SOCIAL SECURITY — MEDICARE

1988

Outcry over hospital fee rises

(299)

C/Pres 3/1/88

By SINNAH KUNENE

THE sick, disabled, unemployed and poor have to dig deeper into their already depleted pockets for treatment at government hospitals.

This is the nasty New Year news for them from the Transvaal Hospital Administration, which this week announced massive increases in hospital fees.

From January 1, a visit to any of the Transvaal Hospital Administration clinics or hospitals will cost R5 on weekdays and R7,50 at weekends for people earning less than R200 a month – classified as H2 patients.

Patients who earn between R200 and R250, classified as H3, will pay R8 and R12 on weekdays and weekends, respectively.

The H4 – people earning between R250 and R400 – will pay R13 and R19,50, while private patients are faced with a whopping R20 consultation fee for weekdays and R30 at weekends.

In July 1987, H2 patients were exempt from paying hospital fees and were charged R2 a visit. Most such patients are pensioners and disabled people who have to make constant visits to the clinics – sometimes three times a week.

Announced only three days before they would come into effect, the new hospital tarrifs have caused an uproar in medical circles.

The Health Workers' Association, formed by doctors, paramedics and general workers, condemned the latest move by health authorities and called it a "further aggravation on the plight of the poor".

"This has once again clearly shown the total insensitivity and disregard by the hospital authorities concerned for the welfare of the majority of our people," said a spokesman.

He feared the latest increase would keep patients away from hospitals and clinics.

It was becoming increasingly difficult for the poor and unemployed to budget for the health needs of the family.

"HWA would also like to point out that this increase comes in the light of severe criticism being levelled by health workers on the general deterioration of our health services," he said.

He refuted the argument that there was "not enough money available" to run the health services.

"One glance at the expenditure on defence, R6-billion a year, and the massive cost of maintaining the system of apartheid, clearly shows the adverse effects apartheid has on every aspect of our lives – including health," said the spokesman.

He said HWA urged the community organisations to challenge the new increase. The spokesman pointed out patients had a right to medical treatment, even if they had no money.

Clinic waiting rooms may not be so crowded following the rise in fees.

Hospital hikes slammed

ALAN FINE

THE increases in medical tariffs introduced at the 69 Transvaal provincial hospitals on January 1 were yesterday deplored by the National Council of Trade Unions (Nactu).

The organisation repeated a call for a "national people's health service" and said it believed the unfair advantage and profiteering in medicine through the state tender system, and other perks abuses, could be eliminated only if the system was open to public scrutiny.

Nactu also said the medical brain drain needed to be halted. Since their education was subsidised by taxpayers' money, personnel should be forced to work in state hospitals for at least four years before being allowed to leave the country.

Nactu said the increases bore out its assertion when the last Budget was announced that increases in military and police expenditures were at the expense of already inadequate basic social services.

WCP
, 1988 7/1/88 (29) Swaziland

WILL GET ATMENT

ETAN, Thursday, January 7

ALL TRE

Hospital tariff increases

NO patient would be left without medical care or medicine if he was genuinely unable to pay, one of the Transvaal's Provincial MECS, Mr D P Kirstein, said yesterday in response to recent Press reports on increased tariffs in the province's hospitals.

Sapa

"Recent statements in the Press have made it necessary to correct certain misconceptions and to place in perspective the issue of provincial hospital rates," he said in a statement in Pretoria.

The decision to introduce higher tariffs and a basic fee on medicine had been taken in May last year for implemention on July 1.

Medicine

For administrative reasons however, this had only been introduced on January 1, with medicine being supplied free up to then.

"As a result of the dramatic increase in the price of medicine it became necessary to charge a basic fee of R3 on prescriptions for hospital patients. This normally includes one month's supply of medicine."

Mr Kirstein said private patients would in future be required to pay for their own medicine in provincial hospitals.

He pointed out that tariffs had last been adjusted in 1982 and that increased costs had made it necessary to increase the tariff to maintain a reasonable standard in basic health services.

Classification tariffs had also risen by about 100 percent.

