contibutions for blacks will amount to between R2,40 and R14,40 per month, and for coloureds, between R4,32 and R23,40 per month.

Mr Mare said that the council hoped most coloured municipal workers would join but that only a small percentage of blacks would join the medical aid scheme as "These were mostly migrant work-

Battle to keep Parktown school premises

The Transvaal Society for Autistic Children has appealed to the Townships Board to reverse a decision of the Johannesburg City Council refusing it permission to operate from premises in Rhodes Avenue in Parktown.

The appeal last week was the latest round in the society's battle to keep a school for autistic children open at 7 Rhodes Avenue. In May several Parktown residents objected to the school because they felt there would be a reduction in property value and an increase in traffic noise.

The city council's town planning committee subsequently turned down an application from the society to remain at the premises after hearing objections from about 50 residents.

The society then appealed to the Townships Board. Advocate Mr Sydney Kentridge appeared for the society and told the board the children were "far from noisy."

"Autistic children are unable to communicate with those around them because of a mental condition," he said. "They are far from noisy."

Mr Kentridge also said the home of two objectors, Mr and Mrs K E Hildenbrand, of 5 Rhodes Avenue, was large and had extensive grounds.

He said the school was useful because of its teaching function and because it served as a research centre.

Miss Judy Starling, the school principal, said some of the 13 children at the school had improved beyond expectations in the "calm, serene environment" of Parktown.

The chairman of the Townships Board, Mr Le Roux van Niekerk, asked the society to make written submissions within 30 days. The objectors would then be allowed to reply.

A STORY TO TOUCH YOUR HEART

The little girl no school will have



Melanie has to suffer because of her colour

By CHERYL ROBERTS

A CHILD who is deaf and dumb and has mild cerebral palsy may have to attend a school overseas because there is no school in South Africa for coloured children who have more than one physical handicap.

Six-year-old Melanie Vahed's parents — Linda and Clive Vahed — have spent three years applying to schools all over South Africa to accept their physically handicapped daughter.

But all their applications have been turned down.

There are two schools in the Cape for physically handicapped coloured children, Wittebome and Eros. However, neither school can accept Melanie.

Wittebome accepts only deaf and not cerebral palsied children. The reason for this is that it does not have a physiotherapist.

Overcome

Eros, a school for the cerebral palsied, on the other hand, cannot accept deaf children because it does not have adequate skilled personnel.

Because of the non-availability of a school, Melanie, who has been deaf since birth, has to stay at home and attempt to overcome her problems by herself.

Now her desperate parents are saving up to send their daughter to a school overseas.

Mrs Vahed said: "We have been trying to get her into a school for the deaf since she turned three.

"Wittebome, which is the only school for coloured deaf children, refused to accept her because she has mild cerebral palsy.

"Even though her going to Cape Town would have neant our seeing her only twice a year, we desperately wanted her to go because it would have meant the best for her."

Various attempts by the Vaheds to have their daughter placed in a private white school also met with negative responses despite their willingness to pay the prescribed fees.

"We were willing to pay the fees to get her into a white school but there was no way that they were prepared to accept Melanie.

"Now, it seems as if she will just have to suffer because of the colour of her skin."

In a desperate attempt to help her daughter lead a normal life, Mrs Vahed took it upon herself to teach Melanie.

However, due to economic circumstances at home she had to give this up and go back to work.

"When Melanie was two years old, I tried to help and teach her. I did this by doing the John Tracy course with her. But after two years I had to stop because I had to go back to work.

"I would love to stay at home and spend my time with her but I am forced to work to supplement the family income," said Mrs Vahed.

The couple have two other normal children, Raman, eight and Keenan, who is 14 months old.

Like any curious six-year-old, Melanie, despite her physical handicap, was determined to ride a bicycle and this she did within one week. Now she enjoys many happy hours cycling around the block of flats where she lives.

According to her mother, Melanie's favourite television programme is Family Hour Festival — which highlights the problems of handicapped children.

Clever

"We are trying to save as much as possible to send her overseas," said Mrs Vahed.

"I know that Melanie is clever and I would not like to see her intelligence wasted."

"Even though there have been numerous promises that schools will be built in Durban for the physically handicapped, this may come about only in the next 10 years."

Mr Henry Africa, school psychologist for the Department of Internal Affairs (coloured education) confirmed that there are no facilities for coloured children with double physical handicaps.

"There are just no facilities," he said. "However, a special class has been created for the hard of hearing at the Spearman Road School which is under the wing of Coloured Affairs.

Melanie Vahed . . . praying for a school Picture: M S ROY

New R250 000 coloured centre

Mercury 11/1/82

Mercury Reporter

THE Natal Association for the Care of the Coloured Physically Disabled has embarked on a R250 000 project of converting the disused police garages in Wentworth into a complex for the care of disabled coloureds.

Mr Derrick Williams, the association's regional secretary, said the new complex would comprise workshops for 60 disabled men and women, school for disabled and cerebral palsied children, a clinic, gymnasium and other facilities.

He said the disused police garages and the property had been purchased for R25 000 from the Department of Community Development.

'If we had to build a completely new complex it would cost at least R500 000,' said Mr Williams, adding that most of the cash for the project had been raised by public subscription.

Mr Williams said the association planned to use the complex for a 'total care' programme which it has already drawn up, and which would provide for the care of disabled coloureds throughout their lifetime, from childhood to old age.

They were hoping to assist young people to learn a trade and work at the complex, Mr Williams said.

The complex is expected to be opened by April.



MR JAMES NTOMBELA: Both legs amputated, now living with 17 other inmates under appalling conditions at the Mzimhlophe Single Men's Hostel.

'Home' is a crowded hostel, communal toilet

Handicapped live in misery

12/11/82

By SINNAH KUNENE

HOSTEL life is unbearable.

It is even more traumatic when you are a paraplegic, lost touch with your next of kin, have to sleep amid exchanges of gun-fire shots and above all, pretend to be happy with everybody, though some ill-mannered or alcoholic inmates happen to be pestering you.

For James Ntombela (53), and 17 other inmates, the hostel is a home — reminiscent of a pigs' sty. The hostel block is partitioned by a communal kitchen, and has 16 beds around which each inmate has stacked his belongings.

The place is not suitable for the disabled, especially as some of them actually use this "home" as a latrine.

Like the physically fit inmates, they also have to use the communal toilets which are a few paces from the hostel block. At night, there is no other alternative.

Mr Ntombela was born in Sophiatown and was employed by Roberts Construction when he met misfortune and lost a leg. He has been a year at the hostel and states that he has nowhere to go. He claims he has no relatives.

Among the first to be placed at the camp was Mr Fanyana Binda (63), who is the disciplinarian and caretaker. He adminsters and liaises with the West Rand Administration Board social worker, Mr J Nkile. The latter is said to be supplying them with rations while another inmate, Mr John Nkunyana cooks for the men and cleans the floor.

For Mr Tshepiso Sekake (77), life has never been favourable. His mother died when he was ten days old. Born in Ficksburg, he landed in glittery Johannesburg during his childhood. His father was a miner, so he was left in the care of a Boksburg woman who died.

A polio victim during childhood, he had nowhere to go as the woman's grandchildren felt he was a burden.

The hostel inmates pay a bi-monthly rent of R18.50. Some have already been pensioned, while others are awaiting their grants. They were placed at the hostel after the 1976 riots, when some of the original hostel dwellers returned back home.

According to the caretaker, the inmates have been exposed to muggings and harrassment. A fridge and radio (which were donated by the welfare section of the Wrab) were reported stolen. All the windows have been broken — and this has instilled more fear among the inmates — handicapped people who have to put up with shocking conditions, and who should be in a home where they can be properly cared for.

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NOTE CAREFULLY

1. Enter at the top of each page and in column (1) of the block on this cover the number of the question you are answering.
2. Blue or black ink must be used for written answers. The use of a ball point pen is acceptable. Red or green ink may be used only for underlining, emphasis or for diagrams, for which pencil may also be used.
3. Names must be printed on each separate sheet (e.g. graph paper) where sheets additional to examination book(s) are used.
4. Do not write in the left hand margin.

WARNING

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Any dishonesty will render the candidate liable to disqualification and to possible exclusion from the University

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CKGROUND to the news

Payments delayed

Doctors hit at medical aid bodies

S205 48/1/1/82

Own Correspondent

Doctors say they are losing thousands of rands and some are suffering severe hardship because of delays in payments by medical aid schemes.

But for the delays — which have caused their seeking large overdrafts with costly interest charges — their claim for a 17 to 18 percent increase in medical fees need have been only 10 percent, Pretoria doctors said.

One said he and his three partners were at one stage owed R80 000 by medical aid schemes.

Of this R47 000 was owed by Transmed, formerly the sick fund of South African Transport Services.

"I am taking home R1 000 a month less than I did two years ago and I haven't taken my family out for three months because I can't afford it," he said.

The doctors say their problems stem from the system of submitting accounts to their patients instead of direct to the Medical aid organisations.

Patients continually forget to pass the accounts on to their employers and it is only after three accounts have been ignored that the doctors can submit a reminder direct to the scheme.

A new computer system at Transmed had had serious teething troubles, causing yet more delays.

"Because of these delays our position is desperate," said the doctor.

"The R47 000 owed to us by Transmed has been outstanding for five months.

"I have had to get overdrafts at 22 percent interest to pay my staff and ever-increasing expenses. At one stage we had an overdraft of R35 000.

"We have asked for a 17 to 18 percent increase but if I could submit my accounts direct to the medical aid scheme I would be satisfied with a 10 percent increase."

Another Pretoria doctor, in partnership with three others, said Transmed had not paid him since June.

"We have had to run to the banks for overdrafts and we have had to pay tax on money we have not been paid," he said.

"I asked the tax people for an extension and this was refused."

A spokesman for Transmed admitted there had been problems over payment of doctors' accounts.

"The problems have now been ironed out and we are up-to-date with payments," he said.

"When delays are encountered doctors should contact their local Transmed managers."

A spokesman for the Medical Association in Pretoria said no official complaints of delays in payments had been received from doctors.

Mr John Ernstzen, chairman of the representative Association of Medical Schemes, said he believed other medical aid schemes were bein criticised because of Transmed's "unfortunate predicament."

Mr Ernstzen said he was against any move to submit accounts directly, because of ethical considerations.

"I don't see how a doctor can have a proper relationship with his patient if he sends his account straight to the medical scheme," he said.

"The Act was changed and for 15 months direct submission was allowed but it proved to be a disaster.

"The rights of the patient were not considered at all.

"We have a tremendous turnover of members through changes in employment.

"Patients didn't always tell their doctors they had changed jobs.

"Consequently, we were receiving an enormous number of claims from people who were no longer members.

"This caused a huge administrative burden.

"There were even cases of claims being submitted for work which had never been done.

"All of these were found to be genuine errors. I don't know of one which was the result of dishonesty."

Guiding light to blind people

UNSUNG HEROINE

Blind Ruth Machobane of Soweto, who formed the Transvaal Association for Blind Black Adults, has never allowed her disability to get in the way of helping others, writes BARRY RONGE.

It was characteristic of Ruth Machobane's spirit that she never passively accepted her disability and that she always strove to improve the lot of all blind blacks as well as herself.

The Transvaal Association for Blind Black Adults (Tabba), which she formed, addresses itself to the needs of the blind in Soweto and the rest of the province.

She went blind when she was eight years old, but was able to obtain a Junior Certificate. She then went to Ezenzeleni, on the Rand, for vocational training in basketry, spinning, weaving and other skills.

Life for the blind community being trained there was dull, so Ruth formed a cultural club, the first at the centre, and organised play readings, record evenings, drama sessions and even dance classes to fill the empty leisure time.

These activities were not only recreational, however. They also had an educational function.

Led by Ruth, the students petitioned for more extensive training and, as a result, a telephonists course was instituted.

After one partially sighted trainee telephonist had successfully been placed with a company, Ruth Machobane became the first completely blind black woman to be employed as a telephonist.

She worked for a commercial company and then for the city council but she was aware all the time of the fragile situation she and other blind people occupied in the labour market.

For blind whites there was the South African Blind Workers Organisation which had a staff of social workers to help with finding work, to monitor the situation and to offer support and help if people lost their jobs. For blacks there was nothing.

When a blind friend lost her job and was left with no one to turn to and no means of assistance, Ruth realised there was a need to establish an organisation to help such people.

But the clinching factor came when she went to the blind school at Pietersburg to write her matric and encountered a group of young students facing the future in fear and anger.

They were frustrated by the prospect that they would have to spend the rest of their lives making brushes or weaving baskets, living on the sporadic charity of society.

They were being educated for a menial half-life and the grief they felt at this prospect touched Ruth so intensely that she returned to Johannesburg, more intent than ever on doing something to change the situation.

The problems she faced were increased by the removal of the National Council for the Black Blind from Johannesburg to Garankuwa in the homelands and so she was literally on her own.

She sat down and wrote a constitution which she submitted to the National Council for the Blind in 1973. It took five years of constant revision and endless meetings before it was accepted, but in 1978 Tabba was accepted as an affiliate.

For four years she worked from her home while still doing a full-time job and caring for a partially sighted husband and two children, both of whom suffer from an eye complaint.

In September this year she was granted a subsidy to pay her and a secretary an adequate salary. A church gave office space which could function as Tabba's headquarters.

After seven years of single-minded determination, the organisation set up to act on behalf of the black adult blind had become a reality. Rather than being the end of the story, however, Ruth Machobane sees it as only the beginning because Tabba has come into being at a time when it faces mountainous tasks.

The recession makes it more difficult than before for blind black adults to find a job and the situation in schools is desperately inadequate. There are only two schools for the black blind in the Transvaal and they accept only children under the age of 12.

Waiting lists are years long and many children do not make it before their 12th birthday. For them this is a great tragedy, for they are then beyond help, destined to live without education or training of any kind and to find themselves inevitably begging on the streets.

It is vital that an information centre be set up, that workshops be started and that the black blind in Transvaal become a force on the job market, to speak with an authoritative, concerted voice.

Tabba provides that rallying point. The association Ruth Machobane has fought so long and hard to bring to life has kindled a spark of light.



RUTH MACHOBANE — her efforts led to the establishment of the only association in the Transvaal catering for the black blind.

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Centre for skills

25/11/82

African Affairs Reporter

A TRAINING centre for 75 mentally retarded African children has been opened in Umlazi with the help of a German organisation, Kindernothilfe.

The Ekuthuthukeni Training Centre is run by the Lutheran Church in conjunction with the Durban Mental Health Society.

The centre is concerned with the rehabilitation of handicapped children, who, although unable to benefit from instruction in a formal school can be taught skills in preparation for their time in a sheltered workshop when they reached the age of 18.

A parents' association has been formed.

Sharp practice by aid schemes, say doctors

w/c ARGUS 27/11/82

299

Weekend Argus Correspondent

PRETORIA. — Frustration over delayed payments of their accounts has given rise among some doctors to suspicions of sharp practice by medical aid schemes.

They suspect that payments are deliberately held up so that the schemes can gain interest from the outstanding amounts.

"And when you talk about interest from the contributions of schemes' members, you are talking about millions," said one doctor.

"All of us are convinced that medical aid schemes are a rip-off and that somebody is pocketing this money which we are being deprived of".

NOT ENOUGH

In 1980 the 241 registered schemes invested a total of about R200-million which accrued interest totalling about R18-million.

But large as these amounts seem, they are not enough to satisfy the registrar of Medical Aid Schemes, who monitors the schemes for the Government.

A spokesman for the registrar's office said the amount invested in 1980 represented about 15 percent of total contributions from members that year.

"That has increased to about 16 percent of total annual contributions and that is still short of the 25 percent that we require", said the spokesman.

"It is impossible for any business to exist without an accumulated fund".

NO PROFIT IN IT

The spokesman said the doctors' suspicions did not make sense. Medical aid schemes contributions were controlled and could be used only for members' benefits and a reasonable administration fee.

"There would be no profit in it for anyone to hold back payments deliberately to gain interest, because the interest goes into the fund and can be used only for the benefit of the members."

Countering the doctors' allegations Mr John Ernstzen, chairman of the Representative Association of Medical Aid schemes, pointed out that the registrar's report showed 557 complaints had been received from doctors about late payments and that 175 of these had been found to be unwarranted.

"This leaves 382 justifiable complaints, which is neglible when you consider that the schemes make about 50 million payments every year," he said.

Saviour of the world's lost

299 STS 29/11/82

Dr Jean Vanier, the founder of communities worldwide where the mentally handicapped can find peace, is in South Africa to talk about his work. BARRY RONGE interviewed him.

Dr Jean Vanier is visiting South Africa as guest of the Academy for Christian Living, but his reputation has preceded him.

To many, the L'Arche communities for the physically and mentally handicapped seem miraculous and their founder has been likened to Mother Teresa and called a latter-day saint.

L'Arche means, "the Ark", a symbol of rescue and safety in a world of storm and his visit to South Africa is in keeping with his philosophy of visiting countries where the situation is potentially violent and explosive.

This is not only because the handicapped are more seriously neglected in such countries, but because he seeks to bring hope.

"We wish through our actions and visits to teach people the value of establishing community and trust where there is division and suspicion. Trust breaks down aggression and people who love each other live in safety", he says.

"That is our intention — to create safe communities for the wounded and broken people of the world, places that are not necessarily safe from physical danger, but they create the safety of shared trust", says Jean Vanier.

This is the principle on which the communities operate. They create a home environment in a real functioning community, operating within towns and cities and not separated from society. The handicapped are not placed in institutions or meagre sheltered employment, but integrated into a group, where they are encouraged to achieve their full potential — financially, physically and spiritually.

The communities are run by groups of assistants who roughly match the number of handicapped people in the community. There is thus a close, caring, personal supervision for each member and the resulting progress made by the handicapped towards taking up a full and responsible place in society has provoked widespread admiration and praise for the work.

The project began when Jean Vanier moved into a house with two mentally handicapped men and founded the first L'Arche community. That was in 1964 in France. Today there are 60 other communities in 14 countries, all of them founded, either directly, or through the influence of Jean Vanier.

The learning process he describes began while he was teaching philosophy at the University of Toronto in Canada. He visited a small community where a friend was teaching the mentally handicapped.

"They approached me with such simplicity and directness and they pulled such a spirit of friendship and warmth from me that I was struck by the paradox. "The mentally handicapped", he noted, "do not have a consciousness of power. Because of this, perhaps, their capacity for love is more lively and developed than that of other men, because they do not desire power.

"Living in a society where simplicity has been submerged by criticism and sometimes by hypocrisy, is it not wonderful to find people who can be aware, who can marvel? Their open natures are made for communion and love."

He goes on to elaborate by saying that these qualities are often obscured by insecurity and stress under which the handicapped live. They have no rational nature, and frequently not the physical capability to adapt themselves to the conventions and laws of society.

They live in doubt and anguish, and become violent and angry, often withdrawing completely into a catatonic state, and seeking only an immediate gratification in food and sexuality.

He believed that if these people were placed in a happy, humane community, where each is loved and respected as a unique person with a rightful place in the world, they would see their weakness in a different way, which could lead to a great flowering of love and healing.

The philosophy of these communities is simple. "We have learned to live each other's differences in the style of the Beatitudes of Christ, learning that physical and mental differences do not create barriers, they provide a richness of experience in which we can all share", he says.

"We have learned that this is essential, for after they come to us, many people get worse before they get better."

He explains that when they arrive at the centre they are as controlled and defensive as they know how to be, but as the atmosphere of love envelops them, they relax.

That relaxation, however, allows the most deep-seated wounds and anger to be released. It is then that the spirit of forgiveness is most needed, and is most richly rewarding for both the handicapped person and the assistant.

Some of the centres are aiming at self-sufficiency through farming and, in all, there are workshops where crafts are produced which they try to sell.

The communities are essentially religious but not exclusive or dogmatic and, although Jean Vanier is Roman Catholic, he says that one community in India has 25 people in it, of which 18 are Hindu, three Muslim and one Catholic.

They try to teach nothing but how to deal with life within the capabilities of the person.

"If you can walk then you must be given the desire to walk, somewhere to walk to, and a reason for walking there, which is what the communities try to do."

This kind of attention is impossible in institutions because of overcrowding, inadequate staff and because many of the staff are simply doing a job. They come to work when they must, go home when they can, and do only what the job requires.

Such faith and dedication is rare, and it is what Jean Vanier and his colleagues have brought to those who have lived at the edge of despair.

Dr Vanier will speak tomorrow at the Central Methodist Church, corner Pritchard and Smal Streets, Johannesburg. For further details, telephone Johannesburg 37—5949.



DR JEAN VANIER — philosopher and theologian whose work has led to comparisons with Mother Teresa of Calcutta.

Principal denies wanting to stop transport of pupils

By SELLO RABOTHATA

THE PRINCIPAL of the Ezibeleni School for Cripple Children in Natalspruit has refuted allegations that he intended withdrawing transport facilities for children attending secondary schools in the township.

Mr J C H Durand said this after a number of parents had accused him of issuing a directive advising the children of the move. They said he told the children that the school could no longer afford to transport them as it (the school) could not afford the petrol.

One parent said: "My child, who is attending form two, said the principal had told them to inform their parents that the school would no longer provide transport for them. This move will deprive our children of their education and we are now at our wits' end as to what steps to take."

But yesterday Mr Durand denied these allegations. He said most parents had been misled by their children who had not understood him. He said most of the children who were attending school in the township were those at secondary school level and over the age of 16.

ORPHANAGE

Mr Durand said: "We only offer primary education and those who pass to secondary school are presently being transported to the township schools by me. I told the children to tell their parents I would like to meet them for some discussions. Most of these children are supposed to be back home with their parents as they are above 16 years and in secondary school. Now some parents think this is an orphanage.

1249 Hansard Q.61. 375-376

National Housing Fund 28/2/83

266. Dr. W. J. SNYMAN asked the Minister of Community Development:†

Whether loans at reduced interest rates are available from the National Housing Fund for the provision of housing to the aged and handicapped of all population groups; if so, what are these interest rates in respect of each population group?

The MINISTER OF COMMUNITY DEVELOPMENT:

Yes, at a uniform interest rate of 1% but in respect of infirmed aged a loan at a rate of 1/20% can be considered.

299

R1,3m sports, work centre

A R1,3 million centre for paraplegics will be opened soon in Soweto.

The centre, which will house an international sporting complex where games like javellin, discus, basketball and shotput will be played, is being built at Mofolo Park.

This was disclosed to **The SOWETAN** by Mr Friday Mavuso, chairman of the Self-Help Association of Paraplegics (Shap) in Soweto, who added that five offices, a lecture room for group meetings, a kitchen and a dining hall would also be available when the centre was completed.

A workshop where about 50 paraplegics will do packaging and assembly work, is included in the project and paraplegics will also be taught how to repair and maintain their wheelchairs. A leading school of watchmaking in the city will also move into the centre.

Mr Mavuso added that the sport complex would not only be used by disabled people but by anyone who wanted to improve their physical appearance.

Mr Mavuso appealed to paraplegics in Soweto to come forward and join the association.

The association is presently housed at the Molapo Community Centre. About 60 paraplegics will be appointed by Shap to work at the new centre where they will produce light fittings, repair shoes and so on.

(b) 453.

(2) Yes.

(a) Four on one occasion for public violence.

(b) Four.

Hansard Q.61. 623-625

Telephones

428. Mr. K. M. ANDREW asked the Minister of Posts and Telecommunications:

(1) How many applications for private telephones are outstanding in (a) Athlone, (b) Mitchell's Plain, (c) Kraaifontein, (d) Mbekweni, Paarl, (e) Guguletu, (f) Nyanga, (g) Langa and (h) the Cape Town municipal area;

(2) what is the longest period that a private person has been waiting for a telephone in each of these areas?

The MINISTER OF POSTS AND TELECOMMUNICATIONS:

(1) (a) 9 733 (includes Hanover Park),

(b) 3 335 (includes Strandfontein and Swartklip),

(c) 118,

(d) 84,

(e) 2 434,

(f) 588,

(g) 422 and

(h) 3 368 (excluding those areas in the Cape Town municipal area in respect of which figures are furnished against (a), (b), (e), (f) and (g) above);

(2) Athlone—since 1979-09-06,
Mitchell's Plain—since 1979-11-29,
Kraaifontein—since 1981-10-14,
Mbekweni, Paarl—since 1978-09-25,
Guguletu—since 1980-07-01,
Nyanga—since 1979-03-13,
Langa—since 1978-04-07 and
Cape Town municipal area (excluding Athlone, Mitchell's Plain, Guguletu, Nyanga and Langa)—since 1979-11-08.

Telephones

429. Mr. K. M. ANDREW asked the Minister of Posts and Telecommunications:

(1) How many (a) public and (b) private telephones are there in (i) Athlone, (ii) Mitchell's Plain, (iii) Kraaifontein, (iv) Mbekweni, Paarl and (v) the Cape Town municipal area, excluding the Black townships;

(2) how many private telephones were installed in each of these areas in 1982?

The MINISTER OF POSTS AND TELECOMMUNICATIONS:

(1)	(a)	(b)
(i)	200	18 131 (including Hanover Park),
(ii)	80	18 819 (including Strandfontein and Swartklip),
(iii)	43	6 086,
(iv)	3	108, and
(v)	2 297	150 232,

as at 31 December 1982;

(2) Athlone 3 484,
Mitchell's Plain 8 562,
Kraaifontein 2 548,
Mbekweni, Paarl ..... 93, and
Cape Town municipal area (excluding Athlone, Mitchell's Plain and the Black townships) ..... 42 119.

Note: As the Athlone and Mitchell's Plain areas also fall within the Cape Town municipal area, the figures reflected

under items (1)(i) and (ii) have not been included in item (1)(v).

Non-Whites at technikons for Whites

Hansard Q.61.625 11/3/83

432. Mr. S. S. VAN DER MERWE asked the Minister of National Education:

Whether there is any quota in respect of the addmission of non-Whites to technikons for Whites; if so, (a) what is this quota in respect of non-Whites who may be admitted to the (i) Cape Technikon, (ii) Port Elizabeth Technikon, (iii) Witwatersrand Technikon, (iv) Pretoria Technikon, (v) Vaal Triangle Technikon, (vi) Orange Free State Technikon, (vii) Natal Technikon and (viii) RSA Technikon and (b) how many non-White students are at present studying at each such technikon?

The MINISTER OF NATIONAL EDUCATION:

(a) There is no official quota for the admission of non-Whites to technikons for Whites, although a ceiling of 10% of the total number of students of the technikon concerned is a guideline followed for the granting of permission to such non-Whites.

(b)

Cape Technikon	49
Port Elizabeth Technikon	169
Witwatersrand Technikon	117
Pretoria Technikon	7
Vaal Triangle Technikon	4
Orange Free State Technikon	2
Natal Technikon	151
RSA Technikon	1 695

Telephones

435. Mr. E. K. MOORCROFT asked the Minister of Posts and Telecommunications:

(1) How many (a) applications for telephones were received and (b) telephones were installed for (i) private and (ii) business purposes in Grahamstwon in 1982;

(2) whether there is a backlog for this area at present; if so, (a) what was the backlog as at the latest specified date for which figures are available and (b) when is it expected that the backlog will eliminated?

The MINISTER OF POSTS AND TELECOMMUNICATIONS:

(1) (a) (i) 1 022,

(ii) 257, and

(b) (i) 940,

(ii) 247;

(2) yes;

(a) 491 as at 28 February 1983, and

(b) after completion of a 1 400 line extension of the exchange and a major cable work towards the end of 1983 or early in 1984.

Hansard Q.61.626 11/3/83

Mental institutions

440. Dr. M. S. BARNARD asked the Minister of Health and Welfare:

(1) What was the total cost to the State of mental institutions administered by (a) his Department and (b) other agencies for the financial year 1981-'82;

(2) whether the total cost to the State in respect of these intstitutions will be increased for the financial year 1982-'83; if so, by what amount?

The MINISTER OF HEALTH AND WELFARE:

(1) (a) R67 967 664

(b) R18 468 383

(2) Yes;

R20 345 000

Hansard Q.61.626-627

Social pensioners

11/3/83

454. Mr. H. H. SCHWARZ asked the Minister of Health and Welfare:

(a) What is the number of social pensioners, based on the latest available figures, who are White and (b) in respect of what date is the figure given?

P.T.O

The MINISTER OF HEALTH AND WELFARE:

(a) (1) 182 934 (Old aged, war veterans, disability and blind pensions)

(2) 20 006 (Maintenance and family allowances)

(b) February 1983.

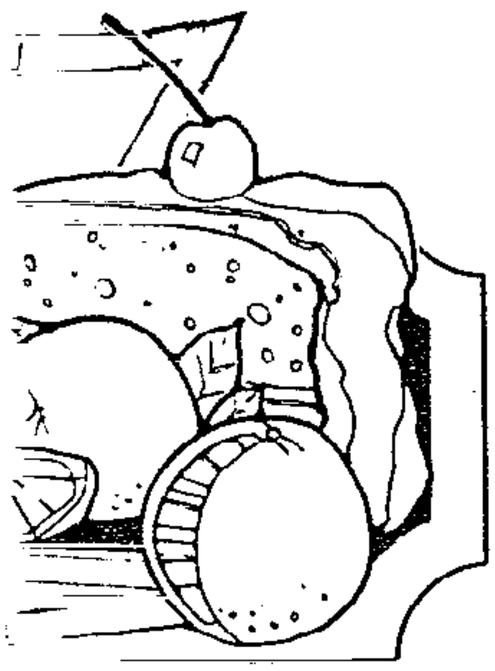
Social pensioners

456. Mr. H. H. SCHWARZ asked the Minister of Internal Affairs:

(a) What is the number of social pensioners, based on the latest available figures, who are (i) Coloured and (ii) Indian and (b) in respect of what dates are the figures given?

The MINISTER OF INTERNAL AFFAIRS:

		(i)	(ii)
(a)	Old age pension	94 270	20 613
	War veterans' pension	7 931	260
	Blind persons' pension	1 566	256
	Disability grant	61 334	17 465
	Maintenance grant	52 920	16 511



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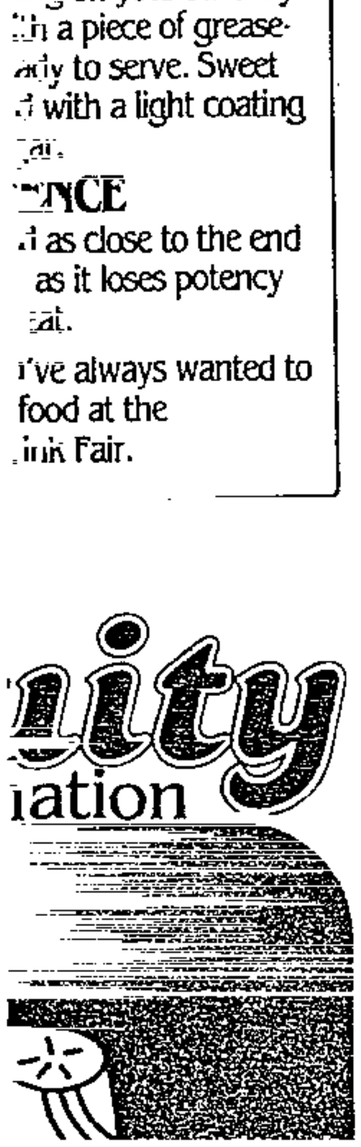

'Attractions of private practice pose threat to medical care in SA'

W/L ARGUS 9/4/83 299

Weekend Argus Reporter

SOUTH AFRICA faces a serious deterioration in standards of medical education and patient care, a top doctor warns in the latest edition of the SA Medical Journal.

"The Medical Association of South Africa and the South African Medical and Dental Council should take note that all is not well in the academic dovecote," writes Professor J W Downing, head of the department of anaesthetics at the University of Natal, in a letter to the journal.

He says provincial and State teaching hospitals and university departments of anaesthetics are suffering from a chronic and critical shortage of anaesthetists "dedicated to public, as opposed to private, practice".

"The training of future doctors in the RSA rests in the hands of a few dedicated individuals whose patience with the notion that the private practitioner is worth two to three times the full-time consultant is fast running out.

"Recently-qualified specialists in many fields, but particularly in anaesthesia, with the potential to undertake a successful full-time or academic career, have taken note of this disparity, and many are going into private practice, or emigrating.

"The final outcome will be a serious deterioration in standards of medical education and hence patient care in this country as we continue to lose many of our best and finest anaesthetists to greener financial pastures."

Professor Downing, recently returned from 13 months' sabbatical leave in the United States, says anaesthetic teaching departments there bill individual patients, raising considerable funds which are paid directly to the departments.

Further funds, running to millions of dollars, come from research grants, "interaction" with the pharmaceutical industry and the state.

The money is used to subsidise salaries in the teaching departments, to buy equipment and for book and travel allowances.

Professor Downing suggests a similar system would be feasible in South Africa. The necessary funds could come from salaries paid by the provinces or the State, research funds, donations from pharmaceutical companies and service organisations and fees charged to medical aid and Workmen's Compensation Act patients.

Patrols organised to stop 'queer bashing'

Gay vigilantes

By DIRK VAN ZYL
Weekend Argus Reporter

CAPE TOWN's only gay rights organisation, 6010, has called on members to form vigilante patrols to protect themselves from "queer-bashing".

Evidence of physical assault on homosexuals by men picked up as casual lovers has emerged recently in a number of court cases in the city.

In its latest newsletter, 6010, which has about 400 members, refers to the formation of the "Pink Panthers" vigilante group in San Francisco "in the early days of gay lib when they were at the rough end of American bashing' is an amusing pastime".

It asks: "Surely it is time for us to show these dreary men that brute force can be a two-way thing?"

The newsletter continues: "There are people at 6010 who would like to see our own vigilante force patrolling and our members trained in the art of self-defence so that next time some thug thinks he can practise for a world title fight on you, you can show him what the real meaning of Bella Bash is." (The term is gay slang for fighting.)

Publicity

A 6010 founder member, Mr Richard Griffith, salesman in a city bookshop, said the biggest publicity the gay community gets, the more homophobic reaction there is, like with AIDS" (the immunodeficient condition which has spread in gay communities).

Mr Griffith, who has been assaulted three times, said the biggest problem facing gays was "lack of education and outdated, misconceived ideas in the 'normal' community, although to a degree there is now more tolerance, which, however, I find condescending".

According to Mr Griffith, "you get the situation where well-respected members of the community are not able to operate normally sexually and are beaten to death in their homes" because desperately needs to relate to someone in physical terms."

Being beaten up was "a basic fact of life for gays".

Mr Griffith continued: "The law in South Africa is ridiculous. It is not illegal to be a homosexual, but just illegal to do something about it. You are virtually condemned to celibacy."

The "biggest battle" facing gays was "their own apathy, which is a form of fear".

According to Mr Barry Kantor, media spokesman for 6010, the organisation "discourages members from 'cruising' — we try to alert them to the dangers involved and to what they are legally entitled to do in case of difficulty".

Soweto's handicapped face a bleak future with nowhere to go

Star 11/4/83

291

By Jean Hey

At Pumla Training Centre — one of two places for intellectually handicapped children in Soweto — an atmosphere of excitement reigns as children from an "ordinary" school visit.

The handicapped children show some of their craft-work with pride. They explain how the shawls, rugs, baby-clothes and trays were made.

While the 70 children at Pumla enjoy a sense of achievement, about 500 other children wait to be placed at one of the two centres.

They were just the tip of the iceberg, the PRO of the Mental Health Society of the Witwatersrand, Mrs Edna Sawady, said.

The chance of a handicapped Sowetan child ever getting a place was remote as many families did not bother to put their children on the waiting lists.

"Recent studies have found that by 2020 Soweto will need at least 30 training centres for the intellectually disabled," Mrs Sawady said.

"That means one new centre must be built almost every year for the next 40 years. At present there is no sign of such progress."

Most children just sit at home. A few attend school but fail the same class year after year.

Until recently there was no psychological testing of Sowetan pupils with learning difficulties.

Now the Department of Health employs nurses with psychology qualifications to assess problem children so those unable to cope at school can be sent to training centres.

However a society social worker, Mrs Josephine Mokoetla, said the situation had not improved. Although the children's problems were recognised at an early age, there was no room for them in the training centres.

Not only were numbers limited to 70 children, but those lucky enough to get a place did not leave quickly. They could stay from six until about 20 with special departmental permission.

Soweto has no permanent homes or institutions for the mentally handicapped. The children are fetched from the different townships at 7 am every weekday and taken home at 4 pm.

During the day they are taught basic skills. Some must be toilet trained and shown how to dress and feed themselves. Others learn to read, write and do craftwork.

Five trained teachers handle supervision while four housemothers help with the basic tasks.

Pumla's headmistress, Mrs Hester Mabotja, said: "There are 14 children to each trained staff member. That ratio is too high as each child needs individual attention."

Now the society is trying to raise money for a large workshop where those over 18 can work and earn some money. It has two pilot workshops going in the training centres' garages where graduates sew buttons on cards or sort materials into different colours.

he Natal Mercury, Tuesday, April 19, 1983

Medical aid fees could go up again

299

Mercury Reporter

SUBSCRIPTIONS for medical aid schemes have jumped this year, with the possibility of further increases before the end of the year likely.

The main reason for the increases, according to spokesmen for the funds, is the imminent increase in doctors' and dentists' fees, coupled with other increased tariffs affecting the medical profession.

Most Durban medical aid schemes said yesterday they had already increased their subscription rates this year or planned to do so before the end of the year.

A spokesman for Medscheme, which runs 27 different medical aid societies which have all increased their rates since the beginning of the year, said 1982 had been a bad year for medical aid schemes.

'Several societies lost money or ran down their reserves last year. The increases are adjusting losses and also taking into account the likely increase in doctors' and dentists' fees.'

According to the Building Industries Medical Aid Fund, which increased voluntary membership rates in November last year and expects to increase other subscriptions before the end of this year, the hike in doctors', dentists' and hospital fees, coupled with increased tariffs approved by the Minister of Health, have pushed up medical aid subscription rates.

The giant National Medical Plan increased its subscriptions earlier this year.

Call for probe into disability payments

By LESLEY LAMBERT

THE State paid R45 million for 26 447 disability grants last year yet, despite reported abuse of grants, there is no co-ordinated body to check how they are used once they have been awarded.

The South African Council for Rehabilitation, which comprises major welfare organisations, has called on a commission of inquiry to review the whole issue.

According to an editorial of the South African Cerebral Palsy Journal, there are people receiving these grants who do not need them.

"Some parents are using them as additional income — to pay off a car or buy something for themselves," the report said.

It expressed the need for a commission of inquiry to include people experienced in the field of rehabilitation and not merely civil servants with paper information.

"Unless a well-conceived and co-ordinated national programme of rehabilitation in South Africa is brought into existence, the handicapped are not going to get a fair deal and the country will be spending money it cannot afford."

The Eastern Cape representative for Welfare Services of the Department of Health and Welfare, Mr J F Odendaal, said 13 572 males and 12 875 females received maximum grants of R138 a month last year.

He admitted that cases of abuse had been reported and that, "besides complaints from neighbours or relatives", the Department had no means of checking the way the money was spent once it had been awarded.

Mrs Peggy Henegan, the organising secretary for the Eastern Province Cerebral Palsy Association said: "We know these grants are often abused, but without organised checking there is nothing we can do about it.

"There are cases of abuse when parents would rather use the money as additional income rather than send the disabled child to a rehabilitation school."

Mrs Henegan cited a case in which neither parents of two disabled children and a disabled grandmother worked because they were living off the grants awarded to the three disabled members of the family instead of using the money to finance their rehabilitation.

The editor of the South African Cerebral Palsy Journal, Mrs F M Tragott-Vorwerg said the main problem seemed to stem from the economic recession.

"Parents begin to use the grants as part of the housekeeping money," she said.

The journal's March editorial described present disability services as "chaotic and fragmented and costing the country money it cannot afford".

The director of the journal, Mr H J C Parker, attributed the fragmentation to the number of different departments involved in the various aspects of rehabilitation, resulting in a lack of continuity.

"There is no attempt to assess the disabled person's potential and develop it. We feel the whole process should be changed to prevent stagnation. Sitting at home waiting for the payment of a disability grant is stagnation, not rehabilitation," said Mr Parker.

1974/75 Affiliates

Address: P.O. Johan 2000

Officials: Secre

Area of Operation

Founded: 1950s

Registration: No

Year	Total	$
1980		25
1979		100
1978		100
1977		100
1976		100
1975		100
1974		..
1973		..
1972		..
1971		..
1970		..

834 8029

AFRICAN TRUNK AND BOX WORKERS UNION

Detainees

873. Mrs. H. SUZMAN asked the Minister of Law and Order:

How many persons were detained under (a) section 28 (1) and (b) section 31 (1) of the Internal Security Act, No. 74 of 1982, at the latest specified date for which figures are available?

The MINISTER OR LAW AND ORDER:

On 16 May 1983

(a) Three persons

(b) Three persons

FRIDAY, 20 MAY 1983

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†Indicates translated version.

For oral reply:

Krugersdorp: meat processing plant

*1. Mr. R. W. HARDINGHAM asked the Minister of Agriculture:

What number of cattle carcases has been processed at the meat processing plant at Krugersdorp since 1 April 1983?

The MINISTER OF AGRICULTURE:

8 441 as from 1 April 1983 to 13 May 1983.

Krugersdorp: meat processing plant

*2. Mr. R. W. HARDINGHAM asked the Minister of Agriculture:

On what basis are permits granted in respect of animals allocated to the meat processing plant at Krugersdorp?

†The MINISTER OF AGRICULTURE:

Two agents who are joint owners of the processing plant concerned, made as from 14 March 1983 to 12 April 1983 slaughter allocations to producers residing in disaster drought areas. Complaints regarding these allocations were lodged with the Meat Board as a result of which a committee consisting of agents under the chairmanship of the Branch Manager of the Meat Board, Johannesburg, handled allocation as from 13 April 1983.

The basis for the allocations is proven land- and cattle ownership in recognized disaster areas, size of herd and the marketing record of every producer. Each producer was allowed market access once only.

*3. Mr. E. K. MOORCROFT.—Law and Order—[Withdrawn.]

Teaching of autistic children

*4. Mrs. H. SUZMAN asked the Minister of Internal Affairs:

(1) Whether there are any facilities in the Transvaal for the teaching of autistic Coloured and Indian children; if so, how many children can be accommodated at these facilities; if not, why not;

(2) whether it is being planned to provide any such facilities in the Transvaal; if not, why not; if so, what is the nature of these plans;

(3) whether he will make a statement on the matter?

The MINISTER OF INTERNAL AFFAIRS:

(1) and (2) No, because such a need has not as yet been identified.

(3) There is a special school for autistic Coloured children at Athlone in Cape Town which is subsidized by the State. Should the need for such a school develop in the Transvaal, financial assistance for that school will also be forthcoming from the State. It is not our policy that the State should establish schools for special education but financial assistance is available to private organizations establishing such schools.

Mrs. H. SUZMAN: Mr. Speaker, arising out of the reply given by the hon. the Minister, could he tell us what the position is in respect of children in the Transvaal—although they are not numerous, there are at least some—who are autistic and require special care? Is the State prepared to subsidize their coming to stay as boarders at the school at Athlone, or will such children be permitted to attend White schools for autistic children?

The MINISTER: Mr. Speaker, my Vote will be coming up for discussion next week. I suggest to the hon. member to raise the matter then. We can then deal with it at length.

Schools: holidays

*5. Mr. H. D. K. VAN DER MERWE asked the Minister of Education and Training:†

Whether additional holidays have been granted to Black schools in the Transvaal in respect of the 1983 school calendar year; if so, (a) by whom, (b) what are the names of the schools concerned and (c)(i) when were the holidays granted and (ii) on which dates did they fall?

†The MINISTER OF EDUCATION AND TRAINING:

No. For the information of the hon. member I wish to mention that the school calendar, school holidays and periods of instruction are determined by the Director-General in terms of section 36 of Act 90 of 1979. At present the same school calendar and school holidays apply to all schools in the seven regions into which the Department's activities are organized.

†Mr. H. D. K. VAN DER MERWE: Mr. Speaker, arising out of the reply given by the hon. the Minister, I should like to know from him whether the report is correct that the hon. the Minister of Co-operation and Development did in fact give a certain part of the day off to the pupils of a particular Black school in the Northern Transvaal. What is his reply to that? [Interjections.]

†The MINISTER: Mr. Speaker, I am perfectly aware of the fact that the hon. the Minister of Co-operation and Development visited a Black school at Vaalwater by invitation and that the principal, in consultation with the hon. the Minister, adjourned the school an hour earlier than usual. I fully approve of that. If the hon. member has problems with it, it does not create any problems for me. I believe the hon. the Minister acted in the interests of excellent relations with the school concerned and the community there. I therefore have no objection to his having done that. If the hon. member feels unhappy about the fact that this happened, I want to tell him here today that the hon. the Minister of Co-operation and Development has my permission to give the pupils certain hours and times off, in consultation with the principal concerned, at every school at which he is invited to appear. [Interjections.]

†Mr. SPEAKER: Order!

†Mr. H. D. K. VAN DER MERWE: Mr. Speaker, further arising out of the hon. the Minister's reply, does the hon. the Minister also give other hon. Ministers the right to give Black pupils certain hours off in consultation with Black principals. [Interjections.]

PE to get school for blind Xhosa children

16/6/83

E. Post

Post Reporter

A SCHOOL for blind Xhosa children in Port Elizabeth will open later this year, according to the national director of the South African Council for the Blind, Mr William Rowland.

Speaking at a function to mark the 25th anniversary of Tape Aids for the Blind in Port Elizabeth, Mr Rowland said a teacher was being trained in the methods of teaching the blind at the Transkei School for the Blind.

He said other Eastern Cape and Border branches of Tape Aids for the Blind were sponsoring pupils and the Lions were doing a project for a bus to transport the children to and from school.

The concept of tape aids was that people who could see should read to those who could not, he said. The organisation provided reading material for the blind in the form of audible tapes.

The national chairman of the organisation, Mr Bernard Boulle, said in his address that membership had swelled to 3 700 since its inception 25 years ago.

He said the recent changeover from two-track to four-track cassettes had allowed for fewer cassettes, smaller containers for books and fewer libraries.

Also on the drawing-board was the establishment of mobile studios to transport books to the townships. He said it was often difficult for users to come to the studios in town.

'Exempt blind from means test'

Post Reporter

WORKERS at the workshop run by the Port Elizabeth Society for the Blind should not be subjected to the means test which seriously affects their income, according to the secretary of the society, Mr Denis Glendining.

Mr Glendining was commenting on a complaint by one of the workers, Mr John Petersen, of Bongo Street, Gelvandale, whose wages were reduced from R27 a week to R8 a week so he could retain his pension of R83 a month.

Mr Petersen told the Evening Post he was employed at the workshop for nearly 21 years and found it hard to make ends meet because of his reduced income. His wife, Mrs Leah Petersen, was also blind and received the same pension and wages.

Mr Petersen claimed the society had deliberately reduced his wages. But this was denied by Mr Glendining, who said it was done at Mr Petersen's request.

He said Mr Petersen was afraid of losing his pension and had asked for his wages to be cut instead.

Mr Glendining said the Government's means test made it difficult for people like Mr Petersen to earn enough money because if their earnings were too high they were in danger of losing their pension.

Mr Glendining appealed to the authorities not to subject blind people to a means test.

Wednesday 22 June 1983
For immediate release

Press

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33-83

NEW STANDARDS TO AID DISABLED WORKERS AND EXTEND SOCIAL SECURITY PROTECTION ADOPTED BY ILO CONFERENCE

GENEVA (ILO News) - International labour standards to promote the employment of disabled persons and to guarantee improved social protection for millions of people who work or live in countries other than their own were adopted by the 69th session of the International Labour Conference which ended in Geneva today.

The assembly of 1,850 government-employer-worker delegates and advisers from 138 member countries of the International Labour Organisation paved the way for the possible adoption next year of standards on employment policy, and in a general discussion underlined the social objectives of industrialisation.

The Conference carried out is regular monitoring of the application by member States of ILO standards. It called for intensified action against apartheid in South Africa, and adopted the Organisation's programme and budget -- amounting to US $254.7 million -- for the two years 1984-85.

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Tel. 99.61.11
ext.7940
Distribution:
ext.7913

International Labour Office,
CH-1211 Geneva 22, Switzerland.

For use of information media. Not an official record.

Vocational rehabilitation and employment

In adopting, in addition to the envisaged Recommendation, an international Convention on vocational rehabilitation and employment, the Conference underlined the importance it attached to the formulation and implementation of a coherent national policy in this field.

Countries ratifying the Convention shall aim -- taking account of their possibilities -- at ensuring that appropriate vocational rehabilitation measures are made available to all categories of disabled persons and at promoting employment opportunties for these persons in the open labour market.

Some 500 million persons worldwide "whose prospects of securing, retaining and advancing in suitable employment are substantially reduced as a result of a duly recognised physical or mental impairment" stand to benefit from such measures.

The preamble stresses the need to ensure equality of opportunity and treatment to all categories of disabled persons, in both rural and urban areas, and the text states that special positive measures taken to this end shall not be regarded as discriminating against other workers.

The representative organisations of employers and workers shall be consulted on policy implementation, including measures to be taken to promote co-operation and co-ordination between the public and private bodies engaged in vocational rehabilitation.

The Recommendation sets out a series of measures aimed at increasing employment opportunities for the disabled, such as assistance and incentives to employers, establishment of various types of sheltered employment, encouragement of the creation of production workshops and co-operatives by and for disabled persons, elimination of physical and architectural barriers or obstacles, facilitation of adequate means of transport, exemption from taxes or other charges on materials and equipment required for rehabilitation programmes, provision of part-time employment, and research.

The instrument emphasises collective participation -- notably that of representatives of organisations of employers and workers and of the disabled themselves -- in determining needs and developing vocational rehabilitation services at national as well

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22/06/83

as community level.

(299)

The Recommendation also deals with -- among other matters -- the special problems of rural areas and, the training of personnel involved, directly or indirectly, in training, vocational rehabilitation, guidance and placement of disabled persons.

Maintenance of rights in social security

In order to promote the establishment of an international system of maintenance of rights in social security, the Conference adopted a Recommendation complementing last year's Convention on this theme.

Millions of persons who for various reasons work or live beyond their national frontiers should benefit from the conclusion of bilateral or multilateral agreements ensuring them social protection independent of their nationality or place of residence.

All ILO member States -- not only those having ratified the Convention -- are invited to conclude among themselves and with the States concerned appropriate administrative or financial arrangements to remove possible obstacles to the provision of invalidity, old-age and survivors' benefits, pensions in respect of employment injuries and death grants, to which a right is acquired under their legislation, to beneficiaries who are nationals of another country or refugees or stateless persons resident abroad.

Where one of the countries bound by a bilateral or multilateral social security instrument has no legislation in force in respect of unemployment benefit or family benefit, the countries concerned should endeavour to conclude between themselves appropriate arrangements to compensate equitably the loss or the absence of rights resulting therefrom for potential beneficiaries.

The Recommendation indicates that where cash benefits have to be paid to beneficiaries residing in the territory of a State other than the one in whose territory the institution liable for the payment is located, this institution should whenever possible pay the beneficiary direct, particularly in the case of invalidity, old-age and survivors' benefits and also pensions in respect of employment injuries. The transfer should be made with the minimum delay so that beneficiaries may have them at their disposal as quickly as possible. In the case of indirect payment, the

.../...

institution acting as intermediary should do its utmost to see that the beneficiary shall receive promptly the benefits due.

Annexed to the Recommendation are model provisions for the conclusion of bilateral or multilateral social security instruments and a model agreement for the co-ordination of these instruments.

Employment

The Conference adopted comprehensive conclusions leading to the adoption next year of a new complementary recommendation on employment policy. It also expressed grave concern at the present world unemployment situation and suggested steps that the ILO and its member States can take to fight it.

The Conference confirmed that promotion of full, productive and freely chosen employment, called for by the ILO's Employment Policy Convention, 1964 (no. 122), remains valid as a basic principle and as the means of achieving in practice the realisation of the right to work. This was defined as "including the right of everyone to gain his living by work which he freely choses or accepts." Economic and social policies, stressing this aim, should be drawn up in co-operation with employers and workers. Satisfaction of the basic needs of the population remains an essential objective.

The Conference discussed a number of factors which have come to light since Convention 122 was adopted. The first is the need to ensure employment of the most disadvantaged groups, such as women, young workers, disabled persons and older workers. The conclusions stress the need for systematic recruitment and training of young people and for special programmes involving their employment on community projects.

One of the major elements of national employment policy, according to the conclusions, is to facilitate the development of and investment in technology as a means of increasing production and employment. The effects of new technologies on the volume, structure and conditions of employment need to be better understood. Workers should be informed of the effects of new technologies and be associated in decision-making concerning their use.

The conclusions recall that national employment policy should

.../...

recognise the importance of small undertakings and, at least for a transitional period, of the informal sector as providers of jobs.

They also call for increased attention to regional development as a means of correcting the uneven spread of growth and employment between different areas of a country. Measures such as the creation of growth poles and investment on infrastructures and services are advocated. The implementation of public investment and special public works programmes was mentioned as a particularly important method of job creation.

The Conference agreed, as the basis of next year's new standard, that member States should promote the expansion of international trade and economic and social development in order to help one another attain employment growth. Joint policies should be designed to promote a fair distribution of the social costs and benefits of structural adjustment.

The conclusions also cover the need to ensure that international migration takes place under conditions designed to promote full, productive and freely chosen employment, and that persons wishing to remain in their countries or origin do find employment opportunities.

A resolution adopted by the Conference invites member States to ratify and apply ILO standards on employment, and to give priority to measures for the creation of employment opportunities. The ILO is requested to elaborate an international strategy to this effect, to prepare a revised World Employment Programme in the light of recent economic trends and to prepare and publish regularly a "world employment report." It should also strive to promote awareness of employment and basic needs issues in other international fora.

Social aspects of industrialisation

"In order to ensure that industrialisation strategies will be fully effective, the Conference affirmed, it is essential that there be a positive investment climate and that those strategies, in addition to seeking to achieve the goals of rapid growth, modernisation, creation of wealth and self-reliance, give due importance to the achievement of social goals such as increased employment and income-earning opportunities, greater equality in

income distribution, better working conditions especially in the field of safety and health, the satisfaction of basic needs of the population and the social protection of workers and their families."

The general discussion in the Committee on this item reviewed, for the first time since 1967 at international tripartite level, problems relating to social aspects of industrialisation, a subject of special interest for all member States.

For the last several years, the conclusions stated, there had existed a serious worldwide economic recession with record levels of unemployment and major trade and investment obstacles to progress in industrialisation.

The Committee agreed on certain fundamental issues regarding the social aspects of industrialisation. These related to respect for basic human rights, tripartite and bipartite co-operation, comprehensive and co-ordinated policies in this field, measures to facilitate the introduction of technological changes, and effectiveness and efficiency of programme implementation.

Reaffirming the importance of the contribution the ILO can make to industrialisation, the Conference underlined the ILO's mandate to establish labour standards and undertake activities in the field of aspects of industrialisation linked to social and labour questions. In particular it stressed the need for the ILO to continue its activities in the field of industrial training. Future ILO activities in these fields should benefit more directly categories of vulnerable workers, notably women and migrants.

Application of Standards

Of 49 countries of all regions present at the Conference which were invited to give information concerning the discharge of their obligations in respect to international labour standards or compliance with conventions they have ratified, 45 entered into dialogue with the Conference Committee on the Application of Standards. The Committee regretted that Congo, Malawi, Togo and Yemen had failed to take part in the discussion, and noted that seven countries (Democratic Kampuchea, Lao Republic, Mauritania, Paraguay, Poland, St. Lucia, Seychelles) were not represented at the Conference and had consequently been unable to participate in the examination of cases relating to them.

.../...

Adopting the Committee report by 263 votes against 4, with 164 abstentions, the Conference noted progress in several countries in meeting the obligation to submit newly-adopted ILO standards to their legislative authorities but regretted failure to submit by five countries.

It noted with regret 19 cases of failure to supply reports or information requested concerning ratified Conventions.

The Conference noted with interest steps taken by well over 50 governments to ensure compliance with ratified Conventions -- expressing satisfaction at progress in five countries (Bolivia, Guinea, Kuwait, Peru and Uruguay), in particular -- and a proposal by one government (Nicaragua) for direct contacts with the ILO.

Three countries (Chile, Czechoslovakia and Turkey) were reported in "special cases" paragraphs, all concerning human rights Conventions.

Taking stock of the application of standards on freedom of association, the right to organise, collective bargaining and rural workers' organisations, the Conference firmly hoped that the survey by the ILO Committee of Experts and the Conference Committee discussion would encourage the recognition and the promotion of freedom of association and would form the basis for member States which had not yet ratified these Conventions to subscribe formally to the principles they contained -- respect for which was indispensable for the effective defence of workers and employers throughout the world. It was noted that divergencies existed, particularly in socialist countries, on the provisions concerning the right of workers to establish organisations of their choice. The Conference hoped these divergencies, which reflected different concepts of freedom of association, could be overcome and clarified with ILO assistance.

Noting that this year's discussions had covered such major issues as the principles and methods governing the ILO supervisory system, the situation among the ILO's entire membership in the field of trade union rights, and complex situations affecting the application of fundamentally important standards, the Conference affirmed that a strength of the supervisory system was the opportunity it gave to governments,

employers and workers to make known their views. The concern which almost all governments had shown to participate in the discussion testified to their responsiveness to those views. The Conference hoped that its discussions this year would lead to measures ensuring a better application of ILO standards and, through them, a better life for working men and women in all continents.

Structure

Following the work conducted by the working group on the structure of the ILO and its own Committee on the same subject, the Conference had available to it all the constitutional and standing orders texts necessary to put into effect the important structural reforms envisaged at such time as the appropriate conditions are present. Even if it was not able to adopt the amendments to the constitution and standing orders placed on the agenda and prepared by the working group, the Conference could only conclude that the questions still in suspense could and should be resolved between now and next year's session in a spirit of co-operation and on the basis of consensus. To this end the Conference decided to establish a delegation to the Conference -- composed of 6 government, 3 employer and 3 worker delegates -- which would have as its mandate to encourage, follow and coordinate the continuation of discussions within the groups concerned. These would meet as frequently as would be useful and regularly inform the Conference delegation.

In a resolution the Conference decided to place on the agenda of the 70th session of the Conference all of the questions relating to amendment of the ILO constitution.

Resolutions

On subjects not on the Conference agenda, the Conference unanimously adopted a resolution on "young people and the ILO's contribution to International Youth Year," which invited member States to take co-ordinated action without delay to combat youth unemployment, apply fully to young people the principle of equal remuneration for work of equal value, and take specific action to raise the standard of living and improve the quality of work as well as job opportunities for young people in rural areas. The resolution invited the ILO to reflect in the ILO's activities the specific Programme of Measures and Activities to be implemented before and during the Year, in particular those concerning the employment and training of young people for work and for life.

*

The Conference President was New Zealand's Minister of Labour, Mr. James B. Bolger, Vice-Presidents were Mr. V. Mratchkov (Bulgaria, government), Mr. G. Polites (Australia, employer) and Mr. G. Lloyd (United Kingdom, worker).

...wheel of his 1931 Chev fire engine is Mr Ray Bokers of Tamboer... and his 15-year-old daughter Marika Malan are the "firemen".

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...oned, Mr Van ...aid he had not gained financially from his dealings with Mr Matthee.

Mr Attwell Maxaki, testified that he had received a driver's licence from Mr van Aarde. During June last year he was stopped by a traffic officer who asked to see his driver's licence.

He was then told that his licence was forged and asked where he had obtained it. He said he had obtained it from Mr van Aarde.

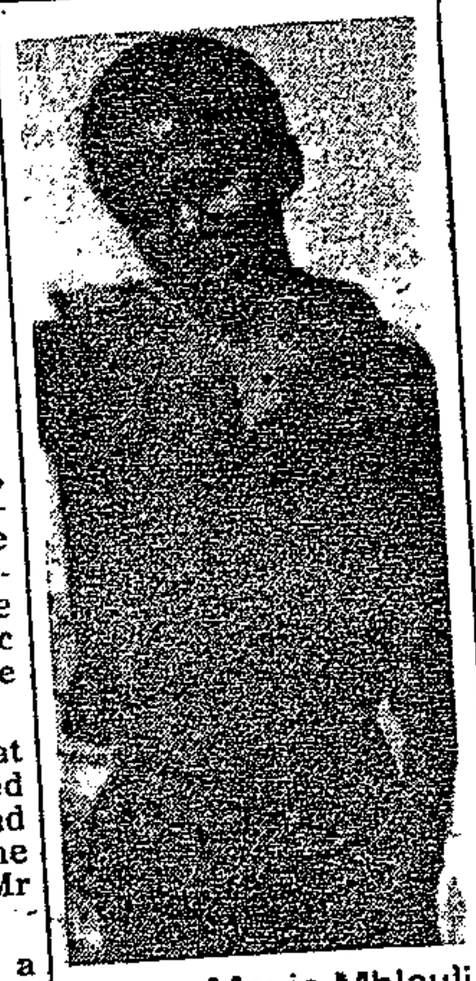
Mr John Lotriet, a traffic officer at Kraaifontein, told the court that after learning where Mr Maxaki had obtained the licence, he went to Mr van Aarde's home who told him that he had received it from a traffic officer.

'Paid R150'

Mr Mzwandile Livane testified that he had paid R150 for his licence. He subsequently went to Ottery for an additional licence and was informed that his existing licence was illegal.

The hearing was adjourned to July 27.

Mr P D Theron was the magistrate. Mrs P J Atkinson appeared for the State and Mr G Bellingham for Mr Matthee.



Nceba Maxie Mhlauli

Search for missing son

Crime Reporter

A TAMBOER'S Kloof domestic worker has appealed for assistance in tracing her 10-year-old son, who disappeared from her place of employment nearly four weeks ago.

Nceba Maxie Mhlauli disappeared on June 3 and his mother, Mrs Gertie Mhlauli, has not heard from him since.

Anyone seeing the boy is asked to contact Mrs Mhlauli at her employer's home at ☎ 46 2757 or the police at 46 4326.

Contracted out doctors push up fees

CAPE TIMES 25/6/83

Own Correspondent

PRETORIA — Doctors contracted out of the Medical Aid Schemes Act have been granted a 12 percent increase in fees, according to the Medical Association of South Africa (Masa).

According to the association the unit charge has been increased from between R1,40 and R1,90, and R2,10 in exceptional cases, to between R1,55 and R2,10, and in exceptional cases to R2,85.

General practitioners' charges remain at six units a visit.

This means that a visit charge at a consulting room will rise from R7,70 to R9,20 based on the R1,55 unit charge.

Last May contracted out doctors were granted an overall increase of 15 percent.

All patients, according to the association, will not be charged at the higher rate, depending on circumstances.

Factors determining the actual rates include the experience of the doctor and the financial status of the patient.

Meanwhile the Minister of Health, Dr Nak van der Merwe, has angered "contracted in doctors" for the "incomprehensible" delay in responding to the submission last October for an increase of 17,5 percent in their fees.

The minister rejected the original demand in January and referred it back to the SA Medical and Dental Council.

Still waiting

The demand was resubmitted by the council in April, and doctors are still waiting for the minister's decision.

The minister has indicated recently that he is considering returning the fee-fixing responsibility to the profession.

The president of the Representative Association of Medical Aid Schemes, Mr J Erntszen, said the new tariff meant the gap between what the medical aid societies would pay and the patient would pay would widen.

...y Control is vital for the continued ...perity of our manufacturing industries and our economy.

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...**of the topics covered:** ...jects of quality control — Feedback — Samp... — Acceptable quality levels — Cost ...ctiveness — Tolerances — Inspection — Test ...hedules — Supervisor responsibility.

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...**ertificate:** The course leads to a Technikon ...ertificate in Quality Control on the successful ...mpletion of a written examination.

...**ourse Fee:** R130,00 (including a comprehensive ... and folder).

Man found dead in cell

Crime Reporter

A 24-YEAR-OLD man had been found dead in a cell at the Mitchells Plain police station on Thursday afternoon, police said yesterday.

Captain Jan Calitz, a police liaison officer for the Western Cape, said Mr Neville Plaatjies, 51, of Mitchells Plain, was arrested on Thursday morning on a charge of possessing dagga.

He was lodged in the cells about 10am and a regular check was kept by policemen.

About 1pm, Mr Plaatjies was found hanged by his neck with a scarf.

Police do not suspect a crime.

Couple found dead in room

Staff Reporter

A SOMERSET WEST man and his wife were

5 children butchered

JOHANNESBURG. — An irate father hacked his five children to death and then hanged himself following a quarrel with his wife.

Mrs Pauline Mathinye, 33, of Sebokeng township near Vereeniging, said yesterday that trouble had started with her husband Michael when he began spending weekend nights away from home.

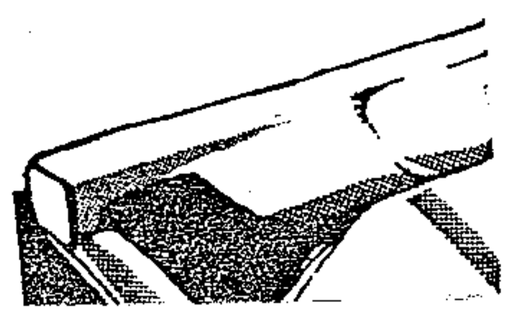
"When he came back he demanded money and I gave him the last R20 I had, then he went away again. When he returned he started attacking me."

He was arrested but later released after police had urged him to settle his differences with his wife peacefully.

She returned to her home on Thursday to check on the children and found all five butchered.

Live with a touc... of Weylandt.

It's difficult to define.
It's not so much the style of furniture.
Or shade of colour.
Or even choice of material that most distinguishes



Medical men to get more

CAPE TIMES 30/6/83

Political Staff

DOCTORS and dentists contracted to medical aid schemes have been granted a 15 percent tariff increase.

The Minister of Health, Dr Nak van der Merwe, announced yesterday that the increases would be effective from September 1.

Last year the South African Medical and Dental Council was approached by the Medical Association and the Dental Association to revise tariffs applicable to members of medical aid schemes.

As a result the council recommended a 17 percent increase for doctors and a 30 percent increase for dentists with effect from March.

But any increases are subject to ministerial approval and Dr Van der Merwe said that while an increase was justified the cabinet had decided it should not exceed 10 percent.

"I believe medical practitioners and dentists, like others in South Africa, must contribute towards the fight against inflation and an adjustment of their tariffs by 10 percent from March, 1983, is justified.

"But since medical schemes will not be able to implement any adjustment before September 1, I believe a further increase of 5 percent is justified."

Representatives of medical schemes had agreed to the increase, he said.

Doctors contracted out of medical schemes were granted a 12 percent tariff increase last week.

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Centre for cripples sacks 11 workers

299

RDM 2/7/83

By SOPHIE TEMA

ELEVEN women workers were sacked yesterday at the United Cerebral Palsy's Harry Kesler Centre — which suffered extensive damage in a fire last weekend — after objecting to working 12 hours a day, some for as little as R45 a month.

The women, all of whom claimed that they had helped carry crippled children to safety when the blaze ripped through their quarters, have asked the Black Sash to give them temporary housing and help in their fight against their dismissal.

The sackings will be the second shock the children have experienced this week. One of the women said: "We love those children, and they love us too. They were away when we left this morning — it will be a shock when they find out we've had to go."

Ten of the women are from Transkei, Lebowa and Bophuthatswana. Only one lives in Soweto and has worked for the home for 15 years. They said their salaries ranged from R45 to R89 a month.

The workers claimed they were sacked because they had gone to the matron in charge of the centre, which has 52 children, to complain about the new working hours introduced from Monday this week. They say they were also insulted.

The secretary of the centre, Mr W Wasserzug, said yesterday: "Nobody insulted them. All they were required to do was to work the normal nine hours a day.

"They have been working for less hours and we are only trying to put the routine straight.

"When we told them that they were to work their normal hours, they opted to go and I could not hold them back.

"I have more than 100 people working for me and losing 10 is not a serious issue.

Asked about the workers' claim that they were poorly paid, Mr Wasserzug said: "You either accept a salary or you reject it."

The workers claim they were to work more hours and were told they would no longer be given their weekly day off.

One of them said: "All along we worked from 7am to 5.30pm and were required to wash, feed, help dress the children and look after them.

"And last week we were told that as from Monday we would have to work from 6am to 6pm for the same salary.

"We went to the centre's matron-in-charge to complain that the hours would be too long for the same salary, but we were insulted and told to go."

Giving the handicapped a little purpose in life

299
Star 9/7/83

"The handicapped person who finds a job is no longer handicapped. He is a worker like any other person."

By following this motto closely during the past seven years, the administrative staff at the Kadimah Occupational Centre in Kensington have provided gainful employment for many who, because of mental or physical disabilities, could not find or hold down a job on the open market.

The organisation provides unpressured employment which is suited and adapted to the skills of the handicapped people who attend the centre during the day.

"To be able to work like others instils dignity and self respect, which is essential for balanced living and mental well-being. The lack of skills are compensated for by job simplification," said the centre's principal, Mr P Odendaal.

The centre contracts out to manufacturers and distributors who provide it with assembly, packaging and sorting jobs which do not entail costly equipment and supervision, such as counting and packing machine and electrical equipment.

"But while we are able to provide employment for many of the handicapped people who attend the centre, we are finding it increasingly difficult to find manufacturers or distributors to supply us with work," Mr Odendaal said.

"Since the main object of the organisation is to counter boredom, with its attendant dangers, we normally negotiate prices to meet competition and guarantee that the work we undertake is up to the required standards."

Any "nuisance job" that could be "broken down", and which required a minimum of thought and concentration was suitable for the handicapped people at Kadimah, said Mr Odendaal.

At present, there are 40 handicapped people who attend Kadimah Centre, which is mainly financed by Johannesburg's Jewish community.

"Kadimah — and other organisations like it — try to provide work for handicapped people because gainful employment remains the most effective means to combat emotions which, if allowed to build up unchecked, can lead to terrible despair," Mr Odendaal said.

● Prospective donors should contact Mr Odendaal at the centre, 80 Orion Street, Kensington, or phone 615-5340.



A group of people at the Kadimah Occupational Centre fit the tops on to tubes which will be used in one of the industrial laboratories on the Reef.



Some of the the homeless Kliptown people at the Good Shepherd Centre with the Rev Cecil Begbie, who is arranging accommodation for them. They were arrested and released on their own recognisances after appearing in court yesterday.

25 Kliptown squatters in court

By SOPHIE TEMA

THE homeless people arrested in the veld at Kliptown on Tuesday morning appeared in court yesterday and were released. They will appear in court again on August 19.

They are now likely to be accommodated at the Methodist Centre in Soweto.

When they appeared in the Johannesburg Commissioner's Court yesterday, 25 were released into the care of the Rev Cecil Begbie of the Methodist Church.

They appeared in three separate courts but their attorney, Mr Ismael Ayob, arranged that they all be given the same remand date — August 19 — for the next hearing.

The people — most of them women — were arrested in the veld behind the Kliptown market on Tuesday morning.

Fourteen people were arrested then. At 3am on Wednesday, a further 11 were arrested and taken to John Vorster Square.

All faced charges of trespassing, being in a prescribed area for more than 72 hours without permits and failing to produce their reference books.

After the court adjourned, two minibuses were hired by Mr Begbie to take the 25 to the Good Shepherd Community Centre in Eldorado Park.

Mr Begbie warned them not to go back to the area.

Most of them had left their blankets and other belongings in the veld where they were sleeping when police swooped on them.

The only person at the spot yesterday was 60-year-old Mrs Mabel Davidson, who was arrested on Tuesday but was later released by the police.

Another woman, Mrs Mpho Letsoalo, was picked up with her two children but was also released.

Those who appeared in court yesterday are:

Ms Esther Hlatshwayo, Mr Ishmael Moletsane, Ms Meisie Cefu, Mr Juda Zondo, Ms Betty Koba, Mr Isaac Mkhwanazi, Ms Agnes Modise, Mr William Khumalo, Ms Wilhemina Mokone, Ms Sophie Cefu, Ms Doris Siwane, Mr Bishop Mashindi, Ms Aletta Makgalemele, Ms Lilian Siwela, Ms Ntombifikile Majola, Ms Maria Tsotetsi, Ms Theodora Hlakutsa, Ms Maria Maneetsi, Ms Lydia Mogoane, Mr Johannes Thom, Mr Joseph Rafel, Mr Jeremiah Makgetha, Mr Gideon Dlamini, Mr Amos Mkhize and Mr Tommy Mofokeng.

'Educate public about handicapped'

Pretoria Bureau

THE Human Sciences Research Council (HSRC) has recommended a national guidance programme to draw the attention of the public to the problems of the handicapped and to the unique contributions they can make to society.

Dr Giovanni Urbani, of the HRSC's Institute for Sociological and Demographic Research, found in his investigations that it cost parents on an average between R880 to R2 100 a year to provide for a genetically-impaired child.

The investigation was conducted among 176 parents with handicapped children.

Dr Urbani found that the average yearly expenses for medical and para-medical care for parents in respect of four genetic handicaps were: spina bifida R881, heamophilia R930, osteogenesis imperfecta R2 140 and Down's syndrome R1 670.

The inquiry found that costs related to genetically-handicapped children were covered only if the parents were members of a relevant medical aid scheme before the conception of their child.

The report recommended that the genetic services programme of the Department of Health and Welfare should be considered as a priority programme. Funds should be made available for research, development and technological aids to prevent and eliminate the consequences of genetic handicaps as far as possible.

'3 forces behind unity'

By MAURITZ MOOLMAN
Mail Reporter

IT WAS not a question of better or worse Afrikaners, if they oppose one another in such fields as the church or politics, a former Minister of Bantu Affairs, Mr M C Botha, said yesterday at the 34th general meeting of the Fe-

FAK wants a pact with the homelands

By MAURITZ MOOLMAN

THE Afrikaner cultural organisation, the Federasie van Afrikaanse Kultuurverenigings (FAK), is negotiating with the Government for the establishment of a cultural agreement between South Africa and the so-called black homelands following reports that Bophuthatswana is to start its own TV service.

Professor J H Senekal, chairman of the language committee of the FAK, told

gotiations were continuing between the organisation and the Government to establish a cultural agreement which would allow all aspects of the Afrikaner culture to come to its full rights — including the Afrikaans language.

"We won't be satisfied with some lucrative agreements or some or other small aspects.

"We are being swamped by the electronic media. There are seven broadcasting sta-

State's wording under fire ...

Mail Reporter

THE "bad" Afrikaans used in the Government's constitutional proposals came under fire at the annual meeting of the Federasie van Afrikaanse Kultuurverenigings in Pretoria yesterday.

A delegate, Mr Nic van

Finding joy in caring for prize Jersey herd



ight: robust and orthright PETER, hose daily work in- olves looking after ne Lake Farms prize ersey herd.

Lake Farm is a haven for the handicapped

23/07/83 (299)

By GARTH KING

NESTLING in gentle hills near the Seaview road is a very special little farm — a sort of kibbutz for unique people described by some as "handicapped adults".

The Lake Farm community, in its small way, caters for the tidal wave of need which exists in the Eastern Cape — not to mention the rest of the country — for "care centres" of this calibre.

The farm, intitially called the Lake Farm Rudolf Steiner Centre, for handicapped children, has pulled through on a wing and a prayer since 1958, often battling against enormous financial odds and gross lack of facilities and equipment.

Today, despite pressing problems of overcrowding and a closed waiting list — with almost daily, desperate applications for residence — Lake Farm has been transformed into a little piece of heaven for the handicapped men and women who spin out tranquil and productive days there.

The principal of the 70-strong community is dynamic co-founder Mrs Ebba Booth who helped convert the old Lake Farm Hotel into a centre for handicapped children.

Then, as now, the farm's leaders were influenced by the progressive philosophy of Rudolf Steiner, the founder of anthroposophy, who believed that education and therapy should offset the conveyor-belt mentality of society and concentrate on building an individual into a harmonious, constantly stimulated human being.

Thus, the community has consciously avoided taking on piecemeal, repetitive work (like coat hanger making) and has aimed at productive, creative activities.

This on-going refusal was initially frowned on by some authorities, but the doggedness has paid off and the farm is slowly becoming a fairly sophisticated money-spinner, whereby the residents can pay the seven house parents reasonable salaries, feed themselves (to an extent), and regularly pay off instalments on a R330 000 Department of Community Development loan for a new wing built in October, 1979.

Initially, the farm started purely as a self-reliance project but it has progressed into a fully-fledged farm.

"With the down-turn in the economy, similiar care centres which took on depressingly mundane and repetitive work found themselves in financial difficulties because companies, rather than retrench their workers, have taken this work back. We have always believed that to survive it is necessary to compete imaginatively in the economy — and it's slowly starting to pay off," said Mrs Booth at Lake Farm this week.



Mrs EBBA BOOTH
... principal

In the last financial year, the farm reaped a gross profit of R18 000.

Much of the farm labour is done by the residents. The 22-morgen farm has a dairy, egg battery, ducks, a herd of prize Jersey cattle and barley and fields of kikuyu grass.

Daily activities at Lake Farm include pottery, carpet making, jersey making on knitting machines, baking (biscuits and bread), leather work and vegetable and decorative gardening.

However, Mrs Booth said commercial laws and agricultural boards being what they are, their farm produce had to be sold on the premises.

Good news was that work on a display shop was to begin next week and Mrs Booth urged the public to take a weekend drive to Lake Farm, where fresh eggs, milk and cream pottery, jerseys, carpets, wallhangings and leather goods were available.

Everybody is kept busy, according to his or her ability and Mrs Booth and her staff try to stimulate the residents with as much extra-mural activity as possible.

In addition to the income accrued from the community's production, each resident receives a R138 a month disability pension and the farm receives a *per capita* grant of about R180 per person every month from the Department of Health, Welfare and Pensions.

"One can easily realise that this is hardly enough to run the farm and feed and clothe us all."

Mrs Booth, like her vice-principal, Mr Grant de Beer, are keen to emphasize that Lake Farm is not an institution, but "an extended family living in a harmonious residential community where each individual is given the unique opportunity of following a life which is as normal as possible".

The community's plans for refurbishing and extending the old hotel wing — approved by the Department of Community Development late last year — includes new workshops, rooms for an additional 50 residents, a swimming pool, a new bakery, a recreational centre, sports grounds and municipal services.

Mrs Booth said: "The Department has approved our request for a R1,5 million loan for the project but they have not yet allocated the money — which we hope for every day."

Undaunted, residents are currently clearing the bush in preparation for the planting of a large recreational park.

Aside from the success of the farm and its idyllic setting and functioning, there are problems — mostly ones of too little space.

"We are the only centre in the Eastern Cape of its kind — and consequently we are perpetually inundated with totally worthy applications. There is just no way we can cope with this and we turn people away every week."

Mrs Booth believes that, ideally, handicapped people should live with and be accepted by society at large.

"We must start educating our children that 'they' are individuals in their own right, just as a 'normal' adult is. 'They' just need different approaches and opportunities to cope.

"Handicapped adults want to work, want to be acknowledged and accepted. They need psychiatric care — but not the kind that's ladled out in institutions at present," she said.

Mrs Booth professed a horror of the conventional mental hospital — and one can easily see why when one watches happy people at work on Lake Farms' fields.

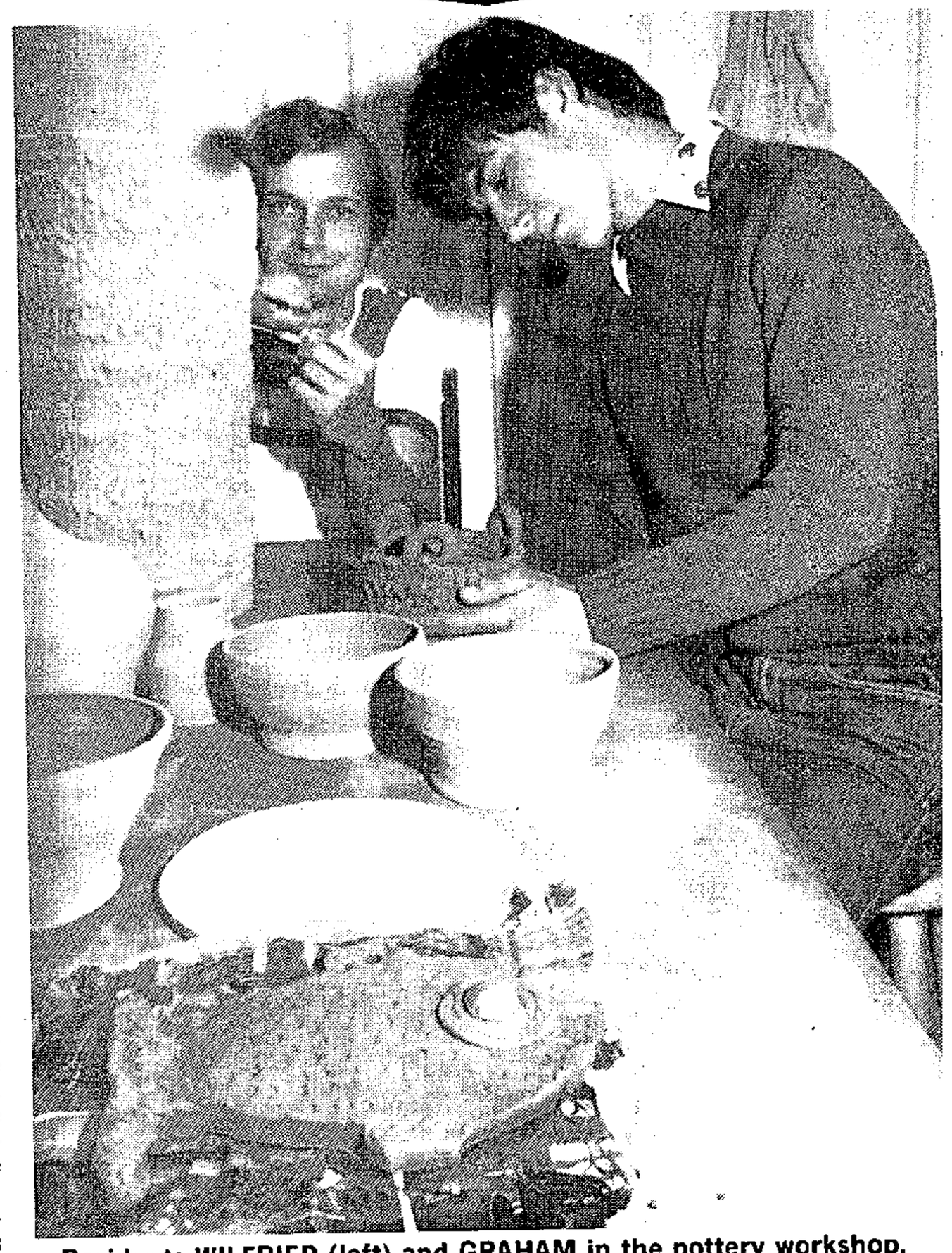
For those who want to help, there are requests for a video recorder, furniture, a motor vehicle, a good fridge and sports equipment.

Besides that, the farm people, like others, crave stimulation.

Amateur magicians, puppeteers, folk dancers, musicians, literally any exponent of an art or craft are most welcome to approach Mrs Booth and visit Lake Farm to present what personal gifts they have to the residents.

A grand, mutually-satisfying welcome awaits them.

Creating beauty at a potter's wheel



Residents WILFRIED (left) and GRAHAM in the pottery workshop.

State urged to do more for South Africa's handicapped

A NATIONAL guidance programme should be launched to draw the attention of the public to the problem of the handicapped and to the unique contributions that they can make to society, a report by the Human Science Research Council recommends.

By SELLO RABOTHATA

The HSRC report on the economic implications of a number of genetic handicaps, also recommended that handicapped persons in South Africa should be helped to become a lot more independent and productive so that their manpower potential can be fully utilised.

Dr Giovanni Urbani, of the HSRC's Institute for Sociological and Demographic Research, found in his investigation that it costs parents on an average between R880 to R2 100 a year to provide for a genetically impaired child. In a survey, 176 parents completed questionaires on the costs they incurred annually for their handicapped children. The average yearly expenses for medical and paramedical care for parents in respect of four genetic handicaps were as follows: Spina bifida R881; haemophilia R930; osteogenesis imperfecta R2 140 and Down's syndrome R1 670.

He said: "In many cases parents had to even found that 20 percent of the mothers had to start working for the sake of their child. Approximately 35 percent of the respondents indicated that their future prospects were obscure because they were anxious about the financial independence of their handicapped child.

COSTS

"The inquiry established that costs related to genetically handicapped children would only be covered if the parents were already members of a relevant medical aid scheme before conception of their child. Parents changing their jobs and therefore probably their medical aid schemes as well, would thus lose this coverage for their handicapped child. A striking discovery by this survey was that the majority of parents were unaware of the existance of social allowances for their impaired children."

The HSRC also found that parents were ignorant of the fact that their child's handicap was due to genetic deviation. All parents who have already given birth to a genetically handicapped child should visit a genetic advisory clinic, particularly in order to determine the risk factors in cases where they desire additional child-

them.

Apart from the financial burden to parents, handicapped persons also cost the Government millions of rands. Persons suffering from spina bifida and haemophilia receive free medical treatment at provincial hospitals. It was not possible to obtain reliable data on the cost of such treatment, but is suffice to say that the blood products alone for haemophilia sufferers cost the Government approximately R8 700 a year for each patient.

The report recommends that the genetic services programme of the Department of Health and Welfare should be considered as a priority programme and that funds be made available for research, development and technological aids in order to prevent and eliminate the consequences of genetic handicaps as far as possible. Combatting and preventing genetic handicaps should be the highest priority since this will effect substantial financial saving for the country.

On account of parents' expenses, the report also recommends that relevant tax concessions be extended to the

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The story of Kathy Jagoe. Crippled at 5...

Kathy has come home to help free disabled folk from restrictions

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□ Wheelchair bound Kathy Jagoe — her role is to make people understand the difficulties faced by those with disabilities. "I'm not doing anything unusual or exceptional," she says.

QUOTE

Disabled people mustn't sit in their back rooms or institutions refusing to go out because they can't get about. They must go to movies or wherever and ask people to carry them up and down the stairs if necessary. It is only by doing so that they make people aware of the lack of facilities in this country.

— Kathy Jagoe

Reports by ARLENE GETZ

KATHY JAGOE was 15 when she swam into a sandbank off an East London beach and surfaced with a broken neck.

It was an accident which sent her to hospital for a year, robbed her of the use of her legs and left her with only limited movement in her arms.

The first three months of Ms Jagoe's hospitalisation was spent in East London lying in traction on her back, steel pins in her skull keeping her head straight and her gaze directed towards the ceiling.

She was unable to talk for the first month because of a tracheotomy performed to remove water in her lungs.

At that stage neither she nor her doctors believed the damage was permanent, but by the time she was transferred to the spinal unit at Cape Town's Conradie Hospital, she knew she would never walk out of the hospital.

"I suppose it was something I realised gradually, but there was one occasion when it just hit me with a shock," Ms Jagoe said in an interview this week.

"People tell you that it's easier if you accept your disability, but I don't believe it's something that can be accepted. Rather, one has to make an adjustment to one's life and that adjustment is ongoing."

After her discharge from hospital Ms Jagoe returned to her home in East London and the school at which she had previously been a pupil.

"It was difficult, but it was necessary," she said of that period.

"Before the accident I'd played a lot of sport and been friendly with people with similar interests.

"Suddenly I was largely an outsider and people found it difficult to relate to me.

"I couldn't do a thing on my own, and I needed help to get up stairs, write notes and use the cloakroom.

"But everybody, including the principal and my teachers, were super and supportive, and I was helped to catch up on all the classes I'd missed."

That was 13 years ago.

Since then Ms Jagoe has studied through Unisa and obtained a Fine Arts and B Ed degree at Rhodes University in Grahamstown.

She has also dedicated her career to liberating disabled people from both the restrictions placed on them by society and the limitations they imposed on themselves.

Currently a visiting associate at the University of the Witwatersrand's Department of Social Anthropology, she views the disability movement as similar to that of black consciousness, the women's liberation movement and the gay liberation movement.

"Disabled people mustn't sit in their back rooms or institutions refusing to go out because they can't get about.

"They must go to movies or wherever and ask people to carry them up and down the stairs if necessary.

"It is only by doing so that they make people aware of the lack of facilities in this country."

Ms Jagoe herself has no qualms about asking for help whenever she needs it.

While she agrees it does need the development of a particular brand of self-confidence and assertiveness to request aid she describes the public reaction as "very good".

Nevertheless, she has encountered her fair share of discrimination during her own battle to remain in the mainstream of society.

In 1976 she was refused a teaching bursary after being told she was unable to reach a blackboard and "children tend to leave their suitcases in the aisles".

"When I mentioned I could use an overhead projector — standard equipment in all white schools at the time — neither the circuit inspector to whom I was speaking nor his deputy even knew how they worked."

Similar problems were encountered when she applied to attend Rhodes University the following year.

"My application was turned down on the grounds that the campus was located on a hill and I would have problems getting about," said Ms Jagoe.

"But once the Rhodes authorities realised I intended to arrive anyway they were very good to me and even adapted a house."

Part of the difficulty was the "string of stereotypes" with which people associate those who are disabled.

"They think of us as dependent, pitiable or unemployable.

"If we're none of these things, then we're brave," said Ms Jagoe.

Little infuriates her more than being described as "courageous", "unusual", "unique" or "exceptional".

"I'm only doing what other disabled people could do if they'd had my opportunities," she said.

Ms Jagoe is also vehemently against 'special' schools for orthopaedically disabled people.

Describing these schools as a "disaster", she said she was pleased with her decision to return to her own school after her accident.

"I was lucky in that I had people I could use as my role models.

"Two of the pupils at my school were polio victims walking with crutches and callipers, while my mother had a very badly disabled friend who had a job.

"It is important for people to have these role models, and for me that is the value of publicising individuals in the media."



● Kathy Jagoe says she has no qualms about asking for help — and describes the public reaction as "very good".

She has fought back to ...

299 S. Express 7/8/83

Research action for wheelchair folk

KATHY'S formal work involves an 'action reseach project' aimed at overcoming architectural barriers and discriminatory attitudes and sending disabled people back into the mainstream of society.

Informally it could best be summed up as a move to bring people with disabilities out of homes and institutions into an arena where, as consumers, they have the right to make demands to meet their needs.

She has been working on this project since she moved to the Transvaal in 1981 and obtained sponsorship from several trust funds and business concerns, but she doubts it will be completed before funds run out at the beginning of the year.

"My role is to make people such as architects, doctors, occupational therapists and physiotherapists understand the difficulties facing disabled people," explained Ms Jagoe.

To this end she gives numerous lectures to students at the University of the Witwatersrand in these fields as well as acting as a consultant to various architectural concerns.

She has been instrumental in setting up support groups to provide a peer counselling service — resembling that run by bodies such as Alcoholics Anonymous — to help people who are newly disabled or about to start a new job, school or university.

She has also made a concerted attempt to force awareness upon the general public about the handicaps imposed by society.

"My disability itself is not a disaster — it is the environment that makes it so," she said firmly.

and Shipping

Blind workers provide valuable labour source

299 E.P 05 11/8/83

By LOUIS BECKERLING
Business Editor

A VALUABLE source of labour overlooked by many industrialists is provided by the Port Elizabeth Society for the Blind.

The secretary, Mr Denis Glendining, points out that highly competitive wage rates are charged by the subsidised society, which is thus in a position to provide a cost-effective service despite the limitations of its members.

One Port Elizabeth company making beneficial use of the society is Sentech Industries (Pty) Ltd, manufacturer of components for the original and replacement markets in the automotive industry.

The managing director and joint owner of Sentech, Mr Peter de Klerk, told the Evening Post yesterday that his company had approached the society about four months ago and was delighted with the service provided.

"We manufacture clamps for the replacement market in exhaust systems, and this involves zinc-plating U-bolts and allied "saddles", together with washers and nuts — the washers we manufacture ourselves, though we buy-in the nuts.

"We send a variety of sizes, together with collapsed cartons, to the society and the workers marry together the U-bolts, saddles, washers and nuts, and pack them into the cartons.

"We provided a special guage which the blind workers can use to ensure that the different sizes are not mixed up during the packing process."

Mr De Klerk says Sentech is delighted with the standard of the work and "had we more work we certainly would offer it to the society".

He adds that he has not yet finely calculated the cost-saving available as a result of employing blind workers and imagined that such a saving did exist.

"But the reason we had to have the work done outside of the factory is that currently we have a space problem and thus looked elsewhere."

Mr De Klerk hastens to add that his company's space problem will shortly be resolved when it moves to premises twice the size of its existing operation.

"Good news for Port Elizabeth, I suppose, is that despite the recession we are currently working at near to full capacity — even with a little overtime."

Apart from Sentech's expansion to larger premises, this demand has led to the import of a computer-numerical pipe-bending machine with application in several areas, including the bending of fuel filler pipes.

Mr De Klerk attributes the success of his company to the fact that, whereas these filler pipes were previously imported, his company has acquired contracts from three Eastern Cape motor manufacturers — BMW, Sigma and CDA — for the local manufacture and supply of the pipes.

Mr Glendining said the members of the society were available to do a wide variety of tasks that either did not require sight or could be supervised by those with limited vision.

Jobs currently done by the society include:

- The wiring and eye-letting of tags (R39,78/'000).
- Affixing gummed pre-addressed labels onto envelopes (R6/'000).
- Folding and inserting bulletins or brochures into envelopes (R11/'000).
- Packaging of screws (R8/'000).

Mavuso realises dream



VISIBLY MOVED: Mr Friday Mavuso dabs his tear-streaked eyes during a function to mark the official opening of the international sports centre for the disabled.

THE well-known campaigner for the better treatment of paraplegics, Mr Friday Mavuso, who was crippled by a police bullet himself, wept openly at the official opening of the R5-million sports complex for disabled people in Soweto.

By ELLIOT TSHINGWALA

Addressing over 100 people who attended the launching of the first of three phases of the international sports stadium, in a speech interspread by sobs, Mr Mavuso told how he struggled through the difficult years walking from door-to-door begging for money to build the centre.

Mr Mavuso, a former sportsman and keep fit enthusiast who became paralysed after he was shot by police nine years ago, said he became aware of the frustrations of the disabled while in hospital.

He had seen men, who before their accidents were the family breadwinners, disintergrate and "rot" because of society's attitude towards them.

A fund was started at the hospital by nurses, doctors and other staff members after he had arranged several meetings to air the plight of his fellow disabled. It became very successful and he thought it was going to be a permanent thing until the hospital authorities intervened and stopped it.

After he was discharged from the hospital he made several attempts to get sponsors to help build a centre for the disabled but was met everywhere with empty promises.

After nearly losing hope Mr Mavuso said he was introduced to the South African Sports Association for the Physical Disabled who promised to "look into the problem."

"I did not have much hope as I had been disappointed on several occasions. As a try I decided to play on," Mavuso said.

Soon afterwards things started moving with a R1-million Government grant and a site near the Dube Bowling Club.

Building of the first phase, which comprises of a workship and a hall, followed soon thereafter. The second and third phases — which includes volleyball and basketball courts, an archery range, a swimming pool and a place for field events such as javelin and shot put — will be completed at the end of 1984.

The day to day running of the centre will be in the hands of Mr Mavuso and his committee.



Dr P van der Merwe, director general of the Department of Manpower and Mrs Priscilla Stevenson, head of training at Access College, seen here with one of the students.

New centre for disabled

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Sowela 2/10/83

By SELLO RABOTHATA

A CENTRE for advanced education for paraplegics, called Access College, has been established at Avalon Centre, near Kensington, Johannesburg, and it caters for all race groups.

This is the first of its kind in South Africa. The physically disabled students are able to study in accessible surroundings and achieve recognised qualifications available to able-bodied people.

Lectures for 12 selected students started on Monday, September 5. These students were selected from among more than 100 applicants wishing to undertake a six months' course covering business studies (business methods, business English, calculations and accounting); typewriting, telesales and market research; work preparedness, self-management, and practical office techniques.

Access College will help its students to develop skills which are needed by commerce and industry, and therefore earn realistic salaries in the open labour market. The courses are designed to emphasise the residual ability, and not to concentrate on the disability, as is often the case in sheltered employment, eg. touch-typing will be taught to persons who have the use of one or both hands.

"There is no reason why a person who is paralysed from the neck down, who has been taught to type accurately, knows layout, typing of business letters, invoices and so on, should not work a word processor as effectively as an able-bodied person," said Mrs Priscilla Stevenson, head of training. "We are very fortunate to have lecturers from the business sector, who have made their courses available to us and lectures from the Human Resources Institute and the Foundation for Business Studies.

"Participation in class activities, mastering of self-management techniques, and preparation for work are considered equally as important as having the skills to do the job. We believe that the time has come for people with disabilities to take their rightful places in society, to become tax payers rather than tax users. We abhor the old-fashioned "welfare" approach of giving hand-outs. We expect something from our students, and the beauty of it is, we get it," Mrs Stevenson said.

Financed initially by the Cripple Care Association of Transvaal, and with some generous donations from companies like IBM — who have donated 20 self-correcting golfball typewriters — Access College has been designed to create a modern office environment where correct habits are taught.

According to Mrs Stevenson, the first "graduates" are expected by May next year, after six months of lectures and one month of practical experience. "Classes will take place from 8.30 am to 4.30 pm, five days a week, to build up tolerance, and a tuition fee of R450 is charged. This in no way covers the full cost of approximately R4 500 per person, since lecturers' fees have to be paid and allowances made for the cost of setting up the college," Mrs Stevenson said.

Access College will also be providing an employment placement service, not only for the students enrolled for the course, but also for other physically disabled people. This will be headed by Ms Phyllis Woolf, who is experienced in this field.

Plea for funds to aid township handicapped

Star 14/11/83

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At last it's happening. This is the feeling of these four members of the committee behind the building of a centre for handicapped children in Alexandra Township. From left: Mrs Constance Mngomezulu, vice-chairman of the committee, Dr Joan Wagner, committee member, Mrs Pauline Mkalipe, chairman, and Mrs Ziona Steinbuch, chairperson of the Saida Toy Library and also a committee member, look at the work done by Mr Ephraim Manzini, who last week began levelling the site for the new Nokuthula Centre.

By Staff Reporters

A bulldozer levelling the site was the sign to hundreds of handicapped children of Alexandra Township north of Johannesburg that some people care very much about them.

The Nokuthula Centre for handicapped children — a first in this township — is slowly rising on the piece of ground next to the Alexandra Clinic.

In spite of the lack of money that plagues so many community service efforts, the people behind this new facility for Alexandra are detemined to open doors early in the new year.

Last week The Star's TEACH Fund, convinced of the real need for a place where handicapped children can be cared for and learn, sent a cheque for R20 000 to the Nokuthula Committee for the centre.

With the other donations that have so far been raised the committee has almost R59 000 in the kitty, about half of what is needed to complete the centre.

"Frankly, our financial position is terrifying," said Dr Joan Wagner, one of the Nokuthula Committee.

But the need in Alexandra dictated that risks had to be taken. The committee swallowed hard and commissioned the contractors to move on to site and erect the prefabricated structure as soon as possible.

"We aim through this centre to help the children to learn as much as they can and also to provide relief for their families, particularly for the mothers who need to work," Dr Wagner said.

"The centre is a desperately needed one and sadly overdue."

According to a doctor member of the Nokuthula Committee, between 300 and 400 children attending the Alexandra clinic have been diagnosed over the past seven years as needing the care this centre could give them.

At first only a small number of children would be admitted but it was hoped up to 70 children would eventually be cared for there, Dr Wagner said.

Staff members at the centre will include a supervisor, a social worker, speech and occupational therapists, a physiotherapist and three assistants, a driver (to transport the children to and from the centre) and two domestic servants.

Besides the R100 000 it will cost to build and the R26 000 needed to equip it, Nokuthula will cost at least R39 500 a year to run.

"We do hope the public will respond to our appeal for funds to build this centre," said Dr Wagner who also works part-time at the busy Alexandra clinic.

Chairperson of the committee behind the centre is Mrs Pauline Mkalipe of Alexandra. Her vice-chairperson, Mrs Constance Mngomezulu, has been appointed supervisor of Nokuthula.

The committee has also embarked on a drive to encourage the public to become members of Nokuthula at an annual fee of R10 or a life membership fee of R150.

A "Buy-a-brick-to-build-Nokuthula" drive has so far brought in nearly R800, Dr Wagner said.

Donations may be made out to Nokuthula Centre and sent to P O Box 150, Bergvlei 2012.

Below are a list of the main donations to date to the Nokuthula Centre:

- TEACH — R20 000.
- Anglo American — R20 000.
- JCI — R10 000.
- Lowenstein Trust — R5 000.
- Premier Milling — R1 000.
- Gencor — R500.
- Mr U Fritelli — R150.
- Mrs C Visser — R50.
- Mrs J Hallett — R50.
- Rennies — R100.
- Dr Ismail — R75.
- FNP — R50.
- Toyota — R500.
- Buy-a-brick — R795.
- Membership — R230.

Social Security

→ Medicare

1984 → 1986

New jobs boost for handicapped

297
Herald
12/1/84

By Nazeem Howa

MOST people do not consider handicapped people to be normal. And even slightly disabled people are finding it increasingly difficult to persuade employers to give them jobs, mainly because of this preconceived notion.

In an attempt to help the thousands of disabled people who are unable to find suitable employment, a Goodwood man has decided to start an employment agency for disabled people only.

Mr Charles Geldenhuys, who is also disabled, decided to start the agency after he had spent R120 advertising for employment through newspapers without receiving a single response.

"With this experience behind my back, I thought about the thousands of others, less fortunate than I am, who cannot find jobs either," he said.

"So I thought of opening this agency which will find work for others, while keeping me employed as well.

"We already have more than enough people looking for jobs, but we desperately need vacancies.

"We sent hundreds of letters to employers asking for positions. The response was fair, but we still need more vacancies," he said.

Mr Geldenhuys can be contacted at ☎ 54 4624 or through P O Box 418, Goodwood 7460.

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Here are helpers with facts about living more fully

Newly disabled people and their families are often at a loss on how to plan the different kind of life the disabled must lead. Others do not know to what extent disabled people can lead a full, economically active and independent life.

They can now apply to the Independent Living Centre (ILC) in Johannesburg for advice and information on aids available locally and overseas.

The ILC is open free of charge to people of any age, race or income group suffering from any form of disability.

It provides an information and demonstration service by professional staff (occupational therapist, physiotherapist and speech therapist) for all types of commercially available aids together with adapted household appliances and fittings to help the disabled become more independent at home, at work and during leisure time.

The equipment can be tried out in the area in which it is to be used as the centre is fully equipped with its own kitchen, bathroom, bedroom and other areas modified for the needs of disabled people.

Information concerning other services required as well as the rights of disabled persons is also available. The ILC provides contact with other people coping with similar problems if this is required.

The ILC is in Happiness House, 120 Loveday Street, and appointments should be made by phoning (011) 724-3225/6/7/8/9.



The additional living costs for a disabled person, excluding housing, medicines and doctors' bills, amount over 30 years to a staggering half a million rands.

Disabled people pay heavy price for their independence

The cost of being disabled is incalculable. How do you add up the value of two moving legs — even though compensation has been given? But today, options for disabled people allow for independence never dreamt of before. CARINA LE GRANGE reports.

Over a period of 30 years, at today's prices, the difference between the normal cost of living and that of the cost of living for a disabled person — excluding housing, medicines and doctors' bills — amounts to a staggering R500 000.

What this money would buy is all the equipment available and needed to make the life of a particular, severely disabled person as independent and worthwhile as possible. The amount would not, however, cover the initial cost of hospitalisation — usually lasting about six months at a cost of at least R50 a day.

The most basic aid needed by almost every disabled person is a wheelchair. And a self-propelled wheelchair costs between R490 and R650, with a pair of puncture-proof tyres adding another R44, and a fitted tray for working, eating and reading a further R150.

But the price can go up to R1 600 for a light (about 7,5 kg), strong and durable American model which is also suitable for games such as tennis. Special chairs suitable for rough terrains — especially needed for outings and trips and usually considered a luxury item — cost between R3 500 and R4 000.

Motorised wheelchairs — by no means a luxury considering the rough "normal" terrain disabled people often have to navigate since South African society is so inadequately geared to the requirements of the disabled — cost about R4 000.