"For example, an unmarried person earning R5 000 or less a year now qualifies as a hospital patient at the fees payable by them, where previously the salary restriction was R2 500 or less.

"For a family of five the maximum income to qualify for these tariffs has been raised from R7 500 to R13 000.

"Arrangements can be made with the superintendent of the hospital concerned," Mr Kirstein said.

299 Star 8/1/88

New tariffs "unreasonably high" . . . pensioners at Kenton Lodge in Kensington, Johannesburg, with Matron Lorraine de Lange and staff.

Pensioners angered by hospital tariff increase

Staff Reporters

The increase in State hospital tariffs, which came into effect on January 1, has angered and dismayed pensioners.

Pensioners who had been charged R2 on weekdays for each visit are now paying R5. Weekend rates have risen from R5 to R7,50.

Black and white senior citizens interviewed by The Star criticised the rises, saying they were already struggling to survive.

Residents at Kenton Lodge, a home for the elderly in Kensington, Johannesburg said the jump from R2 to R5 was unreasonably high.

Mrs Margaret Townsend (76), a Kenton Lodge resident, resented that the increase had been introduced without notice.

"The hospital has been absolutely wonderful to me," she said, but felt that a fee of R5 was "quite a hefty price for pensioners".

An elderly person could easily go to hospital eight times in about two weeks, she added.

Mrs Townsend, who suffers from varicose ulcers, has to pay R5 every Monday when a nurse from Johannesburg Hospital comes to bandage her legs.

Black senior citizens at the new Vosloorus Centre for the Care of the Aged said the new tariffs were "ridiculous".

Ms Priscilla Malaza (83) summed up her fellow residents' feelings when she asked: "Why did they increase the fee from R2? Two rand was okay, even though we were struggling. Does it mean that the Government wants back the (pension) money that we get?"

Mr John Mashiyane (105), a resident at the centre, hoped that pensions would be increased.

The R194 he gets bi-monthly runs out before the end of the first month, he said.

A social worker at the centre, Mrs Faith Rankhumise, believes that black pensioners "will be the most hard-hit because they depend entirely on their pension, which does not stretch far enough".

Anger and dismay . . . elderly people at the Vosloorus Centre for the Care of the Aged, with 105-year old Mr John Mashiyane in front.

Th. 3

MEC explains rise in Tvl hospital tariffs

NO patient would be left without medical care or medicine if he was genuinely unable to pay, a Member of the Executive Committee in the Transvaal, Daan Kirstein, said this week in response to recent Press reports on increased tariffs in the province's hospitals.

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For administrative reasons, however, this had only been introduced on January 1 this year, with medicine being supplied free up to then.