A special model allowing the person to stand up straight — the elevating chair which is much needed for people holding down jobs — costs R2 800, while a combined motorised and elevating chair is as much as R4 500.

The biggest extra outlay for a wheelchair is the special cushion — designed to prevent pressure sores — which ranges from about R40 to R600 for the best on the market.

While wheelchairs are exempt from both import duty and GST — and this includes parts, service and repairs — it has to be replaced every two to five years.

A much more expensive item on the mobility front is a car. A conversion for the disabled costs about R400, but that is the least of the expenses since a more expensive and bigger type of automatic car is needed which has automatic door locks, electronic window and mirror controls as well as air conditioning.

The latter is necessary since the mechanism for the regulation of body temperature is usually also affected in disabled people.

This means that as much as R7 500 more would be spent than would otherwise have been the case. A car-top hoist or tail-gate hoist, in the case of a Kombi, for the lifting of the wheelchair would add R4 500.

Should a person be so severely disabled that he could not drive himself even with a conversion of a car, a salary for a driver/attendant would have to be taken into account.

Regarding accommodation, the cost of adding a bedroom and bathroom adapted to the needs of a disabled person, would run to about R27 500 — including the fee of the architect who is needed as this would be a specialist design job. Conversions to existing rooms would be cheaper but is not always feasible. In any case, other alterations to the house, such as making it accessible from the outside for the wheelchair, must also be taken into consideration.

In the case of disabled people living largely on their own and especially in the case of a disabled housewife, the kitchen would also have to be completely redesigned, often needing new equipment better suited to the specific needs of the case. Today, even normal kitchen renovations can cost between R10 000 and R20 000.

'More thought should be given to the quality of the life saved'

Hardest hit by disability are the poor and the middle income group on medical aid funds since these funds do not cover the cost of equipment for the disabled, says occupational therapist Mrs Margaret Thompson of the Independent Life Centre in Johannesburg.

Medical aid funds only pay for equipment needed for acute post-operative treatment, Mrs Thompson points out.

Thousands of rands are often spent on keeping people alive in intensive care units after an accident but the same kind of "financial" thought is often not given to the quality of the life that is saved, she adds.

"Technology advances almost daily — equipment that seemed sophisticated in 1980 can already be outdated. There is no longer a shortening of life span — and we should ensure that that life be as full as possible," she says.

A great deal is available to make life worthwhile if you can afford it — but the outlook can be bleak if you do not have finanical resources.

"Some companies are very good at assisting individual employees and may buy, for example, a specific piece of equipment. Men who are injured while doing their national service also receive a great deal of assistance, including follow-up treatment and visits."

State disability pensions are available only to people older than 16, which means that parents of disabled children receive no financial assistance from this source until their children reach the required age. The State does, however, provide free wheelchairs to those who need them.

Mrs Thompson says that many people disabled in car accidents are often unaware of compensation they may claim from third party insurance. Those who do may find that this goes a long way towards covering costs. In some cases, people have been awarded substantial sums which provide adequately for the rest of their lives.

The Independent Living Centre — being aware of specific needs — occasionally makes special appeals to service organisations such a Rotary club or through the radio services and the Press for financial assistance to aquire specific pieces of equipment. Organisations such as the Red Cross, Cripple Care and others also provide assistance.

But Mrs Thompson believes that more fund-raising organisations, such as 'Mobile Aid', which is being launched at Kenton-on-Sea and aims to raise money to buy equipment for the disabled, are desperately needed.



Technology advances almost daily, and sophisticated equipment means that severely disabled people can now live a fuller life.

EVENING POST, THURSDAY, FEBRUARY 2, 1984

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Blind workers claim they're getting raw deal

By CLAIRE PICKARD-CAMBRIDGE

TWO worker representatives at the Port Elizabeth Society for the Blind in Mount Road alleged today that workers had many grievances about their conditions of service and failed to receive the co-operation of the director, Mr Denis Glendining.

Mr John Peterson and Mr Dudley Thomas said workers believed Mr Glendining had "no understanding of blind people and their problems" and was not prepared to discuss decisions and grievances

They alleged that some workers had not been paid out the full Christmas bonuses and holiday pay owed to them.

"Now we would like sponsors to give us our bonuses personally at the end of the year so that we can be assured that donations are being correctly distributed," they said.

They were also dissatisfied with the food they were given and claimed they had not been receiving clothing and parcels sent to them by the public.

They said Mr Glendining had been the director for four years and these problems had not existed before his appointment.

Mr Glendining said he was not prepared to comment on the allegations, but dismissed claims that he was not prepared to give workers a hearing as "most unfair".

The chairman of the society, Mr Ed Millard, said he was concerned about the bonus issue and had already arranged for auditors to sort out the problem.

He said he could not comment on personal complaints levelled at Mr Glendining, but confirmed he had received similar ones on a previous occasion.

He said he had heard their complaints about the food and had just replaced the cook

"A blind organisation is also difficult to run because money is so tight and I can only appeal to the public to increase their donations to help matters along."

~~300~~ (299) ~~2561~~ 13/2/84

Hansard Q. 61. 150

Military disability pensions

211. Mr B B GOODALL asked the Minister of Health and Welfare:

(a) How many persons are in receipt of military disability pensions and (b) what amount was paid out in such pensions in respect of the year ended 31 March 1983?

The MINISTER OF HEALTH AND WELFARE:

(a) 12 449.

(b) R25 262 275.

Pay rise needed for disabled doing sheltered work

299 E. Post 25/2/84

Weekend Postbag

SIR — As a former State sheltered employee I should like to voice my concern at the conditions under which disabled people working in Government "shelters" have to work. Rehabilitation, the supposed purpose of these factories, is hardly attempted and a "graduation" to the open labour market is extremely rare.

Following are a few pertinent points:

(1) A maximum wage of R1,80 per hour is paid. Churches and welfare organisations have all repeatedly stated that a city worker cannot live decently on less than a mimimum of R3 per hour.

(2) Membership of the Public Servants Association is not open to them and they have no other union or staff association to fight for them.

(3) They have no pension fund to which they can contribute.

(4) They have no medical aid, apart from visits to the factories by district surgeons. Certificates of illness issued by private doctors are not accepted.

(5) State sheltered employees have only 21 days annual vacation as opposed to the minimum 30 days enjoyed by other public servants.

(6) They have only 21 days sick leave a year, while all other public servants get 40 on full pay.

(7) They are forced to work the April 6 and October 10 public holidays without receiving double pay as accorded to all other public servants and railwaymen.

(8) Their status is always temporary and they are always liable to instant dismissal.

The sheltered employment factories offer menial handiwork to people who often have great potential for more refined work and to whom no consideration is shown in this respect.

To see, for example, a former accountant spending the rest of his foreseeable future engaged in repeatedly glueing cloth to cloth or wood to wood is to see humiliation in the extreme.

The State treats these potentially productive people as rejects. Many have chronic psychiatric problems but are producing much more than they earn with the limited scope. Your child's newlybound library book or his school desk very probably have come from a sheltered factory.

I suggest an appropriate and deserved wage increase of at least 100% and an expansion of the choice and nature of work. Also that State sheltered employees who have a senior certificate or higher qualification be immediately appointed as clerks in the understaffed public service — people treated with respect and given human dignity respond with confidence in most cases.

It is absolutely scandalous that the Department of Manpower can use slave labour and pay starvation wages to persons working in factories under its control.

We as caring citizens in an uncertain world should not let the struggle of those who are hurt become yet another shelved plan. Nurses, the police, teachers and railwaymen all received huge pay adjustments over the past two years, but State sheltered employees who work the hardest of all received nothing.

CHRIS BEER
Sea Point

Private nursing: Medical aid call

CAPE TIMES Medical Reporter 17/3/84

SOUTH African nurses want medical aid societies to repay patients for the services of private nurses — and have drawn up a plan of action to achieve this.

The South African Nursing Association (Sana) stated at their central board meeting yesterday that the legislation should provide for the recognition of private nurses by medical aid societies.

The first phase of their plan is to educate other nurses, the medical profession and the general public.

They decided it was too soon to approach the Department of Health and Welfare at this stage.

It was also suggested that, as most nurses belonged to a medical aid society, they should lobby for this within their own societies.

The work of private nurses was extremely important, especially that done by midwives and those nursing the elderly.

Nurses should be accepted as independent professionals who did not have to rely on doctors to prescribe when they were needed.

Opening the meeting yesterday, the president of Sana, Professor Retha van Huyssteen, said many people held a low image of nursing, in spite of the fact that it was an independent profession with a proud history and a well-defined ethical code.

Natal: White 1 (December 1984)
Coloured 1 (December 1983)
Asian 1 (March 1984)
Black 23 (4 in December 1983, 1 in January 1984, 4 in February 1984, 1 in March 1984, 5 in April 1984, 3 in May 1984, 2 in June 1984, 1 in July 1984, 1 in August 1984, 1 in October 1984)

OFS: White 0
Coloured 0
Asian 0
Black 2 (1 in December 1983, 1 in July 1984)

Transvaal: White 1 (September 1984)
Coloured 1 (December 1983)
Asian 0
Black 11 (1 in December 1983, 3 in January 1984, 1 in April 1984, 2 in May 1984, 1 in October 1984, 2 in November 1984, 1 in December 1984)

(b) Deaths in all Provinces during the period December 1983 to December 1984: 0

(2) (a) health education
(b) continuation of an effective comprehensive immunization programme

(c) surveillance.

Hansard Q.601.811
25/3/85

Family planning section: staff complement

565. Mr G B D McINTOSH asked the Minister of Health and Welfare:

(1) (a) What is the staff complement of the family planning section of his Department and (b) how many posts in this section are vacant at present;

(2) whether any steps are being taken to fill these vacancies; if not, why not; if so, (a) what steps and (b) when is it anticipated that they will be filled?

The MINISTER OF HEALTH AND WELFARE:

(1) (a) 2 349.

(b) 598 posts as at 28.2.85.

(2) Yes.

(a) suitable applicants are being recruited on an ongoing staff recruitment basis.

(b) when suitable applicants become available, and with allowance for present financial constraints.

Substandard A

572. Mr H E J VAN RENSBURG asked the Minister of Co-operation, Development and Education:

How many Black children were enrolled in 1984 in Substandard A in (a) each specified region and (b) the Republic?

The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

The honourable member is referred to table 3.4.2., page 192 of the 1984 annual report of this Department.

Tsitsikamma Toll Road

584. Mr D J N MALCOMESS asked the Minister of Transport Affairs:

(1) Whether a viewing site is being developed at the Tsitsikamma Toll Road; if so (a) what is the total estimated cost involved and (b) what company is constructing it;

(2) whether tenders were called for the construction of the viewing site; if not, why not; if so, (a) who were the tenderers and (b) what was the tender price of each such company.

(3) whether the lowest tender was accepted; if not, why not?

The MINISTER OF TRANSPORT AFFAIRS:

(1) A rest area including a viewing site, picnic facilities, and ablution block, internal roads and parking areas, a tourist information centre and the caretakers accommodation is under construction at the Tsitsikamma Toll Road.

(a) R3,7 million.

(b) Messrs. L.T.A. Earthworks (South).

(2) (a), (b) and (3).

No. In view of the circumstances set-out below the work was performed as a supplementary brief to an existing contract in respect of which tenders were invited. Factors taken into account by the National Transport Commission in not inviting tenders for this part of the work were as follows:

(i) The remoteness of the site;

(ii) To limit construction costs. The contractor was already working on the road adjacent to the rest area; and

(iii) The undesirability of engaging more than one contractor to carry out work on a small site.

Tenders were, however, called for by L.T.A. Earthworks (South) in respect of the construction of facilities at the rest area including electrical installations and power supply units

Buildings:	R million
(i) LTA Building (Eastern Province)	1,55
(ii) B and E Construction	1,61
(iii) Andrew Hannah and son	1,64

As the tendered prices were all considered to be too high the work was undertaken by L.T.A. Earthworks (South) with the assistance of a masonry sub-contractor, Eastern Cape Contracting Services, at a total cost of R880 000.

Electrical installations:	R
(i) Elmec Industrial	396 427
(ii) Crown House Engineering	425 074
(iii) Smith and Weldrich	420 241

The lowest tender namely that of Elmec Industrial was accepted.

Power supply units:	R
(i) Meisner	85 000
(ii) V and R Engineering	93 245

The lowest tender namely that of Meisner was accepted.

399 Hansard
Q.601.814 25/3/85

Military disability pensions

594. Mr B B GOODALL asked the Minister of Health and Welfare:

(a) How many persons are in receipt of military disability pensions and (b) what amount was paid out in such pensions in respect of the year ended 31 March 1984?

The MINISTER OF HEALTH AND WELFARE:

(a) There are currently 12 252 Military pensions in payment.

(b) R26 816 603.

in infant colic and in infants under six months of age is currently being investigated by the Council and a decision in this regard is to be taken at its meeting on 19 April 1985.

Institutions/centres for disabled persons

642. Dr M S BARNARD asked the Minister of Co-operation, Development and Education:

(1) Whether his Department has statistics on (a) institutions for disabled persons and (b) handcraft centres in the national states; if not, why not; if so,

(2) how many (a) institutions for the (i) blind, (ii) deaf and (iii) physically disabled and (b) handcraft centres are there in (aa) KwaZulu, (bb) Qwa-Qwa, (cc) Lebowa, (dd) Gazankulu and (ee) KaNgwane at present;

(3) in respect of what date are these statistics furnished?

The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

(1) (a) Yes, in respect of schools only.

(b) No, because handcraft centres are not controlled by the Education Departments.

(2) (a) (aa) (i) 2 schools.

(ii) 2 schools.

(iii) 1 school.

(bb) (i) 1 school.

(ii) 1 school.

(iii) None.

(cc) (i) None.

(ii) None.

(iii) 1 school.

(dd) (i) None.

(ii) 1 school.

(iii) 1 school.

(ee) (i), (ii) and (iii) None.

(b) Not applicable.

(3) Figures are as on 1 March 1984.

KwaZulu has four schools of which one caters for both death and blind pupils.

Qwaqwa has only one school which caters for both deaf and blind pupils. Gazankulu has only one school which caters for both death and physically disabled pupils.

Pinetown/New Germany: strikes

661. Mr R M BURROWS asked the Minister of Manpower:

(1) Whether any legal and/or illegal strikes occured in the Pinetown/New Germany industrial area in the latest specified year for which figures are available; if so, how many (a) legal and (b) illegal strikes;

(2) whether the South African Police were called in respect of any of these strikes; if so, (a) on how many occasions, (b) how many persons were involved in (i) legal and (ii) illegal strikes in each race group in this area and (c) what were the causes of these strikes?

The MINISTER OF MANPOWER:

(1) According to the records of the Department of Manpower there were no legal strikes in the Pinetown/New Germany industrial area during 1984.

(a) Falls away.

(b) 29.

(2) The Department of Manpower is not aware of and does not keep a record

of Police involvement in strike action.

(a), (b) and (c) fall away.

Footnote: In regard to 1(b) above, the position is as follows:

Workers involved	
Whites	None
Coloureds	48
Asians	746
Members of the Black Population group	4464
Reasons	
Wages	11
Disciplinary measures	5
Conditions of employment	11
Other reasons (Retrenchment)	2

South African Army Women's College

668. Mr P A MYBURGH asked the Minister of Defence:

(a) When was the South African Army Women's College in George established, (b) what were the reasons for establishing the college at that time, (c) how many trainees were based at the college in each specified year since its establishment up to the latest specified year for which figures are available and (d) what is the nature of the training given at this college?

The MINISTER OF DEFENCE:

(a) In 1977 as a development of the Civil Defence College which was established in 1970.

(b) The reason for the establishment of the Civil Defence College was to train young women as future leaders in Civil Defence and to motivate them to perform community service.

When the SA Army College was established the rôle was changed to train young women

—In military skills with a view to attestation in the Permanent Force and the Citizen Force and Commandos.

—To prepare them more fully to play a leading rôle in the South African community.

(c)

1971	128
1972	137
1973	146
1974	152
1975	147
1976	150
1977	151
1978	229
1979	232
1980	222
1981	309
1982	309
1983	330
1984	166
1985	211

Note: Between 1978 and 1983 there were two intakes per year.

(d) It consists of practical and theoretical training in the following subjects:

Squad drill, marksmanship and field craft, first aid, military traditions and customs, personnel, stores and pay administration, telecommunications, fundamentals of civil defence, fire fighting, self defence, physical training and leadership training.

South African Army Women's College

669. Mr P A MYBURGH asked the Minister of Defence:

(1) (a) What was the staff establishment of the South African Army Women's College at George as at the latest specified date for which figures are available and (b) in respect of what posts are these figures given;

(2) whether all the members of the college staff are uniformed members of the South African Defence Force; if not, (a) why not, (b) how many (i) are and (ii) are not uniformed members of the Defence Force and (c) (i) what categories of posts are filled by persons not in uniform and (ii) how

New medical tariff scheme will lead to chaos — PFP

Parliamentary Staff

THE PROPOSED new system of determining medical tariffs according to free market principles will lead to "chaos", the official opposition has warned.

The Medical Schemes Amendment Bill, which was introduced in the Assembly yesterday, was slammed by the official opposition and the Conservative Party which believes it is the first step towards a Socialist medical service.

According to the Bill, doctors' and dentists' tariffs will no longer be determined by the SA Medical and Dental Council, but through negotiations between medical aid schemes and medical practitioners.

Introducing the second reading debate on the Bill, the Ministe Of Health and Welfare, Dr Nak van der Merwe, said the present system was clumsy and had been severely criticised.

The Minister was placed in an insiduous position in approving tariffs because he had to judge on conflicting evidence.

IGNORED

Medical schemes believed they were being ignored, while medical partitioners regarded the Minister as "the fly in the ointment".

With the new system, all red tape and friction would be removed. An additional advantage was that pratitioners and medical schemes had to negotiate, but each would act independently if there was a deadlock.

The market mechanism would force the parties to act realistically in determining fees, he said.

Dr Marius Barnard (PFP Parktown) said the Medical Association was not 100 percent happy with the Bill, while the association of private hospitals was very unhappy with the provisions of the Bill.

Moving an amendment that the Bill be referred to a Select Committee, Dr Marius Barnard (PFP Parktown) said the bill gave medical schemes the final power in determining fees.

There was a danger that the parties would not agree and without controls there would be chaos.

Dr M H Veldman (NP Rustenburg) said doctors and dentists were happy with the Bill. The medical profession did not want the State to meddle in its affairs.

In addition the "unsavoury" seasonal debates on tariff increases could now be done away with.

Mr W J Snyman (C P Pietersburg) said the Bill would leave medical practitioners without any bargaining power. In the final analysis, medical schemes would take a one-sided decision on tariffs.

The Conservative Party viewed the masure as a step towards a Socialist system of medical services, and this was unacceptable.

"It is unacceptable because quality and initiative will suffer and it will cost tax payers more," he said.

Mr A G Thompson (NRP South Coast) rejected earlier claims that doctors were unhappy about the system. The legal advisor of the Medical Association had told the NRP that the association was "99 percent happy" with the Bill.

The NR P would support the Bill because the free market system would be put into effect where the suplier of a service and the recipient could negotiate on tariffs without interference from the Minister.

The present system was degrading for the prefession because they continually had to haggle about tariffs.

Ultimately the new system would benefit John Citizen, he said.

Replying to the debate, the Minister of Health, Dr Nak van der Merwe said the bill did not concern more money for medical practitioners but their right to organise their own affairs.

The Bill was read a second time with the PFP and the CP voting against it.

(2) (a) Commuters 6 215
(b) Migrants 22 445

Children's homes

597. Mr A B WIDMAN asked the Minister of Co-operation, Development and Education:

(a) How many (i) State and (ii) privately administered children's homes were there for Black children in the Republic as at the latest specified date for which figures are available and (b) how many children were accommodated in these homes as at that date?

The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

(a) (i) Nil.

(ii) Nine (31 January 1985).

(b) 665 children.

KwaNdebele

598. Mr R A F SWART asked the Minister of Co-operation, Development and Education:

(a) How many houses were built in KwaNdebele by (i) his Department, (ii) other specified statutory bodies, (iii) the KwaNdebele authority and (iv) private builders in 1984; (b) what type or types of housing were built and (c) what was the total cost involved to each such body in that year?

The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

(a) (i) Nil.

(ii) 125 by KwaNdebele Development Corporation.

(iii) Nil.

(iv) The number is unknown but thousands of Ndebele built their own homes.

(b) (i) Nil.

(ii) Improved 51/9-type four-roomed houses.

(iii) Nil.

(iv) All types, ranging from traditional homes to three- and four-roomed houses built according to approved plans.

(c) (i) Nil.

(ii) R1 620 500.

(iii) Nil.

(iv) Unknown.

Apart from the above, 1 387 houses have been built by the East Rand Development Board at Ekangala outside KwaNdebele and to date R10,5 million have been spent on the provision of services and erection of houses and community facilities there.

Contributions in respect of Black Labour Act

611. Mr E K MOORCROFT asked the Minister of Co-operation, Development and Education:

(a) what amount of money was collected from farmers in the area under the jurisdiction of the Eastern Cape Development Board as contributions in respect of Black workers under the Contributions in respect of Black Labour Act, No 29 of 1972, and (b) what service or services are rendered to farmers by the Board in respect of these contributions?

The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

(a) R369 880 during the 1983/84 financial year.

(b) The Board arranges and regulates seasonal and full-time labour, assists

with the selection and recruitment of suitable labourers from the national states and from independent states, assists where necessary when disputes arise between employer and employee, assists with the settlement of pensioners and displaced persons who are dismissed by farmers and combats squatting.

Immunization of children

624. Dr M S BARNARD asked the Minister of Health and Welfare:

What percentage of (a) White, (b) Coloured, (c) Asian and (d) Black children in South Africa had been immunized by the State against (i) whooping cough, (ii) measles, (iii) diptheria, (iv) poliomyelitis and (v) tuberculosis as at the latest specified date for which figures are available?

The MINISTER OF HEALTH AND WELFARE:

The information as requested is not readily available.

Disability pensions

632. Mr W V RAW asked the Minister of Health and Welfare:

How many war disability pensions were (a) awarded and (b) terminated by (i) death and (ii) cancellation in each year since 1970 up to the latest specified year for which figures are available, and (c) how many in each case were veterans of (i) World War I, (ii) World War II and (iii) the Korean War?

The MINISTER OF HEALTH AND WELFARE:

The present computer program does not register individual award and cancellations of Military Pensions on a current basis.

The information requested is thus not available.

A summary of the total numbers of pensioners who received pensions during the relevant years as reflected in annual reports are quoted below:

	World War I	World War II	Korean War
1970	1 295	16 393	8
1971	1 108	15 491	9
1972	1 041	15 157	9
1973	1 000	14 876	9
1974	922	14 498	9
1975	844	14 027	9
1976	547	13 718	9
1977	474	13 239	9
1978	415	12 699	9
1979	315	12 178	9
1980	321	11 692	9
1981	309	11 460	9
1982	270	10 820	8
1983	237	10 203	8
1984	172	9 104	8

Adoption

649. Mr A B WIDMAN asked the Minister of Co-operation, Development and Education:

How many Black children were placed in adoption in terms of the Children's Act in 1984?

The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

346.

Black Communities Development Act

656. Mr P R C ROGERS asked the Minister of Co-operation, Development and Education:

Whether each Development Board has co-opted persons to serve on each of the committees as laid down in section 8 of the Black Communities Development Act, No 4 of 1984; if so, (a) who are the persons so co-opted on each committee of each Development Board, (b) for what periods were they co-opted and (c) what are their (i) qualifications and (ii) experience in each case; if not, (aa) why not and (bb) when is it anticipated that these persons will be co-opted?

(2) (a) Commuters 6 215
(b) Migrants 22 445

Hansard Q. Col. 1123 16/4/85

Children's homes

597. Mr A B WIDMAN asked the Minister of Co-operation, Development and Education:

(a) How many (i) State and (ii) privately administered children's homes were there for Black children in the Republic as at the latest specified date for which figures are available and (b) how many children were accommodated in these homes as at that date?

The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

(a) (i) Nil.

(ii) Nine (31 January 1985).

(b) 665 children.

Hansard Q. Col. 1123 16/4/85

KwaNdebele

598. Mr R A F SWART asked the Minister of Co-operation, Development and Education:

(a) How many houses were built in KwaNdebele by (i) his Department, (ii) other specified statutory bodies, (iii) the KwaNdebele authority and (iv) private builders in 1984; (b) what type or types of housing were built and (c) what was the total cost involved to each such body in that year?

The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

(a) (i) Nil.

(ii) 125 by KwaNdebele Development Corporation.

(iii) Nil.

(iv) The number is unknown but thousands of Ndebele built their own homes.

(b) (i) Nil.

(ii) Improved 51/9-type four-roomed houses.

(iii) Nil.

(iv) All types, ranging from traditional homes to three- and four-roomed houses built according to approved plans.

(c) (i) Nil.

(ii) R1 620 500.

(iii) Nil.

(iv) Unknown.

Apart from the above, 1 387 houses have been built by the East Rand Development Board at Ekangala outside KwaNdebele and to date R10,5 million have been spent on the provision of services and erection of houses and community facilities there.

16/4/85

Contributions in respect of Black Labour Act

Hansard Q. Col 1124

611. Mr E K MOORCROFT asked the Minister of Co-operation, Development and Education:

(a) what amount of money was collected from farmers in the area under the jurisdiction of the Eastern Cape Development Board as contributions in respect of Black workers under the Contributions in respect of Black Labour Act, No 29 of 1972, and (b) what service or services are rendered to farmers by the Board in respect of these contributions?

The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

(a) R369 880 during the 1983/84 financial year.

(b) The Board arranges and regulates seasonal and full-time labour, assists

HoA

with the selection and recruitment of suitable labourers from the national states and from independent states; assists where necessary when disputes arise between employer and employee, assists with the settlement of pensioners and displaced persons who are dismissed by farmers and combats squatting.

Immunization of children

624. Dr M S BARNARD asked the Minister of Health and Welfare:

What percentage of (a) White, (b) Coloured, (c) Asian and (d) Black children in South Africa had been immunized by the State against (i) whooping cough, (ii) measles, (iii) diptheria, (iv) poliomyelitis and (v) tuberculosis as at the latest specified date for which figures are available?

The MINISTER OF HEALTH AND WELFARE:

The information as requested is not readily available.

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Disability pensions

Q. Col. 1125 16/4/85

632. Mr W V RAW asked the Minister of Health and Welfare:

How many war disability pensions were (a) awarded and (b) terminated by (i) death and (ii) cancellation in each year since 1970 up to the latest specified year for which figures are available, and (c) how many in each case were veterans of (i) World War I, (ii) World War II and (iii) the Korean War?

The MINISTER OF HEALTH AND WELFARE:

The present computer program does not register individual award and cancellations of Military Pensions on a current basis.

The information requested is thus not available.

A summary of the total numbers of pensioners who received pensions during the relevant years as reflected in annual reports are quoted below:

	World War I	World War II	Korean War
1970	1 295	16 393	8
1971	1 108	15 491	9
1972	1 041	15 157	9
1973	1 000	14 876	9
1974	922	14 498	9
1975	844	14 027	9
1976	547	13 718	9
1977	474	13 239	9
1978	415	12 699	9
1979	315	12 178	9
1980	321	11 692	9
1981	309	11 460	9
1982	270	10 820	8
1983	237	10 203	8
1984	172	9 104	8

Adoption Hansard Q. Col. 1126 16/4/85

649. Mr A B WIDMAN asked the Minister of Co-operation, Development and Education:

How many Black children were placed in adoption in terms of the Children's Act in 1984?

The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

346.

Hansard Q. Col. 1126

Black Communities Development Act 16/4/85

656. Mr P R C ROGERS asked the Minister of Co-operation, Development and Education:

Whether each Development Board has co-opted persons to serve on each of the committees as laid down in section 8 of the Black Communities Development Act, No 4 of 1984; if so, (a) who are the persons so co-opted on each committee of each Development Board, (b) for what periods were they co-opted and (c) what are their (i) qualifications and (ii) experience in each case; if not, (aa) why not and (bb) when is it anticipated that these persons will be co-opted?

†The CHAIRMAN OF THE HOUSE: I offer my apologies, because I was under the impression that the hon the Leader of the Official Opposition referred to a debate.

†The LEADER OF THE OFFICIAL OPPOSITION: That is where the information was made known.

Sandy Bay: report

*6. Mr R R HULLEY asked the Minister of Environment Affairs and Tourism:

(1) Whether he has received the report of the Management Committee for the Cape Peninsula Nature Area on the proposed development of Sandy Bay; if not, why not; if so, when;

(2) whether he has taken a decision in this regard; if not, when is it anticipated that a decision will be taken; if so, what (a) are the (i) findings and (ii) recommendations of the report and (b) is the nature of his decision in this regard;

(3) whether he will make a statement on the matter?

The MINISTER OF ENVIRONMENT AFFAIRS AND TOURISM:

(1) Yes, on 23 April 1985.

(2) No. A decision will be taken as soon as practicable.

(a) (i), (ii) and (b) Fall away.

(3) Possibly in due course.

Hansard Q.Gl.1483
14/5/85

Langa/Guguletu: swimming pools

*7. Mr C W EGLIN asked the Minister of Co-operation, Development and Education:

(1) Whether any repairs, renovations or other work has been carried out on the swimming pools in Langa and Guguletu since his reply to Question No 70 on 26 February 1985; if not, why not; if so, (a) what specified work has been undertaken, (b) on what dates was this work carried out, (c) what work remains to be done, (d) what total amount had been spent in this regard as at the latest specified date for which figures are available and (e) when is it anticipated that this work will be completed;

(2) whether any further work is to be carried out in respect of these facilities; if not, why not; if so, (a) what work and (b) what is the estimated cost of this work:

†The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

(1) (a), (b), (c), (d) and (e) No. The task is complicated and the Development Board was compelled to make use of consultants. The consultants will be appointed shortly and the repairs and renovations will be effected during winter.

(2) (a) and (b) Apart from the repairs and renovation, for which R150 000 was found, no work except normal maintenance is foreseen.

Hansard
Q.Gl.1484 14/5/85

Legal Aid Board

*8. Mr D J DALLING asked the Minister of Justice:

(1) Whether an office of the Legal Aid Board has been opened at Mitchells Plain; if so, (a) on what date, (b) what is its staff complement and (c) how many applications for legal aid were handled through this office since it was opened up to the latest specified date for which statistics are available; if not,

(2) whether there is an office of the said Board which serves the needs of the Mitchells Plain community; if so, (a)(i) which office and (ii) where is it situated, (b) what is its staff complement and (c) how many applications for legal aid were handled through this office during the latest specified period of six months for which statistics are available?

†The MINISTER OF JUSTICE:

(1) I have approved the recommendation by the Legal Aid Board that certain offices be created to enable the Legal Aid Board to open an office in the Mitchells Plain area and am now in the process of consulting the Minister of Finance in terms of the Act before appointing officers. In arriving at this decision, Mr Landers MP for Mitchells Plain has played a meaningful part.

(2) Yes.

(a) (i) Athlone.

(ii) Amelia House, Room 401, 211 Belgravia road, Athlone.

(b) 8.

(c) During 1984, 1 892 applications were received at Athlone and 417 at Cape Town from people resident at Mitchells Plain.

Evasion of military service

*9. Mr P R C ROGERS asked the Minister of Defence:

Whether the South African Defence Force is informed or keeps records of South African citizens who are liable for military service and have been evading such service by obtaining (a) citizenship of and/or (b) permanent residence status in Transkei, Bophuthatswana, Venda or Ciskei while continuing to reside in the Republic of South Africa; if so, how many cases of this nature are known to the Defence Force to have occurred during the latest specified period of five years for which statistics are available?

†The MINISTER OF DEFENCE:

No (a) and (b) fall away.

Hansard
Q.Gl.1483

Duncan Village

*10. Mr R A F SWART asked the Minister of Co-operation, Development and Education:

14/5/85

(1) Whether, with reference to his reply to Question No 343 on 14 March 1985, any residents of Duncan Village remain to be resettled; if so, how many;

(2) whether he has decided to reconsider the resettlement of Black communities; if so,

(3) whether the remaining residents of Duncan Village are still to be resettled; if so, (a) why and (b) when;

(4) whether he will make a statement on the matter?

The DEPUTY MINISTER OF DEVELOPMENT AND OF LAND AFFAIRS:

(1) Yes. Approximately 10 000.

(2) All previous decisions regarding the resettlement of Black communities are being reviewed. No final decision has been taken regarding Duncan Village.

(3) (a) and (b) falls away.

(4) No.

299 Hansard
Q.Gl.1486 14/5/85

Chronically ill aged persons

*11. Mr R A F SWART asked the Minister of Co-operation, Development and Education:

(1) Whether his Department has any facilities for the care of chronically ill aged Black persons; if so, (a) where are they situated in each case, (b) what total number of persons can be accommodated in these facilities and (c) what amount was budgeted for the care of the chronically ill aged in the 1984-85 financial year; if not, why not;

(2) whether he intends making provision for chronically ill aged Black persons; if not, why not; if so (a) what provision is to be made in this regard and (b) when?

†The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

(1) Yes.

(a) Krugersdorp.

(b) 150.

(c) R447 000.

(2) Yes.

(a) Accommodation is planned for a further 200 patients at the Rietgat Project in Soshanguve.

(b) It is not possible to indicate a date on which this facility will be completed, but it will possibly be ready by 1989.

The national states also have institutions for such care and chronically ill Black patients are also treated in provincial hospitals at the expense of the Department of Co-operation and Development.

Hansard Q.61.1487

Moutse area: consolidation

14/5/85

*12. Mr P G SOAL asked the Minister of Co-operation, Development and Education:

(1) With reference to his reply to Question No 845 on 26 April 1985, (a) what is the nature of the reports concerning consolidation which are being considered by the Government and (b) by whom were these reports drawn up;

(2) whether the Government has reached a decision regarding these reports; if not, when is it anticipated that a decision will be reached; if so, (a) what is the nature of the decision and (b)(i) when and (ii) with whom will further discussions take place;

(3) whether he or any member of the Government has received any representations regarding the decision to add the district of Moutse to KwaNdebele; if so (a) when, (b) from whom and (c) what was the (i) nature of the representations and (ii) response thereto;

(4) whether he will make a statement on the matter?

The DEPUTY MINISTER OF DEVELOPMENT AND OF LAND AFFAIRS:

(1) to (4) The Proposals of the Commission for Co-operation and Development in connection with the consolidation of Lebowa are under consideration, together with the representations and inputs of various bodies in respect of the District of Moutse.

The Government's decisions will be made known as soon as possible and no statement can be made in the interim.

Mr P G SOAL: Mr Chairman, arising out of the hon the Deputy Minister's reply, could he please explain how it is possible that the proposals for KwaNdebele have been finalized but not those of Lebowa and Gazankulu? In that respect, how do these decisions affect Moutse?

The DEPUTY MINISTER: Sir, as the hon member will recall, discussions were held with the State President and the people involved with Moutse. On account of that, other representations were made and the Rautenbach Commission was set up. As a result, further representations were made and those are now under discussion.

Hansard Q.61.1488

Resettlement

14/5/85

*13. Mrs H SUZMAN asked the Minister of Co-operation, Development and Education:

Whether any persons who decided to move voluntarily from any Black townships to resettlement areas are assisted in moving by his Department; if so (a) what is the nature of the assistance provided, (b) in respect of which (i) townships and (ii) resettlement areas is assistance provided, (c) what total number of persons have been provided with such assistance and (d) in respect of which dates is this information furnished?

HoA

†The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

Yes.

(a) Free transport to their new homes for themselves, their personal property and any loose building materials and goods. The provision of a serviced site to build on. The erection of corehouses. The making available of loans of up to R3 500 at low rates of interest to build or to purchase houses. The provision of building materials at cheap prices. Technical assistance with the building of houses. Compensation for improvements on the sites they leave behind. The assistance provided will differ from place to place depending on the circumstances.

(b) (i) Louis Trichardt, Pietersburg, various towns in the Western Transvaal, Luckhoff, Huhudi, Valspan, Stella, Tokoza (Alberton), Tsakane (Brakpan), Daveyton (Benoni), Vosloorus (Boksburg), Katlehong (Germiston), Ratanda (Heidelberg), Duduza (Nigel), Kwa-Thema (Springs), Soweto, Atteridgeville, Mamelodi and Duncan Village.

(ii) Seshego, Lebowakgomo, Vleyfontein, Atamelang, Itsoseng, Botshabelo, Pudimoe, Pampierstat, Soshanguve, Mabopane West, Eerstehoek, Don Donald, Kwaggafontein, Mdutjana, Madadeni, Zwelitsha, Umtata, Matatiele, Mt Frere, Mt Fletcher, Willowvale, Temba, Mabopane, Garankuwa, Phuthaditjaba and Mdantsane.

(c) 32 462.

(d) The period of 5 years ending 31 December 1984.

Cape Town: English-medium schools

*14. Mr H E J VAN RENSBURG asked the Minister of National Education:

(1) Whether (a) he and/or (b) any member of his Department has received any representations regarding (i) overcrowding at, and (ii) a shortage of, English-medium schools in the northern suburbs of Cape Town; if so,

(2) (a) when, (b) from whom and (c) what was the (i) nature of the representations and (ii) response thereto;

(3) whether he is informed of shortages of schools in the Republic; if not, why not; if so,

(4) whether he has been informed of any shortages of English-medium schools in the Cape Town area; if not, why not; if so, (a) in which areas are there shortages and (b) what is the nature of the shortages;

(5) whether he intends taking any action in regard to this matter; if not, why not; if so, (a) what action and (b) when?

The MINISTER OF NATIONAL EDUCATION

(1) (a) and (b) No.

(2) Falls away.

(3) and (4) No. Such shortages should be brought to the notice of the responsible education departments.

(5) No. Steps should be considered by the responsible education departments; (a) and (b) fall away.

However, I wish to add that the broader problem resulting from the backlogs in respect of the provision of building space will thoroughly be taken into consideration in the determination of norms and standards for the financing of education.

Dunnottar/Alberton: Water

*15 Mr J H VISAGIE asked the Minister of Water Affairs:†

HoA

†The CHAIRMAN OF THE HOUSE: I offer my apologies, because I was under the impression that the hon the Leader of the Official Opposition referred to a debate.

†The LEADER OF THE OFFICIAL OPPOSITION: That is where the information was made known.

Sandy Bay: report

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(1) Whether he has received the report of the Management Committee for the Cape Peninsula Nature Area on the proposed development of Sandy Bay; if not, why not; if so, when;

(2) whether he has taken a decision in this regard; if not, when is it anticipated that a decision will be taken; if so, what (a) are the (i) findings and (ii) recommendations of the report and (b) is the nature of his decision in this regard;

(3) whether he will make a statement on the matter?

The MINISTER OF ENVIRONMENT AFFAIRS AND TOURISM:

(1) Yes, on 23 April 1985.

(2) No. A decision will be taken as soon as practicable.

(a) (i), (ii) and (b) Fall away.

(3) Possibly in due course.

Hansard Q Col. 1483

Langa/Guguletu: swimming pools

14/5/85

*7. Mr C W EGLIN asked the Minister of Co-operation, Development and Education:

(1) Whether any repairs, renovations or other work has been carried out on the swimming pools in Langa and Guguletu since his reply to Question No 70 on 26 February 1985; if not, why not; if so, (a) what specified work has been undertaken, (b) on what dates was this work carried out, (c) what work remains to be done, (d) what total amount had been spent in this regard as at the latest specified date for which figures are available and (e) when is it anticipated that this work will be completed;

(2) whether any further work is to be carried out in respect of these facilities; if not, why not; if so, (a) what work and (b) what is the estimated cost of this work:

†The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

(1) (a), (b), (c), (d) and (e) No. The task is complicated and the Development Board was compelled to make use of consultants. The consultants will be appointed shortly and the repairs and renovations will be effected during winter.

(2) (a) and (b) Apart from the repairs and renovation, for which R150 000 was found, no work except normal maintenance is foreseen.

Hansard

Legal Aid Board

Q. Col. 1484 14/5/85

*8. Mr D J DALLING asked the Minister of Justice:

(1) Whether an office of the Legal Aid Board has been opened at Mitchells Plain; if so, (a) on what date, (b) what is its staff complement and (c) how many applications for legal aid were handled through this office since it was opened up to the latest specified date for which statistics are available; if not,

(2) whether there is an office of the said Board which serves the needs of the Mitchells Plain community; if so, (a)(i) which office and (ii) where is it situated, (b) what is its staff complement and (c) how many applications for legal aid were handled through this office during the latest specified period of six months for which statistics are available?

HoA

†The MINISTER OF JUSTICE:

(1) I have approved the recommendation by the Legal Aid Board that certain offices be created to enable the Legal Aid Board to open an office in the Mitchells Plain area and am now in the process of consulting the Minister of Finance in terms of the Act before appointing officers. In arriving at this decision, Mr Landers MP for Mitchells Plain has played a meaningful part.

(2) Yes.

(a) (i) Athlone.

(ii) Amelia House, Room 401, 211 Belgravia road, Athlone.

(b) 8.

(c) During 1984, 1 892 applications were received at Athlone and 417 at Cape Town from people resident at Mitchells Plain.

Evasion of military service

*9. Mr P R C ROGERS asked the Minister of Defence:

Whether the South African Defence Force is informed or keeps records of South African citizens who are liable for military service and have been evading such service by obtaining (a) citizenship of and/or (b) permanent residence status in Transkei, Bophuthatswana, Venda or Ciskei while continuing to reside in the Republic of South Africa; if so, how many cases of this nature are known to the Defence Force to have occurred during the latest specified period of five years for which statistics are available?

†The MINISTER OF DEFENCE:

No (a) and (b) fall away.

Hansard

Duncan Village

Q. Col. 1483

*10. Mr R A F SWART asked the Minister of Co-operation, Development and Education:

14/5/85

(1) Whether, with reference to his reply to Question No 343 on 14 March 1985, any residents of Duncan Village remain to be resettled; if so, how many;

(2) whether he has decided to reconsider the resettlement of Black communities; if so,

(3) whether the remaining residents of Duncan Village are still to be resettled; if so, (a) why and (b) when;

(4) whether he will make a statement on the matter?

The DEPUTY MINISTER OF DEVELOPMENT AND OF LAND AFFAIRS:

(1) Yes. Approximately 10 000.

(2) All previous decisions regarding the resettlement of Black communities are being reviewed. No final decision has been taken regarding Duncan Village.

(3) (a) and (b) falls away.

(4) No.

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Chronically ill aged persons

Q. Col. 1486 14/5/85

*11. Mr R A F SWART asked the Minister of Co-operation, Development and Education:

(1) Whether his Department has any facilities for the care of chronically ill aged Black persons; if so, (a) where are they situated in each case, (b) what total number of persons can be accommodated in these facilities and (c) what amount was budgeted for the care of the chronically ill aged in the 1984-85 financial year; if not, why not;

(2) whether he intends making provision for chronically ill aged Black persons; if not, why not; if so (a) what provision is to be made in this regard and (b) when?

†The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

(1) Yes.

(a) Krugersdorp.

(b) 150.

(c) R447 000.

(2) Yes.

(a) Accommodation is planned for a further 200 patients at the Rietgat Project in Soshanguve.

(b) It is not possible to indicate a date on which this facility will be completed, but it will possibly be ready by 1989.

The national states also have institutions for such care and chronically ill Black patients are also treated in provincial hospitals at the expense of the Department of Co-operation and Development.

Hansard Q.Col. 1487

Moutse area: consolidation

14/5/85

*12. Mr P G SOAL asked the Minister of Co-operation, Development and Education:

(1) With reference to his reply to Question No 845 on 26 April 1985, (a) what is the nature of the reports concerning consolidation which are being considered by the Government and (b) by whom were these reports drawn up;

(2) whether the Government has reached a decision regarding these reports; if not, when is it anticipated that a decision will be reached; if so, (a) what is the nature of the decision and (b)(i) when and (ii) with whom will further discussions take place;

(3) whether he or any member of the Government has received any representations regarding the decision to add the district of Moutse to KwaNdebele; if so (a) when, (b) from whom and (c) what was the (i) nature of the representations and (ii) response thereto;

(4) whether he will make a statement on the matter?

The DEPUTY MINISTER OF DEVELOPMENT AND OF LAND AFFAIRS:

(1) to (4) The Proposals of the Commission for Co-operation and Development in connection with the consolidation of Lebowa are under consideration, together with the representations and inputs of various bodies in respect of the District of Moutse.

The Government's decisions will be made known as soon as possible and no statement can be made in the interim.

Mr P G SOAL: Mr Chairman, arising out of the hon the Deputy Minister's reply, could he please explain how it is possible that the proposals for KwaNdebele have been finalized but not those of Lebowa and Gazankulu? In that respect, how do these decisions affect Moutse?

The DEPUTY MINISTER: Sir, as the hon member will recall, discussions were held with the State President and the people involved with Moutse. On account of that, other representations were made and the Rautenbach Commission was set up. As a result, further representations were made and those are now under discussion.

Hansard Q.Col. 1488

Resettlement

14/5/85

*13. Mrs H SUZMAN asked the Minister of Co-operation, Development and Education:

Whether any persons who decided to move voluntarily from any Black townships to resettlement areas are assisted in moving by his Department; if so (a) what is the nature of the assistance provided, (b) in respect of which (i) townships and (ii) resettlement areas is assistance provided, (c) what total number of persons have been provided with such assistance and (d) in respect of which dates is this information furnished?

†The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

Yes.

(a) Free transport to their new homes for themselves, their personal property and any loose building materials and goods. The provision of a serviced site to build on. The erection of corehouses. The making available of loans of up to R3 500 at low rates of interest to build or to purchase houses. The provision of building materials at cheap prices. Technical assistance with the building of houses. Compensation for improvements on the sites they leave behind. The assistance provided will differ from place to place depending on the circumstances.

(b) (i) Louis Trichardt, Pietersburg, various towns in the Western Transvaal, Luckhoff, Huhudi, Valspan, Stella, Tokoza (Alberton), Tsakane (Brakpan), Daveyton (Benoni), Vosloorus (Boksburg), Katlehong (Germiston), Ratanda (Heidelberg), Duduza (Nigel), Kwa-Thema (Springs), Soweto, Atteridgeville, Mamelodi and Duncan Village.

(ii) Seshego, Lebowakgomo, Vleyfontein, Atamelang, Itsoseng, Botshabelo, Pudimoe, Pampierstat, Soshanguve, Mabopane West, Eerstehoek, Don Donald, Kwaggafontein, Mdutjana, Madadeni, Zwelitsha, Umtata, Matatiele, Mt Frere, Mt Fletcher, Willowvale, Temba, Mabopane, Garankuwa, Phuthaditjaba and Mdantsane.

(c) 32 462.

(d) The period of 5 years ending 31 December 1984.

Cape Town: English-medium schools

*14. Mr H E J VAN RENSBURG asked the Minister of National Education:

(1) Whether (a) he and/or (b) any member of his Department has received any representations regarding (i) overcrowding at, and (ii) a shortage of, English-medium schools in the northern suburbs of Cape Town; if so,

(2) (a) when, (b) from whom and (c) what was the (i) nature of the representations and (ii) response thereto;

(3) whether he is informed of shortages of schools in the Republic; if not, why not; if so,

(4) whether he has been informed of any shortages of English-medium schools in the Cape Town area; if not, why not; if so, (a) in which areas are there shortages and (b) what is the nature of the shortages;

(5) whether he intends taking any action in regard to this matter; if not, why not; if so, (a) what action and (b) when?

The MINISTER OF NATIONAL EDUCATION

(1) (a) and (b) No.

(2) Falls away.

(3) and (4) No. Such shortages should be brought to the notice of the responsible education departments.

(5) No. Steps should be considered by the responsible education departments; (a) and (b) fall away.

However, I wish to add that the broader problem resulting from the backlogs in respect of the provision of building space will thoroughly be taken into consideration in the determination of norms and standards for the financing of education.

Dunnottar/Alberton: Water

*15 Mr J H VISAGIE asked the Minister of Water Affairs:†

Black veterinarians

507. Mr E K MOORCROFT asked the Minister of Education and Training:

(a) How many Black veterinarians are being trained at present at universities falling under his Department and (b) how many persons qualified as veterinarians in 1983 at each specified university?

The MINISTER OF EDUCATION AND TRAINING:

(a) 21.

(b) None.

Transmed

729. Mr D J N MALCOMESS asked the Minister of Transport Affairs:

(1) What was the amount of the subsidy paid to the Medical Scheme of the South African Transport Services (Transmed) in the 1983-84 financial year;

(2) (a) what amount was collected in that year in respect of the levy on prescriptions and (b) what was the amount of the contribution made by the South African Transport Services in this regard;

(3) what was the number of (a) members and (b) dependants registered in respect of this medical scheme at the end of the financial year in question;

(4) whether any non-White employees are entitled to benefits in terms of the said scheme; if so, how many (a) Coloureds, (b) Indians and (c) Blacks are entitled to such benefits?

The MINISTER OF TRANSPORT AFFAIRS:

(1) R123 648 416 for the first 10 months of the financial year.

(2) (a) Since the change-over from the Sick Fund to Transmed on 1 April 1982, levies on prescriptions are not payable. For the period 1 April 1983 to 31 January 1984 members' contributions in respect of the cost of medicine at Transmed dispensaries amounted to R3 184 388. Particulars of members' liability for the cost of medicine obtained from contracting and private pharmacists and from medical practitioners are not available.

(b) R28 018 773 for the first 10 months of the financial year.

(3) (a) 156 309—As at 16 January 1984.

(b) 385 000—As at 16 January 1984.

(4) Coloured and Indian employees and employees from the different Black peoples are not yet members of Transmed but have an own sick fund system.

TUESDAY, 10 APRIL 1984

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†Indicates translated version.

For written reply:

Tax: farmers

736. Mr J J B VAN ZYL asked the Minister of Finance:†

What amount was paid in tax by farmers in each of the latest specified five financial years for which figures are available?

The MINISTER OF FINANCE:

It is not possible to determine the amount of tax *paid* by farmers as details concerning the source from which a taxpayer derives his income are not recorded when payments of tax are received.

WEDNESDAY, 11 APRIL 1984

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†Indicates translated version.

For oral reply:

Prime Minister:

Salem

*1. Mr D J N MALCOMESS asked the Prime Minister:

(1) Whether the National Intelligence Service has been requested to institute an investigation into the *Salem* affair or any aspect thereof; if so, (a) when and (b) by whom;

(2) whether this request was acceded to; if not, why not; if so, when did the investigation commence;

(3) whether the investigation has been completed; if not, when is it anticipated that it will be completed; if so,

(4) whether the findings have been submitted to an attorney-general; if not, why not; if so, (a) by whom, (b) to which attorney-general and (c) when;

(5) whether the National Intelligence Service has submitted any reports in this regard to any bodies or persons; if so, (a) to which bodies and persons and (b) what is the nature of these reports?

The PRIME MINISTER:

(1) The hon member is referred to Hansard of Wednesday 9 March 1983, column 2600 and column 2668 where this House was informed that on the instructions of the Prime Minister persons were appointed on 30 September 1982 to investigate the *Salem* affair. Two members of National Intelligence Service were detailed for this and other investigations and afterwards one member was seconded to the Department of Mineral and Energy Affairs for this purpose.

(2) Yes, on 30.8.1982.

(3) The investigation has been provisionally concluded pending developments which might result from criminal and civil proceedings in other countries. Due to the wide ramifications of the case information is still received from time to time and being followed up.

(4) Yes.

(a) By the Minister and Energy Affairs via the Minister of Justice.

(b) The attorney-general of the Cape Province.

(c) On 12.3.1984.

(5) (a) and (b) A comprehensive report intended as an interim aid to courts and law enforcement agencies in countries which have an interest in the *Salem* affair has been submitted by the investigator to the Department of Mineral and Energy Affairs. Copies of this report have been supplied to the following bodies and persons:

— the judge in Piraeus, Greece who is investigating the involvement of Greek citizens in the *Salem* affair.

— the Netherlands Department of Foreign Affairs for transmissions to parties involved in a criminal case in Rotterdam.

— officials of the United States Department of Justice and the Federal Bureau of Investigation who are investigating the involvement of US citizens in the *Salem* affair.

— the legal representative of a Swiss company concerned with the case.

In addition other reports of a confidential and domestic nature relating to the *Salem* case and to other investigations have been submitted to the Prime Minister and to the Minister of Mineral and Energy Affairs.

SOWETAN, Wednesday, April 18, 1984

White aged going hungry

THE INCIDENCE of malnutrition was high among white old aged people living on government pensions, the Carnegie Inquiry into Poverty heard yesterday.

Speaking at a report-back session on "Old Age and Poverty," Mrs Zerilda Nel of the SA National Council for the Aged, said many aged white people received pensions which did not provide for their basic needs.

A major problem for the whites was high rentals.

Mrs Nel said many black old aged pensioners in the homelands were providing the entire household income.

"When pensions are reviewed they could be lost. Once lost, re-instatement can take a long time and many of them are not paid for the period when they are being reviewed."

Pension

In urban areas, black pensions of R63 a month were not meeting the basic needs of the aged.

Private pension schemes were generally aimed at skilled labourers.

Mrs Nel recommended the establishment of a contributory national pension scheme for people not in company schemes.

At present, the aged in urban areas were living with "very poor" health facilities, Mrs Nel said.

"People are living with not less than 10 people in a two-roomed house," she said.

* Another paper by Dr I B Friedman, Medical Director of the Valley Trust Project, has found that in some rural communities people use only 10 litres of water per day — 40 litres below the daily amount recommended by the World Health Organisation.

Whites in urban areas used an average of 300 litres a day.

* South Africa spends proportionately less on public health than many poor nations as well as developed ones.

This was submitted to the Carnegie Conference yesterday by Dr Noddy Jinabhai of the Department of Community Health at the University of Natal.

Dr Jinabhai said that South Africa's spending on public health was low by international standards.

For example, its total spending on health in the public sector including government, provincial and local levels was 4,2 percent of its Gross National Product.

By contrast Zambia spent 7,3 percent and Tanzania 7,1 percent on public health while West Germany spent 9,4 percent, the United States 8,6 percent and Sweden 8,5 percent on public health.

(3) No. He was transferred with retention of salary.

Humansdorp Senior Secondary School: facilities

*20. Mr S S VAN DER MERWE asked the Minister of Internal Affairs:

Whether separate facilities for White and non-White teachers are provided at the Humansdorp Senior Secondary School; if so, what are the particulars of these facilities?

†The MINISTER OF INTERNAL AFFAIRS:

No.

Rehabilitation centres

*21. Mr K M ANDREW asked the Minister of Internal Affairs:

(1) (a) Where are the rehabilitation centres for Coloureds in the (i) Western Cape and (ii) rest of the Republic situated, (b) what are the names of these centres, (c) when were they opened in each case and (d) what total number of persons can be accommodated in them;

(2) whether any further rehabilitation centres are to be built in the Western Cape during the next three years; if not, why not; if so, (a) where will they be located, (b) when will they be opened and (c) what total number of persons is it anticipated that they will be able to accommodate?

The DEPUTY MINISTER OF INTERNAL AFFAIRS:

(1) (a) (i), (ii), (b), (c) and (d) There are two rehabilitation centres for Coloureds serving the whole Republic, namely—

— the De Novo Rehabilitation Centre at Kraaifontein, established in 1963 and capable of accommodating 320 persons; and

— the Toevlug Rehabilitation Centre in Worcester, established in 1975 and capable of accommodating 57 persons.

(2) Yes, one.

(a) Kraaifontein.

(b) Expected date 1987.

(c) 100.

Rehabilitation centres

*22. Mr K M ANDREW asked the Minister of Internal Affairs:

(1) (a) How many Coloured persons were admitted to rehabilitation centres in the Western Cape in 1982 and 1983, respectively, (b) what is the (i) name and (ii) location of the centres to which they were admitted and (c) what were the reasons for their being admitted to them;

(2) whether the State (a) administers and (b)(i) fully and (ii) partially subsidizes any of these centres; if not, why not; if so, which centres in each case?

†The DEPUTY MINISTER OF INTERNAL AFFAIRS:

(1) (a) 659 in 1982 and 727 in 1983.

(b) (i) The De Novo Rehabilitation Centre and the Toevlug Rehabilitation Centre.

(ii) Kraaifontein and Worcester.

(c) The hon member is referred to the Coloured Persons Rehabilitation Centres Law, 1971 (Law 1 of 1971 of the Coloured Persons Representative Council), in which the procedures and circumstances prior to committals are set out. It is not feasible in this reply to state the reasons for admission in respect of each case.

(2) Yes. The De Novo Rehabilitation Centre is administered by the Department of Internal Affairs in terms of the aforementioned Law. A subsidy of 75% of the approved expenditures is paid to the Toevlug Rehabilitation Centre, which is registered with the Department in terms of section 6.

Zweletemba

*23. Mr K M ANDREW asked the Minister of Co-operation and Development:

(1) Whether any houses have been built in Zweletemba, Worcester, since 1959; if not, why not; if so, (a) how many and (b) when;

(2) whether there has been an increase in the population of Zweletemba since 1959; if so, what is the increase?

The DEPUTY MINISTER OF CO-OPERATION:

(1) No, but single accommodation was converted into 56 family housing units during 1981.
Consideration is now being given to an application to provide another 100 family housing units.

(2) Yes. 3 080 persons.

Cedarberg Range wilderness area

*24. Mr R W HARDINGHAM asked the Minister of Environment Affairs and Fisheries:

(1) Whether he has received an application from the National Parks Board for the Cedarberg Range wilderness area to be proclaimed a national park; if so,

(2) whether a decision has been taken in this regard; if so, what decision;

(3) whether he will make a statement on the matter?

†The MINISTER OF ENVIRONMENT AFFAIRS AND FISHERIES:

(1) Yes.

(2) No.

(3) No, not at this stage.

Question standing over from Friday, 13 April 1984:

Fund-Raising Act

*13. Mr B B GOODALL asked the Minister of Health and Welfare:

(1) Whether any inspections have been carried out in terms of section 30 of the Fund-Raising Act, No 107 of 1978; if not, why not; if so, (a) how many, (b) when and (c) into which organizations;

(2) whether any organizations have been prosecuted for contravening any provisions of the said Act; if so, (a) which organizations, (b) when and (c) what was the charge in each case?

†The MINISTER OF HEALTH AND WELFARE:

(1) No; auditors reports in respect of the financial statements satisfied the Director of Fund-Raising that no inspections were required, and no requests supported by affidavits as required for inspections were lodged in terms of the Act;

(a), (b) and (c) falls away.

(2) As far as could be ascertained, no;

(a), (b) and (c) falls away.

For written reply:

Social/old-age pensioners

753. Mr B B GOODALL asked the Minister of Health and Welfare:

(1) (a) How many social pensioners were

two unopposed members resigned, creating a further vacancy. The six vacancies which then existed were to be filled in terms of regulation 63 of the Election Regulations. During February 1984 nominations were invited and five candidates were nominated unopposed leaving one vacancy for which nomination have been invited again.

(b) The present councillors are—

Messrs H V Makubalo, G F Magawu, J Badi, I M Moile, N Tsobo and Mrs C. Skweyiya.

*14. Mr P H P GASTROW—Law and Order—Reply standing over.

Wentworth

*15. Mr P H P GASTROW asked the Minister of Community Development:

(1) Whether his Department intends to upgrade Wentworth; if so, (a) when will the work on the project commence, (b) what will the upgrading entail, (c) how much will it cost and (d) when will the upgrading be completed;

(2) whether he will make a statement on the matter?

The MINISTER OF COMMUNITY DEVELOPMENT:

(1) At this stage the improvement of conditions in Austerville is receiving priority whilst the upgrading of Wentworth is still being investigated.

(a), (b), (c) and (d) Fall away.

(2) I hope to be able to make more details in this regard available in the near future.

†The hon member is welcome to discuss this matter further when my Vote is discussed.

Mr D W WATTERSON: Mr Speaker, arising out of the reply of the hon the Minister, can he tell me whether Wentworth forms part of the City of Durban and whether the people living there pay rates to the city council?

The MINISTER: Mr Speaker, I do not know off-hand, but I shall ascertain what the position is.

Q. Col. 1028 27/4/84

Eastern Cape: facilities for mentally retarded Black children

299 Hansard

*16. Dr M S BARNARD asked the Minister of Health and Welfare:

(1) Whether there are any facilities in the Eastern Cape at present for mentally retarded Black children who cannot be cared for at home; if not, (a) why not and (b) where are these children accommodated; if so, (i) where are these facilities located and (ii) how many children can be accommodated in them;

(2) whether there are plans to extend these facilities; if not, why not; if so, (a) what is the nature of these plans, (b) where will these extensions be effected, (c) when is it anticipated that they will be completed and (d) how many children will they be able to accommodate upon completion?

†The MINISTER OF HEALTH AND WELFARE:

(1) No;

(a) thus far retarded children in the Eastern Cape were accommodated in Randwest Sanatorium in Krugersdorp and in Waverley

Sanatorium in Germiston because of financial constraints on available funds;

(b) in Randwest Sanatorium in Krugersdorp and Waverley Sanatorium in Germiston;

(2) no;

(a) there are no plans at present to extend the facilities at Randwest or Waverley Sanatoria;

(b), (c) and (d) falls away.

27/4/84

Port Elizabeth: hospital for Black psychiatric patients

Q. Col. 1029 Hansard

*17. Dr M S BARNARD asked the Minister of Health and Welfare:

(1) Whether a hospital for Black psychiatric patients is to be built in the Port Elizabeth area; if not, why not; if so, (a) where will it be built, (b) when is it due to be completed, (c) what is the total estimated cost involved and (d) how many beds will be provided;

(2) whether he or any member of his Department has received any representations concerning the siting of this hospital; if so, (a) when, (b) from whom and (c) what was (i) the nature of the representations and (ii) his response thereto?

†The MINISTER OF HEALTH AND WELFARE:

(1) Yes:

(a) Missionvale;

(b) 1990;

(c) the provisional estimate is R56 million;

(d) 932;

(2) No.

SABC: discussions on internal memorandum

*18. Mr D J DALLING asked the Minister of Foreign Affairs:

Whether (a) he, (b) the Deputy Minister of Foreign Affairs, (c) any member of his Department and/or (d) any member of the Government had discussions with any officer of the SABC on any of the main points set out in an internal memorandum issued by the SABC on 11 April 1984 and headed "Radio Services in Black Languages: Complete Radio Coverage" (Reference No JHB/cv/0087); if so, (i) when did these discussions take place, (ii) who were parties to the discussions, (iii) what aspects of the contents of the memorandum were discussed and (iv) what was the outcome of the discussions?

†The DEPUTY MINISTER OF FOREIGN AFFAIRS:

(a), (b), (c) and (d): no.
(i), (ii), (iii) and (iv): fall away.

Mahatma Gandhi Memorial Trust

*19. Mr R A F SWART asked the Minister of Health and Welfare:

(1) Whether he has taken any steps in respect of the collection of funds for the Mahatma Gandhi Memorial Trust; if so, (a) what steps, (b) when and (c) why;

(2) whether he has received any representations in this regard; if so, (a) when, (b) from whom and (c) what was (i) the nature of the representations and (ii) his response thereto;

De Loor tells medical societies:

Sick benefits have to be cut

299
Star
4/5/84

The man in the street has to be disabused of the idea that he is always entitled to health services, says the Director-General of Finance, Dr Joop de Loor.

Opening the annual congress of the National Association of Medical Aid Societies in Johannesburg yesterday he said some incentive for self-treatment of minor health problems should be built into the health care system.

"We err and stray grievously if we try to remove the present, albeit small, economic incentive to the individual to keep his medical bill down."

He was heartened by the element of choice, coupled with differential contributions, being mooted in medical aid schemes.

The recent increase in provincial hospital fees was also a step in the right direction.

The achievement of a more moderate rate of growth in the demand for medical services would, however, involve much more than a personal conception on the part of individuals of the social and economic cost of too free a recourse to treatment.

Many physicians argued that the only way to bring medical costs under control was preventive treatment rather than crisis care.

RICH MAN

All sorts of social, cultural, economic and political factors could lie behind the eventual demand for health services.

Problems including unemployment, poverty, slums, high birthrates and insufficient or inadequate sanitation, housing and education had to be addressed.

The trend to reduce the State's role could be extended to health services with the market being fragmented into specialised segments and the private sector assuming responsibility for some of them at economic rates.

"There is no earthly reason why the man in the R500 000 mansion and R90 000 car should expect his medical treatment to be massively subsidised by the Exchequer," Dr de Loor said.

SENTIMENTAL

It had been shown that the middle and upper income groups were the chief beneficiaries of welfare programmes, rather than the poor, "something that cuts across all sound principles of economic, let alone social justice".

"We really must adopt a tougher and less sentimental line on this subject." — Sapa.

Lodgers' fees	3 500
Transfer fees	40
Services charges	287 785
Entry permits	48
Pounds fees	10
Sanitation fees	3 259
Replacement of rental cards	16
Removal of wrecked motor vehicles ...	55
Water sales	494
Interest on sale of houses	393
Insurance: Home ownership scheme	55
Rural scheme fees ..	14
Service charges (School levy)	4 324
Cemetery fees	805
Libary fees	10
Rental of halls	784
Advertising fees	290
Sundry revenue	67
	R350 042

(c) (i) The total expenditure for the period 1 june 1983 to 30 November 1983 amounted to R106 883.

(ii) The proposed development schemes for the period 1 July 1983 to 30 June 1984 will amount to R3 092 487.

(2) Provisions has been made on the capital programme for the financial year 1983/84 for the following amounts to be expended on the construction and services as mentioned in the question:

(a) (i) Nil.

(ii) R700 000.

(b) R364 750.

(c) R132 242.

With regard to (2) (a) (i) it should be noted that the Department of Education and Training is responsible for this matter.

9/5/84
Hansard Q.Col. 1184

Trust farm Devondale 11039

749. Mr R A F Swart asked the Minister of Co-operation and Development:

(1) (a) How many (i) adults and (ii) children have been resettled on the Trust farm Devondale 11039 and (b) how many formal employment opportunities are there for these persons in the Qudeni district at present;

(2) whether any steps are being taken to create further employment opportunities; if not, why not; if so, (a) what steps and (b) how many employment opportunities will be created?

The MINISTER OF CO-OPERATION AND DEVELOPMENT:

(1) (a) (i) 488.

(ii) 820.

(b) Since December 1983 no formal employment opportunity was available. Before that time the people were employed on the Phormium Tenax lands in the area. This Project closed down at the end of November 1983.

(2) Yes.

(a) The farms in the Qudeni/Devondale area are in the process of being handed over to KwaZulu. Forests will be established on these farms, which will created employment opportunities.

(b) At this stage the number cannot be determined.

Hansard
Sibongile/Thembalihle
Q.Q1.1184 9/5/84

754. Mr R A F SWART asked the Minister of Co-operation and Development:

(1) Whether any vacant residential sites in the (a) Sibongile and (b) Thembalihle Black townships in Natal were released for the construction of

houses in 1983; if so, how many in each case;

(2) whether his Department still intends to resettle the residents of these townships; if so, (a) why, (b) when, (c) where will they be moved to and (a) how many persons are involved;

(3) whether persons who have built houses in these townships will be compensated for these houses; if not, why not; if so, on what basis will this compensation be determined?

The MINISTER OF CO-OPERATION AND DEVELOPMENT:

(1) (a) Yes. 181.

(b) Yes. 234.

(2) The matter remains to be considered. (a), (b), (c) and (d) Fall away.

(3) Should it be decided to settle these people they will be compensated according to the value of the improvements they have effected. Compensation will be based on the market value of the improvements.

299 Hansard
National states: institutions/handcraft centres
Q.Q1.1185 9/5/84

756. Dr M A BARNARD asked the Minister of Co-operation and Development:

How many (a) institutions for the (i) blind, (ii) deaf and (iii) physically disabled and (b) handcraft centres there in (aa) KwaZulu, (bb) Qwaqwa, (cc) Lebowa, (dd) Gazankulu and (ee) KaNgwane at present?

The MINISTER OF CO-OPERATION AND DEVELOPMENT:

(a) (i) (aa) 2.

(bb) 1.

(cc) 2.

(dd) 2.

(ee) Nil.

(ii) (aa) 1.

(bb) 1.

(cc) 1.

(dd) 1.

(ee) Nil.

(iii) (aa) 2.

(bb) 1.

(cc) 3.

(dd) 1.

(ee) Nil.

(a) (aa) 1.

(bb) 1.

(cc) Nil.

(dd) 2.

(ee) Nil.

The administration of institutions in national states was transferred to the national states some time ago in terms of the National States Constitution Act, 1971.

Some of the institutions in national states are administered as educational institutions e.g. for physically handicapped or blind persons, but a welfare service is simultaneously offered under the same roof but in different sections e.g. handicraft. In other cases there exists only one welfare institution (building) as such but two or more welfare activities are offered. These do not necessarily appear as separate institutions in the replies to the question.

Hansard Q.Q1.1186
206 **Reference books/influx control** 9/5/84

763. Mr P G SOAL asked the Minister of Co-operation and Development:

How many Black (a) males and (b) fe-

Concern over abuse of medical aid

299 Pretoria Correspondent

The exploitation of medical schemes by a small group of doctors was a "very thorny" problem, said Dr Rene le Roex, president of the Medical Association of South Africa (Masa).

Dr le Roex was delivering his inaugural address as chairman of the Federal Council and president of Masa in Pretoria last night.

There was a tendency for doctors and patients to disregard the costs of medical services and to forget there was a limit to funds available when a third party, namely medical aid, covered those costs, he said.

Educating doctors in the pharmaceutical field and in laboratory services would contribute to cutting these costs, Dr le Roex said.

He also said Masa's first aim was to maintain and protect the honour and interests of the medical profession, which was not something apart from the society in which it existed.

"Unfortunately, we are now faced with a situation where there are voices clamouring for us to become a political force, or mini-political party," Dr le Roex said.

By the very nature of doctors' working circumstances, they became aware of bottlenecks in the provision of health services.

Doctors were not politicians, but it was their duty to express their opinions on these problems, he said.

Doctors told: help to keep fees down

Pretoria Correspondent

Doctors must accept responsibility towards the costs of patients' medical care and eliminate cases of "blatant exploitation", says the Minister of Health and Welfare, Dr Nak van der Merwe.

One of the many objectives of introducing the new method of determining medical fees was to make doctors more cost-conscious, he told the annual meeting of the Medical Association of South Africa in Pretoria last night.

"Doctors are the ones who decide to which hospital a patient should be admitted, for how long he should stay, and what treatment should be given. So it is essential for doctors to be aware of how they contribute to the total costs of a service.

"See the patient as a person who must also make ends meet."

HEALTH TEAMS

The costs of health services were rising out of all proportion, he said. Of these, hospital costs were the most serious.

The emphasis should be shifted from curative services to preventive services. Experience had shown that more than 80 percent of patients could be treated by nurses outside institutions.

Doctors and pharmacists, such as those operating in areas like the Cape Flats, completed the health teams.

"The medical profession is conservative and sees any change or anything new as a threat to its practices. I must, however, say there is too much work for all of us," said Dr van der Merwe.

Decentralisation of medical services by means of health teams and health centres, where doctors were the leaders of teams of experts, evoked wide reaction and was one of the reasons for the poor distribution of doctors, he said.

ARGUS 29/5/84

NATIONAL

'Million disabled in SA'

Staff Reporter

IT could be estimated that about one million South Africans are disabled — 20 percent of them severely, says the latest South African Medical Journal.

An editorial says rehabilitation and aftercare remain the "Cinderella disiplines" in health care practice.

"It is frequently forgotten that . . . the number of people in the community who remain permanently disabled or chronically ill is considerable," it says.

THE ELDERLY

If one were to extrapolate from the British situation, "one could estimate that about one million South Africans are disabled, 20 percent of these severely".

"Chronic disease and the problems of the elderly are, moreover, escalating rapidly, particularly in cities," the editorial adds.

Local authorities responsible for rehabilitation were, with few exceptions, unable to meet the need.

"HALFWAY HOUSES"

Much of the responsibility for the care of the disabled fell on various community organisations.

The editorial says rehabilitation should begin on the day of hospital admission and continue after the return of the disabled person to the community.

An important link between the two may be "so-called 'halfway houses'", where rehabilitation initiated in the hospital can be consolidated before the individual returns to his home.

The journal says more precise knowledge must be obtained about the extent of disability.

An obvious ideal would be a "national register" of disabled people so that services could be constantly upadated to meet the changing needs of the community.

No bus to get Larry to work

Star 299 11/6/84

By Olga Horowitz

Apartheid is working in reverse for a 29-year-old white man called Larry, a cerebral palsy sufferer.

He has had a job in Wynberg for nearly three years — but now there is no "white" public transport to take him to work.

He cannot drive a car. He used to catch a Pretoria bus and walk from the terminus to his place of work — but this bus no longer runs.

"I asked Putco whether they would allow him to board a black bus but they said this was impossible," said his mother.

"I or his father would willingly take him to work, but he has an independent spirit and insists that he does not want to impose on his family.

"He would gladly accept — and pay for — a lift from anybody who regularly travels to work in Wynberg.

"He lives on the corner of Athol Road and Louis Botha Avenue and would wait at a stipulated time at any spot convenient to the driver."

Coming home presented no problem, Larry's mother said.

His firm's courtesy bus gave him a lift to Corlett Drive, not far from his home.

But in the mornings this bus was full and unable to take another passenger.

Larry was the reason for the start of "Talisman" in Parktown.

This is a residence for not entirely fit people who can be encouraged to work in sheltered or open employment if they have somewhere safe to live.

Anybody who can give him a lift to Wynberg in the mornings is asked to telephone his mother at 442-9322.

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...cial Council and official PFP spokesman on education, Mr Herbert Hirsch, described Mr Louw's attack on the SATA as "distressing, disturbing and unfortunate, to say the least".

Failure by leaders such as Mr Louw publicly to recognize and acknowledge the cardinal role teachers play in society could harm the status of the profession and the whole society, he said.

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formed Church — hopes to construct a home for the aged, according to the committee report.

Three blocks of flats, each three storeys high, one two-storey block and a central service block would comprise the complex, which would accommodate 171 aged persons and staff.

Although the flats would abut the 3 Arts complex, the business section of it was 100 metres south-west of the proposed flats, so aged residents would not be troubled by noise, the report said.

The proposed medical centre would include a hospital, six operating theatres, 72 private doctors' consulting rooms, small shops for patients and their visitors, and a 700-bay parking area.

A municipal housing scheme was once planned on the land.



From page 1

...ney made contact with the runway.

At 9.12am Mr and Mrs Botha — he wearing his usual buttonhole, she in a sealskin coat and cap — came down the steps of the aircraft. The waiting ministers set up a spatter of applause which was almost immediately drowned out as the field-guns started a thunderous 19-shot salute, to the accompaniment of startled shrieks from parts of the crowd.

What almost no-one realized was that at that moment the police were notified that a bomb had been planted in the domestic-arrivals building, but this hoax was dealt with in an unobtrusive manner.

Serenade

After greeting the greeters, Mr Botha and General Viljoen mounted the dais and took the salute, then inspected the troops. Then the four Bothas (P W, Pik and wives) moved back to the dais, where the Tygerberg Children's Choir serenaded them in Afrikaans and English, and Dr E J van der Walt of the NGK congregation of Rondebosch offered bilingual thanks.

Then followed a rambling speech of welcome by the acting Prime Minister, Dr Piet Koornhof, to which Mr Botha replied in his usual forthright way.

Medical aid to cost more

Own Correspondent

PRETORIA. — The country's 230 registered medical schemes are to raise their members' subscriptions from the beginning of July.

The chairman of the Representative Association of Medical Schemes, Mr John Ernstzen, said yesterday that conditions and benefits varied from scheme to scheme, but most were talking of increases of between 12 and 15 percent.

One scheme had decided to raise subscriptions by 16½ percent. Reasons for the increases included:

- The increase in GST from July 1 which would further increase the prices of medicines.
- Higher provincial and other hospital fees.
- The fact that provincial hospitals were now referring scheme patients to private practitioners. Mr Ernstzen said that in the past, particularly for outpatients, members were accepted at provincial hospitals, and medication was free.

Even if the provincial hospitals accepted a scheme patient, medicines still had to be paid for, and unless it was a special-case scheme, patients were generally referred to private doctors.

He appealed to members of schemes not to run to doctors "with every ache and pain" but to use self-medication where the condition was not a serious one. This would conserve funds for more serious cases.

Mr Ernstzen estimated that the 230 registered schemes would pay out a total of R1 500-million in benefits this year — about 40 percent to doctors and 17 percent to dentists.

Airport parking fines rise

Staff Reporter

OWNERS of illegally-parked cars which have been towed away at the D F Malan Airport after Monday will have to dig deeper into their pockets to bail out their vehicles.

This was announced yesterday by the airport manager, Mr J J Nel, who said the former R40 fine to get back cars which had been towed away from yellow lines and illegal parking bays would be increased to R60.

He called on motorists to co-operate in combatting illegal parking, which had caused a lot of inconvenience at the airport in the past.

Gaye's father for trial

LOS ANGELES. — The father of slain soul singer Marvin Gaye, a retired clergyman accused of shooting the entertainer 10 weeks ago, has been declared mentally competent to stand trial for the murder.

The entertainer added the "E" to his surname at the start of his music career.

Superior Judge Michael Pirosh ruled that Marvin Gay Snr, who had surgery last month to remove a brain tumour, was fit to go on trial for the murder of his son. Mr Gay said nothing during the brief proceeding.

The greying, 70-year-old defendant was ordered to appear on June 20 so a preliminary hearing date could be set.

"The court, having read and considered the two-page report, finds that Mr Gay in fact, after his surgery, is competent to stand trial," Judge Pirosh ruled.

The judge declared Gay mentally competent based on two psychiatric evaluations conducted by Dr Ronald Markman. In both evaluations, the doctor found Gay mentally competent.

The defence did not contest the findings.

Gay is charged with shooting his Grammy Award-winning son through the heart at his family's south central Los Angeles home on April 1.

The older Gay pleaded not guilty to the charges, claiming in a published interview that he had fired the gun in self-defence during a heated argument with his son. He said he thought the weapon was loaded with blanks.

"In his post-operative period, he continues to be fully oriented, alert and responsive to questions," Dr Markman said in his latest report. "He was soft-spoken, but continued to provide a consistent story regarding the shooting of his son, which he labels as 'self-defence.'

"He is fully aware of the nature and purpose of the proceedings against him, can discuss his available options, is aware of the criminal justice process, the role of judge, jury and prosecutor and does know his attorneys." — UPI

M L Sultan Technikon Department	As at 31-12-83	As at 31-5-84
Electrical Engineering	476	326
Health Sciences	464	370
Hotel and Catering Administration	134	120
Management, Administration and Computer Science	1 277	1 351
Mechanical Engineering	204	122
Secretarial Studies, Communication and Languages	228	268

Technikon Peninsula Department	As at 31-12-83	As at 31-5-84
School of Science	368	314
School of Secretarial Training, Communication and Electronic Data Processing	600	415
School of Art and Design	94	80
School of Business Studies	535	743
School of Engineering and Building	573	463
School of Education	244	256

The above figures include part-time students.

Technikons

1006. Mr H E J VAN RENSBURG asked the Minister of Internal Affairs:

What was the ratio of students to staff in 1983 in each department at each specified technikon falling under the control of his Department?

The MINISTER OF INTERNAL AFFAIRS:

M L Sultan Technikon

1.	Applied Sciences	12:1
2.	Art and Design	8:1
3.	Building and Civil Engineering	20:1
4.	Electrical Engineering	25:1
5.	Health Sciences	19:1
6.	Hotel and Catering Administration	9:1
7.	Management, Administration and Computer Science	19:1
8.	Mechanical Engineering	24:1
9.	Secretarial Studies, Communication and Languages	11:1

Technikon Peninsula

1.	School of Science	9:1
2.	School of Secretarial Training, Communication and Electronic Data Processing	9:1
3.	School of Art and Design	7:1
4.	School of Business Studies	11:1
5.	School of Engineering and Building	7:1
6.	School of Education	14:1

The above ratios are based on full-time students only.

Hansard Q.61.1740 Schools/pupils 20/6/84

1040. Mr S S VAN DER MERWE asked the Minister of Internal Affairs:

How many (a) private and (b) public (i) pre-primary, (ii) primary and (iii) secondary (aa) Coloured and (bb) Asian schools and pupils, respectively, were there in the Republic as at the latest specified date for which figures are available?

The MINISTER OF INTERNAL AFFAIRS:

As at March 1984:

		(aa) Schools	(aa) Pupils	(bb) Schools	(bb) Pupils
(a)	(i)	1	44	21	1 597
	(ii)	7	2 343	—	—
	(iii)	4	843	—	—
(b)	(i) State Schools	1	80	—	—
	State-aided schools	121	11 050	—	—
	(ii) State schools	720	471 196	233	120 409
	State-aided schools	1 139	140 247	93	19 533
	(iii) State schools	194	172 050	110	56 027
	State-aided schools	7	4 290	5	1 [illegible]

(299) Hansard Q.61.1741 20/6/84 Handicapped children

1041. Mr S S VAN DER MERWE asked the Minister of Internal Affairs:

(a) How many (i) training centres and (ii) qualified teachers for handicapped (aa) Coloured and (bb) Indian children were there in the Republic as at the latest specified date for which figures are available and (b) where are these training centres situated in each case?

The MINISTER OF INTERNAL AFFAIRS:

As at 1 April 1984:

(a) (i) (aa) 12

(bb) 8

(ii) (aa) 65

(bb) 61

(b) *For Coloureds*

Athlone, Cape; Heideveld, Cape; Ocean View, Cape; Bonteheuwel, Cape; Elsies River, Cape; Atlantis; Worcester; Port Elizabeth; East London; Durban; Pietermaritzburg; Coronationville, Johannesburg.

For Indians

Pietermaritzburg; Verulam; Laudium; Umzinto; Stanger; Durban (2); Lenasia

The above figures do not include [illegible] schools, eg schools for the deaf, blind, etc.

Hansard Q.61.1742 20/6/84 Inspectors/subject specialists/school principals

1043. Mr S S VAN DER MERWE asked the Minister of Internal Affairs:

How many (a) White, (b) Coloured and (c) Indian (i) inspectors, (ii) subject specialists or advisers and (iii) school principals were in the employ of his Department as at the latest specified date for which figures are available?

The MINISTER OF INTERNAL AFFAIRS:

As at March 1984:

	(i)	(ii)	(iii)
(a)	59	126	225
(b)	45	66	1 880
(c)	16	45	455

Hansard Q.61.1743 Teachers

1045. Mr S S VAN DER MERWE asked the Minister of Internal Affairs:

With reference to his reply to Question No 410 on 7 March 1984, what was the extent of the shortage of (a) teachers and (b) properly qualified teachers at (i) Coloured and (ii) Indian schools as at the latest

Argus 24/7/84 (599)

Medical aid fees set to soar 15%

Argus Correspondent

JOHANNESBURG. — The cash squeeze on family budgets has been tightened still more by sweeping increases of an average 15 percent on medical-id fees that push them to nearly treble the levels of only six years ago.

The monthly fees demanded in a typical scheme from a single person earning R700 a month have soared from R26 in 1978 to R76.

Fees charged a married member with two children, on the same income, jump to R133 compared to R50,50 in 1978.

Mr John Ernstzen, chairman of the Representative Association of Medical Schemes, confirmed today that the pay packets of most of the two million members would be hit by higher subscription rates.

A few schemes had already introduced the increases but the bulk of them would apply the new rates from July or August.

Private hospitals

The new round of rises had been triggered by upward swings of fees charged by doctors and dentists — and now private hospitals.

How hard individual pay packets would be hit depended on how much the employer contributed towards subscriptions, varying from scheme to scheme.

"The increases are a tragedy, especially coming on top of the July rise in general sales tax, interest rates and a renewed surge of inflation", Mr Ernstzen said.

"Unless the brakes are applied soon, only the rich will be able to afford proper medical cost coverage.

"The problem is that too many people are making far too much use of frivolous medical treatments simply because they feel they should take maximum advantage of their cover.

"The general public and the medical profession alike need to exercise more self-discipline and stay within reasonable limits of essential treatment".

An analysis shows that subscription rates have almost trebled since 1978.

Medical aids usually pay maternity benefits

By Susan Pleming

Most medical aid schemes pay maternity benefits to single women and to married women whose husbands do not belong to their (the women's) medical aids.

This emerged during a random survey of eight medical aid schemes in which only one stipulated that married women whose husbands did not belong to their (the women's) own schemes could not claim.

The survey was prompted by a statement issued by the director of the Women's Bureau, Mrs Margaret Lessing, who urged women joining medical aid schemes to ensure they made provision for maternity benefits.

COMPLAINTS

Mrs Lessing said the bureau had received complaints from unmarried women and married women whose husbands did not belong to their (the women's) schemes, that medical aid was not paid for maternity benefits.

The chairman of the Representative Association of Medical Schemes, Mr John Ernstzen, said last week that most medical aid schemes provided for single women and married women whose husbands were not members of their (the women's) own schemes.

"If the scheme does not cover maternity benefits then this should be clearly stated in the medical aid scheme brochure.

"It is an ethical rule that brochures should not be misleading — if they are then it should be brought to the attention of my association," Mr Ernstzen said.

The Sanmed Medical Aid Company provides for unmarried women but not for married women whose husbands were not registered on their (the women's) schemes.

The general manager of Sanmed, Mr Jan Fernhout, said this stipulation was clearly set out in the company's brochure.

A representative from Boart Medical Aid Society said all women were covered for maternity costs on their scheme.

"Any member is covered — even the unmarried pregnant daughter of a man who is a member," she said.

Some medical aid companies, such as the Cape Medical Plan and Compcare Medical Aid stipulate, that a woman must have been a member of the scheme for at least nine months before she can claim maternity benefits.

The claims supervisor of Compcare, Mrs Marilyn Leeder, said: "We pay the Government Gazette rate which is R56 a day. This pays for the woman's hospital bed. We do not pay nursery fees or for the use of a television or telephone."

She added that her company paid for most of the drugs used by the mother.

"We do not pay for extras such as nappies and plasters — these extras usually cost the mother about R40," Mrs Leeder said.

UNMARRIED

A representative for Medicaid said her company had only paid out maternity costs to unmarried woman and women whose husbands did not belong to their (the women's) scheme since 1982.

"Until 1982 we provided maternity benefits only if the wife was a dependent of the husband," a spokeswoman said.

"Now we cover all women whose husbands do not belong to the scheme."

Medical aid members are told: Put the pressure on

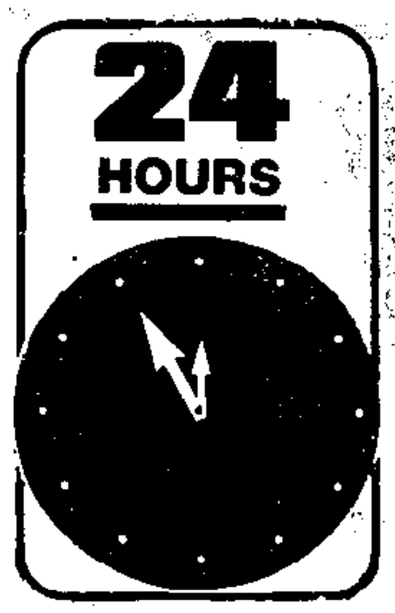
By Michael Chester

Rank and file members of medical aid schemes were urged today to launch pressure groups to demand reforms aimed at curbing increases in subscription fees now nearly three times higher than six years ago.

And employers were advised to join forces and create a special nation-wide standing advisory committee to agree on reforms to check the escalation of fees.

The campaign was triggered by Medicare, one of the largest independent medical aid consultancies, after most medical aid schemes had to fall into line with average increases in monthly subscription rates of about 15 percent.

Mr Barry Elder, managing director, sounded a warning that several schemes which handled medical aid services faced the threat of collapse unless urgent reforms were tackled.



ONLY RICH

Mr John Ernstzen, chairman of the Representative Association of Medical Schemes, confirmed fears that only the rich would be able to afford cover unless new ways were found to rein in on fee increases.

Cash flowing into schemes from subscriptions had risen from R396 million in 1978 to an annual flood of more than R1 000 million.

Medicare had launched a drive to encourage companies and individual members themselves to form their own associations and find ways to reorganise and revitalise the whole movement.

Mr Elder said the crux of the problem was that administration companies — which he accused of usurping the power of management companies — demanded fees based on an 8,5 percent of overall income from subscriptions.

Their combined fees would soar to R85 million a year as total subscriptions were pushed to R1 billion a year by the latest increases.

The first ambition of pressure groups should be to insist that administration fees should be based on the number of members in each scheme. This would encourage schemes to grow and spread the costs.

EXCUSES

The next target should be to strip many schemes of a lengthening list of non-basic extra services that were used as sweeteners and excuses for fee increases, but which should be made the responsibility of members themselves if they wanted to indulge in non-essential treatment.

Also, more patients should be made to settle their own accounts, and then put in claims for refunds, forcing them to be more aware of costs of over-usage of medical cover and exercise more restraint in seeking unnecessary consultations.

This in turn would reduce running costs.

"The time has come for members themselves to demand a new deal that will slow down the nonsensical spiral of fees," said Mr Elder. "Otherwise the whole system will crack".

(299) D. Dispatch 8/8/84

200 on centre's waiting list

EAST LONDON — There was a waiting list of more than 200 people for the Parkridge Workbench Centre, a protective workshop for the mentally and physically handicapped, said Mr Y. Masoet, a spokesman for the Border Round Table organisation which was involved in the project.

Mr Masoet said the centre accommodated 50 people and he hoped that a second phase, the building of second workshop to accommodate 100 more workers, would start soon. A third phase would include a canteen, hostel and other facilities.

The project was the result of a joint effort by the Cripple Care Society and the Mental Health Society and Round Table.

Round Table 229 of East London had motivated the project at a meeting of the National Association of Round Tables.

The association pledged R120 000 of which R10 000 was raised locally by the six Round Table clubs. — DDR

Technical training centre opens for handicapped staff

By Kathy O'Reilly

Disabled people in South Africa will benefit from an exciting and innovative move, thanks to a Benoni technical training centre which recently opened its doors to them.

It is believed to be the first time that a South African technical training centre has been adapted to meet the needs of the physically disabled.

A forgotten minority to many, to the Apex Training Centre they are an important group of potential manpower who could be trained in skills qualifying them for employment on the open labour market.

Mr George Louwrens, Apex's business manager, explains that the centre has applied to the National Development Fund for a loan to pay a whopping R280 000 in building and development costs.

At the moment Access College, a Johannesburg-based division of Apex, offers a six-month business and commercial course to disabled students.

Due to lack of space only 12 students can be accepted on each course.

"Apex is an extension of the Access college concept," explains Mrs Priscilla Stevenson who is responsible for training the disabled students at both centres.

"We realised that it was necessary to be able to cater for another group of disabled people — those who wished to be trained in technical, rather than business and commercial skills — and for this reason Apex has been opened to them," she says.

At Apex students will be trained in technical and operative skills and the proposed hostel will accommodate 18 wheelchair-bound students. Less disabled students will be housed with their able-bodied colleagues.

Mrs Stevenson explains that many of the courses offered by Apex will be suitable for the disabled student.

"Of course this will depend on the aptitude, motivation, interest and physical ability of the applicant," she says.

"We expect courses like mechanical and electrical aid, welding, storekeeping, pipelaying, forklift operating, small plant maintenance and a chef's course to be available."

The centre is multi-racial and students of both sexes are welcomed.

During their technical training students will also be instructed in work preparedness, goal setting, interviewing skills and finding a job on the open labour market.

"Many of the students have never actually worked as disabled people so they have to adapt to a work situation from a wheelchair.

"We'll train them to do that," says Mrs Stevenson. "We take them from a situation of unemployment and prepare them for employment.

"We don't train them to compete with the physically able, but rather to use their potential in the form of skills which they can offer their company," she says.

"We also continually assess the student's ability to cope with any problems he might be experiencing during training."

Integration between disabled and able-bodied at Apex will be encouraged. The dining room will be shared, courses will be taken together wherever possible and all students will be invited to participate in after-class functions such as movies, discussions and socials.

But separate hostels are necessary for the wheelchair-bound students: "They would not cope in the present hostels and the proposed hostel is being very carefully planned," says Mr Louwrens.

"For example, the corridors must be the width of two wheelchairs. The bathrooms must be big enough for a wheelchair's 360 degree turn.

"The baths, toilets, showers and so on must be specially constructed. Even the height of a doorknob will differ and of course we are also adapting the grounds and other buildings with ramps, rails and so on."

On-the-spot nursing care and the availability of psychologists and therapists are further innovations. Mr Louwrens is positive that businesses will employ disabled graduates of the college.

"I visualise a lot of companies showing an interest. If they require specifically trained people I am sure they will come to us," he says.

Inquiries may be addressed to Apex Training Centre, PO Box 1704, Benoni 1500, to Access College, PO Box 59071, Kengray 2100 or to Mrs P Stevenson (011) 615-7323.

urban areas in the Republic to Black states in 1984 or during the latest specified period for which figures are available and (b) (i) from which urban areas and (ii) to which Black states were they moved in each case?

The MINISTER OF CO-OPERATION AND DEVELOPMENT:

(a) 5 122 during 1984.

(b)

(i)	(ii)
Louis Trichardt	Venda (415)
Pretoria	KwaNdebele (13)
Witbank	KwaNdebele (528)
	KaNgwane (53)
	Lebowa (62)
	Gazankulu (5)
Sannieshof	Bophuthatswana (5)
Stilfontein	Bophuthatswana (17)
Klerksdorp	Bophuthatswana (6)
Germiston	KwaZulu (14)
	KaNgwane (9)
	KwaNdebele (5)
	Transkei (5)
	Bophuthatswana (8)
Brakpan	Lebowa (2)
	KaNgwane (5)
	Qwaqwa (9)
	KwaZulu (1)
	KwaNdebele (38)
Boksburg	KwaNdebele (14)
Benoni	KwaNdebele (13)
Delmas	KwaNdebele (8)
Heidelberg	KwaZulu (6)
Krugersdorp	KwaNdebele (6)
Nigel	KwaZulu (6)
	KwaNdebele (26)
	KaNgwane (5)
	Bophuthatswana (2)
Roodepoort	Bophuthatswana (5)
Soweto (Johannesburg)	Qwaqwa (11)
	KwaZulu (4)
	Transkei (3)
	KaNgwane (6)
Springs	Transkei (25)
	Bophuthatswana (12)
	Lebowa (15)
	KwaNdebele (52)
	KaNgwane (27)
	Qwaqwa (4)
	Ciskei (2)
Evaton (Vereeniging)	Qwaqwa (6)
	Lebowa (7)
Pinetown	KwaZulu (15)
Howick	KwaZulu (77)
Sinkwizi	KwaZulu (4)
Hluhluwe	KwaZulu (5)
East-London	Ciskei (2 566)
Jan Kempdorp	Bophuthatswana (336)
Barkly-West	Bophuthatswana (2)
Delportshoop	Bophuthatswana (6)
Salt Rock	Bulwer (5)
Darnall	Bulwer (8)
Umhlali	Bulwer (12)
Allanridge	Botshabelo (357)
Luckhoff	Botshabelo (264)

Z99 Hansard Q.601.449 6/3/85

Amounts paid to disabled persons

273. Mr P A MYBURGH asked the Minister of Health and Welfare:

What amount is paid per month to persons who served in (a) wars prior to World War I, (b) World War I, (c) World War II, (d) the Korean War and (e) post-Korean wars and who are (i) 100, (ii) 70, (iii) 50 and (iv) 30 per cent disabled as a result of injuries sustained in action?

The MINISTER OF HEALTH AND WELFARE:

(a) (i) Nil.

(ii) Nil.

(iii) Nil.

(iv) Nil.

(b) (i) R545,47.

(ii) R981,81.

(iii) R1 051,96.

(iv) R2 711,72.

(c) (i) R82 257,15.

(ii) R48 586,38.

(iii) R11 652,06.

(iv) R177 742,56.

(d) (i) Nil.

(ii) Nil.

(iii) Nil.

(iv) Nil.

(e) (i) R81 454,39.

(ii) R21 881,09.

(iii) R50 400,98.

(iv) R56 754,29.

Communities/townships to be removed

297. Mr R A F SWART asked the Minister of Co-operation, Development and Education:

(1) (a) How many Black communities or townships remain to be removed in each province, (b) what is the (i) nature and (ii) total population of each such community or township and (c) in respect of what date is this information furnished;

(2) (a)(i) where and (ii) when will the inhabitants of each such township or community be resettled and (b) what is the total estimated cost of resettling these communities?

The MINISTER OF CO-OPERATION AND DEVELOPMENT AND OF EDUCATION:

(1) (a), (b) and (c). In view of my recent announcement that the Government is at present reviewing previous deci-

contribution be repaid to the Equalization Fund.

(b) In order to create an improved utilization of local refining capacity thus decreasing production unit costs and to earn foreign exchange for the RSA.

(2) (a) No.

(b) Yes.

(c) No.

(i) and (ii) The South African Government has no say in the prices offered which differs from consignment to consignment as offers are made in competition with foreign refineries. Suppliers must, however, certify that exports will not be to the detriment of local consumption and that it would be a foreign exchange gain for the RSA.

Hansard Q.61.443
(768) 5/3/85

Telephone electricians

390. Mr A B WIDMAN asked the Minister of Communications:

(a) How many (i) Coloured, (ii) Asian, (iii) White and (iv) Black learner telephone electricians completed their training in 1984 and (b) how many electricians in each race group are employed by his Department at present?

The MINISTER OF COMMUNICATIONS:

(a) (i) 162,

(ii) 104,

(iii) 489,

(iv) 186; and

(b) (i) 809,

(ii) 493,

(iii) 7 743, and

(iv) 561

Note: The figures under (b) reflect the position on 31 January 1985 and include all electrician grades except learners.

Commissions/departmental committees

399. Mr K M ANDREW asked the Minister of Defence:

(1) How many (a) commissions and (b) departmental committees of inquiry were appointed in respect of his Department in 1984;

(2) Whether any of the reports of such commissions and committees have been completed; if so, (a) how many and (b) of which commissions and committees;

(3) whether any of the reports of such commissions and committees have been made public; if so, (a) how many and (b) of which commissions and committees;

(4) what is the total estimated cost relating to each of these commissions and committees?

The MINISTER OF DEFENCE:

(1) (a) None.

(b) One.

(2) No. (a) and (b) Fall away.

(3) Falls away.

(4) R74 000.

Commissions/departmental committees

407. Mr K M ANDREW asked the Minister of Transport Affairs:

(1) How many (a) commissions and (b) departmental committees of inquiry were appointed in respect of the Department of Transport in 1984;

(2) whether any of the reports of such commissions and committees have been completed; if so, (a) how many and (b) of which commissions and committees;

(3) whether any of the reports of such commissions and committees have been made public; if so, (a) how many and (b) of which commissions and committees;

(4) what is the total estimated cost relating to each of these commissions and committees?

The MINISTER OF TRANSPORT AFFAIRS:

(1) (a) None.

(b) One.

(2) No.

(a) and (b) fall away.

(3) No.

(a) and (b) fall away.

(4) R1 450 in respect of subsistence- and travel allowances of officers of the Department of Transport serving on the Committtee of Enquiry into Bus Passenger Transport in Kangwane and Adjacent Areas.

Field's Hill bypass road: Toll Plaza

441. Mr R M BURROWS asked the Minister of Transport Affairs:

(1) Whether the National Transport Commission has secured a loan to finance the proposed Toll Plaza on the Field's Hill bypass road; if so, (a) when was the loan obtained, (b) what was the amount of the loan, (c) what is the period of the loan and (d) for what purpose is the loan intended;

(2) Whether the anticipated revenue from this project will be used to defray the loan and the interest on the loan; if not, (a) why not and (b) in what manner will the said loan and interest be defrayed;

(3) what amount in revenue does his Department estimate will be obtained from this toll road annually?

The MINISTER OF TRANSPORT AFFAIRS:

(1) Yes.

(a) Between January 1984 and January 1985.

(b) Five separate loans totalling R32 510 673,19. An additional loan for an amount of R1 650 000 will be negotiated at a later stage to complete the project.

(c) Various redemption periods extending between 3 and 20 years have been negotiated.

(d) To finance the construction of the last road contract of the project namely the section between the Umhlatuzana viaduct and Key Ridge including the toll collection facilities.

(2) Yes.

(a) and (b) fall away.

(3) R2 400 000 during the first year thereafter increasing gradually.

WEDNESDAY, 6 MARCH 1985

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†Indicates translated version.

For written reply:

General Affairs: 271 Hansard 207

Blacks moved from urban areas to Black states

Q.61.446 6/3/85

161. Mr R A F SWART asked the Minister of Co-operation and Development:

(a) How many Blacks were moved from

Medical schemes not responsible for those late payments

Cape Times 20/3/85 299



From DAVIDSON & EWING HOLDINGS (Pty) Ltd, Foreshore, Cape Town:

WE REFER to the article "Medical Aid Payments — other side of the coin", (Watchdog, Cape Times, March 12) under the editorship of Mr Molloy.

It is deplored that Mr Molloy did not see fit to refer the so-called complaints to the various organizations mentioned in order to ascertain where the specific fault lay in each case. If the complaints were indeed valid, in terms of the Medical Schemes Act, the doctors in question have the right to report such matters direct to the Registrar of Medical Schemes for action and not RAMS as suggested in the article.

For the edification of your readers, we state the following facts pertaining to the Davidson & Ewing organization: Our organization administers (not controls) 23 different medical schemes with a membership of approximately 140 000 families. Each month this organization processes in excess of 200 000 claims with a value of approximately R8,5 million.

Each society has a cut-off date for receipt of claims round about the 10th of the month and *every* account which is received by that date is either paid to the supplier, refunded to the member or returned to the member for additional details as required by the Medical Schemes Act. In order to accommodate accounts that arrive later than the cut-off date an interim payment is made to suppliers in the second week of the following month.

All liquid funds of the societies (except such amounts as may be on fixed deposits representing their reserves) are placed in a daily call account until required to pay claims. All interest earned is for the account of the society concerned and obviously assists in balancing the budget of the society.

The administration costs of every society are controlled by the Registrar of Medical Schemes and are in fact a calculated percentage of contribution income determined by the relative management committee of each society. These committees are either elected by the members from the members and/or appointed by the employer organizations.

Mr Molloy has pointed out some of the frailties of members but our experience allows us to be able to list numerous others. Such actions by the members cannot be laid at the door of a scheme or the administrators; for example a member not submitting an account; a member misusing the refund instead of payment to the supplier; delaying submission of account in order not to have to pay his portion thereon.

The medical profession is also not without blame in this respect. As was stated above, after three months the profession may submit an account direct to the society provided it is charged in accordance with the prescribed schedule of benefits. Once again, payment would be delayed if the member's name, number and society are not specified, or if the account is not in terms of the schedule of benefits, to mention only some of the requirements specified in the regulations to the Medical Schemes Act.

An invitation has already been extended to your Mr Molloy to visit our offices and to satisfy himself on the points mentioned above. This invitation was refused. A similar invitation is extended to any of your readers who wish to take the opportunity!

WATCHDOG comments: I am quite satisfied that D & E knows its business, hence there is no need for me to make an uninformed inspection of the operation.

D & E does not deny the complaints and the deafening silence from the medical aid societies in question tends to bolster them.

Perhaps more important to the hard-hit consumer is the fact that the Medical Schemes Act permits an administrative fee of 14 percent. This is paid for administration, which means the control of all subscriptions and claims.

Assuming a monthly income of R10 million, very conservative in view of claims paid out, that means D & E have a monthly cream-off of at least R1,4 million — a bit overpriced for a set-up which administers but does not control.

□ □ □

From ANCILLARY HEALTH SERVICES EXECUTIVE:

RE MEDICAL Aids: Please accept my congratulations on an interesting, analytical and objective piece of journalism.

As mentioned, however, it might be of further interest to point out that nine of the 10 named "culprits" are, in fact, unregistered schemes, falling outside the ambit of the Act by virtue of being state or quasi-state schemes. Perhaps mention of this might put a somewhat different perspective on the situation.

□ □ □

From MEDICAL DOCTOR:

I NOTICED that your article dealt almost exclusively with the length of time doctors had to wait before getting paid. While this is true, and causes a lot of frustration and anger amongst us, I do feel that you have not addressed the most important issue i.e. how is the patient affected by all this?