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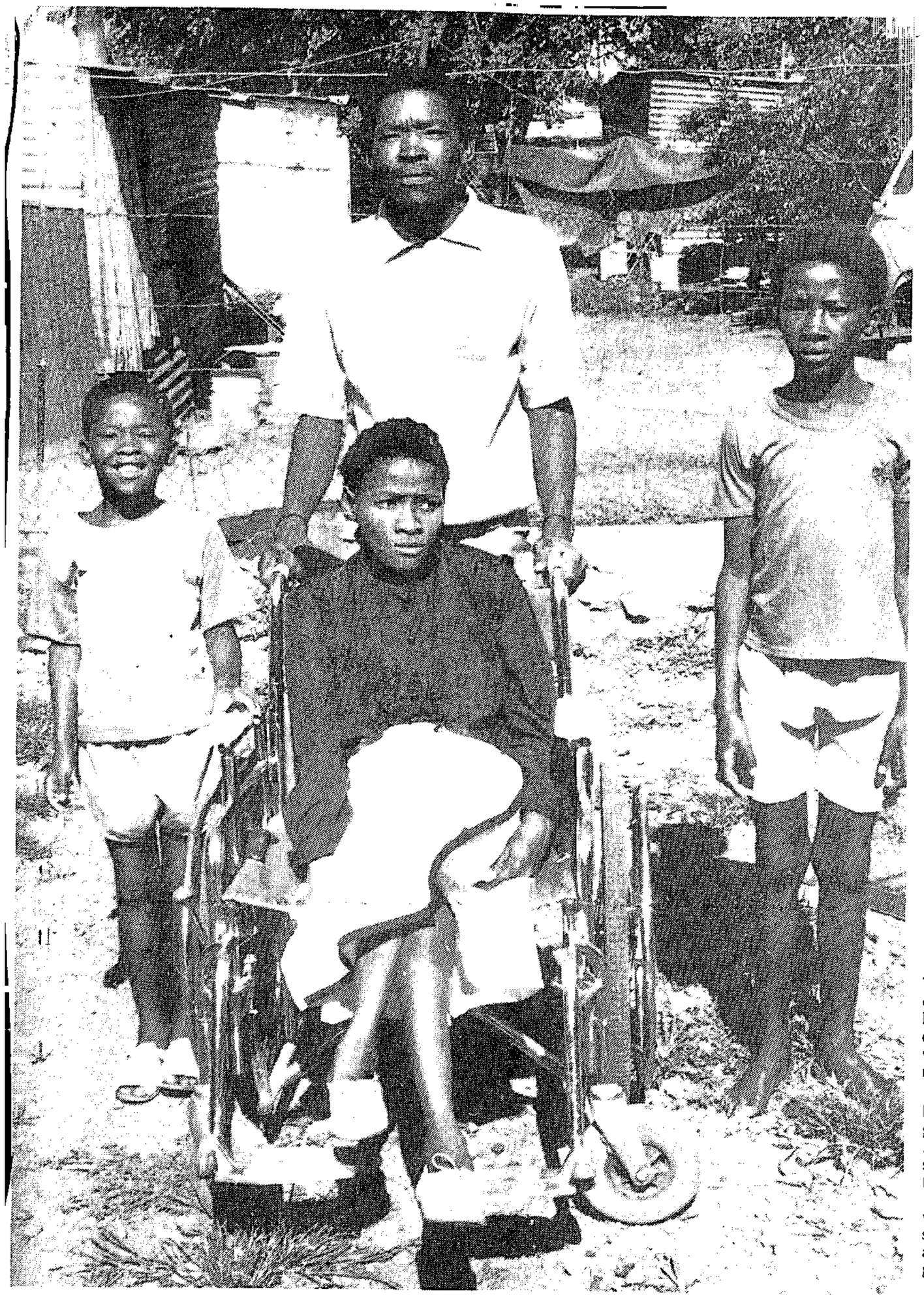
"For a family of five the maximum income to qualify for these tariffs has been raised from R7 500 to R13 000.

"No patient will be left without medical care or medicine if he is genuinely unable to pay," said Kirstein. – Sapa.



William and Margaret Rampai and sons Thabo and Marks (right), face a bleak future.

ANGUISH ABOUT THE HIGH COST OF KEEPING HEALTHY

C/Press 10/1/88 (88) (299)

By SINNAH KUNENE

THE ever-increasing cost of medical care is a cause of great concern to both the general public – the people who need treatment – and also to health workers.

Medical fees appear to be rising almost every six months – the latest hike being a staggering 150 percent increase in tariffs for treatment at provincial hospitals and clinics in the Transvaal.

Worse is still to come – health experts predict another increase in the near future.

However, while medical fees – now ranging from R7,50 to R30 a patient on a weekend visit in the Transvaal – may be demanded from patients, it is against the law to refuse treatment and medicine to those who cannot afford to pay.

"No patient, whether in Rome or in Africa can for ethical reasons, be refused medical treatment. A patient has the right to take legal action against any State health worker who turns him away for failing to pay the medical charges," a medical source told *City Press*.

There is fear among health workers that patients who have been receiving regular treatment in hospitals and clinics might stop reporting for treatment.

"We have been deprived the right to free medical care – the right every living thing on this earth is entitled to. We have actually reached a stage where people would rather die at home than report to hospital because they are discouraged by the high fees," said a retired nursing sister, Frederica Malatsi.

The National Council of Trade Unions has deplored the increases, effected on January 1, and called for a "national people's health service".