Mr Erntzen states that there are 240 MA societies registered with RAMS.

However, what he fails to mention is that there are 987 medical aid societies/funds in South Africa — and this figure has probably increased by now.

Only 65 of these 987 medical schemes are prepared to pay the chemist directly for the medicine dispensed by him. (This is a figure obtained from a list issued by the Pharmaceutical Society.)

With rising costs of drugs, those members of the poorer communities — who have no choice in the matter and are compelled to belong to a medical aid as part of the employment package whether their wages justify belonging to the society or not — haven't the money to buy their medicines at the chemist first and only then to claim a refund from the medical aid society.

This results in many patients not getting their medicines at the chemist.

I think that you would be doing a great service if you could establish why only 65 out of 987 medical aid societies pay chemists directly for medicines, and try to pressurize the others into changing this facet of their operation.

Natal: White 1 (December 1984)
Coloured 1 (December 1983)
Asian 1 (March 1984)
Black 23 (4 in December 1983, 1 in January 1984, 4 in February 1984, 1 in March 1984, 5 in April 1984, 3 in May 1984, 2 in June 1984, 1 in July 1984, 1 in August 1984, 1 in October 1984)

OFS: White 0
Coloured 0
Asian 0
Black 2 (1 in December 1983, 1 in July 1984)

Transvaal: White 1 (September 1984)
Coloured 1 (December 1983)
Asian 0
Black 11 (1 in December 1983, 3 in January 1984, 1 in April 1984, 2 in May 1984, 1 in October 1984, 2 in November 1984, 1 in December 1984)

(b) Deaths in all Provinces during the period December 1983 to December 1984: 0

(2) (a) health education
(b) continuation of an effective comprehensive immunization programme

(c) surveillance.

Hansard Q.601.811
Family planning section: staff complement
25/3/85
565. Mr G B D McINTOSH asked the Minister of Health and Welfare:

(1) (a) What is the staff complement of the family planning section of his Department and (b) how many posts in this section are vacant at present;

(2) whether any steps are being taken to fill these vacancies; if not, why not; if so, (a) what steps and (b) when is it anticipated that they will be filled?

The MINISTER OF HEALTH AND WELFARE:

(1) (a) 2 349.

(b) 598 posts as at 28.2.85.

(2) Yes.

(a) suitable applicants are being recruited on an ongoing staff recruitment basis.

(b) when suitable applicants become available, and with allowance for present financial constraints.

Substandard A

572. Mr H E J VAN RENSBURG asked the Minister of Co-operation, Development and Education:

How many Black children were enrolled in 1984 in Substandard A in (a) each specified region and (b) the Republic?

The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

The honourable member is referred to table 3.4.2., page 192 of the 1984 annual report of this Department.

Tsitsikamma Toll Road

584. Mr D J N MALCOMESS asked the Minister of Transport Affairs:

(1) Whether a viewing site is being developed at the Tsitsikamma Toll Road; if so (a) what is the total estimated cost involved and (b) what company is constructing it;

(2) whether tenders were called for the construction of the viewing site; if not, why not; if so, (a) who were the tenderers and (b) what was the tender price of each such company.

(3) whether the lowest tender was accepted; if not, why not?

The MINISTER OF TRANSPORT AFFAIRS:

(1) A rest area including a viewing site, picnic facilities, and ablution block, internal roads and parking areas, a tourist information centre and the caretakers accommodation is under construction at the Tsitsikamma Toll Road.

(a) R3,7 million.

(b) Messrs. L.T.A. Earthworks (South).

(2) (a), (b) and (3).

No. In view of the circumstances set-out below the work was performed as a supplementary brief to an existing contract in respect of which tenders were invited. Factors taken into account by the National Transport Commission in not inviting tenders for this part of the work were as follows:

(i) The remoteness of the site;

(ii) To limit construction costs. The contractor was already working on the road adjacent to the rest area; and

(iii) The undesirability of engaging more than one contractor to carry out work on a small site.

Tenders were, however, called for by L.T.A. Earthworks (South) in respect of the construction of facilities at the rest area including electrical installations and power supply units

Buildings:	R million
(i) LTA Building (Eastern Province)	1,55
(ii) B and E Construction	1,61
(iii) Andrew Hannah and son	1,64

As the tendered prices were all considered to be too high the work was undertaken by L.T.A. Earthworks (South) with the assistance of a masonry sub-contractor, Eastern Cape Contracting Services, at a total cost of R880 000.

Electrical installations:	R
(i) Elmec Industrial	396 427
(ii) Crown House Engineering	425 074
(iii) Smith and Weldrich	420 241

The lowest tender namely that of Elmec Industrial was accepted.

Power supply units:	R
(i) Meisner	85 000
(ii) V and R Engineering	93 245

The lowest tender namely that of Meisner was accepted.

399 Hansard
Q.601.814 25/3/85
Military disability pensions
594. Mr B B GOODALL asked the Minister of Health and Welfare:

(a) How many persons are in receipt of military disability pensions and (b) what amount was paid out in such pensions in respect of the year ended 31 March 1984?

The MINISTER OF HEALTH AND WELFARE:

(a) There are currently 12 252 Military pensions in payment.

(b) R26 816 603.

in infant colic and in infants under six months of age is currently being investigated by the Council and a decision in this regard is to be taken at its meeting on 19 April 1985.

(299) Hansard
Q. Col. 823 25/3/85

Institutions/centres for disabled persons

642. Dr M S BARNARD asked the Minister of Co-operation, Development and Education:

(1) Whether his Department has statistics on (a) institutions for disabled persons and (b) handcraft centres in the national states; if not, why not; if so,

(2) how many (a) institutions for the (i) blind, (ii) deaf and (iii) physically disabled and (b) handcraft centres are there in (aa) KwaZulu, (bb) Qwa-Qwa, (cc) Lebowa, (dd) Gazankulu and (ee) KaNgwane at present;

(3) in respect of what date are these statistics furnished?

The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

(1) (a) Yes, in respect of schools only.

(b) No, because handcraft centres are not controlled by the Education Departments.

(2) (a) (aa) (i) 2 schools.

(ii) 2 schools.

(iii) 1 school.

(bb) (i) 1 school.

(ii) 1 school.

(iii) None.

(cc) (i) None.

(ii) None.

(iii) 1 school.

(dd) (i) None.

(ii) 1 school.

(iii) 1 school.

(ee) (i), (ii) and (iii) None.

(b) Not applicable.

(3) Figures are as on 1 March 1984.

KwaZulu has four schools of which one caters for both death and blind pupils.

Qwaqwa has only one school which caters for both deaf and blind pupils. Gazankulu has only one school which caters for both death and physically disabled pupils.

Hansard
Q. Col. 824 25/3/85

Pinetown/New Germany: strikes

661. Mr R M BURROWS asked the Minister of Manpower:

(1) Whether any legal and/or illegal strikes occured in the Pinetown/New Germany industrial area in the latest specified year for which figures are available; if so, how many (a) legal and (b) illegal strikes;

(2) whether the South African Police were called in respect of any of these strikes; if so, (a) on how many occasions, (b) how many persons were involved in (i) legal and (ii) illegal strikes in each race group in this area and (c) what were the causes of these strikes?

The MINISTER OF MANPOWER:

(1) According to the records of the Department of Manpower there were no legal strikes in the Pinetown/New Germany industrial area during 1984.

(a) Falls away.

(b) 29.

(2) The Department of Manpower is not aware of and does not keep a record

of Police involvement in strike action.

(a), (b) and (c) fall away.

Footnote: In regard to 1(b) above, the position is as follows:

Workers involved	
Whites	None
Coloureds	48
Asians	746
Members of the Black Population group	4464
Reasons	
Wages	11
Disciplinary measures	5
Conditions of employment	11
Other reasons (Retrenchment)	2

X Hansard Q Col. 825 X
25/3/85

South African Army Women's College

668. Mr P A MYBURGH asked the Minister of Defence:

(a) When was the South African Army Women's College in George established, (b) what were the reasons for establishing the college at that time, (c) how many trainees were based at the college in each specified year since its establishment up to the latest specified year for which figures are available and (d) what is the nature of the training given at this college?

The MINISTER OF DEFENCE:

(a) In 1977 as a development of the Civil Defence College which was established in 1970.

(b) The reason for the establishment of the Civil Defence College was to train young women as future leaders in Civil Defence and to motivate them to perform community service.

When the SA Army College was established the rôle was changed to train young women

—In military skills with a view to attestation in the Permanent Force and the Citizen Force and Commandos.

—To prepare them more fully to play a leading rôle in the South African community.

(c)

1971	128
1972	137
1973	146
1974	152
1975	147
1976	150
1977	151
1978	229
1979	232
1980	222
1981	309
1982	309
1983	330
1984	166
1985	211

Note: Between 1978 and 1983 there were two intakes per year.

(d) It consists of practical and theoretical training in the following subjects:

Squad drill, marksmanship and field craft, first aid, military traditions and customs, personnel, stores and pay administration, telecommunications, fundamentals of civil defence, fire fighting, self defence, physical training and leadership training.

South African Army Women's College

669. Mr P A MYBURGH asked the Minister of Defence:

(1) (a) What was the staff establishment of the South African Army Women's College at George as at the latest specified date for which figures are available and (b) in respect of what posts are these figures given;

(2) whether all the members of the college staff are uniformed members of the South African Defence Force; if not, (a) why not, (b) how many (i) are and (ii) are not uniformed members of the Defence Force and (c) (i) what categories of posts are filled by persons not in uniform and (ii) how

Watchdog

Medical aid admin not 'creaming off' — admin's view

Cape Times 26/3/85

299

From M B W WOLLMER, director of Davidson and Ewing Holdings:

ONCE again it is necessary to point out Mr Molloy's deliberate insistence of not acquainting himself with the facts of a case before rushing into print.

He states: "Perhaps more important to the hard-hit consumer is the fact that the Medical Schemes Act permits an administrative fee of 14 percent. This is paid for administration, which means the control of all subscriptions and claims." It would be interesting to be acquainted under which section of the Act or the Regulation to the Act an administration fee of 14 percent is permitted.

The balance sheets of all societies administered by D & E are available at the office of the Registrar of Medical Schemes. Reference to such documents will reveal that the total administration costs over the entire group of schemes averages less than 5,5 percent of subscription income! The inference that any management committee of the relative schemes would tolerate administration costs as contended by Mr Molloy is a reflection on their responsibility.

□□□

From Mr H WOLFFE:

AS CHAIRMAN (honorary) of Erica Medical Aid Society, one of the schemes administered by SA Medical Aid Consultants, a wholly owned subsidiary of Davidson & Ewing and providing cover for some 3 600 families, I wish to correct certain misconceptions which appear to emerge from your comments to the Davidson & Ewing letter appearing in the Cape Times of March 20, 1985 under Watchdog column.

The management committee "controls" the policy of the society within the confines of the Medical Schemes Act and are elected by/from the members or employers and render their services *without recompense*!

The administrators are appointed by the above-mentioned committee at an agreed fee and such fee embraces the *entire* cost of running the society excluding only the audit fees, medical adviser's fee, statutory levies and advisory association (RAMS — compulsory membership) and in some cases bank charges which are fluctuating and all the above costs in the case of this society amount to 6,79 percent of subscription income.

There are no other administration costs.

The administration business is open to anyone and every society in free to negotiate an equitable administration fee to suit its own best interests.

I think I am in a better position than is Mr Molloy to judge what is involved in the administration of a medical aid scheme and if I were Davidson & Ewing I would take strongest exception to the derogatory inference of his expression "cream off" as applying to them.

WATCHDOG comments: "There is no question that the work of Mr Wolffe and his management committee is both competent and selfless. His leap to the defence of his administrators is admirable, though it would help if his figures agreed with those put forward by Davidson and Ewing.

"Mr Vollmer's information is invaluable and is published here for public debate. I would be grateful for sight of the balance sheets of the societies in question, including those fully controlled by D & E, and assume that Mr Vollmer will dispatch copies by return of post."

Capt Times 9/4/85 299

Watchdog

No concern of yours

From Mr M B W Vollmer, director of D and E:

In finality of this very aptly named "slanging match" we give the following facts:

1. We are quite sure that reference to the Registrar of Medical Schemes will confirm that our *average* costs are as low as the *average* cost of the entire medical aid movement throughout the country.

2. By no stretch of imagination can salaries (we have 231 staff), rental of premises, telephones, postages, stationery, computer costs, printing and equipment hire be described as "fixed minimal overheads".

3. Administration costs vary subject to the type of scheme each of which requires special different expertise, that is in house, conglomerate or Individual membership schemes, and the percentage of benefits allowed i.e. disincentive or 100 percent.

My board of directors wish to inform you that any profit which may be made by Davidson and Ewing can only be due to their expertise after 25 years in this field and is certainly no concern of yours.

Once again we extend an open invitation to anybody who wishes to view our operation and in the meanwhile thank the Cape Times for the massive free publicity.

Medical aid scheme — the costs

THE debate so far: A WATCHDOG survey of city doctors found a surprisingly large percentage of late payments by medical aid societies. Publication of the results of the survey sparked off denials from medical aid administrators, including Davidson and Ewing which administers a number of medical aid schemes. Noting the no-risk, fixed payment nature of the operation, WATCHDOG commented on what appeared to be an oversupply of cream in the medical aid cake and cited the Registrar's authority to permit up to 14 percent administration fees.

D and E bounced back with an average figure for their 71 schemes of 5,5 percent, though none of their member societies which supported this view were able to show an admin rakeoff of less than 6,3. WATCHDOG was directed to look at the member schemes' balance sheets. We gratefully declined the offer, preferring instead to see D and E's balance sheets. The saga continues:

WATCHDOG comments: We have no doubt that the Registrar will decide whose concern it is. However, before we become buried under the red herrings, it would be as well to restate that the original aim was to publicize late payments to doctors by medical aid funds. If the debate has raised the awareness of medaid administrators to the problem then it has been worthwhile. The survey will be repeated six months hence.

Typo Union on the cost of funerals

FROM an editorial in the journal of the SA Typo Union:

Undertakers are exploiting the consumer by specifying a certain coffin in the burial policy. This means that those left behind have to pay in large amounts of money for the specified coffin. Unfortunately, the inadequacies of the burial policy are discovered only after the policy holder has passed away. A spokesman for the Consumer Council has said that he would never advise anyone to take out a burial policy, but rather to take out an ordinary life policy and to cede this to a member of the family.

Investigation found that a coffin purchased from the manufacturer for a price of R750 was displayed by the undertaker for a price of R1 500.

There is a system whereby the consumer now can purchase a coffin from the manufacturer, and for an additional R10 or R20 the coffin can be stored in the factory until the owner passed away.

What is the cost of the funeral to the deceased family? Depending on the choice of the coffin, additional services and transport, a funeral can cost between R648 and R1 185 (for whites) and R361 and R945 (for blacks) on the Witwatersrand. This does not include the price of the plot.

These amounts are for the burial fees and include the cost of the coffin, the transport and care of the corpse, the use of the funeral parlour and chapel, the use of the hearse, labour and administration fees.

There are additional charges for the printing of funeral pamphlets, wreaths, donations to the minister and organist, and for the placing of the funeral and death notices in the newspaper. The family can choose if they wish to attend to these matters themselves or if they wish the undertaker to do so.

Residents in Cape Town who wish to reserve a grave in the Maitland cemetery have to pay R530 for the grave and R110 for the digging: R640. The price of a unreserved grave is R430 plus the R110 digging fee: R540. There are cheaper graves in certain sections of the cemetery available at a cost of R340 for the grave and R110 for the digging: R440.

The above is an indication of the high costs and varying price structures connected with funerals and it is for these reasons that the South African Typographical Union have provided a death benefit scheme to assist members with burial costs.

Medical scheme fees increased by 10 p c

Mercury Reporter

THE Sanitas Medical Scheme, whose members are mainly civil servants, increased its fees by 10 percent from April 1.

Mr A M Jackson, a spokesman for Medscheme, Durban — administrators of the scheme — yesterday confirmed the rise and said it was a 'normal annual increase'.

The management committee found it necessary to increase subscriptions mainly because of an increase in claims costs, he said, adding that they had intended making major improvements in benefits.

'However, the Government was unable to approve this proposal. It nevertheless remains the intention of the management committee to strive for improved benefits for members,' he said.

Mr Jackson said some of the improvements the committee was seeking included an increase in the annual limit of medicines bill, hospital daily accommodation rate and theatre fee benefits.

Hospital fees had been increased recently and the medical scheme needed to keep pace with the higher claims cost, he said.

The monthly contribution of a member without dependants, earning a salary of R3 000 a year increases to R7,65, and for a member with two or more dependants, to R15,55.

For the R3 001 to R6 000 a year pay bracket, a member with one dependant will pay R19,25 and for a member earning an annual salary of above R6 000 the fee will be R11,15 if he has no dependants, R22,90 for two dependants and R26,10 for two or more dependants.

In most cases, employers also contributed towards medical aid schemes for their employees at double the rates paid by its workers.

Part 1 of a two-part series on hospitals and the individual.

The frightening cost of medical treatment

NM 12/4/85 (299)

WHILE, of necessity, we are forced to learn to live with inflation, the steady increase in prices is unlikely ever to wipe a wage-earner out financially.

But the private fear of many of us, even big income earners, is that an unexpected serious illness, perhaps needing months of hospitalisation, could do just that. Hospital and treatment bills, we may feel, could soon exceed the limits of the most generous medical aid schemes.

BILL FAILL reports

Would it then be necessary to sell one's assets, even including one's home, to meet the medical bills, which could be accruing at the rate of hundreds of rands a day?

It seems this is an unnecessary fear, according to the many people I spoke to in seeking an answer to this question. To start with, medical aid schemes are more generous than most of us perhaps think.

A married person with more than one dependant can receive maximum benefits of R11 500 under one particular scheme, which regards itself as 'about average' in terms of what it will pay out.

A single person covered by the same scheme could receive a maximum of R4 500.

These pay-outs would cover the great majority of illnesses which necessitated even fairly lengthy stays in hospital.

However, there are undoubtedly exceptions, cases beyond the scope of the best of medical aid schemes. The answer then seems to be that one would have to turn to the provincial hospitals.

'It is our responsibility to provide curative health services for those who can't afford private medical care,' says Dr Neville Howes, Senior Deputy Director of Hospital Services, Natal.

Regardless of how much money one has, one can also turn to the Province from the outset for certain very expensive and highly sophisticated treatments such as radiation therapy and renal dialysis.

At Wentworth Hospital, the same holds good for cardio-thoracic and neurosurgery. Income is not a consideration.

'By-pass operations are being done in the private sector, and although these can cost as much as R15 000, many people prefer to follow the private route,' said Dr Howes.

But although most salary-earners are members of medical aid schemes, many are not. How would they fare if faced with expensive hospitalisation? I asked Dr Howes.

Generally speaking, such people would not be able to go directly to a provincial hospital, unless they earned what is today quite a small salary.

Discretionary powers

'We have discretionary powers in setting the level, but on paper a single person earning in excess of R901 would have to follow a private route. A married man earning less than R1 100 could be admitted directly to a provincial hospital as a hospital patient,' he said.

Once in hospital, the actual charges depend on income, ranging from a free service for a destitute person to a maximum of R45 a day. The latter figure would cover a private suite with its own bathroom.

●The second part of this series deals with the situation faced by a person with a reasonable income but no medical aid scheme.

Pathology fees to rise by up to 25 p c

May 1985

NM 299

Mercury Reporter

THE only pathology laboratory in Durban to which private doctors can send tissue samples has hiked its fees to some medical aid patients by up to 25 percent — an increase which will not be covered by medical aid

This follows failure by the laboratory and one of the biggest medical aid schemes in the country to reach agreement on ways to administer an amendment made last year to the Medical Schemes Act, which prescribes scales of tariffs and procedures for medical aid claims.

Pathology-test bills can run to hundreds of rands. Members of the schemes which fell out with the laboratory will have to pay the 25 percent difference between the medical aid 'scale of benefits' and the amount charged, as well as any excess charged by the scheme.

The laboratory, described as an extensive operation, was 'the only one we can deal with in just about the whole of Natal', said a private doctor who may not be named.

A spokesman for the laboratory said about a fifth of its patients would now pay 25 percent more.

Last December's amendment to the Act had given practitioners the leeway to 'charge anything you like, but within limits and usually following Medical Association guidelines', he said.

Private patients

It had not been possible to reach agreement with a certain 'very big' medical aid society, as well as one or two smaller schemes, on ways for the pathology laboratory to submit accounts directly and so be paid out directly under the amended Act.

Instead, the pathologists had decided to treat members of those societies — which he declined to name — as private patients.

'Traditionally, private patients have always been charged more than the gazetted tariffs,' the laboratory spokesman said.

'Maybe you'll say it's unfair to those patients who are now discriminated against. But some medical aids are just being difficult — and we have cash flow problems and big bad debts.'

He emphasised the laboratory was not profiteering and, indeed, occasionally did work free or at a reduced rate for poor patients.

A spokesman for a national medical aid society quoted from a letter he had received late last month from the laboratory.

It read: 'We are now dealing directly with our patients in most circumstances and, as such, fees higher than the scale of benefits are being charged.'

He said his scheme operated 'in strict accordance with the provisions of the Act' and the laboratory had not been prepared to comply with all the Act's requirements for direct payment to practitioners by medical aid schemes.

'I think they've decided they want to charge higher fees and that's it,' he said.

'SA 15 years behind in family health care'

Give GP his true role professor

299 8/5/85 Star

More than half of South Africa's population has little or no primary health care available to them, according to Professor P Bundred, head of the Department of Family Health at the University of the Witwatersrand.

Speaking at the Department of Anatomy's Luncheon Club, Professor Bundred said South Africa was 15 years behind the United States and Britain in family practice.

General practitioners (GPs) in those countries had been returned to their rightful place as an integral part of the health care system.

He said the aim of family practice was health for all.

"The GPs were the major suppliers of health care for well over a century. But by the middle of the 20th century things had changed," he said.

"World-wide the GP had been replaced in middle class medicine by specialist orientated care."

Reasons for the decline of general practice included the de—emphasis of general practice and primary medicine in medical schools, lack of definition of general practice as a speciality, and overwork among GPs who had solo practices, he said.

UNIQUE

But the GP's knowledge was just as unique and selective as that of the specialist, he said.

He outlined the principles of family medicine as follows:

- Family physicians are committed to a person, rather than a group of diseases or a special technique. Many of their patients may not be "unhealthy" in the true medical sense.
- They seek to understand the social, personal or family context of the illness.
- They should promote preventive medicine.
- They should see themselves as part of the community "social team".
- They should attempt to live in the areas where they work.
- They should not be tied to their offices, but try to see the patients in their own suroundings.
- They should be sensitive to the feelings of their patients and have some insight into interpersonal relationships.

"The current course offered at our medical schools is totally inappropriate to the health needs of South Africa in 1985," Professor Bundred said.

"It is grossly overloaded in terms of high-tec medicine and the basic sciences to the exclusion of social and communicative skills.

"The course is didactic in the extreme and little or no emphasis is placed on problem-solving."

Medical aid fees shock

20 pc rise in subscriptions?

BY NEVILLE SPILLMAN
Weekend Argus Reporter

MEDICAL Aid Society members can expect an increase in monthly subscription rates soon.

Mr John Ernstzen, chairman of the Representative Association of Medical Aid Schemes, said that members of various societies can expect an increase of "somewhere in the region of 20 percent".

Mr Ernstzen said the increase was due to the rise in the cost of medicines and medical services.

Since July last year the cost of prescribed drugs has risen by 22 percent.

In February provincial hospitals increased their daily fees by 32 percent and private hospitals have been granted a 10 percent increase in their rates as from July 1.

Because of this, one medical aid society has been forced to increase its subscriptions by at least 14 percent with effect from next month.

A rise in the levy on all prescriptions can also be expected.

Mr Gideon Barnard, managing director of Cape Medical Plan, said he does not believe the rise in prescribed drugs was caused only through the current economic situation, but that the over-generosity of doctors was also to blame.

Mr Barnard said the purpose for increasing monthly subscription rates was to strengthen accumulated funds.

"The Central Council of Medical Schemes has prescribed that medical aid societies' reserves should equal 25 percent of its annual subscription income. Currently our accumulative rates are at 13,3 percent.

"Some schemes have a negative figure while others' rates are between five to six percent.

"New members don't contribute to the reserve fund and if there is a fairly large influx of new members the ration can be distorted.

"We believe the accumulated fund is there to protect members in case of an emergency," Mr Barnard said.

In spite of the fact that there were no increases in scale of benefits there has been an increase in medical costs.

Members are making use of more services and there is no control over the issuing of prescribed medicine.

Although the current rand-dollar situation has affected the cost of prescribed drugs, Mr Barnard believes that "the finger must not be pointed at the medical aid scheme member, but at the doctor".

The deputy managing director of South African Druggists, Mr Tony Karis, defended Mr Barnard's statement when he said: "The rise in prescribed drugs stems from the current economic climate and over-genereous doctors."

"Although there has not been a dramatic increase in medicines in the past few years, the cost of a prescription has risen considerably because of more sophisticated medicines being used.

"The prescribing habits of doctors have become far more generous," he said.

Mr Karis said that doctors would prescribe a more expensive drug when a cheaper version would be the remedy. "It is a bit like using a bazooka where a pellet gun would be sufficient."

In view of the rand-dollar crises Mr Karis said: "Many active ingredients are imported either in dollars or hard European currency and local manufacturers end up paying more for the material.

"There was a time when medicine was 10 percent of the medical aid costs — now its about 30 percent."

Disabled will get better deal under new laws

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Mercury Reporter NM 17/6/85

REPRESENTATIVES of disabled people in South Africa are working with the South African Bureau of Standards to amend the National Building Regulations draft, which comes into effect in September, regarding access requirements for disabled people.

This will mean all local authorities in South Africa will require building designs to incorporate facilities for disabled people.

The draft was initially gazetted in 1981 and made provision for disabled people. Local authorities could, if they wished, insist on special access requirements for the disabled.

Because of several general objections a committee was set up to evaluate the draft.

When published again in March this year the original provision had been left out.

'It was like a slap in the face,' said Mr Mike du Toit of the organisation, Disabled People South Africa.

In April representatives from the DPSA, the Transvaal Institute of Architects and the National Building Research Institute visisted Mr Kent Durr, deputy Minister of Finance, Trade and Industry.

Other organisations also expressed their concern.

'We were overwhelmed by the reception,' Mr du Toit said.

'Meetings have already commenced between the DPSA and the bureau of standards to write the chapter involving access requirements of disabled people.'

Mr Durr has assured the DPSA that the new section will be implemented as soon as possible.

'We expected to fight for a couple of years to get this. It was quite a shock,' Mr du Toit said.



The chairman of the East London Society for the Blind. Mrs Helen Bosworth-Smith, left, at the opening of the annual meeting yesterday and the mayor, Mr Joe Yazbek and the society's secretary, Mrs Margaret Bilsbury.

Blind society to cut back in Ciskei

Dispatch Reporter

EAST LONDON — The East London Society for the Blind would be forced to reduce its activities in Ciskei while looking to expand its services in South Africa.

This was said in the chairman's report presented at the annual meeting of the society opened by the Mayor, Mr Joe Yazbek, last night.

Representing the South African Council for the Blind, Mr Fred Peters, the treasurer, attended the meeting

The secretary of the East London Society for the Blind, Mrs E.M. Bilsbury, explained that the society could not take on any more cases or expand in the Ciskei but the clients now there would continue to be supported.

The organisation received subsidies from the Department of Co-operation and development for use within South Africa.

"Many of our clients have been removed from Duncan Village to Mdantsane. While we want to increase our services in areas like Duncan Village, Cambridge and Gonubie, we'll maintain our clients in Ciskei," she said.

"We've got to expand in the Republic but we won't let our Ciskei clients down."

The society has 275 blind and partially-sighted persons of all races with blacks being the largest number, some of whom are residents in Mdantsane.

Members of the executive recently met representatives of the black community as a preliminary to forming a black committee.

The meeting was held on the society's new premises at 12 Elton Street in Southernwood. Mrs Bilsbury said: "Now that we've bought the house, our income from interest will be down in the future. We'll have to look more to fund-raising in the coming year."

The financial adviser, Mr Eric Chapman, said he felt that while the new investment of the house would not bring in money, it would be a worthwhile investment in many other ways.

The financial report stated over R20 000 was spent on aid to blind people during the past year. Among the various uses of the money were schooling, clothing, spectacles, food coupons and reading machines.

The society's street collection last month raised a record R2 031 which will be used for local work. The society also received a minibus given by the Nomad Golfers.

Disinvestment: govt sends six men to US

Dispatch Correspondent

DURBAN — A six... people going over," said Mr Pachai ad...

Medical schemes raise payments to doctors

299 0185 Star 4/7/85

Medical Reporter

Payments to doctors by medical schemes will be increased by 12 percent from January 1 1986.

The effect of the increase on individual medical schemes will not be the same in all cases as each scheme has its own "mix of services" for which benefits are provided.

Announcing the increase, the Representative Association of Medical Schemes (RAMS) said the last increase in the scale of benefits to medical practitioners was made 18 months ago.

The effective date was determined to acheive uniformity in revision of scales of benefits and for more accurate budgeting.

In determining the amount of the increase, consideration was given to the effects of inflation on doctors' practice costs as well as the state of the economy.

The statistics on which the RAMS based its decision showed that the gross amounts paid to medical practitioners in 1984 increased by percentages far in excess of the percentage increases in tariffs which became effective on January 1 last year.

CAPE Times 10/7/85 299

Medical aid near 'collapse'

Own Correspondent

PORT ELIZABETH. — Medical aid schemes throughout the country are on the brink of collapse, says Mr John Ernstzen, chairman of the Representative Association of Medical Aid Schemes of South Africa (Rams).

"Claims' statistics for 1983-84 showed a 19 percent increase in ordinary claims and a 25 percent increase in specialist claims," he said.

Most schemes have been forced to increase tariffs substantially and many employers — who subsidize these funds — have been hit by the recession and are now seriously questioning whether they can afford to continue to do so, Mr Ernstzen said.

"The schemes cannot afford to exist without subsidies and should they collapse there will be a clamour for a national health system which the country cannot afford," he added.

Fears echoed

Mr Ernstzen's fears have been echoed by the Medical Association of South Africa (Masa). Dr Elset Prinsloo, senior assistant secretary of Masa said: "Our organization is as anxious as the medical aid schemes to make both the public and doctors more cost conscious."

Mr Ernstzen's disclosure comes in the wake of a recent report published in Port Elizabeth that higlighted dramatic tariff increases in the medical aid scheme run by the Midland Chamber of Industries (MCI) and its effect on about 600 pensioners contracted to the scheme.

Increases on monthly tariffs for the MCI scheme ranged from about 150 to 900 percent, the report said.

Mr Ernstzen said pensioners were not the only people affected by the high increases. Some schemes, however, had more than a 25 percent membership of pensioners, who are high users. It was becoming virtually impossible for the schemes to carry these people, he said.

Mr Ernstzen blamed both the public and doctors for the financial burden on the medical aid schemes.

"People are a experiencing a new condition called financial stress and as a result are incurring health problems. Another problem is that there is evidence that doctors are offering more services, often unnecessary, to make a living.

Charge more

"Rams has also found that doctors charge more and offer less services at any given consultation," Mr Ernstzen said.

He said the man-in-the-street also insisted on a lot of treatment because he felt he was entitled to it, because of his medical aid membership.

"It's a vicious circle. If the doctor does not prescribe a medicine, the patient feels hard done by, so doctors give them prescriptions which they can claim on medical aid. Essentially it's an abuse of the system."

According to Dr Prinsloo, Masa established a committee some time ago which is specifically concerned with medical cost containment and medical practice, and which, in serious cases, can refer the matter to the South African Medical and Dental Council.

'Collapse' of med-aid denied

Own Correspondent

DURBAN. — Medical-aid schemes have taken a battering because of rising medical fees but they are not about to go under.

This is the view of several medical-aid societies which were approached yesterday after Mr John Ernstzen, chairman of the Representative Association of Medical Aid Schemes of South Africa (RAMS), said a number of schemes were on the "brink of collapse".

"I generally don't hold with that view," said Mr Les Hollis, executive director of Medscheme, which administers 30 medical-aid schemes.

"I agree that some have taken a battering because they did not anticipate the huge increase in medical fees but of the schemes we administer none are on the verge of collapse."

He said, however, that smaller societies would possibly have to look for a "new home" to have a bigger spread of members or impose limits on major surgery.

And a spokesman for the Medical Benefit Society for the Clothing Industry said the "noose was tightening" but it certainly wasn't a case of closing down.

"Medical costs are skyrocketing and all our suppliers are trying to get the maximum amount of money but we are certainly not on the verge of collapsing."

A spokesman for the Medical Aid Society of the SA Printing and Allied Industries Federation said that "if a medical-aid society is in trouble it takes steps immediately to correct the situation by increasing subscriptions or reducing benefits".

Meanwhile, Durban doctors have denied Mr Ernstzen's allegations that they are largely to blame for rising costs because they offer more services, often unnecessarily, to make a living. He also said there was a high rate of recall by doctors.

"I honestly don't think that is a general trend," one doctor said. "First it is unethical and secondly most general practitioners don't have the time to see patients unnecessarily."

A spokesman for the Medical Association of South Africa said it had found that in many cases complaints received about doctors, who allegedly acted "unethically" by recalling patients to get an extra fee, could be attributed to ignorance.

hursday, July 11, 1985

Medical aid schemes hard hit 'but won't collapse'

(299) 11/7/85 NM

Mercury Reporter

MEDICAL aid schemes have taken a battering because of rising medical fees, but they are not about to go under.

This is the view of several medical aid societies which were approached yesterday after Mr John Ernstzen, chairman of the Representative Association of Medical Aid Schemes of South Africa (RAMS), said a number of medical aid schemes in the country were on the 'brink of collapse'.

'I generally don't hold with that view,' said Mr Les Hollis, executive director of Medscheme, which administers 30 medical aid schemes.

'I agree that some have taken a battering because they did not anticipate the huge increase in medical fees, but of the schemes we administer none is on the verge of collapse.'

He said, however, that smaller societies would possibly have to look for a 'new home' to have a bigger spread of members or impose limits on expensive major surgery.

'We have to face up to the fact that we are going through tough times and contributions are having to go up, but it doesn't mean bankruptcy,' said Mr Hollis.

And a spokesman for the Medical Benefit Society for the Clothing Industry said the 'noose was tightening' but it certainly wasn't a case of closing down.

'Medical costs are sky rocketing and all our suppliers are trying to get the maximum amount of money but we are certainly not on the verge of collapsing.'

A spokesman for the Medical Aid Society of the S A Printing and Allied Industries Federation said it 'was hard to believe' that medical aid schemes were in such serious trouble.

'If a medical aid society is in trouble it takes steps immediately to correct the situation by increasing subscriptions or reducing benefits,' the spokesman said.

'Costs are getting out of hand and fees have been increased but there is no need for medical aid societies to go under.'

Meanwhile, Durban doctors have denied Mr Ernstzen's allegations that they are largely to blame for rising costs because they offer more services, often unnecessarily, in order to make a living.

He also said there was a high rate of recall by doctors of patients.

'I honestly don't think that is a general trend,' one doctor said. 'First, it is unethical and secondly most general practitioners don't have the time to see patients unnecessarily.'

Another doctor agreed. 'It obviously can happen but it really doesn't happen much. There aren't enough doctors, too many patients and no time to waste.

'In most cases a patient should be recalled for a second visit as a follow up and we can't even do that because the load is too great.'

And a spokesman for the Medical Association of South Africa said it had found that in many cases complaints received about doctors, who acted 'unethically' by recalling patients to get an extra fee, could be attributed to ignorance.

'It could also be as a result of the lack of adequate provision for cost containment courses in the curriculum of medical students,' the spokesman said.

● See Editorial Opinion

Union questions medical aid increases

STAR 28/9/85

— by —
Jackie Unwin

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Generic replacement, medical aid schemes, price fixing, flexible shopping hours, the testing of donated blood for Acquired Immune Deficiency Syndrome and the abolition of transport regulations were topics discussed by the South African National Consumer Union yesterday.

Resolutions included:

- A commendation of the Government's action in allowing generic replacements as a means of reducing the high costs of prescribed medicines.
- A request that the authorities investigate the desirability of the introduction of a form of "no claim bonus" as a means of containing medical aid increases. The union said it was aware of the burden upon younger members and single contributors and urged that immediate attention be given to keeping increases in contributions to the minimum.
- The union fully supported the Competition Board report which recommended a tight discipline being applied to undesirable practices in the economy such as price fixing and collusion.
- It urged the introduction of more flexible shopping hours in all provinces.
- Restaurants and eating houses would be asked to advertise their menus and prices outside their premises as was done overseas.
- The union was concerned at the incidence of AIDS and would urge the Government to make the testing of all donated blood compulsory although it would mean a minimal increase in the cost of blood transfusions.

Due to increase in claims . . .

Contributions to medical aid to go up by 24%

STEPHEN CRANSTON

CONTRIBUTIONS to medical aid schemes are expected to increase by 24% next year as medical costs soar. Contributions this year have already increased by an average of 22%.

Employees usually pay half the medical aid contribution, with the employer picking up the other half. Self-employed people will bear the full brunt of the increases.

Medical schemes report that the average value of each claim has increased steeply — between 1983 and 1984 there was a 19% increase in ordinary claims and a 25% hike in specialist claims.

People are also making greater use of their medical schemes.

Use of the schemes increased by 3% this year.

To cater for the increased costs patients face, medical schemes will increase doctor's tariffs — the amount paid on a claim regardless of the doctor's charge — by an average of 12,5%.

The tariff for a consultation will rise by 43% from R9,50 to 13,60.

Many doctors already charge more than this for a visit.

Blacks will be hit harder by the higher contribution charges. Their consultations with general practitioners account for 25% of their claims on medical schemes. Visits to GPs make up only 8% of whites' claims.

Medical scheme administrators claim that it is not only the medical profession that is pushing up costs.

White are the most pampered people in the world when it comes to medical attention, says John Ernstzen, chairman of the Representative Association of Medical Aid Schemes (Rams).

"They seem to think that every discomfort must have a pill to cure it. So there are a huge number of unnecessary sedatives, tranquillisers and analgesics that these schemes have to pay for.

"The message I would like to drive home is that doctors and patients must be realistic if the schemes are going to be cost-efficient."

Imported medicines are also contributing to rising costs.

SA produces few medicines and imports a great deal of technical equipment.

Medicines accounted for 23% of schemes' payouts last year, but this figure is creeping up. Schemes which previously allowed R25 on the average medicine bill recently increased this to R36.

Big rise coming in medical aid subs and levies

(399) Mercury 29/11/85

Mercury Reporter

MEDICAL aid contributions are going to jump in January and in some cases the prescription levy on certain plans will also increase by 250 percent.

The chairman of the Representative Association of Medical Aid Schemes, Mr John Erntzen, confirmed that medical aid subscriptions will rise by as much as 30 percent.

Mr Erntzen said that while most medical aid schemes are talking about a 20 to 25 percent increase some will increase their subscriptions by as much as 30 percent.

'The increase will be in relation to the accumulated funds and the mixture of services and benefits,' he said.

And National Medical Plan (NMP) has announced an average 15 percent increase in premiums as well as a prescription levy increase from R2 to R5 for one prescription item.

Imported

For every additional item on the prescription a further R1 levy will be charged to a maximum of R10 a prescription.

Medical aid increases follow the planned January 1986 increase in dental and doctor fees which will increase the total medical aid medical payout by 12,5 percent as well as the rising cost of drugs which is related to the weakening of the rand against the dollar.

Mr R H Basson, NMP's general manager, said: 'NMP's prescription and drug bills comprise about a third of the plan's total expenditure on claims, and as the vast majority of these drugs are imported, the weakening of the rand against the dollar and the recently imposed 10 percent surcharge on medicine imports can be directly related to the additional expenditure that is being incurred.'

Mr Basson emphasised, however, that members could curtail expenses by asking their general practitioners to prescribe generic substitutes where possible.

Surcharges

'This would reduce the cost of their drug bills resulting in a direct saving to themselves by way of reduced surcharges,' he said.

Meanwhile, set tariffs charged by general practitioners for consultations will rise by 43 percent from January 1.

General practitioners who charge according to medical aid scheme tariffs will be charging more than R13 a consultation from next year compared with the R9,50 they charge now.

Physiotherapy tariffs are also expected to increase by about 9 percent and increased duties and raised sales tax has affected the price of lenses and sundry medical goods, all of which now cost medical aid schemes more.

CAR TALKS 9/12/85

National health policy call

By BARRY STREEK

SOUTH AFRICAN medical schools have been challenged by Professor Solly Benatar of the University of Cape Town to state their views on the desirability of a national health service to ensure the right of all people to basic health care.

Professor Benatar, of the department of medicine at UCT's medical school, said the wide disparities in health and health care in South Africa could be rectified only by a national health policy.

His challenge, published at the weekend in the South African Medical Journal, reflects a growing concern in the medical profession about the trend towards privatization of health care and racial division of the administration of medical services.

Sanctity and equality of all human life

Professor Benatar said the practice of medicine was "a moral enterprise based on the concept of the sanctity and equality of all human life. This invokes the principle that all people should be treated beneficiently and with dignity.

"The wide disparities in the health of, and health care facilities available to, different groups of people in South Africa are complex in origin but in part are due to legislated discriminatory policies and to the lack of a national commitment to widely accepted basic human rights.

"The fundamental immorality of such policies is in conflict with the aims and ideals of the medical profession and impairs the ability of individual doctors and medical institutions to teach and practise according to the basic tenets of its morality.

"Within the framework of South African society this can only be rectified by recognition of the right of all people to basic health care and other social services and the development of these on a national non-discriminatory basis.

"The rising costs of medical care, the increasing trend towards privatization and the further fragmentation of health care services in South Africa will widen the gap between health care facilities available to the rich and the poor.

Threaten function of teaching hospitals

"These developments also threaten the function of teaching hospitals in their academic and clinical leadership roles — vital components of a civilized society.

"The creation and development of a national health service in South Africa, while not claimed as a panacea for all the difficulties, will help to establish an environment in which medicine can be taught and practised in accordance with its high moral content, for the benefit of individuals and society," he said.

A national health service would not impinge on the freedom of individuals to provide or purchase additional health if the right to private practice was retained.

Medaid tariffs likely to soar

STAR 21/12/85

299

Medical aid societies may soon have to take drastic action to counter disastrous price increases — this could lead to curtailed benefits, medical aid scheme administrators have warned.

On top of general sales tax, the weak rand/dollar exchange rate and the surcharge on imported medicines, medical aid society members are facing a huge increase in contributions of up to 30 percent from the beginning of next month, bringing the total over a year in some cases, to more than 50 percent.

From January 1, with the tariff increases gazetted yesterday, the average family man can expect to find about R16 less in his monthly pay packet.

Increases announced yesterday were 12,5 percent on medical, dental and physiotherapy tariffs and 12 percent on private hospital tariffs. This means an increase in member's contributions of between 20 and 30 percent.

Medical schemes say there was a 19 percent increase in the average claim between 1983 and 1984 and a 25 percent increase in specialist claims.

Scheme administrators describe the prospects for 1986 as "frightening" and predict that the prices of medicines could double by the end of next year.

With prescribed medicines forming 40 percent of the total medical aid payout, hardest hit will be pensioners who are the largest group dependent on life supporting drugs.

The generic substitution of drugs, introduced by the late Minister of Health, Dr Nak van der Merwe — which was aimed at bringing down the high cost of medicines — is described as "nothing more than a beautiful dream".

Few pharmacists, medical scheme spokesmen say, would accept a lower profit which would necessarily follow the dispensing of a cheaper medicine.

CHANGED CONCEPT

The whole concept of the Medical Schemes Act when it was promulgated in 1967 "has gone haywire", a spokesman said. Then, the whole object was to provide for major illness and surgery.

Now provision was made that members could draw benefits for a wide range of medical services — among them confinements, orthodontists, spectacles, and orthopaedic appliances.

The privatisation of provincial hospitals had been suggested but this would not benefit the man-in-the-street and the establishment of a national health scheme was considered a "retrogressive step" which the taxpayer could not afford.

Concern about escalating premiums

Medical aid only for rich?

Weekend Argus Correspondent

DURBAN — The Durban Metropolitan Chamber of Commerce has warned that unless Government restrictions on medical aid schemes are removed medical aid will be priced out of the market for all but the very wealthy.

The situation is considered so serious that a delegation from the Association of Chambers of Commerce is to meet the Minister of Health in Cape Town in March to discuss the issue.

In a hard-hitting report in its weekly information digest the chamber says that members and their staff are becoming increasingly concerned about escalating medical aid premiums and lower percentage benefits.

The report says: "It is evident that more and more providers of services — doctors, dentists, physiotherapists and so on — are charging their patients above the scale of benefits covered by medical schemes.

'Escalating premiums'

"In addition, most schemes cover members for 80 percent of the scale of benefits for general practitioners and similar consultations. A combination of these two factors can mean that the member still has to pay a substantial proportion of the doctor's bill.

"On the other hand, escalating premiums, particularly with the lower income groups, are now representing unacceptable proportions of employees' salaries — far higher than their contribution to the pension fund.

"Many lower-paid workers are finding it beyond their financial means to meet their share of the premiums needed for the comprehensive cover offered by many schemes.

"Employers, too, are becoming alarmed at the level of subsidy now required for employees. Even the more affluent are beginning to ask: 'Is medical aid worth the comparatively high premiums now required'?"

The chamber says the answer to the problem is to allow medical schemes to cater for different people's needs in different ways, like allowing most people to pay doctors and dentists as well as 'run-of-the-mill' expenses like prescriptions. They would, however, like cover for hospitalisation and more expensive treatments and procedures.

"At the other end of the scale, the lower-income groups must be provided with an affordable package of medical aid cover."

Louw refused city mixed race schemes

Dispatch Reporter

EAST LONDON — The whites-only municipal pension and medical aid schemes were controlled by the Provincial Administration and the city council had no say in the matter, the director of personnel and management services, Mr Leon Deetlefs, said yesterday.

He was responding to inquiries why the municipality had the schemes on a racial basis while at the same time it purported to be an equal opportunities employer.

Mr Deetlefs said the municipality had applied to the administrator, Mr Gene Louw, to have the entire 2 500 staff complement on the same pension and medical aid schemes, but it had been refused.

Explaining the medical aid position, Mr Deetlefs said: "We took a ballot among our African staff about a medical aid scheme but the majority said they were not interested. Our coloured and Indian staff wanted medical aid and we got them a scheme with a company."

On the pension scheme, Mr Deetlefs said: "We have a pension scheme for our staff who are not white. This is also done through a company and the municipal contribution is the same for all."

Mr Deetlefs said the municipality was fully entitled to call itself an equal opportunity employer.

"The pension and medical aid rules are directives from Cape Town in which the municipality has no say. As I said we did apply to have all our staff on the same scheme but it was refused.

"Nevertheless even though our staff are on different schemes, the municipality contributions for each of its staff members are the same irrespective of race, colour or creed," Mr Deetlefs said.



Sordwana Bay is the venue for the National Ski boat fishing tournament to be held from February 17 to 21 this year. The Border team hoping to improve upon its third place achieved in the 1985 tournament comprises from left, Roy Bovey, Malcolm Boucher (captain) and Paddy Hart.

Doctors slam 'no payment, no treatment' stand

8/2/86 STAR

By Joe Openshaw,
Medical Reporter

The Medical Association of South Africa (Masa) has received many complaints from doctors about private hospitals refusing to accept motor accident cases if the patient is not prepared to settle the bill in cash, or his medical aid guarantees to cover costs.

Senior assistant secretary of Masa Dr Elset Prinsloo told *The Star* doctors believe motor accident cases should be treated as emergencies and given priority over financial considerations.

"The real problem is the Medical Schemes Regulation which states medical schemes will only accept responsibility for costs in motor accident cases after a claim has been repudiated by the third party insurer," Masa's legal adviser, Mr A Volschenk, said.

Masa recently received submissions from doctors, the registrar of medical schemes of the Department of Health and Welfare and the Representative Association of Private Hospitals which indicate the need for clarity on the position of medical aid societies and the Motor Vehicle Assurance Fund.

A suggestion by Masa that there be a qualification to the regulations concerning admissions of car accident patients to private hospitals, gazetted in December 1984 ("that medical schemes could recover costs from another source and the patient should be allowed to obtain direct benefits from his medical scheme") was not accepted.

"Apparently medical schemes refuse to honour any third party claim unless the members' claim is turned down, because they maintain members do not pursue third party claims once the costs have been paid by the medical scheme," the registrar of medical schemes told Dr Prinsloo.

Hospitals maintain not all medical aid schemes cover members involved in motor vehicle accidents and hospitals suffer financial loss because they have to wait years for payment, or are often not paid at all.

Medical costs often run into thousands of rands and many patients are unaware that their medical aid will not cover them if there is a possibility of a third party claim.

Union: conditions unequal

Dispatch Reporter

EAST LONDON — The secretary of the East London Municipal Workers Union, Mr G. H. van der Walt, yesterday slated the East London municipality's assessment of itself as an equal opportunities employer.

Mr Van der Walt said he strongly disagreed with, and was "shocked" by, the assessment made by the municipality's director of personnel and management services, Mr Leon Deetlefs, that even though municipal staff were on different benefit schemes, the municipality's contributions for each of its staff members was the same irrespective of race, colour or creed.

"We (the East London Municipal Workers' Union) are extremely disturbed about this statement. We can't accept that general statements are being made like this when they are blatant distortions of the facts," Mr Van der Walt said.

He said that a large gap existed between the municipality's contributions to white and black amployee benefit schemes and until this gap was rectified, East London's municipality had "no right" to call itself an equal opportunities employer.

White municipal employees contributed nine per cent of their salary to the pension scheme while the municipality's contribution was 21,4 per cent.

Black municipal employees contributed six per cent to a pension scheme, and the municipality's contribution here was also six per cent — a gap of 14,6 per cent between the municipality's contribution to the schemes.

Mr Van der Walt said all white municipal employees had to contribute to a compulsory life insurance scheme which covered the family of a male employee for five years after his death, or alternatively, covered the family of a female employee for 2½ years after her death. The municipality's contribution to this scheme was approximately 2,35 per cent and 1,18 per cent respectively.

"So, in fact, when the municipality's contribution to both the white pension and life insurance schemes are added together, white municipal employees benefit almost four times as much as the black employee," Mr Van der Walt said.

He added that only a very small percentage of black municipal employees could afford to contribute to the life insurance scheme.

Mr Van der Walt said that one of the municipality's conditions of employment for all white employees was that they join the South African Association of Municipal Employees — a "whites only" organisation.

"Black municipal employees may or may not join a union, but they cannot join the South African Association of Municipal Employees," he said.

"The East London municipality promised us and its employees that it would employ all its staff on an equal opportunities basis, but it has since shown very clearly that this is not the case," Mr Van der Walt added.

Bookings hit 11-year low

Times keep getting tougher for hotels

288 STAR 1/96 24/2/86

Pretoria Bureau

For South Africa's hotel industry 1985 showed the worst turnover in 11 years. Even December and its holidaymakers brought no relief.

According to figures from Pretoria's Bureau for Financial Analysis, in the past 49 months — the period since November 1981 — hotels have shown a successive decline in trade.

Hotels' total real income in December 1985 was 21,5 percent lower than in the same month in 1984.

One-star hotels were relatively better off, with only a 15,9 percent decline in real income in December while five-star hotels took a drop of 23,9 percent in the same period.

Reduced bookings

Last year, bookings dropped to their lowest level in 11 years.

The average occupancies were 53 percent and 42 percent respectively, compared with the previous lowest levels of 59 percent and 46 percent in 1984.

This meant that, in 1984, 9 million room-nights and 18 million bed-nights went unsold.

Only two out of the country's 20 regions — the Drakensberg and East London — showed increases in room occupancy during December last year and even those increases were less than 6 percent.

Worst-hit regions

Among the regions where hotels showed the greatest decline in 1985 were the Witwatersrand and Vaal Triangle where trade dropped by 28 percent compared with the previous year.

R125-m Sun was planned during boom in industry

By Sue Dobson

One of the world's most modern hotels, the R125-million Johannesburg Sun and Towers, opened at the beginning of the month in the worst conditions the South African hotel industry has known.

The Sun has received a restrained welcome from other Johannesburg hotels, whose occupancy rates are being hammered by the effects of the economic downturn and the state of emergency.

The Sun was planned three years ago during a "boom period" for the hotel industry, when foreign tourists were streaming into the country.

However, marketing director of Southern Sun Mr Bruce Hutchison is confident the new hotel will do well and that it has features that will give it an edge over its competitors.

REVITALISE CBD

"We never envisaged the current political unrest or the recession but we are confident that this hotel will revitalise the CBD," Mr Hutchison said.

The Sun's closest competitor in the five-star bracket is the Carlton Hotel.

The hotel's marketing director, Mr Allan Edgar said: "Although we see the Sun as a competitior we do not believe that it will affect our business adversely — the Carlton is 14 years old and we have an established clientele."

Sales manager for Protea Hotels and Inns, Mr Barry Hurter, said that Johannesburg's new hotel could not really be seen as a competitior to hotels in the group as it was geared towards a different market.

Mr Fred Thermann, a spokesman of the Federated Hotel, Liquor and Catering Association said: "We are confident that state of the hotel industry will improve soon and that South Africa will again be a popular tourist spot."

Call for a medical aid scheme to help the unemployed

PARLIAMENT — The House of Delegates has called on the Government to change legislation governing medical aid schemes in order to help the unemployed.

A motion led by **Mr M Naranjee (NPP, Mariannhill)** calling for the amendment of medical aid legislation was carried almost unanimously yesterday.

Mr Naranjee said that when employees were retrenched or fired, they lost the assistance of the medical aid schemes to which they had been contributing.

To help counteract the problem, a national medical aid scheme along the lines of the Unemployment Insurance Fund should be created, he said.

Mr Pat Poovalingam (Solidarity, Reservoir Hills) agreed, saying there was no reason why some of the money generated through General Sales Tax should not go towards funding such a service.

The Minister of the Budget, **Mr J N Reddy**, suggested that legislation be amended so that former employees could continue to benefit from medical aid schemes for a reasonable length of time after their employment had been terminated.

The Minister of Health and Welfare, **Mr Ismael Kathrada**, argued that the differences between the various medical aid schemes that should first be examined before any steps were taken.

The Minister of National Health and Population Development, **Dr Willie van Niekerk**, pointed out in his reply to the motion that a medical aid scheme was actually a form of insurance whereby the employer paid a percentage of the fee.

However, there existed schemes to which an individual, whether employed or not, could contribute privately.

The differences between the 212 schemes in the country had come about because the schemes had originally been developed by the various companies as perks for their employees. However, he agreed there should be greater uniformity. — Political Staff.

The MINISTER OF TRANSPORT AFFAIRS:

(1) Yes.

(a) To equip and initiate the Administration of South West Africa in the management and exploitation of an own transportation service.

(b) With effect from 1 April 1985.

(c) No losses were incurred as a result of the transfer.

(2) A State President's Proclamation which will be passed in the near future makes provision for the reduction of Treasury loans to Transport Services to the amount of R144,8 million. This amount represents the outstanding book value of the assets transferred to South West Africa.

(3) Yes.

(a) Mainly as a result of the long distances and the under-utilisation of rail and road transport services.

(b) (i) R50,0 million.

(ii) 1985-86: Estimated at R41,0 million of which Transport Services will bear R12,3 million.

Transmed

220. Mr W V RAW asked the Minister of Transport Affairs:

(a) What was the gross profit or loss of the Medical Scheme of the South African Transport Services (Transmed) in each year since its inception and (b) what increases have been made in member contributions during this period?

The MINISTER OF TRANSPORT AFFAIRS:

(a) and (b) Since the change-over to Transmed, no membership fees are payable by members and particulars of a gross profit or loss cannot therefore be furnished. The Scheme is subsidised by Transport Services and the figures in this regard since its inception are as follows:

1982/83—R118,5 million
1983/84—R150,8 million
1984/85—R174,2 million
1985/86—R161,3 million (up to January 1986).

On specified services members are responsible for partial payments ranging from 10 to 50 per cent. In addition, serving members without dependants contribute R2 per month and those with dependants R4 per month towards a provident fund from which assistance is given to members who in unavoidable circumstances are subjected to high medical costs.

Locomotives/passenger coaches/goods trucks

221. Mr W V RAW asked the Minister of Transport Affairs:

(1) How many (a) locomotives, (b) passenger coaches and (c) goods trucks belonging to the South African Transport Services are on average located in (i) Zambia and (ii) Zimbabwe;

(2) how many (a) locomotives, (b) passenger coaches and (c) goods trucks belonging to (i) Zambia and (ii) Zimbabwe are on average operating in the Republic?

The MINISTER OF TRANSPORT AFFAIRS:

(1)	Daily average (i)	(ii)
(a)	9	—
(b)	—	—
(c)	1 093	2 737

(2)	(i)	(ii)
(a)	—	—
(b)	—	15 per week
(c)	33	570.

Newcastle: railway station

222. Mr W V RAW asked the Minister of Transport Affairs:

(1) Whether a new railway station has been built at Newcastle; if so, (a) when and (b) at what cost;

(2) whether the new station was built on the same premises as the old one; if not, (a) why not and (b) how far from the old station was it built;

(3) whether a mainline passenger train regularly stops there at approximately midnight; if so,

(4) whether there is any taxi service at the station at that time;

(5) whether heated waiting rooms are available at the new station; if not, why not?

The MINISTER OF TRANSPORT AFFAIRS:

(1) Yes.

(a) It was completed during 1980.

(b) R1,5 million.

(2) No.

(a) The old station site was not suitable for future development whereas the new site allowed for such development.

(b) Approximately seven kilometres.

(3) Yes.

(4) No, but telephones are available to call for a taxi.

(5) Yes.

Catering

223. Mr W V RAW asked the Minister of Transport Affairs:

How many persons in (a) the superintendent and higher grades and (b) other grades were employed in (i) the office of the Catering Manager, Johannesburg, and (ii) other offices in the catering services in each of the latest specified five years for which figures are available?

The MINISTER OF TRANSPORT AFFAIRS:

(a)	(i)	(ii)
1981	9	4
1982	9	4
1983	11	2
1984	10	2
1985	11	2

(b)	(i)	(ii)
1981	66	15
1982	61	16
1983	62	18
1984	63	18
1985	69	18

Refreshment rooms/dining saloons/buffet cars

224. Mr W V RAW asked the Minister of Transport Affairs:

How many (a) departmental refreshment rooms and (b)(i) dining saloons and (ii) buffet cars were in regular use by the South African Transport Services in each of the latest specified five years for which figures are available?

The MINISTER OF TRANSPORT AFFAIRS:

(a)	
1980/81	12
1981/82	12
1982/83	12
1983/84	11
1984/85	11

(b)	(i)	(ii)
1980/81	28	19
1981/82	30	21
1982/83	25	19
1983/84	23	21
1984/85	28	21

Staff complement

225. Mr W V RAW asked the Minister of Transport Affairs:

(a) What was the staff complement (i) in the General Manager's Office and (ii) of the South African Transport Services, at the beginning of each of the latest specified five financial years for which information is available and (b) how many of these employees were in each of the four highest grades?

The MINISTER OF TRANSPORT AFFAIRS:

(a)	(i)	(ii)
1981-82	3 117	272 120

African Government; if so, (a) on what date and (b) what reasons were furnished for this step?

The DEPUTY MINISTER OF DEVELOPMENT:

No. (a) and (b) Because of a motion that was accepted by the Lebowa Legislative Assembly on 16 January 1986 which reads as follows: "The Legislative Assembly resolves that the Commissioner General of Lebowa be recalled until the Moutse issue has been satisfactorally settled", it was decided that there will be no contact between the Lebowa Government and the Commissioner General.

This decision will be reviewed on request of the Lebowa Legislative Assembly.

KwaNdebele: Rust de Winter

HANS QCOL 275 4/3/86

*12. Dr F HARTZENBERG asked the Minister of Constitutional Development and Planning:† 4/3/86

(1) Whether a decision was taken recently to add the area Rust de Winter to the territory of KwaNdebele; if so, on what date;

(2) whether the (a) landowners concerned, (b) farmers' association concerned and (c) Transvaal Agricultural Union had been consulted before this decision was taken; if so, what was the reaction in each case; if not, why not;

(3) whether the Commission for Co-operation and Development carried out an investigation into the matter before the above-mentioned decision was taken; if so, what was the result of the investigation; if not, why not?

†The DEPUTY MINISTER OF DEVELOPMENT:

(1) Yes. On 25th September 1985 the Minister of Constitutional Development and Planning announced the Government's decision that the Rust de Winter area would be included in the territory of KwaNdebele.

(2) (a), (b) and (c) All the information and particulars obtained from previous evidence of affected persons were once again considered and evaluated. The spokesman of the community who has an interest in land in the area concerned was informed beforehand of the decision of the Government whereafter the local Farmers Association, being an affiliation of the Transvaal Agricultural Union, has also discussed the matter. The Commission for Co-operation and Development also informed the local community of the decisions. Furthermore a delegation of the community discussed the issue with the relative Minister, Deputy Minister and Chairman of the Commission for Co-operation and Development when they objected against the decision of the Government.

The Minister concerned undertook to submit the matter once again to the Cabinet. This undertaking has been carried out.

(3) Yes. The reports of the Commission for Co-operation and Development to the Cabinet are confidential and are not published.

Kirkwood: person detained

HANS. QCOL 276 4/3/86.

*13. Mr A SAVAGE asked the Minister of Law and Order:

(1) Whether a certain person from Kirkwood, whose name has been furnished to the South African Police for the purpose of the Minister's reply, was detained under the emergency regulations in 1985; if so, (a) what is the name of this person and (b)(i) on what date, (ii) why and (iii) where was he detained;

(2) whether this person was subsequently released; if so, (a) on what date and (b) why;

(3) whether this person was charged with any offence; if so, (a) with what offence and (b) in terms of what statutory provision;

(4) whether he will make a statement on the matter?

The MINISTER OF LAW AND ORDER:

(1) Yes.

(a) Jack Salter.

(b) (i) On 10 August 1985.

(ii) I am not prepared to disclose the reasons for his detention.

(iii) At Uitenhage from 13h45 on 10 August 1985 and at North end Prison from 11h26 on 12 August 1985.

(2) Yes.

(a) On 23 August 1985.

(b) I am not prepared to disclose the reasons for his release.

(3) No.

(a) and (b) Fall away.

(4) No.

HANS. QCOL 277 4/3/86

Kirkwood: persons arrested

*14. Mr A SAVAGE asked the Minister of Law and Order:

(1) Whether any member of the South African Police took any action on or about 1 February 1986 at a shop in Kirkwood owned by a certain person, whose name has been furnished to the South African Police for the purpose of the Minister's reply; if so, (a) on whose instructions, (b) for what purpose, (c) what action was taken by the police on this occasion and (d) what is the name of this person;

(2) whether any persons were arrested or taken into custody by the police on this occasion; if so, (a) what are the names of these persons and (b) why;

(3) whether any action was taken against these persons; if so, (a) what action and (b) why;

(4) whether these persons were subsequently released; if so, when?

†The MINISTER OF LAW AND ORDER:

(1) to (4) Whereas an interdict concerning this matter was filed at the supreme Court in Port Elizabeth, I do not deem it appropriate to disclose the required particulars.

Medical aid

HANS - QCOL 278 4/3/86

*15. Mr D J N MALCOMESS asked the Minister of Transport Affairs: 299

(1) Whether White and non-White employees of the South African Transport Services are included in the same medical aid scheme; if not, (a) why not and (b) to which medical aid schemes do (i) White and (ii) non-White employees belong; if so, what is the name of the scheme;

(2) whether the medical aid scheme for (a) White and (b) non-White employees of the South African Transport Services pays for the services of medical specialist doctors; if not, why not; if so, what is the nature of the services rendered by such medical specialist doctors?

The MINISTER OF COMMUNICATIONS (for the Minister of Transport Affairs):

(1) No.

(a) Transmed was introduced experimentally for Whites in order to determine the financial implications. The admittance of Non-White employees to Transmed

Raw calls for benefit probe

Political Staff

PARLIAMENT — The SATS' medical benefits scheme, Transmed, is being ripped off, according to allegations in Parliament.

Mr Vause Raw (NRP, Durban Point) called for an in-depth inquiry into irregularities in Transmed alleged in a railways staff journal.

These included R720 for 36 injections for a patient who suffered superficial burns. "Something is wrong here," he said.

Immediate relief sought for hospital

299 Mercury 14/3/86.

Mercury Reporter

SHORTAGE of funds has postponed plans to develop Durban's King Edward VIII Hospital and short-term measures will be necessary to provide relief for the hospital, the Administrator of Natal, Mr Radclyffe Cadman, said yesterday.

Mr Cadman was speaking during a tour of the hospital, where conditions have been severely criticised by doctors and the public.

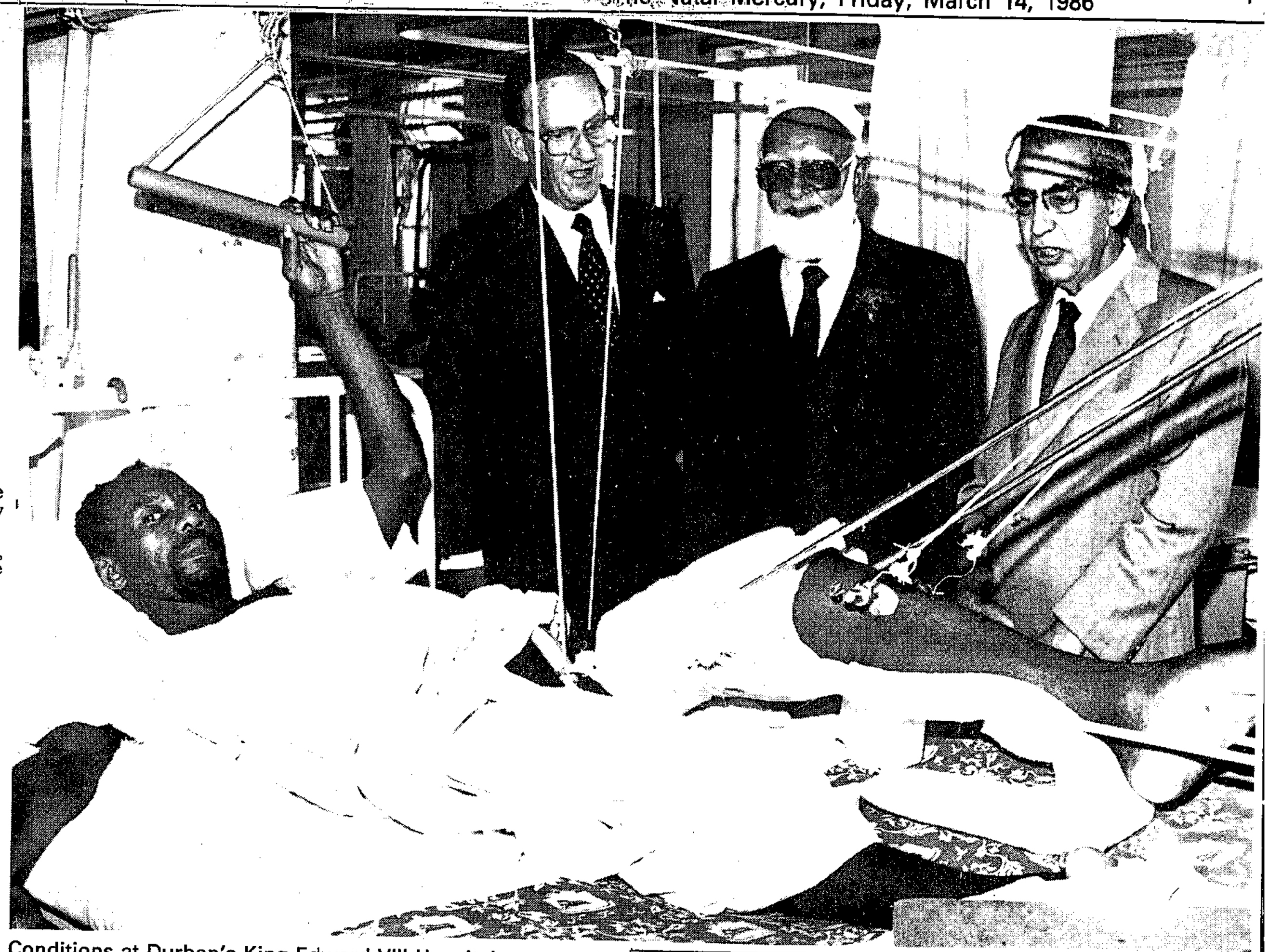
He said that in order to provide relief for King Edward, urgent negotiations with KwaZulu health authorities were under way to try to bring into immediate operation unused facilities at Umlazi's Prince Mshiyeni Hospital.

Dr Fred Clarke, MEC in charge of hospital services, who accompanied Mr Cadman on the tour, said Prince Mshiyeni Hospital, with a bed capacity of 1 600, was supposed to have opened in 1971.

King Edward's chief medical superintendent, Dr Justin Morfopoulos said that unless something was done soon there would be little point in the hospital's continued existence.

Mr Cadman said: 'It seems that we are going to have to think again about the development of the new facilities.'

Also visiting the hospital was the Director of Hospital Services, Dr Neville Howes, who said he attached 'top priority' to the redevelopment of the hospital in the shortest time possible.



Conditions at Durban's King Edward VIII Hospital came under the spotlight yesterday afternoon when the Administrator of Natal, Mr Radclyffe Cadman (standing, left) and members of the Executive Committee toured the hospital. Mr Cadman is discussing the treatment of a patient, Mr Hosana Mntambo, with Mr A G Khan, chairman of the hospital's advisory board, and Prof T L Sarkin, professor of orthopaedic surgery at the University of Natal.

been completed; if not, (a) why not and (b) when is it anticipated that they will be completed; if so, what was the (a) quantity and (b) value of each category of stores involved in these offences;

(4) whether any persons have been prosecuted in this regard; if so, (a) how many, (b) when and (c) with what result;

(5) whether any steps have been taken to prevent a recurrence; if so, what steps?

The MINISTER OF DEFENCE:

Yes. Details iro subsection (1) to (4) are as follows:

Subsection	Fuel	Tyres	Other stores Welding machine	Engines
(1) (a) and (b) and (b)	Theft suspected in December 1985	November 1985	Between January 1984 and January 1986	1981 and 1982
(2)	Yes	Yes	Yes	Yes
(a)	December 1985	November 1985	December 1985	December 1985
(b)	In all cases by the Military Police in co-operation with the SWA Police.			
(3)	No	Yes	No	No
(a)	Evidence is still being gathered	10	Evidence is still being gathered	Evidence is still being gathered
(b)	Undeterminable	R635,50	Undeterminable	Undeterminable
(4)	None	Yes	None	None
(a)		4		
(b)		9 December 1985		
(c)		Found guilty in Magistrate's Court. Fines of between R250-R300 instituted.		

(5) Yes.
—Control staff of the stores concerned is rotated.
—The security fence around the stores area strengthened.
—Guards are posted after normal working hours.
—The officer commanding conducts monthly stock taking.
—Fuel tanks of vehicles sealed with a lead seal.

HoA

Citizen Force

740. Mr G B D McINTOSH asked the Minister of Defence:

(1) Whether any persons liable to perform service of up to 120 days in cycles of two years in terms of sections 21 and 22(3)(b) or section 89A of the Defence Act, No 44 of 1957, did not perform any service in 1984 and 1985, respectively; if so, what percentage of the total number of members of the Citizen Force did not perform such service in each of these years;

(2) what percentage of the total number of members of the Citizen Force performed service for periods of (a) up to 30 days, (b) from 31 to 90 days and (c) from 91 to 120 days in each of the above years?

The MINISTER OF DEFENCE:

(1) and (2) Service records of Citizen Force members who are liable to perform service in terms of sections 21 and 22(3)(b) or section 89A of the Defence Act, 1957 are held on a decentralised basis at units and consequently these figures are not readily available. In view of the extent of the task it would require a great effort, taking up considerable time, to obtain the information.

Aircraft fuel

742. Mr D J N MALCOMESS asked the Minister of Transport Affairs:

What is the estimated saving for the South African Airways on aircraft fuel in the 1986-87 financial year as a result of (a) the rand/dollar exchange rate at present as compared with the exchange rate used for budget purposes and (b) the international and local decline in crude oil prices?

The MINISTER OF TRANSPORT AFFAIRS:

(a) R41 million.

(b) R14 million.

HoA

Own Affairs:

Teacher/pupil ratio

59. Mr R M BURROWS asked the Minister of Education and Culture:

What teacher/pupil ratio was applicable in (a) primary and (b) secondary schools in (i) each of the provincial education departments, and (ii) his Department, as at the latest specified date for which figures are available?

The MINISTER OF EDUCATION AND CULTURE:

Natal

(a) 1 to 21,2;

(b) 1 to 16,32;
(as on 31 December 1985).

Cape

(a) 1 to 18;

(b) 1 to 16;
(as on 31 December 1985).

Orange Free State

(a) 1 to 22,2;

(b) 1 to 16,1;
(information in respect of 1985).

Transvaal

(a) 1 to 24,2;

(b) 1 to 16,8;
(information as on 10th school day 1986).

The Department of Education and Culture

The Department of Education and Culture manages schools for Special Education, schools falling under the Children's Act and training centres for Mentally Retarded Children.

In the schools for Special Education, pre-primary, primary and secondary pupils receive tuition in the same building.

At present the following teacher/pupil

ratio is applicable in the classroom situation:

(1) Schools for the Hearing Impaired: (Deaf and Hard of Hearing)

(i) Pre-primary sections: 8 pupils per teacher;

(ii) Primary sections: 10 pupils per teacher;

(iii) Secondary sections: 10 pupils per teacher.

(2) Schools for the Visually Impaired: (Blind and Partially Sighted)

(i) Pre-primary sections: 9 pupils per teacher;

(ii) Primary sections: 10 pupils per teacher;

(iii) Secondary sections: 10 pupils per teacher;

(iv) Sections for the deaf-blind: 3 pupils per teacher.

(3) Schools for the Neurally Handicapped: (Cerebral palsied, epileptic, physically handicapped, specific learning disabled)

(i) Pre-primary sections: 10 pupils per teacher;

(ii) Primary sections: 10 pupils per teacher;

(iii) Secondary sections: 10 pupils per teacher.

(4) Schools for pupils with Early Childhood Autism

All sections: 3 pupils per teacher.

(5) Child Care and Reform Schools

Information is not available as pupil numbers change daily. Pupils are referred by the Courts and discharges occur regularly.

(i) Practical and/or Secondary courses—

(a) Academic: 17 to 30 pupils per teacher;

(b) Trade, home economics and other vocational fields: 25 pupils per teacher.

(ii) Practical and/or Special courses—

(a) Academic: 25 pupils per teacher;

(b) Trade, home economics and other vocational fields: 25 pupils per teacher.

(6) Training Centres for Mentally Retarded Children

10 pupils per teacher.

Provincial education authorities

60. Mr R M BURROWS asked the Minister of Education and Culture:

(1) Whether his Department is concerned with the co-ordination of financial requests from the provincial education authorities; if not, why not; if so, (a) what is the formula currently applied for, and (b) what factors are taken into consideration in the calculation of, the financing of provincial education;

(2) whether provincial education authorities are permitted to apply the principle of *virement* to their expenditure on education; if not, why not?

The MINISTER OF EDUCATION AND CULTURE:

(1) Yes, the Department of Education and Culture is concerned with this matter from 1 April 1986;

(a) the Department has not yet applied a formula as it was not a function of this Department in the past;

(b) the estimates for 1986/87 were still drafted by the provincial education authorities;

(2) yes; the conditions must however still be determined. The policy of the Department will be determined in accordance with the general policy laid down by the Minister of National Education in terms of the National Policy for General Education Affairs Act, 1984 (Act No. 76 of 1984).

Land Service movement

61. Mr S S VAN DER MERWE asked the Minister of Education and Culture:†

(1) Whether his Department has any connection with the Land Service movement; if so, (a) what is the nature of the connection, (b) how many officials in his Department are charged with the affairs of this movement, (c) what posts do these officials occupy and (d) how many officials are there in each post;

(2) whether the connection with this movement underwent a change recently; if so, what change; if not,

(3) whether any change in the connection is envisaged; if so, (a) what change and (b) when;

(4) whether the staff structure charged with the affairs of this movement underwent changes recently; if so, what changes; if not,

(5) whether any changes in this staff structure are envisaged; if so, what changes;

(6) whether his Department spent any funds on the Land Service movement in the 1985-86 financial year; if so, (a) what amount and (b) for what purpose;

(7) whether his Department envisaged spending funds on the Land Service movement in the 1986-87 financial year; if so, what amount?

The MINISTER OF EDUCATION AND CULTURE:

(1) Yes.

(a) It is a state-aided youth movement,

(b) no officer is exclusively involved in it, but a number pay priority attention to it,

(c) cultural officers and an assistant director,

(d) 13 cultural officers and 1 assistant director.

(2) No.

(3) No.

(a) Falls away.

(b) Falls away.

(4) No.

(5) No.

(6) Yes.

(a) R205 685.

(b) Subsidising camps and courses.

(7) Yes. R216 000.

TUESDAY, 15 APRIL 1986

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†Indicates translated version.

For oral reply:

General Affairs:

&

State President:

Shares in newly listed companies

*1. Mr K M ANDREW asked the State President:

17/3/86 299 STAR



Mr Patrick Nkosi: "Disabled people should be educated with their peers."

No opportunities for many disabled

By Kate McKinnell

Mr Patrick Nkosi and Mr Hendrick "Master" Modise are success stories — both have overcome mountainous obstacles and proceeded with their studies.

But they are only too aware of the many disabled black students who have not had the same opportunities as themselves, and this is why they have helped establish a committee to assist disabled black students.

Mr Modise and Mr Nkosi were wounded and paralysed in their late teens, and both were tempted to leave their studies.

But Mr Modise is at present waiting for the results of his final BComm exams, and Mr Nkosi has just passed matric and registered for an education degree at the University of the Witwatersrand.

ATTITUDE

"When I first arrived at university in the Northern Transvaal, they didn't want to take me because they said I would be too much trouble. But since then, the attitude towards disabled people has changed," says Mr Modise.

Most pressing were and still are the headaches of transport and university fees.

Two students who tackled the obstacles and won

Every year, there has been a panic in scraping together Mr Modise's university fees and he has battled to find transport to Turfloop every term.

And Mr Nkosi, after only two weeks, has already experienced difficulties in getting to Wits from Soweto.

But both Mr Nkosi and Mr Modise have been fortunate to receive the help of the Self Help Association of Paraplegics (Shap), the Soweto-based organisation headed by Mr Friday Mavuso and Mr Mike du Toit.

The aim of this organisation is to enable paraplegic people to work in the open job market, and at present it is running a workshop to raise money for transport and provide provide people with marketable skills.

"Encouraging and helping paraplegic students to continue their studies is an important goal, but we are not doing as much as we would like.

"It's got to the stage now that we feel we can't encourage students to go back to school be cause we are unable to provide the transport and finance they need," says Mr Friday Mavuso.

EDUCATION

But the younger members of Shap, including Mr Nkosi and Mr Modise, are determined to see disabled students continuing their education and they have established a Co-ordinating Committee of Disabled Youth.

"Besides giving moral support and practical advice, we hope to operate a trust fund to finance students' efforts and ideally we would like to buy a bus for transport.

"Most important, we want to see disabled people educated along with their peers, not at special schools or institutions," says Mr Nkosi.

Paul Middleton 6403

ARS NEW.



and serviced by

Flexible medical aid schemes urged

Call for limited health packages

MEDICAL AID schemes should follow the insurance industry in offering limited health packages rather than full cover, Medi-Clinic Corporation MD Dr Buks Hertzog said yesterday.

Addressing a privatisation conference in Johannesburg, he said: "Not everybody wants five-star treatment, but those who want it must be sure they will get it."

Options could include no-claims bonus, percentage payments, inclusion/exclusion of certain services, and cover for catastrophic illness only.

"The government should actively support this movement by regarding medical aid schemes in a similar light to pension funds," said Hertzog. "If patients do not look after themselves in this respect, the government will have to care for them.

"Therefore, it will pay the government to encourage people to belong to medical aid schemes or even make it compulsory above a certain income level."

DAVID FURLONGER

He said government faced massive increases in its health care bill in the next few years. At the end of 1983, only 3,6% of blacks belonged to medical aid schemes, 23,6% of coloureds, 28,4% of Asians and 77,4% of whites.

Hertzog listed three ways in which the State could reduce its financial obligation to health care:

- ☐ Increased efficiency — "up to now not particularly successful";
- ☐ Lowering of standards — "it will inevitably take place in the absence of other developments";
- ☐ Shifting of patients to the private sector — "the logical alternative".

Professor Duncan Reekie, of Wits University's Department of Business Economics, told the conference that medical aid cover could easily be restricted to major-cost treatment.

Most people could afford to buy medicines for minor ills, he said.

ber of the Police Force; if so, (a) when and (b) what was the nature of the charges or complaint;

(2) whether this matter has been investigated by the police; if not, why not; if so, (a) what is the (i) name and (ii) rank of the policeman involved and (b) what progress has been made in this investigation;

(3) whether any departmental steps have been or are to be taken against the policeman concerned; if not, why not; if so, what steps;

(4) whether he will make a statement on the matter?

†The MINISTER OF LAW AND ORDER:

(1) Yes.

(a) 9 April 1986.

(b) Alleged assault.

(2) Yes.

(a) (i) and (ii) I do not deem it in the interest of anyone to make known the name of the member, except to say that he is a detective sergeant.

(b) The investigation has not been completed yet.

(3) Before deciding on departmental steps, the criminal aspect must first be completed.

(4) No.

QCSR 1607
Transmed
HANSARD 6/5/86
299

*17. Mr D J N MALCOMESS asked the Minister of Transport Affairs:

(1) Whether past employees of the South African Transport Services are required to have worked for the South African Transport Services and to have been members of Transmed for a specific period in order to remain members of Transmed once they have left the employ of the South African Transport Services; if so, what is that period;

(2) whether, during the latest specified period of five years for which information is available, any South African Transport Services employees were allowed to continue as members of Transmed despite not having been employed by the South African Transport Services for the necessary qualifying period; if so, (a) how many, (b) what were the circumstances of each case and (c) who took the decision in this regard?

The MINISTER OF TRANSPORT AFFAIRS:

(1) Only employees who retire on account of age limit, reduction in or reorganisation of staff, severe bodily injury, permanent ill-health or physical disability not occasioned by their own default, or are retired in terms of section 11 or 14 of the Conditions of Employees (South African Transport Services) Act, 1983 remain members of Transmed, provided they have completed at least 10 years' continuous service.

However, employees who (a) sustained 100 per cent permanent disablement in an accident arising out of and in the course of their employment and are retired on account thereof or (b) are retired on account of wounds or illness sustained in or as a result of military service in the South African Defence Force, provided they receive compensation in terms of any act regarding military pensions, will remain members of Transmed irrespective of their period of service.

(2) No. (a), (b) and (c) Fall away.

Sebokeng/Vereeniging: commuter line

*18. Mr G B D McINTOSH asked the Minister of Transport Affairs:

(1) Whether the South African Transport Services are considering constructing a commuter line from Sebokeng via Vanderbijlpark and Sharpeville to Vereeniging; if so, when is it anticipated that this line will be completed; if not, why not;

(2) whether the South African Transport Services have conducted a survey of the numbers of commuters in this area and of potential users of this line; if not, why not; if so, (a) when and (b) what were the findings;

(3) whether he has received any representations regarding the construction of this line; if so, (a) from whom, (b) when and (c) what was his response?

†The MINISTER OF TRANSPORT AFFAIRS:

(1) and (2) No. No such requests have been received.

(2) (a) and (b) Fall away.

(3) No.

(a), (b) and (c) Fall away.

HANSARD 6/5/86 QCSR 1609

SATV: photographs of Hèléne Passtoors

*19. Mr D J DALLING asked the Minister of Law and Order:

(1) Whether a certain person, whose name has been furnished to the South African Police for the purpose of the Minister's reply, is being held by the South African Police during her trial; if so, (a) where is she being held and (b) what is her name;

(2) whether he has been informed that photographs of this person were televised by SATV on 14 and 15 April 1986; if so,

(3) whether he intends taking any steps in regard to this matter; if not, why not; if so, (a) what steps and (b) in terms of what statutory provisions?

The MINISTER OF LAW AND ORDER:

(1) Yes.

(a) Johannesburg Prison.

(b) Hèléne Passtoors.

(2) No.

(3) Falls away.

SATV: photographs of Hèléne Passtoors

*20. Mr D J DALLING asked the Minister of Justice:

(1) Whether a certain person, whose name has been furnished to the Minister's Department for the purpose of his reply, is being held in prison during her trial; if so, (a) in what prison and (b) what is her name;

(2) whether he has been informed that photographs of this person were televised by SATV on 14 and 15 April 1986; if so,

(3) whether he intends taking any steps in regard to this matter; if not, why not; if so, (a) what steps and (b) in terms of what statutory provisions?

†The MINISTER OF TRANSPORT AFFAIRS (for the Minister of Justice):

(1) Yes.

(a) Johannesburg Prison.

(b) Hèléne Passtoors.

(2) No, as no offence was committed in terms of the Prisons Act, Act 8 of 1959, as amended.

(3) Falls away.

That is a stupid question!

†The CHAIRMAN OF THE HOUSE: Order! With respect to the hon Minister, the

7/5/86 · STAR (27)

Self-help plan for black disabled

By Michael Tissong

An association for disabled people has launched a campaign to establish self-help groups in the townships and rural areas.

Announcing this 1986 project at a function in Johannesburg, the chairman of Disabled People South Africa (DPSA), Dr William Rowland, said the organisation's campaign last year to get building regulations changed had been successful.

He said that in terms of the new regulations introduced two weeks ago, developers of new public buildings would have by law to meet certain minimum standards concerning disabled people on matters such as access points, lifts and toilets.

At the function, South African Breweries presented the DPSA with a cheque for R10 000 to wards its new campaign.

The campaign will be headed by Mr Friday Mavuso, DPSA vice-chairman and chairman of the Self Help Association of Paraplegics (SHAP), based in Soweto.

Dr Rowland said SHAP, which Mr Mavuso founded in 1981, "has demonstrated that self-help organisations can make a real impact on the lives of disabled people in the township situation".

He added: "The campaign will bring together disabled people in the townships and the rural areas to learn from one another, develop strategies and pool resources.

"DPSA will endeavour to show that the establishment of self-help groups is at least as valuable as professional welfare services and should receive an equal amount of financial support from both the State and the private sector.

"The DPSA also has action groups to deal with the housing needs of disabled people and to negotiate equal services for disabled people travelling on South African Airways because we are denied tickets on the late night flights."

Mr Mavuso said SHAP had established three centres.

"A centre in Eldorado Park makes tracksuits for schools. They are using temporary premises and are applying for a site to put up a proper centre.

"We have others in Kagiso and Soweto. Another one is coming up in Newcastle.

"We have heard complaints from another organisation which helps disabledpeople. We are not in competition with it and we are not a threat to it. We appreciate their work, but we would like to help ourselves because we are most knowledgeable about the problems we face," he said.



Members of the Disabled People South Africa (DPSA) attended a function at which a cheque for R10 000 for the DPSA's 1986 project was handed over. Front row from left, Mr Bhola Lawton, Mr Neille Cohen, Mr Friday Mavuso, Ms Cathy Jagoe and Ms Sandy Heyman. Back row from left, Dr William Rowland, Mr Dunbar Bucknall of the SA Breweries and Mr Mike du Toit.

A top-ranking TRFU official standing — however large. Northern Transvaal would never let him go. Whatever offer we made, they were

Societies seek demise of 'total cover' scheme

Call for revamping of medical aid laws

DAVID FURLONGER

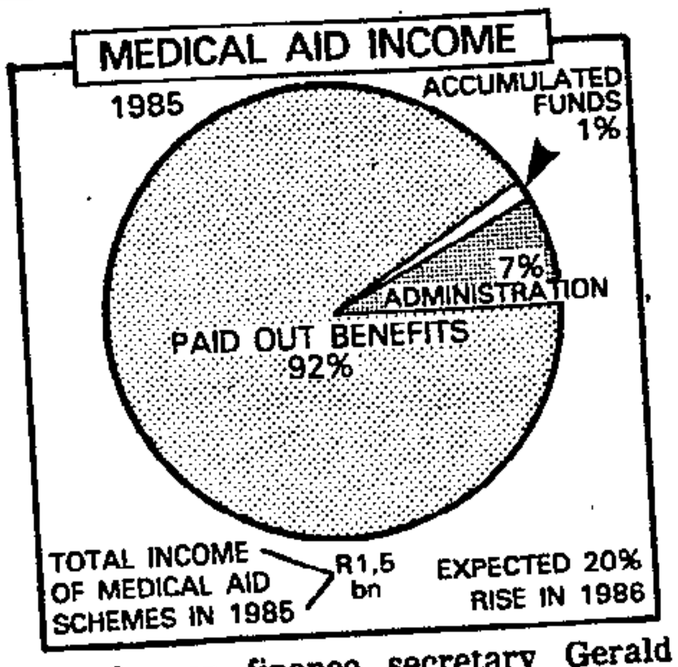
MEDICAL aid societies want government to scrap rigid legislation regulating medical cover, in favour of a more flexible system which could shift liability for minor costs — such as prescriptions — to the public.

Existing regulations force societies to provide total cover for members. The societies want to offer flexible medical packages to suit individual needs.

Options could include cover for major accidents or illness only; medical fees above a certain minimum; percentage payments and a no-claims bonus system.

Medical aid societies are awaiting the findings of the Brown Commission, which has just completed a six-year investigation into the country's health services.

Members of the commission, headed by former finance secretary Gerald Brown, say its report will be tabled in Parliament this session.



The medical aid sector made two main recommendations to the commission: No more guaranteed payments by societies to providers of medical services, and an end to their obligation to provide benefits for every service.

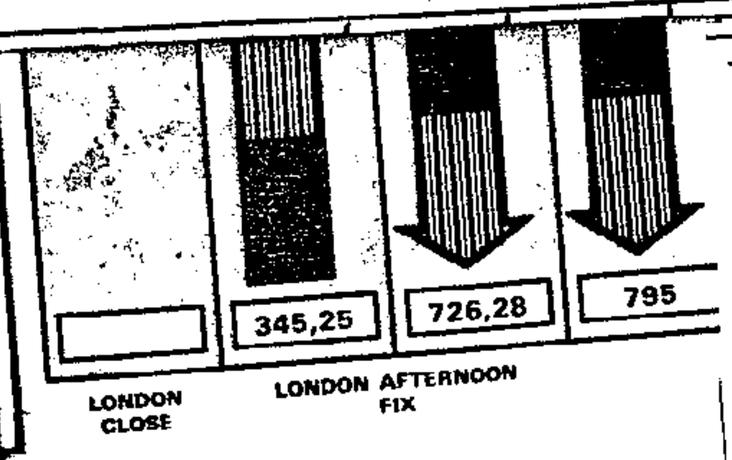
The main intention of such changes is to make members of the public liable for minor medical costs, particularly prescription fees.

An estimated quarter of all medical aid pay-outs are for prescription fees, and societies say the money would be better spent on providing cover for more costly care.

Under the 1967 Medical Schemes Act, societies are obliged to offer a minimum 70% towards the cost of services offered by GPs, surgeons, dentists and physiotherapists. The same minimum applies to hospital accommodation and prescription charges.

John Ernstzen, chairman of the Representative Association of Medical Schemes (Rams), said: "Those who want

● To Page 2



Medical aid moves

● From Page 1

socialised medicine could still buy it, but at a price. We must encourage people to reduce costs."

A medical aid spokesman for SA Druggists said: "Medical aid subscriptions are going up at a phenomenal rate. Patients should be made more aware of what costs are. Incentives have to be built in."

Ernstzen said the concept of flexible health care was accepted by the medical profession but not by the public.

"The man in the street wants socialised medicine. He doesn't care what it costs. About 80% of our members don't want a change, they want 100% cover."

Industry officials say medical aid costs are rising at an alarming rate, both in terms of medical bills and the cost of medical cover.

Total income of medical aid schemes in 1985 was about R1,5bn. This is expected to rise 20% to R1,8bn this year. In 1985, all but 8% was paid out in benefits. Another 7% went on administration, and the remaining 1% into accumulated funds.

According to Ernstzen, the present system encourages medical aid societies to be as wasteful as the public. To attract members, they must compete on the basis of pay-outs rather than efficiency or improved cover.

"The only way to compete is to keep on upping benefits in order to compete with competitors. This in itself is cost-escalating when we are talking of cost-awareness."

Benefits review for police

Mercury Reporter

BLACK policemen's medical aid benefits are being reviewed by the South African Police because at present they do not receive the same benefits as other members of the force.

This was confirmed by a spokesman at Police Headquarters in Pretoria in response to a complaint to the Mercury by a black policeman.

The policeman wrote to the Mercury questioning the discrimination in the police medical aid scheme, Polmed.

He wrote that while whites, Indians and coloureds and their families were treated under the scheme, the wives and children of black members were excluded.

However, in reply, the police spokesman said that black members were paid a monthly allowance for the purpose of medical care for their families.

'Also the situation as it stands at present is under review and should be changed in the near future,' the spokesman said.

Medical aid societies want flexible system

299 CAPE TIMES 12/5/86

Own Correspondent

JOHANNESBURG. — Medical aid societies want the government to scrap rigid, legislation regulating medical cover, in favour of a more flexible system.

Existing regulations force societies to provide total cover. The societies want to offer flexible medical packages to suit individual needs.

Options could include cover for major accident or illness only, medical fees above a certain minimum and even a no-claims bonus system.

Medical aid societies are awaiting the findings of the Brown Commission, which has just completed a six-year investigation into the country's health services.

Members of the commission, headed by former Finance Secretary Mr Gerald Brown, say its report will be tabled in Parliament this session.

The medical aid movement made two main recommendations to the commission — no more guaranteed payments by societies to providers of medical services, and an end to societies' obligation to provide benefits for every service.

The main aim of such changes is to make members of the public liable for minor medical costs, particularly prescription fees.

An estimated quarter of all medical aid pay-outs are for prescription fees, and societies say the money would be better spent on providing cover for more costly care. Societies are obliged to offer a minimum 70 percent towards the cost of services.

Mr John Ernstzen, chairman of the Representative Association of Medical Schemes (Rams), said: "Those who want socialized medicine could still buy it, but at a price. We must encourage people to reduce costs."

Mr Ernstzen said the concept of flexible health care was accepted by the medical profession but not by the public. "The man in the street wants socialized medicine. He doesn't care what it costs."

BUILDING BOLAND

Provident Fund	:	--
Coverage	:	--
Worker Contribution	:	--
Employer Contribution	:	--

4. Pension Fund

Coverage	:	All
Worker Contribution	:	Yes
Employer Contribution	:	Yes

Sick Fund	:	All workers
Coverage	:	--
Worker Contribution	:	All workers
Employer Contribution	:	120days
Annual payment for 5 day week	:	-- days
Annual payment for 6 day week	:	6 months
Qualifying period	:	4 days
Waiting period	:	75.0 %
percentage of wage paid	:	--
Maternity days per pregnancy	:	All workers

Medical aid bodies after flexibility

N/M 12/5/86 299

Mercury Correspondent

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Alarming

'The man in the street wants socialised medicine. He doesn't care what it costs. About 80 percent of our members don't want a change.'

Industry officials say medical aid costs are rising at an alarming rate, both in terms of medical bills and the cost of medical cover.

Total income of medical aid schemes in 1985 was about R1,5 billion. This is expected to rise 20 percent to R1,8 billion this year. In 1985, all but 8 percent was paid out in benefits. Another 7 percent went on administration, and the remaining 1 percent into accumulated funds.

According to Mr Ernstzen, the present system encourages medical aid societies to be as wasteful as the public. In order to attract members, they must compete on the basis of pay-outs rather than efficiency or improved cover.

HRGUS 16/5/86 (299

NATIONAL/CITY

Troubled medical aid society to charge a levy

Staff Reporter

ABOUT 6 500 members of a Cape Town-based medical aid society, Medico, are to be charged a levy of two months' subscription to try to save the scheme from bankruptcy.

Mr H Freitag, managing director of Medicaid, a subsidiary of Price Forbes Federale Volkskas, which this month took over the administration of Medico, said the scheme's troubles followed a sharp increase in medical aid claims since December.

The registrar of medical aids in Pretoria said today that Medico had not been declared insolvent.

"The company is in the red with an accumulated deficit which has been caused by claims exceeding the income of the company.

"In 1984, 67 of the 205 medical aid schemes in South Africa registered a loss, but were able to recoup because they had enough money in their accumulated fund," said the registrar.

It was up to the new administrators and members to try to rectify the situation in Medico and to decide whether the company was insolvent or not, he said.

Mr Freitag explained the need for the levy and a change in the rules of the scheme to members in Cape Town last week.

"The changes and the levy were necessary to get the company back on a sound footing," said Mr Freitag.

"The vast majority of the larger companies subscribing indicated at the meeting that they agreed with the recommendations. Most of those who could not attend have also indicated to me in the past week that they agree with them," said Mr Freitag.

"A few people have contacted our office and intimated that they will be withdrawing, but they have to give three months' notice to do so.

"Among the recommendations are a limit on the amount of medication which may be purchased and the loading of fees for certain members and associations," he said.

"We will be able meet all the outstanding medical claims if the levy and the new recommendations are accepted," said Mr Freitag.

Some members had also abused the scheme by claiming more for medication each a month than they were paying in contributions.

City medical aid scheme insolvent

CPT TIMES 15 feb

299

By GORDON KLING
Financial Editor

SOME 6 000 medical aid scheme members and several companies risk being left without cover-age on considerable medical claims unless a rescue operation succeeds in saving City-based Medico scheme.

The rescue attempt is being made by the Price Forbes Federale Volkskas subsidiary Medicaid.

The registrar of Medical Aid Schemes confirmed from Pretoria yesterday that Medico was insolvent, and that members and the suppliers of medical services and products could suffer financially if a collapse is not averted.

No safety net existed in terms of legislation governing the schemes.

Medico staff would not comment on the situation yesterday.

The Price Forbes deputy managing director in charge of the operation, Mr H Freitag, could not be reached for comment.

'Imbalance'

The scheme, providing up to 100 percent cover-age, evidently went wrong through an imbalance between premiums and claims.

It is understood that Medicaid believed it would be necessary to liquidate the scheme when it discovered its serious financial problems shortly after becoming associated with it last month.

Medico's manager at the time, Mr Jonathan Bloomberg (brother of former mayor Mr David Bloomberg), confirmed he had left the company soon after the link with Medicaid.

He confirmed that he planned to emigrate to the United States shortly, but said this had been arranged some time ago.

Current negotiations were prompted by the registrar's appeal for an attempt to be made to avert the scheme's collapse.

crack of dawn



"Can one watch the Cavaliers' matches without paying? The papers say the match against Natal was a free for all."

BUSINESS BRIEF

Gold (close)	$342,55
Rand	$0,4620/30
FT index (close)	1320,00
BD 100	1285,20
Dow Jones	1 808,28

413- BUSINESS EQUIPMENT INDUSTRY, CERTAIN AREAS

AREA A: Alberton, Bellville, Benoni, Boksburg, Brakpan, The Cape, Durban, Germiston, Goodwood, Inanda, Johannesburg, Kempton Park, Kimberley, Klerksdorp, Krugersdorp, Kuils River, Nigel, Oberholzer, Pietermaritzburg, Pinetown, Port Elizabeth, Pretoria, Randburg, Randfontein, Roodepoort, Simonstown, Springs, Westonaria, Wonderboom, Wynberg; Municipal Areas: Bloemfontein, Paarl, Sasolburg, Uitenhage,
Vanderbijlpark, Vereeniging, Welkom, and Witbank,

AREA B East London. Municipal Areas: Bethlehem, Ermelo, George, Grahamstown, Kroonstad, Ladysmith, Middleburg (Tvl), Nelspruit, Newcastle, Oudtshoorn, Pietersburg, Potchefstroom, Rustenburg, Somerset West, Stellenbosch, Strand, Wellington, and Worcester;

AREA C Municipal Areas: Bethal, Dundee, Empangeni, Eshowe, Graaf-Reinet, King William's Town, Lic[illegible] Trichardt, Parys, Phalaborwa, Port Shepstone, Que[illegible] ton, Tzaneeen, Upington, Vredendal, Vryheid

Footnotes

1. Sunday Work - Shift workers rate for Sund[illegible]

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Current negotiations were prompted by the registrar's appeal for an attempt to be made to avert the scheme's collapse.

Members called on to rescue Medico

14/5/86 · BUSDAY 299

MORE than 6 000 members of the insolvent medical aid scheme Medico have been called on to rescue the fund or accept its demise.

Medico, a scheme supported by almost 650 companies, is unable to meet R2m in outstanding claims.

To save the scheme, members have been called on to pay a double contribution levy which will be reimbursed when the society recovers.

Medico's administration was taken over by a Priceforbes Federale

CHERILYN IRETON

Volkskas subsidiary, Medicaid, in April.

"We were aware of the cash flow problems," says Medicaid MD Herbert Freitag. "Our auditors did a summary and basically the fund had R2m worth of claims which it could not meet."

Members were then presented with the two options: either to chip in with a levy and accept a few minor changes to the scheme's rules or to allow its winding up, says Freitag.

They opted to pay the levy.

Freitag says Priceforbes Federale Volkskas has not pumped any money into the scheme, and even if it wanted to, the law would not allow it.

"The law prescribes that members must balance the books — so we can't introduce any bridging finance."

Last year Medico paid out about R11m in benefits, R3m more than had been paid out in 1984.

Barlan Tel. 51-2016

Cape Times 16/5/86 (299

Medico losses about R2m

Financial Editor

LOSSES by the insolvent Cape Town-based Medico medical aid scheme are about R2m.

Disclosing this yesterday, the MD of the Price Forbes Federale Volkskas medical aid administration company, Medicaid, Herbert Freitag, said it was too early to say if the scheme could be saved.

Medico is a mutual society which is meant to be precluded from making a loss or profit since members simply share in its income and expenses.

Medicaid is playing a supportive role following the departure of previous management.

Angry medical practioners yesterday said they believed the medical aid schemes should be required to establish a fidelity fund to reduce the liability of patients and the medical profession to scheme failures.

Medicaid's rescue attempt centres on a special levy equivalent to two months contributions being asked from the 6 500 members.

A major problem, however, is the possibility that aside from members giving notice to quit, some members may simply abandon the scheme, thus further increasing the burden of those still making contributions.

Should that happen, warned Freitag, Medico's committee might instruct his team to institute legal action against defaulters.

"We can do nothing without the support of the members," he said, acknowledging that some companies were already balking at the levy.

The scheme's problems did not arise from someone running off with the petty cash.

Rather it has been a case of "abuse" by members "right across the board", said Freitag.

"One has to accept that in a recessionary period claims tend to escalate."

A similar situation in the MSP medical aid scheme a few years ago was prevented from becoming more serious by a special dispensation from the Registrar of Medical Aid Schemes which extended the notice period for those wanting to leave to 12 months.

"If that was still available to us it would be relatively easy to get things right," said Freitag.

But it evidently is not since a change in the scheme regulations has removed the enabling mechanism.

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SHE



All smiles after the news that their access campaign had produced results . . . DPSA members Bhola Lawson, Neville Cohen, Friday Mavuso, former East Londoner Kathy Jagoe and Sandy Heyman.

Boost for disabled people

The drive for equal rights for people with disabilities in South Africa was given a considerable boost with the promulgation of minimum legal standards of accessibility for new buildings recently.

Disabled People South Africa, one of the pressure groups responsible for the access breakthrough, says because the new regulations will not relieve the plight of many disabled people in the short term, it has embarked on a new campaign for 1986, known as Emerging Self Help.

The access campaign was mounted by DPSA last year in response to the omission of any reference to the needs of disabled people in the original building regulations.

Experts on accessibility from DPSA held extensive meetings with representatives of the SABS and the building professions over the year, so that the new regulations are a product of close consultation with disabled people.

In terms of the regulations, developers of new public buildings will be required by law to meet certain minimum standards governing such matters as access points to buildings, lifts, toilets and others. These measures will, in the long term, contribute to a more equal opportunity for disabled people wishing to lead a normal life.

However, the DPSA says the situation of black disabled people, both in the townships and rural areas of the country, is so critical that it warrants urgent and decisive action — hence the declaration of the new campaign.

The campaign will bring disabled people in the townships and rural areas together to learn from one another, develop strategies and pool resources. DPSA will endeavour to show that the establishment of self help groups is at least as valuable as professional welfare services and should receive an equal amount of financial support from both the state and the private sector.

DPSA also has action groups to deal with the housing needs of disabled people and to negotiate equal services for disabled people travelling on South African Airways.

Mfesane gives R18 000 for needy children

Dispatch Reporter

EAST LONDON —About 100 homeless and handicapped children in Mdantsane would benefit from the R18 000 allocated to them by Mfesane, it was announced at the association's media conference in King William's Town yesterday.

Mfesane is a Christian association which assists underprivileged and handicapped people in Southern Africa.

The managing-director of Mfesane, the Reverend Almero Cloete, said R9 000 had been allocated to the association's Khayalethemba Children's Home and its school for crippled children, Vukuhambe, would receive the same amount. The money was made available by sponsors in Holland who each "adopted" a child at R180 a year.

"The Word and Deed Foundation for Christian Aid by the reformed churches in Gorinchem, Holland, in consultation with the director of the children's home and the principal of Vukuhambe School, both Mfesane projects, selected 50 children from each project who's photographs were sent to Holland where they were presented to prospective sponsoring parents," Mr Cloete said.

He said Mfesane had 696 handicapped and homeless children in its care. Of these, 218 were sponsored by the Sponsor a Child scheme developed three years ago, and 478 remained unsupported.

Mr Cloete appealed to the public to offer assistance in view of 1986 being the Year of the Disabled.

"The expenditure budget for the 20 Mfesane projects on the go at present amounts to about R4 million for the current financial year. A large portion of this is heavily subsidised by the government.

"There are a further six projects which are selfsupporting and in certain cases also profit generating, whereby a contribution is made towards the Mfesane group's financial commitments

"While assistance from overseas — such as this from Holland, is important — it remains true that charity begins at home," Mr Cloete said.

MEDICAL AID 23/5/86

In need of aid

299

The Cape-based medical aid scheme, Medico, will be saved from liquidation only if emergency measures suggested by the new administrator, Medicaid, are fully supported by the 650 companies involved.

Medicaid MD Herbert Freitag says a payment of extra cash equal to two months' normal contributions, and minor changes to the rules to prevent abuses, should restore the fund to solvency. The measures were accepted at an AGM two weeks ago, but there have since been reports that some companies intend to default.

"The future of the fund depends on whether or not they do. We will monitor the situation and there will be a report-back in June to decide on our next move."

Liquidation is still a possibility.

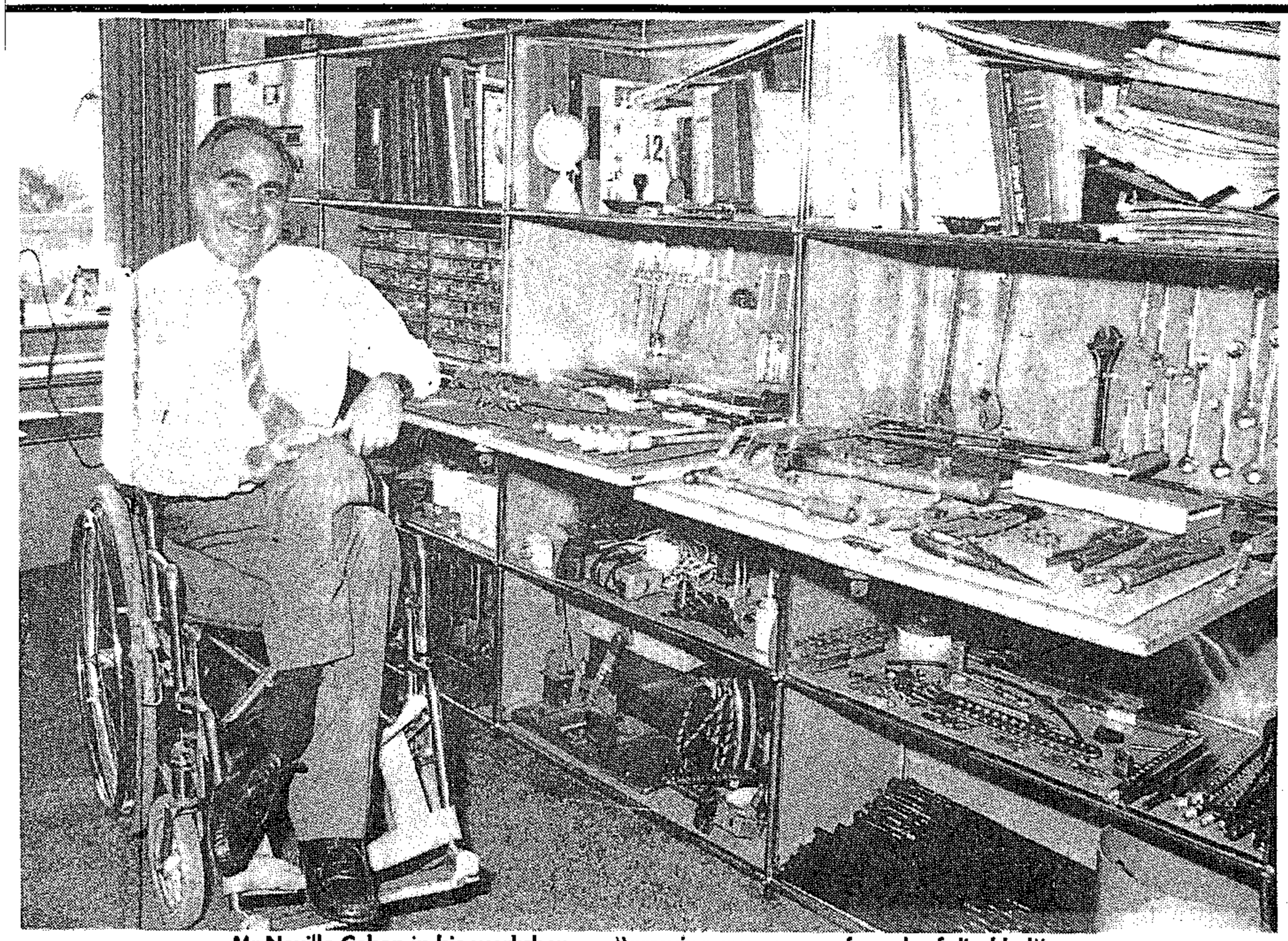
Medico has an accumulated deficit of R2,5m. The full extent of the ailing scheme's troubles was not apparent when Medicaid, a Priceforbes Federale Volkskas subsidiary, took over from former MD Jonathan Bloomberg last month. Freitag confirmed that an in-depth audit showed the scheme's insolvency is due to the high cost of meeting claims and not to maladministration.

It has, however, been in trouble for several years and administrators have received several letters from the Registrar of Medical Schemes asking them to reduce expenditure and build up reserves. Although the requests were complied with, the small increase in reserves could not withstand the giant increase in members' claims.

"Had we been in charge earlier, with our sophisticated systems, we would have picked up the problems earlier," says Freitag, "and avoided the need to take such drastic action now."

Medico is not the only medical scheme battling high costs. "I couldn't put a number on it," said an industry source, "but I believe several schemes could be technically insolvent." Pressure is put on funds by members' tendencies to claim at every opportunity and the high cost of medical supplies and services.

While there is no protection for members in established schemes which founder, administrators of new schemes are required to furnish a guarantee of R200 000 cash, and a further R200 000 guarantee from a financial institution in case of liquidation. ■



Mr Neville Cohen in his workshop . . . "growing awareness of needs of disabled".

SA's 'positive' group of disabled say it's been a good year

STAR 27/5/86 299

By Olga Horowitz

Halfway through this 1986 Government-decreed National Year of the Disabled, the DPSA — Disabled Persons of South Africa — has announced a success story.

"There is most heartening growing awareness of the needs of disabled people, a positive approach to their situation and a lot of helpful activity," says Mr Neville Cohen, a council member of DPSA, who is an active paraplegic in a wheelchair.

"The awareness was initiated during the International Year of the Disabled in 1981. This gave us a launching pad and platform. Now we have reached the desired state when people do not work for us as benevolent uncles handing out charity: they work with us.

"The ratio of seriously disabled people of all races in South Africa is one in 200. This includes disabilities related to hearing, mobility, vision and the geriatric problems of a society which is living longer."

The DPSA strives for total integration at all levels: in education, leisure activity, sports and hobbies and in the open labour market.

"Our success can be attributed to self-help in the quest for equal opportunity. Ask a disabled person what he sees as the obstacle to being a true member of society and he will reply: the attitudes of society and the accessibility to society.

"Today we have emerged as a group of very positive people who don't gripe and groan."

AWARDS

Mr Cohen, who has received scores of awards for sport and effort in his busy life — he is a consulting industrial engineer — lists five organisations which in this Year of the Disabled "have made things happen."

They are Pick 'n Pay, Anglo American Property Services, which has expert Kathy Jagoe as a consultant, Rapp and Maister Construction and the Standard Bank.

"All of them care for all the needs of disabled workers."

19-3

Triumph for deaf operators

The first group of deaf computer operators in South Africa has been successfully trained in Johannesburg by a German-based firm.

Ten deaf men and women, some of whom have never worked, can now go out into a market where demand for labour is endless and salaries begin at R800 a month.

"Deaf people are quite suitable as computer operators," said Mr Brett Botha, personnel manager for the firm. "They process from written material and are much less distracted than operators with normal hearing."

With the success of the first deaf operators the firm plans to train more with the help of a retired teacher of a deaf school "translating" the course by sign language.

The managing director of the firm, Mr Tinus Bosch, said that at first his training staff had some reservations about taking on deaf trainees.

"But with sign language, and a little bit more time, they soon reached effective levels."

The firm recently trained 400 unemployed workers to enter computers on request, and with aid, from the Department of Manpower.

299

Medical aid under stress

GERALD REILLY

MEDICAL aid schemes were under increasing financial stress because of the continually escalating costs of illness, said Representative Association of Medical Aid Schemes (Rams) chairman John Ernstzen yesterday.

And he said because of that many schemes were being forced to consider a rationing of services.

The more than 200 schemes had a combined membership of 1,5-million with a total of 4,5-million beneficiaries. Income from subscriptions last year amounted to about R1,5bn. About 40% went to doctors.

Virtually all schemes had to raise subscriptions by between 20% and 25% this year. It was clear members would soon have to be satisfied with a less comprehensive service.

Ernstzen said: "Funds will have to be rationed, despite the fact that functions of schemes are rigidly controlled by regulation."

Five-star medical care was available only to the top end, or about one-sixth, of the population.

A much restricted service was available to the rest. Whites had been spoiled in the health care field. And there was a marked maldistribution of medical personnel — doctors, nurses and paramedics.

Ernstzen said too many of them were chasing too few patients in the urban areas, which resulted in a serious over-servicing problem. That had led to a lack of cost awareness among patients and doctors.

The doctors' attitude was frequently: "This patient's bill will be paid by a fund, so there is no need to consider costs." That led to excessive diagnostic tests, excessive prescribing and even unnecessary surgical procedures, with members over-utilising and abusing services.

Ernstzen said: "We must curb our medical and health care expectations and be satisfied with a far more basic service."

If medical scheme patients demanded five-star treatment, they would have to pay big excesses to doctors and hospitals. In that way they would become more aware of the actual costs of illness.

Milk and butter prices could go up next week

Argus 6/6/86 (24)

Staff Reporter

ANNOUCEMENTS on milk and butter price changes are expected next week.

In March the Dairy Board recommended that the Minister of Agricultural Economics and Water Affairs, Mr Greyling Wentzel, increase the producer price of fresh milk.

His decision was expected to be announced during the Dairy Board's quarterly meeting from Tuesday to Thursday next week, Mrs Anna Boshoff, board public relations officer, said today.

Speculation is that an increase of about 3c a litre in the producer price will be announced.

The producers' last increase, in June 1984 was between 2c and 3,5c a litre.

The producer price is now 45c a litre and the consumer pays about 83c.

Mrs Boshoff said an announcement on steps to get rid of the 5 000-ton butter surplus was also expected.

At the March board meeting, a committee was appointed to investigate the butter industry. Low butter consumption in South Africa was a cause of concern, said Mrs Boshoff.

Decision on future of Medico may be today

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Staff Reporter ARGUS 6/6/86

THE future of the troubled Cape Town based Medico medical aid society may be decided at a meeting today.

A meeting of the committee administering the society's affairs was adjourned yesterday without decision.

The society was taken over last month after it ran into trouble following a sharp increase in claims by members since December.

About R2-million in outstanding claims will have to be settled by members if the society goes into liquidation.

Medico members angry about paying the bills

W/Re Argus 7/6/86 299

By VIVIEN HORLER
Weekend Argus Reporter

MEMBERS of the crashed medical aid society Medico are angry about having to pay their medical bills.

Clinics and doctors insist the patients are responsible for outstanding payments.

Medico's administering committee decided yesterday to put the society into the hands of liquidators after a last-minute rescue bid failed.

The collapse of Medico leaves the medical profession owed more than R2-million, and almost 6 500 people without medical cover.

The society got into difficulties after a sharp increase in claims earlier this year.

Triple

In an effort to save the scheme, Price Forbes Federale Volksas took over the society last month and said members would have to pay a triple premium for June.

But, according to Mr Herbert Freitag of Price Forbes, only 30 percent of the members paid up, and Medico's committee decided yesterday that nothing more could be done.

Patients used terms such as "desperate" and "devastated" in describing their reaction.

"We suffer"

"I am so angry that we have to suffer because of what appears to be gross mismanagement," said a Clifton woman who is six months pregnant. "What are we supposed to do? We paid our monthly premiums in good faith all along."

Ms Maureen Burlinski, who works in an office on the Foreshore, said: "I knew this was going to be the outcome. I feel devastated. We owe between R800 and R1 000, mainly for dental work. There are a lot of unanswered questions."

Mr Janek Szymonowski runs a tiny company from Hout Bay, with three people on his group scheme through Medico. "We're pretty small, yet between us we're liable for R3 500.

"Disgusting"

"It's ludicrous to suggest that had all 6 000-odd members paid the premium they would have had enough to meet all the bills. It's disgusting to expect members to fork out for bad management."

Mr Box du Toit, administrative manager of Louis Leipoldt Hospital in Bellville, said it was owed a sum running into tens of thousands of rands.

But, he said: "The patient is always responsible for bills."

And a spokeswoman for a city anaesthetist, who said the practice was owed thousands of rands, said the bills would have to be paid by the patients, depending on the settlement arrived at by the liquidator.

Medical aid society crash

7/6/86 SDM 299

Medical Reporter

The Medico medical aid society has crashed leaving more than 6 000 members with unpaid doctors' bills.

Medico's committee decided in Cape Town yesterday to liquidate the scheme which owes more than R2 million in outstanding claims.

A bid by the society's administering committee to rescue the scheme by asking members to pay double the levies failed because only 30 percent of the 6 000-plus members agreed to do so.

"This makes rescue unattainable," said Mr Herbert Freitag of Price Forbes Federale Volkskas, which took over the administration last month.

"The whole medical aid industry is under stress because of enormously escalating medical costs and claims have soared in the first five months of this year," Mr J Erntzen, chairman of the Representative Association of Medical Societies told *The Star* yesterday.

Medaid society liquidated

THE Medico medical aid society has crashed. Its committee has decided to liquidate the scheme, which owes more than R2m in outstanding claims.

Only 30% of the 6 000-plus members paid the double premium levied by Medico's administering committee in a bid to save the society, and many members are understood to have already found medical cover with other societies.

Herbert Freitag of Priceforbes Federale Volkskas, which took over administration of Medico last month after it ran into financial difficulties, said at the weekend that doctors and clinics would probably have to sue members for payment of outstanding accounts.

"If we had had a clear statement from the Registrar of Medical Schemes supporting the rescue mission, we could have come right," he added. — Sapa.

F(N MAIL 13/6/86.

MEDICAL SCHEMES

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Ailing funds

When the Medico medical aid scheme crashed last week, leaving uncovered those of its 6 000 members who had not made other arrangements, the shock waves were felt by all who contribute to similar funds. Its failure, unprecedented in SA, has brought home to everyone that more than 5m members and beneficiaries of medical schemes are vulnerable.

Rumours of Medico's problems started circulating some months ago. In April, its administration was taken over by the Price-forbes Federale Volkskas company, Medic-aid. Attempts to make good the funding deficit failed when members refused to pay in an additional amount equal to two months' contributions — after previously approving the levy at a special general meeting.

"I am feeling sore about this," said Medic-aid MD Herbert Freitag, "because, while we were mounting a rescue operation, companies were joining other schemes — ignoring the three-month notice rule and other provisions of the Medical Schemes Act. With the Registrar of Medical Schemes keeping a passive profile and certain other societies blatantly ignoring the law, our mission could not succeed, so remaining members have been left in the lurch. Possible action by the liquidators against defaulting parties as well as guilty societies cannot be discounted."

The registrar's office was not prepared to respond to criticism of his role.

One problem facing medical schemes, says Freitag, is that they may not charge differentiated rates — unlike insurance companies, which may charge higher premiums for bad risks. So there is no way a medical fund can remedy a shortfall except by asking for a substantial general rise in contributions.

Freitag believes that, because of the severity of the recession in the Cape, schemes there may be worse off than those in other parts of SA. But he is convinced that the problem is widespread.

John Ernstzen, chairman of the Representative Association of Medical Schemes, confirms this, blaming high anxiety and the shrinking rand for eroding reserves. "Claims are higher when times are bad, and are becoming frightening in terms of volume and cost. The imported components have made medical care more and more expensive," he says.

Because no one can accurately predict the effects of stress on usage or the exchange rate of the rand over a year, it is difficult for medical schemes to budget. The result is that the chronic problem — lack of cost awareness on the part of public and the health profession — has become acute.

Another factor to distort budget predictions is that changes to the Medical Schemes Act now allow doctors and dentists to "contract in or out" on a per-service basis. This makes future costs more difficult to assess than under the old system, whereby practitioners made a blanket decision on how they would operate. Says Ernstzen: "The last time we took out statistics, we found that doctors who contracted in service patients 25% more than doctors who contracted out."

Early retirements, another sign of the times, have further drained funds. "Retirees contribute at a subsidised rate and we generally pay out about three times as much on them as we get in."

However, Ernstzen does not believe we will see a series of collapses. Despite cost increases in dental and medical care of 12,5% and in hospitalisation of 12% on January 1, he hopes that increases of 20%-25% in contributions since then will enable funds to meet their obligations and repair past damage. ■

Medical-fees jump of up to 41% suggested

GERALD REILLY

PRIVATE fees of medical practitioners should have been raised by between 19% and 41% from the beginning of the month, says the Medical Association of South Africa (Masa).

It has issued a new set of private tariffs to be used by medical practitioners as a guide only.

"Because the private tariffs are meant to serve as a guide, it creates the opportunity for negotiation between doctor and patient," Masa said in a statement in Pretoria yesterday.

In considering the adjustments, Masa's federal council took into account the possible collapse of private medical services because of spiralling practice costs.

Masa regards the increases as reasonable. It claims the adjustments, based on the consumer price index, would not improve the real income of doctors.

"As in the past, the adjustments were based on the consumer price index, the reason being that practice costs will increase in accordance with CPI increases."

A Masa spokesman said the association realised everyone had to make sacrifices in the current economic climate.

"Doctors are, therefore, asked to take patients' financial circumstances into account when determining tariffs," he said.

The increases are: general practitioners and specialists 19,05%; anaesthetists 20%; radiologists 21,6%; clinical pathologists 20%; anatomical pathology 27%; ultra-sound 41%, and computerised tomography 41,7%.

"This is an average increase of 20,1% and represents an annual increase of 15,1%, which is more or less 4% lower than increases in the CPI over the same period," said Masa.

The last three services listed were seen as immensely cost-intensive. They depend on imports of sophisticated equipment and costly materials and are thus vulnerable to the rand's deteriorating exchange rate.

Masa added that, in terms of the Medical Schemes Act, doctors are not compelled to formally contract in or out. The Representative Association of Medical Schemes (Rams) determines the scale of benefits.

According to calculations by economists, there had been a decrease of between 5% and 10% in the real income of the population over the past 16 months.

"It is therefore accepted that, to maintain their relative position in the economy, doctors' incomes should also reflect this decrease," Masa said.

24/7/86 DD (299)



At the annual meeting of the East London Cripple Care Society last night: from left, the deputy mayor, Mr Ivan Zulman, the chairman of the Cripple Care Society, Mr Bill Cozens, and the chairman of the meeting, Mr David Lazarus.

Report: unrest, recession hit Cripple Care

EAST LONDON — Improvements in two vital facets of working with disabled people — the need for more and improved appliances, and assisting in surmounting problems faced by therapists were the result of a survey conducted on a sample of 100 clients, the chairman of the Criple Care Society, Mr Bill Cozens, said in his report at the annual meeting here last night.

He said improvement of these vital facets would enable more disabled people to live normal lives, integrated with the community, and would subsequently reverse the need for institutional care.

Development and services to the black community had been "bedevilled" by the unrest situation.

Mr Cozens said this resulted in great suffering.

The past year was very difficult for the rendering of welfare services in townships, not only because of the unrest, but also as a result of the recession.

"As a result of the financial squeeze we have had to retrench a social worker and an administration worker," Mr Cozens said.

The workbench centre, which was in its second year of operation and which provided work for 50 disabled people, was proving a great success, and a hostel to house six workers had also been opened.

A bus was donated to the centre for the transport of the workers, he said.

Visits were undertaken to various schools in order to make the youth aware of the problems experienced by paraplegics.

Contact was made in Aliwal North and it was hoped a survey of the handicapped in that area could be conducted soon.

The self-help project for Xhosa people in Cathcart and Goshen also developed continuously, and in Queenstown a specialist surgeon and a technician visited the Frontier Hospital once a month to attend the orthotic clinic.

Patients from a wide area of the Eastern Cape attended the clinic, and about 500 people were registered, with an average attendance of 100 each month, Mr Cozens said.

A workshop which was working one day a week with an average staff of 20 disabled people, had to be limited because of the boycott which prevented the selling of the articles.

In May last year the Criple Care Ekuphumleni Cottage Home was handed over to the Vukuhambe Special School in Ciskei, which provided boarding for 50 female students.

A multiracial basketball team, led by Mrs H. Derbyshire, had participated in tournaments against teams from as far afield as Port Elizabeth.

Mr Cozens thanked all the supporters of the society, the sponsors, and all responsible for the "hard work involved" over the year.

Medical society bows out

Own Correspondent

AN ORDER liquidating Medico Medical Aid Society was granted by the Supreme Court yesterday.

An affidavit by chairman Saul Pick said the company was hopelessly insolvent.

It was registered as a medical aid fund in 1967 and managed by Medical Nominees (Pty) Ltd between January 1979 and April 1986.

Control was then bought by Medicaid Administrations (Pty) Ltd, which found efficiency and cash-flow problems.

Pick said members agreed on May 7 to pay a double levy in June to restore stability. Many subsequently refused, however, so it was impossible to avoid a winding-up.

Only needy to have free health care — Minister

By Sue Leeman

A tariff for State health care may become the rule and only the "needy" will receive free treatment, according to the Minister of National Health and Population Development, Dr Willie van Niekerk.

Speaking at a meeting of the Medical Association of South Africa in Bloemfontein last night, Dr van Niekerk said such a tariff was a necessity.

He warned that the Government was fighting rising costs for health care.

Unless greater effectiveness and cost efficiency were achieved, the financial demands for health services could reach such proportions that they may not be attainable "within the realities of the South African economy".

Health care was a high risk, low profit business and much of it could be privatised, he said.

The private sector, he said, would be expected to provide new facilities in future, but minimum standards and quality control would have to be introduced.

Dr van Niekerk said private initiative would have to take more responsibility for training health care professionals, and promoting primary and preventive health care.

Something would also have to be done about the strong competition which had developed between private and training hospitals for the manpower and expertise needed for sophisticated medicine.

Example of Government initiative

This was detrimental to health care and to the training of health care professionals.

Dr van Niekerk believed that the country's proposed health dispensation would initiate a "new era" and was an example of the Government's initiative in trying to meet the country's changing needs.

"I am convinced that the new health policy and plan are better than any of the previous dispensations and that most worries about the new system will disappear."

He said details of the new plan would be released later.

Embryo defects show

Work at Bourne Hall Clinic, the medical centre near Cambridge, England, has enabled researchers to determine whether an embryo will grow into a healthy or a handicapped individual.

But the ability to replace the defective genes in embryos with normal genes, thus reducing the number of children being born with abnormalities or handicaps, is still a long way away.

Embryo research has been conducted at the centre, internationally famous for its in-vitro fertility techniques, under the direction of of D Robert Edwards and Mr Patrick Steptoe.

They believe the work will help prevent or possibly minimise such conditions as haemophilia, the blood clotting disorder, or muscular dystrophy, suffered by thousands.

Dr Edwards said at his home in Dry Dryton near Cambridge: "We have been doing this work for many years, and we intend to continue with it."

Mr Steptoe said at the weekend that it would soon be possible to screen people for haemophilia so that the disorder could be eliminated once and for all in a family and he forecast that within two years doctors would be able to diagnose systic fibrosis, a distressing condition in children.

Much of the research work has been carried out on animals. — DDC

S. 116

Minimum Monthly Money Wages of Workmen Covered by Industrial Councils: 1976 - 1985

(Wage the median wage in each region. Obtained from agreements between employers and employees)

Year	All Regions.	South Africa	Western Cape	Eastern Cape	Border	Natal
June 1976	0.27	.27	.29	.27	.26	.27
June 1977	0.31	.28	.33	.30	.29	.29
June 1978	0.36	.36	.36	.36	.36	.33
June 1979	0.40	.40	.40	.40	.40	.37
June 1980	0.43	.43	.46	.43	.43	.43
June 1981	0.50	.54	.53	.54	.54	.53
June 1982	0.57	.63	.63	.64	.61	.59
June 1983	0.69	.75	.73	.75	.73	.72
June 1984	0.77	.80	.80	.80	.69	.64
June 1985.	0.89	.90	.90	.89	.90	.89

Medical aid 'scandal'

Evidence of fraud running to R20-m annually

w/e ARGUS 2/8/86 299

Weekend Argus Correspondent

JOHANNESBURG. — Startling evidence has been disclosed of a medical-aid scam in which scores of doctors and several dentists are allegedly swindling medical-aid schemes out of millions of rands.

The frauds, the biggest in South African medical history, are said to be running at R15-million to R20-million a year and spreading by the day.

Six of the country's top medical-aid administrating companies, which represent 81 schemes and 650 000 members and process R700-million in claims a year, have revealed details of an "horrendous level" of fraudulent and unethical activities by medical practitioners throughout the country.

They have uncovered and tracked the extent of the swindle by setting up a full-time computer-backed investigation bureau — and warn that unless the frauds are checked, medical contributions are certain to soar yet again.

This, they say, would come as a hammer blow to hard-pressed contributors already hit this year by a 30 percent increase in membership fees (for whites) and a 110 percent increase for blacks.

On top of this tariffs for "contracted out" doctors have just gone up 20 percent.

This week the administrators opened the investigation bureau's books to show how the frauds are perpetrated — and the evidence that emerged was staggering.

Medical schemes, they said, had become a prime target for abuse and they expressed fear that as the economic recession deepens and their anti-fraud control measures begin to tighten, practitioners — and in many cases patients working in collusion — will try to find other ways of "cashing in" with fraudulent claims.

However, they warned that new control mechanisms were being introduced to flush out malpractice and expose offending doctors at an earlier stage.

One was a new computerised prescription-verifying process to track doctors overcharging on drugs and pocketing the price difference between generics and name-brand products.

Cash deals

Another is a decision to invite 3 000 dispensing doctors to apply for payments to be made on behalf of patients who are members of schemes administered by the six-member group.

Many such doctors are said to be involved in big cash deals selling generic medicines, but to stamp out the fraud a selected number will be invited to become accredited dispensing practitioners.

The bureau, which costs R150 000 a year to run, has uncovered 'at least 20 ways in which the overall scam is operated.

And though it says many doctors are honest and enterprising and providing a necessary service, it claims that a growing number, by using one or more of these methods, are making vast profits and netting up to R250 000 in turnover in medium-size pratices.

DD 4/8/86

Countrywide medical aid fraud — claim

JOHANNESBURG — Members of the medical professions are allegedly perpetrating massive frauds against medical aid companies said to be between R15 million to R20 million a year, a Johannesburg Sunday newspaper said.

A front-page article in the Sunday Star says six of South Africa's medical aid administering companies, which represent 81 schemes with a total of 650 000 members and process R700 million in accounts a year, claim to have evidence of a "horrendous level of fraudulent and unethical activities".

The administration companies claim the fraud is countrywide and the extent of the racket has been uncovered by a specialised computer-backed investigation bureau, the article said.

The companies warn that if the fraud is allowed to continue unchecked, contributions to medical aids are going to be increased again soon.

The administrators also warn that if the racket is allowed to continue unchecked, a number of the smaller medical aid companies are likely to fold, leaving members with unpaid doctors' bills and no cover.

The newspaper quoted one of the investigators as saying that some doctors falsify the number of patients they see a day — with one doctor claiming that he regularly sees more than 70 patients in a normal eight hour working day. — Sapa

My grandfather, who ac
prohibition, was realistic
"the drinker within the ' ... who is deter-

...resented the Local Option
...3 (it was defeated by a ma-
...s none other than Dr D. F.
Malan.

Plan to help mentally disabled

Dispatch Reporter

GRAHAMSTOWN — Plans are afoot to have the Piet Retief Children's Home in Riebeck East, which has been closed since 1976, converted into a sanctuary for the mentally disabled.

According to the committee behind the move, the building housed 100 boys and could easily be converted into a home for 40 to 50 young adults who would otherwise have to go to institutions in other provinces.

Accommodation in the Eastern Cape for mentally disabled people over the age of 18 is limited to two centres in Port Elizabeth: Lake Farm which provides for 100 people and Rainbow, a day care centre for between 20 and 25 people.

The Merryvale Training Centre in Port Elizabeth can accommodate 350 youngsters up to the age of 18 and acts as a feeder but those who do not get into Lake Farm or Rainbow have to go to centres in the Western Cape or Free State, said the principal of Lake Farm, Mrs Ebba Botha.

"There is a crying need for more centres in the Eastern Cape, and indeed countrywide," she said.

Spearheading the move in Riebeck East are two teachers, Mrs Beryl Hoole and Mrs Petro Strydom.

The property belongs to the Dutch Reformed Church and is administered by the synod commission's welfare arm.

The church's secretary for institutions and welfare work in Port Elizabeth, Dominee J. A. Jordaan, said the church had approved the scheme. "We gave the committee the green light at the annual meeting last week."

If the government takes over the project, as the organisers hope, it will be administered by the Departments of Education and Training and of Health and Welfare.

The building, in nearly 70 ha of ground, is structurally sound and would need little conversion or renovation to make it an ideal home.

The bedrooms, previously shared by four boys, would become single homes-from-home for adults. Each person would be able to furnish their room with their own belongings.

There are also four self-contained flats for accommodating staff and a separate homestead.

(299) DD 9/8/86

Argus 15/8/86 299

Masa welcomes new plan for health services

The Argus Correspondent

JOHANNESBURG. — A move by Government to bring health services under a single authority has been welcomed by the Medical Association of South Africa.

Dr W A van Niekerk, Minister of National Health and Population Development, announced in Sandton last night that national health policy and priorities would in future fall under a single health authority, the newly appointed National Health Policy Council (NHPC).

COST-EFFECTIVE

A gathering of about 160 health-care professionals and administrators and representatives of national states were told that in future curative and preventive health services would be combined and the Department of National Health and Population Development and the provincial health services restructured to make health services more cost-effective and "reduce the fragmentation of the past".

Although whites, coloured people and Indians will be represented on the national council and self-governing national states will be consulted on health matters, blacks are excluded from it. Apartheid in provincial and state hospitals will not be dismantled.

"OWN AFFAIRS"

Dr van Niekerk said hospitals occupied by over 95 percent of people of one race would remain "own affairs", ethnic hospitals.

Hospitals occupied by less than 80 percent of one race would be classified as "general affairs" and all teaching hospitals would fall into this category.

The Medical Association of South Africa (Masa) said in a statement the plan was "in keeping with the long-standing campaign of the association against further fragmentation of health services under the present constitutional dispensation.

"Masa is still of the opinion, however, that the provision of health services should be a general affairs matter."

W. DE KLERK,
Vice-President of the Council.

H. C. L. LOOCK,
Secretary of the Council.

No. R. 1727 299 **15 August 1986**

LABOUR RELATIONS ACT, 1956

MOTOR INDUSTRY.—AMENDMENT OF MOTOR INDUSTRY SICK AND ACCIDENT PAY FUND AGREEMENT

I, Pieter Theunis Christiaan du Plessis, Minister of Manpower, hereby, in terms of section 48 (1) (a) of the Labour Relations Act, 1956, declare that the provisions of the Agreement (hereinafter referred to as the Amending Agreement) which appears in the Schedule hereto and which relates to the Undertaking, Industry, Trade or Occupation referred to in the heading to this notice, shall be binding, with effect from 1 September 1986 and for the period ending 30 Junie 1987, upon the employers' organisations and the trade unions which entered into the Amending Agreement and upon the employers and employees who are members of the said organisations or unions.

P. T. C. DU PLESSIS,
Minister of Manpower.

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BYLAE

DIE NASIONALE NYWERHEIDSRAAD VIR DIE MOTOR-NYWERHEID

OOREENKOMS

ooreenkomstig die Wet op Arbeidsverhoudinge, 1956, gesluit deur en aangegaan tussen die

South African Motor Industry Employers' Association

en die

South African Vehicle Builders' and Repairers' Association

(hierna die "werkgewers" of die "werkgewersorganisasies" genoem), aan die een kant, en die

Motor Industry Employees' Union of South Africa
Motor Industry Staff Association

en die

Motor Industry Combined Workers' Union

(hierna die "werknemers" of die "vakverenigings" genoem), aan die ander kant,

wat die partye is by die Nasionale Nywerheidsraad vir die Motornywerheid,

om die Siekte- en Ongevallebystandsfondsooreenkoms vir die Motornywerheid, gepubliseer by Goewermentskennisgewing R. 1600 van 30 Julie 1982, soos gewysig by Goewermentskennisgewing R. 2797 van 31 Desember 1982, te wysig.

1. TOEPASSINGSBESTEK VAN OOREENKOMS

Hierdie Ooreenkoms moet in die Streke wat hierin omskryf word, nagekom word deur alle werkgewers in die Motornywerheid wat lede van die werkgewersorganisasies is en deur alle werknemers in genoemde Nywerheid wat lede van die vakverenigings is.

2. KLOUSULE 6.—BYDRAES

In subklousule (1), vervang die syfer "50 sent" deur die syfer "R1,00".

Namens die partye op hede die 11de dag van April 1986 te Johannesburg onderteken.

F. J. HACKNEY,
President van die Raad.

W. DE KLERK,
Onder-president van die Raad.

H. C. L. LOOCK,
Sekretaris van die Raad.

SCHEDULE

THE NATIONAL INDUSTRIAL COUNCIL FOR THE MOTOR-INDUSTRY

AGREEMENT

in accordance with the provisions of the Labour Relations Act, 1956, made and entered into by and between the

South African Motor Industry Employers' Association

and the

South African Vehicle Builders' and Repairers' Association

(hereinafter referred to as the "employers" or the "employers organisations"), of the one part and the

Motor Industry Employees' Union of South Africa
Motor Industry Staff Association

and the

Motor Industry Combined Workers' Union

(hereinafter referred to as the "employees" or the "trade unions"), of the other part,

being the parties to the National Industrial Council for the Motor Industry,

to amend the Motor Industry Sick and Accident Pay Fund published under Government Notice R. 1600 of 30 July 1982, as amended by Government Notice. R. 2797 of 31 December 1982.

1. SCOPE OF APPLICATION OF AGREEMENT

The terms of this Agreement shall be observed in the Regions defined herein by all employers in the motor industry who are members of the employers' organisations and by all employees in the said Industry who are members of he trade unions.

2. CLAUSE 6—CONTRIBUTIONS

In subclause (1), substitute the figure "R1,00" for the figure "50 cents".

Signed at Johannesburg, on behalf of the parties. this 11th day of April 1986.

F. J. HACKNEY,
President of the Council.

W. DE KLERK,
Vice-president of the Council.

H. C. L. LOOCK,
Secretary of the Council.

DEPARTEMENT VAN OMGEWINGSAKE

No. R. 1679 **15 Augustus 1986**

DIE RAAD VAN KURATORE VIR NASIONALE PARKE

WYSIGING VAN REGULASIES IN VERBAND MET VERLOFVOORWAARDES VAN BEAMPTES EN WERKNEMERS

Die Raad van Kuratore vir Nasionale Parke het, met die goedkeuring van die Minister van Omgewingsake en Toerisme, kragtens artikel 29 van die Wet op Nasionale Parke, 1976 (Wet 57 van 1976), die regulasies uitgevaardig by Goewermentskennisgewing R. 2006 van 6 Oktober 1978, gewysig soos in die Bylae hierby uiteengesit.

BYLAE

Paragraaf (c) van subregulasie 13 van regulasie 24 word hierby deur die volgende paragraaf vervang:

"Alle Saterdae, Sondae en openbare vakansiedae wat binne 'n tydperk van goedgekeurde vakansieverlof, siekteverlof of spesiale verlof, of daartussen val indien meer as een van genoemde soorte verlof aaneenlopend geneem word, word geag by die genoemde verloftydperk ingesluit te wees.".

DEPARTMENT OF ENVIRONMENT AFFAIRS

No. R. 1679 **15 August 1986**

NATIONAL PARKS BOARD OF TRUSTEES

AMENDMENT OF REGULATIONS CONCERNING CONDITIONS OF LEAVE OF OFFICERS AND EMPLOYEES

The National Parks Board of Trustees has, with approval of the Minister of Environment Affairs and Tourism, in terms of section 29 of The National Parks Act, 1976 (Act 57 of 1976), amended the regulations made by Government Notice R. 2006 of 6 October 1978, as set out in the Annexure hereto.

ANNEXURE

Paragraph (c) of subregulation 13 of regulation 24 is hereby substituted with the following paragraph:

"All Saturdays, Sundays and public holidays falling within a period of approved vacation, sick or special leave or between periods of such leave, if more than one type of leave is taken consecutively, shall be deemed to be included in such leave period.".

DD 15/8/86 299

National health plan unveiled

PRETORIA — The functions of the Department of Health and the provincial hospital services have been amalgamated within the framework of the new constitution in terms of a new National Health Plan.

Announcing a comprehensive restructuring of South Africa's public health services yesterday, the Minister of National Health and Population Development, Dr W. A. van Niekerk, said the plan would make it possible to provide a dynamic, comprehensive and cost-effective health service for the first time and would diminish the "fragmentation" of the past.

A newly-formed National Health Policy Board, chaired by the minister, would be responsible for planning, co-ordinating and monitoring the plan.

The ministers of Health Services and Welfare of the Ministers' Councils in the Houses of Assembly, Representatives and Delegates would serve on the board, Dr Van Niekerk said in a statement.

The board would be assisted by an Advisory Committee for Health Affairs. The departmental chief directors of the ministers serving on the board, the surgeon-general and others appointed by the board would serve on the committee.

The committee would, in turn, function with several sub-committees.

Dr Van Niekerk added that the departments of Health Services and Welfare of the three parliamentary houses would be responsible for executing the plan on all three levels of government for their respective communities.

This would entail extensive responsibilities such as providing safe drinking water, environmental health, sewerage and waste disposal services and housing.

Health services for black people would be provided by the Department of National Health and Population Development through powers delegated to the provincial administrations. The provinces would also act as agents for other health authorities.

The National Health Policy Board would liaise with the self-governing homelands and advise the Treasury on expenditures.

Dr Van Niekerk referred to the high costs of private medical treatment and said families who had exhausted their medical aid scheme resources could always apply to their nearest hospital superintendent to be reclassified as hospital patients.

"Everyone in South Africa has access to the health services," he said. — Sapa

Minister agrees to medical aid talks

The Argus Correspondent

DURBAN. — The Minister of Health, Mr Willie van Niekerk, has agreed to an urgent meeting with the Representative Association of Medical Aid Schemes (Rams) to discuss the growing crisis in the country's medical-aid industry.

This was revealed today by Rams chairman Mr Jan Fernhout, who said the meeting would take place "shortly".

"We expect to come to an agreement soon about a date and a time," he said in Cape Town.

He said schemes needed to be able to set their own tariffs and scale of benefits.

This and the question of eliminating the guarantee of payment would be discussed at the meeting with the Minister.

ADJUSTMENTS

Commenting on speculation that many schemes soon would be forced to introduce across-the-board increases in membership fees, Mr Fernhout said he believed many had made adjustments.

However, he was hopeful there would be no further increases until January.

Meanwhile, Mr Carl Schnell, chairman of Allied Pharmaceuticals, has blamed legislation for aid schemes going to the wall, threatening the medical cover of two million people.

Legislation prohibits generics as alternatives to costly medicines.

Mr Schnell added: "If pharmacists were allowed to stock generics, they could offer enormous benefits to medical aid schemes."

25/8/86

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2 Cape Times, M

Minister 'unaware' of appeal

Own Correspondent.

JOHANNESBURG. — The Minister of Health, Mr Willie van Niekerk, says he is unaware of an appeal — reportedly sent to him — to save the sick medical-aid industry.

Mr Van Niekerk said yesterday that he had not received a letter or a request for an appointment from the Representative Association of Medical Schemes.

That was despite weekend reports that a desperate appeal had gone out to him after a spot audit check showed that 32 medical schemes, providing cover for 560 000 members and more than a million dependents, were showing losses of more than R22 million a month.

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Schemes call for greater flexibility

GERALD REILLY

MEDICAL AID schemes would have to be given greater flexibility if they hoped to survive in a climate of spiralling costs of illness, Representative Association of Medical Schemes (Rams) chairman Jan Fernhout said yesterday.

A sub-committee of Rams recently investigated a sample of medical schemes against a background of 1985 balance sheets. A number of them were shown to be technically in the red but this, Fernhout said, did not mean they were on the brink of bankruptcy.

Most schemes had taken corrective action which included increasing subscriptions.

The increases in the scales of benefits for doctors and dentists, although averaging 12,5%, increased actual costs by more than 25% and to compensate for the rise in costs, many schemes had raised their subscriptions for whites by more than 40%.

Fernhout said Rams had asked for a meeting with Health Minister Willie van Niekerk, not to appeal for financial aid but to ask that schemes be given a greater flexibility. This, Fernhout said, would enable schemes to put together packages which would meet the more specific needs of members.

Fernhout said general practitioners fees for consultations in rooms had risen by 43% from January. This had resulted in many more consultations, with patients being referred to specialists — with a consequent bigger demand on funds.

Most funds also found, because of the lesser number of procedures, some GPs had spare capacity which they filled by recommending follow-up consultations with their patients.

Responding to a claim by Van Niekerk that "some schemes were not being administered professionally", chairman of the Rams sub-committee Tony Leveton said most of the 43 schemes investigated were being administered efficiently.

Call for change in medical aid

JOHANNESBURG. — Medical aid membership fees have soared by at least 33 percent since January and legislation to make the schemes more flexible would have to be introduced if further hikes were to be averted.

This was said by the chairman of the representative Association of Medical Schemes, Mr Jan Fernhout, SABC radio news reported.

Referring to the poor financial situation of South African medical aid schemes due to soaring medical costs, Mr Fernhout said it was unlikely that more schemes would be liquidated because they had taken the necessary action by increasing their fees.

A Cape Town medical aid scheme was liquidated recently.

Mr Fernhout said schemes could not simply keep increasing their fees to survive and changes in legislation were crucial for the survival of medical schemes.

● The provision by pharmacists of generic alternatives to increasingly costly medicines could help medical aid schemes, says Allied Pharmaceuticals chairman Mr Carl Schnell.

Following reports that schemes are losing hundreds of millions of rands, Mr Schnell criticized legislation prohibiting the replacement of prescribed drugs with generic — or copy-cat — substitutes.

These substitutes are considerably cheaper.

Mr Schnell said: "In First World countries like the United States, generic substitutions are legal and prevalent. So why not here? If the pharmacists were allowed to stock generics, they could offer medical aid schemes enormous benefits.

"We are in the ludicrous situation of trying to supply First World medicine in Third World circumstances." — Sapa and Own Correspondent

Shock rise in medical aid fees

(299)

CAPE TIMES 27/8/86

JOHANNESBURG. — Medical aid scheme rates are to increase by more than 20 percent country-wide, the Representative Association of Medical Schemes (RAMS), said in a statement released yesterday.

RAMS, which represents South Africa's entire medical aid movement, is battling to survive in the face of spiralling claims costs.

In January this year most schemes raised their rates by 25 percent to meet increased medical, dental and hospital fees, and in at least one case members are now being asked to pay increases of more than 90 percent.

More increases are likely unless rising claims costs, which threaten to sink the medical aid schemes, are controlled.

The increases follow news that out of 43 medical funds surveyed by RAMS, six were insolvent and 32 showed underwriting deficits.

"RAMS realizes that the latest rate increase deals another painful blow to members, who by now must be punch-drunk," a spokesman for RAMS, Mr Tony Leveton, said.

He said the increase was unavoidable because of the continued overrun in claims costs, particularly those for medical fees.

"The compulsory guaranteed fee system should be removed to enable medical aid schemes to set their own tariffs," said Mr Leveton, noting that medical aid was becoming beyond the reach of many people.

He said that blacks — many of whom had joined medical aid schemes in the past few years — and pensioners had been particularly hard hit by the increases.

Mr Leveton added that the increases were also affecting more companies — particularly those battling to show profits, and many "are simply abandoning medical aid".

● The Minister of National Health and Population Development, Dr Willie van Niekerk, has agreed to see a delegation from the medical aid industry.

Dr Van Niekerk agreed there were several features of the medical schemes legislation which probably needed review — and hinted that some of the fundamental problems would be covered in a government White Paper, due to be tabled in Parliament during the current session.

● In Maritzburg last night, the chairman of the Federal Council of the Medical Association of South Africa, Dr Rene le Roex, said he took exception to the statements made by RAMS.

"I do not query the figures they are quoting, but take exception to unsubstantiated statements," he said.

The schemes administered by RAMS were all 100 percent schemes and did not have built-in disincentives, Dr Le Roex said. These schemes pay 100 percent of the prescribed tariffs, while those with disincentives pay a portion of the fee and then claim back from members, he said.

"With this type of system it seems more likely that the downfall of the schemes should be blamed on the medical aid schemes, and not laid at the door of the practitioner." — Own Correspondent and Sapa

● 'Test' case on medical aid, page 3



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Body launched to raise funds for the disabled

Dispatch Reporter

EAST LONDON — A local steering committee of the government initiated Excelsior Honorary Committee, which is intended to raise funds for the disabled throughout the country, was formed last night during a meeting here of members of welfare organisations.

The meeting had been arranged by the Department of Health and Welfare.

The director of cultural and environmental services for the East London Municipality, Mr Albert Janse, told the meeting the Excelsior project had been mooted by the government since it declared 1986 The Year of the Disabled.

It would operate until October.

He said the government had earmarked R1 million to start the project and had appointed co-ordinators for the various regions throughout the country.

Each region would form a steering committee to decide on the projects to be accepted, the amount that would be retained by the committee and the use of the media.

A central committee representing all the regional committees had been appointed and would operate from Bloemfontein.

Donations and letters of pledge would have to be forwarded to the co-ordinator, who would then forwarded them to the central committee in Bloemfontein.

The Exelsior project would also be given television coverage, showing the amounts collected in each region, Mr Janse said.

Each region would decide whether to forward any amount to the central committee.

The steering committee would also decide on how much would be allocated to each welfare project.

The meeting decided the local steering committee would be headed by Dr R. B. Lancaster, who already heads another welfare organisation in the city, and would include Mr Janse, who is the local co-ordinater.

The meeting decided that all members of Dr Lancaster's committee be appointed members of the steering committee to avoid duplication. The steering committee was also mandated to co-opt all interested persons.

Mr Janse said members of the community, welfare bodies and other interested bodies should forward their donations and pledges to The Co-ordinator, Box 984, East London, before October 13.

Ciskei games

BISHO — The Independence Stadium will be the venue of the Coca-Cola National Schools inter-state soccer and netball championships.

'Test' case on medical aid

By CHRIS ERASMUS

THE outcome of a Supreme Court "test case" over who is responsible for the liabilities of the insolvent Cape Town-based medical aid scheme, Medico, will be crucial to the country's crumbling R1,5-billion medical aid industry.

With 32 of the 43 members of the Representative Association of Medical Schemes (RAMS) on the "critical" list because of underwriting deficits (a loss before investment income) and six already insolvent, the pending Cape Supreme Court decision has taken on major significance.

According to Mr David Meaker of Metrust, the liquidator appointed to deal with Medico's insolvency, the judgment will "sort out" the ailing industry.

According to an estimate based on a RAMS survey, the industry looks set for a R600-million crash unless rising claims can be controlled.

Two views of problem

At the heart of the impending judgment, said Mr Meaker, was who was to "carry the can" when medical aid schemes got into financial difficulties.

There were two ways of looking at the problem, said Mr Meaker: From the members' point of view it could be argued that because they had failed to receive benefits promised by an insolvent scheme, there was a breach of the contract between the scheme and its members, allowing members to withhold payment of fees and to quit the scheme.

The counter-argument was that a medical aid society was made up of its members themselves and therefore was a joint financial venture with the members responsible for the liabilities up to the amount of outstanding contributions as at liquidation.

Difficulties being faced by industry had arisen because "medical aid schemes have been heavily abused by both their members and doctors", he said.

Liabilities over R3-m

"The Medico case is the first-ever compulsory insolvency in the industry in South Africa and the big issue is whether members are allowed to summarily fall out or whether they have got to pay their contributions until the day of liquidation.

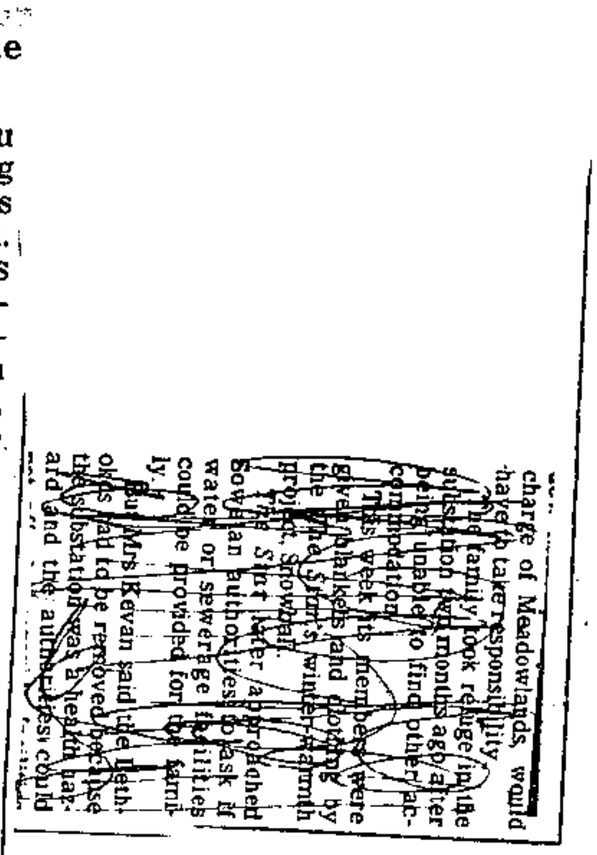
At insolvency, the scheme had 6 500 members and perhaps as many as 14 000 creditors, with liabilities of over R3 million and assets of about R600 000 which could rise to R2 million if the judgment went against members.

Mr J P H Steyn, the Registrar of Medical Aids Schemes, declined to comment on the significance of the Medico case yesterday.

● Dr Rene le Roux, chairman of the Federal Council of MASA, said he was convinced that doctors were not "over servicing" their patients and that the fault lay with medical aid schemes which did not have disincentives.

Medical schemes up 20 per cent

JOHANNESBURG — Medical aid scheme rates are to increase by more than 20 per cent countrywide, the Representative Association of Medical Schemes (RAMS) said in a statement released yesterday.



South Africa's medical aid schemes, battling to survive in the face of spiralling claims' costs, were imposing this further sharp hike in membership rates for the second — and, in some cases, the third — time this year, the statement said.

More increases are on the cards unless steps are taken to stem the tide of rising claims costs which threaten to sink the medical schemes movement.

The latest rate increases, which are being implemented countrywide, exceed 20 per cent. In at least one case, members are being asked to pay as much as 90 per cent more, according to RAMS.

In January this year most medical aid schemes raised their rates by up to 25 per cent — well ahead of inflation — to meet increased doctor, dentist, physiotherapist and hospital fees as well as increases in the prices of medicines.

"RAMS realises that the latest rate increase deals another painful blow to members but we simply have to take this action in order to remain afloat. The continued overrun in claims costs — particularly where the fees of the medical profession are concerned — have left us no option," said a spokesman for RAMS, Mr Tony Leveton.

The latest wave of fee increases follows news that out of 43 medical funds recently surveyed at random by RAMS, six were insolvent and 32 showed underwriting deficits.

"Using that survey as a barometer, it is clear that the country's medical aid movement is headed one way — and that's to the wall," Mr Leveton said.

To prevent this happening, RAMS has formally asked the Minister of Health, Dr Willie van Niekerk, to intervene and, as a matter of urgency, to relax some of the provisions of the Medical Schemes Act.

"Whichever way you look at it, something must happen soon if this crisis is to be solved. Already medical aid is becoming beyond the financial reach of thousands of people — in particular pensioners, who are the people who need it most.

"Black people, too, have been particularly hard hit by the sharp and steady increases in medical aid subscription rates."

In Pietermaritzburg, the chairman of the Federal Council of the Medical Association of South Africa, Dr Rene le Roex, said he took exception to the statements made by RAMS.

"I do not query the figures thay are quoting, but take exception to unsubstantiated statements," he said.

The schemes administered by RAMS are all 100 per cent schemes and do not have built-in disincentives, said Dr Le Roex. They pay 100 per cent of the laid down tariffs.

"With this type of system it seems more likely that the downfall of the schemes should be blamed on the medical aid schemes, and not laid at the door of the practitioner.

"It is a fact that schemes with disincentives are more difficult to administer," he said.

These schemes pay a portion of the doctors' fee and then claim back from members.

Meanwhile, it was reported that Dr Van Niekerk had agreed to see a delegation from the medical aid industry as soon as a meeting could be arranged.

Dr Van Niekerk said he was aware of some problems experienced by certain medical aid schemes and joined in the concern, but he stressed the industry was the domain of the private sector and the state was limited in what it would be able to do. — Sapa-DDC

Medical aid fees to go up

MEDICAL aid scheme rates are going up again — by at least 20 percent.

And further increases are likely, unless steps are taken to stem the tide of rising claim costs.

The Representative Association of Medical Schemes (Rams) said yesterday that in at least one case members will have to pay 90 percent more.

In January this year most medical aid schemes raised their rates by up to 25 percent.

29/8/86

MEDICAL INSURANCE Fin Mail

New status?

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Many areas of short-term insurance have fallen into disarray in the past few years. Medical insurance is no exception. The recent collapse of Medico Medical Aid, soon after the liquidation of AA Mutual Insurance, merely added medical schemes to the pile of short-term insurance problems.

At the same time, the public is generally no more pleased about escalating membership fees of medical aid schemes than about the escalation of personal insurance premiums. Claims haggling is a familiar all-round concept, too.

So will the recent launch of Status Medical Aid — the first new public scheme to be licensed since 1978 — do anything to improve the status of medical aid schemes? Obviously the owners think so.

Says Mike Cox, PRO for Status and also Compcare Medical Scheme: "I have been apalled at the atrocious level of service members tolerate from medical schemes." In response, Status makes noble promises: it will concentrate on providing "very prompt service" and is starting out by offering cover equal to, or better than, any other scheme "at a competitive rate."

Top rate, for example, is R168 for a member and three or more dependants. Apart from the usual benefits, cover also includes contact lenses, voluntary sterilisation, speech therapy, and extended specialised dental benefits, for example, while 100% of the tariff with no limits is provided on most general doctors' and hospital services; there are also no limits for prescriptions.

Sounds good.

Comments from the industry include: "You can't offer better cover for lower rates than the market and come out on the right side" ... "It sounds too cheap; more like R220 should be their top rate" and, "Tell me how they're doing in five years' time."

Richard Kavanagh, director of the administration company of Compcare and Status, says: "Other established schemes, working in the corporate market, offer similar rates which are statistically proven in terms of selectivity."

Cox adds: "We found smaller groups tended to be higher claimers so Status is aiming at groups of 50-plus members, which should also spread risk better." He says that to qualify, a particular group has to satisfy a certain age profile and medical history, with a limit on the percentage of pensioners. Fees are determined by dependants, race and income category.

So far, Status has 2 500 members, backed by a statutory requirement of R400 000, much more than is provided by many schemes previously registered under older legislation, such as Medico.

Where did the members come from? The answer is Compcare Medical Scheme, though the administrators claim it hasn't been denuded. Says MD Ken James, who took over Compcare seven years ago when it was in deficit: "The scheme was quickly turned round and continues to expand within its own particular market."

Kavanagh adds that Status expects a further R1m from "a financial institution," though he is coy about the name. Since Status expects to include personal accident in due course, could be the institution is a life company.

"The authorities like medical aids to have 25% of annual subscriptions in reserve," explains Kavanagh. "A recent survey suggested the top 20 schemes average between 7,5%-8%. We intend to build up a much stronger reserve base than this." ■

Bad blood over sick funds

A SAVAGE dogfight has broken out between medical aid fund administrators — with bitter back-biting as to where the blame for the industry's present R600-million cash crisis lies.

The "disincentive" 80 percent-payment schemes blame the ill health of medical aid funds generally on those schemes which meet 100 percent of members' bills.

And the 100-percenters say that the rash of red bank balances is an epidemic that has raged across the industry irrespective of type or stature of fund.

The timekeeper for this week's bout is the Medical Association of South Africa (Masa), with the referee, the Representative Association of Medical Aid Schemes (Rams), being drawn into the fracas.

By CAS St LEGER

The only short-term antidote to the financial crash that threatens many of the country's 220 funds has been widespread contribution hikes, averaging 20 percent and ranging up to 90 percent — believed to be in respect of Anglo American's black employees' fund.

And the situation could be terminal for many funds, warns Rams, unless doctors' and patients' attitudes and constricting legislation are changed.

Minister of Health Dr Willie van Niekerk has responded to Rams' cry for help — following its disclosure last week that 32 out of 43 funds analysed had underwriting deficits and six were bankrupt on paper — by arranging to meet Rams officials next Friday.

And the office of the Registrar of Medical Schemes, Mr Joseph Stein, is feeding the financial statements of every medical fund into the department's computer to glean the exact picture. Results are expected mid-week.

"This is nothing new. It has been going on for 20 years," Mr Stein said of the financial state of the industry.

At the end of 1984, he said, 67 schemes showed losses and 10 schemes were totally bankrupt.

"They put their rates up; the next year they showed excesses. They're still in business."

The registrar requires that medical funds maintain accumulated funds equal to 25 percent of contributions income; many schemes are unable to achieve this.

The Public Servants' Medical Aid Fund had R30-million in accumulated funds last year with an expenditure of R166-million. Now the percentage is back up to 18 percent.

Schemes ricochet unhealthily between excess and deficit in response to rising drug, hospital, doctor and other medical hikes and the falling rand, balanced against contribution adjustments.

Scalpels drawn in search for cure

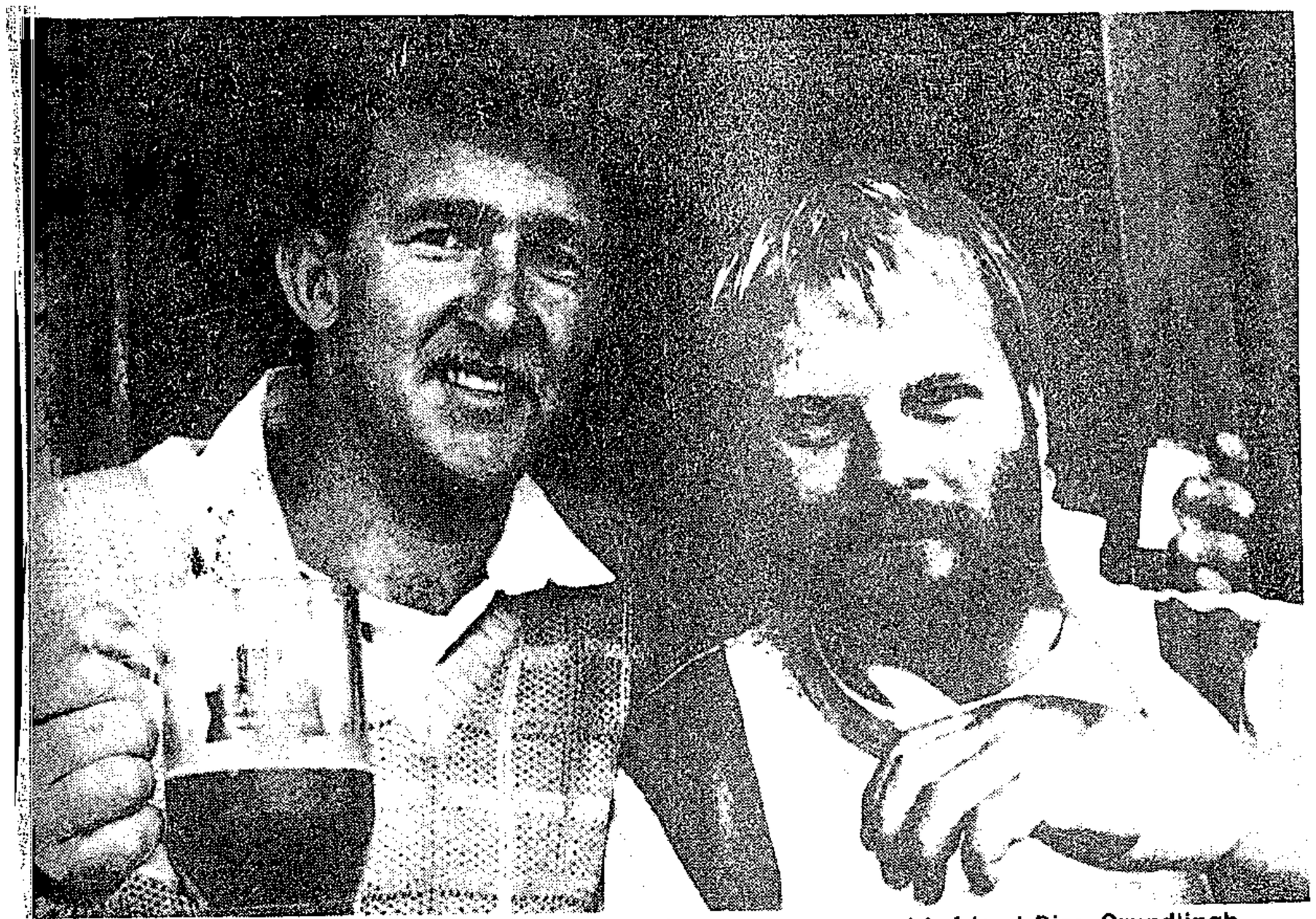
Three of the six schemes on Rams' "bankruptcy" list have already taken steps to put their houses in order since last year's poor performances — Allcare, which is now back in the black; Stability, where fees have been increased; and Bonitas, the State scheme for black public servants.

Rams wants elasticity, including abolition of guaranteed doctors' payments, incorporated into the Medical Schemes Act to bring some stability to the industry.

Masa's response is a flat "no".

Leader of the disincentive pack, Mr Bill Davidson, chairman of Davidson and Ewing, which runs 26 schemes covering 120 000 families, said: "The moment you give somebody something for nothing, he abuses it."

He said costs for disincentive schemes had risen only 12,5 percent as against 25 percent for the 100-percenters.



Glad to be alive ... Paul du Randt, right, celebrates his rescue with friend Dion Grundlingh

Black medical aid claims are 'minimal'

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4/9/86 NATAL Mercury

Mercury Correspondent

JOHANNESBURG—Claims that blacks who earn the same salaries as whites are paying 60% less in medical aid contributions have been confirmed by the Representative Association of Medical Schemes.

But association spokesman Tony Leveton denied that blacks were being heavily subsidised by white members.

'Research has shown that black claims are minimal in comparison to those of whites. If we take white claims as being a 100% base, then our research shows that black claims amount to only 36% of this. If we didn't have different rates, then blacks would be subsidising whites.'

A rates schedule for one medical aid society stipulates that a white single person earning R1 001 plus a month must pay R123. The rate for a black on the same salary is R45.

Mr Leveton said whites have easier access to doctors and medical facilities and so are inclined to overuse these.

'Due to the difference in the rate of claims we are forced to have separate budgetary exercises when formulating rates. With all black claims, we pitch a rate and any surplus is added to reserve funds. As a group, blacks claim far less than either whites or Asians.'

Referring to the recent 20% hike in subscription rates by some societies, Mr Leveton said more increases were on the cards unless steps were taken to stem the tide of rising claims costs.

No option

'We simply have to take this action in order to remain afloat,' he explained.

'The continued overrun in claims costs — particularly where the fees of the medical profession are concerned — have left us no option.'

He said there was an urgent need for medical aid schemes to be given the go-ahead to tailor-make different benefit structures to suit the pockets and needs of different members and their employers.

'Whichever way you look at it, something must happen soon if this crisis is to be solved,' he said.

ARGUS 4/9/86 (283) (279)

Don't ask for more — medical aid plea to doctors

The Argus Correspondent

JOHANNESBURG. — Medical aid schemes facing financial crisis have appealed to doctors to reconsider their planned 20 percent fee increase.

At a three-hour meeting yesterday the Representative Association of Medical Schemes (Rams) said spiralling claims costs were rapidly putting medical aid beyond the reach of companies and people — particularly black and coloured members.

"Increased costs are driving black and coloured members away from medical aid and they are again becoming the responsibility of the State," said Mr Tony Leveton of Rams.

Members of Rams set out to increase the total payout at the scale of benefits for medical practitioners as a group by 12,5 percent at the beginning of the year. Because of greater use the increase had in fact been 25 percent.

"There is just no way we can continue at this rate," Mr Leveton said.

Doubling income

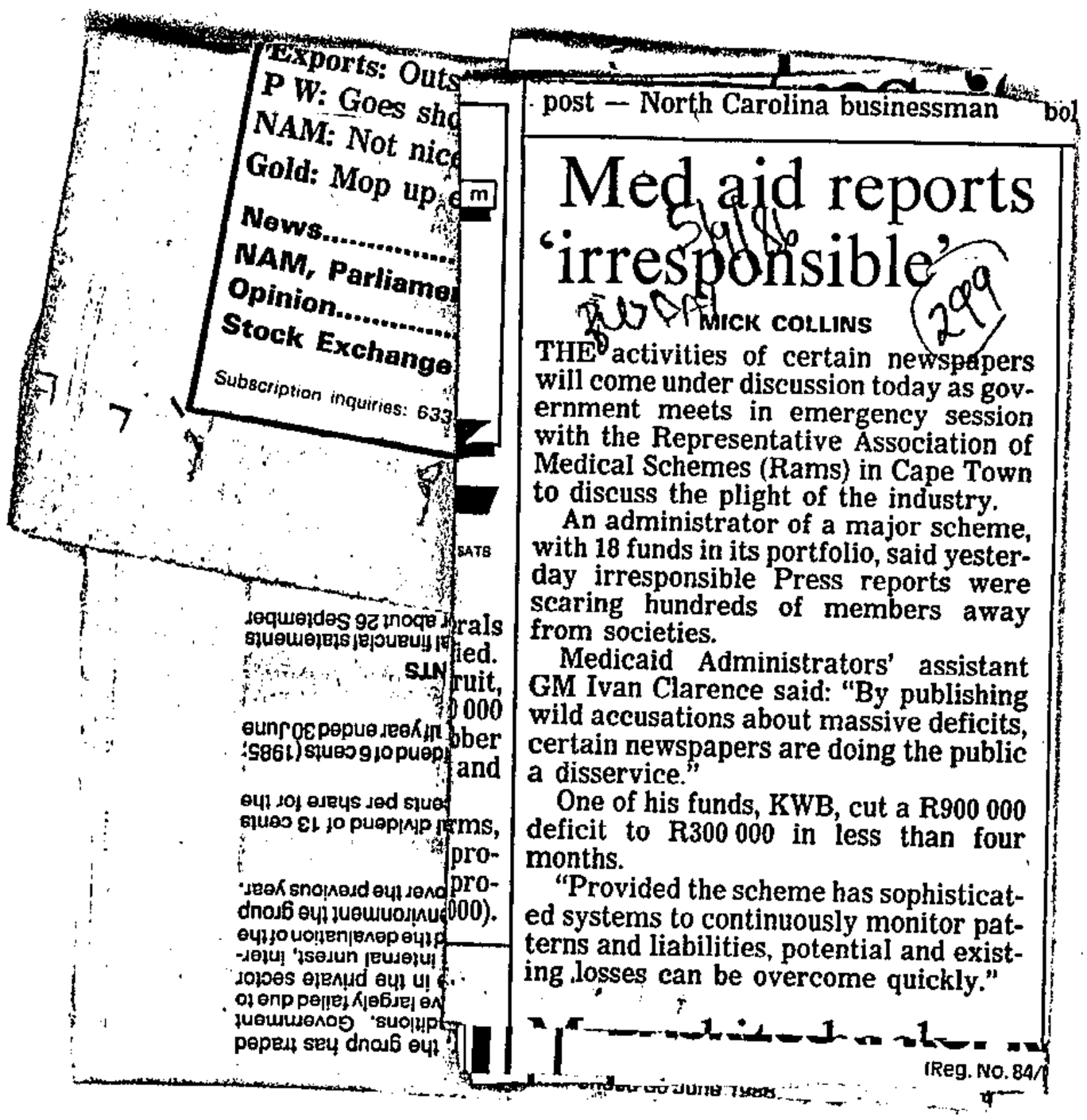
At yesterday's meeting Rams presented data to the Medical Association of South Africa (Masa) saying:

- Doctors who charged at the scale of benefits were doubling their income every four years;
- The same doctors were over-servicing at an alarming rate and earning more than doctors who charged in excess of the scale of benefits; and
- Doctors were dispensing 35 percent more medicine compared to 1985.

"Our objective in talking to Masa is to try to stem the runaway costs of medical aid and solve the financial crisis that has enveloped the medical-aid movement," said Mr Leveton.

Yesterday's meeting came just two days before Rams representatives meet the Minister of Health to ask him to intervene urgently and relax some of the provisions of the Medical Schemes Act.

Rams has recommended that the compulsory guaranteed medical-aid payment system be removed as it would give schemes the leeway to structure different benefits to suit individual needs.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Med aid reports 'irresponsible'

MICK COLLINS

THE activities of certain newspapers will come under discussion today as government meets in emergency session with the Representative Association of Medical Schemes (Rams) in Cape Town to discuss the plight of the industry.

An administrator of a major scheme, with 18 funds in its portfolio, said yesterday irresponsible Press reports were scaring hundreds of members away from societies.

Medicaid Administrators' assistant GM Ivan Clarence said: "By publishing wild accusations about massive deficits, certain newspapers are doing the public a disservice."

One of his funds, KWB, cut a R900 000 deficit to R300 000 in less than four months.

"Provided the scheme has sophisticated systems to continuously monitor patterns and liabilities, potential and existing losses can be overcome quickly."

(Reg. No. 84/

place.

The Federated deal, of course is still to be unravelled. Until then, no one is sure as to the position of AA Mutual Life. ■

FIN MAIL 5/9/86

MEDICAL INSURANCE 299

Who's scheming?

Alarmist press reports that 32 medical aid schemes have gone bust may overstate the mark. In fact, the collective underwriting deficit of these funds, R22m for calendar 1985, is *before* investment income.

Taking this into account the funds scraped home with an overall surplus of just R2m, or 0,36% of total contributions of R592m. Six of them had accumulated deficits at that date. But, says Tony Leveton, a spokesman for the Representative Association of Medical Schemes (RAMS): "They will survive by putting rates up, cutting benefits, or both."

Adds the Registrar of Medical Schemes, Joseph Steyn: "Press reports have caused me a lot of embarrassment, and I am no longer prepared to talk on the matter. Everyone is phoning and blaming me. . ."

Leveton says the situation is nevertheless serious; some societies having increased rates on as many as three occasions already this year. Some have reduced benefits, too.

RAMS has always kept itself informed about medical aid societies — 215 in all, public and private — and matters affecting the industry. Any number of them could be in trouble. RAMS's latest survey covered just 43 larger funds, representing 560 000 members and about 1,7m dependants, but Leveton says there's nothing to suggest the same isn't happening to smaller funds also.

The problem boils down to abuse: overservicing by doctors and over-utilisation by patients "in that order," he says.

The writing was on the wall last year, when many other grievances were aired (*FM* November 29). So why has nothing been done?

It seems schemes are still hamstrung by the Medical Schemes Act.

"The Act doesn't allow us to get involved in cost containment exercises," says Leveton. "If a doctor renders an account at the official scale of benefits we're obliged by law to make direct guaranteed payment."

But increasing contributions is no way to solve problems, any more than raising premiums will solve the problems of insurance companies — who, of course, are in the same boat.

Leveton agrees. "We must create incentives, both at the member level and at the doctor level. We can only do this if the law is changed.

"We want a more flexible benefit structure. For a start, the guaranteed payment system must be stopped. What good is there in holding a member responsible for everything and let doctors who overservice get away scot-free? Unless you involve the doctor in cost-containment, you'll never save anything."

Medical schemes could then offer a degree of self-insurance, excesses (where the client can opt to pay an agreed portion of certain claims), no-claims bonuses, and even special policy wordings to suit the individual.

It's ironic that medical schemes are prevented by law from scientific underwriting while insurance companies are being castigated for getting themselves in a knot precisely because they didn't employ scientific methods of underwriting. Which law is right? ■

THIRD PARTY INSURANCE

Ja, well, no fine

Clarity has never been a characteristic of legislators. The new third party insurance rules have done little to change that. A big area of confusion is AA Mutual Insurance (AAMI) tokens. Are they still valid? Well, yes and no.

A spokesman for the Johannesburg Traffic and Security Department advises that people won't be prosecuted for displaying an AAMI disc — though last year's law prescribed a fine for displaying a token not issued by an agent.

So at last we know, no fine.

The spokesman also said, however, that such people wouldn't be insured. When it was pointed out that most drivers couldn't avoid paying premiums because of the petrol levy, the opinion was reversed to, "yes, they would be insured, but we advise they get a replacement token from another insurer, or how will a claim be handled?"

Robin Scholtz, Controller Road Traffic Affairs at the Automobile Association, says it is advisable to replace the disc "to facilitate claims." But he adds that the new law awaiting the State President's signature could be changed again if it is decided to scrap the token requirement.

Already the Act will relieve State and semi-State vehicles from displaying a token. Claims will be dished out to participating insurers on a roster basis.

It just happens that there are now 12 companies involved: Allianz, Commercial Union, Federated Employers', General Accident, Guardian National, Mutual & Federal, NEG, President, SA Eagle, Santam, Sentraboer, and Standard General. It is understood each will be allotted one month of the year to take turns in tackling non-token carrying vehicles involved in an accident.

Claims by AAMI clients who have not obtained a fresh token could easily be dealt with on the same basis. Indeed, there's no reason why this principle could not be extended to all motorists. So why have a token?

A spokesman for the MVA fund says there were some 9 000-10 000 outstanding claims in AAMI's hands, which "have all been redistributed" among the new members. The actual number of claims is less

Linieerwerk—hernommer 15 na 13;

Litografie—hernommer 16 na 14;

Masjienbediening (Pakgoedvervaardiging)—hernommer 17 na 15;

Riffelbord- en Houermasjienbediening—hernommer 19 na 16;

Rotasiehoogdrukpersbediening—hernommer 20 na 17;

Rotasierubberdrukpersbediening—hernommer 21 na 18;

Setwerk—hernommer 22 na 19; en

Skryfbehoeftes- en Koevertmasjien-versteller—hernommer 24 na 20.

P. T. C. DU PLESSIS,
Minister van Mannekrag.

No. R. 1974 **19 September 1986**

WET OP ARBEIDSVERHOUDINGE, 1956

ELEKTROTEGNIESE AANNEMINGSNYWERHEID, TRANSVAAL—WYSIGING VAN SIEKTEBYSTANDS-, PENSIOEN- EN MEDIESE BYSTANDSFONDSOOREENKOMS

Ek, Pieter Theunis Christiaan du Plessis, Minister van Mannekrag, verklaar hierby—

(a) kragtens artikel 48 (1) (a) van die Wet op Arbeidsverhoudinge, 1956, dat die bepalings van die Ooreenkoms (hierna die Wysigingsooreenkoms genoem) wat in die Bylae hiervan verskyn en betrekking het op die Onderneming, Nywerheid, Bedryf of Beroep in die opskrif by hierdie kennisgewing vermeld, met ingang van die eerste Maandag na die datum van publikasie van hierdie kennisgewing en vir die tydperk wat op 31 Desember 1990 eindig, bindend is vir die werkgewersorganisasie en die vakvereniging wat die Wysigingsooreenkoms aangegaan het en vir die werkgewers en werknemers wat lede van genoemde organisasie of vereniging is; en

(b) kragtens artikel 48 (1) (b) van genoemde Wet, dat die bepalings van die Wysigingsooreenkoms, uitgesonderd dié vervat in klousule 1 (1) (a), met ingang van die eerste Maandag na die datum van publikasie van hierdie kennisgewing en vir die tydperk wat op 31 Desember 1990 eindig, bindend is vir alle ander werkgewers en werknemers as dié genoem in paragraaf (a) van hierdie kennisgewing wat betrokke is by of in diens is in genoemde Onderneming, Nywerheid, Bedryf of Beroep in die gebiede in klousule 1 van die Wysigingsooreenkoms gespesifiseer.

P. T. C. DU PLESSIS,
Minister van Mannekrag.

BYLAE

NYWERHEIDSRAAD VIR DIE ELEKTROTEGNIESE AANNEMINGSNYWERHEID

OOREENKOMS

ooreenkomstig die Wet op Arbeidsverhoudinge, 1956, gesluit deur en aangegaan tussen die

Electrical Contractors' Association (South Africa)

(hierna die "werkgewers" of die "werkgewersorganisasie" genoem), aan die een kant, en

The South African Electrical Workers' Association

(hierna die "werknemers" of die "vakvereniging" genoem), aan die ander kant,

wat die partye is by die Nywerheidsraad vir die Elektrotegniese Aannemingsnywerheid,

Printers' Mechanic—renumber 18 to 14;

Printers' Warehousing (including Cutting)—renumber 19 to 15;

Process Engraving—renumber 20 to 16;

Rotary Letterpress Machine Minding—renumber 21 to 17;

Rotary Offsett Machine Minding—renumber 22 to 18;

Ruling—renumber 23 to 19; and

Stationery and Envelope Machine Adjuster—renumber 24 to 20.

P. T. C. DU PLESSIS,
Minister of Manpower.

No. R. 1974 **19 September 1986**

LABOUR RELATIONS ACT, 1956

ELECTRICAL CONTRACTING INDUSTRY, TRANSVAAL.—AMENDMENT OF THE SICK BENEFIT, PENSION AND MEDICAL AID FUND AGREEMENT

I, Pieter Theunis Christiaan du Plessis, Minister of Manpower, hereby—

(a) in terms of section 48 (1) (a) of the Labour Relations Act, 1956, declare that the provisions of the Agreement (hereinafter referred to as the Amending Agreement) which appears in the Schedule hereto and which relates to the Undertaking, Industry, Trade or Occupation referred to in the heading to this notice, shall be binding, with effect from the first Monday after the date of publication of this notice and for the period ending 31 December 1990, upon the employers' organisation and the trade union which entered into the Amending Agreement and upon the employers and employees who are members of the said organisation or union; and

(b) in terms of section 48 (1) (b) of the said Act, declare that the provisions of the Amending Agreement, excluding those contained in clause 1 (1) (a), shall be binding, with effect from the first Monday after the date of publication of this notice and for the period ending 31 December 1990, upon all employers and employees, other than those referred to in paragraph (a) of this notice, who are engaged or employed in the said Undertaking, Industry, Trade or Occupation in the areas specified in clause 1 of the Amending Agreement.

P. T. C. DU PLESSIS,
Minister of Manpower.

SCHEDULE

INDUSTRIAL COUNCIL FOR THE ELECTRICAL CONTRACTING INDUSTRY

AGREEMENT

in accordance with the provisions of the Labour Relations Act, 1956, made and entered into by and between the

Electrical Contractors' Association (South Africa)

(hereinafter referred to as the "employers" or the "employers' organisation"), of the one part, and

The South African Electrical Workers' Association

(hereinafter referred to as the "employees" or the "trade union"), of the other part,

being the parties to the Industrial Council for the Electrical contracting Industry,

om die Ooreenkoms, gepubliseer by Goewermentskennisgewing R. 1884 van 23 Augustus 1985 (hierna die "Herbekragtigingsooreenkoms" genoem), soos verleng by Goewermentskennisgewing R. 2844 van 17 Desember 1985, te wysig.

1. GEBIED EN TOEPASSINGSBESTEK VAN OOREENKOMS

(1) Hierdie Ooreenkoms moet nagekom word deur alle werkgewers en werknemers in die Elektrotegniese Aannemingsnywerheid—

(a) wat lede is van onderskeidelik die werkgewersorganisasie en die vakvereniging, en

(b) wat betrokke is by of werksaam is in die Nywerheid in die provinsie Transvaal en in die landdrosdistrikte Bloemfontein en Sasolburg.

(2) Ondanks subklousule (1) is die Ooreenkoms van toepassing op vakleerlinge en kwekelinge slegs vir sover dit nie onbestaanbaar is met die Wet op Mannekragopleiding, 1981, of met voorwaardes of kennisgewings wat daarkragtens voorgeskryf of bestel is nie.

(3) Vir die toepassing van hierdie Ooreenkoms word die weeklikse loonskaal van vakleerlinge wat kragtens die Wet op Mannekragopleiding, 1981, voorgeskryf is as die weekloon van sodanige werknemers geag en is die uurloon die weekloon soos hierbo bereken, gedeel deur die getal gewone ure wat in daardie betrokke bedryfsinrigting gewerk word.

2. KLOUSULE 4.—ALGEMENE BEPALINGS

Vervang klousule 4 van die Herbekragtigingsooreenkoms deur die volgende: "Klousule 3 (soos gewysig by klousule 5 van die Herbekragtigingsooreenkoms), 4, 6, 7, 9 tot 10) soos gewysig by klousule 7 en 8 van die Herbekragtigingsooreenkoms), 11, 12 (soos gewysig by klousule 9 van die Herbekragtigingsooreenkoms), 13 tot 15, 16 (soos gewysig by klousule 10 van die Herbekragtigingsooreenkoms), 17, 18 tot 20 (soos gewysig by klousules 11 tot 13 van die Herbekragtigingsooreenkoms), 21 tot 24, 25 (soos gewysig by klousule 14 van die Herbekragtigingsooreenkoms en klousule 3 hieronder), 26, 27 tot 29 (soos gewysig by klousules 15 tot 17 van die Herbekragtigingsooreenkoms), 30 (soos gewysig by klousule 18 van die Herbekragtigingsooreenkoms en klousule 4 hieronder), 31, 32, 33 tot 34 (soos gewysig by klousules 19 tot 20 van die Herbekragtigingsooreenkoms), 35 en 36 van die Vorige Ooreenkoms, is van toepassing op werkgewers en werknemers.".

3. KLOUSULE 25.—LIDMAATSKAP

In subklousule (1), voeg die volgende paragrawe (e), (f) en (g) in na paragraaf (d):

"(e) Indien 'n lid wat op voordele geregtig is tot sterwe kom, is sy vrou en sy afhanklikes op die dag van sy afsterwe geregtig op voordele gedurende die eerste ses maande na sy afsterwe sonder om gedurende daardie tydperk enige bydraes te maak.

(f) Binne die tydperk in paragraaf (e) gestel, kan die weduwee van sodanige afgestorwe lid aansoek doen om lidmaatskap van die Mediese Hulpfonds en kan sy by besluit van die Raad, toegelaat word tot lidmaatskap van die Mediese Hulpfonds en moet sy geklassifiseer word in dieselfde kategorie en op dieselfde lidmaatskapvoorwaardes as dié waarop die afgestorwe lid op die dag van sy afsterwe geregtig was, en moet sy die bydraes van 'n lid in daardie kategorie betaal.

(g) Indien die weduwee van 'n afgestorwe lid weer trou, word haar lidmaatskap van die Mediese Hulpfonds beëindig.".

4. KLOUSULE 30.—BYDRAES

(1) Vervang subklousule (1) (a) deur die volgende:

"(1) (a) 'n Werkgewer moet die volgende bedrae weekliks aan die Mediese Bystandsfonds betaal ten opsigte van ondergenoemde werknemers in hul onderskeie lidmaatskapkategorieë:

[Kolom (1)] Lidmaatskapkategorie	Totale bedrag in rand per week			
	Meesterelektrisiëns, elektrisiëns, finalejaar-vakleerlinge, vakleerlinge met afhanklikes en kwekelinge wat		Vakleerlinge wat nie in Kolom (2) ingesluit is nie	Vakleerlinge wat nie in Kolom (3) ingesluit is nie
	'A'-lede is [Kolom (2)]	'B'-lede is [Kolom (3)]		
M.....	17	14	8,50	7
M1	20	17	—	—
M2	23	20	—	—
M3	26	23	—	—
M4+	29	26	—	—".

(2) In subklousule (1) (a), voeg die kategorieë "ambagsmanne, installasie-operateurs" in na die kategorie "elektrisiëns" waar die kategorieë in die tabel bo kolomme (2) en (3) aangegee word.

to amend the Agreement published under Government Notice R. 1884 of 23 August 1985 (hereinafter referred to as the "Re-enacting Agreement"), as extended by Government Notice R. 2844 of 17 December 1985.

1. AREA AND SCOPE OF APPLICATION

(1) The terms of this Agreement shall be observed by all of Agreement employers and employees in the Electrical Contracting Industry—

(a) who are members of the employers' organisation and the trade union respectively; and

(b) who are engaged or employed in the Industry in the Province of the Transvaal and the Magisterial Districts of Bloemfontein and Sasolburg.

(2) Notwithstanding the provisions of subclause (1), the terms of this Agreement shall apply to apprentices and trainees only in so far as they are not inconsistent with the provisions of the Manpower Training Act, 1981, or any conditions prescribed or any notice served in terms thereof.

(3) For the purposes of this Agreement, the weekly wage rate of apprentices prescribed under the Manpower Training Act, 1981, shall be taken to be the weekly wage of such employees, and the hourly rate shall be the weekly wage calculated as above, divided by the number of ordinary hours worked in the establishment concerned.

2. CLAUSE 4.—GENERAL PROVISIONS

Substitute the following for clause 4 of the Re-enacting Agreement:

"The provisions contained in clauses 3 (as amended by clause 5 of the Re-enacting Agreement), 4, 6, 7, 9 to 10 (as amended by clauses 7 and 8 of the Re-enacting Agreement), 11, 12 (as amended by clause 9 of the Re-enacting Agreement), 13 to 15, 16 (as amended by clause 10 of the Re-enacting Agreement), 17, 18 to 20 (as amended by clauses 11 to 13 of the Re-enacting Agreement), 21 to 24, 25 (as amended by clause 14 of the Re-enacting Agreement and clause 3 hereunder), 26, 27 to 29 (as amended by clauses 15 to 17 of the Re-enacting Agreement), 30 (as amended by clause 18 of the Re-enacting Agreement and clause 4 hereunder), 31, 32, 33 to 34 (as amended by clauses 19 to 20 of the Re-enacting Agreement), 35 and 36 of the Former Agreement shall apply to employers and employees.".

3. CLAUSE 25.—MEMBERSHIP

In subclause (1), insert the following paragraphs (e), (f) and (g) after paragraph (d):

"(e) Should a member who is entitled to benefits die, his wife and dependants at the date of his death shall be entitled to benefits for the first six months after his death without making any contributions during that period.

(f) Within the period stated in paragraph (e), the widow of such a deceased member may apply for membership of the Medical Aid Fund and may, by resolution of the council, be admitted to membership of the Medical Aid Fund and shall be classified in the same category and conditions of membership as the deceased member had at the date of his death and shall pay the contributions of a member in that category.

(g) Should the widow of a deceased member remarry, her membership of the Medical Aid Fund shall cease.".

4. CLAUSE 30.—CONTRIBUTIONS

(1) Substitute the following for subclause (1) (a):

"(1) (a) An employer shall pay the following amounts to the Medical Aid Fund in respect of the undermentioned employees in ther respective categories of membership per week:

[Column (1)] Category of membership	Total amount in Rands per week			
	Master electricians, electricians, final year apprentices, apprentices with dependants and trainees who are		Apprentices not included in Column (2)	Apprentices not included in Column (3)
	'A' members [Column (2)]	'B' members [Column (3)]		
M.....	17	14	8.50	7
M1	20	17	—	—
M2	23	20	—	—
M3	26	23	—	—
M4+	29	26	—	—".

(2) In subclause (1) (a), insert the categories "artisans, installation operators" after the category "electrician" where the categories are given in the table above Columns (2) and (3).

(3) In subklousule (1) (b), (c) en (d), vervang die uitdrukking "R61,00 vir 'n lid in die M-kategorie, R70,00 vir 'n lid in die M1-kategorie, R79,00 vir 'n lid in die M2-kategorie, R88,00 vir 'n lid in die M3-kategorie en R97,00 vir 'n lid in die M4+-kategorie" deur die uitdrukking "R74,00 vir 'n lid in die M-kategorie, R87,00 vir 'n lid in die M1-kategorie, R100,00 vir 'n lid in die M2-kategorie, R113,00 vir 'n lid in die M3-kategorie en R126,00 vir 'n lid in die M4+-kategorie".

Soos gemagtig, vir en namens die partye by die Raad op hede die 1ste dag van Mei 1986 te Johannesburg onderteken.

B. NICHOLSON,
Voorsitter van die Raad.

J. M. FRASER,
Ondervoorsitter van die Raad.

C. P. VENTER,
Sekretaris van die Raad.

No. R. 2003 **19 September 1986**

WET OP ARBEIDSVERHOUDINGE, 1956

DRANK- EN SPYSENIERSBEDRYF (PRETORIA).— WYSIGING VAN OOREENKOMS

Ek, Pieter Theunis Christiaan du Plessis, Minister van Mannekrag, verklaar hierby—

(a) kragtens artikel 48 (1) (a) van die Wet op Arbeidsverhoudinge, 1956, dat die bepalings van die Ooreenkoms (hierna die Wysigingsooreenkoms genoem) wat in die Bylae hiervan verskyn en betrekking het op die Onderneming, Nywerheid, Bedryf of Beroep in die opskrif by hierdie kennisgewing vermeld, met ingang van die eerste dag van die kalendermaand wat volg op die datum van publikasie van hierdie kennisgewing en vir die tydperk wat op 30 November 1988 eindig, bindend is vir die werkgewersorganisasie en die vakvereniging wat die Wysigingsooreenkoms aangegaan het en vir die werkgewers en werknemers wat lede van genoemde organisasie of vereniging is; en

(b) kragtens artikel 48 (1) (b) van genoemde Wet, dat die bepalings van die Wysigingsooreenkoms, uitgesonderd dié vervat in klousules 1 (1) (a), 10 en 12, met ingang van die eerste dag van die kalendermaand wat volg op die datum van publikasie van hierdie kennisgewing en vir die tydperk wat op 30 November 1988 eindig, bindend is vir alle ander werkgewers en werknemers as dié genoem in paragraaf (a) van hierdie kennisgewing wat betrokke is by of in diens is in genoemde Onderneming, Nywerheid, Bedryf of Beroep in die gebiede in klousule 1 van die Wysigingsooreenkoms gespesifiseer.

P. T. C. DU PLESSIS,
Minister van Mannekrag.

No. R. 2004 **19 September 1986**

WET OP ARBEIDSVERHOUDINGE, 1956

DRANK- EN SPYSENIERSBEDRYF (PRETORIA).— VERLENGING VAN OOREENKOMS

Ek, Pieter Theunis Christiaan du Plessis, Minister van Mannekrag, verleng hierby, kragtens artikel 48 (4) (a) (i) van die Wet op Arbeidsverhoudinge, 1956, die tydperk vasgestel in Goewermentskennisgewing R. 2 van 6 Januarie 1984, met 'n verdere tydperk wat op 30 November 1988 eindig.

P. T. C. DU PLESSIS,
Minister van Mannekrag.

In subclause (1) (b), (c) and (d), substitute the expression "R74,00 for an M category member, R87,00 for an M1 category member, R100,00 for an M2 category member, R113,00 for an M3 category member and R126,00 for an M4 + category member" for the expression "R61,00 for an M category member, R70,00 for an M1 category member, R79,00 for an M2 category member, R88,00 for an M3 category member and R97,00 for an M4 + category member".

Signed at Johannesburg, as authorised, for and on behalf of the parties to the Council, this 1st day of May 1986.

B. NICHOLSON,
Chairman of the Council.

J. M. FRASER,
Vice-Chairman of the Council.

C. P. VENTER,
Secretary of the Council.

No. R. 2003 **19 September 1986**

LABOUR RELATIONS ACT, 1956

LIQUOR AND CATERING TRADE (PRETORIA).— AMENDMENT OF AGREEMENT

I, Pieter Theunis Christiaan du Plessis, Minister of Manpower, hereby—

(a) in terms of section 48 (1) (a) of the Labour Relations Act, 1956, declare that the provisions of the Agreement (hereinafter referred to as the Amending Agreement) which appears in the Schedule hereto and which relates to the Undertaking, Industry, Trade or Occupation referred to in the heading to this notice, shall be binding, with effect from the first day of the calendar month following the date of publication of this notice and for the period ending 30 November 1988, upon the employers' organisation and the trade union which entered into the Amending Agreement and upon the employers and employees who are members of the said organisation or union; and

(b) in terms of section 48 (1) (b) of the said Act, declare that the provisions of the Amending Agreement, excluding those contained in clauses 1 (1) (a), 10 and 12, shall be binding, with effect from the first day of the calendar month following the date of publication of this notice and for the period ending 30 November 1988, upon all employers and employees, other than those referred to in paragraph (a) of this notice, who are engaged or employed in the said Undertaking, Industry, Trade or Occupation in the areas specified in clause 1 of the Amending Agreement.

P. T. C. DU PLESSIS,
Minister of Manpower.

No. R. 2004 **19 September 1986**

LABOUR RELATIONS ACT, 1956

LIQUOR AND CATERING TRADE (PRETORIA).— EXTENSION OF AGREEMENT

I, Pieter Theunis Christiaan du Plessis, Minister of Manpower, hereby, in terms of section 48 (4) (a) (i) of the Labour Relations Act, 1956, extend the period fixed in Government Notice R. 2 of 6 January 1984, by a further period ending 30 November 1988.

P. T. C. DU PLESSIS,
Minister of Manpower.

She taught handicapped children for 30 years: tears at farewell

Weekend Post Reporter

THIRTY years ago parents of children with hearing problems often thought they were "backward", or blamed teachers if they failed to progress.

Today parents and children are more fortunate. Hearing and speech problems can be detected at an early age and expert tuition can be arranged.

Mrs Wylda Pretorius experienced this transition during the 30 years she taught the only class for such pupils in Port Elizabeth.

Yesterday she retired, and said farewell to pupils and teachers at the North End Grey Primary School at a tea party.

"These days parents are educated to recognise learning problems resulting from physical disabilities at an early stage, and speech therapists visit nursery schools to do tests on all children for possible problems," said Mrs Pretorius.

Sometimes problems are detected by expert teachers when children are already well advanced into their primary education.

"Learning problems are often associated with hearing loss, and parents should consult us as early as possible," she said.

At present Mrs Pretorius already has a grandchild of one of her former pupils in her class.

Mrs Pretorius started her specialised teaching in 1947, when classes were at the old Albert Jackson School in the Grey Institute building. Classes moved to North End Grey in 1961.

This week she was often tearful when pupils arrived each day with little farewell gifts. A dinner was also given for her by the staff.

"What will I miss most after all these years? The joy of children and their parents at achievements they thought were impossible."



After 30 years of teaching hard-of-hearing and speech defective children at North End Grey Primary School — the only school in Port Elizabeth with this facility — Mrs WYLDA PRETORIUS yesterday took her last class.

Urgent call for overhaul of private payments system

Medaid expenses are going through the roof

23/9/86 STAR 299

The entire system of reimbursement of private hospital expenses in South Africa should be revised, a statement by the Representative Association of Medical Schemes (Rams) said today.

Rams said runaway increases — often in excess of 40 percent — in private hospital costs are forcing patients to fork up still more money for medical aid cover.

Spokesman Mr Tony Leveton said Rams was disappointed with the poor response from the Medical Association of South Africa (Masa) to the request by medical schemes to help verify private hospital accounts.

"In terms of the guaranteed payment system, most of the accounts go direct to the medical schemes without verification from either of the two key people involved, the patient and the doctor.

"The attending doctor is the only person who can logically and accurately verify accounts and we therefore must request Masa to reconsider its position on this and help us get the co-operation of the attending doctors.

"Individual medical aid schemes country-wide are reporting whopping increases in payments to private hospitals and day clinics this year," said Mr Leveton.

He said there were three main reasons for the jump in the cost to medical schemes of treatment at private hospitals and day clinics:

- Bed occupancy has risen significantly, which meant doctors were putting more people into hospital.
- The Government's privatisation moves were chasing patients away from public to private facilities.
- Massive price increases in medicines and theatre drugs and consumables.

Mr Leveton said the last-named aspect was proving to be a windfall for the private hospitals. "Like pharmacists, they enjoy a 50 percent markup on medicines, so their gross profits rise in line with price increases."

"werkgewer/s" enigeen of alle werkgewers in die Nywerheid wat lede van die werkgewersorganisasie is;

"Fonds" die Nuwe Pensioenfonds;

"werknemer, graad I" 'n werknemer, uitgesonderd 'n vakleerling of vakleerling op proef, wat diamante slyp en/of poleer en/of saag.

4. BYDRAES TOT DIE NUWE PENSIOENFONDS

1. Vervang die huidige klousule 4 met die volgende:

(1) Elke werknemer en kwalifiserende vrywillige lid moet elke maand 7 persent van sy verdienste tot die Fonds bydra en sy werkgewer moet 'n gelyke bedrag bydrae.

(2) 'n Werknemer en sy werkgewer en 'n kwalifiserende vrywillige lid en sy werkgewer moet op sy verdienste ten opsigte van jaarlikse verlof bydra.

(3) Benewens die bydraes verskuldig ingevolge subklousule (1) hiervan, moet die werkgewer 'n bedrag van 7 persent van die *pro rata*-verlofbesoldiging waarop 'n werknemer of 'n kwalifiserende vrywillige lid wie se diens voor die jaarlikse verloftydperk beëindig word, geregtig is, van dié verskuldigde bedrag aftrek. Die werkgewer moet 'n gelyke bedrag voeg by dié bedrag, wat afgetrek word.

(4) Die bydrae wat ingevolge subklousules (1) en (2) van hierdie klousule gemaak moet word, moet maandeliks deur die werkgewer van die werknemer of 'n kwalifiserende vrywillige lid se verdienste afgetrek word. Die totale bedrag aldus afgetrek, tesame met die bedrag wat deur die werkgewer betaalbaar is en alle bykomende bedrae ingevolge subklousule (3) hiervan verskuldig, moet voor of op die sewende dag van die maand wat volg op dié waarop die aftrekkings betrekking het, tesame met 'n staat in die vorm wat die Raad van tyd tot tyd voorskryf, deur die werkgewer aan die Nuwe Pensioenfonds, Posbus 8304, Johannesburg, gestuur word.

Op hede die 30ste dag van April 1986 in Johannesburg onderteken.

T. G. DAVIDSON,
Namens die Master Diamond Cutters' Association of South Africa gemagtig.

R. RICH,
Namens die South African Diamond Workers' Union gemagtig.

D. WHITE,
Namens die Nywerheidsraad vir die Diamantslypnywerheid van Suid-Afrika gemagtig.

No. R. 2073 **26 September 1986**

WET OP ARBEIDSVERHOUDINGE, 1956

LEERNYWERHEID, REPUBLIEK VAN SUID-AFRIKA.—WYSIGING VAN AANVULLENDE SIEKTEBYSTANDSFONDSOOREENKOMS

Ek, Pieter Theunis Christiaan du Plessis, Minister van Mannekrag, verklaar hierby—

(a) kragtens artikel 48 (1) (a) van die Wet op Arbeidsverhoudinge, 1956, dat die bepalings van die Ooreenkoms (hierna die Wysigingsooreenkoms genoem) wat in die Bylae hiervan verskyn en betrekking het op die Onderneming, Nywerheid, Bedryf of Beroep in die opskrif by hierdie kennisgewing vermeld, met ingang van die tweede Maandag na die datum van publikasie van hierdie kennisgewing en vir die tydperk wat op 30 April 1987 eindig, bindend is vir die werkgewersorganisasies en die vakverenigings wat die Wysigingsooreenkoms aangegaan het en vir die werkgewers en werknemers wat lede van genoemde organisasies of verenigings is; en

(b) kragtens artikel 48 (1) (b) van genoemde Wet, dat die bepalings van die Wysigingsooreenkoms, uitgesonderd dié vervat in klousule 1 (1) met ingang van die tweede Maandag na die datum van publikasie van hierdie kennisgewing en vir die tydperk wat op 30 April 1987 eindig, bindend is vir alle ander werkgewers en werknemers as dié genoem in paragraaf (a) van hierdie kennisgewing wat betrokke is by of in diens is in genoemde Onderneming, Nywerheid, Bedryf of Beroep in die gebiede in klousule 1 van die Wysigingsooreenkoms gespesifiseer.

P. T. C. DU PLESSIS,
Minister van Mannekrag.

"employer/s" means any or all employers in the Industry who are members of the employers' organisation;

"Fund" means the New Pension Fund;

"Grade 1 employee" means an employee, other than an apprentice or probational apprentice, who is engaged in cutting and/or polishing and/or sawing diamonds.

4. CONTRIBUTIONS TO THE NEW PENSION FUND

Substitute the following for the existing clause 4:

(1) Every employee and eligible voluntary member shall contribute every month 7 per cent of his earnings to the Fund, and his employer shall contribute and equal amount.

(2) An employee and his employer and an eligible voluntary member and his employer shall contribute on his earnings in respect of annual leave.

(3) In addition to the contributions due in terms of subclause (1) hereof, an amount of 7 per cent of the *pro rata* leave pay entitlement, due to an employee or an eligible voluntary member whose services terminate prior to the annual leave period, shall be deducted by the employer from such amount due. The employer shall add an equal amount to such amount deducted.

(4) The contribution to be made in terms of subclauses (1) and (2) of this clause shall be deducted monthly by the employer from the employee's or an eligible voluntary member's earnings. The total amount so deducted, together with the amount payable by the employer and any additional amounts due in terms of subclause (3) hereof, shall be forwarded by the employer to the New Pension Fund, P.O. Box 8304, Johannesburg, not later than the seventh day of the month following that to which the deductions relate, together with a statement in the form prescribed by the Council from time to time.

Signed at Johannesburg this 30th day of April 1986.