"Nactu believes that the unfair advantage and profiteering in medicine through the State tender system and all the 'perks' abuses rampant in the system can only be eliminated if the system is open to the scrutiny of the people," the union said in a statement.

"We further believe that the 'chicken run' of doctors and other medical personnel should be curtailed by ensuring that such individuals are forced to work in State hospitals for at least four years before being allowed to leave the country," said Nactu.

The union argued that taxpayers' money subsidised the education and training of medical workers and they should plough back into the community what they had received from it.

Meanwhile, some private practitioners are finding it difficult to recover money from medical aid schemes.

A Soweto doctor – one of many affected in this way – has had to write letters to patients whose medical schemes had not paid their accounts for some time.

He had already sent out final demand letters to patients.

Family face cost crisis

By DAN DHLAMINI

THE increases in hospital tariffs that came into effect on New Year's day have posed serious problems for a disabled couple who say they have to visit the hospital at least once a month.

Crippled William Ndana, 35, and his wife Margaret, 31, both of Ikageng near Potchefstroom, told *City Press* that they couldn't afford to buy school clothes for their two sons and foot their hospital bills.

Margaret, who is confined to a wheelchair for the rest of her life, said they were both maimed by polio and are pensioners and get disability grants from the government.

Their two sons, Marks and Thabo, will be going to standards three and one and will need school uniforms when the schools open this month.

"Margaret and I usually visit the hospital for check-ups and the news that tariffs have increased is really shocking.

"The Kalie de Haas Hospital is about five kilometres from where we live in Ikageng and we have to pay for transport to get there," said Rampai, who cannot walk properly because of a leg injury.

Margaret said they now live in a shack in the backyard of her mother's home and seem to be a burden on her.

She said her mother, Cecilia Ndana, has been helping them support their sons because they only receive their allowance bi-monthly.

The mayor of Ikageng, Richard Sepotokele, said that his council was considering giving food parcels to the needy and disabled members of the community on a regular basis.

"We have already briefed our welfare office and will arrange a meeting with the nurse in charge of the local clinic to help trace all the deserving cases which will need immediate attention," said Sepotokele.

Chales Ntsizi, of the Ikageng Child and Family Welfare, said his committee was not aware of Rampai and his family's plight, but would try to assist where possible.

He said the ICFW was presently faced with the problem of the twilight children who were accommodated at Molusi's home.

He said the ICFW was appealling to individuals in Ikageng to adopt the children.

Med-aid to jump 20-30%

299 Bldgs 12/11/88

PRETORIA — Most of the 206 registered medical-aid schemes had, or soon would, raise members subscriptions by between 20%-30%, a Representative Association of Medical Aid Schemes (RAMS) spokesman said.

This was part of the effort to keep pace with continually escalating provincial and public hospital charges, doctors and para medical fees.

The costs of medicines and drugs too were constantly rising.

Last week, MEC in charge of hospital services Danie Kirstein said because of dramatic in-

GERALD REILLY

creases in the prices of medicines it had been necessary to charge a base of R3 on prescriptions for hospital patients.

Private patients would have to pay fully for their medicines.

Registrar of medical aid schemes figures show how close to the wind schemes are sailing financially.

In 1986 — the latest figures — members subscriptions totalled R2,09bn and payouts to beneficiaries R2,04bn.

Any income from funds' investments was virtually swallowed up by administration costs.

Sources said although the 1987 figures would not be available until later in the year it was reasonable to add on at least 25%.

And, if this was projected into this year, it could mean that members contributions and scheme payouts would exceed a combined R6bn.

The registrar's office said there were 206 registered schemes and 45 industrial schemes.

Total beneficiaries in 1986 amounted to 5 383 474.

Med-aid tariffs 'hamper private hospitals'

DIANNA GAMES

THE private-hospital industry was being severely hamstrung by medical-aid tariffs, SA's largest private hospital group Afrox said.

Afrox's Dick Williamson, who is also chairman of the National Association of Private Hospitals, said: "It is iniquitous that such an important sector of health care is jeopardised by inadequate returns because of the power of Representative Association of Medical Schemes (Rams) over our financial future.

"Provided we can overcome the restriction placed on the industry by the fact that our tariffs are set by Rams, Afrox is set to play a major role in the future of hospital care in SA."

Williamson was commenting in a statement announcing Afrox's acquisition of the Mater Dei Hospital in East London which followed its purchase of the St Joseph's Hospital in Port Elizabeth.

Afrox now owns 12 private hospitals or clinics and has an interest in another two.

Rams increases, which became effective on January 1, provide for a 10% overall increase for A-tariff hospitals (less sophisticated) and 17% for B-tariff hospitals.

An Afrox spokesman said the increases looked generous but there were many hidden costs that more than counteracted any financial benefits.

She said about 65% of a hospital's costs were nurses' salaries but inadequate medical aid tariffs meant they were severely hampered in trying to improve the lot of nurses.

While "a token" R7 had been added to theatre costs by Rams to compensate for the fact that hospitals were now not allowed to charge for partially used theatre items, this did not go any way to real compensation.

One bottle of opthalmic eyedrops, used only on one patient, could cost up to R250 a bottle.

'No claims' plan for sick funds

ST Times 17/1/88

299

CHEAPER medical schemes are on the way as the Government and the industry move to free health insurance from the straitjacket of the Medical Schemes Act.

The future face of buying health cover in South Africa could be similar to motor insurance, with subscriptions linked to claim patterns.

Over the next three months, the Representative Association of Medical Schemes (Rams) and the doctors' Medical Association of South Africa (Masa) will draw up joint proposals for the Minister of National Health and Population Development to amend the Act and change other medical scheme regulations.

Rams executive director Mr Rob Speedie says: "The objective is to loosen up the law and enable people to select packages that are best suited to their needs and pockets. So far, this has not been possible."

The prospect of relief from the high cost of getting ill comes with medical scheme subscriptions rising by up to 30 percent this year.

And, admits Rams chairman Mr Jan Fernhout, medical aid for the man in the street is being priced out of the market by the "heavy" annual fee hikes.

The new deal being proposed by Rams will enable subscribers to choose what they want to be covered for within a particular scheme.

Annual subscriptions would be cut to the bone by striking ordinary GP consultations from the benefits and being covered for catastrophe only.

Maternity

It is believed, however, the Government would strongly oppose any loss of medical scheme benefits that would start a run on provincial hospitals.

"But the benefits of dropping maternity cover for a married couple who don't intend to have children in a given year would be one example of the sort of cost-effective package that we are looking at," counters Mr Speedie.

Medical scheme members will pick deal they want

Report by HAMISH McINDOE

Masa's federal council chairman Dr Bernard Mandel says:

"There has to be some financial incentive for people not to visit doctors with minor ailments.

"It's a vicious circle at present. Members paying high subscriptions are going to doctors just to get their money's worth."

Consultations

Some medical scheme quarters are prescribing even stronger medicine to help pull the industry out of its dire financial straits.

For instance, certain day-to-day GP consultations could be dropped from the regulations.

"This would cut subscription rates tremendously as such consultations are our biggest burden," says a medical scheme administrator.

South Africa's 200-plus medical schemes are shouldering increases of about 18 percent in this year's benefits hikes to doctors and private hospitals.

Rocketing

The schemes should have reserves of 25 percent of annual subscriptions, but these totalled R2,09 000-million against benefit payouts of R2,04 000-million in 1986.

"Subscriptions will rise by up to 30 percent for some

The perenially ill will not benefit from relaxing the medical scheme laws because they will still need a high degree of cover.

But the healthy, and those that take a gamble on not falling ill, can expect cheaper and tailormade health insurance packages.

And Masa is pressing for a system that rewards medical scheme members who manage to get through the year with no — or low — claims.

schemes to meet expected increases in claims this year.

"But the average will be around 20-25 per cent," says Mr Fernhout.

Medscheme, which administers 29 medical aid funds will increase its subscriptions by 10 to 25 percent depending on the scheme.