T. G. DAVIDSON,
Authorised on behalf of the Master Diamond Cutters' Association of South Africa.

R. RICH,
Authorised on behalf of the South African Diamond Workers' Union.

D. WHITE,
Authorised on behalf of the Industrial Council for the Diamond Cutting Industry of South Africa.

No. R. 2073 **26 September 1986**

LABOUR RELATIONS ACT, 1956

LEATHER INDUSTRY, REPUBLIC OF SOUTH AFRICA.—AMENDMENT OF SUPPLEMENTARY SICK BENEFIT FUND AGREEMENT

I, Pieter Theunis Christiaan du Plessis, Minister of Manpower, hereby—

(a) in terms of section 48 (1) (a) of the Labour Relations Act, 1956, declare that the provisions of the Agreement (hereinafter referred to as the Amending Agreement) which appears in the Schedule hereto and which relates to the Undertaking, Industry, Trade or Occupation referred to in the heading to this notice, shall be binding, with effect from the second Monday after the date of publication of this notice and for the period ending 30 April 1987, upon the employers' organisations and the trade unions which entered into the Amending Agreement and upon the employers and employees who are members of the said organisations or unions; and

(b) in terms of section 48 (1) (b) of the said Act, declare that the provisions of the Amending Agreement, excluding those contained in clause 1 (1) shall be binding, with effect from the second Monday after the date of publication of this notice and for the period ending 30 April 1987, upon all employers and employees, other than those referred to in paragraph (a) of this notice, who are engaged or employed in the said Undertaking, Industry, trade or Occupation in the areas specified in clause 1 of the Amending Agreement.

P. T. C. DU PLESSIS,
Minister of Manpower.

BYLAE

NASIONALE NYWERHEIDSRAAD VIR DIE LEERNYWERHEID VAN SUID-AFRIKA

AANVULLENDE SIEKTEBYSTANDSFONDS

OOREENKOMS

ooreenkomstig die Wet op Arbeidsverhoudinge, 1956, gesluit deur en aangegaan tussen die—

(a) **Midland and Border Leather Industry Manufacturers' Association;**
(b) **Western Cape Leather Industries Association;**
(c) **Transvaal Footwear, Tanning and Leather Trades Association;**
(d) **Natal Footwear, Tanning and General Leather Manufacturers' Association;**
(e) **Southern Cape Leather Industries Association;**
(f) **South African Tanning Employer's Organisation;**
(g) **South African Handbag Manufacturers' Association;**
(h) **Footwear Manufacturers' Federation of South Africa;**

en

(i) **Association of Transvaal Manufacturers of Luggage, Handbags and General Goods**

(hierna die "werkgewers" of die "werkgewersorganisasies" genoem), aan die een kant, en die

(j) **National Union of Leather Workers;**

en

(k) **Transvaal Leather and Allied Trades Industrial Union;**

(hierna die "werknemers" of die "vakverenigings" genoem), aan die ander kant,

wat die partye is by die Nasionale Nywerheidsraad vir die Leernywerheid van Suid-Afrika,

om die Ooreenkoms vir die Aanvullende Siektebystandsfonds, gepubliseer by Goewermentskennisgewing R. 1791 van 3 September 1982, soos gewysig by Goewermentskennisgewing R. 2446 van 4 November 1983 en R. 304 van 21 Februarie 1986, te wysig.

1. TOEPASSINGSBESTEK VAN OOREENKOMS

Hierdie Ooreenkoms moet in die Leernywerheid nagekom word—

(1) deur alle werkgewers en werknemers wat lede van onderskeidelik die werkgewersorganisasies en die vakverenigings is;

(2) in die Republiek van Suid-Afrika, uitgesonderd die hawe en nedersetting van Walvisbaai.

2. KLOUSULE 10.—BYSTAND

(1) Voeg die volgende nuwe subklousule (4) in:

"(4) Die Bestuursraad kan, na goeddunke en by aanbieding van voldane rekeninge, aan voormalige lede wat afgetree het of wat kragtens die bepalings van die Voorsorgfondsooreenkoms ongeskik gesertifiseer is 'n bedrag terugbetaal gelyk aan die voordele waarop 'n lid geregtig is.".

(2) Hernommer die bestaande subklousule (4) om te lui subklousule (5).

Hierdie Ooreenkoms is namens die partye op hede die dag van Julie 1986 onderteken.

O. J. FOURIE,
Lid van die Raad.

D. J. F. LINDE,
Lid van die Raad.

L. M. VAN LOGGERENBERG,
Hoofsekretaris van die Raad.

No. R. 2083 **26 September 1986**

WET OP ARBEIDSVERHOUDINGE, 1956

VLEISBEDRYF, OOS-LONDEN.—VERLENGING VAN OOREENKOMS

Ek, Pieter Theunis Christiaan du Plessis, Minister van Mannekrag, verleng hierby, kragtens artikel 48 (4) (a) (i) van die Wet op Arbeidsverhoudinge, 1956, die tydperke vasgestel in Goewermentskennisgewing R. 2100 van 30 September 1983, met 'n verdere tydperk wat op 30 September 1989 eindig.

P. T. C. DU PLESSIS,
Minister van Mannekrag.

SCHEDULE

NATIONAL INDUSTRIAL COUNCIL OF THE LEATHER INDUSTRY OF SOUTH AFRICA

SUPPLEMENTARY SICK BENEFIT FUND

AGREEMENT

in accordance with the provisions of the Labour Relations Act, 1956, made and entered into by and between the—

(a) **Midland and Border Leather Industry Manufacturers' Association;**
(b) **Western Cape Leather Industries Association;**
(c) **Transvaal Footwear, Tanning and Leather Trades Association;**
(d) **Natal Footwear, Tanning and General Leather Manufacturers' Association;**
(e) **Southern Cape Leather Industries Association;**
(f) **South African Tanning Employer's Organisation;**
(g) **South African Handbag Manufacturers' Association;**
(h) **Footwear Manufacturers' Federation of South Africa;**

and

(i) **Association of Transvaal Manufacturers of Luggage, Handbags and General Goods**

(hereinafter referred to as the "employers" or the "employers' organisations"), of the one part, and the

(j) **National Union of Leather Workers;**

and

(k) **Transvaal Leather and Allied Trades Industrial Union;**

(hereinafter referred to as the "employees" or the "trade unions"), of the other part,

being the parties to the National Industrial Council of the Leather Industry of South Africa,

to amend the Agreement for the Supplementary Sick Benefit Fund published under Government Notice R. 1791 of 3 September 1982, as amended by Government Notice R. 2446 of 4 November 1983, and R. 304 of 21 February 1986.

1. SCOPE OF APPLICATION OF AGREEMENT

The terms of this Agreement shall be observed in the Leather Industry—

(1) by all employers and employees who are members of the employers' organisations and trade unions respectively:

(2) in the Republic of South Africa, excluding the port and settlement of Walvis Bay.

2. CLAUSE 10.—BENEFITS

(1) Insert the following new subclause (4):

"(4) The Board of Management may, in its discretion, and on production of receipted accounts, refund to former members who have retired or who have been certified incapacitated in terms of the provisions of the Provident Fund Agreement, an amount equivalent to the benefits to which a member is entitled.".

(2) Renumber the existing subclause (4) to read subclause (5).

Signed at Port Elizabeth, on behalf of the parties, this day of July 1986.

O. J. FOURIE,
Member of the Council.

D. J. F. LINDE,
Member of the Council.

L. M. VAN LOGGERENBERG,
General Secretary of the Council.

No. R. 2083 **26 September 1986**

LABOUR RELATIONS ACT, 1956

MEAT TRADE, EAST LONDON.—EXTENSION OF AGREEMENT

I, Pieter Theunis Christiaan du Plessis, Minister of Manpower, hereby in terms of section 48 (4) (a) (i) of the Labour Relations Act, 1956, extend the periods fixed in Government Notice R. 2100 of 30 September 1983, by a further period ending 30 September 1989.

P. T. C. DU PLESSIS,
Minister of Manpower.

No. R. 2084 **26 September 1986**

WET OP ARBEIDSVERHOUDINGE, 1956

VLEISBEDRYF, OOS-LONDEN.—WYSIGING VAN OOREENKOMS

Ek, Pieter Theunis Christiaan du Plessis, Minister van Mannekrag, verklaar hierby—

(a) kragtens artikel 48 (1) (a) van die Wet op Arbeidsverhoudinge, 1956, dat die bepalings van die Ooreenkoms (hierna die Wysigingsooreenkoms genoem) wat in die Bylae hiervan verskyn en betrekking het op die Onderneming, Nywerheid, Bedryf of Beroep in die opskrif by hierdie kennisgewing vermeld, met ingang van 1 Oktober 1986 en vir die tydperk wat op 30 September 1989 eindig, bindend is vir die werkgewersorganisasie en die vakvereniging wat die wysigingsooreenkoms aangegaan het en vir die werkgewers en werknemers wat lede van genoemde organisasie of vereniging is; en

(b) kragtens artikel 48 (1) (b) van genoemde Wet, dat die bepalings van die Wysigingsooreenkoms, uitgesonderd dié vervat in klousules 1 (1) (b) en 10, met ingang van 1 Oktober 1986 en vir die tydperk wat op 30 September 1989 eindig, bindend is vir alle ander werkgewers en werknemers as dié genoem in paragraaf (a) van hierdie kennisgewing wat betrokke is by of in diens is in genoemde Onderneming, Nywerheid, Bedryf of Beroep in die gebiede in klousule 1 van die Wysigingsooreenkoms gespesifiseer.

P. T. C. DU PLESSIS,
Minister van Mannekrag.

BYLAE

NYWERHEIDSRAAD VIR DIE VLEISBEDRYF, OOS-LONDEN

OOREENKOMS

ingevolge die Wet op Arbeidsverhoudinge, 1956, gesluit deur en aangegaan tussen die

East London Meat Traders' Association

(hierna die "werkgewers" of die "werkgewersorganisasie" genoem), aan die een kant, en die

East London Meat Trade Union

(hierna die "werknemers" of die "vakvereniging" genoem), aan die ander kant,

wat die partye is by die Nywerheidsraad vir die Vleisbedryf, Oos-Londen.

om die Ooreenkoms gepubliseer by Goewermentkennisgewing R. 2100 van 30 September 1983.

1. TOEPASSINGSBESTEK

(1) Hierdie Ooreenkoms moet nagekom word:

(a) in die landdrosdistrik Oos-Londen; en

(b) deur alle werkgewers wat lede van die werkgewersorganisasie is en in die Vleisbedryf is en deur alle werknemers wat lede van die vakvereniging is en in daardie Bedryf werksaam is.

(2) Ondanks subklousule (1) is hierdie Ooreenkoms van toepassing slegs op werknemers vir wie lone in klousule 4 van die Ooreenkoms gepubliseer by Goewermentskennisgewing R. 2100 van 30 September 1983, voorgeskryf word.

2. KLOUSULE 3.—WOORDOMSKRYWING

(1) Voeg die volgwende omskrywing na die omskrywing van "Wet":

" 'kassier' 'n werknemer, uitgesonderd 'n klerk, wat in 'n bedryfsinrigting in diens is om geld te ontvang en wat ook telefoonbestellings mag ontvang;"

(2) Voeg die volgende omskrywing na die omskrywing van "Raad":

" 'Snyer' 'n werknemer, uitgesonderd 'n vleistegnikus, wat onder die toesig van 'n gekwalifiseerde tegnikus, vleis sny en voorberei vir verkoop;".

(3) In die omskrywing van "algemene werker" voeg die volgende na item "O";

"(p) en gaar of bewerkte vleis mag sny;"

No. R. 2084 **26 September 1986**

LABOUR RELATIONS ACT, 1956

MEAT TRADE, EAST LONDON.—AMENDMENT OF AGREEMENT

I, Pieter Theunis Christiaan du Plessis, Minister of Manpower, hereby—

(a) in terms of section 48 (1) (a) of the Labour Relations Act, 1956, declare that the provisions of the Agreement (hereinafter referred to as the Amending Agreement) which appears in the Schedule hereto and which relates to the Undertaking, Industry, Trade or Occupation referred to in the heading to this notice, shall be binding, with effect from 1 October 1986 and for the period ending 30 September 1989, upon the employers' organisation and the trade union which entered into the Amending Agreement and upon the employers and employees who are members of the said organisation or union; and

(b) in terms of section 48 (1) (b) of the said Act, declare that the provisions of the Amending Agreement, excluding those contained in clauses 1 (1) (b) and 10, shall be binding, with effect from 1 October 1986 and for the period ending 30 September 1989, upon all employers and employees, other than those referred to in paragraph (a) of this notice, who are engaged or employed in the said Undertaking, Industry, Trade or Occupation in the areas specified in clause 1 of the Amending Agreement.

P. T. C. DU PLESSIS,
Minister of Manpower.

SCHEDULE

INDUSTRIAL COUNCIL FOR THE MEAT TRADE, EAST LONDON

AGREEMENT

in accordance with the provisions of the Labour Relations Act, 1956, made and entered into by and between the

East London Meat Traders' Association

(hereinafter referred to as the "employers" or the "employers' organisation"), of the one part, and the

East London Meat Trade Union

(hereinafter referred to as the "employees" or the "trade union"), of the other part,

being parties to the Industrial Council for the Meat Trade, East London,

to amend the Agreement published under Government Notice R. 2100 of 30 September 1983.

1. SCOPE OF APPLICATION

(1) The terms of this Agreement shall be observed:

(a) in the Magisterial District of East London; and

(b) by all employers who are members of the employers' organisation and who are engaged in the Meat Trade, and by all employees who are members of the trade union and who are employed in that Trade.

(2) Notwithstanding the provisions of subclause (1), the terms of this Agreement shall apply only in respect of employees for whom wages are prescribed in clause 4 of the Agreement published under Government Notice R. 2100 of 30 September 1983.

2. CLAUSE 3.—DEFINITIONS

(1) Insert the following definition after the definition of "Act":

" 'Cashier' means an employee, other than a clerical employee, who is engaged in an establishment in receiving cash from customers and who may receive telephone orders;".

(2) Insert the following definition after the definition of "Council":

" 'Cutter' means an employee, other than a meat technician, who may, under the supervision of a qualified meat technician, cut and prepare meat for sale;".

(3) In the definition of "general worker" insert the following after item (o):

"(p) and who may slice cooked and/or processed meat;".

(4)Vervang die omskrywing van "uurloon" deur die volgende:

"(a) die dagloon, gedeel deur agt, vir werknemers vir wie lone in klousule 4 (c) voorgeskryf word:

(b) die werkloon, gedeel deur 46, vir werknemers vir wie lone in klousule 4 (a), (b), (f), (g) en (h) voorgeskryf word;

(c) die werkloon, gedeel deur 24, vir werknemers vir wie lone in klousule 4 (1) (i) voorgeskryf word;

(d) die maandloon, gedeel deur—

(i) 200, vir werknemers vir wie lone in klousule 4 (d) en (e) voorgeskryf word;

(ii) 130, vir werknemers vir wie lone in klousule 4 (1) (i) voorgeskryf word;".

(5) Vervang die omskrywing van "deeltydse werknemer" deur die volgende:

" 'deeltydse werknemer' 'n werknemer wat as sodanig hoogstens 30 gewone ure in 'n week by dieselfde werkgewer in diens is;"

(6) Vervang die omskrywing van "winkelhulp" deur die volgende—

" 'winkelhulp' 'n werknemer wat onder toesig van 'n gekwalifiseerde vleistegnikus vleis verkoop wat vooraf opgesny en geprys is en wat ook die werk van 'n algemene werker kan verrig;".

(7) Skrap die omskrywing van "lewende hawe" en "vleistegnikus se assistent".

3. KLOUSULE 4—BESOLDIGING

Vervang klousule 4 deur die volgende:

"Geen laer besoldiging as die volgende mag deur 'n werkgewer betaal en deur 'n werknemer aanvaar word nie:

	Per week R
(a) Bestuurder	258,50
Winkelkontroleur	172,50
Vleistegnikus, bereider van vleisprodukte en/of spekbereider, gekwalifiseer	207,00
(b) Vleistegnikus, bereider van vleisprodukte en/of spekbereider, ongekwalifiseer:	
gedurende eerste jaar ondervinding	127,50
gedurende tweede jaar ondervinding	180,00
(c) Loswerknemer: 'n pro rata bedrag vir die werklike tydperk wat hy gewerk het teen die voorgeskrewe loon van toepassing op die klas werk wat hy verrig.	
	Per maand R
(d) (i) Klerk, gekwalifiseer	682,00
(ii) Klerk, ongekwalifiseer—	
gedurende eerste jaar ondervinding	531,00
gedurende tweede jaar ondervinding	607,50
	Per week R
(iii) Kassier—	
gedurende eerste jaar na die inwerkingtreding van hierdie Ooreenkoms	80,00
daarna	100,00
(e) Winkelassistent	90,00
(f) Algemene werker—	
gedurende eerste jaar na inwerkingtreding van hierdie Ooreenkoms	52,00
Daarna	58,00
(g) Motorvoertuigdrywer:	
Drywer van 'n motorvoertuig waarvan die onbelaste massa, tesame met die onbelaste massa, van 'n sleepwa of sleepwaens wat so 'n voertuig trek—	
(i) hoogstens 500 kg is	75,00
(ii) meer as 500 kg maar hoogstens 2 500 kg is	91,50
(iii) meer as 2 500 kg is	106,50
(h) (i) Massameter en prysvasteller—	
gedurende eerste jaar na inwerkingtreding van hierdie Ooreenkoms	60,00
daarna	66,00
(ii) Winkelhulp—	
gedurende eerste jaar na inwerktreding van hierdie Ooreenkoms	60,00
daarna	66,00
(iii) Verpakker en toedraaier—	
gedurende eerste jaar na inwerkingtreding van hierdie Ooreenkoms	52,00
daarna	58,00

(i) *Deeltydse werknemer.*—Minstens 60% van die gekwalifiseerde besoldiging teen die voorgeskrewe loon van toepassing op die klas werk wat hy verrig.)

(4) Substitute the following for "hourly wage":

" 'hourly wage' means—

(a) the daily wage divided by eight, in respect of employees for whom wages are prescribed in clause 4 (c);

(b) the weekly wage divided by 46, in respect of employees for whom wages are prescribed in clause 4 (a), (b), (e), (f), (g) and (h);

(c) the weekly wage divided by 30, in respect of employees for whom wages are prescribed in clause 4 (1) (i);

(d) the monthly wage divided by—

(i) 200, in respect of employees for whom wages are prescribed in clause 4 (d);

(ii) 130, in respect of employees for whom wages are prescribed in clause 4 (1) (i);".

(5) Substitute the following for "part-time employee":

" 'part-time employee' means an employee who is employed as such by the same employer for not more than 30 ordinary hours in any one week;".

(6) Substitute the following for "shop attendant":

" 'shop attendant' means an employee who, under the supervision of a qualified meat technician, is engaged in selling meat which has been pre-cut and pre-priced and who may, in addition, perform the work of a general worker;".

(7) Delete the definitions of "livestock" and "meat technician's assistant".

3. CLAUSE 4.—REMUNERATION

Substitute the following for clause 4:

"No employer shall pay and no employee shall accept remuneration lower than the following:

	Per week R
(a) Manager	258,50
Shop controller	172,50
Meat technician, smallgoodsman and/or bacon curer, qualified	207,00
(b) Meat technician, smallgoodsman and/or bacon curer, unqualified—	
during first year of experience	127,50
during second year of experience	180,00
(c) Casual employee: Pro rata amount for the actual period worked by him at the prescribed rate applicable to the class of work he performs.	
	Per month R
(d) (i) Clerical employee, qualified	682,00
(ii) Clerical employee, unqualified—	
during first year of experience	531,00
during second year of experience	607,50
	Per week R
(iii) Cashier—	
during first year of experience	80,00
during second year of experience	100,00
(e) Shop assistant	90,00
(f) General worker—	
during first year of operation of this Agreement	52,00
during second year of operation of this Agreement	58,00
(g) Motor vehicle driver—	
driver of a motor vehicle, the unladen mass of which, together with the unladen mass of any trailer or trailers drawn by such vehicle—	
(i) does not exceed 500 kg	75,00
(ii) exceeds 500 kg but not 2 500 kg	91,50
(iii) exceeds 2 500 kg	106,50
(h) (i) Mass measurer and pricer—	
during first year of operation of this Agreement	60,00
thereafter	66,00
(ii) Shop attendant—	
during first year of operation of this Agreement	60,00
thereafter	66,00
(iii) Packer and wrapper—	
during first year of operation of this Agreement	52,00
thereafter	58,00

(i) *Part-time employee.*—Not less than 60 % of the qualified remuneration at the prescribed rate applicable to the class of work he performs.".

4. KLOUSULE 5.—BETALING VAN BESOLDIGING

Skrap subklousule (3) (e) en vervang "(e)" deur "(f)" in die volgende paragraaf.

5. KLOUSULE 6.—VERHOUDING VAN WERKNEMERS

(1) Vervang subklousule (1) deur die volgende:

"(1) *Vleistegnikus*.—'n Werkgewer mag nie 'n ongekwalifiseerde vleistegnikus of 'n snyer in diens neem nie, tensy hy 'n gekwalifiseerde vleistegnikus in sy diens het, en vir elke gekwalifiseerde vleistegnikus in sy diens mag hoogstens een ongekwalifiseerde vleistegnikus en een snyer in elke bedryfsinrigting in diens geneem word;".

(2) Vervang subklousule (4) deur die volgende:

"(4) 'n Werkgewer mag nie 'n winkelassistent, 'n winkelhulp of 'n snyer in diens neem nie tensy hy 'n gekwalifiseerde vleistegnikus in sy diens het, en vir elke gekwalifiseerde vleistegnikus mag hoogstens twee winkelassistente en een winkelhulp of een winkelassistent en twee winkelhulpe in diens geneem word;".

(3) Vervang subklousule (5) deur die volgende:

"(5) As 'n winkelhulp, 'n winkelassistent, 'n klerk, 'n snyer of 'n algemene werker die werk van 'n vleistegnikus verrig, word hy geag 'n vleistegnikus te wees;".

6. KLOUSULE 7.—WERKURE

(1) Vervang subklousule (1) (d) deur die volgende:

"(d) In die geval van 'n deeltydse werknemer, hoogstens 30 uur per week, en in die geval van 'n los werknemer, agt uur per dag, met dien verstande dat—".

(2) Vervang subklousule (6) deur die volgende:

"(6) Klousule 7 (1) (b), 8 (2) en 9 (1) is nie van toepassing op 'n werknemer wat R12 000 of meer per jaar verdien nie.".

7. KLOUSULE 9.—OORTYDWERK

Vervang die syfer "24" deur "30" in subklousule (3) (c).

8. KLOUSULE 11

(1) Vervang subklousule (2) deur die volgende:

"(2) Aan elke werknemer vir wie daar lone in klousule 4, uitgesonderd los werknemers, voorgeskryf word, moet daar in elke jaar diens by dieselfde werkgewer drie agtereenvolgende weke verlof met volle besoldiging toegestaan word, met dien verstande dat as 'n openbare vakansiedag binne die toegestane verloftydperk val, so 'n vakansiedag by die genoemde verloftydperk met volle besoldiging gevoeg moet word: Voorts met dien verstande dat die volle verloftydperk verminder kan word met die getal dae waarop daar aan die werknemer op sy skriftelike versoek geleentheidsverlof met volle besoldiging gedurende die betrokke dienstydperk toegestaan is. Die werkgewer moet die tyd vasstel wanneer sodanige verlof geneem moet word sodat dit begin binne ses maande na voltooiing van 'n jaar diens, maar sodanige verlof mag nie met 'n tydperk van militêre diens ingevolge die Verdedigingswet, 1957, of met siekteverlof wat ingevolge klousule 12 toegestaan is, saamval nie. Die werkgewer moet aan sy werknemer sy loon vir die vakansietydperk betaal voordat sodanige werknemer met verlof gaan.".

(2) Vervang subklousule (3) deur die volgende:

"(3) As die diens van 'n werknemer vir wie lone in klousule 4, uitgesonderd 'n los werknemer, voorgeskryf word, beëindig word voor voltooiing van 'n jaar diens maar na voltooiing van 'n maand diens, moet die werkgewer die werknemer vir en in plaas van die verlof drie twee-en-vyftigstes van 'n week se loon betaal vir elke voltooide week diens in die onvoltooide jaar, bereken teen die loon wat die werknemer ontvang het toe dié diens beëindig is: Met dien verstande dat 'n werkgewer 'n eweredige bedrag kan aftrek ten opsigte van 'n verloftydperk wat ingevolge die tweede voorbehoudsbepaling van subklousule (2) aan 'n werknemer toegestaan is. In die geval van 'n maandeliks besoldigde werknemer word "weekloon" geag die maandloon gedeel deur vier en 'n derde te wees.".

(3) Vervang subklousule (6) deur die volgende:

"(6) Waar die diens van 'n werknemer vir wie 'n loon in klousule 4, uitgesonderd 'n los werknemer, voorgeskryf word na voltooiing van 'n jaar diens maar voordat sodanige jaarlikse verlof ooreenkomstig subklousule (2) toegestaan is, moet die werkgewer by sodanige beëindiging aan die werknemer, in plaas van sodanige verlof, vir elke maand van sodanige diens 'n kwart van 'n week se loon betaal bereken teen die besoldiging wat die werknemer ten tyde van sy diensbeëindiging ontvang het. Vir die toepassing van hierdie subklousule word "weekloon" in die geval van 'n maandeliks besoldigde werknemer geag die maandloon, gedeel deur vier en 'n derde, te wees.".

9. KLOUSULE 18.—FONDSE VAN DIE RAAD

(1) Vervang subklousule (1) (a) en (b) deur die volgende:

"(1) (a) Elke werkgewer moet ten opsigte van elke sakeonderneming wat hy besit of dryf, 'n jaarlikse bydrae van R25,00 aan die Raad betaal. Hierdie bedrag is verskuldig op die datum van inwerktreding van hierdie Ooreenkoms, of op die datum waarop hy tot die vleisbedryf toetree, naamlik die jonste datum, en moet betaal word binne twee weke na die datum waarop dit verskuldig is.

4. CLAUSE 5.—PAYMENT OF REMUNERATION

Delete subclause (3) (e) and substitute "(e)" for "(f)" in the following paragraph.

5. CLAUSE 6.—PROPORTION OR RATIO OF EMPLOYEES

(1) Substitute the following for subclause (1):

"(1) *Meat technician*.—An employer shall not employ an unqualified meat technician or a cutter unless he has in his employ a qualified meat technician, and for each qualified meat technician employed not more than one unqualified meat technician and one cutter may be employed in each establishment."

(2) Substitute the following for subclause (4):

"(4) An employer shall not employ a shop assistant or a shop attendant unless he has in his employ a qualified meat technician, and for each qualified meat technician employed, not more than either one shop assitant and two shop attendants or two shop assitants and one shop attendant may be employed by him.".

(3) Substitute the following for subclause (5):

"(5) Whenever a shop attendant, a shop assistant, a clerical employee, a cutter or a general worker performs the work of a meat technician, he shall be deemed to be a meat technician.".

6. CLAUSE 7.—HOURS OF WORK

(1) Substitute the following for subclause (1) (d):

"(d) in the case of a part-time employee, not more than 30 hours in any week and in the case of a casual employee, eight hours on any one day; Provided that—".

(2) Substitute the following for subclause (6):

"(6) The provisions of clauses 7 (1) (b), 8 (2) and 9 (1) shall not apply to an employee who is in receipt of R12 000 or more per annum.".

7. CLAUSE 9.—OVERTIME

(1) Substitute the figure "30" for the figure "24" in subclause (3) (c).

8. CLAUSE 11.—HOLIDAYS AND PAYMENTS

(1) Substitute the following for subclause (2):

"(2) Every employee for whom wages are prescribed in clause 4, other than a casual employee, shall be given in each year of service with the same employer, three consecutive weeks' leave of absence on full pay, provided that should any public holiday fall within the period of leave granted, such holiday shall be added to the said period of leave of absence on full pay: Provided further that the full period of leave may be reduced by any number of days on which the employee, during the relevant period of employment, was granted occasional leave on full pay at his written request. The employers shall fix the time when such leave shall be taken so as to commence within six months after the completion of a year's service, but this leave shall not run concurrently with any period of military service in terms of the Defence Act, 1957, or sick leave granted in terms of clause 12. The employer shall pay his employee his wages for the holiday period before such employee goes on leave.".

(2) Substitute the following for subclause (3):

"(3) Where the service of an employee for whom wages are prescribed in clause 4, other than a casual employee, is terminated before the completion of a year's service, but after completion of one month's service, the employer shall for and in lieu of leave pay to the employee for such completed week of service in the uncompleted year three fifty-seconds of a week's pay at the rate which the employee was receiving when such service was terminated: Provided than an employer may make a proportionate deduction in respect of any period of leave granted to an employee in terms of the second proviso to subclause (2). In the case of a monthly-paid employee, "week's pay" shall be deemed to be the monthly rate, divided by four and one third.".

(3) Substitute the following for subclause (6):

"(6) Where the service of an employee for whom wages are prescribed in clause 4, other than a casual employee, is terminated after the completion of any year's service, but before such annual leave has been granted in terms of subclause (2), the employer shall upon such termination pay the employee in lieu of such leave one-quarter of a week's pay in respect of each month of such service at the rate the employee was receiving when his service was terminated. For the purposes of this subclause, a "week's pay" in the case of a monthly-paid employee shall be deemed to be the monthly rate, divided by four and one third.".

9. CLAUSE 18.—COUNCIL FUNDS

(1) Substitute the following for subclause (1) (a) and (b):

"(1) (a) Every employer shall, in respect of each business he owns or conducts, pay to the Council an annual contribution of R25,00. Such sum shall become due on the date of coming into operation of this Agreement, or on the date on which he enters the meat trade, whichever is the later, and shall be paid within two weeks of the due date.

(b) Elke werkgewer moet R1,00 per maand aftrek van die lone van elkeen van sy werknemers wat 'n loon van minder as R100,00 per week ontvang en R2,00 per maand van elkeen van sy werknemers wat R100,00 of meer per week ontvang.".

(2) Skrap subklousule (2).

10. KLOUSULE 21.—ORGANISASIE

(1) Skrap die volgende van subklousule (1):

"en motorvoertuigdrywers".

(2) Voeg die volgende subklousule in:

"(3) Elke werkgewer sal van die lone van elke werknemer in sy diens, wat lede van die vakunie is, die ledegeld toekomstig aan die vakunie, van die werknemer se lone aftrek en sal die totale bedrag saam met 'n lys van die betrokke werknemers aan die Sekretaris van die vakunie, Posbus 1005, Oos-Londen, nie later as die vyftiende dag van die volgende maand wanneer die aftreksel toekomstig was.".

(3) Vervang "(3)" deur "(4)".

Geteken te Oos-Londen, soos gemagtig, namens die partye by die Raad op hede die 18de dag van June 1986.

A. SUTHERLAND.
Voorsitter van die Raad.

R. G. CONWAY.
Ondervoorsitter van die Raad.

J. A. NICHOLAS.
Sekretaris van die Raad.

(b) R1,00 per month shall be deducted by every employer from the wages of each of his employees who are in receipt of wages of less than R100.00 per week and R2,00 per month from each of his employees who are in receipt of wages of R100,00 or more per week.".

(2) Delete subclause (2).

10. CLAUSE 21.—ORGANISATION

(1) Delete the following from subclause (1):

"and motor vehicle drivers" or (b)

(2) Insert the following subclause:

"(3) Every employer shall deduct from the wages of each member of the trade union in his employ, the monthly subscription due by such employee to the trade union and shall forward the total amount deducted, together with a list showing the names of the relevant employees, to the Secretary of the union, P.O. Box 1005, East London, not later than the fifteenth day of the month following that in which the deduction became due."

(3) Substitute "(3)" for "(4)".

Signed at East London, as authorised, for and on behalf of the parties to the Council, this 18th day of June 1986.

A. SUTHERLAND,
Chairman of the Council.

R. G. CONWAY,
Vice-Chairman of the Council.

J. A. NICHOLAS,
Secretary of the Council.

DIE BLOMPLANTE VAN AFRIKA

Hierdie publikasie word uitgegee as 'n geïllustreerde reeks, baie na die aard van Curtis se "Botanical Magazine". Die doel van die werk is om die skoonheid en variasie van vorm van die flora van Afrika aan die leser bekend te stel, om belangstelling in die studie en kweek van die inheemse plante op te wek, en om plantkunde in die algemeen te bevorder.

Die meeste van die illustrasies word deur kunstenaars van die Navorsingsinstituut vir Plantkunde gemaak, dog die Redakteur verwelkom geskikte bydraes van 'n wetenskaplike en kunsstandaard afkomstig van verwante inrigtings.

Onder huidige omstandighede word twee dele van die werk in een omslag gepubliseer, maar met onreëlmatige tussenpose; elke deel bevat 10 kleurplate. Intekengeld bedra R15 per uitgawe van twee dele (buitelands R16 per uitgawe): Vier dele per band. Vanaf band 27 is die prys per band in rexine gebind R40; in luukse rexine gebind R45. (Buitelands, rexine gebind R45; luukse band R50).

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This publication is issued as an illustrated serial, much on the same lines as Curtis's Botanical Magazine, and for imitating which no apology need be tendered.

The desire and object of the promoters of the publication will be achieved if it stimulates further interest in the study and cultivation of our indigenous plants.

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(7) Voeg die volgende subklousule in na subklousule (17) (a) (ix):

(x) aansoek doen om deernisverlof wat nie drie dae per geval te bowe gaan nie, ten einde die begrafnis van 'n gesinslid of nabye bloedverwant by te woon.".

J. F. M. VAN DER MERWE,
Voorsitter.

N. C. GEY VAN PITTIUS,
Ondervoorsitter.

A. J. VAN SCHALKWYK,
Sekretaris.

No. R. 2068 **26 September 1986**

WET OP ARBEIDSVERHOUDINGE, 1956

NYWERHEIDSRAAD VIR DIE ELEKTROTEGNIESE NYWERHEID (NATAL).—WYSIGING VAN MEDIESE HULPFONDSOOREENKOMS

Ek, Pieter Theunis Christiaan du Plessis, Minister van Mannekrag, verklaar hierby, kragtens artikel 48 (1) (a) van die Wet op Arbeidsverhoudinge, 1956, dat die bepalings van die Ooreenkoms (hierna die Wysigingsooreenkoms genoem) wat in die Bylae hiervan verskyn en betrekking het op die Onderneming, Nywerheid, Bedryf of Beroep in die opskrif by hierdie kennisgewing vermeld, met ingang van die tweede Maandag na die datum van publikasie van hierdie kennisgewing en vir die tydperk wat op 30 Junie 1987 eindig, bindend is vir die werkgewersorganisasies en die vakverenigings wat die Wysigingsooreenkoms aangegaan het en vir die werkgewers en werknemers wat lede van genoemde organisasies of verenigings is.

P. T. C. DU PLESSIS,
Minister van Mannekrag.

BYLAE

NYWERHEIDSRAAD VIR DIE ELEKTROTEGNIESE NYWERHEID (NATAL)

MEDIESE HULPFONDSOOREENKOMS

ooreenkomstig die Wet op Arbeidsverhoudinge, 1956, gesluit deur en aangegaan tussen die

Electrical Contractors' Association (South Africa)

(hierna die "werkgewers" of die "werkgewersorganisasie" genoem), aan die een kant, en die

South African Electrical Workers' Association

(hierna die "werknemers" of die "vakvereniging" genoem), aan die ander kant,

wat die partye is by die Nywerheidsraad vir die Elektrotegniese Nywerheid (Natal),

om die Ooreenkoms, gepubliseer by Goewermentskennisgewing R. 994 van 23 Mei 1986 (hierna die Herbekragtigingsooreenkoms genoem) soos verleng by Goewermentskennisgewing R. 1335 van 27 Junie 1986, te wysig.

1. TOEPASSINGSBESTEK VAN OOREENKOMS

(1) Ondanks andersluidende bepalings in hierdie klousule, is hierdie Ooreenkoms van toepassing op en moet dit nagekom word in die Elektrotegniese Nywerheid deur alle werkgewers en werknemers wat onderskeidelik lede van die werkgewersorganisasie en die vakvereniging is wat betrokke is by of in diens is in die Nywerheid in die landdrosdistrikte Alfred, Babanango, Bergville, Camperdown, Chatsworth, Dannhauser, Dundee, Durban, Eshowe, Estcourt, Glencoe, Hlabisa, Impendle, Inanda, Ingwavuma, Ixopo, Kliprivier, Kranskop, Lionsrivier, Lower Tugela, Lower Umfolozi, Mahlabatini, Mapamulo, Mooirivier, Msinga, Mtonjaneni, Mtunzini, Ndwedwe, Newcastle, New Hanover, Ngotshe, Nkandla, Nongoma, Nqutu, Paulpietersburg, Pietermaritzburg, Pinetown, Polela, Port Shepstone, Richmond, Ubombo, Umbumbulu, Umvoti, Umzinto, Underberg, Utrecht, Vryheid en Weenen, maar uitgesonderd die gedeeltes van hierdie landdrosdistrikte wat ingevolge Proklamasie R. 11 van 1977 wat in die *Staatskoerant* van 28 Januarie 1977 verskyn het, binne die selfregerende gebied KwaZulu val, in die werksaamhede uiteengesit in paragrawe (a), (b) en (c) van die omskrywing van "Elektrotegniese Nywerheid" in klousule 3 van die Ooreenkoms gepubliseer by Goewermentskennisgewing R. 967 van 13 Mei 1983.

(7) Insert the following subclause after subclause (17) (a) (ix)

(x) apply for compassionate leave which shall not exceed three days per event in order to attend the funeral of a member of his family or close relative."

J. F. M. VAN DER MERWE,
Chairman.

N. C. GEY VAN PITTIUS,
Vice-Chairman.

A. J. VAN SCHALKWYK,
Secretary.

No. R. 2068 **26 September 1986**

LABOUR RELATIONS ACT, 1956

INDUSTRIAL COUNCIL FOR THE ELECTRICAL INDUSTRY (NATAL).—AMENDMENT OF MEDICAL AID FUND AGREEMENT

I, Pieter Theunis Christiaan du Plessis, Minister of Manpower, hereby, in terms of section 48 (1) (a) of the Labour Relations Act, 1956, declare that the provisions of the Agreement (hereinafter referred to as the Amending Agreement) which appears in the Schedule hereto and which relates to the Undertaking, Industry, Trade or Occupation referred to in the heading to this notice, shall be binding, with effect from the second Monday after the date op publication of this notice and for the period ending 30 June 1987, upon the employers' organisations and the trade unions which entered into the Amending Agreement and upon the employers and employees who are members of the said organisations or unions.

P. T. C. DU PLESSIS,
Minister of Manpower.

SCHEDULE

INDUSTRIAL COUNCIL FOR THE ELECTRICAL INDUSTRY (NATAL)

MEDICAL AID FUND AGREEMENT

in accordance with the provisions of the Labour Relations Act, 1956, made and entered into by and between the

Electrical Contractors' Association (South Africa)

(hereinafter referred to as the "employers" or the "employers' organisation"), of the one part, and the

South African Electrical Workers' Association

(hereinafter referred to as the "employees" or the "trade union") of the other part,

being the parties to the Industrial Council for the Electrical Industry (Natal),

to amend the Agreement published under Government Notice R. 994 of 23 May 1986 (hereinafter referred to as the Re-enacting Agreement), as extended by Government Notice R. 1335 of 27 June 1986.

1. SCOPE OF APPLICATION OF AGREEMENT

(1) Except as otherwise provided in this clause, the terms of this Agreement shall apply to and be observed in the Electrical Industry by all employers and employees who are members of the employers' organisation and the trade union respectively, who are engaged or employed in the Industry in the Magisterial Districts of Alfred, Babanango, Bergville, Camperdown, Chatsworth, Dannhauser, Dundee, Durban, Eshowe, Estcourt, Glencoe, Hlabisa, Impendle, Inanda, Ingwavuma, Ixopo, Klip River, Kranskop, Lions River, Lower Tugela, Lower Umfolozi, Mahlabatini, Mapamulo, Mooi River, Msinga, Mtonjaneni, Mtunzini, Ndwedwe, Newcastle, New Hanover, Ngotshe, Nkandla, Nongoma, Nqutu, Paulpietersburg, Pietermaritzburg, Pinetown, Polela, Port Shepstone, Richmond, Ubombo, Umbumbulu, Umvoti, Umzinto, Underberg, Utrecht, Vryheid and Weenen, but excluding any portions of those Magisterial Districts falling within the self-governing territory of KwaZulu in terms of Proclamation R. 11 of 1977, which appeared in the *Government Gazette* of 28 January 1977, in the operations set forth in paragraphs (a), (b) and (c) of the definition of "Electrical Industry" in clause 3 of the Agreement published under Government Notice R. 967 of 13 May 1983.

(2) Die bepalings van hierdie Ooreenkoms is nie van toepassing nie op werkgewers en hul werknemers wat saam met die werkgewer deelnemers is in 'n skema wat mediese voordele verskaf wat bestaan het op 3 Januarie 1966 en waartoe die betrokke werkgewer weekliks minstens 45 sent bydra ten opsigte van elke werknemer wat lid van die skema is en andersins deur hierdie Ooreenkoms gedek word, terwyl die skema in werking bly en genoemde werkgewer en werknemers voortgaan om deelnemers in die skema te wees en die werkgewer voortgaan om 'n bydrae van minstens 45 sent per week ten opsigte van elke sodanige werknemer te betaal.

(3) Ondanks subklousule (2), is hierdie Ooreenkoms van toepassing op werkgewers en werknemers ten opsigte van werknemers wat nie gedek word deur 'n fonds of skema wat in daardie subklousule bedoel word nie, of wat ophou om daardeur gedek te word.

2. KLOUSULE 3.—ALGEMENE BEPALINGS

Vervang klousule 3 van die Herbekragtigingsooreenkoms deur die volgende:

"Die bepalings vervat in klousule 3 (soos gewysig by klousule 4 van die Herbekragtigingsooreenkoms) 4 tot 8, 9 (soos gewysig by klousule 3 hieronder), 10 (soos gewysig by klousule 4 hieronder) en 11 tot 19 van die Ooreenkoms gepubliseer by Goewermentskennisgewing R. 1429 van 13 Julie 1984 (hierna die "Vorige Ooreenkoms" genoem), is van toepassing op werkgewers en werknemers.".

3. KLOUSULE 9.—BYDRAES

In subklousule (1), vervang die syfer "R6,75" deur die syfer "R8,75".

4. KLOUSULE 10.—BYSTAND

Vervang subklousule (1) deur die volgende:

"(1) 'n Lid is daarop geregtig om, behoudens die reëls van die Fonds, bystand van die Fonds soos volg te eis ten opsigte van mediese, tandheelkundige en gesigkundige dienste:

(a) Betaling van koste, uitgesonderd koste vir tandheelkundige en gesigkundige dienste, van hoogstens altesaam R5 000 (met inbegrip van koste vir bevallings van hoogstens R450 per bevalling) in elke siklus van 52 weke bydraende diens vir die lid en sy afhanklikes;

(b) betaling van koste vir tandheelkundige dienste van altesaam hoogstens R400 in elke siklus van 52 weke bydraende diens vir die lid en sy afhanklikes;

(c) betaling van koste vir gesigkundige dienste van hoogstens altesaam R200 in elke siklus van 52 weke bydraende diens vir die lid en sy afhanklikes;

(d) betaling van bystand vir dienste kragtens hierdie klousule van hoogstens die bepaal in die bystandskale wat van tyd tot tyd in die *Staatskoerant* verskyn ingevolge die Wet op Mediese Skemas, 1967, en waar geen sodanige bystandskale bepaal word nie mag die bystand nie die bedrae oorskry soos van tyd tot tyd deur die Bestuursraad ooreenkomstig die Reëls bepaal word nie.".

Soos gemagtig, vir en namens die partye op hede die 1ste dag van April 1986 te Durban onderteken.

B. NICHOLSON,
Voorsitter van die Raad.

M. F. PRINSLOO,
Ondervoorsitter van die Raad.

D. F. ANTHONY,
Sekretaris van die Raad.

No. R. 2069 **26 September 1986**

WET OP ARBEIDSVERHOUDINGE, 1956

NYWERHEIDSRAAD VIR DIE ELEKTROTEGNIESE NYWERHEID (NATAL).—WYSIGING VAN SIEKTE-BYSTANDSFONDSOOREENKOMS

Ek, Pieter Theunis Christiaan du Plessis, Minister van Mannekrag, verklaar hierby—

(a) kragtens artikel 48 (1) (a) van die Wet op Arbeidsverhoudinge, 1956, dat die bepalings van die Ooreenkoms (hierna die Wysigingsooreenkoms genoem) wat in die Bylae hiervan verskyn en betrekking het op die Onderneming, Nywerheid, Bedryf of Beroep in die opskrif by hierdie kennisgewing vermeld, met ingang van die tweede Maandag na die datum van publikasie van hierdie kennisgewing en vir die tydperk wat op 30 Junie 1987 eindig, bindend is vir die werkgewersorganisasies en die vakverenigings wat die Wysigingsooreenkoms aangegaan het en vir die werkgewers en werknemers wat lede van genoemde organisasies of verenigings is; en

(2) The terms of this Agreement shall not apply to employers and their employees who are participants with the employer in any scheme providing medical benefits in existence on 3 January 1966, to which the employer concerned contributes not less than 45 cents per week for each employee who is a member of the scheme and otherwise covered by this Agreement whilst such scheme continues to operate and the said employer and employees continue as participants in the scheme and the employer continues to pay a contribution of not less than 45 cents for each such employee per week.

(3) Notwithstanding the provisions of subclause (2), the terms of this Agreement shall apply to employers and employees in respect of any employee who is not covered by, or ceases to be covered by, a fund or scheme referred to in that subclause.

2. CLAUSE 3.—GENERAL PROVISIONS

Substitute the following for clause 3 of the Re-enacting Agreement:

"The provisions contained in clauses 3 (as amended by clause 4 of the Re-enacting Agreement), 4 to 8, 9 (as amended by clause 3 hereunder), 10 (as amended by clause 4 hereunder) and 11 to 19 of the Agreement published by Government Notice R. 1429 of 13 July 1984 (hereinafter referred to as the "Former Agreement"), shall apply to employers and employees.".

3. CLAUSE 9.—CONTRIBUTIONS

In subclause (1), substitute the figure "R8,75" for the figure "R6,75".

4. CLAUSE 10.—BENEFITS

Substitute the following for subclause (1):

"(1) Subject to the provisions of the rules of the Fund, a member shall be entitled to claim the following benefits from the Fund in respect of medical, dental and optical services:

(a) Payment of expenses, other than expenses for dental services and optical services, not exceeding the amount of R5 000 (including payment of expenses for confinements up to a maximum of R450 per confinement) in the aggregate in each cycle of 52 weeks of contributory service for the member and his dependants;

(b) payment of expenses for dental not exceeding the amount of R400 in the aggregate in each cycle of 52 weeks of contributory service for the member and his dependants;

(c) payment of expenses for optical services not exceeding an amount of R200 in the aggregate in each cycle of 52 weeks of contributory service for the member and his dependants;

(d) payment of benefits for services under this clause not exceeding those determined in the scale of benefits as published from time to time in the *Government Gazette* in terms of the Medical Schemes Act, 1967, and where no such scale of benefits has been determined, the benefits shall not exceed amounts as decided from time to time by the Board of Management in terms of the Rules.".

Signed at Durban, as authorised, for and on behalf of the parties, this 1st day of Arpil 1986.

B. NICHOLSON,
Chairman of the Council.

M. F. PRINSLOO,
Vice-Chairman of the Council.

D. F. ANTHONY,
Secretary of the Council.

No. R. 2069 **26 September 1986**

LABOUR RELATIONS ACT, 1956

INDUSTRIAL COUNCIL FOR THE ELECTRICAL INDUSTRY (NATAL).—AMENDMENT OF SICK PAY FUND AGREEMENT

I, Pieter Theunis Christiaan du Plessis, Minister of Manpower, hereby—

(a) in terms of section 48 (1) (a) of the Labour Relations Act, 1956, declare that the provisions of the Agreement (hereinafter referred to as the Amending Agreement) which appears in the Schedule hereto and which relates to the Undertaking, Industry, Trade or Occupation referred to in the heading to this notice, shall be binding, with effect from the second Monday after the date of publication of this notice and for the period ending 30 June 1987, upon the employers' organisations and the trade unions which entered into the Amending Agreement and upon the employers and employees who are members of the said organisations or unions; and

(b) kragtens artikel 48 (1) (b) van genoemde Wet, dat die bepalings van die Wysigingsooreenkoms, uitgesonderd dié vervat in klousules 1 (1) (a), 2, 4 en 5, met ingang van die tweede Maandag na die datum van publikasie van hierdie kennisgewing en vir die tydperk wat op 30 Junie 1987 eindig, bindend is vir alle ander werkgewers en werknemers as dié genoem in paragraaf (a) van hierdie kennisgewing wat betrokke is by of in diens is in genoemde Onderneming, Nywerheid, Bedryf of Beroep in die gebiede in klousule 1 van die Wysigingsooreenkoms gespesifiseer.

P. T. C. DU PLESSIS,
Minister van Mannekrag.

BYLAE

NYWERHEIDSRAAD VIR DIE ELEKTROTEGNIESE NYWERHEID (NATAL)

SIEKTEBYSTANDSFONDS

OOREENKOMS

ooreenkomstig die Wet op Arbeidsverhoudinge, 1956, gesluit deur en aangegaan tussen die

Electrical Contractors' Association (South Africa)

(hierna die "werkgewers" of die "werkgewersorganisasie" genoem), aan die een kant, en die

South African Electrical Workers' Association

(hierna die "werknemers" of die "vakvereniging" genoem), aan die ander kant,

wat die partye is by die Nywerheidsraad vir die Elektrotegniese Nywerheid (Natal),

om die Ooreenkoms, gepubliseer by Goewermentskennisgewing R. 992 van 23 Mei 1986 (hierna die Herbekragtigingsooreenkoms genoem) soos verleng by Goewermentskennisgewing R. 1334 van 27 Junie 1986, te wysig.

DEEL I

1. TOEPASSINGSBESTEK VAN OOREENKOMS

(1) Hierdie Ooreenkoms moet nagekom word deur werkgewers en werknemers in die Elektrotegniese Nywerheid—

(a) wat lede van onderskeidelik die werkgewersorganisasie en die vakvereniging is; en

(b) wat betrokke is by of in diens is in die Nywerheid in die landdrosdistrikte Alfred, Babanango, Bergville, Camperdown, Chatsworth, Dannhauser, Dundee, Durban, Eshowe, Estcourt, Glencoe, Hlabisa, Impendle, Inanda, Ingwavuma, Ixopo, Kliprivier, Kranskop, Lionsrivier, Lower Tugela, Lower Umfolozi, Mahlabatini, Mapamulo, Mooirivier, Msinga, Mtonjaneni, Mtunzini, Ndwedwe, Newcastle, New Hanover, Ngotshe, Nkandla, Nongoma, Nqutu, Paulpietersburg, Pietermaritzburg, Pinetown, Polela, Port Shepstone, Richmond, Ubombo, Umbumbulu, Umvoti, Umzinto, Underberg, Utrecht, Vryheid en Weenen, maar uitgesonderd die gedeeltes van hierdie landdrosdistrikte wat ingevolge Proklamasie R. 11 van 1977 in die *Staatskoerant* van 28 Januarie 1977 verskyn het, binne die selfregerende gebied KwaZulu val, in die werksaamhede uiteengesit in paragrawe (a), (b) en (c) van die omskrywing van "Elektrotegniese Nywerheid" in klousule 3 van die Ooreenkoms gepubliseer by Goewermentskennisgewing R. 967 van 13 Mei 1983.

(2) Ondanks subklousule (1), is hierdie Ooreenkoms nie van toepassing nie op—

(a) werknemers in diens van die werkgewers in subklousule (1) bedoel wat, hoewel hulle ingevolge die geregistreerde bestek van 'n vakvereniging wat 'n party by hierdie Ooreenkoms is lede van so 'n vakvereniging kan word, nie lede van so 'n vakvereniging is nie;

(b) werknemers uitgesonderd dié in diens van werkgewers in subklousule (1) bedoel.

2. KLOUSULE 3.—SPESIALE BEPALINGS

Vervang klousule 3 van die Herbekragtigingsooreenkoms deur die volgende:

"Die bepalings vervat in klousule 9 van Deel I en klousule 1 (soos gewysig by klousule 4 hieronder), klousule 2 (soos gewysig by klousule 5 hieronder), 3 en 4 van Deel II van die Ooreenkoms soos gepubliseer by Goewermentskennisgewing R. 2827 van 30 Desember 1983, soos gewysig by Goewermentskennisgewing R. 2481 van 16 November 1984 (hierna die "Vorige Ooreenkoms" genoem), is van toepassing op werkgewers en werknemers."

(b) in terms of section 48 (1) (b) of the said Act, declare that the provisions of the Amending Agreement, excluding those contained in clauses 1 (1) (a), 2, 4 and 5, shall be binding, with effect from the second Monday after the date of publication of this notice and for the period ending 30 June 1987, upon all employers and employees, other than those referred to in paragraph (a) of this notice, who are engaged or employed in the said Undertaking, Industry, Trade or Occupation in the areas specified in clause 1 of the Amending Agreement.

P. T. C. DU PLESSIS,
Minister of Manpower.

SCHEDULE

INDUSTRIAL COUNCIL FOR THE ELECTRICAL INDUSTRY (NATAL)

SICK PAY FUND

AGREEMENT

in accordance with the provisions of the Labour Relations Act, 1956, made and entered into by and between the

Electrical Contractors' Association (South Africa)

(hereinafter referred to as the "employers" or the "employers' organisation"), of the one part, and the

South African Electrical Workers' Association

(hereinafter referred to as the "employees" or the "trade union"), of the other part,

being the parties to the Industrial Council for the Electrical Industry (Natal),

to amend the Agreement published under Government Notice R. 992 of 23 May 1986 (hereinafter referred to as the Re-enacting Agreement), as extended by Government Notice R. 1334 of 27 June 1986.

PART I

1. SCOPE OF APPLICATION OF AGREEMENT

(1) The terms of this Agreement shall be observed by employers and employees in the Electrical Industry—

(a) who are members of the employers' organisation and the trade union, respectively; and

(b) who are engaged or employed in the Industry in the Magisterial Districts of Alfred, Babanango, Bergville, Camperdown, Chatsworth, Dannhauser, Dundee, Durban, Eshowe, Estcourt, Glencoe, Hlabisa, Impendle, Indanda, Ingwavuma, Ixopo, Klip River, Kranskop, Lions River, Lower Tugela, Lower Umfolozi, Mahlabatini, Mapamulo, Mooi River, Msinga, Mtonjaneni, Mtunzini, Ndwedwe, Newcastle, New Hanover, Ngotshe, Nkandla, Nongoma, Nqutu, Paulpietersburg, Pietermaritzburg, Pinetown, Polela, Port Shepstone, Richmond, Ubombo, Umbumbulu, Umvoti, Umzinto, Underberg, Utrecht, Vryheid and Weenen, but excluding any portions of those Magisterial districts falling within the self-governing territory of KwaZulu in terms of Proclamation R. 11 of 1977, which appeared in the *Government Gazette* of 28 January 1977, in the operations set forth in paragraphs (a), (b) and (c) of the definition of "Electrical Industry" in clause 3 of the Agreement published under Government Notice R. 967 of 13 May 1983.

(2) Notwithstanding the provisions of subclause (1), the terms of this Agreement shall not apply to—

(a) employees employed by the employers referred to in subclause (1) who, whilst being allowed in terms of the registered scope of a trade union which is a party to this Agreement to become members of such a trade union, are not members of such a trade union;

(b) employees other than those employed by employers referred to in subclause (1).

2. CLAUSE 3.—SPECIAL PROVISIONS

Substitute the following for clause 3 of the Re-enacting Agreement:

"The provisions of clause 9 of Part 1 and clause 1 (as amended by clause 4 hereunder), clause 2 (as amended by clause 5 hereunder), 3 and 4 of Part II of the Agreement published under Government Notice R. 2827 of 30 December 1983, as amended by Government Notice R. 2481 of 16 November 1984 (hereinafter referred to as the "Former Agreement"), shall apply to employers and employees."

3. KLOUSULE 4.—ALGEMENE BEPALINGS

Vervang klousule 4 van die Herbekragtigingsooreenkoms deur die volgende:

"Die bepalings vervat in klousule 3 (soos gewysig by klousule 5 van die Herbekragtigingsooreenkoms) 4 tot 8 en 10 tot 16 van Deel I en klousule 1, 2 (soos gewysig by klousule 6 hieronder), 3 en 4 van Deel III van die Vorige Ooreenkoms, is van toepassing op werkgewers en werknemers."

DEEL II

SKEMA A

3. KLOUSULE 1.—LIDMAATSKAP

(1) In subklousule (1) (a), vervang die syfer "R2,26" deur die syfer "R2,48".

(2) In subklousule (1) (c), vervang die syfers "R3,32", "R149,40" en "R647,40" deur onderskeidelik die syfers "R3,60", "R162,00" en "R702,00".

(3) In subklousule (2), vervang die syfers "R2,26", R101,70" en "R440,70" deur onderskeidelik die syfers "R2,48", "R111,60" en "R483,60".

4. KLOUSULE 2.—BYDRAES

In subklousule (1), vervang die bestaande tabel deur die volgende:

"Loongroep per week	*Bedrag per week*
	c
Oor R242	40
Oor R217 en tot R242	36
Oor R174 en tot R217	34
Oor R150 en tot R174	30
Oor R124 en tot R150	27
R124 en minder	20".

DEEL III

SKEMA B

5. KLOUSULE 2.—BYDRAES

In subklousule (1), vervang die bestaande tabel deur die volgende:

"Loongroep per week	*Bedrag per week*
	c
Oor R242	40
Oor R217 en tot R242	36
Oor R174 en tot R217	34
Oor R150 en tot R174	30
Oor R124 en tot R150	27
Oor R107 en tot R124	20
Oor R90 en tot R107	18
R90 en minder	16".

Soos gemagtig, vir en namens die partye op hede die 1ste dag van April 1986 te Durban onderteken.

B. NICHOLSON,
Voorsitter van die Raad.

M. F. PRINSLOO,
Ondervoorsitter van die Raad.

D. F. ANTHONY,
Sekretaris van die Raad.

No. R. 2070 **26 September 1986**

WET OP ARBEIDSVERHOUDINGE, 1956

JUWELIERSWARE- EN -EDELMETAALNYWERHEID (KAAP).—HERNUWING VAN HOOFOOREENKOMS

Ek, Mattheus Willem Johannes le Roux, Direkteur: Mannekrag, behoorlik daartoe gemagtig deur die Minister van Mannekrag, verklaar hierby, kragtens artikel 48 (4) (a) (ii) van die Wet op Arbeidsverhoudinge, 1956, dat die bepalings van Goewermentskennisgewing R. 1133 van 8 Junie 1984, van krag is vanaf die datum van publikasie van hierdie kennisgewing en vir die tydperk wat op 31 Januarie 1987 eindig.

M. W. J. LE ROUX,
Direkteur: Mannekrag.

3. CLAUSE 4.—GENERAL PROVISIONS

Substitute the following for clause 4 of the Re-enacting Agreement:

"The provisions contained in clauses 3 (as amended by clause 5 of the Re-enacting Agreement), 4 to 8 and 10 to 16 of Part I and clauses 1, 2 (as amended by clause 6 hereunder), 3 and 4 of Part III of the Former Agreement, shall apply to employers and employees."

PART II

SCHEME A

3. CLAUSE 1.—MEMBERSHIP

(1) In subclause (1) (a), substitute the figure "R2,48" for the figure "R2,26".

(2) In subclause (1) (c), substitute the figures "R3,60", "R162,00" and "R702,00" for the figures "R3,32", "R149,40" and "R647,40" respectively.

(3) In subclause (2), substitute the figures "R2,48", "R111,60" and "R483,60" for the figures "R2,26", "R101,70" and "R440,70" respectively.

4. CLAUSE 2.—CONTRIBUTIONS

In subclause (1), substitute the following for the existing table:

"Wage group per week	*Amount per week*
	c
Over R242	40
Over R217 and up to R242	36
Over R174 and up to R217	34
Over R150 and up to R174	30
Over R124 and up to R150	27
R124 and under	20".

PART III

SCHEME B

5. CLAUSE 2.—CONTRIBUTIONS

In subclause (1), substitute the following for the existing table:

"Wage group per week	*Amount per week*
	c
Over R242	40
Over R217 and up to R242	36
Over R174 and up to R217	34
Over R150 and up to R174	30
Over R124 and up to R150	27
Over R107 and up to R124	20
Over R90 and up to R107	18
R90 and under	16".

Signed at Durban, as authorised, for and on behalf of the parties, this 1st day of April 1986.

B. NICHOLSON,
Chairman of the Council.

M. F. PRINSLOO,
Vice-Chairman of the Council.

D. F. ANTHONY,
Secretary of the Council.

No. R. 2070 **26 September 1986**

LABOUR RELATIONS ACT, 1956

JEWELLERY AND PRECIOUS METAL INDUSTRY (CAPE).—RENEWAL OF MAIN AGREEMENT

I, Mattheus Willem Johannes le Roux, Director: Manpower, duly authorised thereto by the Minister of Manpower, hereby, in terms of section 48 (4) (a) (ii) of the Labour Relations Act, 1956, declare the provisions of Government Notice R. 1133 of 8 June 1984, to be effective from the date of publication of this notice and for the period ending 31 January 1987.

M. W. J. LE ROUX,
Director: Manpower.

Sports plan for disabled in PE

Weekend Post Reporter

A CAMPAIGN to encourage more disabled people to take part in sport has started in Port Elizabeth's northern areas.

This follows the recent introduction of sports at the Northern Lights School in Schauderville for children with learning problems.

Forty-nine cerebral palsy pupils, aged between three and 17, attend the school.

They are concentrating on shot put and javelin events before starting other outdoor sports, like bowls.

The pupils also play table tennis and swim in an indoor pool.

Sports was introduced as an extra-mural activity because it instills self-confidence in the pupils and all are keen to play.

Sport is part of the pupils' therapy, says the principal, Mrs Estelle Davies.

"Although it is something new at the school, our sports activities are successful," she said.

"The pupils are excited about being able to play like those at other schools."

Once a week they are driven to a field behind the Livingstone Hospital to run and play their favourite team games.

Most have never played in teams before.

Those with television sets at home watch sports programmes regularly, but had never attended a live sports event because of their handicap.

Other disabled people in the area have recently shown an interest in sports.

Mrs Davies has decided to form a "well-organised" club for them in the region and wants more to become sports-aware.

She says it would help them to meet others with similar handicaps and give them the chance to make better use of their spare time.

Inquiries: Mrs Davies, ☎ 433210 or ☎ 843915.

NM1/3/10/86 (299)

Medical aid schemes 'must explain rises'

PRETORIA—The Representative Association of Medical Schemes (RAMS) had said it would not be granting increases in the 1987 scale of benefits for doctors' services, but the time had come for the schemes to explain this in view of the increases in members' contributions, the Medical Association of South Africa (Masa) said yesterday.

In a comprehensive statement issued in Pretoria, the medical association rejected allegations by RAMS that doctors doubled their incomes every four years as 'deliberate mischief-making' and an attempt to justify the supposed financial problems of medical schemes.

Masa's federal council chairman, Dr Rene le Roux, said in the statement that RAMS had informed it there would be no increase in the scale of benefits for next year as far as doctors were concerned, but that there would apparently be minor adjustments when it came to hospitals and day clinics, dentists and physiotherapists.

'Masa is most dissatisfied and upset about this extremely shortsighted decision ... it will be to the detriment of the public at large.

'RAMS's recent allegations against the medical profession were clearly an attempt to influence public opinion in order to justify this step,' Dr le Roux said.

According to Masa's information, about 80% of doctors charged medical scheme tariffs and not the tariffs Masa recommended.

It was, however, obvious that because of uncontrollable increases in practice costs, doctors could be forced to apply the higher tariff in order to make ends meet.

'This means that patients would have to pay out of their own pockets the difference

'Masa believes the time has come for medical aid schemes to explain to their members exactly why they are not prepared to increase their benefits for medical services, in spite of increases in membership contributions of between 25% and 100% during 1986.'

If one took into account that the total monthly contribution (including the employer's contribution) of a member of a scheme with three dependants and earning between R800 and R1 000 monthly was more than R200, 'it is obvious that assurance for private medical services is becoming an increasingly heavy burden to the consumer'.

RAMS had granted an overall increase of 12,5% in the scale of benefits at the beginning of the year and the previous adjustment, 8,8%, had been in July 1984, Dr le Roux said.

He was 'extremely concerned about the future of private health care in South Africa'.

'Whereas the State has expressed its commitment towards privatisation, the private practitioner is finding it increasingly difficult to render the best standards of health care,' he said. — (Sapa)

DD.11/10/86 299

Medical aid: Masa challenges schemes

PRETORIA — The Representative Association of Medical Schemes (Rams) said it would not be granting increases in the 1987 scale of benefits for doctors' services, but the time had come for the schemes to explain this in view of their members' contributions having been raised by between 25 and 100 per cent in 1986, the Medical Association of South Africa (Masa) said yesterday.

In a statement, Masa rejected allegations by Rams that doctors doubled their incomes every four years as "deliberate mischief-making" and an attempt to justify the supposed financial problems of medical schemes.

Masa's federal council chairman, Dr Rene le Roux, said in the statement that Rams had informed it there would be no increase in the scale of benefits for next year, as far as doctors were concerned, but that there would apparently be minor adjustments when it came to hospitals and day clinics, dentists and physiotherapists.

According to Masa's information, about 80 per cent of doctors charged medical schemes tariffs and not the tariffs Masa recommended.

It was, however, obvious that because of uncontrollable increases in practice costs, doctors could be forced to apply the higher tariff in order to make ends meet. — Sapa

Medical aid scheme chief warns doctors

No direct payment if you charge more

Mercury Reporter

DOCTORS can charge patients more than the prescribed medical aid rates, but then they may not demand direct payment from the schemes.

This was said yesterday by Mr Jan Ferhout, chairman of the Representative Association of Medical Schemes (RAMS).

He was reacting to a statement made by Dr Renee le Roux, federal council chairman of the Medical Association of South Africa (Masa) after RAMS had announced that there would be no increase in the scale of benefits for doctors.

In the statement, Dr le Roux had warned that more doctors could be forced to apply the higher costs and that patients would then be forced to pay the difference out of their own pockets.

It was time, the Masa statement went on to say, that medical aid schemes explained to their members why they were not prepared to increase their benefits for medical services in spite of increasing membership contributions by between 25% and 100% during this year.

But Mr Ferhout hit back, saying the reasons behind the exclusion of doctors had been carefully explained at a meeting with Masa.

'The cost of medical services increased by 25% last year, against an expected 12%, and the doctors benefitted from it.

'Our decision not to give them an increase is not harsh, but the costs of private hopsitals, dentists and medicines have all gone up as well and have to be taken into consideration. It has to be evenly spread out,' he said.

Prerogative

While emphasising that he did not want 'to pick a fight' with doctors, Mr Ferhout said it was strange that Masa had not made it clear — when threatening that more doctors would charge the higher rate — that they would not be able to demand direct payment for their services.

'In terms of the Medical Aid Act, if a doctor treats a patient and charges the fixed rate he is entitled to expect to be paid out by the scheme immediately. If he charges the higher rate, he does not,' he said.

He added that charging the higher rate 'is nothing new' and that doctors have always had the prerogative to do so and that many do.

'But the patient does have to pay the difference out of his own pocket and payment from the schemes then takes longer,' he said.

● See Editorial Opinion

DD 31/10/82

Call to use special job skills

299

BLOEMFONTEIN — Although a general economic revival had been predicted, it could safely be accepted that the unemployment problem in South Africa would not be solved in the short term, Professor N. P. du Preez, of Potchefstroom University, said at the symposium on disablement in Bloemfontein yesterday.

He said there was a great shortage of certain categories of skilled and highly-skilled labour in South Africa and disabled people were a unique resource for those fields.

Professor Du Preez is the director of the postgraduate School for Management and professor of the Department of Business Administration.

He said it offered a unique opportunity and a great challenge to disabled people in South Africa to sell this resource to the private sector.

The low employment of disabled persons could be ascribed to a variety of factors. There was ignorance on the employers' part as to the capabilities and skills of disabled persons. This ignorance was largely due to deficient and unco-ordinated "marketing" of the disabled.

Professor Du Preez said as the costs of training the disabled were high, the country could not afford that people on whom so much time, energy and money had been spent to make them labour-ready and self-supporting, should be wrongly or unemployed.

There was thus a need for a national awareness of the disabled as an employee. Employers would have to be informed of their productivity, potential, social acceptance, low absenteeism and skills. Emphasis would have to be laid on the fact that disabled employees achieved the same or better in these respects than non-disabled. — Sapa

Doctors' medical benefits frozen

Dispatch Correspondent

JOHANNESBURG — Medical aid benefits for doctors' bills will not be increased next year.

Announcing the decision, the Representative Association of Medical Schemes (Rams) said it was trying to "shelter" medical aid members and their employers by slowing down the "huge escalation in medical aid costs that they have been subjected to over the past year".

Dentists are to get an across-the-board increase of 9,25 per cent, while an amended scale of benefits for physiotherapists would give them an effective eight per cent increase.

Rams, the statutory body representing the country's entire medical schemes movement, also voted a 12 per cent increase in private hospital ward fees.

The increases are all below those requested, but they would still force most medical schemes to put up their subscription rates from January 1 when the new fees go into effect, said the Rams chairman, Mr Jan Fernhout.

Rams decided that as doctors had effectively increased their incomes by 25 per cent this year — double the increase granted on January 1 this year — they should not enjoy an adjustment to the existing scale of benefits.

Cost of staying alive set to spiral with higher medical fees

Hospital expenses range from basic of 50c a day in a general ward to R113 for private room with a bath



Soaring bills will hit the mid-income group

By YVONNE STEYNBERG

THE man in the street faces massive hikes in personal payments for medical treatment next year.

Medical fees are set to increase dramatically.

The result will be that after medical aid has paid its portion of the costs, the average patient will be left with a considerably high payment to cover his share of the bill.

"People should be warned they are going to be faced with escalating medical bills because costs are soaring and the cost of drugs is increasing again," Dr Angus Hofmeyr, Eastern Cape branch chairman of the Medical Association of South Africa (Masa), told Weekend Post.

It is estimated that medical aid subscriptions will go up by a minimum of 10% to 12% to cover basic costs in 1987, but even without this patients will already be paying more.

This follows a year in which some medical aid contributions have risen by as much as 25%. Many subscribers are already battling to pay additional charges because of the spiralling cost of living.

Dr Hofmeyr said the Representative Association of Medical Schemes (Rams), which had obtained statutory rights in the Medical Schemes Act and was the mouthpiece for all medical aid schemes, did not want to increase fees.

Rams' schedule of benefits was gazetted and became legally binding.

One doctor said he knew of a case where a family man received a R4 488 bill. His medical scheme paid R1 250 and he had to pay the remaining R3 238.



Dr ANGUS HOFMEYR ... There are going to be escalating medical bills.

Bills totalling thousands of rands are possible for private hospitalisation.

A low-income patient pays from 50c a day for a bed in a provincial hospital, but when a patient's tax bill exceeds R645 a year — the lower middle income group — he pays full fees.

This is at present R63 a day in a general ward, plus medicine, theatre fees, X-rays and doctors.

Doctors maintain they are being unfairly blamed for rising costs.

"Considering that there are three main categories of medical expenses — hospitalisation, drugs and doctors — the doctor accounts for less than one-third of the bill," Dr Hofmeyr said.

All energies seemed to be directed at discrediting the medical profession. He felt the other costs involved in illness should be investigated by medical schemes in an effort to cut costs.



Dr PIERRE DU TOIT ... "tests and expensive drugs are major factors".

Many people being admitted to hospitals had no idea of the eventual costs possible.

But Dr Pierre du Toit, chairman of the Provincial Hospital Medical Committee, said: "At least in provincial hospitals a patient knows that less expensive though equally effective drugs will be used, and expensive investigations, scans, X-rays and tests will be kept to a necessary minimum."

Patients should not be kept in hospital unnecessarily, he said.

Medical costs could soar when doctors prescribed expensive drugs, investigations and X-rays or kept patients in hospitals too long.

A study of the Government's "New Dispensation Health Plan for South Africa", which gives six levels of service, is said by some medical men to give a false impression that all people and all races would benefit from the plan, as stated in the glossy booklet.

● A study of the dispensation indicates that the middle income groups will be hit hardest by the increases

WHAT expenses could you face in hospital?

Claims by doctors that middle-income earners will fare worst under the Government's "New Dispensation for Health Services" plan, led the Weekend Post to investigate costs at various hospitals.

Here they are:

PROVINCIAL HOSPITAL:

● A poor patient or pensioner can get a bed in a general ward from 50c a day.

● If such a patient cannot pay for drugs, X-rays and theatre, the charges are mostly waived.

● Anyone paying income tax of more than R645 a year is admitted at the normal rate, presently R63 a day for a bed in a general ward, plus medicine, theatre and relevant fees.

● Theatre fees can range from about R80 to a maximum of R168.

● A private room (no bathroom) costs R88 a day.

● The intensive care fee is R144 a day.

(Doctors said many people were unaware intensive care units carried an additional fee.)

ST JOSEPH'S HOSPITAL, Park Drive:

● A bed in a general ward costs R73,50 a day.

● A private room with a shower and toilet being shared between two adjoining rooms costs R81,50.

● A suite with full separate bathroom and French doors leading to a private balcony costs R89,50 a day. Telephones are provided at an extra charge.

St Joseph's has no intensive care section.

Medicine and theatre fees must be added to these charges.

POLIYCLINIC, GREENACRES MEDICAL CENTRE:

Dr Jaap Huisamen, executive chairman of Poli Clinic, said costs fell within the spectrum of medical aids and workmen's compensation payments as gazetted.

Costs differed between patients on a medical aid scheme or without one.

● A bed in a general ward — R73,50 for medical aid patients and R81,70 for patients with no medical aid.

● Semi-private wards (two beds and bathroom) — R87,60 for patients with medical aid and R97,30 for patients with no medical aid.

● Private ward (one bed and bath) — R107,70 for patients with medical aid and R113,00 for patients with none.

● An intensive care unit costs R168 a day (medical aid) and R187,50 (no medical aid).

● To these charges must be added theatre costs, medicine, X-rays and doctors' fees.

● Theatre fees are: 1 to 15 minutes — R103,50; 16 to 30 minutes — R121,50; 31 to 45 minutes — R140,50; 46 to 60 minutes — R160,50; after the first hour, R39 for each 15 minutes.

● The initial fee for admission to casualty is R20, plus medicine and treatment.

Private hospitals threaten to quit

Another row brews over medical aid

3 Dec 1985
14/10/85
299

PRIVATE hospitals are threatening to quit the medical aid system over the low level of benefit increases granted by medical aid societies.

If they do, patients will have to dig into their own pockets to pay towards the cost of their hospital treatment.

Representative Association of Private Hospitals (RAPH) officials will meet on Thursday to discuss whether to stay within the system. Chairman Dick Williamson said there was "a strong chance" they would opt out.

The hospitals are angered by the latest table of benefit scales approved by the Representative Association of Medical Schemes (Rams). These scales are the maximum amount medical aid societies will pay for members' treatment.

Hospitals say the new scale, which applies from January 1, offers an average 7% increase. The hospitals had asked for 20%.

Williamson said: "That's an enormous disparity."

He said annual increases approved by Rams had been consistently below inflation. Average benefit scales rose 12% on January 1 this year, 10% last year and 6,25% in 1984. During the same period,

DAVID FURLONGER

overall hospital costs had risen faster than inflation.

The private-hospitals sector is dominated by three investors — Afrox, Clinic Holdings and the Rembrandt Group. However, many smaller investors are also involved.

Williamson said: "Return on private hospitals capital is declining. Margins are down substantially."

He blamed rising costs on improved nursing salaries, particularly among blacks, and the cost of imported equipment. Private hospitals would probably have to match recent pay rises among provincial nursing staff of between 20% and 40%.

Williamson said: "It would be bad for the health industry if we pulled out of the medical aid system. It would have a serious effect on people and there would be an uproar."

If private hospitals decide to opt out and charge their own rates for treatment, patients themselves could be faced

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New row over medical aid

⇦ ● From Page 1

with major medical bills. Medical aid societies would continue to pay the approved benefit, and members would pay the difference.

Rams chairman Jan Fernhout said: "If hospitals charge the agreed tariff, we pay direct and in full. If they charge more, we pay the member our benefit and he has to settle with the hospital."

Fernhout said that in setting its latest benefit scale, Rams had anticipated hospital rebellion. He said: "We foresaw some hospitals might want to withdraw — but not all of them."

He said the latest 7% increase could be less than the hospitals' needs but added it was the most medical aid societies themselves could afford without substantially increasing members' contributions.

Fernhout said: "We had to look at our own cost problems. That was the most the schemes could bear."

He said a benefit of patients having to pay towards treatment was that they would become more cost-conscious. They would "shop around" for hospital treatment they could afford instead of wasting money on unnecessary "five-star" treatment.

Hospitals may quit medical aid system

Mercury Correspondent

JOHANNESBURG—Private hospitals are threatening to quit the medical aid system because of the low benefit increases granted by medical aid societies.

If they do, patients will have to dig into their own pockets to pay towards the cost of their hospital treatment.

Officials of the Representative Association of Private Hospitals will meet on Thursday to discuss whether to stay within the system. According to chairman Dick Williamson, there is 'a strong chance' they will opt out.

The hospitals are angered by the latest table of benefit scales approved by RAMS, the Representative Association of Medical Schemes. These scales are the maximum amount medical aid societies will pay for members' treatment.

Disparity

Hospitals say the new scale, which applies from January 1 next year, offers an average 7% increase. The hospitals had asked for 20%.

'That's an enormous disparity,' said Mr Williamson.

He said annual increases approved by RAMS had been consistently below inflation.

'It would be very bad for the health industry if we pulled out of the medical aid system,' Mr Williamson added. 'It would have a serious effect on people and there would be an uproar.'

RAMS chairman Jan Fernhout said last night that in setting its latest benefit scale, RAMS had anticipated hospital withdrawal. 'We foresaw some hospitals might want to withdraw — but not all of them.'

He admitted the latest increase could be less than the hospitals' needs but said it was the most medical aid societies themselves could afford.

14/10/86

Some medical aïds will pay for self-medication

(299)

By DENISE BOUTALL

YOU can take every cough to the doctor, but you can also take it to your local pharmacist — and some medical aid societies will even pay for the cough mixture.

Two Port Elizabeth-based medical societies took the lead last year when they introduced self-medication schemes (SMS) as an additional benefit to members.

However, in an interview the chairman of the Eastern Cape branch of the Medical Association of South Africa, Dr Angus Hofmeyr, warned that quick, accurate diagnosis by a doctor was vital when it came to dealing with potentially serious illnesses and accused the medical aid societies of introducing SMS for financial rather than health reasons.

Spokesmen for the two societies, Midland Medical Plan (MMP) and the MCI Medical Scheme, said, however, that it was impossible to say yet whether they had actually saved money over the last year.

Under both schemes members suffering from any one of 19 minor ailments can discuss their symptoms with their pharmacist who can recommend that they take a certain drug which can be bought over the counter. The drugs should be sufficient for only three days and if the symptoms persist the member is encouraged to consult a doctor.

The medical aid societies will pay up to R10 for drugs recommended by pharmacists.

Dr Hofmeyr said self-medication schemes were an attempt to bypass doctors. "The sooner a patient receives proper services and access to diagnostic facilities, the better the chances of quick, accurate diagnosis."

Medical aid societies were big business and he suspected that their motives for introducing self-medication schemes were financial.

Dr Hofmeyr said he found it distasteful that medical aid societies were dictating the relationship between the medical and the pharmaceutical professions.

The societies should look at the increasing costs of hospitalisation and drugs rather than at the medical profession to save costs.

Masa could not condone the introduction of self-medication schemes and the matter was being discussed at national level.

A spokesman for the MCI Medical Scheme said the self-medication scheme had been introduced in October, 1985, as an additional benefit, not to encourage members to consult a pharmacist rather than a doctor.

He could not comment on the cost saving involved. He said he was surprised at the response of the medical profession to self-medication. "We've approached the whole thing in a very responsible manner."

The general manager of the Midland Medical Plan, Mr Mike Cross, said one of the reasons for introducing the scheme was that some members never used a pharmacist but always consulted dispensing doctors so that they could claim all their medicines from the society.

"This scheme makes it easier for them to get basic medication without paying a doctor's consultation fee as well."

The saving to the society, if anything, was minimal but was picking up in certain areas.

He said the society was not trying to push its 14 500 members into unsafe health practices.

The executive director of the Cape Midland Checking Services of the Pharmaceutical Society of South Africa, Mr Alan Walter, said before the advent of medical aid societies people had often depended on their pharmacists for advice on medicines to treat minor ailments.

Medical aid made it possible for them to claim all their costs if they consulted a doctor. "Now we are channelling them back to the pharmacies."

Due to the high cost of medicines patients tended to look at the price of over the counter medicines and then opt to consult a doctor so that they could claim the cost from their medical aid societies.

Clinics divided over medical aid

PRIVATE hospitals failed to reach a decision yesterday on whether to opt out of the medical aid system.

However, sources said a decision could not be ruled out in the future.

The issue was discussed at an executive committee meeting of the Representative Association of Private Hospitals, following the latest hospital fee increase approved by medical aid societies.

The hospitals asked for an average 20% but were granted 7%.

A source said: "It would be true to say no decision was reached on the matter, rather than that members decided against opting out of the medical aid system."

The private hospitals sector is dominated by three investors — Afrox, Rembrandt and the Clinic Holdings Group.

Clinic Holdings, which this week expressed its opposition to quitting the medical aid system, did not attend yesterday's meeting.

Private hospital fees to be raised

Mercury Reporter

PRIVATE hospital fees throughout South Africa are expected to go up by 12% from January next year — an increase of up to R22 a day in some instances.

Most private hospitals in Durban confirmed yesterday that they currently charged according to the scales agreed to by the Representative Association of Medical Aid Schemes (RAMS), and that fees would increase by 12% once official agreement had been reached.

Earlier reports had indicated that several private hospitals had threatened to contract out of their agreements with the medical aid societies after losing the battle for a 20% increase.

Instead, RAMS agreed to a 12% increase in ward benefits.

But Mr Lionel Goldman, administrator of St Augustine's Hospital, said there was never any question of any of the Natal hospitals — Parklands, Kingsway and St Augustine's — which fall under Mediclinic Holdings, 'contracting out'.

'There was never any question of our pulling out of the agreement. As it is we have had no official notification of the 12% increase, and will only implement it when we do,' he said.

The current benefits allowed for general wards are R73 50 a day in a surgical ward; R78 a day in a medical, thoracic or neurological ward; R113 a day in a post operative care ward, and R168 50 a day in an intensive care or coronary care ward.

Go up

A spokesman for Entabeni Hospital confirmed that charges at the hospital were also in accordance with the set benefits and that they would go up once the increase had been officially accepted by the Private Hospitals' Association.

Asked to comment on the increases, Dr Roy Davey, chairman of the General Practitioners' Society, said: 'RAMS granted their increases, yet turned down the doctors request for an increase. Surely some questions should be asked?'

RAMS 27/10/86 299

Medical-aid decision 'bad, bad news'

Medical Reporter

THE decision not to increase the scale-of-benefits fees for doctors next year was "bad, bad news", an editorial in the South African Medical Journal says.

The decision by the Representative Association of Medical Aid Schemes (Rams) was bad not only for doctors charging scale-of-benefits fees, but also for the public.

The Medical Association of South Africa (Masa) was "well aware of the financial stringencies" being experienced by many of its members and had continued to negotiate with Rams "in a reasonable and responsible manner in spite of a growing awareness that Rams was playing a game of its own", the editorial says.

Eleven doctors had been declared insolvent in the first six months of this year, making suggestions that doctors doubled their incomes every four years "ludicrous".

Masa took seriously the suggestion that medical schemes were in financial difficulties and invited the chairman of Rams to discuss the matter with its federal council.

The editorial said about 80 percent of doctors charged medical-aid tariffs and not the tariffs recommended by Masa.

"The result of the Rams decision not to raise the scale-of-benefits fees is that more doctors will be tempted to charge the higher Masa tariff and patients will have to pay the difference out of their own pockets."



THIS was the scene at the Sandton Town Council mayoral parlour this week when the Disabled People South Africa (DPSA) launched its "Self-Help Week" for the physically disabled. (From left) are, Mr Ivan Louw, Mr Patrick Mabunda, Mr Allen Kaas and Mrs Penny Metcaf.

Pic: MBUZENI ZULU

Self-help for the disabled

299 Sowetan 27/10/86

THERE is a growing awareness of the desperate situation faced by disabled people in townships and rural areas, says the chairperson of Disabled People South Africa.

According to Dr William Rowland, this together with the spectacular success of some self-help initiative, has prompted DPSA to campaign for the development of self-help groups on a national scale.

The DPSA is a national coalition of disabled individuals and self-help groups which gives its members a forum for the exchange of views and experiences. It also seeks to stimulate the self-help initiative among the disabled people in the country.

It was founded in September 1984 and launched in March last year. It comprises of people of different disabilities, colour, race, age and culture who have come together to work for equal opportunity and participation in the society to which they all belong.

Campaign

DPSA has designated this year as the year of "Emerging Self-Help Campaign". This campaign is led by DPSA's vice-chairperson, Mr Friday Mavuso, who is the driving force and chairperson of the Self-Help Association of Paraplegics in Soweto (Shap).

Dr Rowland says the aim of the campaign is to seek out potential co-ordinators of self-help groups and expose them to successful projects.

It is also aimed at bringing them together to share experiences, assist them in questions of goal setting, administration and fund-raising and maintaining the process of development through continued contact and evaluation.

To date, contact has been made with emerging groups in Soweto; Kagiso, Sebokeng, Duduza, Mamelodi, Tembisa, Alexandra, Eldorado Park, Ennerdale, Newcastle and other areas.

DD 31/10/86

Call on transport for handicapped

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BLOEMFONTEIN —The transport of the physically handicapped by public or private vehicles had been sadly neglected, a senior Road Safety Council member said yesterday.

Mrs F. V. Muller, the Council's acting assistant director for education, was speaking at a symposium on disablement in Bloemfontein.

She said that if the physically handicapped were to be self-supporting and contribute to the economy, all aids should be used to make them mobile and of service to society.

Much attention was being given to mass transport, but the largest portion of wheelchair-bound people used private motor vehicles.

She said the general feeling toward disabled drivers was relatively negative, but research had shown the driving skills of physically handicapped people were significantly higher than those of other drivers. — Sapa

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Action on rights for SA disabled urged

BLOEMFONTEIN — There should be a Bill of Rights for disabled people, cast in a mould appropriate to the South African legal system, the executive director of the South African National Council for the Blind and chairman of Disabled People South Africa, Dr William Rowland, said at the National Symposium on Disablement in Bloemfontein yesterday.

Such a bill would extend to people with disabilities the civil liberties and fundamental freedoms enjoyed by all citizens. It would provide opportunities for disabled people to develop their abilities in the most varied fields, promote their integration into normal life and ensure social justice, said Dr Rowland.

In South Africa, as elsewhere in the world, there had emerged a new spirit of independence among disabled people, expressed in a movement known, variously, as independent living, self-help or the disability rights movement. It meant that disabled people wished to be consulted in matters that affected their lives, that they chose to represent themselves and that they expected to be employed in the service system.

It was of the utmost importance that this movement be recognised officially and that a channel of direct communication be established between the elected leaders and the government.

"We accept that rights are matched by obligations. Therefore, it is our responsibility to contribute to society in general and our special responsibility to defend the rights of all minorities, but especially of disability groups more disadvantaged than our own," said Dr Rowland.

● The representative of the Department of Health, Dr G. S. Watermeyer, said he would dissociate himself from the symposium if political issues continued to be raised.

Dr Watermeyer, the chairman of the co-ordinating committee for the Year of Disabled Persons, said polarisation should not interfere with the needs of the disabled.

He said the polarisation started when a paper directed critical comment at the quality of health and other services for various population groups.

Questions and comments with political content should not be allowed to mar "this golden opportunity" of working together. — Sapa

Poll reveals vital roll of medical aid

A third of white South Africans claimed that doctors over-prescribed on medicine and treatment, a Research Survey Omnichek public opinion poll found.

The poll revealed that 85 percent of all breadwinners in urban white homes were members of medical aid schemes.

"The high percentage of subsidised medical cover reflects the enormous umbrella cost of health care carried by medical aid societes."

Asked what sort of medical schemes their families could afford, half of the respondents wanted 80 percent cover. Forty percent said they needed 90 percent cover.

The poll followed reports that medical aid schemes were experiencing financial problems and having to increase fees.

Medical aid subs will go up yet again

GERALD REILLY

"THE spiralling cost of illness will force most of the more than 200 medical aid schemes — if not all — to raise members' subsciptions from January, or soon thereafter.

Representative Association of Medical Schemes (Rams) spokesman Tony Leveton said yesterday that the increases are likely to be 15% or more.

This comes on top of increases in subscriptions during 1986 of up to 40%.

Leveton said a straw poll indicated the costs of medicines and drugs would rise by between 30% and 35% next year.

Added to this would be the increase of 12% in all private hospital ward charges from the beginning of next year.

About half the payments made by funds to private hospitals were for drugs and medicines.

The increased medicine costs would inevitably be passed on to patients.

Leveton said Rams would not grant doctors any increases next year.

This year they got 12½%, but when the frequency-of-servicing factor was taken into account at the higher tariff, the effective increase in doctors' earnings was closer to 25%.

"When all costs hikes coming down the road are taken into account it can be expected that most funds will raise their subscriptions, some by more than 15%," Leveton said.

Medical aid fees 'set to rocket'

12/11/82 N/M

299

Mercury Reporter

ROCKETING medicine costs are the main factor which will force most medical aid societies to raise members' subscriptions by an average of 15% early next year.

This is the opinion of Mr Tony Leveton, spokesman for the Representative Association of Medical Aid Schemes (RAMS).

The increases he expects in January or shortly afterwards will come on top of subscription increases this year of up to 40%.

Mr Leveton said yesterday that by making inquiries at pharmaceutical companies — all of which had been 'cagey' — he had established that medicine price increases of between 30% and 35% were being budgeted for.

'I've no idea why the increases should be so high. We're supposed to be finished with rand-dollar variance effects and inflation.'

Private hospital ward charges would also rise by 12% at the beginning of next year. Dentists and physiotherapists would also receive an increase.

But RAMS would not grant doctors any increase next year, he said.

'We meant to give them 12,5% this year but our data shows that, for whatever reason, we gave them 25% instead.'

Patients back their doctors

NM (299) 18/11/86

Mercury Correspondent

JOHANNESBURG—A majority of white South Africans taking part in a poll on medical aid schemes have given a vote of confidence to their doctors and rejected claims that they prescribed unnecessary medicines or treatment.

A poll by Research Surveys Omnichek conducted among 1 300 men and women shows that while 35% of respondents claimed overtreatment, 61% said they had not come across unnecessary prescriptions of medicine or treatment.

The survey also revealed that 85% of all breadwinners in urban white homes are members of a medical aid scheme.

Of those who claimed experience of unnecessary prescriptions, only 39% said they had queried or registered a protest at the cost. This is compared with 52% who said they had accepted and passed such prescriptions and charges without demur.

More English-speaking respondents (48%) than Afrikaans-speaking people (28%) claimed they had registered protests about unnecessary prescriptions.

The questions were posed in the wake of recent publicity about medical aid schemes experiencing financial problems and the price of medical aid schemes being increased.

Research Survey's director Binky Kellas said: 'Given the paternalistic nature of South African business and Government, the high percentage of subsidised medical cover is not surprising. But it also reflects the enormous umbrella cost of health care carried by medical aid societies.'

When respondents were asked about the kind of medical schemes their families could afford with the increased costs, 50% nominated a scheme that provided 80% cover, 33% nominated a scheme with 100% cover while 5% said they could only afford a scheme which provided catastrophe cover.

When it came to medical cover, 88% of the breadwinners in Afrikaans families and 81% in English-speaking families said they enjoyed protection.

Married

The best-protected section was the 25-34 age group with 92% claiming a breadwinner with medical aid cover.

But 26% of whites aged 50 years or older said breadwinners did not have medical cover.

A striking 90% of people with breadwinners earning R3 500 a month or more said they had cover compared with only 79% earning R1 999 or less a month.

Results of the poll among women showed that 79% who were single or had never married had medical cover, compared with 69% who were widowed or divorced. Of the respondents questioned, 89% were married.

20/11/96
STAR

Priority needs of disabled in kaNgwane examined

By Janine Simon

Wheelchairs are a scarce resource and a priority need in kaNgwane for some disabled people. They are forced to crawl or be carried, according to Mr Friday Mavuso, on his return from a visit to the homeland.

This month the Soweto Self-Help for Paraplegics (Shap) organisation gave three wheelchairs to kaNgwane's newly formed self-help committee for disabled people.

The self-help committee, the 15th to be instigated by three-year-old Shap, is investigating priority needs of kaNgwane's disabled community.

According to a recent survey by kaNgwane's Department of Health and Welfare, the community totals almost 800.

Plans for a workshop for the disabled have already won the support of eight schools in the district. They have indicated they will order uniforms from local rather than Johannesburg-based industries, according to Miss Elda Oliphant, Shap's co-ordinator of emergent self-help projects.

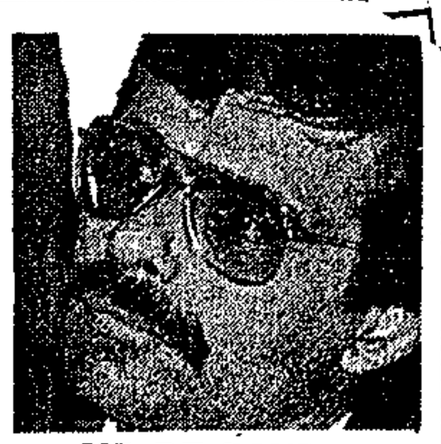
The self-help group has also been given workshop premises in a building in Mlondolozi, Don Donald, owned by the kaNgwane Development Corporation.

Priority needs for the disabled established by the departmental survey include:

- That a workshop for physically disabled people was need in each district of kaNgwane.
- That a central training centre for the 26 blind people over 18 was needed.
- That a protective and supportive service was necessary for the 28 mentally disabled adults in the Mswati district.

DD2 5/11/86 (299)

Move to establish remedial school



MR DE PONTES

Dispatch Reporter

EAST LONDON — The MP for East London City, Mr Peet De Pontes, will lead a delegation to the Minister of Education and the director of the Department of Education and Culture to discuss the establishment of a school for learning-disabled children in East London.

This was decided at a public meeting held last night by the steering committee for the establishment of the school under the auspices of the Rotary Club for Arcadia.

The chairman of the steering committee, Mr Tom Haylock, said the school would cater for pupils with average or above mental ability who had serious difficulties in learning to read, spell, write or calculate.

He said that at present such children were being catered for at schools for the neurologically handicapped and that no provision had been made in East London or the Border area for the education of these children.

"There are at present pupils from the Border area attending the Cape Recife School in Port Elizabeth.

Mr De Pontes said there was an increasing need for such a facility in the city.

"The government is aware of the problem, and is doing a substantial amount to provide the facilities in our area. Hence, the Cape Recife school was extended to accommodate another 90 children.

"The minister has been very sympathetic indeed. According to the department however, there is not a sufficient number of children with specific learning disabilities to warrant the establishment of such a school in East London especially seen against the present financial restraints."

Mr De Pontes felt that updated statistics showed a clear need for the facilities.

Mr Haylock said estimates suggested between 468 and 656 primary school children in East London could ostensibly require intensive and full-time remedial teaching.

He said the cost of establishing a school for learning-disabled children in East London need not be prohibitive, and suggested a modest beginning of a school with two classes.

He said the club had committed itself to providing financial support for the establishment of the school.

More to be spent on preventive care

Dispatch Correspondent

JOHANNESBURG — Lack of a central policy direction in South Africa's health system had led it to cater for expensive secondary and tertiary health services at the expense of preventive and primary health care.

The government, in a White Paper on the Browne Commission of Inquiry into Health Services released yesterday, said 65 per cent of its total health services went on cost intensive curative services with 4,7 per cent on preventive services, but this trend would be reversed.

The commission, appointed in 1980, finished its inquiry into the country's health services in March.

Recommendations made by the commission and accepted by government include:

● A system of accreditation for private hospitals and unattached operating theatre units.

● The curbing of excessive and unnecessary use of medical aid services by disincentives.

● The establishment of a central co-ordinating pharmaceutical authority and revision of the state's system of buying, storing and distributing medicines.

● Special assistance for trained black pharmacists to enable them to start retail pharmacies in black townships.

● The privatisation of patient transport services with emergency public ambulance services made available to all races on a 24-hour basis.

● The introduction of "catastrophic" medical aid cover, in addition to the minimum service already offered, for example for cardiac surgery.

● That the Medicine Control Council compile a list of generic equivalents it considers to be therapeutically equivalent to the original product and only those appearing on the list should be eligible for substitution.

● The reintroduction of subsidised hospitals as a method of community involvement in the health care system.

Amongst the recommendations not accepted by government are:

● The marketing of medical insurance packages and greater flexibility in setting benefit levels.

● The differentiation of blacks and whites medical aid contributions based on the lower claim percentage of blacks.

The commission recommended that private hospitals should set a comprehensive all-inclusive tariff. Government suggested tariffs should be set on a treatment-procedure-time basis instead of an item basis and the number of items that could be charged for be limited.

More to be spent on preventive health care

299 85 N/M 27/11/86

Mercury Correspondent

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Recommendations made by the commission — appointed in 1980 and which finished its inquiry in March — and accepted by the Government include:

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The curbing of excessive and unnecessary use of medical aid services by disincentives;

The establishment of a central co-ordinating pharmaceutical authority and the revision of the State's system of buying, storing and distributing medicines;

Special assistance for trained black pharmacists to enable them to start retail pharmacies in black townships;

List of generics

The privatisation of patient transport services with emergency public ambulance services made available to all races on a 24-hour basis;

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The Minister of National Health and Welfare, Dr Willie van Niekerk, said in Pretoria yesterday that profiteering by private hospitals had been alleged in evidence to the commission but was not being investigated.

The commission recommends the Government should draw up a national health policy, setting out the broad framework of the health system it will seek to establish.

Soaring heart costs stressed

WEPost 29/11/86 299

By YVONNE STEYNBERG

MEN over the age of 60 should step up their medical cover as they have reached a time in their lives when they could face massive bills for cardiac surgery not covered by medical aid.

The increased costs of surgery — already as high as R20 000 — have been stressed by medical aid societies, medical experts and cardiac specialists.

The highest risk factor is among white males over 60, many of whom may have retired from firms where they were covered for medical costs.

Most medical aids do not cover costs for cardiac operations in private hospitals, where many operations are performed.

Dr A Bosman, head of the department of medicine and physician in charge of the cardiac section of the Provincial Hospital, Port Elizabeth, said it was an excellent idea for medical aid societies to start drawing attention to the need for providing additional cover for cardiac operations.

"In Cape Town the costs could be anything from R15 000 to R18 000 in a private hospital, depending on the length of stay and treatment, and in Johannesburg it would be more," he said.

He said the two provincial hospitals in Cape Town often had waiting lists and patients forced to go to a private hospital would have to bear the additional costs themselves if they were not covered by medical aid for such an emergency.

"A waiting period is, of course, extremely dangerous for a patient with severe cardiac problems, as thrombosis and many other factors can complicate conditions," Dr Bosman said.

He confirmed that the high risk group was white males aged about 65.

Dr Bosman said the Provincial Hospital's recently opened cardiac section had three or four beds.

They had to serve all cardiac operations, including bypass and heart valve operations, and treatment of congenital heart disease.

A spokesman for a major medical aid society in PE said his organisation was negotiating with firms to introduce a higher medical aid cover for cardiac surgery.

He knew of a case of a man who had recently retired and had to have a bypass operation.

Because of the waiting list in Cape Town, he had to go to a private hospital where his bill was already about R14 000.

Provincial Hospital superintendent Dr L Cilliers said that depending on the length of stay of a patient, provincial hospital costs for a cardiac operation could be about R3 000 to R5 000.

But if a person was poor and needed such surgery the cost could be as low as R50.

This showed that patients in the middle income group would suffer if they were not covered for such operations.

The Browne Commission's White Paper recommended that the introduction of "catastrophic" medical aid cover in addition to the minimum service already offered, should be increased, and cardiac surgery was specifically mentioned.



CHAIRMAN Mr Friday Mavuso congratulating Mr Hendrick "Master" Modise, a B Comm graduate who has been offered a job by a leading bank.

Pic: LEN KUMALO

11/2/86 Sowetan 299

'An unused labour force'

THERE was a great need to extend the Soweto Self Help Association of Paraplegics (Shap) centre in Mofolo, Soweto, chairman Mr Friday Mayuso, said at a celebration to mark the third anniversary of the centre on Friday.

Established in 1983, the centre has a workforce of 80 paraplegics whose duties cover the manufacturing of underground lighting for the mines, sewing, packaging and repairs to Kodak cameras.

Mr Mavuso said they have between 450 and 500 people on the waiting list who want employment at the centre, but lack of space and funds was the main obstacle.

"We have even partitioned our dining room to make space for our sewing workshop," he said.

Talking about the past three years, Mr Mavuso said the period has proved that paraplegics can compete in an open market if only given a chance.

"When we approached companies to sponsor us to create this centre they could not believe it. They said it was an impossible thing to do. But today we have proved that we can be counted and I am very proud of it," he said.

Mr Mavuso added that plans for the extension of the centre have already been drawn and they will soon be embarking on a project to raise funds towards this.

He said it will be phase two of the centre and will create employment opportunities for about 100 people.

"We are an unused labour force and not a problem," Mr Mavuso added.

Medical aid bodies are showing stress

(299) NJM 5/12/18

Mercury Correspondent

JOHANNESBURG—South Africa's medical aid movement has all the symptoms of an industry under stress, and it faces the threat of collapse unless its underlying problems are urgently addressed, Old Mutual's chairman, Johann van der Horst, warned in Cape Town yesterday.

Mr van der Horst added his weight to the calls made by the Representative Association of Medical Schemes (RAMS) for a major revision of legislation governing medical aid schemes to permit a far greater degree of flexibility in designing benefit packages.

His plea was echoed yesterday by Mr Bill de la Beck, chairman of Willis Farber and a director of the Reserve Bank, who declared that legislation in a private enterprise society which limited the individual's choice between security and risk is outdated.

Mr de la Beck said changes were urgently needed which would allow medical aid schemes the flexibility to design benefit packages which the market place desired and supported, and not those which bureaucrats believed are good for the individual.

Reject

The Government's response so far has been to reject such overtures — reasoning is that it would subvert attempts to privatise health care, in that people given an option to insure themselves would not do so, and the State would be left to carry the can.

In his chairman's address, Mr van der Horst maintained that one of the root causes behind the problems facing the medical aid industry is the trend by any funds to offer an increasing percentage cover of medical expenses — to the extent that many now provide 100% cover with a very high, or no, ceiling on claims.

The members, therefore, bear none of the risk themselves and have little interest in keeping claims down.

'They are thereby encouraged to seek the most expensive treatment or services available without relating cost to need.'

Mr van der Horst expressed the view that medical aid funds could contribute to their own good health by declining to offer 100% coverage, thereby ensuring that members have a financial interest in keeping their claims down.

He proposed further steps, saying: 'I believe that in reality medical aid should provide cover against bills that cannot comfortably be accommodated within the normal household budget.

'Unfortunately, the SA Medical Schemes Act severely restricts medical aid funds in the type of benefit structure they may offer,' he concluded.

'Med-aid under stress'

SA'S medical aid movement had all the symptoms of an industry under stress and faced collapse unless underlying problems were urgently addressed, Old Mutual's chairman Johann van der Horst said in Cape Town yesterday.

Van der Horst, in his chairman's address, added his weight to the calls made by the Representative Association of Medical Schemes (RAMS) for a major revision of legislation governing medical aid schemes to permit

CHRIS CAIRNCROSS

a far greater degree of flexibility in designing benefit packages.

He said: "This will enable funds to design benefits to suit the needs of the public and will promote the healthy and dynamic development of the industry."

Van der Horst said a root cause behind the problems facing the industry was to be found in the trend for many funds to offer a greater percentage cover of medical expenses ...

Medical aid crisis: Plea to change the laws

By VIVIEN HORLER, Weekend Argus Reporter

MULTI-CHOICE medical aid packages, similar to insurance policies, could be the solution to the crisis facing medical aid schemes.

Mr Tony Leveton, spokesman for the Representative Association of Medical Aid Schemes, suggests that the law should be changed to give members of schemes the choice of package to suit their pockets.

He said he would like to see a situation where medical schemes could offer a choice from an expensive, comprehensive Rolls-Royce package, to cheaper, less comprehensive packages in which members would be responsible for minor ailments and bills, and would rely on the scheme for big expenses.

Mr Leveton made these suggestions following his warning that medical aid schemes could price themselves out of existence. A survey of schemes representing 40 percent of South Africans on medical aid showed most were losing money. Earlier this year a Cape Town-based scheme crashed and thousands of members were left to pay bills.

Mr Leveton said a two-pronged approach was needed — legislation was necessary to allow schemes to be more flexible and innovative, and doctors had to be persuaded to reduce costs.

He said he was disappointed that similar recommendations contained in the Brown Report into national health policy had been vetoed in a Government White Paper.

It was vital that doctors be encouraged to reduce medical costs.

'No incentive'

"As long as legislation provides that doctors get paid 100 percent if they charge the medical aid rates, there is no incentive for them to reduce costs. We have to find a way of bringing the doctor into the cost-containment mechanism.

"I believe a fairly large proportion of the increased costs of medical care is due to doctor over-servicing. For instance, he tells a patient to 'come back tomorrow' unnecessarily because, after all, why should he try to save costs when he will be paid 100 percent of fees?

"Everyone must be concerned about the rising cost of medical aid. But there is no one standard formula that can solve the present problems," he said.

Med-aid future is 'tough'

GERALD REILLY

MEDICAL aid schemes were in for a rough ride next year unless legislation governing funds was drastically revised, Representative Association of Medical Schemes (RAMS) Tony Leveton said at the weekend.

He was reacting to a claim by Old Mutual chairman Johann van der Horst that the movement had all the symptoms of an industry in stress, and faced collapse unless underlying problems were urgently addressed.

Leveton said RAMS agreed with most of what Van der Horst had said "but where we disagree is on his claim that member abuse of the funds is the major reason for the plight of the industry".

As great, if not a greater, problem was doctor over-servicing, and the fact the doctor always got 100% payment if he accepted the RAMS scale of fees.

Leveton said the Brown Commission had recommended a greater flexibility in fund benefits, but government had rejected that because it was claimed, it would interfere with the privatisation campaign.

RAMS also disagreed with Van der Horst that most of the funds in trouble were those which paid 100% benefits. A RAMS survey had shown many 80% benefit funds were under similar pressure.

Argus 18/12/81

NATIONAL

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Medical schemes fees to rise sharply

The Argus Correspondent

JOHANNESBURG. — Many medical aid schemes would increase their rates substantially next year, some as high as 20 percent, a spokesman for the registrar of medical aid schemes said.

The spokesman said in Pretoria that a substantial number of medical aid societies had applied to increase their subscriptions from January 1.

The new dental, physiotherapy and private hospital scale of benefits would apply from January 1 and societies intended increasing their subscriptions to meet the new tariffs as well as the increasing cost of medicines.

Burden

The Johannesburg Chamber of Commerce was increasing contributions to its medical aid scheme by 20 percent from January 1, it said in a bulletin.

Mr Pat Corbin, president of the chamber, said rising medical costs had forced medical aid schemes to increase members' monthly contributions by as much as 25 percent during the past year.

This had imposed an additional financial burden on both employers and employees.

Mr Corbin said the Government's privatisation programme was making it increasingly difficult for members of medical aid schemes to be admitted to provincial hospitals.

The additional cost of obtaining services in private hospitals would have an adverse effect on the finances of medical societies.

Also the treatment of infectious and contagious diseases would no longer be free of charge adding to medical aid societies' financial burden.

Medical aid schemes would in future also be responsible for expenses resulting from bomb blasts and other unrest incidents.

Improvements

To meet growing costs and improved benefits to members, the Johannesburg Chamber of Commerce Medical Aid Society — covering about 6 000 principal members and 12 000 dependants — had decided to increase monthly contributions by 20 percent from next month.

The improvements included raised annual limits for medicine, special dentistry and spectacles.

Mr Corbin said employers could help to keep costs down by encouraging their employees not to over-utilise services.

Judge lays down medical aid rights

w/t Argus 20/12/86 299

Supreme Court Reporter

THE rights and duties of members of an insolvent medical aid society have been laid down in a Supreme Court judgment for the first time.

Mr Justice Tebbutt yesterday settled a dispute between Medico medical aid scheme and two Cape Town companies who terminated their membership after their employees' claims totalling more than R14 000 were not paid by the society.

Liquidator Mr David Meaker sued Roup, Wacks, Kaminer and Kriger, a firm of attorneys, for R8 040, and Campbell and Williams (Western Cape) Pty Ltd, insurance loss adjusters, for R4 932,90, after the two companies terminated their Medico membership.

They refused to pay Medico some monthly contributions and a special levy of double their monthly contributions.

Medico was provisionally liquidated on June 11 1986.

On May 28, the two firms sent a letter of demand to Medico threating to cancel membership if the claims were not paid by June 4. Medico did not pay and the companies carried out their threat.

Meanwhile, in April, Medico was discoved to have a cash-flow deficiency and accumulated loss of more than R2-million.

The judge found that in terms of the Medical Aid Schemes Act, members of a scheme should be treated as deferred creditors. "In other words, they and their claims go to the back of the queue."

The judge said questions were raised about the rights of the plaintiff (Mr Meaker) and the defendents (the two companies): was Medico obliged to pay the claims of the employees of the two defendents in respect of services?

The judge found the answer was "Yes".

Are the defendents excused by reason of Medico's failure to pay their employees' claims from paying their normal contributions and the special levy? Again, the answer was "Yes".

Were the defendents and their employees entitled to end their membership as a result of Medico's failure to pay the latters claims? The answer was "Yes, the society's failure to perform its major oblication, settling claims, was a breach, entitling the employees to cancel their contract".



LUCKY WINNER: Mr Frik van Wyk, a visitor from Roodepoort, won second prize a holiday for two — in the UCT Diamond Rush at Clifton Beach. Here he receives his prize from Olivia McAdie, UCT debutantes' business manager, while Lesley Kallas (left) and Dale Kaplan, convenors of the debutantes, look on. First prize was a R2 200 diamond pendant.

the ministry' in hot water

ign Service

is been rocked by aling — this time

ient, the monopo- ce of fair trading — are themselves

under suspicion of having made share killings by exploiting sensitive information on take-over bids.

The astonishing revelation came from trade secretary Paul Channon who stunned MPs when he announced that the Government had appointed a team to investigate the alleged corruption.

BACK TO

DION FOR BACK

POLY ROLLS 19c
• 2 m x 500 mm transparent polyethene • For covering books
PER ROLL

BROWN KRAFT BOOK COVERING PAPER 19c
• Roll of brown kraft paper, 48 cm x 2 m



ROXON WAX CRAYONS
• 12 lively coloured wa crayons • Non-toxic
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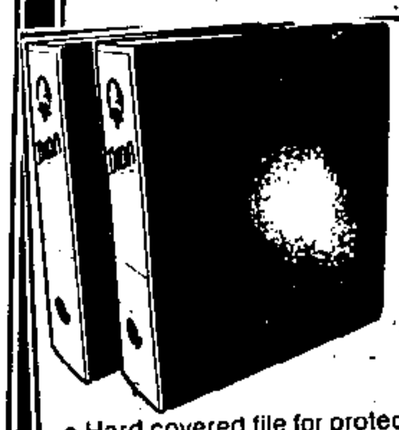

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• Hard covered file for protection • Fin hole for removing file easily • Metal lev for opening and closing • Grey ingraine colour
PACK OF 2 FOR ONLY 4

Medical aid collapse highlighted growing burden of health expenses

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23/12/87 SMM

By Joe Openshaw,
Medical Reporter

This year saw the dramatic crash of Medico, a 6 000-strong medical aid society, which highlighted the poor financial state of most medical aid schemes in South Africa.

Some schemes have been forced to increase their subscriptions by as much as 25 percent, or go under.

Medico, based in Cape Town, decided in June to liquidate the scheme, which owed more than R2 million in outstanding claims.

The plight of medical aid societies reflected the burdensome increase in medical fees, private hospital charges and the continued rise in the cost of medicines and medical equipment.

A substantial number of medical aid societies intend increasing subscriptions — some by as much as 20 percent — from January 1.

Perhaps the most encouraging medical news this year was the announcement on August 14 by the Minister of National Health and Population, Mr Willie van Niekerk, that health policies and priorities were to fall under a single authority — the National Health Policy Council (NHPC).

This dispensation was welcomed as providing for a comprehensive health service in this country and as a move away from the fragmentation of services implicit in the tricameral Constitution.

Coupled with the new dispensation was the announcement by the former Minister of Health and Social Welfare, in the House of Assembly, Mr De Villiers Morrison, that the private sector would have to share the responsibility for erecting new hospitals.

Outlining the private sector's role in the new dispensation, Mr Morrison said the following aspects would receive urgent attention:

- Empty beds in State hospitals would be made available to the private sector.
- Private hospital entrepreneurs would have to shoulder a greater share in training nurses and paramedical personnel.
- The State would turn over hospitals at present accommodating private patients to the private sector.

Where hospitals are concerned, the announcement in April that the number of beds in the Johannesburg Hospital was to be reduced and 25 percent fewer private patient admitted, drew attention to the shortage of white nurses in the country.

Dr Reg Broekmann, superintendent of the hospital, gave the assurance that priority would be given to needy patients.

IMPROMPTU STRIKE

The impromptu strike by 800 Baragwanath student nurses last November had a sequel in Pretoria this year when in May and August they appeared before a disciplinary council of the Nursing Council and were found guilty of disgraceful conduct for failing to report for duty on November 14 and 15.

The 800 student nurses were dismissed by the superintendent of Baragwanath Hospital during the strike, but later reinstated after an urgent application to the Rand Supreme Court.

The nurses pleaded guilty and were cautioned by Miss Iris Roscher, president of the council, who said the committee had considered the stressful situation at the time.

This year saw a victory for the anti-smoking lobby when a flood of protest was lodged with the SABC in February over cigarette advertisements it broadcast on the English and Afrikaan radio services and the offending advertisements were withdrawn.

At a Press conference in August the Chamber of Mines dropped a bombshell by announcing that a survey had established 130 mineworkers employed on the mines were infected with the AIDS virus.

The survey established a prevalence of human immuno-deficiency virus (HIV) the virus which can cause AIDS — among all races in the mining industry.

Blood from 26 525 miners was tested and it was found all infected workers were clinically well, doing a full day's work and could continue to be employed.

There was not one proven case of AIDS on the mines.

A blitz to immunise 15 000 children in Alexandra township against polio was undertaken in July, and medical teams from the Alexandra Health Centre, aided by volunteers from the Wits University medical school, averted a threatened outbreak of the disease.

Five cases had been reported in the township, and appalling sanitation, poor housing, infrequent refuse removal and bad stormwater drainage — classic conditions associated with poverty and urban neglect — were listed by Dr Tim Wilson, head of the Health Centre, as causes of the polio threat.

Some interest was generated when Siamese twins, joined by tissue at the spine, were born to a 32-year-old Sandton woman on April 2, and a few days later successfully separated in a relatively simple operation.

SOCIAL SECURITY — MEDICARE

1987

JANUARY — DECEMBER.

Three crucial choices for medical aid

JOHANNESBURG — Faced with a cash crisis and their own collapse, members of the medical aid industry must make three crucial choices this year or run an increasing risk of liquidation.

Mr Barry Simpson, chairman of the scheme serving the country's largest corporate group, the R16 billion Barlow Rand comglomerate, says the crisis has been precipitated mainly by the collapse of the rand, making imported ingredients for medicines far more exensive.

Secondly, the number of claims submitted by members has skyrocketed.

"Either we've been markedly more sick this year or there's been an element of irresponsibility among members who have adopted the attitude: "Medical aid will pay.'"

Thirdly, the cost of treatment has leapt.

Mr Simpson says the choices most widely accepted in answer to these problems are:

● Medical aid societies and schemes can attempt to increase members' contributions substantially yet again. Last year contributions were increased two or three times, in each case by at least 20%.

● Societies might have to reduce benefits. "This would almost certainly lead to individual hardship," says Mr Simpson.

● The third alternative is a combination of the first two.

Mr Simpson said: "None of the alternatives will be popular. So it's really up to members to think twice before seeking medical assistance if it's not really essential."

Interviewed in the latest issue of the Barlows publication, Barlows '86, Mr Simpson says that, like other schemes, the Barlow Rand Medical Scheme (BRMS) is looking at ideas like a sort of "no claim bonus" for members whose total annual claims are below the average.

"Unfortunately an obstacle to many of the developments we've considered is that the statute regulating medical schemes does not permit many of the new ideas to be implemented."

He says BRMS is financially sound "for the moment".

"But to remain viable we've had to increase our 23 000 members' contributions twice in a year — by 20% last January and a further 20% in October."

"The three key reasons are:

● Higher treatment charges.

● The much higher cost of medicines.

● The substantially greater number of claims submitted by members."

Record is set straight over disabled

(299) W/E Post 3/1/87

By RAYMOND HILL

PORT ELIZABETH's publicity chief, Miss Cynthia van der Mescht, has been upset because of a "misunderstanding" about the type of facilities provided in the city for disabled folk.

She has now drawn up a five-page list with the necessary information to put the record straight.

The list was compiled after an article in a travel publication claimed there was no response from the association about inquiries concerning facilities for handicapped folk in PE.

But now the list — obtainable free of charge from the PE Publicity Association's office — contains the names of places where special toilets, telephone booths and ramps have been provided for them.

Public places where special facilities are available include the main post office in Baakens Street, the Opera House and the airport.

The names, addresses and telephone numbers of various organisations are also given.

Details of an in-depth survey regarding facilities that are provided for the disabled in the country are included in the November-December issue of Travelog, an independent newspaper on travel and tourism. It compiled the comprehensive information as 1986 was the Year of the Disabled.

This included information on each major centre, and it was in this section that Port Elizabeth showed up out of step with other centres.

The article says: "Telephonic queries from the PE Publicity Association elicited no response, and no offer of further investigation to find the requested information was made."

An upset Miss Van der Mescht telephoned the publication's editor after reading the article.

A letter explaining that there was a "misunderstanding" was written to the editor, and will be published soon.

The letter said PE tried to live up to its reputation as the Friendly City.

"When I was asked if there was a list of facilities available in the city I said no, but but I mentioned there were, in fact, special facilities for them at certain buildings."

The article carries details of facilities for the disabled in all major centres and gives a general run-down on restaurants, hotels, the railways and airways, museums and other places of interest.

It says of East London: "Information [is] not yet available in printed form, but will be given verbally on request. Any unanswered queries are dealt with speedily and effectively."

The article says it was not its aim to paint a "bleak picture" of the situation in the country — but it was found that the South African tourist industry still had a "long way" to go where disabled folk were concerned.

Mr Johan Fourie, director of standards for the national tourism organisation, Satour, urged prospective hoteliers to keep the disabled in mind when they erected new hotels. He also urged local authorities to play a role in solving the problem of the lack of facilities for the disabled, especially as "tourism now seems to slant more to the economy-class hotel, which normally does not feature these facilities".



Miss van der Mescht, publicity chief

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TOUGH FOR MEDICAL AID SCHEMES

Societies face collapse

FACED with a cash crisis and their own collapse, members of the medical aid industry must make three crucial choices this year or run an increasing risk of liquidation.

According to Mr Barry Simpson, chairman of the scheme serving the country's largest corporate group, the R16-billion Barlow Rand conglomerate, the crisis has been precipitated mainly by the collapse of the rand, making imported ingredients for medicines far more expensive.

Secondly, the number of claims submitted by members has skyrocketed.

"Either we've been markedly more sick this year or there's been an element of irresponsibility among members who have adopted the attitude: "The medical aid will pay for everything".

Thirdly, the cost of treatment has leapt ahead.

Mr Simpson says the choices most widely accepted in answer to these problems are:

- Medical aid societies and schemes can attempt to substantially increase members' contributions yet again. Last year contributions were increased two or three times, in each case by at least 20 percent.
- Societies might have to reduce benefits. "This would almost certainly lead to individual hardship", says Mr Simpson.
- The third alternative is a combination of the first two.

Mr Simpson: "None of the alternatives will be popular. So it's really up to members to think twice before seeking medical assistance if it's not really essential".

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Obstacle

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He says BRMS is financially sound "for the moment".

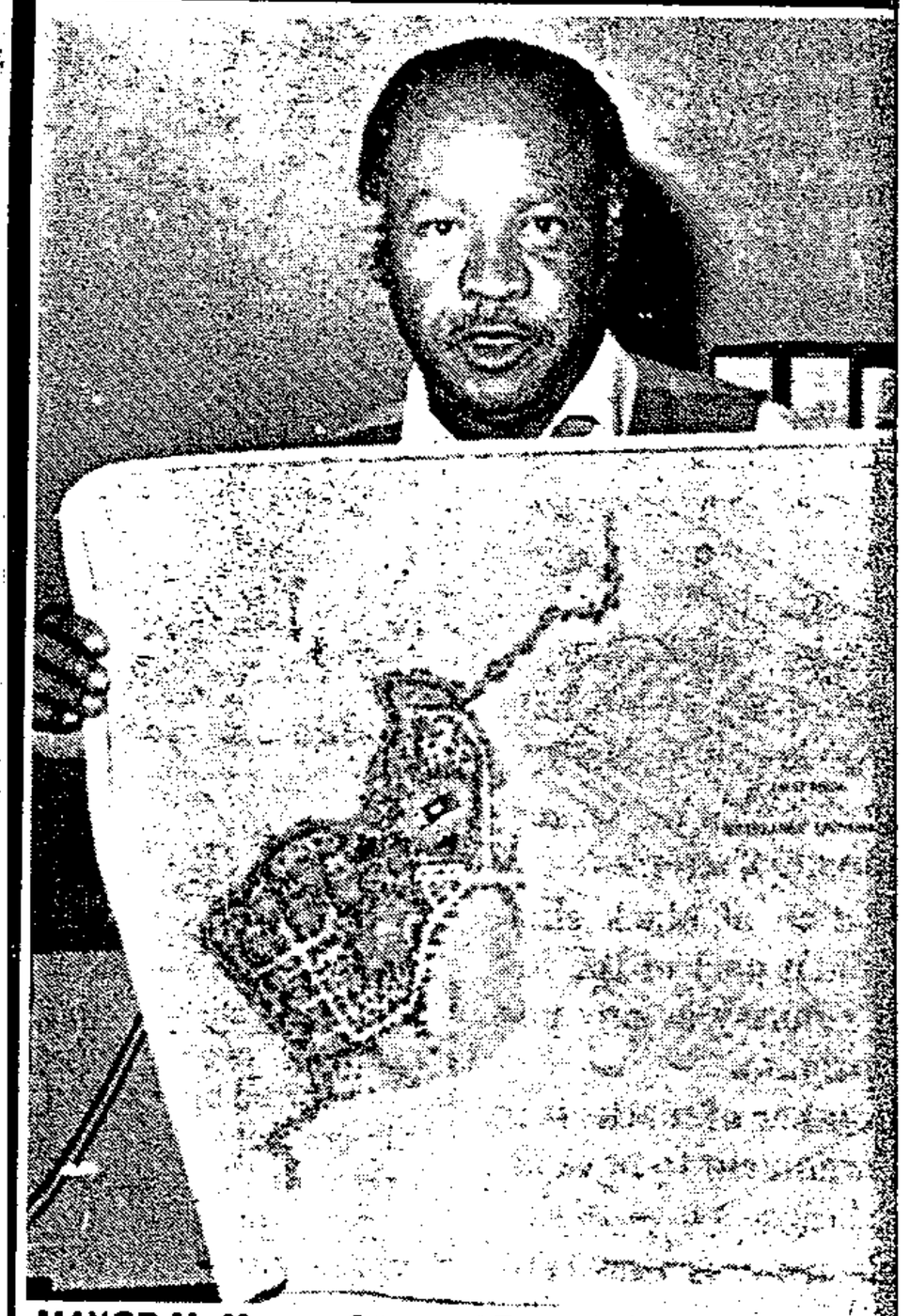
"But to remain viable we've had to increase our 23 000 members' constributions twice in a year — by 20 percent last January and a further 20 percent in October".

This represents a cumulative total of 44 percent — twice the rate of inflation.'"The three key reasons are:

- Higher treatment charges;
- The much higher cost of medicines; and
- The substantially greater number of claims submitted by members".

In the case of professional fees, says Mr Simpson, covering doctors, specialists, dentists and hospitals, there have "inevitably" been quite dramatic increases. This has resulted in each claim being more costly.

"Regarding medicines, an insignificant proportion of the ingredients is produced commercially in South Africa. This means that we have to rely heavily on imports. Consequently, the decline of the rand against overseas currencies has pushed up prices very significantly" — Sapa.



MAYOR Mr Morgan Sibaya of Ratanda holding the map of picnic resort. Work will start this month, he sa

Ratanda to get re

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THE Ratanda Town Council has approved the development of a picnic resort on the

By NKOPANE MAKOBANE

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Weak rand leaves medical aid societies in crisis

299 SMM 6/1/86

Faced with a cash crisis and collapse, members of the medical aid industry must make three crucial choices this year or run an increasing risk of liquidation.

Mr Barry Simpson, chairman of the scheme serving South Africa's largest corporate group, the R16 000 million Barlow Rand conglomerate, the crisis has been precipitated mainly by the collapse of the rand — making imported ingredients for medicines far more expensive.

And the number of claims by members has skyrocketed.

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"Unfortunately, an obstacle to many of the developments we've considered is that the statute regulating medical schemes does not permit many of the new ideas to be implemented."

He sid the BRMS was financially sound "for the moment".

"But to remain viable we've had to increase our 23 000 members' contributions twice in a year — by 20 percent last January and by a further 20 percent in October."

This represented a cumulative total of 44 percent — twice the rate of inflation.

Mr Simpson said professional fees — doctors, specialists, dentists and hospitals — have had dramatic increases.

He added: "Regarding medicines, an insignificant proportion of the ingredients is produced commercially in South Africa. This means that we have to rely heavily on imports.

"Consequently, the decline of the rand against overseas currencies has pushed up prices very significantly."

Referring to the treatment of members, Mr Simpson said: "The average number of treatments per member has risen considerably above 1985 levels.

"This suggests we have either been markedly more sick or there's been an element of irresponsibily on the part of some members.

"Our graphs show clearly the large increase in number of treatments. Our analyses also show that there has been a substantial growth in so-called minor ailments.

"It's possible that the psychological state of the nation has has been a factor in more frequent visits to doctors, but I'm not aware of any statistics or research to prove it.

'DRAMATIC RISE IN OVERSERVICING'

"Certainly we've noticed a large increase in medication dispensed. This trend has been marked for a few years now.

"But 1986 suggests that a dramatic rise in overservicing has also occurred."

Mr Simpson acknowledged that many specialists send patients to expensive private clinics without considering the financial status of the patient, who often has to "pay in" for treatment.

He commented: "If the patient's problem is serious or urgent and cannot wait — as in heart by-pass and bad trauma — the important thing is to get the quickest and best treatment.

"However, if there's a low urgency factor, I believe the time has now come for members to develop the habit of negotiating the cost.

"Some specialists are also shareholders in private clinics, and it's only natural that they promote these clinics ahead of those in which they do not have a direct interest.

"The final choice, however, ought to be what suits the patient most. If he's in doubt, he should refer back to his general practitioner in very much the same way as he would get a second opinion.

"We shop around when we buy consumer goods. We've got every right to get value in our health care too."

Of the breakdown in communication between the medical profession and medical aid schemes, Mr Simpson said: "Until recently, the Medical and Dental Council would hear evidence for tariff increases and make a ruling. But this system has changed.

"Currently, for example, where doctors increase their charges, the Representative Association of Medical Schemes (RAMS) must review its tariff in three months and may adjust tariffs.

"Thus we see Press reports of furious rows developing between RAMS and the associations representing various branches of the nation's health services.

"Obviously, the argument relates to conflicts over what are excessive fees.

"At present, Rams has not offered doctors who charge tariff rates (contracted in) any increase for 1987.

"Therefore, the way for them to fight inflation is to cut costs, increase the number of visits per patient per day or, possibly, to dispense medicines."

The other option is for them to charge above the tariff. In this case, the medical scheme will usually only reimburse the patient at the tariff rate and he then has to settle the doctor's account in full himself.

"However, the currently adverse financial situation cannot be solved just by controlling external cost increases.

"We are all simply going to have to exercise more restraint over the number of visits we make to doctors and specialists, the treatments received, and presciptions dispensed." — Sapa.

...e to bear the costs of ... could amount to large ... said.

... residents did not get ... draw up a petition. ... seek legal redress.

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..." Mr Dudu said.
...e said his association ... pleased by a decision ... a few weeks ago by ... community allowing ... to trade as they like ... binding them to sell ... liquor between 9am ... 9pm.

Women barred from the ... last year have ... allowed to patronise ... again.

Mr Duru is appealing to ...mbers of his association ... trade within business ... and maintain order at ... shebeens.

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Krige, said the four-month-... and was badly missed. chest and a black tail. He

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... eyesore and ... the Port Elizabeth Child and Family Welfare Society to a firm of undertakers.

Neighbours and passers-by have criticised the state of the building saying it is overdue for demolition.

Some have described it as an "unsavoury place where all sorts of things" happen. Prostitutes and vagrants use it as a hideout.

Every window pane has been smashed and a strong stench emanates from it.

The building, on the corner of Harrower Road and Hancock Street, was officially opened by the Countess of Clarendon in October, 1931.

It was used as a child day centre until about 12 years ago when an organisation for handicapped children moved in temporarily.

Last year the whole property was valued at ...

Mrs Enid Smuts, the society's outgoing director, said she was aware that the building had fallen into disrepair.

The society had considered hiring a security guard to protect it during the past three years that it has been vacant.

But the costs were too high. The society's staff had tried to keep it clean but it was badly vandalised.

The building was considered a hazard by municipal health officials, who recently asked the society to do something about it.

Mrs Smuts said it was now in the process of being transferred to its new owners.

The money will be used for the society's new headquarters. Their present offices in the Feather Market Hall are inadequate.

Drop in ... EL beach numbers

Weekend Post Reporter

EAST LONDON — A marked drop in the number of bathers using East London's beaches during the holiday season was disclosed this week in a report to the City Council.

But some query whether the statistics, compiled by acting Beach Manager, Mr Colin Broomhead, reflect a drop in the number of visitors to the city last year.

Orient Beach attendance in December dropped from 20 900 the previous year to 7 000.

The number at Nahoon dropped from 31 000 to 9 000 and at Eastern Beach from 20 000 to 12 000.

Mr Broomhead blames the drop largely on overcast days in December and the fact that many visitors are now taking shorter holidays.

Medical aid organisation snubs 'unfair' doctors

By RAYMOND HILL

SEVERAL doctors claimed to be dispensing medicines at "unfair" prices have been snubbed by a large medical aid organisation. Some are in Port Elizabeth.

But the Association of Medical Scheme Administrators (Amsa) is prepared to review their cases.

There were also other reasons for the decisions, an Amsa spokesman said.

The association's Johannesburg head office has been flooded with complaints from doctors whose applications were turned down.

The new ruling means that the "offending" doctors may no longer submit the accounts of patients directly to the medical schemes.

This action had been taken because of unfair prices being charged for medications, and in order to regularise a "chaotic" situation, the spokesman said.

Now doctors must send the accounts directly to the patient concerned.

It is the patient's responsibility to send the account to his or her scheme after checking it properly.

When the patient receives the money from the scheme, he or she must pay the doctor.

Many doctors fear that they will not get their money. One, with a busy practice in PE's northern areas, was offended when his application failed.

He said he was performing an essential service by dispensing medicines, especially at night when no chemists were available in the northern areas.

He preferred dealing directly with medical aid societies.

Mr K Hollis, chairman of Amsa, said his office was "inundated" with complaints from doctors whose applications failed.

He said the unhappy doctors could re-apply and their cases would be reviewed.

"There is a certain 'mark-up' in the price of medicine that varies from doctor to doctor.

"My association only wants to deal with doctors charging fair prices.

"We are determined to stamp out abuse, and are more than willing to have a sound working relationship with doctors," he said.

Dr Angus Hofmeyr, chairman of the Eastern Cape branch of the Medical Association, said doctors were "very upset" about the association's ruling.

Row brews over thinking behind disability work

(299) Star 22/11/87

By Janine Simon

Workers in the disability field are being faced with a choice — to collaborate with the growing Independant Living Movement, or to ignore the ILM's call to review service provision to the disabled.

According to Dr Wilma Hoffmann of the School of Social Work at Wits University, a decision to ignore the ILM would lead to polarisation, increasingly irrelevant services, disillusioned professionals and a manpower drain.

Writing in the December issue of "Cripple Care News", Dr Hoffmann said South Africa had reached a crucial period in the history of service provision to the disabled.

The ILM, which had become a force in rehabilitation since its founding in 1979, was challenging the effectiveness of services rooted in the "medical model".

DISABILITY DEFINED

The movement encouraged self-help and defined the problems of disability as the physical and social barriers the environment imposed on the disabled person.

By contrast the medical model assumed the doctor was the expert heading the treatment and rehabilitation of the permanently sick and "in need of care" disabled person.

This model often carried in it a loss of human status for the disabled patient.

"It therefore behoves those delivering services to re-evaluate service delivery and the philosophical value base on which this is founded," Dr Hoffmann said.

Such reviews were not easy, especially for those who had been in the field for years, and who had been recognised as "specialists".

Reviews evoked strong reactions, predominantly centering on vested interests.

But they were essential to keep services consumer-oriented, she said.

WOMAN

Aid for cerebral palsied kids

29/1/87

By Nthabi Moreosele

THE pupils at the Phillip Kushlick School for Cerebral Palsy whiz down the corridors on their tricycles having fun.

The corridors are divided into left and right with stop signs on the floor where corridors branch off to the classes. And yet these tricycles are not merely for fun but serve a dual purpose.

Mrs Happy Shibambo, the school's occupational therapist, says the bikes teach the children normal movement, tone their muscles, and help those who cannot walk properly.

Our visit to the school dispelled the notion that therapy was a hideous and painful process. The pupils were eager and enthusiastic about their lessons.

"The children are given treatment through games and activity," Mrs Shibambo said.

"We use toys and other aids to help them and also educate them. Cerebral palsied children are often bright, but sometimes they cannot walk, cannot talk or write. So it is difficult for them to communicate.

"We make aids and supports from any material to improve their co-ordination, improve their perception and make them sit properly."

Happy

One child played shopkeeper with a cash register, gleefully putting the money back to start all over again. His happy activity is assistance for his spastic muscles. Another was busy with a jigsaw puzzle of a man (Elementary Physiology).

Keletso, a five-year-old, was using the computer to learn direction, shapes and writing, all at the same time.

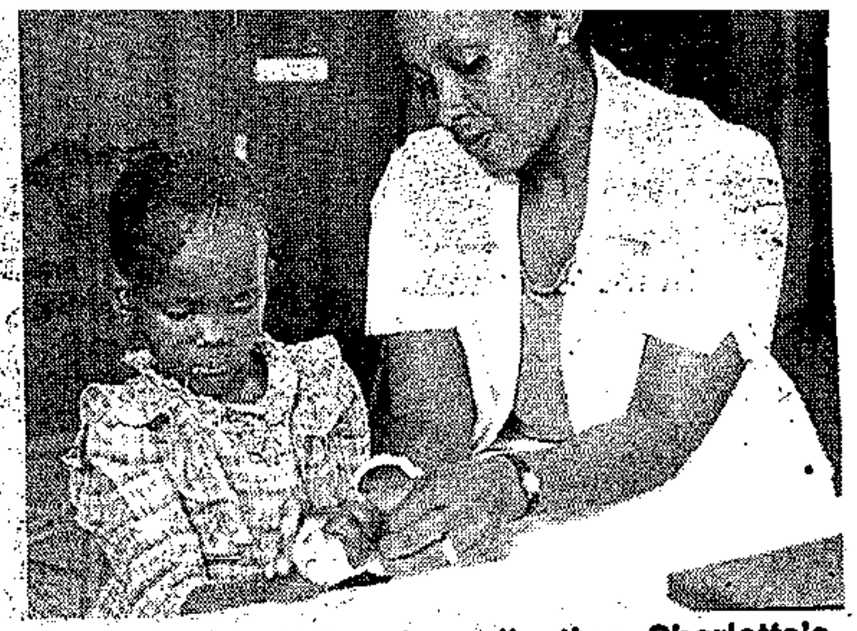
"We like to use aids that serve several functions all at the same time. We have adapted second-hand computers to teach those children who have severe difficulty in writing. They do their mathematics, art and writing exercises with them."

The children are just as mischievous and excitable as any schoolchild. While we were chatting to the Standard Four teacher, his pupils immediately stopped their lessons, took out their knitting bags and others congregated for a gossip session.

Mrs Shibambo said some pupils deteriorate during school holidays and have to start again from scratch when school resumes.

"The parents' attitudes change if their children improve. Some come to the school to see what it is all about and they continue the training at home."

The school follows the Department of Education and Training syllabus and all the children at the school are assumed to be educatable.



MRS HAPPY Shibambo adjusting Charlotte's splint to encourage thumb opposition.

Concert over handicapped youngsters

ENERGY is poured into stimulating, educating and rehabilitating handicapped children, but what happens, asks Mrs Jo Campion, when they reach adolescence?

Mrs Campion, a consultant with the United Cerebral Palsy Association of South Africa (UCPA), has been so concerned by this question that she has initiated an international conference on the subject to be held in Johannesburg in March.

She points out that specialist teams of paediatricians, physiotherapists, occupational therapists and other professionals care for handicapped children — but only scattered facilities are concerned with older adolescents.

"We give children therapy from an early age, and then call their parents in and tell them we've done all we can. All too often, the children go home to sit and do nothing — there are no opportunities to play a meaningful part in the community.

Isolated

"If they need medical attention, they are likely to be placed in a general ward, where the doctors have no specialist knowledge of their specific handicap," says Mrs Campion.

She has worked with handicapped people for eight years, and when she moved to South Africa from Ireland two years ago she was struck by the absence of handicapped people in streets and public places.

They tend to be isolated, with little attempt made by the community to integrate them, develop the vital facilities they need, provide employment or recognise their rights.

"But the last thing I want to do is to make comparisons with overseas conditions. I think we in South Africa need to get together and discuss what is needed for our specific situation. The intention behind our conference is to provide that opportunity," says Mrs Campion.

She hopes that professionals, parents, the community in general — and most important handicapped people themselves — will express and discuss their needs at the conference.

Ideally, efforts will be made to form a cohesive strategy regarding handicapped adolescents.

Over-servicing by GPs costs fund members R6-m a year

Medical Reporter

Over-servicing and increased charges by doctors are driving the cost of medical aid to "frighteningly high levels", says Mr Tony Leveton, chairman of the Affiliated Medical Administrators.

In an article titled "Doctor, we're in trouble" in the latest *Portfolio*, an insurance journal, Mr Leveton says over-servicing by GPs alone will cost medical fund members R6 million a year.

GUARANTEED PAYMENT

"Last year, despite a huge increase in medical aid rates for consultations, general practitioners who charged at the scale of benefits and obtained guaranteed payment, rendered 39 percent more consultations a patient than those general practitioners who charged in excess of the scale of benefits," he said.

Although contracted-out doctors charged on average 15 percent more than the official medical aid rate, the contracted-in section grossed nearly 24 percent more.

"The contracted-in practitioners who receive guaranteed payments obtained income by performing more services, while the contracted-out doctors, who render potentially fewer services, obtain income by charging more for each service.

"If doctors in my own group of societies who render services on a guaranteed fee basis reduced their activity to the level of doctors who do not, we could have saved our members more than R3 million a year in general practitioners's consultations alone," Mr Leveton said.

He said that while the Representative Association of Medical Schemes (RAMS) was allowed to set its own fees, it was obliged, in terms of the new Medical Schemes Act, to adhere to relative values asigned to various procedures by the Medical Association of South Africa (MASA).

"In simple terms, this allows RAMS to decide on the size of the cake but forces it to allow MASA to decide how to slice it up."

The solution, says Mr Leveton, is substantial deregulation of the medical aid movement and includes:

- Replacing the compulsory guaranteed payment system by a volutary system.
- RAMS being allowed to establish a scale of benefits independently of MASA.
- Allowing medical aid schemes to offer a variety of benefit packages.

Student clinic at Muldersdrift tailored to community needs

(299) 9/2/87 Star

By Kate McKinnell

The wide-eyed three-year-old is worryingly underweight — her clinic card shows she lives in a household of 10, surviving on a single-parent's wage of R50 a month.

She lives, not as you might expect in a remote rural area, but on Johannesburg's northern outskirts. This Saturday morning she has been brought to the Muldersdrift Health Clinic established by University of the Witwatersrand medical students in the area.

The child's mother has carried her a long way from their tumbledown hut to meet the clinic transport. They will be spending most of the day at the cluster of prefabricated buildings where the clinic is run every Saturday.



GETTING THROUGH: health workers at the Muldersdrift clinic, run by medical students from the University of the Witwatersrand, are important communication links because they are able to discuss health issues with mothers in their own languages. ● Picture: KAREN SANDISON.

NO CHARGE

The toddler will be weighed and immunised before being examined by doctors and her mother may consult the family planning department. Both mother and child will be supplied with the medicines they need free of charge — few can afford to pay.

There is a strong emphasis on health education and at every stage of the clinic's routine particular efforts are made to discuss and explain issues like nutrition, immunisation and sanitation.

But these practical services are only a skeleton of the role the university clinic would like to play in this rightless community.

Central to the students' philosophy are the ideas that ill-health is linked to poor living and working conditions, and that prevention is important — not just the treatment of sickness.

Just one benefit of preventative medicine is seen in the cost of immunising thousands of children against tuberculosis which is equal to treating one child for the disease.

The clinic's research has shown the majority of people in the area are farmworkers, some receiving wages of below R100 a month and often working six days a week, 12 hours a day, and living under appalling conditions.

The medical students say: "We believe communities know their own needs best and should become involved in running the clinic so it serves these needs. Our role is to promote confidence in the community's ability to make decisions and in some way help restore to these people the dignity they are denied in all other aspects of their lives."

This starts, says one student, with the way the clinic is run and the way the students and staff relate to the patients. The women become directly involved in decision-making — for example, when Operation Snowball donated blankets to the clinic last year, the community identified the people most in need and organised the distribution of the blankets.

Direction is also taken from the clinic's health workers — members of the community who have been trained to work at the clinic and are now on the verge of running the clinic on their own with doctors doing examinations.

An important role of health workers is to aid communication by discussing health issues with mothers in their own language.

In keeping with the idea that health care extends beyond simple medical treatment, the clinic hopes to serve as a community centre where the scattered and isolated families in the area can meet.

WOMAN'S GROUP

One move towards this has been the the planning of a women's group, where women will meet at the clinic to discuss issues and topics that concern them.

A clinic committee member says that a serious concern has been that the clinic runs only on Saturdays, serves only women and children, and cannot hope to provide the full health care needed in the area.

But an exciting development recently has been the employment of a primary health care nurse who will work full-time in the area and run health programmes such as feeding schemes.

"We desperately need a solid financial foundation, because at the moment we operate on scattered donations. Before we can even think of meeting more demands we have to cover general running costs," says a student.

Anyone interested in helping should telephone (011) 647-245 mornings, or Karen at (011) 648-6152 evenings.

MD: friends use medical aid scheme cards of holders

By JUDY SPARG

EAST LONDON — The abuse of medical aid facilities is an escalating problem countrywide and has become a matter of increasing concern to pharmacists, doctors and the administrators of medical aid schemes.

This is the opinion of the managing director of a Johannesburg-based medical aid scheme, Mr K. Hollis, who said difficult economic conditions had aggravated the problem.

"One of the problems is that valid members of our scheme allow friends to make use of their cards, and charge expenses to the medical aid scheme. We hold doctors responsible for keeping a record of their patients, and do not carry these costs."

"Another problem is that people whose membership has expired due to retrenchments or a change of employer sometimes continue to claim on their medical aid months after their membership has lapsed."

"Doctors and pharmacists supply services and medication, and often have to contend with a financial loss when they are unable to trace the patient."

"It is difficult for pharmacists to keep a check on lapsed memberships, and they only become aware that the claim is invalid once it is returned from the medical aid scheme several weeks later," he said.

Mr Hollis said that controlling the situation presented a challenge, and that his organisation had warned the Medical and Dental Council to keep a close check on the validity of their patients' medical aid memberships.

"It is more difficult for pharmacists, particularly those offering a late night service, to check up on the validity of memberships, and a solution would be to charge cash and refund members afterwards.

"These refunds can only be issued in the form of a crossed cheque, however, which is a problem in a third world country, where members of lower income groups seldom have banking accounts."

The chairman of the Pharmaceutical Association here, Mr Kevin Flint, said abuse of medical aid facilities had escalated dramatically in the last year, resulting in the loss of considerable sums of money for some businesses.

"A large proportion of these cases are fraudulent, but others are the result of desperation — people have lost their jobs due to the tough economic conditions and just can't afford medical attention," he said.

Interviews with local pharmacists, who cannot be named for professional ethical reasons, revealed that some businesses had scarcely been affected while others had been particularly hard hit.

Pharmacists were hesitant to say that the abuse was deliberate, and cited examples of people who had genuinely believed their membership to be valid for several months after changing jobs.

The owner of a business who had suffered considerable financial loss said adverse economic conditions and the loss of jobs were the root cause of the problem.

"Tracing offenders is often difficult, as they have often changed addresses by the time their claims are rejected. It costs so much in time and effort to track them down," he said.

the new 3 568 line automatic Kingsflats exchange during the first half of 1989, if nothing unforeseen occurs. The remaining 148 applications are in respect of services required in the Black residential area. The tempo at which these services can be provided will depend on the extent to which technical personnel are allowed to enter the area freely.

Contributions from farmers

521. Mr E K MOORCROFT asked the Minister of Constitutional Development and Planning:

What amount of money was collected from farmers in the area under the jurisdiction of the Eastern Cape Development Board as contributions in respect of Black workers under the Contributions in respect of Black Labour Act, No 29 of 1972, during the 1985-86 financial year?

The MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING:

R316 206,50.

Pietermaritzburg police district: offences

523. Mr G B D McINTOSCH asked the Minister of Law and Order:

How many cases of *(a)* murder, *(b)* culpable homicide, *(c)* assault with intent to do grievous bodily harm, *(d)* common assault, *(e)* rape, *(f)* robbery, *(g)* theft of vehicles and cycles, *(h)* damage to property, *(i)* housebreaking with intent to steal and theft and *(j)* possession of drugs were reported at each specified police station in the Pietermaritzburg police district in 1986?

The MINISTER OF LAW AND ORDER:

	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*	*(g)*	*(h)*	*(i)*	*(j)*
Pietermaritzburg	66	8	352	416	36	346	373	179	1 052	2
Inchanga	14	13	130	86	16	34	5	34	234	—
Mid-Illovo	29	7	50	15	6	14	6	9	51	—
Alexandra Road	26	13	117	164	9	41	260	73	740	—
Bishopstowe	8	2	69	31	5	12	6	17	46	—
Boston	3	4	16	5	2	3	6	5	38	—
Camperdown	21	21	156	115	23	54	22	43	266	—
Cramond	11	8	75	34	9	7	2	10	53	—
Hilton	4	5	42	28	6	11	13	22	142	—
Howick	35	22	262	149	22	36	33	100	280	—
Impendle	6	1	90	36	3	11	3	19	70	—
Mountain Rise	46	32	445	1 114	74	162	232	596	629	12
Nottingham Road	7	5	59	51	4	2	11	21	128	—
Plessislaer	298	60	991	1 040	170	378	111	695	1 148	—
Prestbury	—	1	3	21	1	8	35	7	130	—
Richmond	36	13	193	89	23	32	22	46	300	—
Thornville	8	4	57	51	4	23	12	13	86	—
Town Hill	6	12	26	28	6	11	31	14	208	—
Hammersdale	160	32	238	149	50	174	68	152	492	—

Note: Statistics are furnished for the period 1 July 1985 until 30 June 1986.
Because statistics for the period 1 July 1986 until 31 December 1986 are not yet programmed, particulars for this period are not readily available.

I wish to point out to honourable members that should the above-mentioned figures be brought into perspective, it will be noticed that crime tendencies fluctuate. In some instances crime reflects drastic increases and in others it reflects similar decreases. Crime tendencies differ from one area to another, while the population density is also an important contributing factor. Increases in crime can mainly be ascribed to:

(a) the economical recession,

(b) resulting unemployment; and

(c) the abuse by criminal elements of unrest situations to commit crime.

The increase in crime is an universal tendency, and even causes great concern during international crime conferences.

Military disability pensions

527. Mr B B GOODALL asked the Minister of National Health and Population Development:

(a) How many persons are in receipt of military disability pensions and *(b)* what amount was paid out in such pensions in respect of the year ended 31 March 1986?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(a) 12 031.

(b) R30 505 656.

Pollutants

528. Mr K M ANDREW asked the Minister of National Health and Population Development:

What was the average recorded atmospheric *(a)* lead level, *(b)* sulphuric acid level and *(c)* level of other specified significant pollutants measured at the monitoring points in the Cape Town area in winter and summer, respectively, over the latest specified 12-month period for which figures are available?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

The following average concentrations are all expressed in terms of micrograms per cubic metre.

Summer 85/86 — October 1985 to March 1986

Winter 86 — April 1986 to September 1986

(a) *Lead* Results from semi-automatic sampler at City Hall

Summer 85/86	Winter 86
1,16	1,16

Standard Samplers

Site	*Summer 85/86*	*Winter 86*
Epping Market	0,65	0,65
Tamboerskloof	0,23	0,26
City Hospital	0,25	0,53
Foreshore	0,8	1,35
Salt River	0,4	0,65
Paardeneiland	0,76	0,95
Drill Hall	0,4	0,8

(b) Sulphuric acid concentrations in the air are not monitored as such, but the following concentrations are those of sulphur dioxide a precurser to the formation of sulphuric acid.

Site	*Summer 85/86*	*Winter 86*
City Hall (discontinued)	8	—
Drill Hall (new station)	—	10
Foreshore	14	10
Epping Market	7	6
Paardeneiland	7	2
Salt River	10	9
Greenpoint	7	9
Tamboerskloof	3	4
Edgemead	18	11

(c) The following concentrations reflect the presence of particulates in air.

Site	*Summer 85/86*	*Winter 86*
City Hall (discontinued)	15	—
Drill Hall (new station)	—	20

Southern joins in

On the heels of the Lifegro/Status Medical Aid tie-up (*FM* November 14), Southern Life has bought 50% of Affiliated Medical Administrators from W & A. This links Southern with a company that has annual contribution income in excess of R280m and membership of almost 160 000 families. Medical Funds Administrators has the other 50%.

The joint shareholders will benefit from the administration fee, amounting to some R16m or almost 6% of premium throughput, before expenses, charged to medical aid societies under Affiliated's administration. These include two public funds, Consolidated Employers Medical Aid and Medical Expenses Distribution (Meds). Affiliated also has six large in-house funds.



Affiliated's Leveton . . . hidebound by law

Says Bill Haslam, executive director of Southern Life: "The main advantage we see is possible opportunities should the Medical Schemes Act be changed following the Browne Commission's report and recent moves toward privatisation of health care."

Tony Leveton, chairman of Affiliated, adds, however: "Under present legislation, we are all hidebound. If legislation were relaxed, we could jointly structure more flexible packages." He says the industry has been pressing for changes for some time.

Southern is already active in the employee benefit field: medical aid administration is the one complementary facility it needed. Both sides will in time be able to share expertise and computer facilities. Affiliated gains a qualified actuary, Bill Haslam, and an accountant, Adrian Arnott (also of Southern), on its board. ■

State to revise laws on medical aid schemes

AR645 9/2/87.

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Medical Reporter

THE Medical Schemes Act of 1967 is to be revised to avoid differing interpretations of certain clauses, the Minister of National Health and Population Development, Dr Willie van Niekerk, announced today.

Dr van Niekerk said all interested parties would be invited to a conference in Pretoria next month when the Act and possible draft legislation would be discussed.

The main philosophy of the Act — that the State not involve itself in setting tariffs — would remain the same.

The Representative Association of Medical Aid Schemes, the Medical Association of South Africa, the Dental and Physiotherapy Associations, private hospitals, large companies and insurance companies would be represented.

One of the most important changes to the Act was that the registrar of medical aid schemes should have "more real power" to investigate medical aid schemes so there would not be another incident like the one in Cape Town last year when a scheme went insolvent.

Bid to thrash out medical aid problems

Cape Times 10/3/87

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By CHRIS ERASMUS

THE major parties involved in South Africa's growing medical aid crisis are to meet in a round-table discussion on April 9 in a bid to iron out the problems which have brought the medical aid industry to its knees.

The Minister of National Health and Population Development, Dr Willie van Niekerk, announced the meeting at the opening of the 55th congress of the Medical Association of SA (Masa) in Cape Town yesterday.

Dr Van Niekerk said the major players in the medical aid crisis would attend the Pretoria conference, including the Representative Association of Medical Schemes (Rams) and Masa, as well as consumer bodies such as the Afrikaans Handelsinstituut (AHI) and Assocom.

The chairman of the Federal Council of Masa, Dr Rene le Roex, said he welcomed the minister's announcement as change in the legislation in question to remove the scope for differing interpretations was long overdue.

Limit coverage

Masa's point of view was that the medical profession reserved the right to prescribe to patients what treatments they required.

Rams claimed the right to limit the extent of coverage its members were prepared to give on rapidly escalating medical claims.

□ The president of the Medical Research Council, Professor Andries Brink, said more doctors would have to emerge from SA's black population to be able to cope with the health demands of SA's rapidly growing population.

Only 4% of SA's doctors were black, while that population group made up 70% of SA's population.

State's aim is 'free market health services'

Staff Reporter

THE privatization of South Africa's health services was the government's goal, said Dr Willie van Niekerk, the Minister of National Health and Population Development, in Cape Town yesterday.

Speaking at the 55th congress of the Medical Association of South Africa, Dr Van Niekerk said health care was a personal responsibility and a privilege, although the underprivileged had to be catered for.

Subsidization of the individual and not the institution had to take place, while effective competition and a free-market approach had to be adopted in the health field, he said.

"Nevertheless, South Africa has a socialistic element as part of its health services. No person in this country, regardless of race, colour, creed or income, is without access to some medical care provided by the state."

Third World

The basic needs of the country's Third World element had to be catered for if the ideal of "Health for All" was to be obtained by the year 2000, he said.

Within this framework, the academic hospital had to be seen as the apex of the health pyramid, with the broad base formed by the essential amenities of water, housing, sanitation and primary health care.

To ensure that the best service was given to the greatest number, patients had to be treated at the lowest possible level of the pyramid, to prevent an excess flow of patients to the most specialized and expensive services.

It was imperative that trainee doctors be exposed to less sophisticated and community-based health care services, he said.

Medical aid Act to be redrafted

CHRIS CAIRNCROSS

CAPE TOWN — The Medical Schemes Act was to be redrafted substantially with a view to resolving some of the difficulties it was still creating for the medical aid industry, the medical profession and government, National Health and Population Development Minister Willie van Niekerk said yesterday.

Opening the 55th annual congress of the Medical Association of SA (Masa), he said he had decided to convene a major closed conference, in Pretoria on April 9, at which it was hoped to collect evidence of the problems being experienced and the sort of options interested parties would hope to offer to resolve those issues.

Van Niekerk told a Press conference the issues involved would be treated with some urgency, spurred on by the financial state of the medical aid industry, and through a desire to prevent another medical aid scheme from crashing.

An important clause in the Act, governing how members of the medical profession might stay in or opt out of the medical-schemes industry, was the subject of considerable dissension, and needed to be resolved, the Minister added.

Medical aid changes mooted

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Sowetan

THE Medical Schemes Act of 1967 is to be revised to avoid differing interpretations of certain clauses, the Minister of National Health and Population Development, Dr Willie van Niekerk, announced yesterday.

10/3/87

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The main philosophy of the Act — that the State not involve itself in setting tariffs — would remain the same.

The represenative Association of Medical Aid Schemes, the Medical Association of South Africa, the Dental and Physiotherapy Associations, private hospitals, large companies and insurance companies would be represented.

Medical aid revamp urged

GERALD REILLY

PRETORIA — The need for amendments to the Medical Schemes Act had become urgent, Tony Leveton, a representative of the Association of Medical Aid Schemes (Rams) said yesterday.

He was reacting to an announcement by Health Minister Willie van Niekerk that the Act was to be amended to solve some of the difficulties it created for the medical aid industry, doctors and goverment.

Leveton said any move to bring relief would be welcome.

Cost containment had become the major problem, which could be alleviated by greater flexibility, he said.

This could include moves to discourage over-utilisation of funds by memebers.

It could also include an element of self-insurance in which the member would be responsible for a basic amount for every claim made.

Leveton said Rams would be represented at a closed conference in Pretoria on April 9 on problems of the medical aid industry and the options available to solve or alleviate them.

When announcing the conference, Van Niekerk said the issue involved would be treated as urgent because of the financial state of the industry.

National plan for care of disabled

Mercury Reporter

IT WAS hoped that a major investigation at present being conducted would culminate in a national policy for the care of the disabled, the Minister of National Health, Dr Willie van Niekerk, said yesterday.

Opening the annual congress for the cerebral palsied in Durban, he said a team of 27 working committees, consisting of almost 300 experts on the care of the disabled, was doing research on the subject to formulate a national policy.

At the congress, a report on cerebral palsy would be tabled which would identify major needs, he said.

One area that had been identified was the need for provision of after-school accommodation and employment for the cerebral palsied.

'Much time, manpower and money is being invested in the training of the cerebral palsied child, whereupon he is often delivered to the mercy of the parents or the community with little hope of employment.

'For this reason, the community at large will have to be educated to accept the disabled as an integral part of the community and to afford them equal opportunities in all spheres of life,' he said.

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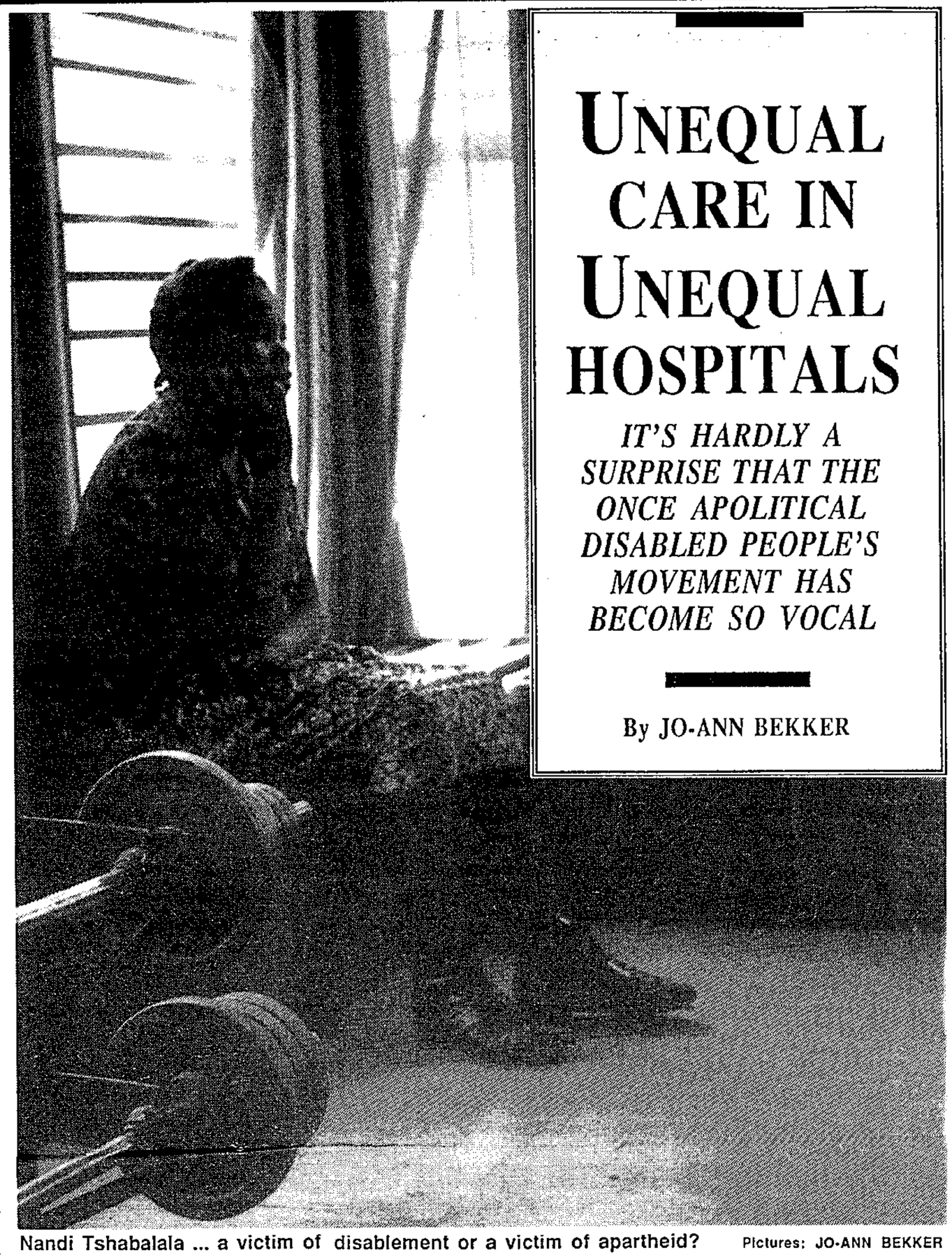
UNEQUAL CARE IN UNEQUAL HOSPITALS

IT'S HARDLY A SURPRISE THAT THE ONCE APOLITICAL DISABLED PEOPLE'S MOVEMENT HAS BECOME SO VOCAL

By JO-ANN BEKKER



Nandi Tshabalala ... a victim of disablement or a victim of apartheid? Pictures: JO-ANN BEKKER

A QUIET revolution is taking place among the disabled community — South Africa's fastest growing minority group.

Initially focused on issues like improving access to public buildings and changing society's prejudiced attitudes, the disability rights movement is, inevitably, becoming involved in the political sphere.

The lines emerged clearly at the National Symposium on Disablement in Bloemfontein at the end of last year, when the multi-racial, apolitical Disabled People South Africa (DPSA) group issued its first overtly political statement.

"The condition of poverty and unequal opportunity" of black urban and rural disabled people "arises from the disadvantages which are economic, social and political," the statement said. "We believe that this situation has been created by the policy of apartheid which includes unequal pensions, unequal education and unequal hospital facilities. Until this changes, our people will remain doubly handicapped."

One of the people at the forefront of the movement is Kathy Jagoe, a quadriplegic since a diving accident at the age of 15 and a founding member of the DPSA. A doyenne in the disabled community since she headed a successful campaign for legislation to make new buildings accessible to disabled people, Jagoe was invited to deliver a paper at the Bloemfontein convention. She used the platform to deliver a scathing attack:

"While we (disabled people) find barriers to equal accessibility in architecture, transport, negative attitudes, employment, education and health care," she said, "nowhere do we find a larger, more pervasive, more insidious barrier to equal access to our society than in apartheid."

Jagoe concluded: "And however much we dismantle other barriers, we will fail to address the problems of the majority of disabled people in South Africa until we dismantle apartheid."

The speech created quite a furore. The head of a subsequent session threatened to withdraw if there were further mention of politics. A speaker from the floor launched a virulent attack on Jagoe's speech, and when her colleagues were ignored in their efforts to respond to the criticism, Jagoe and the DPSA delegation left the State Theatre in protest — wheeled out by members of the South African Defence Force who had been assigned to assist at the convention.

But the seed had been planted. The DPSA was given permission to present its statement on apartheid at the symposium and Jagoe was asked to develop her thesis further in a paper for the Organisation for Appropriate Social Services of South Africa (OASSA).

Since then the fight for equal rights for disabled people has quietly gathered pace. A major part of the revolution concerns the assertion of the right of disabled people to take control of their lives which, for decades, were run by well-meaning welfare agencies who sponsored separate homes, transport and sheltered workshops for those with disabilities.

Jagoe and Thulane Tshabalala, who lost the use of his legs after he was stabbed in 1980, operate a spinal clinic and counselling service at Baragwanath Hospital once a week through which they aim to break down the monopoly medical professionals traditionally hold on medical knowledge.

Tshabalala and Muzi Nkosi, a 24-year-old Wits student who became a quadriplegic after being shot by an off-duty policeman in 1981, visit disabled people in Baragwanath and Hillbrow hospitals to counsel and advise the newly disabled.

And Nkosi heads the country's first Disabled Students Action Group, co-ordinated by the Soweto Self Help Paraplegics Action Group (Shap), which — while encouraging students to become independent through furthering their education — also aims to build leadership skills.

The bottom line is to motivate students to return to ordinary schools. "There are no special universities," Nkosi puts it simply.

These developments are closely tied up with current political developments. Tshabalala and Nkosi say most of the people they counsel are victims of security force action. Many accept they are part of the inevitable casualties, but this does not make any easier their personal readjustment to never walking again.

"Normal" township schooling is in turmoil as a result of the education crisis. Most of the students do back-up correspondence courses.

"Master" Modise, who, like Tshabalala, was confined to a wheelchair after being stabbed in 1979, was caught up in the middle of the education turmoil at the University of the North, where he studied for his Bachelor of Commerce degree, in the early Eighties.

"It was difficult," he recalls. "Some students were detained and the authorities gave an ultimatum to everyone to be off the campus by 3pm. I was left alone in the hostel and waited four days for my father to fetch me."

The disability rights movement has also gained impetus by the addition of highly politicised people to its ranks — people like South African African Allied Workers Union vice president Sisa Njikelana.

Njikelana's spine was injured in a motor accident last November when he was returning to Soweto from union business. The full extent of his injury is not yet known and doctors are optimistic about his chances of recovery, but he has spent the past four months lying flat on his back in one of Baragwanath Hospital's wards with almost as many people on stretchers on the floor as on beds.

"It is an appalling situation," he says of the overcrowded ward and overworked staff. "And the kind of work done for full rights for the disabled cannot be viewed outside the confines of the broad struggle for freedom.

"We envisage a kind of health service which will be based upon people's needs. Ensuring the best treatment for the disabled is part of the whole concept of people's health services, which will not be confined to hospitals and clinics but will be extended right into the community."

Njikelane, who testified before the Aggett inquest about electric shock torture during one of his 10 stints in prison, is however, fatalistic about his injury. "Even if I am permanently disabled, I can still do a lot for the union. It's the political grooming you get in participation in the struggle. You do not get freedom overnight."

INDUSTRIAL RELATIONS

JUNE 1987 – FEBRUARY 1988

The important and highly acclaimed Certificate Programme in Industrial Relations is again being offered by the Wits Business School. The programme is intended for trade union officials, office bearers and managers responsible for Industrial Relations.

The practical emphasis of the course assists delegates to face the Industrial Relations challenges in South Africa.

The full programme covers the period from 22 June 1987 to 12 February 1988 with four full-time lecture weeks* at the School. The remainder of the time will be spent on projects and assignments.

The course will be conducted by senior university staff and

WBS

The
Roman Catholic
Bishops of Natal

invite applications for the newly-created position of

RURAL TRANSFORMATION OFFICER

The Roman Catholic Bishops of Natal have recently conducted a survey of all rural land owned by the Church in Natal. One of the recommendations is that the Church should establish the post of Rural Transformation Officer to implement the recommnedations of the survey.

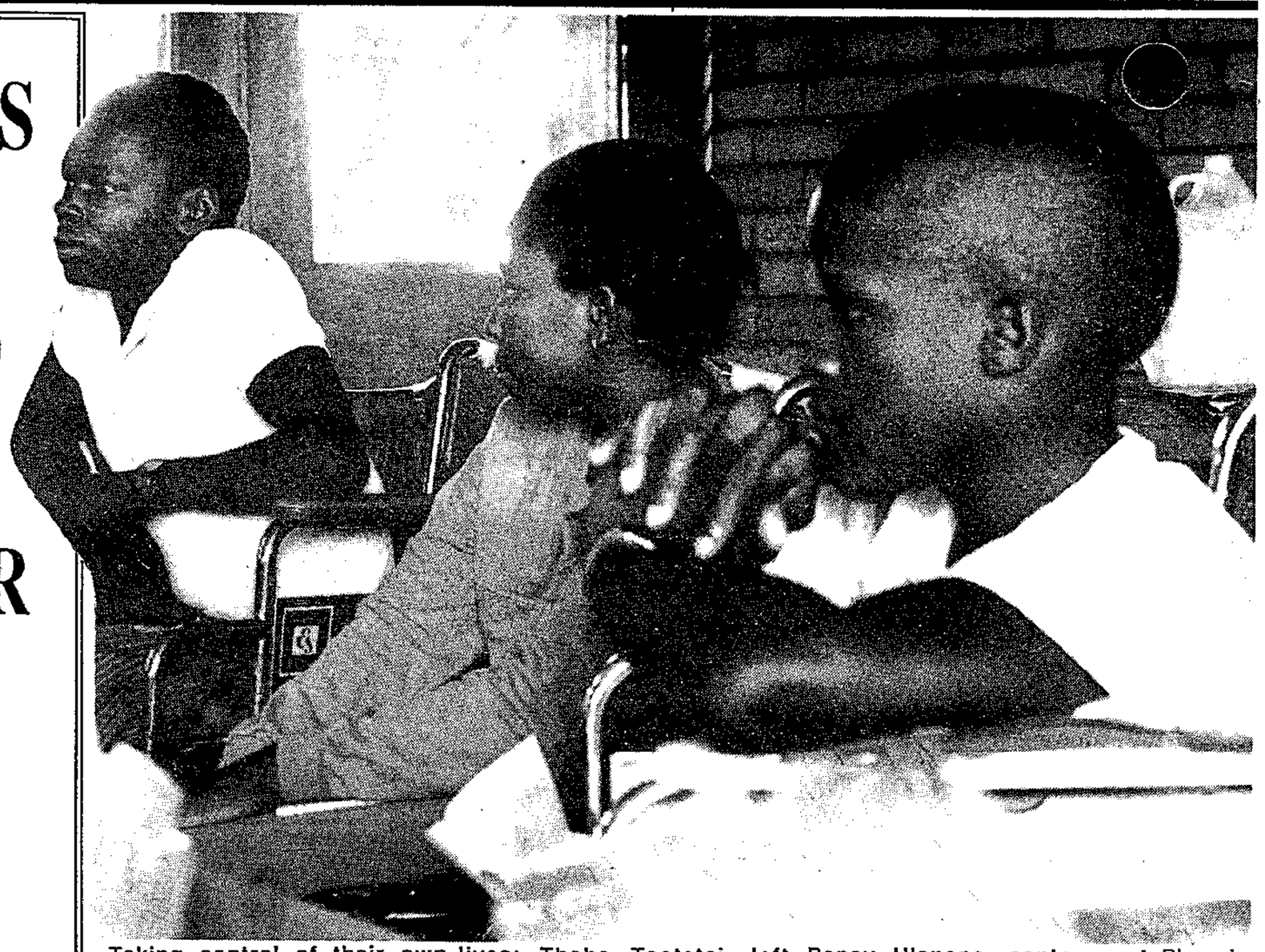
DUTIES

- Assisting the Church in dealing with issues of land and rural transformation.
- Working with tenants on church-owned farms on the above issues.
- Researching aspects of transformation in rural areas.
- Establishing pilot development and training projects on the Church farms.
- Liaising with various diocese, religious orders, researchers and development agencies in Natal, as well as with other de-

THE POLITICS OF FACING THE WORLD FROM A WHEELCHAIR

A BLACK PERSON WITH A SPINAL INJURY HAS, ON AVERAGE, FOUR YEARS TO LIVE. AND THE REASON HAS NOTHING TO DO WITH THE INJURY

By JO-ANN BEKKER



Taking control of their own lives: Thabo Tsotetsi, left, Pansy Hlapane, centre, and Phansi Moeti at a meeting for disabled students in Soweto.

BLACK disabled people are caught in an information vacuum which kills.

The stark facts, according to medical professionals and disabled people themselves, is that those with spinal injuries will not live longer than four years in black townships — unless they are specially educated about their disabilities.

Through ignorance and neglect, people suffering from quadriplegia (paralysis of the arms and legs) and paraplegia (paralysis of the lower part of the body) die from kidney failure as a result of bladder infections. Or they are killed by septicaemia — poisoning of the system — caused by blisters which, if not treated, turn into festering pressure sores which become septic and infect the entire body.

Some patients, while receiving hospital treatment for pressure sores, reopen their healing wounds with razor blades rather than return to a squalid township with corrugated roads impassable for anyone in a wheelchair, to small, crowded homes with inaccessible backyard tin toilets — to a life of social isolation.

While groups like the South African Institute of Race Relations record the number of people killed in the civil violence which has swept South Africa for the past two and a half years — 2 387 at the last count — there are no statistics for how many men, women and, especially, children have been permanently disabled.

But there is no doubt the numbers are increasing.

In South Africa, the total of disabled whites, most injured in road or sport accidents, falls within First World ratios — about 10 percent of the white population. But the number of disabled people of all races, a representative of the Association for the Physically Disabled (formerly Cripple Care) says, is roughly 20 percent of the population, a ratio found in the Third World.

Government policies have resulted in an increasing number of black disabled people.

In townships under virtual occupation by the armed security forces, violent confrontations which will result in death and permanent disablement have become endemic.

On a more long-term basis, crowded, unsanitary townships foster disabling violence and diseases like typhoid and polio which have practically been stamped out in white communities.

And black workers do the bulk of unskilled work which carries the highest risk of injury on mines and in factories.

The trend is not arrested in the overflowing, segregated black hospitals which are forced to concentrate on curative rather than preventive medicine.

In large black hospitals without spinal care units, medical staff estimate that more than 80 percent of patients with paralysis develop pressure sores in hospital, wounds which multiply quickly.

A physiotherapist said one of her patients had 15 such wounds. "He looked like he'd just come out of a concentration camp," she said.

And yet, pressure sores are fully preventable if patients are turned every two hours and provided with a high protein diet. But they will continue to develop for as long as patients are scattered in different wards throughout the hospitals — often spending a fortnight on a stretcher on the floor waiting for a spare bed — where the critically ill demand the overworked nurses' immediate attention, and where follow-up medical supervision is made difficult.

Baragwanath Hospital plastic surgeon Dr Greta Drummond is concerned about the number and severity of the pressure sores she has to repair.

"We should be the very last medical people to be involved in the treatment of spinal injuries. If patients were well looked after we would not see any of them," she says.

"Our problem is that once a patient has a bed sore, his skin is damaged. We can always get him healed, but the skin becomes so damaged and scarred after a while that it can't stand up to normal wear and tear and he will be back in another two weeks with another sore."

A doctor said lack of co-ordination in the treatment of disabled people also hampered basic instruction in how to prevent kidney problems — the importance of drinking about four litres of fluid a day, to flush out the system, for example, and how to read the colour of urine for bladder infection.

A small group of disabled people, working with sympathetic health workers, are running weekly clinics and peer counselling services in order to break the information gap. Medical staff and spinal cord injured patients speak highly of their assistance, but they are still up against considerable odds which continue after patients leave hospital.

While unemployed disabled people receive a state grant of about R200 a month, the Disabled People South Africa point out, coloured and Indian disabled people receive only half of this. Black disabled people receive a monthly grant of less than R80.

And even when disabled people have combatted the physical and financial barriers preventing their living full lives, society's prejudiced attitudes remain a handicap.

"You don't want special treatment because you're disabled," "Master" Modise, a BComm graduate who works for a major bank, says bitterly. "I don't want to be reminded of my disability. Pity does not help me. It kills a disabled person when you try to do everything for them, expect them to be dependent on you.

"My aim is to live the life I was living before I was injured. I want to have my own family and my own house."

It's an aim constantly undermined by society's false conception of disabled people as passive, asexual and inferior.

"People don't realise how important it is to meet disabled people," says Modise, who was paralysed after being stabbed. "You never know when you could be next."

The gun shots which changed two lives

By JO-ANN BEKKER

POPI BUTHELEZI and Pansy Hlapane are both in wheelchairs today, but the bullets which put them there were fired by people from diametrically opposed sides.

It was June 16, 1976 when Buthelezi walked for the last time. A 17-year-old Std 8 student, she had joined the Soweto march to protest the decision to make Afrikaans the medium of instruction in certain subjects at black schools.

"At about 7pm I was walking to an aunt's house to collect my books when I was shot in the back, between the shoulder blades," she recalls, pointing to the scar on her chest where the bullet left her body.

Three days later she regained consciousness — in a ward in Baragwanath Hospital, where she remained for eight months. She was in hospital with seven other students who were also disabled after being shot in the uprising.

Pansy Hlapane is the daughter of Bartholomew Hlapane, an African National Congress defector who gave evidence on the exiled organisation before a United States government commission in April 1982.

"I was shot by the ANC," Hlapane says when asked about the incident which left her a paraplegic at the age of 12.

"In December 1982 a man came to our house one morning at about 8.30 and asked for my father. He was sleeping and I went to call him. When the man heard my father's voice calling: 'Who's there?' he just started shooting. He started on me — using an AK47 — and then he killed my parents."

Hlapane, now 19 years old, is a matric student at Damelin College and lives with her sister in Soweto. Next year she plans to enrol at an American university and tackle a Bachelor of Arts degree in Administration. "My father's friend promised to get me a scholarship," she says.

Recalling the day she lost her parents and the use of her legs, "It was terrible", she murmurs in her American accent.

"But I'm not feeling terrible anymore. It took time and courage."

Asked whether her burden is different from those paralysed by police bullets, "I still feel angry," she says. "There is a reason why demonstrators are shot. I was shot without any reason; I did not do anything. That's how I see the difference."

Popi Buthelezi, 27, who is a switchboard operator and wage clerk at the Soweto Self Help Association for Paraplegics — where Pansy attends a student group — says "the hatred came" for the security forces who caused her disability.

"We were demonstrating peacefully," she insists. The eldest of six children, Buthelezi says her mother was badly "affected by my shooting and passed away in 1981".

"I won't say I forgive them (the police)," she adds. "Many people are still injured at their hands. But I've told myself one day everything will be okay. We will get what we need — just as education, it changed after that day, what we had been forced to learn in Afrikaans we could learn in English."

FOR SUBSCRIPTION INQUIRIES — TELEPHONE

McClelland care unit officially opened

DD 299
19/3/8

Dispatch Reporter

EAST LONDON — The extended care unit at the McClelland Centre for the handicapped was officially opened here by the Mayor, Mrs Elsabe Kemp.

In her opening address, Mrs Kemp said the centre provided an invaluable service to many families in East London.

"It does not bear to think about that, without the centre, many parents would experience the anguish of parting with these special and beloved children by having to send them away from East London to other cities," Mrs Kemp said.

"We will never forget Major McClelland and his wonderfully gentle and patient wife, Dorothy, who were so caring and laid the foundations of what we have here today.

"The McClelland Centre, rendering a service to both adults and young children who are mentally handicapped, has come a long way since its inception in 1955.

"Having started out in wooden prefabs near the Cambridge Town Hall, it has developed into the establishment it is today having two sections, one for the training of 68 children and the other for giving meaningful occupation and simple work opportunities to 78 adults.

"The growth of the centre has often not been as fast as the demand requires, but this has always been related to the availability of funds," Mrs Kemp said.

Mrs Kemp also paid tribute to the local community through whose support and generosity the extended care wing had been made possible.

The idea of this new wing was initiated a number of years ago when the centre found it difficult to place their aging residents in old age homes.

"It was a battle to place mentally handicapped residents in old age homes so we knew we had to find an alternative," Mrs Ilva Andreas of McClelland said.

The wing was completed at the end of last year and will house 12 residents who, either due to old age or other physical handicaps, need extra care and nursing.

20/2/87
20/3/87

299

Medical aid society hit by rise in claims

MICK COLLINS

BENEFITS paid out by one of the largest medical aid schemes in the country were 24% more in 1986 than in the previous year — and 14 times greater than 10 years ago.

Sanmed chairman Herbert Peters said yesterday the increase in benefits was greater than could have been reasonably expected.

Apparently, a change in practice has been responsible for the steep rise since April 1986, Peters said.

"According to statistical analyses, in 1986 general practitioners concentrated much more on consultations. Follow-up consultations, in particular, increased out of all proportion.

"Benefits per member for dental services rose by more than 18%, whereas the tariff increases were expected to limit the rise to 12,5%. In addition to this, expenditure on hospital services and medicine on average rose by 34% and 31% respectively."

He said the year had been a difficult one for Sanmed and medical schemes in general, and appealed to all members to make prudent use of medical services.

The medical aid society paid out a total of R123m on behalf of members of its schemes for the year.

He said net income totalled only R365 000 notwithstanding an interim increase in subscriptions from September 1, 1986. This, together with a net profit of R625 000 from the sale of investments, was transferred to Sanmed's reserves, which currently amounted to R25,7m.

Meanwhile, the Johannesburg Chamber of Commerce Medical Aid Society has appealed to doctors to prescribe generic drugs in an effort to curtail costs.

Chairman Pat Corbin said: "Generic drugs are chemically identical and therapeutically equivalent to their brand-name equivalents. Generic drugs can be sold more cheaply, because the manufacturer is not involved in research and development."

Medicine prices need to be cut, say medical aids



Post Correspondent

DURBAN — Medicine prices will have to drop by the end of the year because medical aid societies cannot cope with high costs incurred by members.

To do this, manufacturers, wholesalers and pharmacists will have to "pull their belts in" and reduce medicine costs to encourage those on medical aids — but who cannot afford current costs and use provincial facilities — to return to the private sector.

This is the opinion of by Mr Sid Hurwitz, vice-president of the National Wholesale Drug Association, and MD of South African Druggists (SAD), one of the country's largest medicine wholesalers.

He was reacting to the controversy surrounding a call by the South African Association of Retail Pharmacists (Saarp) for a change in the Government tender system for medicine.

Saarp says the Government is paying ridiculously low prices for medicines and that those people buying medicines in the private sector are being forced to subsidise the low costs.

Only 15% of the population gets its medicines in the private sector and, according to Mr Hurwitz, there are a large number of people, mainly geriatrics, who need long-term therapy.

If they bought their medicines in the private sector, their medical aid allowance would be soon used up.

These were the people who needed to be enticed back into the private sector with lower prices.

"If prices were reduced, they people would be encouraged to come back into the market. Understandably, pharmacists are nervous about dropping their prices — legislation prevents them from advertising — but if more people came into the sector the prices would be kept down and it would still pay."

Focus on education for handicapped

Education for handicapped black children is under close scrutiny in three of the country's main centres this month, as researchers of the Human Sciences Research Council discuss the issue with educationists. DEBBIE REYNOLDS reports on the conference held in Durban this week.

THE investigation launched by the Human Sciences Research Council (HSRC) last year has released preliminary recommendations, but the purpose of the three conferences in Durban, Pretoria and Port Elizabeth this month is to add comments and suggestions from people closely involved with handicapped black children, as well as from handicapped people themselves.

'We would like the preliminary recommendations to be scrutinised before the final document is published and submitted to the relevant authorities for possible implementation,' Dr Schalk Engelbrecht of the HSRC said at the opening of the conference at Umhlanga.

Prof Willem Steenkamp, director of the Institute for Personal Guidance at the University of the Western Cape, spoke on the philosophy of education for the disabled, with special reference to the black child.

He stressed that impaired children should have as normal an environment as possible: 'There should be a move away from the institutionalisation and isolation of the impaired'.

Prof Steenkamp, like the other researchers, stressed the need for impaired children to be placed in mainstream education wherever possible. Special education should only be advised in extreme cases and children should not be removed from their parents unnecessarily.

He also recommended that a single authority or department provide all services for the impaired, as well as maintain a central databank.

'At present, for example, in the course of their lives handicapped children would probably be handled by the Departments of Health, Education and Manpower,' said Prof Steenkamp.

The current and future role of the media (especially television) in the education of the black disabled child was discussed under the leadership of Prof Giel Stander, a lecturer in educational psychology at the University of Stellenbosch.

The researchers found that a central databank with the necessary segmentation to fulfil the specific needs of each medium was essential if the existing gap was to be filled effectively.

It would include up-to-date information such as the definition of different impairments and the causes and treatments, and address lists of experts in the field of disabled children.

'The absence of such a service leads to uncertainty among the media (often resulting in sensationalism) and confusion among parents and interest groups, and is cost-ineffective for all parties,' said Prof Stander.

The final report is expected to be completed before the end of the year.

southNEWS

CARTER WON'T HELP HANDICAPPED KIDS - all because of a name

299 SOUTH 28/4/1987

By ANTON FISHER

FUNDS which a day care centre for severely handicapped children desperately need are being refused by the coloured Labour Party because of the centre's name.

Officials of the Kairos Day Care Centre in Oudtshoorn say the House of Representative's Department of Education and Culture will not approve a R229 000 subsidy until the centre's name is changed.

But the coloured Minister of Education and Culture, Mr Carter Ebrahim, says his door is open to discuss the matter with the Kairos officials.

Mr Tinus Dempsey, a spokesman for Mr Ebrahim, says he cannot say whether the name is the problem.

Meanwhile, the centre is struggling along on donations from local businessmen, providing two meals a day for 35 children and employing a qualified teacher on a salary which amounts to charity, says Kairos committee member Mrs Rachel Mooney.

She says: "We will continue though we don't know for how long. But we are not prepared to change our name. If the state doesn't help us we will be forced to close."

The centre shares the name of the Kairos Document. This was drawn up by South African priests and is a statement on the role of the church in the crisis the country is experiencing.

The chairman of the Kairos committee, Mr Gert Mooney, says politics is being read into the centre's name which was chosen without any intention of making a political statement.

He says the committee received a letter from the Department of Education and Culture which said the application for a subsidy had been refused because of the centre's name.

The committee chose the name because it was brief, could be used in both official languages and had a biblical link. Kairos in biblical Greek means the right moment, Mr Mooney says.

"I have never seen the Kairos Document. I don't know what's in it. But now I am going to read it.

"We are bitterly disappointed at the way the matter is being handled," Mr Mooney says.

AKGuys 7/4/87 299

National health service for SA mooted at health congress

Medical Reporter

HEALTH was a right and not a privilege, delegates to a medical congress focusing on a national health service for South Africa were told.

The National Medical and Dental Association (Namda) congress held during the weekend at the University of the Western Cape (UWC) drew about 500 people. Speakers from Britain, the Netherlands, Zimbabwe and Lesotho spoke on various aspects of a national health service for South Africa.

A Namda executive said they felt it was time to do something about a future health system for all in South Africa".

"Chewing gum"

Professor Jerry Coovadia of the University of Natal, presented "the case for an NHS" and said the essential arguments were based on moral, ethical, ideological, medical, economic, political, social and cultural foundations.

"Health is not a commodity, like a car or chewing gum," he said.

A session entitled Health Under Repression dealt with, among other things, patient care and the doctor-patient relationship in a largely authoritarian society, where doctors practising in townships could be seen as part of such authority.

Dr Stanley Levenstein, a general practitioner, said working-class people were "conditioned by society not to question those in authority" and "progressive doctors could easily fall into the trap of reinforcing the system's views" and alienating their patients.

A member of the Namda Johannesburg branch presented the results of a study by Namda doctors of 131 released detainees of whom 70 percent alleged they had been physically assaulted.

Of detainees who spent time in solitary confinement, 84 percent suffered psychological trauma, the study found, drawing the conclusion that existing acts and associated legislation did not safeguard the health of detainees.

Victims of township unrest were faced with three choices: to be treated at local (usually provincial) hospitals, to see local general practitioners, or to stay at home. Increasingly they found that to go to hospital with injuries suggestive of political involvement meant almost certain detention.

Several general practitioners in the affected areas alleged harassment by security forces and an incident was quoted where a doctor's consulting room was barricaded by Casspirs parked outside the entrance.

The emergency service group of Namda had devised a first aid training programme for township youths so that they would be able to identify injuries requiring urgent medical care.

A Western Cape spokesman for the Organisation for Appropriate Social Services in South Africa said teachers of young children were concerned that their charges would be permanently scarred through living with and witnessing violence.

At the height of the unrest, children in care centres were playing games like "Casspir, Casspir," "Witdoeke and Comrades," and later "Funerals" which were worrying and distressing for teachers.

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Medaid legislation set to come under review

GERALD REILLY

PRETORIA — Drastic amendments to legislation governing the troubled medical aid industry will be discussed at a top level conference here this week.

The conference, called by Health and Population Development Minister Willie van Niekerk, will be attended by the Medical Association of SA (Masa), the Representative Association of Medical Aid Schemes (Rams) and the Private Hospitals Association.

Van Niekerk said the Medical Schemes Act had to be amended to resolve some of the difficulties experienced by the medical aid industry, doctors and government.

The issues involved would be treated as urgent because of the financial state of the industry.

RAMS spokesman Tony Leveton said cost containment had become a major problem which could be alleviated by greater flexibility in regulating the schemes.

That could include moves to discourage over-utilisation of funds by members. It could also include an element of self-insurance in which members would be responsible for a basic amount of every claim.

Leveton said it was not only abuse of schemes by members that had caused the industry serious financial problems.

Huge aid for underprivileged

JOHANNESBURG — Esso, the South African subsidiary of America's largest oil company, Exxon's, is being converted into a new company, Zenex, which could become one of the country's biggest charitable organisations.

Up to R20 million a year in profits is to be used to finance educational and social programmes for SA's underprivileged once the new company has paid Exxon an undisclosed purchase price.

The moves follow the disinvestment decision by Exxon, which announced its withdrawal from SA

The announcement was made today by Zenex Oil (Pty) Ltd chairman and managing director Mr John Truscott. — Sapa

CAPE Times 9/4/87

Top level medical aid meeting today

Own Correspondent

JOHANNESBURG — A top-level meeting between Health Minister Dr Willie van Niekerk and representatives of the medical aid societies and medical profession takes place behind closed doors in Pretoria today.

Long-standing problems experienced with the Medical Schemes Act are likely to be discussed, though no formal agenda exists.

Announcing the event last month, Van Niekerk said he was convening the conference to collect evidence on the problems caused by the Act and views on redrafting it.

The cash crisis facing the medical aid industry — which led to one society collapsing last year — has already led to increases of 15% to 20% in rates this year, says Tony Leveton of the Representative Association of Medical Schemes (Rams).

Rams is in favour of greater flexibility in the Act to enable societies to design a variety of benefit packages.

10 medical schemes in danger — Minister

ARGUS 9/4/87
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The Argus Correspondent

PRETORIA. — At least 10 South African medical aid schemes are in danger of liquidation, the Minister of National Health and Population Development, Dr Willie van Niekerk, said today.

He was addressing a conference here aimed at reviewing medical legislation.

"There are 60 schemes whose accumulated funds represent between only one and 10 percent of their incomes instead of the desired 25 percent," he said.

"This could lead to the liquidation of some schemes."

He said the the Medical Schemes Act would have to be adapted to "present-day circumstances."

Attention would have to be given to the recommendations of the recent Commission of Inquiry into Health Services and the White Paper which followed.

LIMITS SPREAD

"Package insurance covering only 'catastrophic' medical expenses limits spreading of the risk," he said.

"Members of schemes offering only this cover will inevitably become the responsibily of the State for their basic medical needs."

"The State cannot afford anything like the R1 700-million paid out by medical schemes in 1985.

"It is in the national interest that schemes continue to provide benefits for at least the most essential services needed by patients."

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Place of safety: 1st phase opens

THE first phase of the R20-million place of safety was opened officially in Rietgat, near Soshanguve on Friday.

The place is known at Tsosoloso (revival) and will cater for underprivileged children.

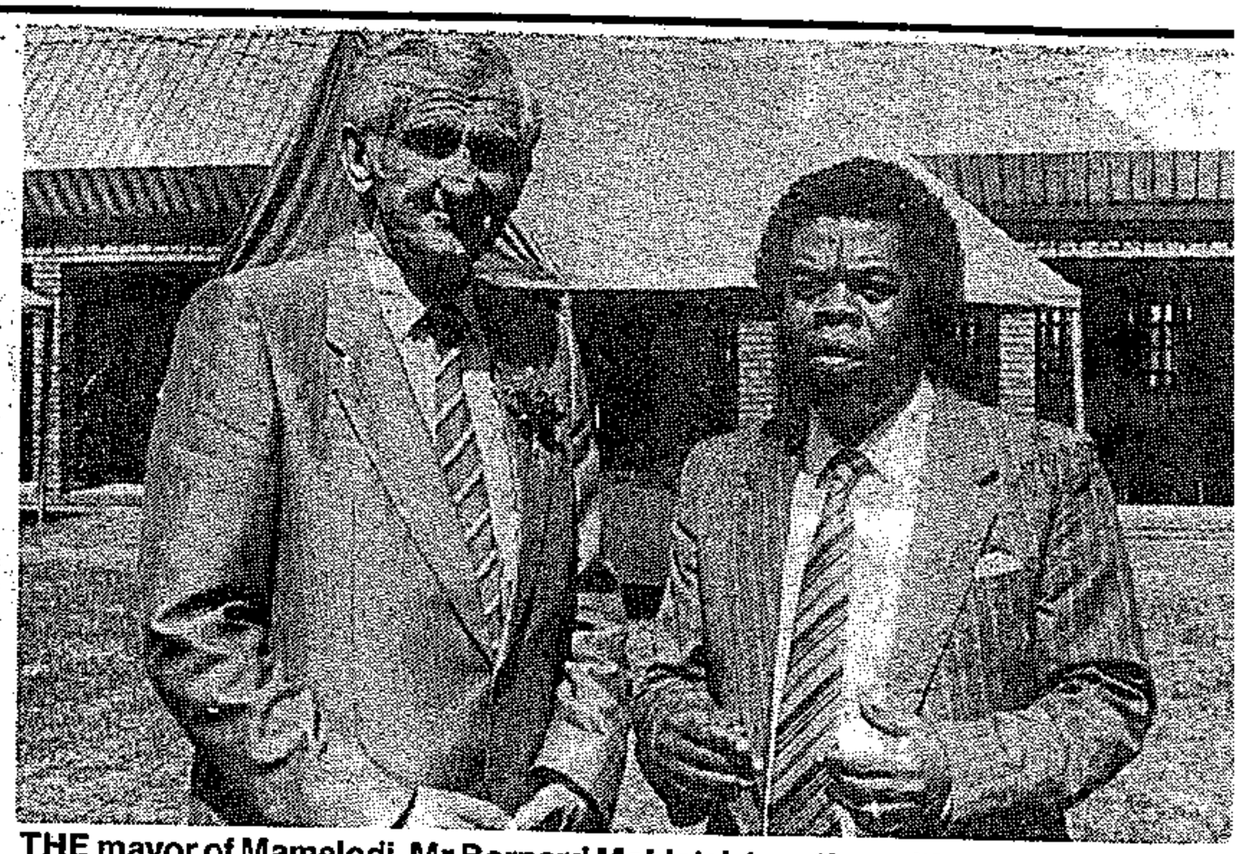
In his speech read for him by a senior official of the Department of Constitutional Development and Planning, Minister Chris Heunis, said the centre was meant to establish professional rehabilitation programmes.

The Government, he added, often dealt with problems affecting needy children, the handicapped and chronically disabled persons who were being refused admission to private institutions.

Backbone

Some of the departments still to be erected at this newly established institute will help alleviate such problems and also act as a backbone to services rendered by private initiative, the Minister said.

The completed part of the "home" includes a place of safety, a school, a kitchen, an administrative block and a boiler room. About R6,2-million has been used on the project.



THE mayor of Mamelodi, Mr Bernard Mahlatsi, together with a senior official of the Department of Constitutional Development and Planning, who represented Mr Chris Heunis at the opening of the place of safety in Soshanguve last Friday.
Pic: ROBERT MAGWAZA

Minister wants medical schemes adapted

PRETORIA — It was time to reconsider all aspects of medical aid schemes and there was no doubt the Medical Schemes Act would have to be amended to adapt to present day circumstances, the Minister of National Health and Population Development, Dr Willie van Niekerk, said yesterday.

Addressing a specially convened conference in Pretoria on medical aid problems, he said the costs during 1985 for private health care born by medical schemes alone amounted to over R1,7 billion — a tremendous increase compared to past years.

There had not been an increase in services provided for which benefits had to be paid.

Financial reports for 1985 indicated that of the 206 existing organisations, 10 medical aid schemes' liabilities had exceeded assets, and 60 had accumulated funds of between only one and 10 per cent instead of the desired 25 per cent.

This was an undesirable tendency which could lead to liquidiation of schemes, he said.

Dr Van Niekerk warned delegates however that any proposals "which might result in greater government responsibility for health services or result in government becoming involved in the determination of fees or scales of benefit or have an effect on the interests for the patient, cannot be accepted".

Referring to the Snyman commission of 1965, which investigated the high cost of medical services and led to the present Act, Dr van Niekerk said: "We have come full circle since then and we are once again at the point where be must consider costs, the efficiency of control measures and their applicability in current circumstances."

There were however certain policy aspects which were important to government.

Firstly, much had been made in the past few years of a "package" medical insurance deal to cater for a particular class of person or for "catastrophic" medical expenses only, but this would result in these people's basic medical needs becoming the responsibility of the State.

The second policy aspect was the determination of fees and the scales of benefits.

The third aspect was that the patient's interests always had to come first.

"The government cannot allow the interests of the patient to be subjected to those of other groups," he said. — Sapa

[redacted] Pcont.

(294) SPARK 14/4/1987

Interface, a group aiming for total communication for the disabled, recently held South Africa's first series of training workshops on an international augmentative communications system called Blissymbolics, and its application for communicatively handicapped people. Janine Simon reports.

Speech therapy the Blissymbolics way

Blissymbolics literature is peppered with examples of severely handicapped people who learnt the system and — often for the first time in their lives — were able to communicate effectively and expressively.

Just two examples are the stories of "Anna" and "Alex", who both have cerebal palsy.

"Anna" was introduced to Blissymbolics as an adult by her occupational therapist. In a few months she learnt 60 symbols and joined an official Bliss group. Her speech improved and she became far more extrovert.

Bliss allowed "Alex", a young boy, to learn new skills including reading. The symbols helped him express emotions and make a contribution to mature conversation.

SUCCESS STORIES

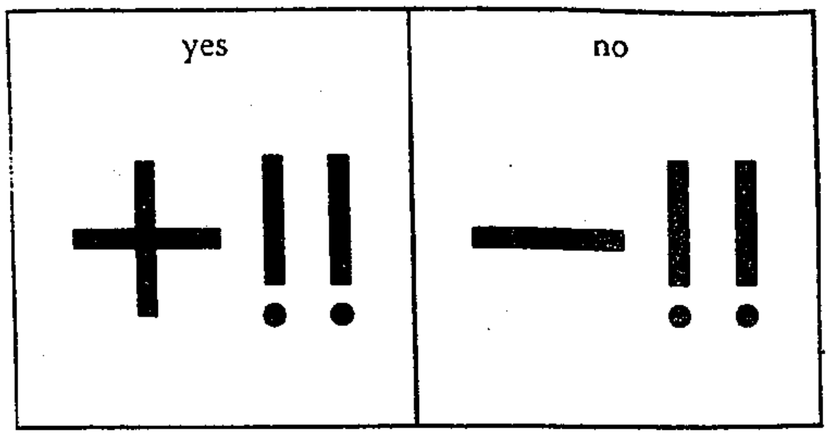
If Interface achieves its aims, there may soon be many similar South African success stories.

Last year Interface became the first South African affiliate of the Blissymbolics Communications Institute (BCI) in Canada, which has 15 affiliated countries and the legal authority to provide a worldwide standard for all published Blissymbols.

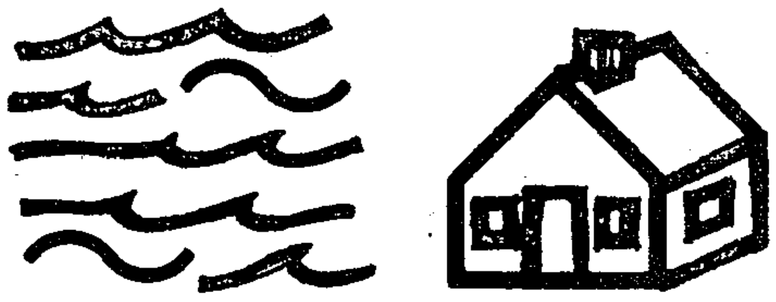
Although international work on alternative communication began in the early 1970s, the Interface training seminars, held in Cape Town, Durban and Johannesburg, were among the first on the subject offered in this country.

According to course leader Miss Annalu Waller, Blissymbolics is widely used in special schools in Canada, Israel, Holland, Britain, and the United States.

South African therapists and teachers are aware of alternate communication systems such as sign, gestural body and symbolic languages, but few have been trained in the theory, teaching and use of these systems, she said.



These are the Bliss symbols for "yes" and "no".



"Water" is an ideographic symbol because it is represented by association, that is, by the symbol for waves. "House" is a pictographic symbol because it looks like a simple drawing of a house.

Until recently therapists had often been hesitant to teach Blissymbolics, believing their patients would never learn to talk.

"But speech is still the most natural form of communication, if you give someone the ability to start communicating, they will want to expand," Miss Waller said.

"Blissymbolics take away the frustrations of trying to talk and enhance the ability to relax. It is the fundamental right of a handicapped person to have basic communication," said Miss Waller, who has cerebral palsy and is a masters student at the Uni versity of Cape Town.

"Children with cerebral palsy are often assessed at having IQs so low they are thought to be untrainable. They are written off.

LIMITATIONS

"Professionals are used to accepting limitations. The people who assess children are not aware of what to look for and can't conceive that such a child can develop to a state of communicating.

"They also need an ability to pick up an existing communication skill, which may be very limited. For example, a child glancing once at his trousers may indicate he needs to go to the toilet — if you miss, or misinterprate the glance, you think he can't communicate," she said.

Blissymbolics literature stresses it is not the only system available, nor the best for every non-speaking person, but that it is an extremely valuable part of the spectrum of augmentative communication, which includes systems of picture sets, graphic systems and sign systems.

Blissymbolics, as devised by Charles K Bliss, was based on a centuries-old Chinese model. He intended it as a graphic medium for people who spoke different languages — communicating maximum breadth of information with the minimum number of symbols.

There are four types of symbols and each is made up of a meaning-based unit.

The line shapes of the symbols are relatively simple which allows them to be written by hand, displayed or printed with computers. Originally 1 400 symbols were published by BCI, but new symbols are added annually.

Interface has identified two main needs regarding Blissymbolics — to train people across the whole spectrum of those involved with the communicatively disabled and the need not to pre-judge and assume a person who appeared not to communicate, could not do so.

Participants at the recent Johannesburg seminar also stressed that Blissymbolics had a role to play in residential, educational and community situations. Public awareness and knowledge of the sytem could allow a verbally handicapped person to intergrate to mainstream society.

Media exposure of Blissymbolics was essential for news of the system to reach disabled people who could not get to formal teaching and assessment facilities and also to break down public prejudice against the severely disabled.



Blissymbolics course leader Annalu Waller shows a Bliss Board. Each board can contain a selection of symbols suitable for the individual's communication needs.

● Picture by Garth Lumley.

Medical aid costs rocket

SANLAM is seriously concerned over the state of affairs in the medical aid industry, perceiving many shortcomings and problems.

Sanlam medical aid subsidiary Sanmed chairman Herbert Peters said recently average monthly benefits paid per member by Topmed and Helpmed, two major Sanlam medical aid schemes, increased by 93% and 87,8% respectively between 1983 and 1986. Sanlam regards these claims experiences as "indicative of the situation in the industry".

And claims rose dramatically after April 1986, with the five winter months showing "hair-raising" increases.

299 Bus 14/9/87

PERSONAL FINANCE

Minister opposes bigger govt role in health care

GOVERNMENT has recognised the need for changing current medical aid arrangements to deal with the pressing problems of the industry.

But the Minister of Health rejects measures that might result in greater governmental responsibility for health services, including responsibility for fee-setting.

Addressing a specially convened conference on medical aid problems last week, Health Minister Dr Willie van Niekerk said that since the appointment of the Snyman Commission in 1965 "we have come full circle and are once again at the point where we must consider costs, and the efficiency of control measures and their applicability in current circumstances".

During 1985, the cost borne by medical schemes amounted to R1,7bn — a big increase compared with earlier years. The schemes' financial reports for 1985 indicated that out of 206 in operation, 10 had liabilities that exceeded assets, while 60 had accumulated funds of only 1%-10% — instead of the desired 25%.

This was an undesirable tendency, which could lead to the liquidation of schemes. It was therefore time to reconsider all aspects of medical aid schemes, Van Niekerk said.

The Minister emphasised certain important points in considering changes:

☐ It was unacceptable for government to become involved either in greater responsibility for health services or in the determination of fees or scales of benefits;

☐ Government was opposed to the introduction of package medical insurance deals that made provision only for particular classes of person or for "catastrophic" medical expenses only. The State would be obliged to assume responsibility for peoples' basic medical needs, which was unacceptable;

☐ The negotiation of rates for fees and for types of benefit had to be conducted in a free-market setting, without government becoming a party. This goal had not been fully attained in the past;

☐ The patient's interests had to come first and cannot be subjected to the interest of other groups. The cake of R1,7bn was trust money that belonged to the members of medical schemes; and.

☐ In modernising and adapting governing legislation, account must be taken of the growing number of black, coloured and Indian members, which had more than doubled since 1969.

Whole page 2/4 except advert

Edited by Robin Friedland

Basic changes needed to overcome problems

GRAVE financial problems face the medical aid movement in SA, and the industry requires fundamental reform.

Restructuring of the basis of payments to doctors and other providers of services is needed to motivate the evolution of "cost-effective medicine".

These measures could include regulating practitioners' charges to a monthly fee and charging members a substantial excess for services rendered.

Affiliated Medical Administrators chairman and an appointed member of the executive of the Representative Association of Medical Schemes (RAMS) Tony Leveton says the Minister of Health recently convened a round table conference to consider revising the Medical Schemes Act.

This was prompted by increasing strains on the finances of medical aid funds.

Leveton says there appear to be two reasons for the crisis.

There is a lack of cost awareness by members and by providers of services. Under current arrangements, "the doctor or other practitioner can write his own cheque", Leveton says. Once the practitioner has elected to charge at the scale of benefits, the scheme must, according to the Act, pay him directly and in full.

Although the member may be docked a share of the consultation fee according to the rules of the scheme, the practitioner is paid the full cost at the time of rendering the service.

And it is the practitioner himself who decides how many consultations are required, Leveton says. This is bound to drive costs up.

Leveton says the cost of prescriptions during 1986 increased by nearly 35% compared with the previous year, while RAMS expects a further 35% costs rise for the current year.

To aggravate the problem of prescription costs there have been excessive price increases, even allowing for the fall in the rand, he says.

Leveton draws attention to a specific pricing problem — the retail price of pharmaceuticals is up to 2 000% of the price charged to the Province, because the drug companies cut their prices to the bone to get large contracts from the Provincial hospitals. This problem of cross-subsidisation is "one of the curses" of the industry, he says.

Leveton considers the increase in import prices caused by currency factors important.

Under recent adverse economic conditions the schemes could not push rates of contribution as there is resistance both from employers and employees.

But there is still unsatisfied pressure from the suppliers of services, especially doctors, for higher tariffs. In the short run, only some combination of higher charges and reductions in the scope of benefits can avoid insolvency.

For the longer term, Leveton advocates a fundamental restructuring of the basis of operation, to create a more cost-effective form of medical practice. Both practitioner and patient must be made cost-aware.

Ways to reduce abuse of schemes

ONE way to reduce excessive use of medical schemes would be to use a combination of capitation fees for practitioners and a mix of incentives and disincentives, says executive member of the Representative Association of Medical Schemes (RAMS), Tony Leveton.

Modern systems of this kind of practice are already working well in America.