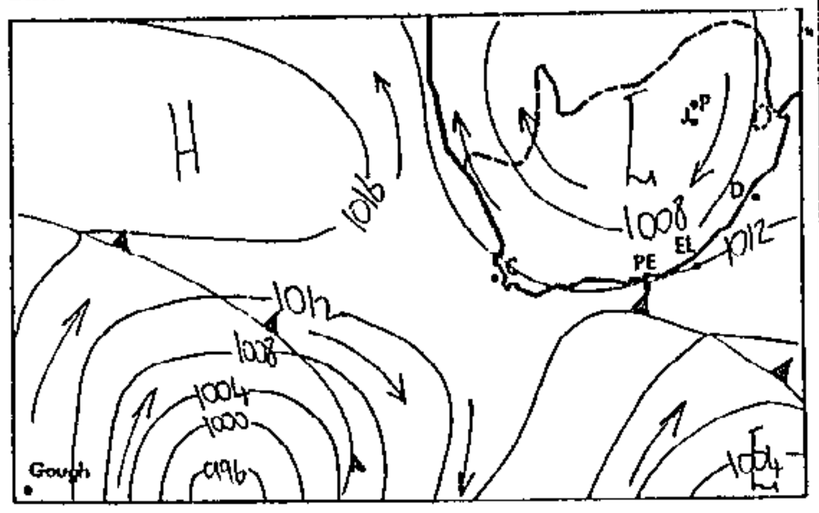
But, says MD Mr Keith Hollis: "We expect the average rise to be around 20 percent."

ARGUS 19/1/88 Z494

Cheaper medical schemes possible

Insurance-type cover is investigated

WEATHER TODAY



A cold front to the west of Cape Town should cause showers tomorrow.

Showers tomorrow

WEATHER forecast for the Peninsula, Boland and Overberg for the period ending 6pm tomorrow:

☐ **Partly cloudy and warm but hot over the Boland becoming cloudy and cooler overnight with occasional light rain tomorrow.**

☐ **Wind moderate southerly becoming moderate to fresh north-westerly tomorrow.**

☐ **The minimum temperature at D F Malan Airport will be 16 deg C and the maximum temperature 22 deg C.**

THE MOON

New moon	Jan 19
First quarter	Jan 25
Full moon	Feb 2
Last quarter	Feb 11

THE SUN

Sets today	2000
Rises tomorrow	0556

THE TIDES

High water:

Today: 0325; 1538

The Argus Correspondent

PRETORIA. — Medical schemes similar to insurance policies, where members pick the deal they want and subscriptions are linked to claims, may be established soon.

This cheaper health cover system is being investigated by the Representative Association of Medical Schemes (Rams), and the Medical Association of South Africa (Masa).

Over the next three months the two organisations will draw up proposals for the Minister of National Health and Population Development to amend the Medical Schemes Act and change other medical scheme regulations.

The object is to "loosen up the law" to enable people to select the package best suited to their needs and pockets.

These may include:

- Annual subscriptions to be cut to the bone by striking ordinary GP consultations from the benefits.
- Members being covered for "catastrophy only".
- A married couple not paying for maternity cover until they intend to have children.
- Members with no — or few — claims a year paying a lower subscription.

However, the chronically ill will not benefit from relaxing the medical scheme laws because they will still need a high degree of cover.

But at least their health insurance packages can be tailormade for their needs.

Masa is pressing for a system that rewards those members of the medical aid scheme who rarely file claims, yet also face the annual subcription increase.

A Masa spokesman said too many people visited their doctors with minor ailments.

"It's a vicious circle at present. Members who pay high subscriptions go for consultations just to get their money's worth," he said.

Doctors, societies welcome cheaper medical schemes

Daily Dispatch Reporter

EAST LONDON — Cheaper medical aid schemes which may enable people to choose a package to suit their needs have been welcomed by medical aid societies and doctors here.

The executive director of the Representative Association of Medical Schemes, Mr Rob Speedie, said the objective of the change was to loosen the law and give people the chance to choose what they wanted to be covered for over a particular period.

"So far this has not been possible."

The managing director of Medscheme, Mr Keith Hollis, said he welcomed the flexibilty which the new system would bring.

There was clear evidence that people in coastal areas had a lower level of claims than people inland, so coastal dwellers would benefit from the new system, he said.