If properly designed, this type of arrangement can avoid the spread of socialised medicine, he says.

Leveton emphasises arrangements of this sort must be designed to preserve practitioners' earning capacity, so there is no need for alarm on this score within the medical profession.

The effect of such an arrangement is to put the practitioner on a budget for all items, including hospitalisation, pathology and prescriptions.

The arrangement can usefully be coupled to group practices, which are allowed in the US to compete for patients — even to the extent of advertising.

The result is to achieve a contemporary cost-effective, competitive form of medical practice.

As for the member, a few years ago the Brown Commission said s/he should pay for small items — in effect proposing a system of excesses like that in use in motor insurance.

The need to make the member as well as the doctor cost-conscious must be addressed, says Leveton.

Clinical psychology should get better deal

WHEN restructuring the Medical Schemes Act, the Minister of Health should give serious attention to a better deal for clinical pyschologists.

While psychiatrists are gazetted as medical practitioners, and their fees for consultations are dealt with accordingly, clinical psychologists are still treated as the suppliers of para-medical services. The medical schemes therefore only grant limited allowances for consultations with clinical psychologists.

In the opinion of leading practitioners, this is out of keeping with trends in psychological medicine, which is evolving along the lines of dividing responsibility for treating mental illness between psychiatrists and clinical psychologists.

P.T.O.

Medaid: Lifegro urges end to pattern of high claims

LIFEGRO considers that most medical aid schemes are not in a parlous financial position, although there are major problem areas in the industry.

What is needed is the introduction of disincentives to the pattern of high claims to prevent the price of medical aid from soaring further.

Rick Kavanagh, financial director of Personal Benefit Services (in which Lifegro has a 25% interest) says the major sore point is the guarantee of payment to suppliers of services who charge at scale of benefit.

This criticism applies to private hospitals too. The existing arrangement cuts across private enterprise and is in contrast with government's privatisation policy.

Kavanagh mentions with approval a recent article in Reader's Digest that enumerated the following major structural problems in the medical aid industry: over-servicing of patients by doctors, over-testing in the area of pathology, over-usage by members, fraud by members, and high drug prices —caused mainly by exchange rate problems and the existence of "too many transaction stages" before final sale.

The first step towards solving the problems must be to move towards greater free enterprise.

The principle would be expressed in a number of ways. Firstly, the guarantee of payment should be removed. Members of schemes should be liable in future for payment of accounts and should be reimbursed by the scheme.

Suppliers of medical services, like all businesses, should be responsible for credit control over their patients.

With the onus on members to meet their obligations, they would be forced to audit their accounts and also "chivvy up payment" and press for efficiency from their medical aid. This reform would require an amendment to the Medical Schemes Act.

Changes are also required to the Act to allow the introduction of an excess system. The excess could be annual — for example, the member could be obliged to pay the first R400 a year of medical costs.

But Kavanagh would prefer an excess per claim, which would motivate the member to economise on his claims and audit his accounts.

Further amendments to the Act would allow schemes to offer several packages, ranging from the present 100% cover to "pure calamity insurance".

Employers could choose the most appropriately priced package.

But the Minister appears to be against this type of selective cover for fear it could burden the Treasury with the cost of ordinary medical care.

Medaid scheme 'a must'

A GUARDIAN National Insurance spokesman emphasises that the individual salary-earner should not regard the accident and sickness insurance offered by life offices as a substitute for a proper medical aid scheme.

Nor should these benefits be considered a substitute for a "correctly arranged" life assurance programme.

Individual cover for accidents and sickness, especially the latter, was played low by the life offices before the arrival of direct-response advertising.

Products in the range, which vary from large capital-sum payments for accidental death or disability to cash payments for each day of hospitalisation, have proved acceptable to direct-response buyers, the spokesman says.

But experience has indicated "the initial pricing structures were inadequate — particularly for products including a sickness benefit".

It was thought that mass marketing techniques would lead to economies of scale, which, in turn, were discounted into the rating scales.

This assumption has proved false and, in the case of Guardian's own products — and those of some competitors — it has been necessary to return to basic individual rates (the price at which an individual could buy the cover over the counter) to ensure the continued viability of some of the packages.

But despite rate increases, direct mailing has proved to be an ideal medium for the marketing of this type of cover, the spokesman says.

One new development that might cause problems has been the emergence of identifiable unrest-related losses.

"We have seen two in the last five months — admittedly a small percentage relative to overall exposures — but at R100 000 a day they have an impact on the results for the schemes."

'Living benefits' plan available

AA MUTUAL LIFE now offers assurance that includes protection against catastrophic illness. It is designed to supplement medical aid schemes, which do not cover income losses due to illness.

Assistant GM Bruce Howard says the life industry has traditionally placed emphasis on death and retirement, but over the last three years his company has shifted emphasis to living benefits.

He claims AA Mutual has been a pioneer in the area of supplementary benefits, filling a need in the market to cater for accidents, illness and disability.

In July 1986 the company introduced its Crisis Protection Plan — cover for personal catastrophe as a standard packaged policy.

instate life cover as well as the living benefit after a dread-disease claim, regardless of the policyholder's subsequent state of health.

Unlike more-familiar hospital plans that provide a daily allowance to cover medical expenses, the plan pays out a lump sum in full.

The diseases or disasters that justify a payout include heart attack, coronary artery disease, cancer, stroke, liver transplant, kidney failure, paraplegia and injury caused by urban terrorism.

The policy terms provide for cover up to R150 000, and the subsequent free life cover is available up to the same limit after a crisis benefit payout.

The crisis cover itself may be re-

A health supplement

PROTEA Assurance offers a life policy called Health Emergency Cover to supplement medical aid benefits.

Protea's life division manager Jim Brayson says it provides cover in the event of heart attack, most forms of cancer, stroke, coronary artery disease requiring surgery and kidney failure. Cover is provided up to R150 000, provided the applicant has at least the same amount of cover on the company's 2 000 Univer-

sal policy. Cover may be varied and permanent total

Medical scheme claims to rocket

JOHANNESBURG — South Africa's medical scheme administrators expect claims to rocket to between R2,3 billion and R2,4 billion this year.

The bill for prescribed medicines, excluding those given at hospitals could reach R700 million, according to Mr Tony Leveton, spokesman for the Representative Association of Medical Schemes.

Over-the-counter medicines, such as common cough remedies and painkillers, could account for R140 million.

In 1985 medical schemes paid R1,6 billion in benefits.

Mr Leveton said prices of medicines were escalating at an alarming rate. Administrators of medical schemes are predicting a 35% medicine price hike this year. Last year prices rocketed by around 35%.

"Medical schemes must introduce cost awareness among their members and the medical practitioners serving them,"...

(299) EP 15/4/87.

Sky-high rises in medicine costs forecast

By CAS St LEGER

SHARP increases in the price of medicines are on the way — and pharmacists, medical aid societies and the industry are blaming one another for the spiral.

Medical claims are expected to top R2,3-billion this year, with the bill for privately prescribed medicines, excluding hospitals, calculated at R700-million.

According to research by the Representative Association of Medical Schemes (Rams), medical scheme administrators predict a huge 35 percent price hike for medicines this year, while the Pharmaceutical Society of SA (PCSA) puts the figure at 30 percent.

Not so, says the industry.

"With the strengthening of the rand, it could well be that the increases in medicine costs at manufacturing level will be in line with the inflation rate," said Mr John Toerien, executive director of the Pharmaceutical and Chemical Manufacturers Association (PCMA).

But Rams spokesman Mr Tony Leveton said manufacturers had already admitted that a 25 percent increase was in the pipeline. "Add to this utilisation increases and mark-ups, and by the time it hits the man in the street, it's going to be 35 percent."

Cures

Mr Leveton suggested several cures:

- Medical schemes must introduce cost awareness among their members and the medical practitioners serving them.
- Members could bear the cost of small items. "We believe it totally unnecessary for a member to obtain a prescription for a common painkiller."
- A free market system with decontrolled prices to hold down medicine costs.

"We should press for a cost-based mark-up. At present there is a published retail price, irrespective of the purchase price of the medicine," said Mr Leveton.

"There must be greater awareness by doctors about the cost effectiveness of the medicine they prescribe.

"Quantity is another factor. The concept of charging for broken bulk should be re-examined, particularly when drugs can be pre-packaged in appropriate quantities."

The Medical Association of SA (MASA) has little quarrel with that and has returned the ball firmly to Rams.

"We have told Rams we have no objection to their excluding Schedule 1 and 2 drugs (that is, drugs where no prescription is necessary)," said MASA chairman Dr René le Roex.

Opposed

But MASA remained opposed to the use of cheaper substitute drugs — the choice of medicine must remain with the doctor.

"But we do urge all our members to bear the cost of medicine in mind," said Dr le Roex.

PCMA's Mr Toerien said rather than prices being too high, the consumer had benefited from stocks of cheaper raw materials.

"The 1986 price increase at manufacturing level amounted to only 25 percent compared with 1985," he said.

Before 1986, private sector price increases had been below the consumer price index. The upward pressure in 1986 Mr Toerien attributed to "extraordinary high inflation" and the negative exchange rate.

Mr Boet van der Merwe, executive director of the Pharmaceutical Society, said the society had been calling for price unity since the Competition Board abolished price control in 1981, and had asked the Government to make medicines exempt from GST

Other recommendations were that medical schemes should be allowed to negotiate prices with retail pharmacists and that pharmacists should have the right to give substitutes.

(399) DD 23/4/87

TO ADVERTISE ON THIS

Concern over lack of welfare support

Steering Committee attempts to unify

Dispatch Reporter

EAST LONDON — The chairman of the Steering Committee for the Rehabilitation of the Disabled, Dr Richard Percy-Lancaster, yesterday expressed his concern over the lack of attendance and support of the various welfare organisations at their quarterly meetings.

"The committee is concerned with the rehabilitation of people suffering from any type of disability, be it mental or physical", Dr Percy-Lancaster said.

"It is important for representatives from different welfare organisations to attend these meetings, to share views, point out specific problems they may have encountered and to assist generally in the overall welfare and rehabilitation of all disabled people," he added.

A letter had been sent out to organisations to inform them of the objectives of the steering committee, he said, "but it seems to have fallen on deaf ears."

Dr Percy-Lancaster stressed that the committee did not want to take over the invaluable work done by existing organisations. It intended to function as a body under which these organisations can be unified, and make contributions to assist the Steering Committee in aiding disabled people in East London.

Appeals had been made through the press and radio for people who are seeking such help to contact the organisation. The response up to now had been very poor, he said.

The committee also reported on their attempt to have the timing of traffic lights in the centre of town, especially in Oxford Street, slowed down to enable elderly or disabled people to cross safely.

After having approached all the relevant authorities, the committee was told that the municipality had said it was not possible, since "it would slow up traffic too much, especially during peak hours."

The access sub-committee has been active in approaching businesses and public buildings to examine their premises with view to improving accessibility for the handicapped, Dr Percy-Lancaster said.

"The City Hall is to include building a ramp in its alterations," he said. It was stressed by all members present at the meeting, that the disabled themselves should get involved in campaigns such as these, to push for their demands.

The next meeting of the committee will be in July.



Workshops for disabled on Reef ask for contracts

We want work! That's the call coming from six new Reef workshops for disabled people which are having a hard time finding permanent contracts.

The workshops in Lenasia, Coronationville, Soweto, Tembisa, Daveyton and Dewetshof in Johannesburg provide occupation and an income for 136 disabled people.

Running costs of each are borne by the Association for the Physically Disabled (Transvaal), which established the workshops last year using the stimulus created by the Year of Disabled People.

All earnings from contract work go to the workers.

EXPANSION

The workshops handle assembly or light packaging work and have also been very successful at quality control and inspection.

Mr Guy Houghton, director of the Association, said: "The expansion in our workshops and improvement in work disciplines and efficiency allows us to take on a good deal more work and more contracts of a permanent nature are needed.

"Work is of a very high standard and workshop managers are accustomed to meeting deadlines."

● For information, contact Mr Houghton or the contracts manager at the association at (011)646-8331.

Dyslexic people are not abnormal, says lecturer

By Sian Blackburn

Dyslexic people are not abnormal, says Dr Luce Rubin, communications lecturer at the Witwatersrand Technikon.

She was referring to a recent article in The Star in which American neurologist Dr Albert Galaburda said that "dyslexia stems from abnormal cell development".

The report said researchers who had studied the brains of dyslexic people discovered a pattern of cellular and structural abnormalities.

This suggested that reading disorders were caused by abnormal prebirth brain development.

Doctors hoped that these findings would result in specialists identifying children with abnormalities and recommending special tutoring or other studying treatments.



LUCE RUBIN: "Teachers and parents should be more aware of children's individual learning styles."

DETRIMENTAL

Dr Rubin said: "These children will grow up thinking they are abnormal. They are being labelled. This could be detrimental to the child.

"There certainly may be a differerence in cell and brain organisation but I don't think we can actually say that cells are abnormal."

Dr Rubin believed dyslexia should be referred to as a learning disability and people suffering from it should say they had a learning problem.

"They should not be referred to as dyslexic people. The word dyslexia means different things to different people and could lead to a breakdown in communication when discussing learning difficulties," she said.

She said there were many children (interestingly, a higher percentage was male) with learning disabilities and in this country alone more than 40 percent of the younger population had problems, although only four percent had a "true learning disability".

"There are problems with different learning disabilites but I disagree with telling a child that something is not expected from him or her because of their learning disability.

"These children will continue to learn ineffectively because they were told it was not expected of them.

"A great deal of research has been done on learning and about the left and right side of the brain. Researchers now understand that brain areas have different functions.

"These different functions could affect individual learning styles.

"I have found that the school system favours children who excel in the left-brain areas.

"Their work is presented in a very verbal, logical manner. Those children who prefer the right side of the brain have a more creative approach to learning and usually need visual aids and pictures."

Dr Rubin said there were some children who needed only audio-visual techniques to learn — this could take the form of pages of notes and written points.

Others learned more easily from additional diagrams and pictures and some children needed to make things in order to learn — "they need to touch and feel".

However, she thought more teachers should ensure that all learning styles were catered for and children were given the opportunity to learn in the area they preferred. They and parents should be more aware of the child's individual learning style.

"A child who loves English but loathes maths is probably a very creative person and I firmly believe that teachers should make maths a more verbal subject to cater for the more verbal children.

"Often the situation can be the problem not the child," she said.

Stylish



For Better or For Worse

by Lynn Johnson

Doctors to be paid directly for dispensing

DIANNA GAMES

DISPENSING doctors are to be paid directly the cost of medicine dispensed by them, if they agree to adhere to newly devised guidelines on reducing medical costs.

The Association of Medical Scheme Administrators (AMSA) has concluded an arrangement in which it will pay the cost of medicine directly to the doctors instead of reimbursing the patients — but only where the guideline is in force.

Previously, AMSA paid out dispensing doctors — 60% of whom operate in rural areas — on an arbitrary basis depending on their costs.

Doctors whose claims are extraordinarily high will now be able to present their cases to AMSA, whereas previously payment to them would simply be stopped.

AMSA chairman Keith Hollis says the Society of Dispensing Family Practitioners has drawn up a cost-containment scheme to make doctors more aware of costs and protect AMSA's 550 000 members' interests.

Medical fees shoot up by 20%

CAPE TIMES 25/6/87 299

Deterioration

Explaining the increase, Masa's federal executive chairman, Dr Bernard Mandell, said no general increase in doctors' fees was implied and the maximum rate laid down in the tariff guide did not have to be charged.

However, the benefits offered by medical schemes were only 50% of a "reasonable remuneration" for doctors' services, he said.

Pointing to the rising costs of running a medical practice, Dr Mandell warned that if doctors were denied reasonable incomes the quality of services would deteriorate.

Only about one doctor in five charged the guideline tariffs, he said, the remainder adhering to the Rams tariffs, which were last increased by 12,5% in January this year.

Doctors' costs had, meanwhile, increased to more than 60% of a GP's gross earnings and to 90% in some high-cost specialists' practices such as pathology.

Everything possible had to be done, he said, to keep medical services within the reach of as many as possible and doctors had to take into account patients' financial circumstances.

But doctors were finding it increasingly difficult to continue rendering an acceptable standard of service at the Rams rates and the medical aid industry would be urged to consider more realistic rates of remuneration.

For instance, said Dr Mandell, medical schemes offered only R13,60c for a GP visit while Masa believed R27 was not unreasonable.

But both Rams and the Consumer Council have expressed concern over the rising costs of health care in recent years.

The Consumer Council urged doctors to keep the economic plight of consumers in mind if they intended to increase their tariffs.

"It is essential that medical services remain affordable for all consumers," said Mr Cronje.

He endorsed Masa's

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From Page 1

viewpoint that doctors' fees were negotiable and that no doctor should put financial consideration before the welfare of patients.

The council was concerned at the "great expense facing consumers" and said it was aware that the Minister of National Health and Population Development, Dr Willie van Niekerk, viewed the matter in a "serious light".

Mr Cronje said that "if the exhorbitant cost of medical services does not receive urgent attention, consumers will simply not be able to afford such services in future".

Mr Leveton admitted the costs of medical care were being driven beyond the reach of the average person, creating a "very serious situation".

"We are very alarmed at the way costs have gone up in the last few years, but we feel that the major cause for this is the legislation governing medical aid schemes and their scale of benefits.

"The legislation prevents de-regulation, which I believe would eliminate the in-built structural costs currently borne by medical aid schemes' members," he said.

By CHRIS ERASMUS and Own Correspondent

DOCTORS' fees are to soar — some by as much as 20%, triggering warnings from the medical aid industry and consumer watchdogs that rocketing costs are driving health care beyond the reach of ordinary South Africans.

The director of the Consumer Council, Mr Jan Cronje, warned that consumers would "simply not be able to afford" medical services in future.

The recommended increase in tariffs was announced yesterday by the Medical Association of SA (Masa) and comes into effect from July 1 this year to December, 1988.

A spokesman for the Representative Association of Medical Aid Schemes (Rams), Mr Tony Leveton, said it was not certain that medical aid schemes would match the 20% increase when their scale of benefits was re-assessed in the light of Masa's increase.

Rams would conduct detailed surveys, as well as consult with Masa, before deciding on its new scale of benefits within the statutory three months in which it had to do this, he said.

Without having seen details of the new tariff guide, Rams was not in a position to comment at this stage.

But, said Mr Leveton, it was true that if Rams did not increase its scale of benefits to fully cover the Masa increase, the man in the street would have to bear the difference.

Increases start health costs spiral

Medical aid fees likely to shoot up

29

29/6/87
Star.

Big increases in medical aid subscriptions are expected to follow the massive rises in provincial hospital tariffs and the 20 percent increase in recommended doctors' fees.

Mr Tony Leveson, spokesman for the Representative Association of Medical Schemes, said the percentage increase in subscriptions would vary depending on the scheme.

From July 1 private patient tariffs at provincial hospitals in the Transvaal will increase by up to 100 percent for theatre fees and more than 40 percent for ward fees.

Theatre fees will rise from R50 to R110 for the first half-hour and from R100 to R141,50 for the first hour.

Daily tariffs will rise from R45 to R71 in hospitals with up to 70 beds, and to R82,50 in those with more than 70 beds.

Transvaal Provincial Administrator Mr Willem Cruywagen said in Pretoria the increases were necessary because of increased running costs.

He said the daily tariffs would include the cost of medicines "for the time being".

About 27 percent of hospital patients were "private", he said. Of these, about 85 percent subscribed to medical aid schemes.

He said the new tariffs would place a heavier burden on the medical aid schemes but they were still within their scales of benefits.

The tariffs for part-paying patients had only been increased in a few instances.

Subscriptions

Pensioners and those with incomes equal to pensioners' incomes would pay R2,00 per admission.

On medical aid subscriptions Mr Levenson said these would probably rise in January when the doctors' fees go up.

He said the sweeping increases would hit black people particularly hard as they used the provincial hospitals more than whites.

Last week the Medical Association of South Africa announced a 20 percent increase in its recommended fees for doctors.

The Consumer Council has expressed concern.

Direct pay likely for dispensing doctors

DD 26/6/87

Dispatch Correspondent

JOHANNESBURG — Dispensing doctors are to be paid directly the cost of medicine dispensed by them if they agree to adhere to newly devised guidelines on reducing medical costs.

The Association of Medical Scheme Administrators (AMSA) has concluded an arrangement in which they will pay the cost of medicine directly to the doctors instead of reimbursing the patients, but only where the guideline is in force.

Previously AMSA paid out dispensing doctors, 60% of whom operate in rural areas, on an arbitrary basis depending on their costs. Doctors whose claims are extraordinarily high will now be able to present their cases to AMSA, whereas previously payment to them would just be stopped.

Mr Keith Hollis, AMSA chairman, said yesterday the Society of Dispensing Family Practitioners (SDFP) had drawn up a cost-containment programme to make doctors more aware of costs and to protect the interests of AMSA's 550 000 members.

Dispensing doctors, who now number up to 3 000, will be monitored by the society from July 1. Its guidelines are to be determined and measured from statistics of claims analyses provided by AMSA.

Mr Hollis said it was thus hoped that the profession would discipline itself in the area of cost.

He said the surge of new members into medical schemes could be explained by the growth in medical schemes for blacks. He said that membership of a state medical scheme for government-employed blacks stood at 83 000 principal members, one of the country's largest.

Black medical needs presently differed from Indians, coloureds and whites. There was little demand by blacks for specialist services, but high demand for GP services including the provision of medicines, he said.

Full cover for day clinics

MANDY JEAN WOODS

DAY CLINIC patients will be able to claim 100% of medical expenses, in terms of a new fee structure to be introduced by the Representative Association of Medical Aid Society (Rams) early next year.



● GRILLENBERGER

The new structure means patients who want treatment at day clinics, instead of private or provincial hospitals, will be able to reclaim all their expenses — instead of 70% under the present system.

Presmed MD Carl Grillenberger says a survey conducted in May showed private hospitals charged about R398 for a tonsilectomy — which most medical aids would pay for in full.

Day clinics charged about R221 — of which most medical aids paid only R157. The patient would have to pay the difference of R64.

"The problem was that medical aids would pay the full bill from a private hospital, provided it was charged in terms of the Rams recommended fee structure," he said.

"In comparison, the majority of day clinics utilise the tariffs recommended by the Association of Day Clinics of SA, which is higher than the tariff recommended by Rams. The result was that if a patient went to a day clinic, he would have to pay a portion of the cost himself."

Grillenberger said Rams had agreed to revise the fee tariffs applicable to day clinics during the next four months, and to finalise negotiations by the end of October.

It is estimated that from 25% to 40% of all surgical operations currently performed in hospitals can be performed in day clinics. Only 5% of all surgical operations in SA took place in day clinics.

SA has 62 day clinics and 72 private hospitals.

Union calls on Rams, Masa to agree on fees

299
85

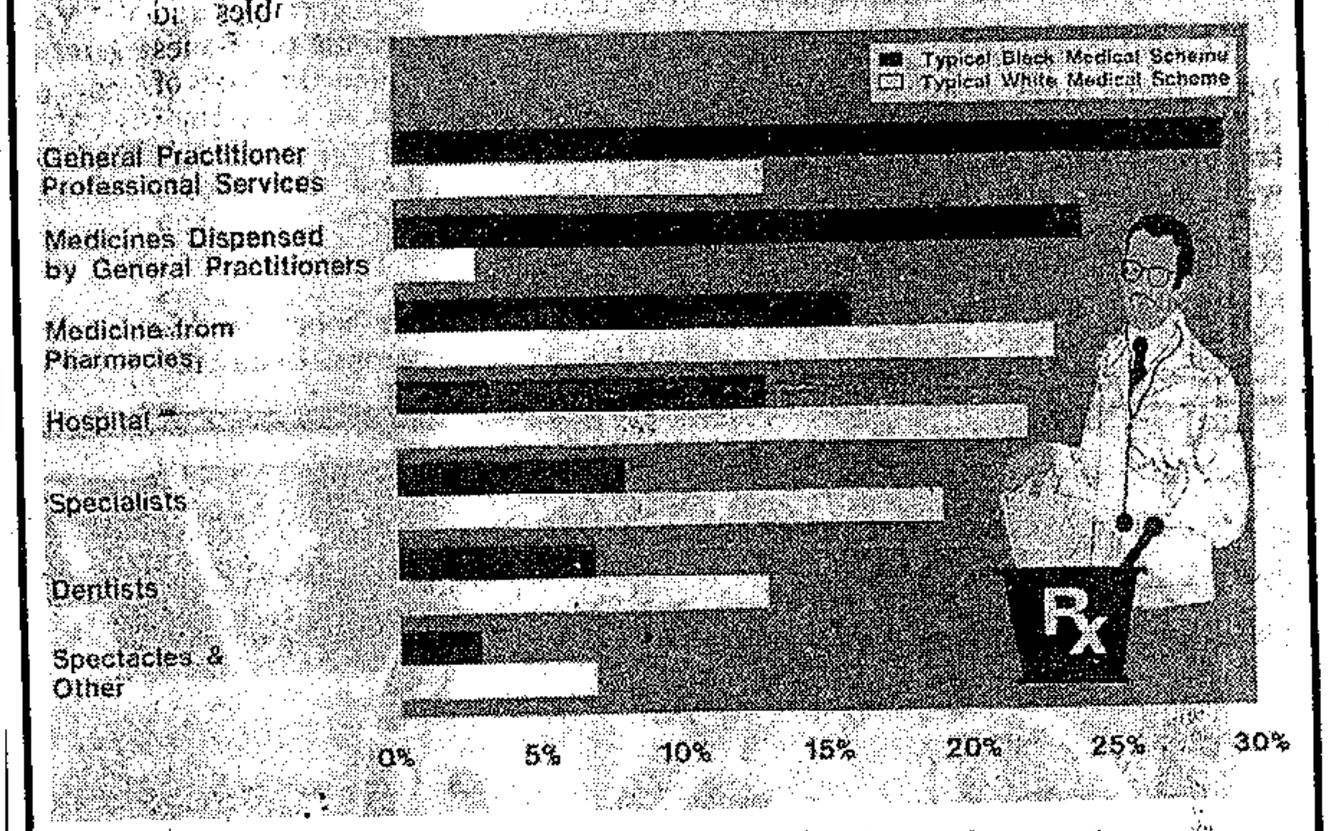
B/Day 3/7/87

GERALD REILLY

PRETORIA — If the Medical Association of SA (Masa) and the Representative Association of Medical Schemes (Rams) fail to agree, another method of determining doctors' fees will have to be found, the SA National Consumers Union says.

It says the continuing argument between allegedly responsible organisations is not in the interests of the patient or the economy. It recommends Masa's guidelines for fees and Rams' fee structure be published on the same schedule.

All patients should know fees are negotiable and should discuss that openly with their doctors. If agreement on fees cannot be reached, the union recommends patients consult another doctor.



This chart reveals the differences in medical requirements.

Relief on its way

CP Correspondent

THE RECENT launch of a cost-containment program could see the end of the days when medical practitioners could benefit unfairly from members of medical aid schemes.

This follows an agreement entered into by the Association of Medical Scheme Administrators and the Society of Dispensing Family Practitioners.

Amsa chairman Keith Hollis said the new program – from which its estimated 550 000 members stand to benefit – would ensure that norms that would monitor the prescribing and dispensing perfomance of individual doctors would be developed.

According to the program, Amsa will in future pay the cost of prescribed medicine directly to the dispensing doctors.

"The procedure of doctors submitting claims directly to medical schemes for both professional services and dispensed medicines opened up several pitfalls.

"It would be unlikely that inexperienced new members would check whether the account was properly detailed or whether additional charges had been inserted," said Hollis.

Hollis added that the program was necessitated by the growth in the number of dispensing doctors caused by the increasing number of medical aid scheme members.

Members who stand to benefit from the new arrangement include the following: Medscheme, Davidson and Ewing, and Medicaid, who jointly administer 74 medical schemes.

Medi-costs rocket with privatisation — editor

Medical Reporter

PRIVATISATION of the medical industry was leading to a "colossal escalation in medical costs at a time of galloping inflation," the editor of the South African Medical Journal, Dr N C Lee, said in an editorial in the magazine.

At the same time there had been a "very real decline" in the living standards of those people who were supposed to make use of private hospitals and clinics.

A closer look at privatisation had to be taken with a view to exerting "firm regulatory control," said Dr Lee.

In an editorial entitled *Privatisation — desirable development or recipe for rip-off*, Dr Lee said medical aid societies could well be forced to take action if the trend continued because they were limited in the extent to which they could raise membership fees to meet the demands of private medical services.

He quoted a comparison of provincial and private clinic fees for a minor operation, which included hospital care, theatre fees, medication, laboratory fees and radiographs. The provincial account came to R121 while the private clinic's account was R443,71.

Standards fell

He said there was no such thing as free medical care. In socialist countries it was usually the consumer who paid through a compulsory levy.

Although the principle of free medical care had a great deal to recommend it, it encouraged bureaucratic growth and standards inevitably fell as money was siphoned off for increasing administrative costs.

The alternative to socialised medicine was private care, in which the major incentive was profit, which meant users financed not only the service but also the profits of the shareholders, said Dr Lee.

"The Government is firmly committed to privatisation and there has been a scramble to put up private hospitals and clinics — some of them excellent, high-class facilities, others less so," he said.

A feature common to all of them was the high cost to the patient, apart from the fees payable to doctors, surgeons and anaesthetists.

ficial use of a private vehicle will be paid on a kilometre tariff determined, periodically, by the Administrator.

(b) This will be the situation when the RSCs come into being on 1 July 1987.

Mr D J N MALCOMESS: Mr Speaker, arising out of the hon the Deputy Minister's answer, the question quite clearly asks what the annual salary is including allowances. It is also quite clear that that particular question has not been answered. [Interjections.] May I therefore ask the hon the Deputy Minister whether regional services councillors in the Algoa area in fact do receive a salary and, if so, whether that salary is irrespective of the number of days on which they actually sit—in which case it could, in fact, be increased by an allowance for attending such a meeting—or whether they only receive a sum dependent upon how many days they have attended?

†The DEPUTY MINISTER: Mr Speaker, it is very clear from the reply before us that it is impossible at this stage to determine how many days there are going to be sittings. The responsibilities of each member of each regional services council still have to be determined, because in the Transvaal they are different from those in the Cape.

†An HON MEMBER: Algoa!

†The DEPUTY MINISTER: In Algoa. I believe that in due course we shall be able to supply to the hon questioner with a detailed reply. [Interjections.]

lew Questions:

1. Mr D J N MALCOMESS—Agriculture. *Withdrawn.]*

Medical Schemes Act

. Dr M S BARNARD asked the Minister National Health and Population Develop-ent:

(1) Whether he recently received any representations in regard to the Medical Schemes Act, No 72 of 1967; if so, (a) from whom, (b) when and (c) what was (i) the nature of the representations and (ii) his response thereto;

(2) whether he intends amending this Act; if so, (a) when and (b) what amendments are contemplated; if not, why not;

(3) whether he will make a statement on the matter?

†The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) Yes.

(a) The Medical Association of South Africa; The Dental Association of South Africa; The National General Practitioners' Group of the Medical Association of South Africa.

(b) 22 January, 1987;
28 January, 1987;
27 March, 1987.

(c) (i) Scales of benefits must be determined for all services, including the supply of medicine by medical practitioners, rendered to members and dependants of members of medical schemes; the Representative Association of Medical Schemes must be compelled to amend and publish the scale of benefits within three months from the date of the determination of a revised guide of fees by a professional association and to retain in the new scale of benefits the ratio between fees as determined by the professional association in its new guide of fees;
all suppliers of services must be paid direct by a medical scheme in respect of services rendered to members of medical schemes and their dependants unless the account has already been paid by the member or credit facilities have been granted to the member;
medical schemes should be bound to respect medical ethical rules;
if an account is rendered by a supplier of services which corresponds with the scale of benefits, such account must be paid in full.

(ii) A meeting was held on 9 April 1987 with all interested parties to discuss problems encountered with the provisions of the Act.

(2) Yes.

(a) As soon as the proposals have been cleared with the interested parties.

(b) It cannot be indicated at this stage.

(3) No.

Statements critical of Government

*3. Mr S S VAN DER MERWE asked the Minister of Law and Order:

Whether any persons or organisations have been prohibited from issuing or making statements critical of the Government; if so, (a) what persons or organisations, (b) when, (c) why, (d) in terms of what statutory provisions and (e) who took the decision in this regard?

The MINISTER OF LAW AND ORDER:

No. (a) to (e) Fall away.

Independent Black states

*4. Mr S S VAN DER MERWE asked the Minister of Foreign Affairs:

Whether the South African Government has reached any agreements with the governments of any independent Black states regarding (a) the operating of members of the police forces of either country in the territory of the other and (b) joint operations; if so, with which such states?

HoA

†The MINISTER OF FOREIGN AFFAIRS:

Agreements and understandings of this nature are normally confidential and details thereof ought not to be made known unilaterally. I am however prepared to inform the hon member about agreements of this nature on a confidential basis.

Elsies River: death of 2 children

*5. Mr P G SOAL asked the Minister of Law and Order:

(1) Whether, with reference to his reply to Question No 48 on 18 February 1987, the investigation into the death of two children in Halt Road, Elsies River, has been completed; if not, why not; if so, (a) when and (b) what were the findings;

(2) whether the Attorney-General has reached a decision regarding this case; if so, (a) when and (b) what was the decision;

(3) whether the South African Police have taken any action in regard to this matter; if so, what action; if not, why not;

(4) whether any charges have been laid against any members of the Police Force as a result of the death of these children; if so, (a) what charges and (b) what are the (i) ranks of and (ii) positions held by these members?

The MINISTER OF LAW AND ORDER:

(1) Yes.

(a) 6 February 1987.

(b) The case docket was forwarded to the Attorney-General for his decision.

(2) Yes.

(a) 19 February 1987.

(b) That a member of the South African Police stand trial in the Regional Court on a charge of culpable homicide, alternatively contravening section 138 (1) of the Road Traffic Ordinance, 1966,

AK645 29/7/87 (299)

Medical Aid Act requests

ALL payments by medical schemes should be made directly to the suppliers of services unless it had been paid for by the member.

This was one of several requests by medical associations to the Minister of National Health and Population Development, Dr Willie van Niekerk, for him to incorporate into the Medical Schemes Act.

They asked that scales of benefits be determined for all services, including the supply of medicine by medical practitioners to members of medical schemes. The Representative Association of Medical Schemes should be compelled to amend and publish the scale of benefits within three months of the date of a revised guide being determined, and to retain in the new scale of benefits the ratio between fees as determined by the professional association.

Dr van Niekerk said he intended amending the Act as soon as the proposals had been cleared with the interested parties. — Sapa.



Mr Earnest Maholela . . . "If I do not find a job soon I will just go home and wait to die".

He needs a job soon — or will 'go home to die'

Star 29/12/87

By Janine Simon

Earnest Maholela has the same dreams and hopes of most 25-year-old South Africans — but he is close to despair.

He is battling against the odds of being unemployed and paralysed from polio which he contracted at the age of 13.

TRAVELLING

Since 1984, Mr Maholela has used his R97 monthly disability grant to travel from his Groblersdal, northern Transvaal, home to kwaNdebele, Durban and Maritzburg to look for training and work — to no avail.

The best position he could find was as a R20-a-week assistant in a Maritzburg dressmaking school.

Finally, last month, in a last-ditch attempt to find a job, he took a taxi from Maritzburg to Johannesburg hoping to find Friday Mavuso — founder/director of Self-Help for Paraplegics (Soweto) or Shap.

Mr Maholela said: "I'm a man who likes reading newspapers and magazines. I read that Mr Mavuso helps disabled people and I thought he could help me."

His taxi reached Baragwanath Hospital at 4 am and with the help of local police, Mr Maholela was taken to Shap in Soweto early one morning.

Mr Mavuso found him there at 7 am, shivering in the winter cold.

"What do we do with a man like this? Shap is full and it is meant for Sowetans. We have a waiting list of 500 people — but how can we turn him away?" Mr Mavuso told The Star.

Mr Mavuso organised Mr Maholela temporary accommodation with the Salvation Army and sent him to Shap's various workshops for training in assembly work and wheelchair maintenance.

But time is running out. Mr Maholela cannot afford the R4 a day the Salvation Army charges for board. And he needs a job.

DIE

"If I don't find work now there is nothing for me to do but to go home and wait to die," said Mr Maholela, who has also been trained in welding, weaving, carpentry and dressmaking.

Anyone who can help should contact Mr Mavuso at Shap telephone (011) 982-1036/7 immediately. Shap is a registered welfare organisation and an affiliate of Disabled People South Africa, a disability rights organisation.

d baby



Graphic: CARL BECKER

That it is agreed that women and men must
...yment with family life.

A criticism of this non-sexist, family concerned ...roach is that many men will abuse such rights ... not use the hard-bargained time off playing ...sponsible parent.

Some labour movement sources have expressed ...ervations about the committment of male ...kers to this issue and profess reluctance to ...gotiate extensively on their behalf.

Ccawusa negotiations co-ordinator, Jeremy ..., disagrees. While admitting that the pos...ty existed of some men using parental leave ... an opportunity to broaden their experience of ...tleens, he asserts that a start must be made ...where.

"It is important to establish the principle and ...vide the necessary space for men to at least ...t moving in the right direction in terms of be... properly responsible parents." Daphne adds ... as these provisions are being negotiatied, the ...on is running education programmes on this subject. "These days we're getting some very ... especially the worker leadership, who are putting across the idea that responsible parenthood is an admirable characteristic for men too."

Turning around chauvinistic attitudes is not merely a matter of appealing intellectually and morally to die-hard prejudice, but increasingly, a practical necessity. Metro Cash and Carry shop steward Georgina Mbileni points out that, with the urban disintegration of the extended family in favour of the nuclear unit, men have little choice but to participate in child-care.

"Many young couples don't live with their families anymore, so men are being forced to help at home because often there is no-one else."

Mbileni, who was on the negotiating team of the watershed agreement with Metro, has three children — two born before it (the agreement) and one after. She comments that the financial and psychological effects on her own family after benefits became available, improved substantially

"To know that with the birth of my third child I would not be left financially destitute and with no guarantee of getting my job back, eased the pressure on the whole family. Now we must fight very hard for proper child care facilites."

Current moves to broaden maternity issues into not only family issues, but by implication, social and community responsibility, is still embryonic and mostly paper-bound. But then, so was practical progression on basic maternity rights five years ago. Education programmes in support of these issues are ceaseless.

Union negotiators agree that the mechanics of change in this area, as in many others, is a long, hard haggle. First you establish principles; most are rejected, a few accepted, you expect that. You put them forward again. Next time round a couple more are accepted and the stakes are upped on others ... and so it goes on.

CWIU's Chris Bonner is frank about the present limitations of the battlefield: "In practise the fight is still squarely on the maternity front in factories. This is now seen an an automatic issue and is pushed pretty hard. Company resistance has lessened and it is now very rare to find a company who won't countenance some kind of agreement.

"For the first time this year we tried to involve everyone, not only women because it *is* a social, political and economic issue not just a 'women's' issue."

A heady resolution about women passed at the first national congress of Cosatu in 1985 made an enormous impact on workers' goals in this area.

Mooted by Ccawusa, the resolution resolved, among other things, to fight:

- For full maternity rights, including paid maternity and paternity leave and job security
- For the protection of men and women from all types of work proved to be harmful to them, including work which interferes with their ability to have children and
- For child care and family facilities to meet workers' needs and make it easier for them to combine work and family responsibilities.

A point significantly left out of the resolution dealt with contraception — it was considered by most unions "too controversial".

But Ccawusa believes that the issue of contraception education is vital. Says Daphne: "Companies like Pick 'n Pay give family planning clinics free access to workers who are then given contraceptive shots with no information back-up. We say the company must take responsibility for informing workers about various forms of contraception — and the drawbacks.

"Managements will still put across the view that it is better to have fewer children — not because they are concerned about population control, but because it becomes expensive for them to bear the costs of pregnant women. Some companies even build in conditions on maternity agreements whose available benefits relate directly to the number and spacing of children a woman has."

Child care is beginning to nudge its way forward as a vital and logical next step. Some progress has been made in terms of women being allowed to visit post and ante natal clinics and maternity leave obviously addresses some of the basic physical requirements of babies. But further than that, more comprehensive care of children up to the age of 12 remains principle-bound.

Again, as sociologist Jacklyn Cock remarks, "this campaign is not a 'women's issue' but a campaign about social responsibility for the care of children".

Cock points to the way in which Cosatu has been stressing the link between the exploitation of workers in the workplace and their oppression outside it: She sees struggles about maternity or paternity rights and childcare as another aspect of trade unions taking up issues affecting workers in the wider community.

This new thinking is becoming less tentative among unions generally, as more begin to address the subject as a working class right.

Ccawusa, again using as a blueprint rights that have been established in Sweden, have put together a package on child care that has not yet been tested.

In the South African context, it appears no less than radical, its recommendations including: A six-hour working day for all parents of children under the age of eight, two days paid leave for parents when their children start school, preschool and after-school child care facilities, a child minding allowance of R50 a month for each child under the age of six, and 18 days paid leave a year to enable parents to care for a sick child under the age of 12.

The priority is for the immediate creation of workplace nurseries to enable mothers to nurse their children during working hours.

The unions themselves have adopted a realistic approach to these seemingly utopian ideals and make no bones about how long some of these demands will take to materialise.

A daunting reminder of the arduous road ahead for the trade unions is that even the rights won to date affect no more than a few thousand workers in a limited number of industries.

Most black women are employed in agriculture and domestic service where there is no labour legislation to protect them at all and unionisation remains in its infancy.

...when one third of their wages during the mater...y leave period. The assumption is a worker ... be receiving 78 percent of her usual wage.

But the UIF system is inflexible on maternity ... women can only get paid for four months be...re and two months after the birth. And it means ... a woman who can take six months off after ... baby is born can claim UIF money for only ...o of these months.

This is a problem unions still have to address.

But certain unions have won far-reaching victo...s on the maternity pay issue. The Rolfes agree...nt negotiated by the CWIU gives workers six-...d-a-half months' leave at full pay. CWIU now ... maternity agreements at 32 factories, of ...ch 18 are paying full leave.

While all the agreements guarantee women their ..., many still do not provide for pay. The two ...strial council agreements in textiles and engi...ring cover job security but not maternity pay.

But in the steel and engineering industries, ...omen workers can now claim maternity pay for ... months from the Sick Pay Fund administered ... the industrial council. The amount they can ...m is 50 percent of the minimum wage for ... pay grade. Since payments from the fund do ... count as wages, women on maternity leave ... claim these and still get UIF.

The National Union of Metal Workers is nego...ting in individual workplaces for employers to ...e up the difference between amounts received ...om UIF and the Sick Pay Fund and women workers' full wages.

In the homelands, getting UIF payments can be particularly difficult. At BMW the agreement negotiated by the union provides for women to be paid by the company in cases where they cannot get UIF, since many live in homeland townships.

Unions such as the NUM, Ccawusa, and CWIU have also been demanding paternity leave for the biological fathers. Here, there has not been much success.

The NUM's demands for paternity leave have not been met by any employers. CWIU was the first union to win paternity leave for workers and now has this at 20 factories. Ccawusa, too, has negotiated paternity leave in some retail chains.

An important issue in negotiations for maternity — or parental — rights for workers are those around health and safety. Unions have demanded that pregnant women be relieved of jobs which could endanger their health. And they have called for paid time off for pregnant women to attend ante natal clinics

Neither of the industrial council agreements include such provisions, but health and safety clauses are a feature of many of the plant level maternity agreements

Many of these maternity agreements have been negotiated by unions in industries where women workers are not a majority. This is an indication of the unions' commitment to the question as a broader working class issue rather than simply a "woman's issue".

Case study: The model creche at the factory

AFTER workers at BMW negotiated a maternity agreement with employers in 1985, they said to themselves: "But we still haven't solved the problem ... who is going to look after these children?"

And so the idea of the BMW creche was born. Two years later, the creche is nearing the final planning stage and could be in operation early next year.

When the trade union, then the National Automobile and Allied Workers' Union, approached BMW, the German auto manufacturer agreed to the creche proposal in principle. A committee consisting of worker and employer representatives was set up to implement the plan.

The creche, which will cater for the children of all employees at BMW's Rosslyn and Garankuwa plants, is the first such facility negotiated by a trade union.

"We proposed to the company that it was part of their social responsibility to do something about childcare," say BMW shop stewards Solomon Ndlovana and Albert Mateunche.

They see the creche as playing an important role in educating workers' children, equipping them for school and hopefully university.

The committee visited other childcare centres and chose the Montessori model. It hopes to recruit a trained nursery school teacher as principal.

So the object of this creche won't just be to keep the kids off the streets.

At a seminar run in March this year by the Health Information Centre, which has assisted in research for the project, participants identified six objectives for the creche.

It should give parents the peace of mind that comes with knowing their children are safe. Mothers will have a chance to breastfeed. The children's growth will be monitored and they will receive adequate medical care. Proper nutritious food should be provided. Children will get a sense of love and security, stimulating the development of their minds and bodies.

Another benefit is the creche will be non-racial: "We believe it's a very good opportunity for black and white kids to mix," says BMW communications manager Michael Brandt.

BMW is to finance the building of the creche and will subsidise its running costs. But administration of the creche will be in the hands of a social responsibility committee made up of representatives of the company, parents and the union (now the National Union of Metalworkers of South Africa). It is hoped that the creche principal will join the team soon and be involved in the final planning stages.

Setting up a creche is not an easy nor a cheap matter. Stringent regulations, governing such things as the minimum space per child and the number of toilets, have to be met. Creches which take children under the age of two years have to meet particularly strict standards, in terms of facilities.

The BMW creche will cater for children from two to six years old but a decision has not been made on whether it will also take babies.

The major problem holding up the project was finding a site. The creche is likely to be situated at the Rosslyn plant and the company is negotiating the land.

There is a company medical clinic at the Rosslyn plant, with a full time nurse and a doctor who visits regularly. An advantage of having the creche at Rosslyn is children would have access to medical care.

Architects have started working on the plans — in consultation with the committee — but can't go much further until the site is finalised.

The creche planners favoured siting the creche at the Rosslyn plant — rather than where the workers live — because BMW draws its workers from a range of townships, such as Soshanguve, Mabopane, Garankuwa, which are far apart.

As the first project of its kind the creche may serve as a model to other trade unions pushing for employers to get involved in childcare and in the education of workers' children.

The liberate

By CHARLOTTE BAUER and HILARY E



South African law, which stipulates that women stop working a month before and two months after a birth, has never offered protection from dismissal — if anything, the law lays the way for employers to get rid of pregnant women. But some landmark agreements between employers and unions are changing that

UNTIL very recently in South Africa, the fastest way to lose your job in a shop or factory was to become pregnant.

For many workers this meant instant dismissal. No severance pay. No guarantee of future employment. No guarantee of much future at all.

Desperation has led some into back-alley abortions or dangerous ploys to try hiding the fact from employers as long as possible (one woman strapped down her stomach until she miscarried); it has led others into private re-hiring deals with their bosses which have forced them to return to work almost immediately after the birth.

This was accepted practice, not even questioned by the workers themselves, who received dismissal as a necessary evil. And as far as employers were concerned, such Dickensian methods were not only acceptable but desirable ("There is no need to make concessions as there is a large working group to choose from," was one argument).

South African labour legislation, which stipulates that women must stop working for a month before and two months after a birth, has never offered protection from dismissal — if anything, this law exacerbates the problem by paving the way for employers to get rid of pregnant women altogether.

The historic first maternity agreement reached in this country was negotiated by the Commercial, Catering and Allied Workers' Union of South Africa and the OK Bazaars in 1983. A proposal, encompassing mostly job security and health and safety aspects of confinement, was put forward to a stunned management who refused for a solid year to agree even to negotiate such an issue. They referred scathingly to the document as the "maternity scenario", although today are quick to capitalise on having been "the first".

It is only in the last four years that, largely through the efforts of Congress of South African Trade Union affiliates, some workers have won such fundamental rights as the ability to bear children without losing their jobs, along with a degree of financial security during the period of absence — rights established by the International Labour Organisation 68 years ago.

Since then, significant victories have been gained in the retail, chemical, metal, food and textile industries.

Many of the agreements unions have signed with employers afford women six months' maternity leave. And some of the agreements further commit employers to pay workers part of their wages while they are away. The more comprehensive maternity agreements protect pregnant women from health hazards in the workplace and allow them paid time off to attend ante and post natal clinics.

It is telling of the level at which unions are having to push employers on this issue when it is revealed that negotiating points include the demand that pregnant workers be allowed to "go to the toilet whenever they wish and this shall not be monitored". It makes agreements such as those struck by Ccawusa with Metro Cash and Carry in 1985 and Chemical Workers' Industrial Union with Rolfes a year later, all the more astonishing.

The Metro agreement, regarded as the most all-round comprehensive deal struck to date, includes 12 months maternity leave with the guaranteed right to return to work, paternity leave, health and safety protection for pregnant and nursing workers and free baby goods. The Rolfes agreement, the most far-reaching yet on the pay issue, makes available six-and-a-half months leave at full pay.

It is not only in individual factories that maternity rights are being won. Two national industrial council agreements gazetted within the last month have made maternity rights statutory in the steel and engineering industry and in the textile industry. The leave periods and pay specified in these agreements are not as good as unions have been winning in factory level negotiations. But what is significant about minimum conditions won in the industrial councils is they cover entire industries — and give protection to unorganised workers.

The unions in these industries will be using the industrial council minimums as bases from which to negotiate more comprehensive agreements for workers in individual workplaces.

Some of Cosatu's unions have called for paternity leave as well — and in certain cases, particularly in retail, this right has been won, albeit at a basic level (two to three days). However, the principle of paternity rights is significant in terms of the new thinking emerging in union circles.

If only four years ago employers were outraged by the notion of maternity rights, there is no telling — yet — how they may react to Ccawusa's latest proposal that both men and women receive the same benefits when a child is born under the sweeping new banner of "Parental Rights".

Pick 'n Pay is about to become the other team in South Africa's first parental rights agreement, compliments of Ccawusa which has used Sweden as its model on the subject. It leaves "maternity rights" standing alongside "bra-burning" in the archive of outdated concepts for change.

The objective of this agreement is to ensure that "women employees are not unfairly discriminated against on the grounds of pregnancy and that male and female employees who are parents of young children are able to fully exercise their parental responsibilities". The proposal further requires the company to acknowledge that the family carries the major expense of childrearing; that young workers entering the workplace were fed, clothed and educated by present workers; that the company profits from the labour of workers; and that therefore the company agree to contribute "directly towards the making of the next generation of workers"..

Demands contained within this novel proposal, which will reach other companies within the year, include:

- Fourteen months leave until the child is four years old. Of the 14 months, parents may save leave for later occasions until the child's fourth birthday. Both parents may share the leave if they both work for the company. This provision also applies to adoptive parents
- Full normal weekly wages for the parent for 10 of the 14 months.
- Full pension fund and medical aid coverage during parental absence
- The transfer of pregnant employees with physically demanding jobs with the proviso that if the company is unable to do this, they should be given an extra two months leave
- That employees returning to work be entitled to any increase awarded during the leave period including bonuses.

THE NEW AGREEMENTS: BETTER JOB SECURITY, BETTER PAY WHILE ON LEAVE

THE basic right which all the maternity agreements negotiated by Cosatu unions has given workers is job security. The agreements, at plant or industrial council level, provide leave for or guaranteed re-employment for women due to give birth.

In addition, many of the agreements oblige employers to pay women at least part of their wages while they are on leave.

And some of them contain health and safety clauses which protect pregnant and nursing workers.

South African labour legislation provides no protection against dismissal for pregnant women: The Basic Conditions of Employment Act, which sets minimum working conditions for all manual workers, prevents women from continuing to work for a month before and two months after confinement. It's this provision which has often resulted in women losing their jobs.

Most of the maternity agreements which the trade unions have negotiated guarantee that their jobs will be kept for them for up to six months.

National industrial council agreements in the steel and engineering industry and in the textile manufacturing industry allow women to take six months off, to cover the period before during and after the birth.

The textile workers have won six months authorised unpaid leave, while in terms of the steel and engineering agreement, pregnant workers have to resign but are guaranteed their jobs back.

What is significant about both these agreements is that they cover all workplaces in these industries — thus providing protection even for ununionised workers — and their provisions have the force of law.

However, industrial council agreements, because they cover all employers in an industry, tend to cater to the lowest common denominator.

Trade unions which have negotiated maternity rights on a factory by factory basis have in some cases won much better terms. The Ccawusa agreement with Metro Cash and Carry gives 12 months leave. Some of the agreements in the chemical industry provide 10 months.

But in other industries trade unions have only succeeded in winning three months' job security: The maternity agreement at BMW, for example, only grants three months' leave. Agreements which the National Union of Mineworkers has negotiated also provide only three months.

Not all workers qualify for maternity leave: Usually, only those who have been on the company's payroll for at least 12 months are entitled to take time off.

Metro agreement is again an exception: There is only a one-day qualifying period and the company may not refuse to employ workers on the grounds that they are pregnant. But particularly stringent on this score is the engineering agreement — which grants rights only to women who have been with a company for two years.

This was a contested issue in negotiations, says Numsa's Adrienne Bird. The engineering employers initially insisted that there should be a qualifying period of five years. This would have meant women workers were limited to one pregnancy every five years if they wanted to keep their jobs. Numsa's members refused to accept this clause and the employers compromised on this, as they did on their initial demand that plants employing fewer than 10 women be excluded from the agreement.

The qualifying period is not the only problem in this industrial council agreement. In both textiles and engineering, the maternity clauses cover only those workers whose wages are prescribed by the industrial council agreement. This tends to exclude some women, for example teamakers.

Ensuring that all workers are entitled to these rights will be one of Numsa's priorities in plant level negotiations.

Job security is an important victory for the unions. But perhaps even more significant is what is being won now in terms of pay.

For women workers, usually in very low paid jobs and often the sole breadwinners for their families, taking six months off work to have a baby may be an intolerable financial burden.

A survey of 885 black women workers by Jackie Cock, Erica Emdon and Barbara Klugman in 1983 indicated that over half of the mothers interviewed went back to work when their last child was six months old or younger. "Economic necessity propels most of these African women into wage labour — often reluctantly," the three researchers conclude.

The consequences for the health of the babies — and of the mothers — can be serious.

The Health Information Centre has emphasised the importance of breastfeeding to combat diseases such as gastro enteritis and diarrhoea: 140 of every 1 000 black babies in South Africa die each year and the main cause is gastro enteritis, a disease related to socio-economic conditions.

"If a mother returns to work before her infant is six months old it will significantly affect the health of the infant. It will prevent optimum nutrition. The child will be liable to diarrhoeal and respiratory infections which are potentially fatal," says a document compiled by HIC.

Women who stop work to have babies can claim from the Unemployment Insurance Fund.

But there are many problems for these women in the workings of the UIF system and it is these that the unions are trying to address in their negotiations for maternity pay.

UIF offers women maternity pay — but to get UIF benefits for a full six months a worker would have had to contribute to the fund continuously for three years.

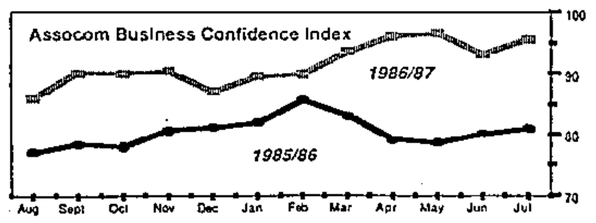
The amount paid out is 45 percent of normal wages — and that is on condition the worker is not getting paid more than a third of her wages by her employer.

Many maternity agreements — Metro, for example — thus provide for employers to pay

A cordial invitation to help bail out apartheid

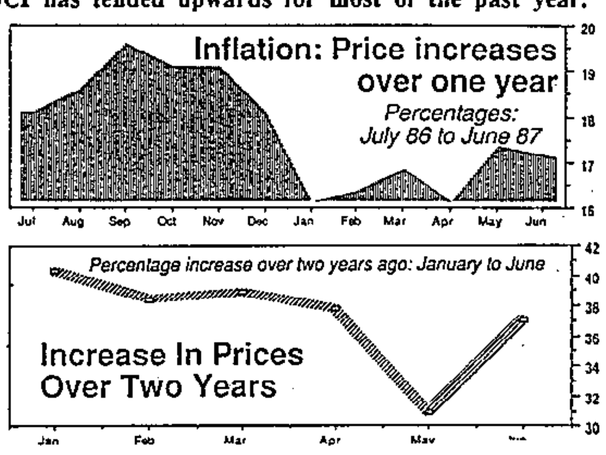
BUSINESS BAROMETER

GENERAL INDICATORS



BUSINESS CONFIDENCE

Assocom's business confidence index increased by 2,5 points to 95,5 in June, after falling by 3,5 points in May. The BCI is not a survey of the confidence of business people. Rather, it measures the performance of major economic indicators, such as the stock exchange, exchange and interest rates, foreign trade and local sales. As the graph shows, the BCI has tended upwards for most of the past year.



INFLATION

June's inflation rate as measured by the consumer price index was 17,2 percent — only marginally lower than the rate for May. As the graphs show, the inflation rate has gone up in the last couple of months after dropping earlier this year from last year's 18 percent plus levels. But compared with two years ago, prices are 30 to 40 percent higher. Once again, the poor suffered highest inflation rates in June: The rate for the lower income group was 19,2 percent, compared with 16,3 percent for the higher income group.

MONEY SUPPLY

The amount of money in the economy continues to grow but is still below the Reserve Bank's target range. M3, the broadest definition of money, grew by 11,17 percent in the year to June, whereas the *Reserve Bank would like to see growth rates of 14 to 18* percent. Money, as narrowly defined by M1 which includes cash plus cheque and demand deposits in banks, increased 25,6 percent in May, indicating higher demand for credit and thus reflecting some improvement in the economy.

FINANCIAL INDICATORS

Johannesburg Stock Exchange Indices

JSE Indexes	4/8/87	WEEK AGO	% CHANGE
All Market Index	2689	2561	+5
All Gold Index	2459	2312	+6,4
Industrial Index	2205	2111	+4,5

Short-term interest rates

	4/8/87	WEEK AGO	YEAR AGO
Three-month bankers acceptances	8,8%	8,95%	11,5%
Prime overdraft rate	12,5%	12,5%	14,5%

Gold Price

	5/8/87	WEEK AGO	% CHANGE
	$470,60	$457,9	+2,8

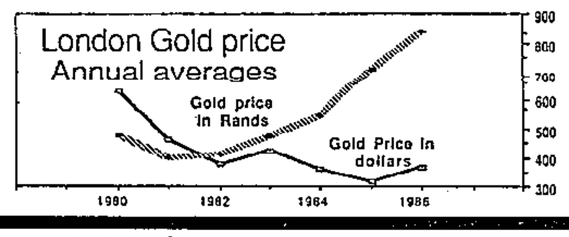
Selling price: Major currencies against rand

	5/8/87	WEEK AGO	% CHANGE
US dollars	48,13	48,30	-0,4
Pounds Sterling	328,07	331,41	-1
Deutsche Mark	0,9036	0,8972	+0,7
Yen	72,48	72,76	-0,4
Swiss Franc	0,7491	0,7431	+0,8
Financial Rand	0,3038	0,3088	-1,6

US Dollar against major currencies

	5/8/87	WEEK AGO	% CHANGE
Dm	1,8785	1,8576	+1,1
Sterling	1,5790	1,6007	-1,4
Yen	150,60	150,65	-0,03
SwFr	1,5565	1,5385	+1,2

Source: First National Bank



The state, beset with fiscal troubles, has hit upon what appears a handy solution: sell off the public goods to private enterprise. But first, a few provisos ...

DUNCAN INNES reports

THE government white paper on privatisation and deregulation has so far met with a mixed response.

Representatives of major employers' associations like Assocom, the Chamber of Mines, the Afrikaanse Handelsinstituut, the Federated Chamber of Industries and the South African Agricultural Union have cautiously welcomed the paper, while more forthright sections of the commercial press have dismissed it as "a mouse bound up in red tape".

The white paper begins by addressing the question of why the need for privatisation has arisen in the first place. In essence, its answer is that while demands on the public sector for services have been increasing, the economy has been buffeted by various forces, both international and local, which make financing this sector increasingly difficult.

In other words, the government finds itself caught in a fiscal crisis.

Total government spending has in fact been rising consistently, having more than doubled in nominal terms every five years since 1975, while government debt has followed a very similar pattern. Consequently, by 1985 public sector expenditure had reached 38,1 percent of the gross domestic product.

The effect of this, coupled with the recession, has been to reduce the tax base which, in turn, has made higher levels of taxation necessary. This, in turn, has in various ways contributed to restricting economic growth.

The government's intention, as spelt out in the white paper, is to promote growth through a number of means, including privatisation and deregulation of the economy. It is hoped that by privatising certain public enterprises and services they will become profitable, thereby contributing to the creation of wealth.

However, there are certain reservations.

The first, and no doubt a priority for the government, is to ensure that privatisation must contribute to the "maintenance of a comprehensive political system which will ensure self-determination for the various communities". Privatisation "must not entail a real risk to state security or internal order", nor must it "defeat the constitutional objectives" of the state..

Furthermore, privatisation "must be integrated with the total economic strategy for the Republic" and there should be "closer liaison and co-operation between the authorities and the private sector".

What this means of course is that the government is seeking through privatisation to draw the private sector into supporting its political policy of apartheid.

This is reinforced by the white paper's proposal that one of the methods for privatisation should be partnerships between the state and the private sector. Such partnerships, we are told, "could have the benefit of reconciling a private sector approach to management with public sector strategic interest in such an undertaking".

Furthermore, the white paper reminds us that since "the state has a responsibility to maintain an effective security force", defence will not be privatised. However, certain related functions, such as the "supply of certain defence equipment", can be privatised.

So the private sector is being invited to manufacture the armaments which the state will use to defend itself and keep apartheid in place.

The second reservation is that the government is not prepared to sell off the assets of a public sector monopoly corporation "if it is to be replaced by a private sector monopoly".

The government's concern here is that private sector monopolies might give rise to higher rather than lower prices and consequently it envisages that privatisation should aim at establishing "a number of enterprises", thereby creating competition in the market.

This argument has been challenged by the privatisation lobby which argues that the way to prevent monopolies forming is to deregulate the economy.

In particular, proponents of privatisation argue that were exchange controls to be lifted, large local companies would be free to invest overseas, thereby reversing the tendency towards mergers and takeovers in our local economy. Also, the lifting of import controls and tariff barriers would promote competition on the local market.

However, the privatisation lobby neesd to be careful it does not throw the baby out with the bath water.

Since 1985, South Africa has become a net exporter of capital, both as a result of disinvestment and the forced repayment of foreign debt. Under these circumstances it makes no sense to allow large companies to export precious capital abroad.

And, of course, were foreign exchange controls to be lifted, that is exactly what they would do. The effect on unemployment levels, officially estimated at 3,3-million, would be disastrous.

Similarly, lifting import restrictions would not simply increase competition for many local industries; it would wipe them out.

The problem of private sector monopolies is a real one and cannot simply be brushed aside. Between 1981 and 1984, 54,4 percent of net investment in the private sector went into the finance, insurance, fixed property and business services sector, while only 16,7 percent went into the production sectors of mining, manufacture and agriculture.

This means that investment which should have been used to create employment opportunities was instead being employed in takeovers and creating concentrations of financial power.

One of the most serious problems with privatisation is that it reproduces this tendency, since it basically involves transferring existing public assets into private hands rather than creating new jobs for people. In fact, since one of the main claims of the privatisation lobby is that public corporations are over-staffed, one of the main initial effects of privatisation will be to increase unemployment.

The government has set itself a three-year target to investigate the issue of privatisation further. In response, the private employers' federations referred to earlier have asked that the committee of ministers on privatisation be expanded into a formal joint body, with private sector representation.

Both the government and private sector are clearly interested parties: the government does not wish to relinquish political control over the economy and the private sector seeks to gain access to lucrative assets.

However, they are not the only interested parties.

The spoils which they seek to divide up among themselves are national assets to which the population as a whole has a right to lay claim. Perhaps it is time the debate was widened to include the trade unions and also the communities which depend so heavily on social services.

Rembrandt tipped for Stanbic

Weekly Mail Reporter

LIBERTY LIFE and the Rembrandt Group are being tipped as buyers in what is likely to be the biggest banking disinvestment move so far, British bank Standard Chartered's sale of its 38,9 percent stake in Standard Bank Investment Corporation of South Africa.

Trading in Stanbic's shares was suspended a week ago in anticipation of the disinvestment announcement. By Tuesday this week, negotiations were still under way, and the shares have now been suspended again until stock exchange trading closes today.

Stanbic managing director Conrad Strauss told a press conference that if the transaction takes place, it will be substantially larger than any previous banking disinvestment.

The move would make Standard Chartered the third foreign parent bank to sell its South African holdings.

Britain's Barclays plc sold its 40,4 percent stake in Barclays South Africa, now First National Bank, last year for R527-million. The sale gave Anglo American Corporation and its associates, Southern Life and De Beers, ownership of more than half of First National. Earlier this year First National paid American parent Citicorp R130-million for its South African banking arm Citibank SA.

In the wake of Barclays' disinvestment last year, Stanbic's Strauss told *Weekly Mail* that Standard Chartered was likely to reduce its shareholding in the South African banking group to about 25 percent.

But now it seems likely that the British bank is considering pulling out altogether. The move has probably been prompted by its situation in the London finance world, rather than any sudden pressures on the South African front. In response to pressure from rival Lloyd's Bank it may choose to buy another London bank. Disinvesting would provide some cash and, by removing the taint of a South African connexion, might assist it in raising further capital.

Liberty Life is the second biggest shareholder in Stanbic, with a 22,8 percent stake and is almost certainly one bidder for Standard Chartered's stake. But in terms of the Banks Act a life assurance company such as Liberty is not allowed to own more than 30 percent of a bank.

The mystery then is who else will buy in. Liberty is likely to be looking for a friendly partner.

Speculation is that the Rembrandt Group may be in line for the remaining chunk of Stanbic.

The tobacco multinational recently bought 10 percent of Gold Fields of SA from British-based Consolidated Goldfields. Gold Fields is already a significant shareholder in Stanbic and may be bidding to enlarge its stake. And Rembrandt has been moving into the field of finance, acquiring interests in companies such as Sage and Allied and building close ties with Volkskas.

If it sells, Standard Chartered will probably take the money out in financial rands, presently at 30 US cents. — Own Correspondent and Sapa.

War and strike talk drive up gold

Weekly Mail Reporter

JUST a couple of weeks ago economists were predicting that the gold price would hover between $440 and $460 for a while. But this week gold shot over the $470 mark, reaching $475 before dropping back somewhat.

The crystal ball gazers are now confidently predicting that the gold price will reach $500 before the end of this year.

This week's increase was largely a result of the escalating war in the Gulf, although talk of a South African mines strike also had something to do with it.

Gold is seen by investors as a "safe haven" for their money in times of political uncertainty in the world — and particularly when the uncertainty involves oil as it does in the Gulf. The prices of other precious metals such as silver and platinum have also been rising.

The gold price in rand terms is now around R980 an ounce and this increases the appeal of gold shares — as reflected in the leaps of the gold index of the Johannesburg Stock Exchange this week.

The soaring gold price may lead people to believe that the South African economy is taking off, but this, says one economist, could be a misconception.

An unusual feature of this week's events in the financial markets was that the dollar also rose against other currencies — although usually gold and the dollar are inversely related. But, it seemed, investors were also seeing dollars as a "safe haven": The dollar's rise certainly did not reflect any improvements in the American economy.

The dollar was soon restored to its previous levels.

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IN THE WEEK OF NATIONAL WOMEN'S DAY, A LOOK AT THE FAMOUS PROTEST MARCH 31 YEARS AGO

Memories of a foot-soldier in the women's army that occupied Pretoria



Hilda Tshaka: still itching for action Picture: Mono Badela

Hilda Tshaka, aged 77, carried a banner with the words "Away with passes' in the march on Pretoria this week, 31 years ago. She talks to MONO BADELA

HILDA TSHAKA was not one of the generals on the Federation of South African Women's march to the Union Buildings 31 years ago.

She was one of the foot-soldiers of the women's army that marched through Pretoria on August 9, 1956 behind Lilian Ngoyi, Helen Joseph, Frances Baard and Ameena Cachalia to tell JG Strijdom: "Strijdom, you have struck the women — you have struck a rock."

When you talk about August 9, names like Ngoyi, Joseph, Baard, Sisulu, Matomela spring to mind. But there were thousands more women with them outside the Union Buildings on that historic day, many of whom have suffered the same hardships as those women whose names are known and remembered.

One such woman is Hilda Tshaka, from KwaZakhele outside Port Elizabeth.

Harassed, jailed, banned and banished — it was during her banishment that she lost her husband and a son — the 77-year-old woman dreams of the march through Pretoria and the banner she carried, bearing the words "Away with passes".

Although she is less active than she was in the old days, this tireless fighter of apartheid is still itching for action.

On the eve of National Women's Day, she said this week: "It is time the women of South Africa march to Pretoria again."

On Sunday, special services and rallies will be held throughout the country to commemorate the day 31 years ago when some 20 000 women marched to the steps of the Union Buildings — citadel of apartheid — and challenged the prime minister as part of a nationwide campaign against the proposed extension of passes to African women.

The women came from all over the country — from Bethlehem and Bloemfontein, Port Elizabeth and Paarl, from Durban, Cape Town and Johannesburg. They were women of all racial groups.

Tshaka was born in Grahamstown in 1910 and moved 15 years later to Port Elizabeth, where she worked for the old African Food and Canning Workers Union. In 1951 she joined the African National Congress and the

at home and look after the children because we were going to march on Pretoria. They said we were mad ...

following year was one of the hundreds of people in Port Elizabeth to take part in the ANC's defiance Campaign. As a member of the ANC Women's League, she was among the women who helped to organise protests against rent hikes. She was there when Fedsaw was formed in 1954.

She said when Bantu education came in, "women came together and we rejected it. I was part of the committee. We said we would take our children out of the schools and into the open veld; the shade under the trees would became the classrooms." In the event, "I had to open my house in KwaZakhele to make a classroom."

She said the children attending these makeshift schools were harassed. "They would be arrested and we would follow and demand our children."

When the government decided to extend the pass to women, "we asked our men to stay at home and look after the children because we were going to march to Pretoria to protest against it. They called us mad because we did not have money to travel to Pretoria. But we baked cakes and sold them to pay the fare. We were even prepared to sell our furniture."

She said the night before the march, the women gathered in houses and halls in the Pretoria townships. "Many brought their babies.

"On the morning of August 9, the women met at the Union Buildings in Pretoria. They were so many, it took two and half hours for them to file through the gardens in the Union Building Amphitheatre. Then they sang "Strijdom, Uthinta abafazi, uthint'imbokotho!" (Strijdom, you've struck the women, you've struck a rock."

Leaders were chosen to present the petitions to Strijdom. They gained entry to the building but the prime minister refused to see them, so they left their petitions in his office.

Later the leaders reported to the mass of the women waiting outside. The women rose to their feet. The women stood in silence for 30 minutes. All you could hear was the crying of babies.

Then they sang "Nkosi Sikelel' iAfrika" and "Morone Boloka". Slowly the women left the gardens.

Tshaka said women had seen what the passes had done to their men. They did not want the same thing to happen to them.

In their petition to Strijdom, they said that if passes were extended to women, homes would be broken up when women were arrested under pass laws; children would be left uncared for and mothers torn from their babies if they couldn't produce a pass; women would be humiliated and degraded by policemen searching for passes; and they would lose their right to move freely from one place to another.

The anti-pass campaign did not stop the extension of passes to women. But according to [illegible] and how it would affect them. It also gave women an idea of their strength.

When the ANC was banned in 1960, "we also went underground," Tshaka said. "We were not seen but our action was seen."

She was arrested in 1964 and charged with furthering the aims of the ANC. Her husband James Tshaka and two of her sons, Patrick and Siphetho, were also arrested. "Only my 15-year-old son and my 10-month-old baby were left behind." She was imprisoned for three years; when she was released she was put under house arest for two years — until her husband and two sons were released from Robben Island, when the entire family was banished to Burnshill, a remote area near Keiskamahoek.

Her husband was ill, but their departure could not be delayed. They were merely given train tickets and when they arrived there there was not a house to live in; they had to build their own.

They were given a weekly food ration — which arrived irregularly — of two loaves of bread, two tins of jam, a pound of tea, condensed milk and 20 cents worth of sugar. They had to report at the police station once a week in Keiskamahoek. "We had to go through a dark forest. My husband died in Burnshill."

The family was transfered to another resettlement colony in Dimbaza in 1972, "where we found conditions even worse than in Burnshill."

Dimbaza was really the last grave for the Tshakas — as for many others. Not only did she see her son Siphetho die in Dimbaza in 1974 but several of her colleagues also died

The women rose to their feet and stood in silence for 30 minutes. All you could hear was the crying of the babies

there. These included Emily Vara and her husband Richard Vara, Tabita Tuzana Tshaba, Vuyelwa Bissett, Grace Maqungo, Emily Qabela. Many of these women had served up to eight years in prison for being members of the ANC. They had all participated in the Pretoria march.

Women today are once again being called on to challenge "the monster that is apartheid" as did the women on the 1956 march, Federation of Transvaal Women administrator Ohara Diseko told *Weekly Mail* this week.

"Today as women we are daily suffering the pain of seeing our children detained, killed, maimed. Our men and brothers are being detained and brutalised. Again it is the women who feel the pain more when families are being evicted from their homes.

"The rock still stands today. 'The hand that rocks the cradle will rock the boat.'"

In the Transvaal, thousands of women will commemorate the day with a cultural programme at the University of the Witwatersrand starting at 10 am.

The theme of this year's celebrations is "Forward to national women's unity"; "We are calling on all women," Diseko said, "to organise themselves in their local areas to help establish strong women's organisations."

She said Fedtraw was also calling on all women who are not already part of the United Democratic Front Women's Congress, and all women in other progressive organisations, to join a committee working towards reviving the Federation of South African Women (Fedsaw).

Diseko said women today were organising under very difficult conditions.

"There is the State of Emergency and repression from the state. It is therefore difficult to speak in terms of numbers. But we are happy with the growth of the organisation. We see ourselves having taken big strides."

She said in order for the women to meet they had to arrange secret venues. "We have to work very guardedly if we want to make a move." But she hoped Fedsaw would be launched later this year.

The revival of the organisation would follow the launch of the UDF Women's Congress, inaugurated on April 26 by women from all sections of the country meeting in Cape Town.

The woman who refused to carry a pass

By EDYTH BULBRING, Port Elizabeth

A VETERAN women's rights activist died in New Brighton last Saturday night without ever having carried a pass, a reference book or an identity document.

Pauline Nombayiso Mbunye, 74, a founder and executive member of the Port Elizabeth Women's Organisation, died of natural causes at a friend's home.

Her refusal to carry an identity document disqualified her from housing, a formal job and, eventually, a pension

A founder of the Federation of South African Women in the Eastern Cape and a member of the ANC Women's League, she worked in the anti-pass and and anti-Bantu education campaigns. In 1956, she was one of the women who marched on the Union Buildings in Pretoria.

In a statement to the Black Sash two years ago, made in an attempt to obtain financial assistance, she said: "I am part of the struggle. I do not want to apply for aid from the state, especially now that I feel that the end is near for the state." A vegetable hawker, she said she had never asked for assistance from the state because it would have necessitated application for a reference book, which she felt would compromise the beliefs she had fought for throughout her life.

She has no children and her husband died years ago.

Friends say she stopped wearing shoes when Nelson Mandela was imprisoned. She told them this made her more determined than ever never to carry a pass. Thus, she told friends, she would never have a job — and could not afford to become accustomed to wearing shoes. — ECNA

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Dismissal denied

MORE than 80 paraplegics employed at the Orlando Sheltered Workshop in Soweto, yesterday claimed that they were dismissed by their employer after their strike over overdue wages last week.

The workers claimed that their employer, Mr Roy Webber, paid them this week and told them that they should no longer come back because there was no transport to ferry them to and from work.

The assistant general manager at the workshop, Mr Mike Bartlett, said the workers were not fetched from their homes because the kombi was taken in for repairs. He denied that they had been dismissed.

He said: "We have encouraged most of them to continue to work at home so that they should be able to earn some money at the end of the month."

13/8/87

Sowetan

299

Self-help seminar

MORE than 200 delegates representing self-help organisations of disabled people throughout the country meet at Ipelegeng Community Centre in Soweto for a two-day leadership seminar starting tomorrow.

Mr Friday Mavuso, vice-chairman of Disabled People South Africa, said the seminar was a follow-up to a similar one which was held earlier this year at the same venue.

He said delegates will report back on progress they have made since the last seminar.

Funds

According to Mr Mavuso, who is also founder and chairman of Self-Help Association of Disabled People (Shap) in Soweto, at the first seminar delegates were lectured on how to start a self-help project, the role of executive committee members, how to write a letter to a donor and how to raise and administer funds.

"Our aim to start these projects is to assist disabled people to help themselves in fighting unemployment, especially in the rural areas.

Grants

"Disabled people in the rural areas receive little or no grants at all. We want to prove that given a chance and facilities they can be productive and be able to support themselves," he said.

At this week's seminar, speakers will address those attending on poultry farming, running a tuck-shop, sign language and setting goals for an organisation.

can Police have a statutory obligation to preserve the security of the State and to this end, like its counterparts the world over, indulge in monitoring the actions of revolutionary activists whether on or off campus.

Taking into account several instances that have occurred in the past that necessitated the arrest, trial and conviction of individuals, connected with the University of Cape Town either as students or as lecturers and who has acted as ANC or SACP agents, the police would be failing in its duty if it should exclude the said university from such action.

This was further necessary because the South African Police, as well as parents and the moderate majority of South Africans are concerned about the situation at the particular university.

I have asked the Commissioner of Police to investigate fully why Mr Pretorius has exposed his involvement with the South African Police.

Furthermore, I am quite prepared to discuss the matter with the vice chancellor of the University of Cape Town, dr Stuart Saunders. I also have a few other matters which I would like to raise with him.

2-8-87.

ADRIAAN VLOK.

MINISTER OF LAW AND ORDER.

Mr S S VAN DER MERWE: Mr Speaker, arising from the hon the Minister's reply, I would just like to ask him whether it is the policy of his department to recruit people for these purposes while they are still at school and whether it did indeed happen in other cases.

The MINISTER: Mr Speaker, I do not think we could send people to the university as spy who are for instance 60 years old. I will therefore not add to the reply I had given previously.

Mr K M ANDREW: Mr Speaker, arising from the hon the Minister's reply, may I ask in whether any steps are being taken in the light of the photographic evidence of the participation of this policeman in certain activities?

The MINISTER: Mr Speaker, for the benefit of the hon member I have explained it in full in my reply and in the Press release about the activities of the Police. I will not add to my reply.

Mr K M ANDREW: Mr Speaker, further arising from the hon the Minister's reply, in view of the photographic evidence may I ask him whether he expects anybody to believe his answer? [Interjections.]

Disability rebate

*12. Mr M J ELLIS asked the Minister of Finance:

(1) Whether he has given any consideration to increasing the maximum disability rebate of R3 000 from the income of severely handicapped persons for tax purposes; if so, with what result; if not, why not;

(2) whether he will consider increasing this rebate in the light of the direct and indirect additional expenses of severely handicapped persons; if not, why not; if so, (a) by what amount and (b) when;

(3) whether he has received any representations for this rebate to be increased; if so, (a) when, (b) from whom and (c) what was his response thereto;

(4) whether he will make a statement on the matter?

The DEPUTY MINISTER OF FINANCE (Mr K D S Durr):

(1) No. No representations have been received in this regard.

(2) I wish to point out that the relief in question is given in the form of a deduction from income and is not a rebate, i e a reduction in tax. An increase in the amount of the deduction, or relief in some other form will be considered, together with other personal reliefs, in the light of recommendations contained in the Margo Report.

(3) No.

(4) No.

Hansard 25/8/87

ANC/SA businessmen: discussions

*13. Mr T LANGLEY asked the Minister of Foreign Affairs:†

(1) Whether his Department was in contact with a group of South African businessmen and newspaper editors who held discussions with the ANC in the Luangwa Game Park in Lusaka on or about 13 September 1985; if so,

(2) whether his Department was in contact with the said group (a) before and (b) after these discussions: if so, (a) with what purpose, in each case;

(3) whether he gave (a) instructions and/or (b) permission that this group be so contacted;

(4) whether he will make a statement on the matter?

†The MINISTER OF FOREIGN AFFAIRS:

(1) No, the Department of Foreign Affairs was not in contact with the group. The then Deputy Minister of Foreign Affairs, Mr D J L Nel, was informed of the visit by one of the persons involved in the arrangements of the group which would visit Lusaka. Mr Nel informs me that he discouraged them most strongly from talking to the ANC and said that nothing could be achieved by talking to the ANC. Mr Nel also supplied facts to the person concerned about the ANC's violent aims and furnished them with particulars to indicate that the ANC was dominated by the South African Communist Party. This was done to underline that nothing could be achieved from talking with that organisation. Mr Nel's views were repeated in an interview with the BBC which fact was reported in SA.

(2) and (3) Falls away.

(4) No.

Lusaka: airport

*14. Mr T LANGLEY asked the Minister of Transport Affairs:†

(1) Whether the South African Transport Services have received any complaints and/or representations about the landing facilities at the airport in Lusaka, particulars of which have been furnished to the Transport Services for the purposes of the Minister's reply; if so, what is the purport of these complaints and/or representations;

(2) whether the Transport Services have taken or are contemplating any action in this connection; if not, why not; if so, (a) what action and (b) when;

(3) whether he will make a statement on the matter?

The MINISTER OF TRANSPORT AFFAIRS:

(1) No.

(2) Falls away.

(3) No.

†Mr T LANGLEY: Mr Speaker, arising from the hon the Minister's reply, we are dealing here with transport facilities which could have very serious complications for the South African public flying to Lusaka, and I therefore want to ask the hon the Minister whether he knows absolutely nothing about it, and whether he intends doing something about the matter.

†The MINISTER: Mr Speaker, I have answered the hon member's question exactly. If he requires further information, he must put a new question.

Mr D J N MALCOMESS: Mr Speaker, further arising out of the hon the Minister's reply and in view of the fact that earlier this week or last week in reply to a question of mine he stated that the ILS and a number of runway approach lights at Lusaka Airport were out of action, I want to ask whether he is prepared to reconsider the fact that SAA's planes are apparently still landing in Lusaka.

The MINISTER: Mr Speaker, we will at all times ensure the complete safety of our aircraft.

Mr K M ANDREW: What about the passengers?

HoA

Hansard 25/8/87

Battling claims

PROFMED — the medical aid society available to PPS members — had a total of 11 587 members at the end of the 1986 financial year (June 30, 1986). The members have 28 476 dependents, so that Profmed catered for the medical needs of 40 063 people.

During the financial year Profmed — in common with all medical aid schemes — again suffered an increase in its claims experience, which necessitated the raising of subscriptions with effect from January 1, 1987. Profmed chairman Edwin Letty, in the annual report, noted that the higher claims were not only due to the escalating cost of medicines and the increasing cost of medical services, but were also in part "due to an over-utilisation" of medical services by members. Letty notes that the tendency towards over-utilisation "and has no doubt contributed to the rising claims recorded by all medical aids in the country".

At the same time, suppliers of medical services have also been faced with spiralling cost increases. The cumulative effect of these factors has been the increase in medical aid subscriptions over the last few years.

As a result of the increase in premium rates, a deficit of R500 000 in 1985 was converted to a surplus of R976 000 in 1986 on claims totalling R12,484m against R10,847m.

The MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING:

(1) 664: specified date 8 June 1987.

(2) (a)

Post level	Number of persons employed
1	1
2	1
3	4
4	8
5	22
6	11
7	33
8	13

(b) (i) 88.

(ii) 5.

(c) Whites: 93;
Coloureds: Nil;
Indians: Nil;
Blacks: Nil.

(3) (a)

Post level	Salary scale with effect from 1 July 1987
1	R119 136
2	R75 993
3	R70 017
4	R62 199
5	R54 954
6	R48 879 – 50 709
7	R43 389 × 1 830 – 47 049
8	R33 624 – 34 803 × 1 431 – 39 096/40 527 × 1 431 – 43 389 × 1 830 – 47 049.

(b) (i) Annual service bonus that amounts to 93% of one month's salary.

(ii) Housing subsidy on interest and capital redemption up to a maximum of a housing loan of R50 000,00, subject to the compliance with certain conditions.

(iii) Car financing scheme for officers occupying posts in the *management echelon* (ie those officers who are in receipt of an annual salary of R54 954 fixed and higher). The amount payable varies for each level as it is based on an officer's grading.

HoA

Reply substituting reply to Question 241 on 28 and 31 July 1987, put by Dr M S Barnard (Col 431 and Col 448):

Aids

241. Dr M S BARNARD asked the Minister of National Health and Population Development:

How many carriers of the acquired immune deficiency syndrome virus had been identified in respect of each race group in South Africa as at the latest specified date for which information is available?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

Whites	1 140
Coloureds	31
Indians	3
Blacks	*1 093
Unknown	57
Total	2 324

*Of which 946 were miners.

FRIDAY, 28 AUGUST 1987

†Indicates translated version.

For written reply:

General Affairs:

Group Areas Act

342. Mr J J S PRINSLOO asked the Minister of Justice:†

(1) Whether any criminal cases have been heard in terms of the Group Areas Act, No 36 of 1966, since 1 January 1987; if so, how many such cases have been heard in (a) district and (b) regional courts in each province;

(2) whether any eviction orders have been made by courts since that date against persons who occupied premises in contravention of the provisions of the said Act; if so, how many such orders have been made in (a) district and (b) regional courts in each province;

(3) in respect of what date is this information furnished;

(4) whether he will make a statement on the matter?

The MINISTER OF JUSTICE:

(1) Yes.

(a) 1 (Transvaal)

(b) 0.

(2) No.

(3) 1 January 1987 to 31 July 1987.

(4) A statement is not necessary.

Own Affairs:

~~Teachers: handicapped pupils~~

64. Mr M J ELLIS asked the Minister of Education and Culture:

(1) Whether his Department intends making it compulsory for persons teaching at training centres for mentally handicapped children to have a special qualification for teaching such pupils; if so, (a) what diploma will be required and (b) what will be the duration of this diploma course;

(2) whether this course will be available on a part-time basis; if so, at which institutions?

The MINISTER OF EDUCATION AND CULTURE:

(1) No, although the ideal is for every post incumbent to have such a qualification a specialised course is at present a recommendation.

(a) and (b) Fall away.

(2) Falls away. However, a two-year diploma course in Special Education for the Severely Mentally Handicapped, is available on a part-time basis. It is offered by the University of South Africa.

Schools of industry/reform schools/technical colleges

65. Mr M J ELLIS asked the Minister of Education and Culture:

Whether his Department intends altering the functions of the governing bodies of (a) schools of industry, (b) reform schools, (c) schools for special education, (d) training centres for mentally retarded children and (e) technical colleges; if so, (i) what changes are to be introduced in each case and (ii) when will these changes become effective?

The MINISTER OF EDUCATION AND CULTURE:

(a), (b), (c), (d) and (e) No, not for the present. The proposed Act on Education Affairs may have the result that anomalies which may exist are eliminated.

(i) and (ii) Fall away.

Mentally handicapped children: training centres

66. Mr M J ELLIS asked the Minister of Education and Culture:

Whether his Department intends changing the formulae for nominating persons to the governing bodies of (a) training centres for mentally handicapped children and (b) special schools; if so, (i) what are the present formulae, (ii) what changes will be made to each formula and (iii) why are these changes being made?

The MINISTER OF EDUCATION AND CULTURE:

(a) and (b) No, not for the present. The proposed Act on Education Affairs may have the result that anomalies which may exist are eliminated.

(i), (ii) and (iii) Fall away.

Cultural affairs: regional councils

67. Mr R M BURROWS asked the Minister of Education and Culture:

What are the names of the persons serving on each of the regional councils for cultural affairs falling under the control of his Department?

The MINISTER OF EDUCATION AND CULTURE:

The following persons have been appointed to the different regional councils for cultural affairs for a three year period from 1 August 1987:

Paraplegics down tools because wages are late

MORE than 100 paraplegics at the Orlando Sheltered Workshop, in Orlando East, Soweto, this week downed tools after demanding their overdue wages.

The workers said they went on strike after their employer, Mr Roy Webber, did not give them their pay on Friday and told them it would be available this week.

On Monday the workers met Mr Webber who said he was waiting for five of the six signatories to authorise their cheques.

When they insisted that he pay them because they did not believe him, Mr Webber ordered a driver to take them home and not to fetch them the next day.

Mr Webber said the signatories, who had been away on business, arrived yesterday. The workers would get their money today, he added.

He denied that he had fired the workers for going on strike.

"They will be fetched from their homes to collect their money. There is no problem at the workshop and everything is operating normally," Mr Webber said.

32 000 children die in one year

Star 18/8/87

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By Toni Younghusband

More than 32 000 children under the age of five died in one year in South Africa, said a comprehensive report on death by the South African Medical Research Council.

The report said the greatest mortality rate was recorded among infants under a year old — 73 percent of all child deaths in 1984.

The Medical News Tribune wrote that this was the first comprehensive report on death statistics and the causes of death in South Africa.

The report recommended health care strategies for South Africa and highlighted areas of concern with a major effect on society.

It was critical of the reliability of information on deaths for the black population and recommended ways of improving information gathering.

Major findings of the report were:

● Unnatural causes of death accounted for 36 percent of the total loss of potential years of life. This meant that of the 2,5 million years of life lost in 1984, nearly 1 million were due to traumatic injuries.

● The most common cause of death for the white community was disease of the heart and circulatory system.

Cancer ranked second and diseases of the respiratory system third.

25/8/87 Hansard

(3) whether the new draft regulations are to be reconsidered after the receipt of comments thereon; if not, why not; if so, (a) by what body and (b) when are they expected to be reconsidered;

(4) whether he will make a statement on the matter?

The DEPUTY MINISTER OF NATIONAL HEALTH:

(1) Yes.

(a) 5 June 198[illegible] in *Government Gazette* 1208.

(b) To consolidate numerous local authorities' regulations in one national regulation.

(c) With major organizations concerned with caravan parks, *inter alia* the:

(1) South African Caravan and Camping Council.

(2) Natal [illegible] Board.

(3) Development and Services Board of Natal.

(4) A[illegible] Africa.

(5) Jurgens Caravans.

(6) City [illegible] of Durban, Cape [illegible] and Port Elizabeth.

(7) Overview Resorts.

(8) Director [illegible] Local Government of [illegible]aal.

(9) SABC.

(2) Yes.

(a) Contains [illegible] restrictive clauses.

(b) Compiled [illegible] Department from various [illegible]ments received.

(3) Yes.

(a) By the [illegible] in consultation with [illegible] groups.

(b) Before the [illegible] the year.

(4) No.

Witwatersrand: disqualified persons

*25. Mr S S VAN DER MERWE asked the Minister of Law and Order:

Whether the South African Police or any section of the South African Police has compiled a record of premises in the Witwatersrand area which are occupied in part or in whole by persons who are disqualified in terms of the Group Areas Act from residing in them; if so, (a) who compiled this record, (b) (i) when and (ii) why was it compiled and (c) how many (i) buildings and (ii) persons have been included in this record?

†The MINISTER OF LAW AND ORDER:

No, not as far as could be ascertained.

(a) to (c) Fall away.

Professional wrestling

*26. Mr A E NOTHNAGEL asked the Minister of National Education:†

(1) Whether he has received any representations on the abolition of statutory control over professional wrestling; if so,

(2) whether he will make a statement on the matter?

†The MINISTER OF NATIONAL EDUCATION:

25/8/87

(1) Yes.

(2) Yes. In accordance with the Government's decision on deregulation the provisions of the Boxing and Wrestling Control Act, 1954, have been reviewed. The possible deregulation of professional wrestling was disussed with the South African National Wrestling Control Board. The Board supported the principle of totally deregulating professional wrestling, and a draft amendment Bill to this effect was recently approved by the Cabinet. The draft amendment Bill provides for the deletion of the provisions of Act 39 of 1954 that pertain to professional wrestling. The provision prohibiting females from participating in wrestling (and boxing) is, however retained. The provision in terms of which the Police and magistrates may in certain cases stop or prohibit wrestling (or boxing) contests or exhibitions is also retained.

Hansard

The draft amendment Bill will soon be published for general information and comment. The existing legislation will remain in force and the present control over professional wrestling will continue until legislation for the abolition of wrestling control boards is accepted. The term of office of the present wrestling control boards expires on 31 March 1988, and they will continue to functon under the Boxing and Wrestling Control Act, 1954.

The Chairman of the SA National Wrestling Control Board has requested me so to amend the regulations that the licence fees payable to the Board will be reduced from 6% to 4% of the income derrived from wrestling tournaments. Promoters, wrestlers and officials will also be exempted from the payment of registration fees. I wish to appeal to wrestling promoters and all those concerned with the presentation of professional wrestling tournaments to help make the transition a smooth one.

I would like to pay tribute to the Chairman and members of the SA National Wrestling Control Board as well as the members of the various provincial wrestling boards for their selfless service to wrestling over many years. It is often difficult to exercise control over a sport such as professional wrestling without inhibiting the spirit of competition that characterises the sport. I fully appreciate that the loyal and voluntary service, rendered by members on a vuluntary basis is often accompanied by great personal sacrifice, and I wish to extend my sincere gratitude to all concerned.

†Mr S S VAN DER MERWE: Mr Speaker, arising from the hon the Minister's reply, does he feel that the need of women to wrestle and to box with each other, is still of such a nature that it still justifies a statutory prohibition in the long term?

†The MINISTER: Mr Speaker, just as we have laws regulating morals in many fields and preventing the same evil situation which exists overseas from also coming about in South Africa, so we maintain this provision, because female wrestling overseas is an accepted principle which is part of the decadence which we do not want to have here.

Own Affairs: Hansard

Mentally handicapped children: training centres

25/8/87

*1. Mr M J ELLIS asked the Minister of Education and Culture:

Whether the procedures for the (a) staffing of training centres for mentally handicapped children and (b) promotion of teachers of these schools are to be changed; if so, (i) what procedures are being followed at present and (ii) (aa) what changes are to be effected, (bb) when will they come into effect and (cc) why are they being effected?

†The MINISTER OF EDUCATION AND CULTURE:

(a) No, not for the present.

(b) No, it was amended with effect from 1 January 1987,

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(i) the Selection Boards of provincial education departments submit shortlists to Governing Bodies of training centres. Appointments in promotion posts at State-aided training centres are made by the Governing Bodies after prior approval by the Minister. In the case of State training centres, the appointments are made by the Minister on the advice of the Governing Body.

(ii) (aa) Falls away.

(bb) Falls away.

(cc) Fall away.

Hansard

25/8/87

Mentally handicapped children: training centres

*2. Mr M J ELLIS asked the Minister of Education and Culture:

Whether (a) teachers and (b) other members of the professionel and administrative staff of education departments falling under his Department may (i) be nominated to serve on and (ii) serve on the governing bodies of training centres for mentally handicapped children and special schools; if not, why not?

The MINISTER OF EDUCATION AND CULTURE:

(a) and (b)

(i) No, it is not advisable to have members of a Department serve in a Body that has to decide on professional aspects of other members of the same Department.

(a) and (b)

(ii) Yes, in cases where appointments were made under the old dispensation and the encumbents' periods of office have not run out.

Severely handicapped children: training centres

*3. Mr M J ELLIS asked the Minister of Education and Culture:

Whether (a) training centres for severely handicapped children and (b) special schools will be represented on the regional councils or school boards in each of the provinces; if not, why not; if so, from what date?

†The MINISTER OF EDUCATION AND CULTURE:

(a) No. State training centres for severely handicapped children are not represented in these bodies since the provincial education ordinances do not provide for their inclusion. This matter will be attended to in the proposed Education Affairs Act.

State aided training centres for severely handicapped children are not represented as they are controlled by autonomous Governing Bodies.

(b) Yes, since the establishment of special schools in Transvaal, Orange Free State and Cape, and since the amendment of the Provincial Education Ordinance in 1986 to provide for the institution of these bodies in Natal.

I may for further edification point out that in questions 1, 2, 3 and 7 the term "special schools" or "schools for special teaching" is used. These terms are not synonyms. Special schools are schools that have always been provincial schools and education and vocational guidance are given to children with learning problems but who are not handicapped. Schools for special or extraordinary education are schools for children who are physically, mentally and/or behaviourally handicapped.

Teachers of Chinese descent

*4. Mr R M BURROWS asked the Minister of Education and Culture:

(1) Whether teachers of Chinese descent are permitted to teach in schools under the control of his Department; if not, why not; if so,

(2) whether such teachers are obliged to register with the Teachers' Federal Council;

(3) whether the Teachers' Federal Council has undertaken the registration of such teachers; if not, why not?

The MINISTER OF EDUCATION AND CULTURE:

(1) Yes, at certain schools at this stage.

(2) No, not at present. The registration of these teachers is receiving urgent attention.

(3) Not yet, to my knowledge. Negotiations with the Teachers' Federal Council on this matter are at present under way.

Statistics on housing

*5. Mr K M ANDREW asked the Minister of Local Government, Housing and Works:

(1) Whether his Department keeps statistics on housing for Whites; if not, (a) why not and (b) who is responsible for keeping such statistics; if so,

(2) whether there is a (a) shortage or (b) surplus of housing for Whites in the Cape Peninsula; if so, what was the extent of the shortage or surplus as at the latest specified date for which information is available?

†The MINISTER OF LOCAL GOVERNMENT, HOUSING AND WORKS:

(1) Yes.

(a) Falls away.

(b) With the co-operation of local authorities the Department maintains a housing data bank in so far as it concerns persons of the White population group.

(2) Yes.

(a) According to the computerised waiting list programme, 1 479 persons have as at 24 August 1987 registered a housing need. The need survey is an ongoing process and it is envisaged that the shortage will come to some 2 000 as soon as the outstanding applications for housing assistance have been computerised.

(b) Falls away.

Mr K M ANDREW: Mr Speaker, arising from the hon the Minister's reply, may I ask him whether separate figures on shortages and surpluses are kept in respect of people who require subsidised housing and those who do not require subsidised housing or accommodation?

†The MINISTER: Mr Speaker, the survey that is being done is about income groups and age groups. I shall reply more fully to the question the hon member has just asked me.

Rondebosch Boys' Preparatory School

*6. Mr J J WALSH asked the Minister of Education and Culture:

(1) Whether his Department intends providing new school buildings for the Rondebosch Boys' Preparatory School; if so, (a) what stage has the planning reached, (b) when will the construction work (i) commence and (ii) be completed, (c) when was it first decided that the school needed additional facilities and (d) what steps are envisaged in respect of (i) each of the buildings, (ii) the sporting facilities and (iii) the grounds at the present school site;

(2) whether there have been any delays in this regard; if so, (a) what delays and (b) why?

The MINISTER OF EDUCATION AND CULTURE:

(1) Yes.

(a) Sketch plan stage.

(b) (i) 1990, provided that funds will be available.

(ii) 1992, provided that funds will be available.

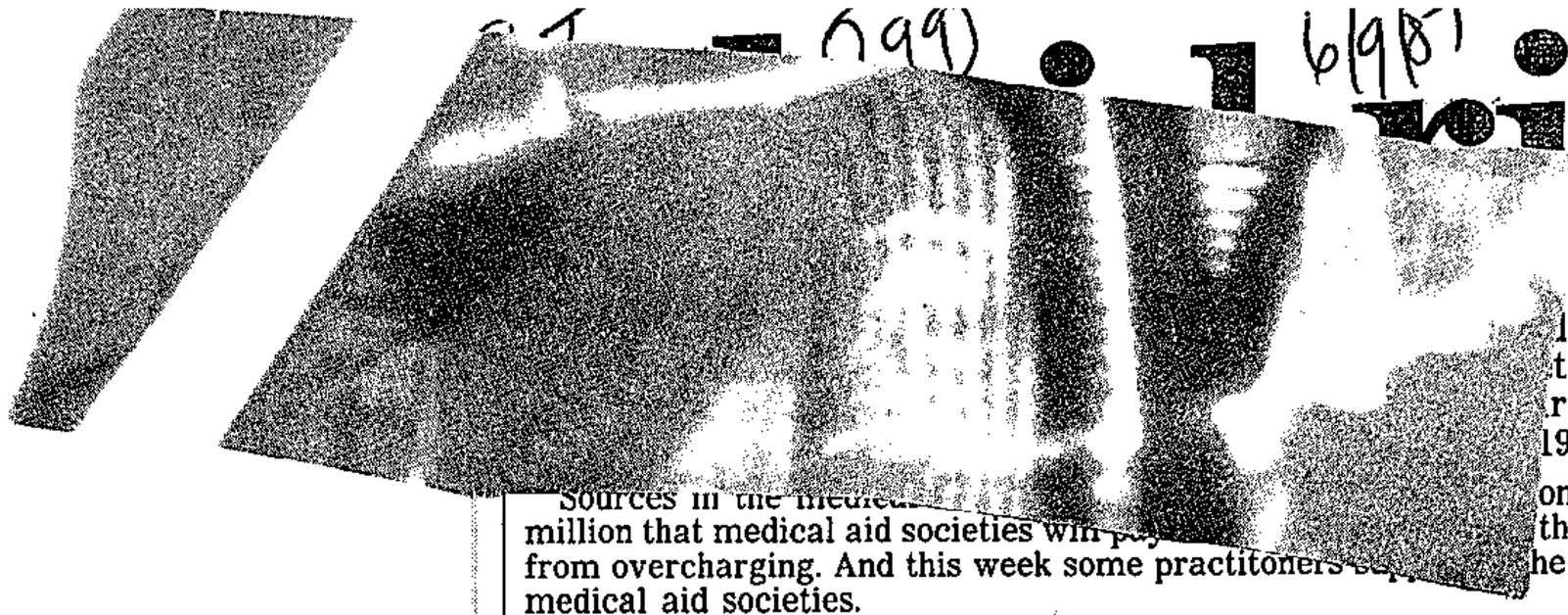
(c) 1980.

(d), (i), (ii) and (iii) To be retained for educational purposes.

(2) Yes. (a) and (b) Owing to representations received during 1980 it was decided to replace the existing school building with a new building on a more suitable site. A previously approved scheme for extensions to the existing buildings had to be discarded.

The proposed new building was researched and designed in co-operation with the National Building Research Institute, which resulted in the planning stage being much longer than normal.

In addition, there were protracted negotiations to obtain a suitable new site.



rip-off

Special report by HAMISH McINDOE

PRIVATE CLINIC SCAMS FLEECE THE PATIENTS

l societies of
t still reeling
r, the news of
1988.

Sources in the medical
million that medical aid societies will pay
from overcharging. And this week some practitioners
on of the R460-
this year comes
he claims of the
medical aid societies.

Now, the majority of private hospitals who are sick of having their reputations wrecked by racketeers are planning a drive to clean up their tarnished image.

Dodges used by some unscrupulous hospital administrators to pep up their bills include charging for unused theatre time and padding accounts with charges for unused drugs and surgical equipment.

A doctor who may not be named says many hospitals are now using these methods as a "matter of policy" to drum up profits.

The fledgling National Association of Private Hospitals (NAPH) has declared total war on the swindlers — and the operating licences of the worst offenders could be revoked.

NAPH chairman Dick Williamson said: "Most hospitals are honest, but a few people are making huge inroads into the industry's reputation."

Watchdog

The NAPH, which represents 85 percent of all private hospitals, wants to appoint external auditors to do random checks on hospital bills.

"Persistent violators will face our disciplinary committee, with the bottom line being the withdrawal of their licences," said Mr Williamson.

Government's attempt to stop the rip-offs by the appointment of a watchdog council for private hospitals later this year has been cautiously welcomed by medical aid societies.

The Representative Association of Medical Schemes (RAMS) is currently reviewing the scale of benefits for private hospitals for the 1988 round of increases.

This will set the new contribution levels for members of medical aid schemes, which rocketed by an average 20 percent this year.

RAMS vice chairman Arnold Fair said: "We're very concerned about the abuses and overcharging, but it's our job to set the scale of benefits for private hospitals — not to investigate accounts.

"And, anyway, medical aid societies go to extreme lengths to control abuses."