The federal councillor for the Medical Association of South Africa here, Dr H. J. S. Kayser, thought it was a good idea because there was an over-utilisation of medical services at the moment.

He said the new scheme would do away with people going to the doctor for minor ailments.

Different packages that may be introduced include no cover for consultations but just for operations and hospital fees.

The area manager for Medscheme, Mrs Jenny Masella, also felt it was "a good thing" and that she had been hoping for it for a long time.

She said the Minister of National Health and Population Development, Dr Willie van Niekerk, had approved the concept in principle but that it had not yet been promulgated.

Each scheme which wished to adopt the new system would have to apply to the minister for approval.

The Medical Schemes Act would also have to be altered to incorporate the new amendments.

Mrs Masella said she was not sure how long it would take to come into effect if the concept was passed but she "hoped it was not too long".

299

DD 22/11/88

Alfred Mehlape explains how he repairs radios at the Association for the Disabled at Tembisa.

Better future for Tembisa disabled

C/Pnen 24/1/88 (299)

By BONGANI HLATSHWAYO

THE Association for the Disabled in Tembisa began a year of promise this week with an offer of continued support from one of the township's leading businessmen, Chris "Zniko" Ndaba.

Ndaba offered the services of his luxury coach whenever it was needed, and any other assistance he could give.

His close relationship with the association started last yearwhen he took its members, who number up to 40, to the Morula Sun where he hosted a Christmas party.

According to a committee member, Jerry Khumalo, Ndaba came to the association's rescue in October when it was faced with a survival crisis after the Omega Plastics company withdrew the assistance it had provided since the beginning of last year in the form of jobs for members.

The association runs a workshop at Tsepo Hall in Tsepo Section, Tembisa. Members engage in various jobs, including the assembling and trimming of technical products, dressmaking and TV and radio repairs.

Some of the companies that support the association through jobs include Symo Corporation and Marley Technical Products. These companies use the members in the production of hinges and medicine spoons.

On completion of the jobs, the association is able to pay each member according to his work.

For every 1 000 of the above products completed, the companies pay between R10 and R18. The more products members complete, the more they earn.

Khumalo said the association aimed at clinching more jobs for members this year.

Khumalo told *City Press* the association was supposed to receive a subsidy from the government last year, but due to the unavailability of its financial statement, it was unable to qualify. It lost R10 000.

However, the association was able to raise R17 900, which it kept with the Association for the Physically Disabled in the Transvaal. Isando-based company, Squib, donated R10 000 of that amount.

Khumalo said: "The APD told us to be independent and run our own affairs. They advanced us R5 000 last year to pay our members."

In addition to its working program, the association offers some training opportunities to its members. They receive free training in welding, dressmaking, knitting and other handiwork courses.

State grant for Kairos rival

A LABOUR Party-backed centre for handicapped children, launched as a counter to the controversial Kairos centre, is expected to be the recipient of a R200 000 State subsidy, according to several residents in Oudtshoorn's Bridgton township.

The subsidy to the Kairos centre was blocked by authorities in the House of Representatives after claims that its name was "communist inspired".

But the new daycentre — as yet unnamed and operating from the local library — will not be receiving the subsidy if Bridgton residents have their way.

More than 2 000 townsfolk of all races have signed a petition supporting Kairos and its choice of name.

The department maintains the name is unacceptable to the Labour Party because it is linked to the Kairos Document and therefore politically inspired.

The centre's executive insists that the name comes from a Biblical quotation and, translated, means "now is the time".

Mr David Piedt, of the Kairos Day Centre, said it would be disgraceful if the subsidy went to the new centre after Kairos had fulfilled the main requirement of being self-sufficient.

"We've knocked on the doors of nearly 3 000 homes in Oudtshoorn and the response has been overwhelming. We've also had fantastic support from businesses in the town and from a few multi-nationals."

28/1—3/2/88

Star 1/2/88

You can't just kick the habit, says user

299

Drug abuse in Lenasia is on the increase in spite of the role played by the drug rehabilitation centre there. In a frank discussion a group of drug users spoke about their own experiences.