Some observers believe the medical aid societies are soft targets for unscrupulous hospitals.

"They often pay hospital bills without looking at the charges too closely," said a doctor.

"I know," he added, "My wife was recently discharged from a private hospital and we received a R700 bill for medicines.

"On checking the invoice, several items had clearly never been used."

Medscheme, the country's biggest medical aid administrators, queries about 20 percent of its monthly R4-million pay-outs to private hospitals.

Complaints

"And that's really the tip of the iceberg. We just don't know at what level the swindles are occurring. But one thing is clear: the fiddles mean higher contributions for our members," said Medscheme MD Keith Hollis.

According to NAPH figures, there were only 24 complaints over accounts from the patients who spent 1,5-million nights in private hospitals last year.

As matters stand, invoices are sent directly to medical aid societies — but the NAPH is urging its members to send copies to patients.

Mr Hollis, for one, believes that patients should be sent a copy of their hospital bills automatically to help unmask the blatant fiddles.

PFP health spokesman Dr Marius Barnard said: "It is an absolute must that patients and their doctors look at the accounts.

"But the medical profession is not keen to do this because of the administration hassles it would create."

South Africa's 41 registered medical aid schemes expect to pay R2,600-million to health care services this year. Of this, R460-million will go to private hospitals.

RAMS is trying to get private hospitals to agree to standard charges for routine treatment to cut the red tape.

And the Government has already proposed that private hospitals should introduce all-inclusive tariffs based on a treatment-and-time basis.

Domino

Medscheme director Pie van der Merwe said: "We've had a continual battle on our hands for the last 10 years over the charging of the 'so called' disposables in wards and theatres.

"And the domino effect of having to check all the small amounts ends with increased yearly payments for members because of the massive administrative cost of weeding each account."

On the flip side, the average private hospital shells out about R15 000 a month for non-chargeable items, such as peptic swabs, face masks and formalin.

● South Africa's private hospitals are still among the cheapest in the West. According to NAPH figures, the tariff cost of a day in intensive care is R163 against R2 138 in the US and R1 190 in Britain.

'Disabled need sexual rights'

By Janine Simon

Sex education should be available for mentally handicapped people and professionals working with the mentally handicapped should re-examine their own sexual prejudices.

This was said at the weekend by Mr Morgan Williams, director of the British voluntary agency to aid the sexual and personal relationships of people with a disability (Spod), at a symposium entitled "Handicap and the three R's — rights, relationships, resources", in Johannesburg.

"Most professionals need conciousness-raising to the fact that their disabled clients have the same sexual and emotional needs as themselves, but not always the knowledge, freedom or privacy for a relationship," Mr Williams said. Lack of privacy inherent in facilities for the handicapped could lead to misrepresentation.

Residents were sometimes accused of inappropriate behaviour, when it was not their actions but the place where they were conducted that was in question.

Spod operated on the philosphy that people with disability had the right to sex education, a sexual identity and, where applicable and possible, the right to a normal relationship.

'It's not State's duty to be main provider'

Focus on funding for handicapped

The State's attitude to funding of the care of handicapped people and problems regarding facilities for mentally handicapped black people were two of the issues raised at the recent symposium "The Three R's of Handicap — Rights, Relationships, Resources".

Dr A Levin, director of mental health at the Ministry of Health and Welfare Services told the symposium it could no longer be assumed that it was the State's duty to be the primary provider of community resources.

Dr Levin said that the limitations on the amount of taxes that could be levied and thus on state funding, had led to a dramatic reappraisal of the community's needs and resources.

It was also realised that the handicapped individual, the family and extended family were a great untapped resource.

One of the most profound changes had been in the attitude towards the role of the parent in the care and habilitation of the handicapped child — a move applauded as an overdue recognition of parental rights but also criticised for placing expectation and thus strain on the marriage and family life of the parent concerned.

The symposium also discussed the problems presented by proper assessment of black handicapped children.

According to Mr E R Makwe, a clinical psychologist at Baragwanath Hospital, services there were so fragmented that even he was not aware of what programmes were being run.

A particular problem was that patients were referred from department to department, requiring several visits and a separate payment for each.

Proper assessments were hampered by the number of children involved, the few able and willing professionals, limited assessment skills, difficulties in involving parents who were employed full-time, and the lack of treatment facilities once a diagnosis had been made.

New Soweto home for the mentally handicapped

A desperately needed new facility to cater for 800 of Soweto's 15 000 mentally handicapped is to be built as soon as the Soweto Council grants the organisers a site.

Plans for the Takalani Home for the Mentally Handicapped have been completed and all of the estimated R5 million capital cost has been raised, Mr John Rees, executive director of the Avril Elizabeth Home for Mentally Handicapped, said this week.

Takalani, Shangaan for "place of joy", will have accommodation for 400 people, day care facilities for a further 400, and a training centre, a stimulation centre and workshops.

A needs survey showed Takalani would only be "scratching the surface", Mr Rees said.

South African agricultural organisations have offered certain kinds of food.

(b) Yes. The representatives concerned were informed that the South African authorities are sympathetic towards the possibility of training members of the relative communities in disciplines such as medical services.

(2) Not relevant.

(3) No.

Patrols: plain clothes/unmarked vehicles

*2. Mr P G SOAL asked the Minister of Defence:

(1) Whether any members of the South African Defence Force conduct patrols in the Black townships while dressed in plain clothes and using unmarked vehicles; if so, (a) why do they conduct plain-clothes patrols, (b) which townships are patrolled in this manner and (c) what tasks are undertaken by plain-clothes members of the Defence Force in unmarked vehicles;

(2) whether any members of the Defence Force conducting a patrol in an unmarked vehicle in Atteridgeville on or about 11 August 1987 made enquiries as to the whereabouts of the home of a certain person, whose name has been furnished to the South African Defence Force for the purpose of the Minister's reply; if so, (a) to what purpose was this information put, (b) who instructed these members to obtain this information and (c) what is the name of this person;

(3) whether he will make a statement on the matter?

†The DEPUTY MINISTER OF DEFENCE:

(1) Yes.

(a) To be as inconspicuous as possible.

(b) Any township where the need may arise.

(c) Collection of information.

(2) Yes.

(a) To confirm where the person resided.

(b) Their Officer Commanding.

(c) It is not considered in the public interest to divulge the name.

(3) No.

Social pensions: pay-out points

*3. Mr K M ANDREW asked the Minister of Constitutional Development and Planning:

(1) With reference to his reply to Question No 19 on 25 August 1987, where in the magisterial districts of (a) Eshowe and (b) Mtunzini are the pay-out points for social pensions to Blacks located;

(2) whether any Black pensioners permanently resident in (a) the magisterial districts of Eshowe and Mtunzini, respectively, and (b) any other magisterial districts in Natal are required to collect their pensions in KwaZulu; if so, (i) why, (ii) in terms of what agreement or arrangement does this take place and (iii) in respect of such pensioners resident in Eshowe and Mtunzini, respectively, (aa) where are the nearest pension pay-out points located and (bb) what is the longest distance they have to travel to reach these pay-out points;

(3) whether the KwaZulu Government is fully compensated for pensions paid to such persons; if not, why not; if so, in what manner?

The DEPUTY MINISTER OF DEVELOPMENT PLANNING:

(1) There are no pension pay-out points maintained by the Natal Provincial Administration in the (a) Eshowe and (b) Mtunzini magisterial districts as there are no Black social pensioners in these two districts who are paid by the Administration.

(2) (a) There are no pensioners resident

in Eshowe or Mtunzini magisterial districts who are required to collect their pensions in KwaZulu.

(b) There are ± 110 pensioners in the Pietermaritzburg magisterial district who collect their pensions in the KwaZulu magisterial district of Vulindlela and ± 60 pensioners in the Impendhle district who collect their pensions in the KwaZulu magisterial district of Hlanganani.

(i) It is more convenient for the pensioners concerned.

(ii) There is no specific agreement in terms of which these pensioners are paid by the KwaZulu Government on behalf of the Natal Provincial Administration.

(iii) (aa) and (bb) Fall away.

(3) The KwaZulu Government submits claims in respect of all pensions paid on behalf of the Natal Provincial Administration. The claims are accompanied by suitable supporting documentation and are paid in full by the Administration.

Mr K M ANDREW: Mr Speaker, arising out of the hon the Deputy Minister's reply, may I ask him why, in answer to Question No 19 on 25 August, in which I asked whether there was a pay-out point for social pensions to Black pensioners in each magisterial district of the Republic, the answer given was "yes"?

†The DEPUTY MINISTER: Mr Speaker, I am prepared to go into that matter and to furnish this information to the hon member.

Reformatories/industrial schools

*4. Mr K M ANDREW asked the Minister of Education and Development Aid:

Whether it is the intention to open any (a) reformatories and (b) industrial schools for Blacks; if not, why not; if so, (i) when, (ii) where will they be located and (iii) what total number of juveniles will it be possible to accommodate in these (aa) reformatories and (bb) industrial schools?

†The DEPUTY MINISTER OF EDUCATION:

(a) and (b) Yes.

(i) With a view to the acceleration of the provision of these facilities, negotiations to obtain existing facilities are taking place. If at all possible, the Department envisages admitting the first pupils during the course of 1988.

(ii) Still under negotiation.

(iii) According to the planning of this type of school, a reform school can admit a maximum of 216 pupils and an industrial school a maximum of 360 pupils.

In this regard I also refer to the statement by Minister F W de Klerk, Chairman of the Cabinet Committee for Social Affairs, which was released on 15 August 1987.

Mr K M ANDREW: Mr Speaker, arising out of the hon the Deputy Minister's reply, in view of the fact that his colleague the hon the Minister of Justice last week told us they do not keep figures of how many juvenile offenders there are, may I ask him on what basis his department plans reformatories and industrial schools in terms of the numbers required to be accommodated there?

†The DEPUTY MINISTER: Mr Speaker, these surveys will be done from time to time as these pupils who are sentenced under the Children's Act and the Criminal Procedure Act are referred to these schools. On this basis we will from time to time see to our requirements.

Sectional Titles Act

*5. Mr K M ANDREW asked the Minister of Public Works and Land Affairs:

Whether the status and/or rights of persons living in rent-controlled (a) units and (b) blocks of flats will be affected when the Sectional Titles Act, No 95 of 1986, comes into operation; if so, in what manner?

CAPE Times 18/9/82 299

Hospital costs pushed up by hi-tech 'toys'

Own Correspondent

PORT ELIZABETH. — Hospital costs were being pushed up massively by the use of hi-tech diagnostic tools which were often "toys" and which had scarcely brought about any improvement in the treatment of diseases, a leading medical aid administrator said last night.

Dr J J du Toit, director of the Midland Medical Aid Society, gave startling examples of how, what he called a "toy-complex", escalated the cost of hospital treatment.

He said that since 1950 the cost of healthcare had increased 30 times — "yet more than 60% of this expenditure goes towards procedures, medicines, etc which have no demonstrable health benefit".

In a speech to the Eastern Cape branch of SA Federation of Hospital Engineering held here on Wednesday, Dr Du Toit said the biggest cause of hospital cost increases was not treatment — that had remained relatively unchanged — but the use of diagnostic technology.

Yet, this technology and resulting costs had hardly improved treatment.

Hi-tech, for the hospital, had "enormous marketing value to the public and doctor". However, he said, "notwithstanding the expense, the time and the trouble of hospital hi-tech, only diagnosis has really improved and we are improving the diagosis and treatment of the same 5% of illness conditions. The other 95% of illness are scarcely touched and infective conditions not at all".

All over Africa today, he said, tuberculous peritonitis was diagnosed with a small incision in the abdomen, with treatment following the next day. The total cost: About R400.

However, although the final diagnosis was still made in the same way and the same treatment followed, "pre-operative investigations (in modern hospitals), treatment and tests will amount to approximately R3 600 — all because of an attempt at a non-invasive diagnosis and the use of hi-tech, almost as if these tools are toys — which they often are".

The elimination of smallpox, he said, had been achieved worldwide at "two-thirds the cost of the development and insertion of an artificial heart into two patients (in the US) ... who failed to survive.

"Such is the monster of technology and its costs — and please note that this magnificent surgical experience was directed towards treatment of degenerative arterial conditions that are preventable in the first place."

"Perhaps in RSA, where we straddle First and Third World medicine, we should be wary of non cost-effective technology. While the United States keeps its living dead alive, we should concentrate on the old-fashioned killing of mosquitoes and microbes, the eradication of inappropriate nutrition and pollutant disposal."

With the eradication of infectious diseases as a cause of death having "increased our aged population amongst whites five times", this "opened the door for the miracle of technology to lead us to spend money on our living dead".

Medical technology not used 'sensibly'

Cape Times 19/9/87

By PETER DENNEHY

WONDERFUL high-technology medical tools were often not used in a particularly cost-effective way — and this pushed health-care costs up unnecessarily, a medical aid spokesman said yesterday.

Mr Tony Leveton, a spokesman for the Representative Association of Medical Schemes (RAMS), was commenting in qualified support of a speech by a medical aid director in Port Elizabeth this week, Dr J J du Toit.

Dr Du Toit slated what he termed the "toy complex" of doctors who used a lot of expensive equipment while only marginally improving treatment.

"I agree with him to some extent," Mr Leveton said. "There are wonderful high-tech tools which are not used sensibly.

"The problem in South Africa is that not enough people share the benefit of the technology, and with a smaller throughput per machine, the cost per person is higher."

In some instances, private medical practices bought equipment to be competitive with other practices, although the equipment would be underutilized, he said.

Another problem was that some machines could do, say, 20 different tests on a single drop of blood, and it was tempting for doctors to run more tests than were necessary.

The medical superintendent of Groote Schuur Hospital, Dr Joyce Kane-Berman, said expenditure on "non-consumable equipment" had averaged only 5% of the total Groote Schuur budget, on average, in the past 10 years.

"It is also important to note that high-technology equipment is not only used for diagnostic processes, but also for treatment which considerably reduces the period of hospitalization."

● It is reliably understood that a medical academic, who declined to comment yesterday, is in the process of setting up a committee to give some guidance to potential buyers of expensive medical equipment.

S. Times

S, September 20 1987 7 3

Doctors to ram RAMS for 25pc fee hike

29c

By HAMISH McINDOE

DOCTORS will demand tariff increases of at least 25 percent when they meet the Representative Association of Medical Schemes (RAMS) tomorrow to fix next year's scale of benefits.

RAMS spokesman Tony Leveton refused to comment on the doctors' demands.

"We were specifically asked by the Medical Association of SA (MASA) not to talk to the Press in the run-up to the meeting," he added.

Medical aid schemes are expected to shell out about R150-million to SA's 20 000 doctors this year. Another R300-million will go to hospitals, dentists and for medicine.

Warning

In short, the high cost of getting sick will rise further once RAMS has set the new scale of benefits.

Medical aid members have suffered bruising hikes of at least 40 percent in their contributions over the past two years. And, according to MASA figures, certain membership categories have soared by a staggering 112 percent.

MASA's economic adviser, Professor Fritz Steyn, warned that unless RAMS awarded "significant" increases:

- More doctors will opt out and patients will have to pay about 50 percent of the bill from their own pockets.
- Health care standards will slump as doctors find they are increasingly unable to buy the latest medical equipment.
- More doctors will quit SA — or switch to more profitable areas of the medical profession.

Professor Steyn believes the case for higher doctors' tariffs has been sacrificed on the altar of higher benefits to hospitals and medicine costs.

Added MASA spokeswoman Marileen van Wyk: "Benefits offered by RAMS are a minimum 50 percent short of a reasonable renumeration for doctors' services."

(3) whether the Transvaal Education Department has conducted or is conducting an investigation into these incidents; if not, why not; if so,

(4) whether this investigation has been completed; if not, when is it anticipated that it will be completed; if so, (a) what were the findings and (b) what action has been taken as a result;

(5) whether he will make a statement on the matter?

†The MINISTER OF LOCAL GOVERNMENT, HOUSING AND WORKS (for the Minister of Education and Culture):

(1) Yes.

(a) 10 to 18 August 1987.

(b) It it not considered advisable in the interest of education to mention the names of the relevant schools.

(2) Yes.

(a) Pupils from a visiting school threatened pupils from another visiting school. No incident of anti-semitism was reported.

(b) This occurred during the night of 11 August when pupils of both schools spent the night in a pine tree plantation. On a separate occasion a pupil from a school threatened a pupil from another visiting school with a knife. Both incidents took place during or just before bedtime. No violence was reported to the veld school staff or visiting staff and no injuries to pupils were noticed.

(c) See (1) (b).

(3) Yes.

(4) Yes.

(a) It was found that—

— eight pupils were involved in incidents;

— the staff of the veld school and the visiting staff handled the situation effectively and diffused the animosity between the two groups in a educationally responsible way; and

— after the steps mentioned in (b) below had been taken, the pupils of both schools worked together without further incident.

(b) The principal of the veld school and the head of department severely reprimanded the ringleaders and the guilty parties apologized to the other pupils. The supervisory staff monitored the behaviour of the pupils.

The Transvaal Education Department is giving continuous attention to the orientation of pupils on arrival to ensure harmonious integration with the educational program.

(5) No.

Handicapped couples: disability grants

*2. Mr J J S PRINSLOO asked the Minister of the Budget and Welfare:†

(1) (a) What is the means limit in respect of handicapped White married couples for the purposes of the payment of disability grants, (b) on what date was this limit determined and (c) what, as at the latest specified date for which information is available, was the amount of the disability grant paid monthly to such married couples;

(2) whether consideration is being given to increasing this means limit and these disability grants; if not, why not; if so, (a) why, and (b) when, in each case?

The MINISTER OF LOCAL GOVERNMENT, HOUSING AND WORKS (for the Minister of the Budget and Welfare):

(1) (a) A married couple qualify for the full disability pension of R198 per month each if their assets are less than R10 000 and if their income does not exceed R2 160 per annum. The pensions are decreased with R2 per month in respect of every R24 per annum income exceeding R2 160. The maximum income is R4 752 per annum in order to receive the minimum pension of R90 per month each.

The full pension (R198 per month each) are paid with assets not exceeding R28 000 and no other income. Pensions are reduced by R2 per month for every R400 which exceeds assets of R28 000. No pensions are payable with assets exceeding R24 000.

If a couple have assets and other income the pensions are calculated on a sliding scale and the amount of pension depends on the combination of assets and income.

(b) October 1986.

(c) Maximum of R198 per month each.

(2) Yes.

(a) The means limit is adapted annually to keep pace with the rise in pensions.

(b) October 1987, R240 per person per annum.

†Mr J J S PRINSLOO: Mr Chairman, arising from the reply of the hon the Minister, I should like to ask whether he is aware that the department concerned replies in writing to queries by stating that the means limit is R396 in respect of such married couples that qualify for the disability pension. If so, on what basis is that amount calculated, in the light of the information which he has provided?

†The MINISTER: Mr Chairman, naturally I do not have knowledge of the matters to which the hon member is referring. I will bring the supplementary question which the hon member has put to the attention of my hon colleague.

Std 10 examination in African language

*3. Mr K M ANDREW asked the Minister of Education and Culture:

How many White pupils at Government schools wrote the Std 10 examination in an African language in (a) 1981 and (b) 1986?

†The MINISTER OF LOCAL GOVERNMENT, HOUSING AND WORKS (for the Minister of Education and Culture):

	1981	1986
OFS	20	44
Natal	5	6
Cape	130	190
Transvaal	453	499
Total	608	739

Teachers: jobs lost

*4. Mr K M ANDREW asked the Minister of Education and Culture:

(1) Whether it is anticipated that any teachers in schools in the Cape School Board area will lose their jobs at the end of 1987 as a result of (a) a reduction in the number of pupils and (b) the implementation of revised pupil/teacher ratios; if so, how many in each case;

(2) whether changes in pupil/teacher ratios are to be implemented in stages; if so, (a) when and (b) why; if not, (i) in what manner will they be implemented and (ii) (aa) when and (bb) why will they be implemented in this manner?

The MINISTER OF LOCAL GOVERNMENT, HOUSING AND WORKS (for the Minister of Education and Culture):

(1) (a) Yes, 67.

(b) No.

(2) The matter of pupil/teacher ratios is being studied and no final decisions in this regard have yet been taken.

(a) to (bb) Fall away.

employees after the strikes; if so, (a) why and (b) how many;

(3) whether he will make a statement on the matter?

†The DEPUTY MINISTER OF TRANSPORT AFFAIRS:

(1) Yes, 3 835 persons, including scholars.

(2) Yes.

(a) In terms of the agreement reached, the employees who took part in the strike were re-employed as a result of which it became necessary to terminate the services of the White employees who were engaged on a day to day basis.

(b) 3 688 persons from the beginning to the end of the strike.

(3) No.

†Mr J J S PRINSLOO: Mr Chairman, arising out of the reply of the hon the Deputy Minister, could he please indicate how many of the persons who were initially employed on these conditions, were not scholars and how many of them were fired eventually when the striking workers returned?

†The DEPUTY MINISTER: Mr Chairman, unfortunately I do not have a breakdown of figures at my disposal now, but I shall furnish the hon member with that reply.

Hillbrow: exemptions from Group Areas Act

*12. Dr M S BARNARD asked the Minister of Constitutional Development and Planning:

(1) Whether, since 1 January 1986, his Department has received any applications for exemptions from the provisions of the Group Areas Act, No 36 of 1966, in respect of residential premises in the Hillbrow constituency: if so, (a) how many such applications had been (i) granted and (ii) refused as at the latest specified date for which information is available and (b) what were the reasons for (i) granting and (ii) refusing each application;

(2) whether any action has been taken against (a) owners and (b) occupants of residential property in the Hillbrow constituency in terms of the provisions of the said Act during the above-mentioned period; if so, (i) in respect of the owners or occupants of which properties, (ii) what action was taken, (iii) who initiated the action, (iv) who decided that action should be taken, (v) why was action taken and (vi) what was the outcome of this action in each case?

The DEPUTY MINISTER OF DEVELOPMENT PLANNING:

Statistics regarding applications for permits in terms of the Group Areas Act, 1966, are not maintained according to parliamentary constituencies. The question, therefore, cannot be answered in its present form.

Police Station commanders

*13. Mr J J S PRINSLOO asked the Minister of Law and Order:†

Whether there are any White police station commanders in the South African Police Force at present who do not hold officer rank; if so, (a) how many, (b) what ranks do they hold and (c) how many of them are commanders of police stations in urban areas?

†The MINISTER OF JUSTICE (for the Minister of Law and Order):

Yes.

(a) 478 station commanders.

(b) 377 warrant officers.
90 sergeants.
11 lance-sergeants.

(c) 17.

Strikes: saving in salaries/wages

*14. Mr C J DERBY-LEWIS asked the Minister of Communications:

(1) Whether the recent strike by Post Office employees resulted in any saving in salaries and wages for his Department; if so, (a) what approximate amount was saved in this manner and (b) on what date did the strike (i) commence and (ii) end;

(2) whether his Department employed any temporary workers to assist in doing the work of striking employees; if not, what steps were taken to maintain services while the strike was in progress; if so, (a) at what total cost and (b) what steps will be taken in respect of the temporary workers employed for this purpose;

(3) whether this strike was legal; if not, what steps will be taken against the strikers?

The MINISTER OF COMMUNICATIONS:

(1) Yes;

(a) R6 million.

(b) (i) 23 June 1987 in respect of a specific construction gang near East London and gradually spread to other areas in the country, and

(ii) 7 September 1987;

(2) yes;

(a) approximately R1 million.

(b) depending on the quality of their services they are being retained in replacement of workers who have been dismissed as a result of the strike;

(3) Unlike the Labour Relations Act (Act No 28 of 1956), which is not applicable to Post Office officials, the Post Office Service Act (Act No 66 of 1974) does not make provision for either legal or illegal strikes. However, by striking the employees concerned contravened stipulations of their service contracts. Strikers were from time to time and during the course of negotiations served with suitable ultimatums and those who failed to resume duty on or before specified dates were dismissed. At the time the strike ended, approximately 4 000 workers had been dismissed in this way. Only 1 431 have to date been re-employed.

Cordless telephones for disabled persons

*15. Mr M J ELLIS asked the Minister of Communications:

(1) Whether his Department has given any consideration to allowing severely disabled persons to use cordless telephones; if so, (a) when and (b) what was the decision taken; if not,

(2) whether he will give consideration to this matter; if not, why not; if so, when;

(3) whether he will make a statement on the matter?

†The MINISTER OF COMMUNICATIONS:

(1), (2) and (3) The use of cordless telephones has up till now not been allowed as tests carried out on various types of these instruments have shown that they have technical disadvantages which render them unacceptable for use on the telephone network. It was namely found that poor transmission performance, the occurrence of blind spots within a dwelling, noise interference and limited range restrict the use of these present generation cordless telephones, which all operate in the frequency bands below 100 megahertz.

Unlike the limitations of the present models, the indications are that the models of the future, which will operate in the 900 megahertz band, will bring about a great improvement in so far as quality and work performance are concerned. These models are not yet freely available, but the Post Office is watching developments closely and if it should be found that the new generation cordless telephones meet with requirements, consideration will be given to allowing their use on the telephone network.

*16. Mr J VAN ECK—Defence. [Reply standing over.]

Medaids agree to 17,5% rise for doctors

Cutt 7-15 30/9/87 299 A3

Own Correspondent

JOHANNESBURG. — The Representative Association of Medical Schemes (Rams) has agreed to pay medical practitioners between 12% and 17,5% more next year.

Rams spokesman Mr Tony Leveton said Rams had been compelled to accept a 17,5% tariff increase for the medical profession, a 15% increase for the dental profession and a 12% increase for physiotherapists from January 1, 1988.

He said that, with medicine prices constantly increasing and hospitals about to raise tariffs, employers and medical aid society members would have to find a further R700m to finance the expected 25% jump in medical costs next year.

The extra R700m — which would take total annual medical-aid payments to more than R3bn (from R2,4bn) — was worked out on an estimate of all increases and societies would have to adjust their members' fees and employer contributions according to their expenses, structure and membership.

Mr Leveton said: "In a nutshell, the man in the street and his employer

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Medical aid

will have to find at least an additional 25% in medical-aid subscriptions to meet the increases.

"In reaching this estimate, Rams has taken into account that medicine prices will continue to increase at an alarming rate."

Medicine-price increases formed a large part of hospital charges and so would affect the cost of treatment at private hospitals and clinics.

Doctors got a 12,5% increase in January. Mr Leveton said their gross incomes rose a further 13% because of an increased level of service.

Medical aid fees set to rocket

JOHANNESBURG — Medical aid society members and their employers are going to have to pay out an additional R700 million in increased medical aid fees next year.

The extra contributions will be needed to finance the various medical, dental and hospital increases which the Representative Association of Medical Schemes (Rams) has been, and will be, compelled to grant from the begining of next year.

According to a Rams spokesman, Tony Leveton, the increases so far are:

- 17,5% in medical fees.
- 15% in dental fees.
- 12% in physiotherapy fees.

The extent of the increases for priyate hospitals and clinics would be announced soon.

He said the additional R700 million would take anticipated total medical aid payments from R2,4 billion a year now to more than R3 billion in 1988.

"In a nutshell, the man in the street and his employer will have to find at least an additional 25% in medical aid subscriptions to meet the latest increases," said Mr Leveton.

"In reaching this estimated increase, Rams has taken into account that medicine prices will continue to increase at an alarming rate."

Mr Leveton said it was important to note that medicine price increases — which form a major component of hospital charges — would affect the cost of treatment at private hospitals and clinics. — Sapa

owners to keep bitches of any breed in season on their property.

Sandton's chief licensing officer, Mr Carl Rea, tremendous step forward and she wished the Johannesburg City Council would follow suit.

Medaid societies must find R700-m

Members of medical aid societies and their employers will have to find an additional R700 million to finance medical, dental and hospital increases which the Representative Association of Medical Schemes (Rams) has been, and will be, forced to grant from the beginning of next year, according to a Rams spokesman.

The increases so far are:

- 17,5 percent in the payout to the medical profession.
- 15 percent to the dental profession.
- 12 percent for physiotherapists.

The extent of the increases for private hospitals and clinics would be announced soon, according to Rams spokesman Mr Tony Leveton.

He said the additional R700 million would take anticipated total medical aid payments from R2,4 billion a year now to more than R3 billion.

"In a nutshell, the man in the street and his employer will have to find at least an additional 25 percent in medical aid subscriptions," said Mr Leveton.

"In reaching this estimated increase of 25 percent, Rams has taken into account that medicine prices will continue to increase at an alarming rate."

Mr Leveton said medicine price increases, which were a major component of hospital charges, would affect the cost of treatment at private hospitals and clinics.

Doctors last received an increase in January 1986.

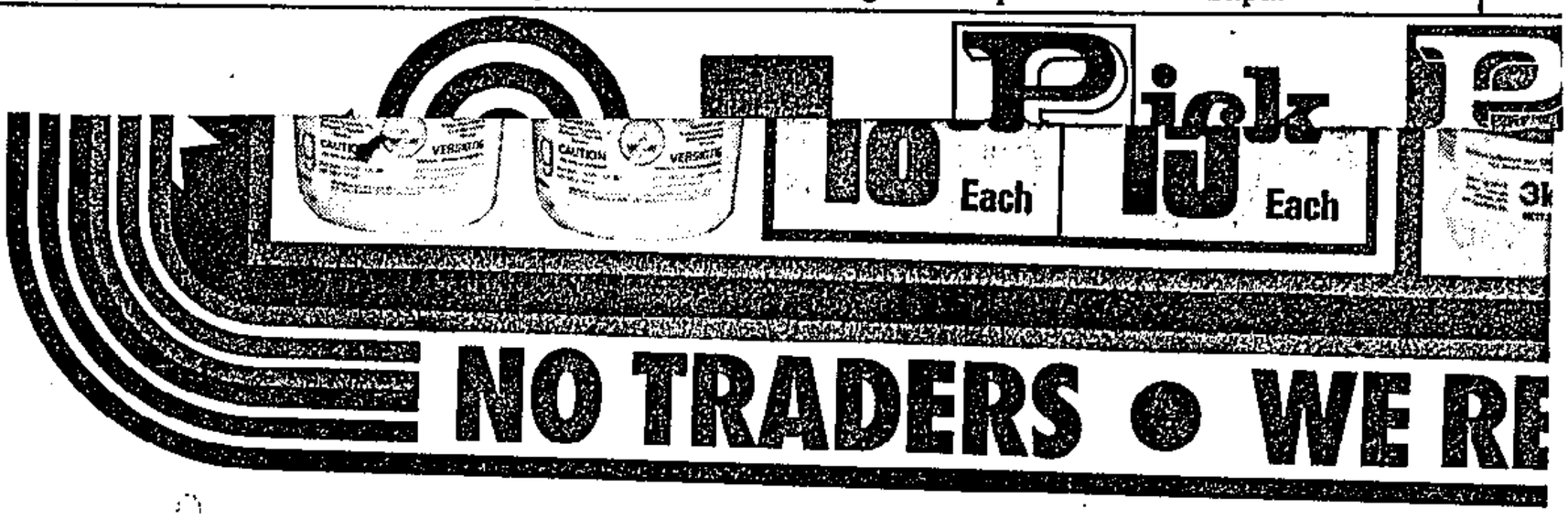
"This increase, which was designed to yield 12,5 percent, actually increased doctors' gross incomes by 25 percent.

"Rams' extensive data survey this year revealed that even though medical aid tariffs for doctors had not been adjusted, their gross incomes increased by a further 13 percent overall so far in 1987," said Mr Leveton.

"These increased payments per patient to the medical profession since January 1986 are due mainly to increases in the level of service both demanded by patients and offered by doctors."

He said the Rams decision to increase the total payout to doctors by 17,5 percent did not mean that each doctor would receive a 17,5 percent increase in his fees.

"Current medical aid legislation dictates that the Medical Association of South Africa will decide how the increase is apportioned." — Sapa.



Medical costs 'to jump 25% in 1988'

NORMAN SHEPHERD

THE Representative Association of Medical Schemes (Rams) has agreed to pay medical practitioners between 12% and 17,5% more next year.

Spokesman Tony Leveton said Rams had been compelled to accept a 17,5% tariff increase for the medical profession, a 15% increase for the dental profession and a 12% increase for physiotherapists from January 1, 1988.

With medicine prices constantly increasing and hospitals poised to raise tariffs, employers and medical aid society members would have to find a further R700m to finance the expected 25% jump in medical costs that would result next year, he said.

The extra R700m — which would increase total annual medical aid payments to more than R3bn (from R2,4bn) — was calculated on an estimate of all increases.

Leveton said: "In a nutshell, the man in the street and his employer will have to find at least an additional 25% in medical aid subscriptions."

He said medicine price increases formed a large part of hospital charges and so would affect the cost of treatment at private hospitals and clinics.

Doctors got a 12,5% increase in January. Leveton said their gross incomes had risen a further 13% because of an increased level of service.

New medical aid tariffs still too low — doctors

1/10/87

Post Correspondent

JOHANNESBURG — The South African Medical Association (Masa) has criticised the increase in benefits offered by medical aid schemes as "a meagre increase and a blow to doctors who charge 'scale of benefit' fees," it was reported today.

The Representative Association of Medical Schemes (Rams) announced yesterday that they would be granting an overall increase of 17,5% in their scale of benefits effective from January 1.

The chairman of the federal council of Masa, Dr Bernard Mandell, reacting to the increase, said it appeared to be unfair to doctors working within medical aid schemes.

Doctors last received an increase of 12,5% on January 6 while medical schemes at the same time increasedd their membership contributions by between 40% and 112,5%.

Dr Mandell said Masa was aware that in recent years the community had been unable to hold their incomes on par with the inflation rate, but Masa had taken that into account in their own tariff deliberations.

The increases could have serious consequences for private medical practice and would leave doctors with the option of either maintaining standards by working according to Masa's tariffs or of lowering standards and working according to the Rams scale of benefits.

Dr Mandell said the Masa tariff scale was now almost double that of Rams.

Rams also announced that dentists would receive an increase of 15% and physiotherapists an increase of 12%.

The executive director of the Dental Association of South African, Dr Helmut Heydt, said he was happy with yesterday's announcement by Rams. — Sapa

management or executive committees of Black local authorities in (aa) Mamelodi, (bb) Atteridgeville, (cc) Soweto, (dd) Tembiza, (ee) the Bloemfontein area and (ff) the Cape Peninsula; if so,

(2) what were the relevant rates of remuneration paid to such (a) members and (b) chairmen in respect of each of the above categories during 1984, 1985, 1986 and the period 1 January 1987 up to the latest specified date for which information is available, respectively?

The MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING:

(1) (a) No, no salaries are paid.

(b) Allowances: Yes, members and chairmen of executive committees of Black local authorities receive allowances. Allowances are only payable to executive committees of city councils. The Black local authorities in the Cape Peninsula are town committees without executive committees.

(c) No, no other emoluments or fringe benefits are payable.

(2) (aa) *Mamelodi*

Year	(i) *Members Annual allowances*	(ii) *Chairmen*
1984	R2 640-3 168	R3 960-4 752
1985	R3 168-4 176	R4 752-6 264
1986	R4 176	R6 264
1987	R4 176-7 200	R6 264-21 600

(bb) *Atteridgeville*

Year	(i) *Members Annual allowances*	(ii) *Chairmen*
1984	R2 100	R3 150
1985	R2 100-2 520	R3 150-3 780
1986	R3 024	R4 536
1987	R3 024-6 000	R4 536-18 000

(cc) *Soweto*

Year	(i) *Members Annual allowances*	(ii) *Chairmen*
1984	R5 544-6 648	R19 404-23 280
1985	R6 648-7 977,60	R23 280-27 936
1986	R7 977,60	R27 936
1987	R7 977,60	R27 936

(dd) *Tembisa*

Year	(i) *Members Annual allowances*	(ii) *Chairmen*
1984	R2 904-3 480	R7 260-8 700
1985	R3 480-4 176	R8 700-10 440
1986	R4 176	R10 440
1987	R4 176-7 200	R10 440-28 800

(ee) *Bloemfontein*

Year	(i) *Members Annual allowances*	(ii) *Chairmen*
1984	R4 200-5 040	R5 250-7 560
1985	R5 040	R7 560
1986	R5 040-6 048	R7 560-9 072
1987	R6 048-16 920	R9 072-22 560

HoA

Munsieville

424. Mr C J DERBY-LEWIS asked the Minister of Constitutional Development and Planning:

What was the (a) actual or (b) estimated population of the Black township of Munsieville, near Krugersdorp, as at (i) 1 January 1986 and (ii) the latest specified date for which information is available?

The MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING:

(a) (i) and (ii) Not available.

(b) (i) 25 700

(ii) 29 600 as at 1 July 1987

Ministers: motor-car schemes

428. Mr F J LE ROUX asked the Minister in the State President's Office entrusted with Administration and Broadcasting Services:†

(1) Whether he will furnish information on motor-car schemes for Ministers; if not, why not; if so,

(2) whether Ministers of the Cabinet or of the Ministers' Councils have switched over from the motor-car scheme for Ministers to the motor-car purchasing scheme for public servants in the past five years; if so, (a) which Ministers and (b) what was the (i) make, (ii) year and (iii) model of the vehicles concerned in each case;

(3) whether this switch-over was subject to conditions and other provisions; if so, what (a) conditions and (b) other provisions;

(4) whether (a) general sales tax and (b) customs and excise duties were paid in respect of the vehicles concerned; if not, why not; if so, (i) by whom, and (ii) what amount, in each case?

The MINISTER IN THE STATE PRESIDENT'S OFFICE ENTRUSTED WITH ADMINISTRATION AND BROADCASTING SERVICES:

(1) Yes. The honourable member is referred to my answer to question 16 for oral reply on Thursday, 15 September 1987.

(2) No.

(3) and (4) Fall away.

Blind persons: switchboards

429. Mr K M ANDREW asked the State President:

(1) Whether his Office makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by his Office;

(2) whether it is the intention to adapt any switchboards in use by his Office; if not, why not; if so, when;

(3) whether any blind persons are employed by his Office; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether his Office intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The STATE PRESIDENT:

(1) No, but the facility exists on one for adaptation.

(i) There has never been a need.

(ii) 7.

(2) Yes, if there is a need.

(3) No. Attempts were actually made to recruit a blind person for a specific switchboard, but a suitable candidate could not be recruited.

(4) No. It is not necessary to create posts for this purpose as blind persons can be appointed in existing posts.

Blind persons: switchboards

430. Mr K M ANDREW asked the Minister in the State President's Office entrusted with Administration and Broadcasting Services:

HoA

(1) Whether his Department makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by his Department;

(2) whether it is the intention to adapt any switchboards in use by his Department; if not, why not; if so, when;

(3) whether any blind persons are employed by his Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether his Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER IN THE STATE PRESIDENT'S OFFICE ENTRUSTED WITH ADMINISTRATION AND BROADCASTING SERVICES:

(1) Yes.

(a) One.

(b) Five.

(i) Telephone switchboards are very small—between 6 and 8 incoming lines. Persons who serve these switchboards are also used for other clerical tasks.

(ii) Six.

(2) No—See reply (1) (b) (i) above.

(3) Yes.

(a) One.

(b) Telephonist.

(4) No—At this stage there is no need for additional posts where blind persons can be accommodated.

(a) and (b) Fall away.

Blind persons: switchboards

431. Mr K M ANDREW asked the Deputy Minister of Information:

(1) Whether the Bureau for Information makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by the Bureau;

(2) whether it is the intention to adapt any switchboards in use by the Bureau; if not, why not; if so, when;

(3) whether any blind persons are employed by the Bureau; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether the Bureau intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The DEPUTY MINISTER OF INFORMATION:

(1) Yes;

(a) One;

(b) Fifteen;

(i) There is no further requirement at present, but the present switchboards can, if necessary, be adapted with a minor adjustment at any stage;

(2) See (1) (b) (i).

(3) Yes;

(a) One;

(b) Switchboard Operator.

(4) No, because blind persons can be employed against existing posts; (a) and (b) Fall away.

Blind persons: switchboards

432. Mr K M ANDREW asked the Minister of Foreign Affairs:

(1) Whether his Department makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not

and (ii) how many switchboards are in use by his Department;

(2) whether it is the intention to adapt any switchboards in use by his Department; if not, why not; if so, when;

(3) whether any blind persons are employed by his Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether his Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF FOREIGN AFFAIRS:

(1) Yes.

(a) One.

(b) Two.

(i) Falls away.

(ii) Falls away.

(2) No. The existing switchboards address the Department's needs as also the need to employ blind persons.

(3) Yes.

(a) One.

(b) Telephonist.

(4) No. Blind persons are appointed in existing posts.

Blind persons: switchboards

433. Mr K M ANDREW asked the Minister of National Education:

(1) Whether his Department makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by his Department;

(2) whether it is the intention to adapt any switchboards in use by his Department; if not, why not; if so, when;

(3) whether any blind persons are employed by his Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether his Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF NATIONAL EDUCATION:

(1) No.

(i) Such a need has not been established.

(ii) Nine.

(2) No. Such a need does not exists at present.

(3) Yes.

(a) One.

(b) Dictaphone Typist.

(4) No. Existing posts can be utilised for this purpose.

Blind persons: switchboards

434. Mr K M ANDREW asked the Minister of Constitutional Development and Planning:

(1) Whether his Department makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by his Department;

(2) whether it is the intention to adapt any switchboards in use by his Department; if not, why not; if so, when;

(3) whether any blind persons are employed by his Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether his Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING:

(1) No.

(i) Thus far there was no need for the use of such adapted switchboards.

(ii) Three.

(2) No. The need to adapt switchboards does not exist at present.

(3) No. No blind persons applied for employment in recent years.

(4) No. Blind persons can be appointed as switchboard operators in existing posts.

Blind persons: switchboards

435. Mr K M ANDREW asked the Minister of Education and Development Aid:

(1) Whether the Department of Education and Training makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by this Department;

(2) whether it is the intention to adapt any switchboards in use by this Department; if not, why not; if so, when;

(3) whether any blind persons are employed by this Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether this Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF EDUCATION AND DEVELOPMENT AID:

(1) Yes. Departmental Head Office only.

(a) One.

(b) Five at Head Office, seven at Regional Offices and 59 at Circuit Offices.

(i) Necessity thereof not identified.

(ii) Seventy two.

(2) Yes, it is the intention to install adaptable electronic switchboards at Head Office and at Regional Offices during this financial year.

(3) No.

(a) None.

(b) No applications from blind people have been received.

(4) No. Should applications be received from blind people they can be considered for vacant posts as switchboard operators.

(a) Not applicable.

(b) Not applicable.

Blind persons: switchboards

436. Mr K M ANDREW asked the Minister of Education and Development Aid:

(1) Whether the Department of Development Aid makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by this Department;

(2) whether it is the intention to adapt any switchboards in use by this Department; if not, why not; if so, when;

(3) whether any blind persons are employed by this Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether this Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF EDUCATION AND DEVELOPMENT AID:

(1) Yes.

(a) One.

(b) Eleven.

(2) Yes, should the need arise.

(3) No. No applications for appointment were received from blind persons.

(4) All telephonist posts at the abovementioned adapted switchboard are accessible to blind persons.

Blind persons: switchboards

437. Mr K M ANDREW asked the Minister of Manpower:

(1) Whether his Department makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by his Department;

(2) whether it is the intention to adapt any switchboards in use by his Department; if not, why not; if so, when;

(3) whether any blind persons are employed by his Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether his Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF MANPOWER:

(1) No.

(a) Falls away.

(b) 42.

(i) No blind switchboard operators are presently employed by the Department of Manpwer. The telephone traffic on many of the telephone switchboards in the smaller district offices is relatively low and consequently the operators are also required to perform normal clerical duties over and above manning the telephone switchboards. Posts of telephonists were created on the staff establishment of the Department at its Head Office in Pretoria and at the regional offices at Johannesburg, Durban, Pietermaritzburg, Pretoria, Bloemfontein and Alberton, but none of these telephone switchboards are specifically adapted for operation by blind persons.

(ii) 42.

(2) No, because no blind switchboard operators are employed by the Department of Manpower at persent for the reasons stated under (1) (b) (i). The Department is, however, quite willing to adapt switchboards where practicable should blind operators offer themselves to the Department for employment and if a vacancy for a switchboard operator exists.

(3) No.

(a) and (b) Fall away.

Blind persons are not employed as the Department's work does not generally lend itself to their employment.

(4) No, because existing posts can be utilized for this purpose.

(a) and (b) Fall away.

The Department of Manpower, has great empathy with the plight of the blind and is actively involved in the creation of work opportunities for blind persons as well as their placement and training, in that:

— Eight workshops for the blind, operating under the auspices of the SA National Council for the Blind, where, on average, 350 blind persons are employed are subsidised by the Department in respect of the wages of blind workers, salaries of administrative and instructional personnel, acquisition of capital assets, maintenance of machinery, buildings etc. The total amount expended by the Department in

this way during the 1986/87 financial year, amounted to R1 352 667,76;

— the salaries of two Placement Officers who are in the service of the SA National Council for the Blind are also subsidised by the Department. The expenditure of the Department on this item amounted to R14 162,50 in the 1986/87 financial year; and

— the National Re-adjustment Committee and Vocational Board, operating through the Department of Manpower, considers the allocation of study bursaries for the disabled, including blind persons, for the purpose of promoting their placement possibilities. Bursaries, including bursaries for overseas study, amounting to R152 085,75 were made available to blind and partially sighted persons by the Department during the 1986/87 financial year.

Blind persons: switchboards

438. Mr K M ANDREW asked the Minister of Public Works and Land Affairs:

(1) Whether his Department makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by his Department;

(2) whether it is the intention to adapt any switchboards in use by his Department; if not, why not; if so, when;

(3) whether any blind persons are employed by his Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether his Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF PUBLIC WORKS AND LAND AFFAIRS:

(1) Yes.

(a) 6.

(b) 29.

(i) 18 switchboards are manned part-time by clerical personnel. The number of personnel at the relevant offices does not warrant the services of a full-time telephonist.

4 switchboards are manned by the Department of Posts and Telecommunications.

No requests for the employment of blind persons have been received in respect of 4 switchboards.

2 Switchboards are on the programme for adaptation.

1 Switchboard's load is too heavy for use by a blind person.

(ii) 35.

(2) Yes, two switchboards. It is planned to adapt them in the 1988-89 financial year.

(3) Yes.

(a) 8.

(b) Telephonist 6
Factotum 1
General Assistant ..... 1.

(4) No. The department does not create separate posts for blind persons. Such persons are appointed in existing posts.

(a) Fall away.

(b) Fall away.

Blind persons: switchboards

439. Mr K M ANDREW asked the Minister of Justice:

(1) Whether the Department of Justice makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by this Department;

(2) whether it is the intention to adapt any switchboards in use by this Department; if not, why not; if so, when;

(3) whether any blind persons are employed by this Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether this Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF JUSTICE:

(1) Yes.

(a) 9.

(b) 338.

(2) Not at this stage. The number of telephone calls handled by the majority of offices in the Department does not justify full-time switchboard operators. Those switchboards are attended to by employees performing other duties as well.

(3) Yes.

(a) 17.

(b) 15 as switchboard operators; 1 as an article clerk at the office of the State Attorney, Johannesburg; 1 as Senior Assistant State Attorney at the office of the State Attorney, Pretoria.

(4) If blind persons are suitable for appointment in the Department, their employment is considered on merit.

Blind persons: switchboards

440. Mr K M ANDREW asked the Minister of Justice:

(1) Whether the Prisons Service makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by this Service;

(2) whether it is the intention to adapt any switchboards in use by this Service; if not, why not; if so, when;

(3) whether any blind persons are employed by this Service; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether this Service intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF JUSTICE:

(1) No.

(a) and (b) Fall away.

(i) Switchboards in use in the South African Prisons Service are not big and busy enough to justify the employment of fulltime operators; therefore these personnel are also utilized for administrative- and security tasks;

(ii) 87.

(2) No.

Apart from the fact that the switchboards are relatively small, safety considerations at prisons dictate that blind personnel cannot be employed.

(3) No, primarily for reasons of safety.

(a) and (b) Fall away.

(4) Idem.

Blind persons: switchboards

441. Mr K M ANDREW asked the Minister of Defence:

(1) Whether the South African Defence Force makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b)

have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by the Defence Force;

(2) whether it is the intention to adapt any switchboards in use by the Defence Force; if not, why not; if so, when;

(3) whether any blind persons are employed by the Defence Force; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether the Defence Force intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF DEFENCE:

(1) Yes.

(a) 29.

(b) 299.

(2) Yes, as there are, however, 19 switchboards that are adapted but not manned by blind persons, it will be considered as and when the need arises.

(3) Yes.

(a) 17.

(b) 1 flight controller
1 physiotherapist
3 language officers
2 provisioning administration clerks
10 switchboard operators.

(4) No. Posts are not specifically created for blind persons. The job description determines whether it can be filled by a blind person or not.

Blind persons: switchboards

442. Mr K M ANDREW asked the Minister of Agriculture:

(1) Whether his Department makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by his Department;

(2) whether it is the intention to adapt any switchboards in use by his Department; if not, why not; if so, when;

(3) whether any blind persons are employed by his Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether his Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF AGRICULTURE:

(1) Yes.

(a) Two.

(b) 24.

(i) The switchboards not adapted for use by blind persons do not justify the services of separate telephonists. They are attended to by clerks and typists as part of their duties.

(ii) 26.

(2) No, for the reasons set out under (1) (b) (i).

(3) Yes.

(a) Two.

(b) Telephonists.

(4) No, blind persons qualifying for appointment to existing posts are appointed as and when vacancies occur.

Blind persons: switchboards

443. Mr K M ANDREW asked the Minister of Economic Affairs and Technology:

(1) Whether the Department of Trade and Industry makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by this Department;

(2) whether it is the intention to adapt any switchboards in use by this Department; if not, why not; if so, when;

(3) whether any blind persons are employed by this Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether this Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF ECONOMIC AFFAIRS AND TECHNOLOGY:

(1) Yes.

(a) One at the Department's head office in Pretoria.

(b) Three at Directorates of the Department in Pretoria which are not housed in the same building as head office and eighteen at regional offices.

(i) The relevant switchboards are operated by persons other than full time telephone operators.

(ii) Twenty two.

(2) No. Full time switchboard operators are employed at head office only. The other switchboards are operated by typists or clerks in addition to other duties.

(3) Yes.

(a) One.

(b) Telephone operator.

(4) No. Posts exist to which blind persons can be appointed.

(a) and (b) Fall away.

Blind persons: switchboards

444. Mnr K M ANDREW asked the Minister of Economic Affairs and Technology:

(1) Whether the Department of Mineral and Energy Affairs makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by this Department;

(2) whether it is the intention to adapt any switchboards in use by this Department; if not, why not; if so, when;

(3) whether any blind persons are employed by this Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether this Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF ECONOMIC AFFAIRS AND TECHNOLOGY:

(1) Yes.

(a) One.

(b) Two.

(i) No such need.

(ii) Three.

(2) No, no such need.

(3) No, no applications have been received.

(4) No. Blind persons can be employed in existing posts provided they comply with the post requirement.

Blind persons: switchboards

445. Mr K M ANDREW asked the Minister of Finance:

(1) Whether his Department makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by his Department;

(2) whether it is the intention to adapt any switchboards in use by his De-

partment; if not, why not; if so, when;

(3) whether any blind persons are employed by his Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether his Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF FINANCE:

(1) Yes.

(a) 3.

(b) 66, (i) and (ii) Fall away.

(2) Yes, when the appointment of blind persons necessitates such adaption.

(3) Yes.

(a) 9.

(b) Telephonist/Telephone operator.

(4) No, distinction of posts for seeing and blind persons is not made.

(a) and (b) Fall away.

Blind persons: switchboards

446. Mr K M ANDREW asked the Minister of Environment Affairs:

(1) Whether his Department makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by his Department;

(2) whether it is the intention to adapt any switchboards in use by his Department; if not, why not; if so, when;

(3) whether any blind persons are employed by his Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether his Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF ENVIRONMENT AFFAIRS:

(1) Yes.

(a) One.

(b) 95.

(i) No further need thus far. Great majority served by units who also perform clerical work.

(ii) 96.

(2) No, only if the need arises.

(3) Yes.

(a) One.

(b) Telephonist.

(4) Not necessary. Blind persons are considered for appointment when candidates are available and vacancies exist.

(a) and (b) Fall away.

Blind persons: switchboards

447. Mr K M ANDREW asked the Minister of Water Affairs:

(1) Whether his Department makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by his Department;

(2) whether it is the intention to adapt any switchboards in use by his Department; if not, why not; if so, when;

(3) whether any blind persons are employed by his Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether his Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF WATER AFFAIRS:

(1) Yes.

(a) Three.

(b) Six.

(i) In view of optimum utilization of staff, incumbants of telephonist posts are also required to do clerical work in addition to operating switchboards. This variety of duties makes it impractical to use blind persons.

(ii) Nine, where approved posts of telephonists exist.

(2) No. At present there is no intention to adapt any switchboards for reasons stated in (1) (b) (i) above.

(3) No. Blind persons are not always capable to fulfil all the functions attached to specific posts and it subsequently places an impediment on their employment, in as much that with the filling of each post cognisance is taken of interest of the employer, but with due regard to the attributes, capabilities, etc., of the candidates for each post.

(4) No. The Department cannot create special posts to accommodate blind persons. Creation of posts of this kind will be a function of the Commission for Administration. No person is, however, excluded from any post in the Department solely because of blindness. Suitability for appointment in a post depends on the applicant's ability to cope with all the duties attached to the specific post.

Blind persons: switchboards

448. Mr K M ANDREW asked the Minister of Home Affairs:

(1) Whether his Department makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by his Department;

(2) whether it is the intention to adapt any switchboards in use by his Department; if not, why not; if so, when;

(3) whether any blind persons are employed by his Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether his Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF HOME AFFAIRS:

(1) Yes.

(a) 4.

(b) 98.

(i) and (ii) Fall away.

(2) No. There is at present no need to adapt any telephone switchboards.

(3) Yes.

(a) 2 Blind and 3 partially sighted persons of whom 1 partially sighted person is seconded from the Department of Posts and Telecommunications to the Department of Home Affairs.

(b) As telephonists.

(4) No, posts are created according to need. The Department of Home Affairs is at present not considering the creation of any posts in which blind persons can function effectively.

(a) and (b) Fall away.

Blind persons: switchboards

449. Mr K M ANDREW aksed the Minister of Communications:

(1) Whether his Department makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not

and (ii) how many switchboards are in use by his Department;

(2) whether it is the intention to adapt any switchboards in use by his Department; if not, why not; if so, when;

(3) whether any blind persons are employed by his Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether his Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF COMMUNICATIONS:

(1) Yes;

(a) 29,

(b) 273; (i) and (ii) fall away;

(2) Yes, as and when the opportunity to accommodate additional blind applicants presents itself the adaptation of further switchboards will be considered;

(3) Yes;

(a) 29*; and

(b) as telephonists;

*This figure does not include the telephonists on the Department's staff establishment who perform duty at other State departments to whom the Post Office renders telephonist services on an agency basis.

(4) No. Existing posts on the staff establishment are utilized to accommodate blind persons in positions commensurate with their training and ability;

(a) and (b) fall away.

Blind persons: switchboards

450. Mr K M ANDREW asked the Minister of Transport Affairs:

(1) Whether the Department of Transport makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by this Department;

(2) whether it is the intention to adapt any switchboards in use by this Department; if not, why not; if so, when;

(3) whether any blind persons are employed by this Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether this Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF TRANSPORT AFFAIRS:

(1) Yes.

(a) One console on one switchboard; and

(b) Fifty-eight.

(i) and (ii) Fall away.

For reasons of clarity it is pointed out that of the fifty-nine switchboards mentioned above thirteen are located at the Department's Head office and regional offices and are manned by telephonists who are exclusively employed for this purpose. The remaining forty-six switchboards are located at regional offices of the Department. Personnel manning these switchboards are not telephonists as such but employees such as private secretaries, typists or clerks who man these switchboards as a secondary function.

(2) No. It is not the intention of the Department to adapt any of the other switchboards for use by blind persons at this stage as no applications of such persons for employment are pending. The conversion cost will therefore be an indefensible fruitless expenditure at present.

(3) No, the Department has not received any applications for employment from blind persons to date.

(a) and (b) Fall away.

(4) No, not at this stage. If applications for a post as telephonist are received such applications will be considered on merit. Other posts where blind persons can possibly be accommodated have not yet been identified but if suitable applications are received each application will be adjudicated on merit and appointments considered in consultation with the Commission for Administration.

Blind persons: switchboards

451. Mr K M ANDREW asked the Minister of Transport Affairs:

(1) Whether the South African Transport Services make use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by the South African Transport Services;

(2) whether it is the intention to adapt any switchboards in use by the South African Transport Services; if not, why not; if so, when;

(3) whether any blind persons are employed by the South African Transport Services; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether the South African Transport Services intend creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF TRANSPORT AFFAIRS:

(1) Yes.

(a) One.

(b) 199.

(i) Falls away.

(ii) 200.

(2) No. At present there is no need for such switchboards.

(3) Yes.

(a) Two.

(b) Telephonist.

(4) Transport Services does not create posts specifically for blind persons but to comply with the exigencies of the Service.

All suitable candidates, including blind persons, are considered for appointment in accordance with the requirements of the posts concerned.

Blind persons: switchboards

452. Mr K M ANDREW asked the Minister of National Health and Population Development:

(1) Whether his Departments makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by his Departments;

(2) whether it is the intention to adapt any switchboards in use by his Departments; if not, why not; if so, when;

(3) whether any blind persons are employed by his Departments; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether his Departments intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) Yes.

(a) 3.

(b) 74.

(i) No further applications for employment of blind persons have been received. Switchboards are only

adapted if a blind person is appointed.

(ii) 77.

(2) No, no definite necessity has at present been identified for the adaptation of the switchboards and unnecessay expenditure cannot be justified.

(3) Yes.

(a) 2.

(b) Telephonist.

(4) The Department does not create posts specifically for blind incumbents. Blind persons are employed on tasks for which they are deemed suitable.

(a) and (b) Fall away.

Blind persons: switchboards

453. Mr K M ANDREW asked the Minister of Law and Order:

(1) Whether the South African Police make use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by the Police;

(2) whether it is the intention to adapt any switchboards in use by the Police; if not, why not; if so, when;

(3) whether any blind persons are employed by the Police; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether the Police intend creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF LAW AND ORDER:

(1) Yes.

(a) 13.

(b) 298.

(i) and (ii) Fall away.

(2) No, but should further needs arise to adjust switchboards, such needs will be considered on merit.

(3) Yes.

(a) 6 persons,

(b) as telephonists.

(4) No, but should a blind person apply for a vacant post, this application will be considered on the same merits as applications of persons with eyesight.

(a) and (b) Fall away.

Exemptions from Group Areas Act

454. Mr D J N MALCOMESS asked the Minister of Constitutional Development and Planning:

Whether, since 1 January 1986, his Department has received any applications for exemptions from the provisions of the Group Areas Act, No 36 of 1966, in respect of residential premises in the East London, Gonubie and Beacon Bay municipal areas; if so, in respect of each of these municipal areas, (a) how many such applications had been (i) granted and (ii) refused as at the latest specified date for which information is available and (b) what were the reasons for (i) granting and (ii) refusing each application?

The MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING:

The Cape Provincial Administration which has been responsible for the issuing of permits since 1 October 1986, has supplied the following information for the period 1 January 1986 to 31 August 1987.

	East London	*Gonubie*	*Beacon Bay*
(a) (i) Granted	5	0	0
(ii) Refused	15	1	0

(b) (i) Five applications were granted in respect of Indians and Blacks who wanted to occupy Coloured group areas. No objections were received and the House of Representatives recommended the applications.

(ii) Applications were refused because it would have been contradictory to Government policy, objections were received and occupation would not have been in the interests of the qualified group.

Fire-arms

458. Mr J VAN ECK asked the Minister of Constitutional Development and Planning:†

(1) Whether (a) his Department, (b) the provincial administrations and (c) any institutions or individuals falling under him have the authority to issue (i) firearms and (ii) other weapons; if so,

(2) (a) what institutions and/or individuals, (b) (i) what types of arms or weapons and (ii) how many of each type were issued by his Department and each administration, institution or individual during the period 1 January to 30 June 1987, (c) under what conditions were these arms or weapons issued and (d) who issues the licences for these arms or weapons;

(3) in respect of the above-mentioned arms or weapons, (a) how many were (i) lost, (ii) stolen and (iii) recovered during the above-mentioned period and (b) (i) on how many occasions were they used and (ii) how many persons were (aa) injured, (bb) seriously injured and (cc) killed as a result?

The MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING:

(1) (a), (b), (c) (i) and (ii) Yes.

(2) (a) and (b) (i) and (ii). I do not consider it to be in the public or the country's interest to divulge this information.

(c) The same conditions applicable to a licensee who obtained a license in terms of the Arms and Ammunition Act, 1969 (Act 75 of 1969).

(d) The arms resort under the conditions of Article 45 of the Arms and Ammunition Act, 1969 (Act 75 of 1969).

(3) (a) (i), (ii) and (iii) none;

(b) (i) one;

(ii) (aa), (bb) and (cc) none.

Pinelands: exemptions from Group Areas Act

459. Mr J J WALSH asked the Minister of Constitutional Development and Planning:

(1) Whether, since 1 January 1986, his Department has received any applications for exemptions from the provisions of the Group Areas Act, No. 36 of 1966, in respect of residential premises in the Pinelands constituency; if so, (a) how many such applications had been (i) granted and (ii) refused as at the latest specified date for which information is available and (b) what were the reasons for (i) granting and (ii) refusing each application;

(2) whether any action was taken against (a) owners and (b) occupants of residential property in the Pinelands constituency in terms of the provisions of the said Act during the above-mentioned period; if so, (i) in respect of the owners or occupants of which properties, (ii) what action was taken, (iii) who initiated the action, (iv) who decided that action should be taken, (v) why was action taken and (vi) what was the outcome of the action in each case?

The MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING:

Statistics regarding applications for permits in terms of the Group Areas Act,

in police stations as places of safety as at the latest specified date for which information is available and (b) for what period had each such child been held in police cells;

(2) whether any steps are being taken to find alternative accommodation in other places of safety for children being held in police cells; if not, why not; if so, (a) what steps, (b) by whom and (c) what progress has been made in this regard?

The MINISTER OF LAW AND ORDER:

(1) Yes. I, however, wish to point out to the honourable member that the Child Care Act, 1983 (Act 74 of 1983) which took effect on 1 February 1987, no longer makes an exception with regard to children in need of care or awaiting sentencing. Reference is only made to the protection and welfare of *certain children*.

(a) and (b). Because the compilation of this information country-wide, however, is voluminous and time-consuming, it is not practically feasible to furnish this information.

(2) Yes.

(a) to (c). The South African Police and also those persons who, in terms of the Child Care Act, 1983 are concerned with the protection and welfare of *certain children* as defined in the Act, endeavour as far as possible to refer those children who must necessarily be detained, to places of safety, other than police stations.

Accommodation at places of safety is, however, limited. It often happens that such children must be detained at police stations, which in terms of the Child Care Act, 1983 are regarded as places of safety, until accommodation become available.

Own Affairs:

Blind persons: telephone switchboards

84. Mr K M ANDREW asked the Minister of the Budget and Welfare:

(1) Whether the Department of Budgetary and Auxiliary Services makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by this Department;

(2) whether it is the intention to adapt any switchboards in use by this Department; if not, why not; if so, when;

(3) whether any blind persons are employed by this Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether this Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF THE BUDGET AND WELFARE:

(1) No;

(i) no need has as yet arisen,

(ii) one;

(2) no, for the reason mentioned in (i) above. If, however, the need arises, adaptation will receive attention;

(3) no, for the reason mentioned in (i) above;

(4) no, blind persons can be employed in existing posts if the nature of the work makes it feasible.

Blind persons: telephone switchboards

85. Mr K M ANDREW asked the Minister of the Budget and Welfare:

(1) Whether the Department of Welfare makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by this Department;

(2) whether it is the intention to adapt any switchboards in use by this Department; if not, why not; if so, when;

(3) whether any blind persons are employed by this Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether this Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF THE BUDGET AND WELFARE:

(1) Yes.

(a) 7 big switchboards.

(b) 44 (small switchboards).

(b) (i) The small switchboards can be operated by employees who perform other duties such as typing and enquiries.

(ii) 51.

(2) No. At present no need exists and it would not be cost-effective.

(3) None in the employ of the Department of Health Services and Welfare. Eight blind persons in the employ of the Department of Posts and Telecommunications, however, operate switchboards of the first-mentioned Department.

(4) No. Due to the limitation of State expenditure and the curtailment of posts.

(a) and (b) Fall away.

The honourable member's attention is drawn to the fact that although the Department of Health Services and Welfare serves two Ministers, only one Department exists in respect of which the above information is furnished. Kindly refer to the similar reply to Question No 89.

Blind persons: telephone switchboards

86. Mr K M ANDREW asked the Minister of Agriculture and Water Supply:

(1) Whether his Department makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by his Department;

(2) whether it is the intention to adapt any switchboards in use by his Department; if not, why not; if so, when;

(3) whether any blind persons are employed by his Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether his Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF AGRICULTURE AND WATER SUPPLY:

(1) Yes.

(a) 1.

(b) 33.

(i) No need.

(ii) 34.

(2) Yes, as the need arises.

(3) Yes.

(a) 1.

(b) Head Telephonist.

(4) Posts exists.

(a) and (b) Fall away.

Blind persons: switchboards

87. Mr K M ANDREW asked the Minister of Education and Culture:

(1) Whether his Department makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by his Department;

(2) whether it is the intention to adapt any switchboards in use by his Department; if not, why not; if so, when;

(3) whether any blind persons are employed by his Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether his Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF EDUCATION AND CULTURE:

(1) *OFS**

No.

(a) and (b) fall away.

(i) The OFSED does not have its own switchboard.

(ii) None.

*NATAL**

No.

(a) and (b) fall away.

(i) No such need has been registered.

(ii) 2.

*CAPE**

No.

(a) and (b) fall away.

(i) The Department of Posts and Telelcommunications renders the exchange service to the head office.

(ii) None.

*TRANSVAAL**

Yes.

(a) 2.

(b) None.

(i) and (ii) fall away.

HEAD OFFICE

No.

(a) and (b) fall away.

(i) No such need has been registered.

(ii) 2.

(2) No, not until the need has been demonstrated.

(3) Yes.

(a) 8.

(b) Telephonist 1;
Teacher 2;
Inspectress of telephony 1;
Braille proof-reader 4.

(4) No, since there is no prohibition which debars blind people from occupying Departmental posts for which they qualify (see 3 (b) above).

*Switchboards at educational institutions have not been included, since the volume of calls does not justify the appointment of a full time telephonist.

Blind persons: telephone switchboards

88. Mr K M ANDREW asked the Minister of Local Governent, Housing and Works:

(1) Whether the Department of Transport makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by his Department;

(2) whether it is the intention to adapt any switchboards in use by his Department; if not, why not; if so, when;

(3) whether any blind persons are employed by his Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether his Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF LOCAL GOVERNMENT, HOUSING AND WORKS:

(1) No.

(a) Falls away.

(b) Falls away.

(i) The Department has one blind telephonist in its service who makes use of a standard electronic switchboard.

(ii) Seventeen.

(2) No. Only one person operates each telephone switchboard and considering that there is at present no vacancies for telephonists, the adaptation of the existing telephone switchboards is thus not now necessary, but should the need arise, it would be considered.

(3) Yes.

(a) One.

(b) Telephonist.

(4) No. The Department of Budgetary and Auxiliary Services is responsible for the investigation of the personnel structure in the Administration: House of Assembly according to the needs and to make recommendations to the Commission for Administration. However, blind persons can be employed in existing posts if the nature of the work makes it feasible.

Blind persons: telephone switchboards

89. Mr K M ANDREW asked the Minister of Health Services:

(1) Whether his Department makes use of any telephone switchboards that have been adapted for use by blind persons; if so, how many switchboards (a) have and (b) have not been so adapted; if not, (i) why not and (ii) how many switchboards are in use by his Department;

(2) whether it is the intention to adapt any switchboards in use by his Department; if not, why not; if so, when;

(3) whether any blind persons are employed by his Department; if so, (a) how many and (b) in what capacities; if not, why not;

(4) whether his Department intends creating posts for blind persons; if not, why not; if so, (a) what posts and (b) when?

The MINISTER OF HEALTH SERVICES:

(1) Yes.

(a) 7 big switchboards.

(b) 44 (small switchboards).

(b) (i) The small switchboards can be operated by employees who perform other duties such as typing and enquiries.

(ii) 51.

(2) No. At present no need exists and it would not be cost-effective.

(3) None in the employ of the Department of Health Services and Welfare. Eight blind persons in the employ of the Department of Posts and Telecommunications, however, operate switchboards of the first-mentioned Department.

(4) No. Due to the limitation of State expenditure and the curtailment of posts.

(a) and (b) Fall away.

The honourable member's attention is drawn to the fact that although the Department of Health Services and Welfare serves two Ministers, only one Department exists in respect of which the above information is furnished. Kindly refer to the similar reply to Question No 85.

Posts reserved

94. Mr C J DERBY-LEWIS asked the Minister of the Budget and Welfare:

Whether any posts in the Department of Budgetary and Auxiliary Services are reserved for (a) Whites, (b) Coloureds, (c) Indians and (d) Blacks; if so, (i) what posts and (ii) what are the salary scales attached to these posts?

The MINISTER OF THE BUDGET AND WELFARE:

(a) to (d) No, but in accordance with the

Call for more educated use of medical aid schemes

Medical Reporter

The educated use of medical aid schemes by members would help to keep medical aid rates down, Mr Tony Leveton, chairman of Affiliated Medical Administrators (AMA), said yesterday.

Speaking at the launch of a video designed to help keep medical aid costs down, Mr Leveton said medical aid costs were fast pushing medical care out of the working man's reach.

"And it is inevitable that the recent increases in medical aid rates will lead to larger contributions for every medical aid member next year," he said.

"I believe it is AMA's responsibility to show employers and employees how their informed use of medical aid schemes can help to keep costs down. Cost containment must mean less pressure to increase contributions," said Mr Leveton.

MASSIVE PROBLEM

He said that with the medical aid industry spending about R2,4 billion this year, the size of the problem was massive and would not be alleviated by the Government's plan to privatise medical services.

"Price hikes and the withdrawal of provincial services for medical aid members are forcing more and more people to rely exclusively on their medical aid societies.

"What we hope to do is to educate people to make more cost-effective use of medical aid and help them understand many of the day-to-day situations they face," Mr Leveton said.

"There is a growing disquiet among employers and employees about their ever-increasing contributions."

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Mental treatment: outcry as patients face new charges

by JILL JOUBERT

GRAHAMSTOWN — Thousands of people who suffer from some form of mental sickness are now faced with paying for their own medication as long as they are on medical aid — or have incomes of more than R276 a year.

This applies to patients in all state hospitals and should have been enforced from April, although some hospitals delayed implementing it.

Fort England Hospital here delayed introducing the new ruling until last month.

Many outpatients, of which there are about 3 000, could be affected.

Since 1983, inpatients have been paying an admission charge and daily rate on a reducing scale depending on their length of stay.

After 180 days they are exempt from payment, the hospital secretary, Mrs G. R. Bosman, said.

Short-term patients are required to pay R38 a day, depending on their circumstances, she said.

Indigent outpatients and those whose medical aid runs out would continue to receive their medication free.

The costs, however, to the private sector were difficult to calculate.

Clinical psychologists here said it had been estimated that as many as 30 per cent of the population would suffer at some point in their lives from depression strong enough to disturb normal functioning.

A widely used anti-depressant now costs a patient or medical aid as much as R60 a month.

"Unfortunately most medications used in treating mental sicknesses are sophisticated drugs and commensurately more expensive," said a pharmacist.

This was because the active ingredient had to be imported.

Costs were related to the exchange rate which had caused all medication prices to escalate more so in the last 18 months.

Conversely pharmacists were facing liquidity problems. Costs escalated during shelf life.

Fort England Hospital holds clinics throughout the region — in Somerset East, Cookhouse, Bedford, Adelaide, Port Alfred and Alexandria — as well as from the hospital.

The move to make some patients pay for their drugs is deplored by psychiatrists and clinical psychologists.

"It is part of the pattern of deteriorating health services throughout largely due to bad planning," said one.

With patients going off with their own prescriptions, patient numbers checking for treatment would drop, another said.

"The next thing is the state will want to know the reason why and we'll be back to square one," another said cynically.

Doctors' consulting fees may go up

PRETORIA — Members of medical schemes may soon have to pay more for consulting fees for visiting doctors, the Medical Association of South Africa (Masa) confirmed yesterday.

Masa's public relations officer, Mrs Marileen van Wyk, said the recently announced increases in the scale of benefits for doctor's services (benefits offered by medical schemes) to come into effect on January 1, were "inadequate".

Medical aid society members may soon have to pay about half the consulting fee for visiting a doctor.

This means that on top of medical aid subscriptions of about R60 a month they will pay an extra R12 for a consultation.

They will also have to pay hundreds of rands more for other expensive medical procedures.

Observers said not all doctors would necessarily charge a higher fee and that not all patients would have to pay more. — Sapa

Patients may soon pay half doctor's fee

DURBAN. — Some medical aid society members may soon have to pay about half of their doctor's consulting fee.

Patients are being caught in the middle of a clash between medical aid societies and doctors, who yesterday warned they were being forced to adopt the Medical Association of South Africa's higher tariffs, including R27 for a visit to a GP.

Doctors are angry at the recent 17,5% increase in fees set by the Representative Association of Medical Schemes.

A Masa spokeswoman confirmed that the recently announced increases in the scale of benefits for doctor's services, to come into effect on January 1, were "inadequate".

"It is quite possible that in order to maintain a high standard of service and yet be able to run viable practices, more and more doctors will have to charge the higher fees recommended by the Masa.

"At present the benefits offered by medical schemes are about 50% lower than the maximum recommended tariffs.

"It is regretted that patients who, in addition to paying high monthly subscriptions to medical aids, will have to pay the difference out of their pockets."

Observers said not all doctors would necessarily charge a higher fee and that not all patients would have to pay more.
— Sapa

Medic Alert will help

SOME members of the public with certain illnesses may not be aware that they can protect themselves from hospitalisation or death by taking out Medic Art membership.

Medic Alert is an organisation that provides emergency medical identification service. It caters specifically for people who suffer from illnesses such as heart ailments, hypertension, diabetes, seizure disorders such as epilepsy and allergies to certain medicines and asthma.

For the member, Medic Alert identifies their particular medical characters which are easily identified by trained personnel throughout South African hospitals in times of emergencies.

Each member is given a bracelet or necklace engraved with a personal identification number, special emergency medical information and a telephone number to Medic Alert. All this is useful in times of emergency when a patient is injured.

Those interested can join and membership fees are kept low through subsidies by the Lions Club throughout Southern Africa. The Medic Alert office is in Cape Town and the telephone number is (021) 46-7328.

WEEKLY MAIL, November 6 to November 12, 1987

How breast-feeding can save lives. And save the state money

By CARMEL RICKARD, Durban

NATIONAL breast-feeding week has a message which should make good economic sense — even to the government.

Natal University's Professor of Maternal and Child Health, Walter Loening, said the government could save millions of rands every year if it took the breast-feeding message seriously.

"The annual bill to hospitalise and treat babies under one year old suffering from gastroenteritis and similar conditions is enormous.

"Statistics seem to indicate that only two babies in 500, admitted to hospital suffering from diseases related to inadequate or poor diet, are fully breast fed."

At King Edward VIII Hospital alone, he estimates R780 000 is spent "unnecessarily" each year on treating infantile diarrhoea which could have been prevented if the baby had been fully breast fed.

At least 50 percent of children admitted to other wards are malnourished and the level of malnutrition and complications could be appreciably decreased by breast-feeding.

"Even pneumonia and other respiratory diseases are far less common among breast fed babies, and the total which could be saved each year could be really significant to the health budget."

He said gastroenteritis was often caused by a combination of impoverished home circumstances and lack of knowledge. "Together these factors make the breast substitute a hazard to the baby's health."

Chris Theron, senior manager of a company making breast milk substitute, said the size of the market had decreased by about two percent during the last two years. Both he and Loening said it was too early to tell whether this represented a new trend.

Theron said he believed if there was any decline in the market it was due to "economic factors" which made substitute products too expensive — even for mothers who already dilute the product to dangerous levels.

His company, like others making milk substitutes, adheres to a code which bans direct contact with mothers and cosy adverts of happy, healthy bottle-feeding babies. However, even when these adverts stopped some years ago, the demand continued.

Theron puts this down to the ignorance of many health professionals. He says the attitude of clinic nurses has changed sharply since those days and nurses at clinics are now strong supporters of breast-feeding. However, he says there are still difficulties with general practitioners, many of whom appear to be badly informed about the benefits of breast-feeding, and are badly equipped to help mothers who are experiencing difficulties with feeding.

What could the state do to help reverse the trend and increase the number of women who breastfeed their babies?

The secret could lie with experienced "aunties" who know the difficulties involved and have the patience to encourage mothers to persist.

Loening says that research in Durban's KwaMashu area showed these "aunties" can make an astounding difference.

"We looked at two groups, one where there was no support at home and one where an 'auntie' — sometimes a neighbour, sometimes a relative or a woman with whom the mother has a good relationship — was available to visit the mother at home."

In the first group only five percent of women were breast-feeding by 16 weeks, in the second the figure soared to 76 percent.

He says the second priority for the state is audio-visual aids which should be made in conjunction with the medical schools and take into account research into attitudes and prejudices.

"These aids should be aimed at those parts of the black community most vulnerable to the image of 'bottle being better' — and to schoolchildren, since this is the age group at which attitudes are formed about parenthood issues.

"It is attitudes formed during this time which seem to decide a woman's feelings about breast-feeding — rather than conditions at the time she has a child. For example, we find that only a very small number of women stop breast-feeding because they work outside their home."

'Let disabled speak for themselves'

(299 SPRL 19/11/87

A Cabinet-commissioned report has recommended the appointment of a board for the care of the disabled on which government departments, national councils and disabled people will be represented.

Reacting to the report on the disabled which the Department for National Health and Population Development said will be ready for publishing in the next week, the chairman of Disabled People South Africa, Dr William Rowland, said:

"The time has passed when people spoke for us and we would expect a strong participation of our leaders on such a national committee.

"As a blind person, I would like to stress the need for the participation of disabled people themselves as the most important part of this board.

"We will be watchful that this committee will not be a group speaking for the disabled but the disabled speaking for themselves."

The confirmation of the number of disabled people in South Africa justified greater Government expenditure on programmes to develop their potential, said Dr Rowland, who is also executive director of the SA National Council for the Blind.

Dr Rowland said it was estimated that almost 13 percent of South Africa's population — about 3,5 million people — was disabled.

While the national states were included in these estimates, the TBVC states were excluded.

"After this research we now really feel that we make up a substantial part of the total pop ulation and our needs can therefore, with justification, be moved up the priority scale of Government."

Services for disabled people were limited mainly to urban areas, the report found.

There were also developing areas where there was "nearly a total lack of primary services for the care of the disabled".

"The rural areas are likewise inadequately served," the report noted further.

Said Dr Rowland: "Priority will have to be given to the provision of adequate services both in the townships and in rural areas."

The investigation, which cost nearly R500 000, revealed that the State and the private sector between them spent about R3 billion each year on care of the disabled.

State expenditure for the financial year 1985/1986 constituted R942,7 million of this total.

EXCELSIOR AWARDS WINNERS NAMED

At a function this week, recipients of the Excelsior Awards were announced.

They are:

- Mr Neville Cohen, a paraplegic engineer from Johannesburg, for his outstanding achievements in making the community more accessible for the physically disabled.
- Ms Thelma Dekile, an East London social worker, who as a physically disabled person herself has dedicated her life to serving the community.
- Mr Hannes Fourie of Welkom for his achievement and contribution to the advancement of sport for disabled people and his unselfish service to the community.
- Ms Dawn Hare, a quadriplegic from Cape Town, for outstanding community service which she undertakes voluntarily.
- The Rev Jacobus Marais of Kimberley and his wife, Aletta, for their selfless community service and for their perseverance in carrying the evangelical message, in particular to the mentally disabled.
- East London regional social worker, Ms Mercy Mkalipi, for rendering community service to disabled people.
- Ms Tina Mostert, a typist in Pretoria, for adapting her way of life to her particular circumstances and for living an independent life.
- Mr Tommy Motswai of Rustenburg, an artist who is deaf and who has already received various awards for his works.
- Mr Albert Risimati, departmental head at the Risinga High School in Gazankulu, who, despite his visual disability, is an extraordinary achiever academically and in the cultural field.
- Professor Christiaan Wicht, head of the Department of Community Health at Tygerberg Hospital, for the establishment of disability care services and the promotion of general health in the community.

Private hospitals slam 14 pc grant

JOHANNESBURG — The chairman of the Representative Association of Private Hospitals — the umbrella body of the private hospital industry — Mr Dick Williamson, has expressed disappointment at the 14 per cent increase granted to private hospitals by the Representative Association of Medical Schemes (Rams).

He pointed out that the 14 per cent 1988 increase came on top of only 8 per cent in 1987 and 12 per cent in 1986.

He said that, although Rams had announced a 17 per cent increase, this applied only to B category, high technology hospitals, while A category, lower technology, smaller hospitals received only 10 per cent.

He said that both categories experienced similar cost increases, while tariff increases had been well below the rate of inflation.

"Over the past year, the food price component of the consumer price index has risen about 25 per cent while nurses salaries have risen an effective 25 per cent in 1987, and nurses can no longer be considered to be poorly paid."

Food, wages and salaries make up more than 70 per cent of private hospital costs with the result that, despite strenuous controls, hospital costs have risen faster than inflation.

Mr Williamson said a much closer working relationship had been developed with Rams resulting in a far greater appreciation of the problems facing private hospitals.

But he pointed out that the 14 per cent increase granted was considerably below the 26,5 per cent requested.

"The 26,5 per cent increase we asked for was not simply an opening bargaining position, but was what we arrived at after considerable research and investigation and was the level of increase we considered adequate to keep the private hospital industry in South Africa on a viable footing," he said.

He said that it remains iniquitous that private hospital tariffs can be arbitrarily set by Rams in terms of the Medical Schemes Act. He feels that tariffs should be set by negotiation.

"The private hospital industry is an integral and essential part of South African health care and it is vital that this industry remains financially viable.

"The steady erosion of the viability of the private hospital industry after tariff increases of less than cost rises, is cause for considerable concern.

"It is the government's stated intention to increasingly privatise medical care in South Africa, but the private sector will only take over if there is a fair return available on capital invested," Mr Williamson said. — Sapa

DECEMBER 5, 1987

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Ex-Rhodes student will head UCT unit

Weekend Post Reporter

A FORMER Rhodes University student will head a new disability unit at the University of Cape Town.

She is Miss Kathy Jagoe, herself a paraplegic and a leading campaigner for disabled people's rights.

Miss Jagoe is at present co-ordinator of the Disabled Students Programme and lecturer in the social aspects of disablement and disability-related design at the University of the Witwatersrand.

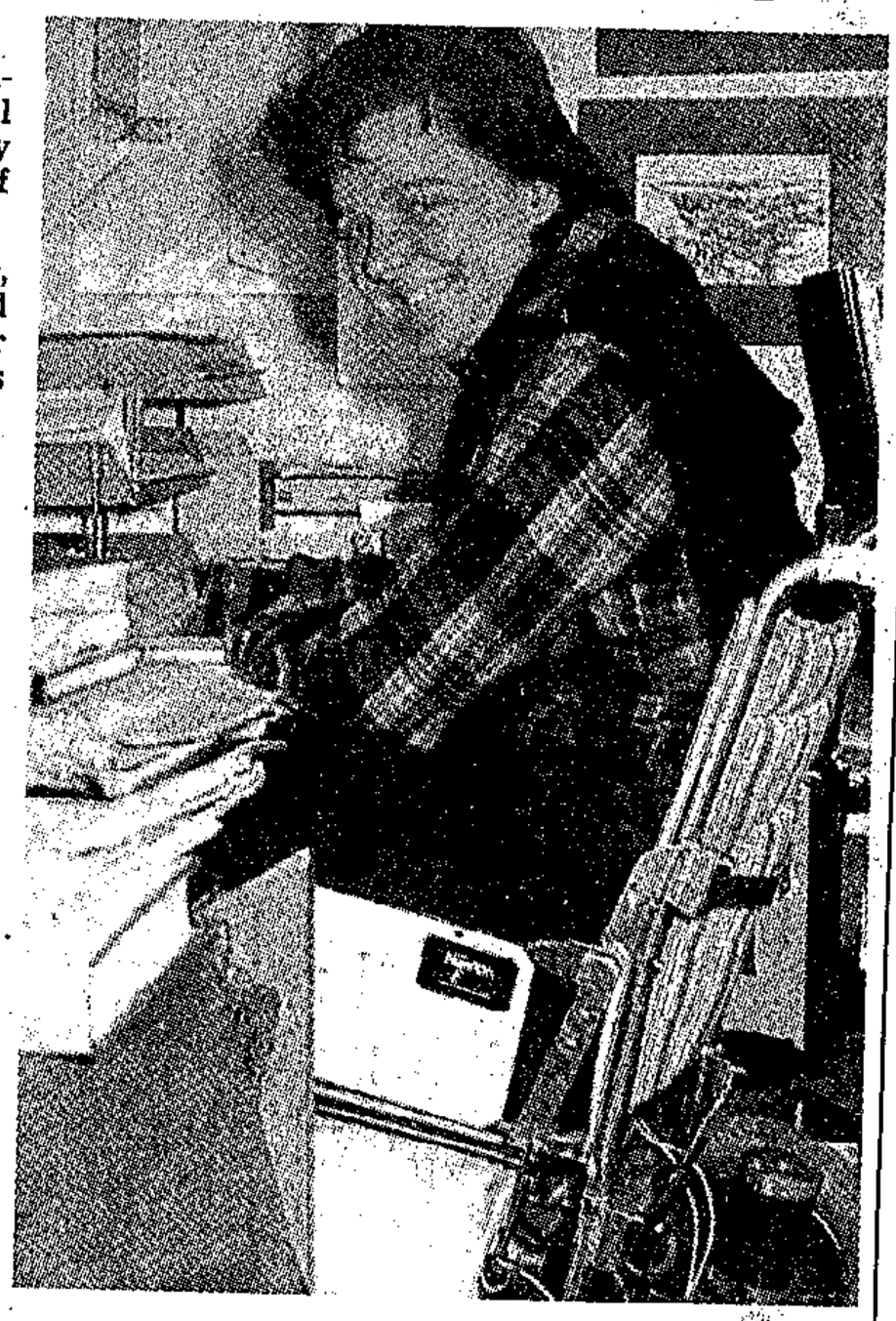
AT UCT she will teach disability studies, conduct a programme for disabled students and act as consultant for barrier-free designs for architects and the construction industry throughout South Africa.

Speaking from Johannesburg this week Miss Jagoe said interest had been growing in countering problems of disabled people and she was pleased to learn of the new awareness of this in Port Elizabeth.

A major barrier for disabled people is the design of inaccessible buildings and environments.

Her programme for disabled students will aim to identify and eliminate barriers which handicap them at UCT.

Miss Jagoe injured her cervical spine in a diving accident while in Std 8 at Clarendon Girls' High School in East London.



Miss KATHY JAGOE, a paraplegic, is co-ordinator of the Disabled Students Programme and lecturer at Wits University.

Paralysed in all four limbs, she regained the use of her arms after a year in hospital.

She returned to school and matriculated in 1973.

After studying for several years through Unisa, Miss Jagoe completed a BA Fine Arts at Rhodes University in 1978 and completed a BEd in 1981.

As co-ordinator of UCT's disability unit, she will teach medical, engineering, sociology, social work, psychology, architectural and biomedical engineering students.

She has published many articles and papers and has addressed conferences throughout SA and in the US and Britain.

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Argus
10/12/87



Picture: LEON MÜLLER, The Argus

The vice-chancellor and principal of UCT, Dr Stuart Saunders, and Mr Justice Pat Tebbutt, chairman of the Convocation, at a ceremony yesterday in which an honorary Doctor of Science in Medicine degree was conferred on Dr Saunders.

Apartheid in health care SA's 'greatest tragedy'

Medical Reporter

A STRONG plea for a unitary health system in South Africa has been made by Professor George Dall, Dean of the Faculty of Medicine at the University of Cape Town.

Opening the medical faculty's graduation ceremony last night, he said the country could not afford the expensive policy of "duplication, triplication and quadruplication" which the Government openly defended at recent National Party congresses.

"I must oppose with every grain of my being this most expensive, cost ineffective, immoral and unethical fragmentation of our health services.

"It is the greatest tragedy that has befallen all our people — and I mean all our people," said Professor Dall.

PRIVATISATION

"So the white Nationalist Government has decided we will afford the luxury of a tricameral system of separateness no matter the infant mortality rate or the life expectancy of the majority of South Africans."

Professor Dall said there was no place for apartheid in health care. He said there was no doubt that a unitary health system would be the most cost-effective system.

One of the key measures the Government intended using to reduce the level of inflation was privatisation. Health care had been included in the scheme in spite of the fact that the gap between the Medical Association tariff — "or so-called private fee tariff" — and the Medical Aid Scheme's tariff was widening more and more, Professor Dall said.

Privatisation of health care in South Africa would not contain costs, he said. The economic behaviour of the health care market did not, and should not, correspond to the idealised rules of the free market system.

"HUMANISTIC SIDE"

The technological explosion of the 20th century, which had resulted in unprecedented progress in scientific medicine, had tended to push the humanistic side of medicine into the background.

"There is no doubt that we need to look at the training of our students very critically and as a faculty we are constantly taking stock, evaluating our courses and planning new ones," Profesor Dall said.

Three important considerations for the future of medicine in South Africa were the maintenance and improvement of the scientific base, the adaptation of training to suit the particular needs of South Africa's kaleidoscopic society, and the importance of the doctor-patient relationship.

BITTER PILL FOR NEW YEAR

MASSIVE increases at all provincial hospitals in the Transvaal come into effect from January 1 with pensioners facing an increase of 150 percent in hospital fees.

The increases were yesterday confirmed by the Department of Hospital Services in the Transvaal Provincial Administration while the Health Workers Association issued a blistering attack on them.

The increase is the second in six months. The last was on July 1.

For pensioners and disabled people, classified as H2 patients, weekday tariffs have risen from R2 to R5, meaning a 150 percent increase. Weekend rates have risen from R5 to R7,50; a 50 percent increase.

For H3 patients (people earning between R200 and R250 per month) weekday rates have gone up from R5 to R8 while weekend rates have risen from R7,50 to R12. In both cases this is a 60 percent increase.

Patients

The H4 patients (people earning between R250 and R400 per month) face a weekday tariff increase of R10 and R13 and a weekend increase from R15 to R19,30.

In both cases this is a 30 percent increase. There have been no increases for people earning over R400 who are classified as private patients.

The Chief Director of Hospital Services, Dr J A Fourie, yesterday said people who could not afford the new charges could apply to hospital superintendents for reclassification.

By THABISO LESHOAI

The increases, he said, were to cover the "escalating" cost of medicines.

"Everybody must contribute within their means to the medicine bill," he said.

"Everybody can't get everything for free. We need extra money for improving facilities."

He indicated that the extra money could come from a surplus left over from the new tariffs after the costs of medicines had been covered.

A spokesman for the Health Workers Association retorted by saying even though health tariffs have been raised ever year, "we have not seen any improvement in health services. Health services have actually deteriorated," he said.

Hospital fees to rise by up to 150%

Percy Qoboza 'seriously ill'

THE editor of *City Press* newspaper, Mr Percy Qoboza, is in a coma at Baragwanath Hospital in Soweto.

Mr Qoboza, former editor of the banned *World* and *Weekend World* and the defunct *Post* and *Sunday Post* newspapers, was admitted to the hospital's Intensive Care Unit last week Thursday, suffering from an ulcer of the stomach.



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New medical fees unrealistic — Masa

Daily Dispatch Reporter

EAST LONDON — The Medical Association of South Africa (Masa) has expressed its concern at a Representative Association of Medical Schemes' (Rams) announcement on an increase in doctors' fees in terms of the Rams scale of benefits.

The overall increase in the Rams scale of benefits, effective from the beginning of next year, would increase all doctors fees by 25 per cent, the federal councillor for Masa here, Dr H. J. S. Kayser, said yesterday.

He said the benefits for consultations and operations would only increase by 10,6 per cent, and was the first increase in two years.

Some specialist services would increase by 11,4 per cent and 12,5 per cent, while the highest increases of 37,8 per cent and 25 per cent were for C. T. Scans and radiotherapy procedures only.

Dr Kayser said that over the last eight years the scale of benefits of the medical aid schemes had fallen behind the projected consumer price index for 1988 by approximately 90 per cent.

He said that on the other hand, membership subscriptions of medical aid schemes had been increased by between 40 per cent and 112 per cent over the past 18 months alone and a further increase of 25 per cent appears to be unavoidable.

Dr Kayser said Masa considered the meagre increase of benefits a blow to doctors and patients alike.

Masa was aware that the community had been unable to hold their incomes on a par with the inflation rate and all Masa tariff deliberations have taken into account the relative income position of the population as a whole.

There were many factors which contributed to an increase of payout per patient by medical schemes, and Dr Kayser said that by blaming doctors for this and ungranting them lower increases for the services, doctors were being penalised for the increased demand in services, ignoring the fact that they had to work longer hours, have less time off, have to appoint more staff and increase their overheads.

Masa considered the new medical aid fees totally unrealistic as a remuneration for doctor's services.

Dr Kayser advised patients to consult with their medical schemes should they have any reason to be dissatisfied with the benefits offered.

Recognition for Border social workers

DD 27/11/87

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Two women from the Eastern Cape have received Excelsior awards for their achievements in the field of disabled people. Marietjie Myburg spoke to them at Cripple Care, East London.

Of the 116 social workers from all over the country nominated for the Excelsior awards, only 11 received the award, which was presented at the home of the Minister of Health and Population Development, Dr Willie van Niekerk.

Among them were Mrs Mercy Mkalipi, a district social worker for the East London Cripple Care Society, who received the award for community service to disabled people, and Miss Thelma Dekile who received her award for her achievements as a disabled person. Thelma is also a social worker for East London Cripple Care.

Thelma Dekile contracted tuberculosis at the age of one which resulted in a deformity of the spine with a Khyphosis. She spent most of her early childhood at Victoria hospital in Alice and started her education there.

When she was discharged, she continued her primary education at Lovedale school. Although she became ill again and was paralysed for three years, she finished Std 8 at Lovedale and came to East London to do matric at Welsh High School in Duncan Village.

"The principal of the school referred me to the Cripple Care Society in East London where they taught me shorthand, typing and bookkeeping. I worked in a lawyer's office for two years after that," Thelma said.

"I had always watched the social workers at Cripple Care and thought, that was something I would really like to do. So, when I received a scholarship from the National Council for the Care of the Physically Handicapped in 1963, I was thrilled."

Thelma was one of the first group of students to study social work at Fort Hare. She graduated in 1965 and started working for the Cripple Care office in East London. Here, it is her daily task to get jobs for disabled persons, to handle pension application and "to care for the social needs of the disabled in general".

But, Thelma was rewarded for her service in the community and the list of things she does apart from her job is quite comprehensive. She is a member of several organisations ranging from social workers' associations, to church organisations, to school committees. She regularly delivers speeches on topics concerning the disabled and has recently published an article on Socialisation and Road Safety in a social work magazine.

"It has always been my wish to uplift disabled people. I wanted to be an image to them of what a disabled person can do — especially for the children. I wanted to show them that I can compete well despite



my disability. I am proud of the award because in a way it shows me that I have succeeded," says Thelma.

Although Mercy Mkalipi is plagued with arthritis and already has her left hip replaced as a direct result of her constant travelling for Cripple Care projects, she still renders a service to disabled people in the Border area.

Mrs Mkalipi travels from early morning to late at night in a cold panel-van without heating and it is not surprising that she developed osteo-arthritis in her legs and shoulders. The work carries on though, and it is for this kind of endurance that she received the Excelsior award.

Mercy was born in the very same community that she now works in most of the time. "It pleases me to work amongst my own people at Goshen; to try to improve the standard of their living."

Mercy attended Goshen Primary School and, like Thelma, did her high school training at Lovedale College in Alice. After her school career she studied at Emgwali Teachers Training School, the Jan H. Hofmeyer school of social work and the Frere Hospital Nurses College.

Mercy was the first black professional social worker employed by the Cripple Care Society in 1956.

Her first project was a shoe-repairing and hand-knitting centre in Duncan Village where disabled persons who could not find employment in East London, could earn a small income.

Under Mrs Mkalipi's guidance the Mdantsane Cripple Care Society was formed in 1973.

Various other Cripple Care societies were started by her throughout the Border area. In 1985 a sewing, spinning and knitting workshop was started at Cathcart. In April this year the Cripple Care committe of Goshen in conjunction with the local primary school started a creche and a feeding scheme. This school feeds 103 children.

"An award is as good as a certificate," says Mercy. "It speaks for you. And it encourages my children.

"Because I work in my hometown, the work you done is often not recognised. An award like this gives you some recognition."

Recognition well deserved by both Thelma Dekile and Mercy Mkalipi.

→ cont.

24/11/87

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Mrs Mercy Mkalipi (left) and Miss Thelma Dekile. They received Excelsior Awards for their services to disabled people.

HUGE HOSPITAL FEE HIKES IN TVL

Post Reporter

MASSIVE tariff increases come into effect at all provincial hospitals in the Transvaal from January 1, with pensioners facing rises of 150%.

However, no similar increases are envisaged for provincial hospitals in the Cape, the MEC in charge of hospitals, Mr Koos Theron, has confirmed.

The Transvaal increases were confirmed yesterday by the Department of Hospital Services in the Transvaal Provincial Administration, and spokesmen for the Health Workers' Association issued blistering attacks on the cost hikes.

They are the second in six months. The last was on July 1.

But in the Cape a different system operates, Mr Theron said. He said two years ago a fee structure was adopted in the Cape whereby "we expect everyone to contribute according to their means".

He added: "It is still our policy that anyone who can't afford to pay, won't be refused medical treatment."

Mr Theron said the fee structure in the Cape was adapted annually after each budget. The last increases came into effect on April 1, 1987, and the 1988 increase would be determined after the increases in civil pensions were announced in the Budget, he said. "There is no increase in the pipeline at present," he said.

● Weekday tariffs for pensioners and disabled people in the Transvaal classified as H2 patients have risen from R2 to R5. Weekend rates go from R5 to R7,50.

For H3 patients (people earning between R200 and R250 a month) weekday rates are up from R5 to R8 while weekend rates are up R7,50 to R12. In both cases this is a 60% increase.

The H4 patients (earnings R250 to R400 a month) face a weekday tariff increase of R10 to R13 and a weekend increase from R15 to R19,30.

There have been no increases for people earning over R400 monthly. They are clasified as private patients.

The Chief Director of Hospital Services, Dr J A Fourie, commented that people who could not afford the new charges could apply to hospital superintendents for reclasification.

The increases, he said, were to cover the "escalating" cost of medicines.

"Everybody must contribute within their means to the medicine bill. Everybody can't get everything free. We need extra money to improve facilities," he said. — Sapa

Iscor increases its medical aid fees

B/day

20/12/87

MICK COLLINS

DRASTIC increases in provincial hospital tariffs and other expected increases in medical costs had forced increases in membership fees for both its medical aid schemes, Iscor said.

"Unless these increases are implemented, each fund — the Iscor Medical Benefit Fund (IMBF) in Pretoria and the Vanderbijlpark Medical Benefit Fund (VMBF) — would end 1988 with a large deficit," said a spokesman for both schemes.

Quoted in the corporation's monthly newsletter, the spokesman said that Transvaal provincial hospital fees had been increased by 85% and theatre fees by 100% on July 1, 1987 after only one week's notice.

"In accordance with government policy, provincial hospitals will increasingly recover costs, which will mean that these costs will come close to those of private hospitals. A further increase of 30% in total hospital expenditure in 1988 is forseen," he said.

The expected cost increase in respect of general practitioners and specialists would be approximately 17,5%, those of dental services 15% and of medicine about 20% during 1988.

He said membership fees for both medical aid funds had only been increased by 12% in 1986.

"If we had implemented a 15% increase in 1986, as allowed by the Iscor board of directors, we would have broadened the base on which to calculate the present increases and we would have required a smaller increase in membership fees to meet the operating cost requirement."

In the case of the IMBF, a member with dependants would contribute R79 instead of R61 a month (a 29,5% increase), while a VMBF member in similar circumstances would contribute R57 instead of R42 a month (a 35,7% increase) as from January 1, 1988.

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299 Bday 31/12/87

A TIMES MEDIA PU

New hospital tariffs will bring in R30m

MEDICAL tariff increases for provincial hospitals, gazetted yesterday, are expected to bring in an additional R30m in the year to March 1989.

Hospital tariff increases imposed last July, together with the new increases which become effective on January 1, will add R12m to provincial hospital income for this financial year, boosting total estimated income to R112m.

Hospital services acting director Dr J A "Joon" Fourie said yesterday the increases would affect all 69 Transvaal provincial hospitals.

Prescription and consultation fees for out-patients and private in-patients, pathological services at three major hospitals, and orthopedic and surgical appliances are affected by the increases.

MANDY JEAN WOODS

An extra R3 has been added to existing tariffs for private and out-patients in the H2, 3 and 4 categories (primarily low-income people and pensioners).

Fourie said the tariff now included consultation and prescription charges irrespective of the number of items on a prescription. Patients now pay a basic consultation fee plus R1 for each prescription item.

The increase was a rationalisation of fees paid by patients.

Fourie said: "Now by paying R3 more they only pay one fee and no extra charges will be made for prescription items. Patients who paid R2 for a consultation now pay R5, R5 now R8 and R10 now R13."

Private patients will pay more for medicines, while in provincial hospitals patients will be charged cost plus 100%. Fourie said hospital medicines would still be cheaper than medicines bought from the private sector.

Three provincial hospitals which allow private patients to be treated by hospital staff — the H F Verwoerd, J G Strijdom and Johannesburg General — will now have accounts rendered for pathological services at cost plus 20% for private patients.

Orthopaedic and surgical appliances and prosthesis (artificial limbs) services will now be cost plus 30% to all patients.

'Poor, unemployed and elderly worse hit'

HWA attacks rise in hospital fees

The Health Workers' Association (HWA) is bitterly opposed to the proposed increase in Transvaal hospital fees from January 1.

The HWA says the proposed increases show the total insensitivity of the authorities for the welfare of the majority of the people, particularly the elderly, the unemployed and the poor.

The HWA says the latest increases will keep people away from hospitals and clinics, as it is becoming increasingly difficult for the poor and unemployed to pay for the health heeds of their families.

150 PERCENT

No official confirmation could be obtained today of the size of the increases, but it is believed that fees will increase by up to 150 percent.

Dr J A Fourie, acting chief of hospital services in the Transvaal, said hospitals had been warned of the pending increases in a confidential document.

The HWA statement said the latest tariff increases came in the wake of severe criticism being levelled at the general deterioration of health services in the province.

It rejected the argument that increases were necessary because there was not enough money to run the health services.

It said the increases were an indication of the adverse effects of massive expenditure on defence, and maintaining the apartheid system.

"The increasing cost of maintaining apartheid at the expense of other essential services is not only further polarisation of our society but is creating further tension," the HWA said.

"People must be made aware they cannot be turned away from clinics or hospitals because they cannot pay, and we urge all community organisations, trade unions and women's organisations to oppose this issue," it said.

Doctors at Cape provincial hospitals are seething over the latest salary scales for the medical profession.

Meetings to discuss the situation and possible action were held at the Red Cross War Memorial Children's Hospital on Tuesday and the Groote Schuur Hospital yesterday.

Doctors said the problem arose with the announcement of "big" increases for consultants and medical officers, but nothing for registrars.

"We are all hopping mad about it," said a Groote Schuur source.

He said registrars were doctors who had completed their housemanship and were studying to become specialists. After at least four years' further study they qualified as consultants.

Medical officers and senior medical officers were doctors who had not specialised in a branch of medicine.

Details of these increases were not available.