Those interviewed have not been identified to protect their families and friends.

"I started taking drugs when I was 13. That was 16 years ago. I have been in and out of rehabilitation centres but I still smoke pipe," said Mr X.

Family pressure sure led Mr X (29) to join various rehabilitation centres. He spent three months at a drug centre in the Magaliesberg area.

Within an hour of his release he was back on drugs.

"I did it to please my family, I didn't want to give up."

Mr X was introduced to drugs by older friends and found it difficult to break away.

SUPPORT STRUCTURE

"I could relate to all my friends better when I was high."

For the users the smoking circle is an important support structure because it gives them an identity and a sense of belonging. It is also a way of socialising and gaining access to drugs cheaply.

"I could afford to smoke up to 50 buttons a night because I smoked with the merchants and got the drugs for next to nothing. I even got my hands on some coke (cocaine)."

To support their habit many users become pedlars. Users said that Mandrax is manufactured at 10c a pill, it is then sold to the wholesaler for R3 to R4, who in turn supply the dealers.

"I was really into drugs, it cost me my marriage but now I can sit and smoke one joint and feel good. I don't need to have more but I know I'll always be a smoker. You just can't kick the habit. It becomes a part of your life," he said.

Medical schemes fear AIDS costs

MEDICAL schemes are campaigning for the Government to foot most of the AIDS treatment bill for members who contract the killer disease.

An urgent meeting has already been held between the Representative Association of Medical Schemes (RAMS) and National Health and Population Development Minister, Dr Willie van Nierkerk, to persuade Government to "substantially meet" the sky-high cost of treating and caring for medical scheme members who contract AIDS.

By HAMISH McINDOE

Figures released by US health authorities have put the cost of caring for AIDS sufferers at a staggering R120 000 a year.

RAMS believes the cost of treating AIDS would be similar in South Africa.

And, as AIDS gains a firmer foothold in South Africa, medical schemes fear they will have to pay out millions to treat members suffering from the disease.

Said RAMS executive director Mr Rob Speedie: "We want to impress on Dr Van Niekerk the horrendous financial impact that the future cost of treating AIDS patients will have on the medical aid schemes."

Last year, 76 South Africans and 22 foreigners were diagnosed as having symptoms of the killer disease, while an estimated 10 000 are carriers of the Human Immune Deficiency (HIV) virus.

Golaith "Oom Gollie" Meyer, principal, busdriver, handyman

From rents to classrooms

By RYLAND FISHER

A MUNICIPAL pay booth and a railing to regulate queues are the only indications that the Kairos Day Centre in Oudtshoorn used to be a place where people paid their rents.

In the past year, the building in Bridgton has taken on a completely new identity as the place of learning for 35 mentally retarded children.

The neat classrooms, with brightly-painted pictures of animals and cartoon characters on the walls, give no indication of the struggle for survival the school has fought since it opened.

The centre has been refused a subsidy by the Department of Education and Culture (House of Representatives) because the Labour Party finds its name unacceptable and "communist-inspired".

The name has been linked to the controversial Kairos Document, which supports liberation theology.

"Our subsidy was approved in May last year when we sent a delegation to the Department's head office in Cape Town. Afterwards we heard the subsidy had been frozen because of certain objections to the centre's name," says Mr Gert Mooney, chairperson of the centre.

"In December, we were finally told we would not get a subsidy because the community objected to the name.

"Up to now, we have been surviving solely on the support of the community. This is a true people's project. It has been built from grassroots level.

"We get a little bit from this one and a little bit from that one. We have to have many fundraising functions.

"Our two teachers work for minimal salaries and our principal, Mr Goliath 'Oom Gollie' Meyer, acts as bus driver, handyman and everything else for the same salary," says Mooney.

The building used to house the municipal offices but now belong to a local welfare organisation which rents it out for R50 a month.

"The building was dilapidated and we had to spend a lot of money to fix it up," says Mooney.

The centre has two classrooms for junior and senior groups (the children range from three to 18 years). On the walls of the senior class are sketches of Mickey Mouse and other characters. The walls of the junior class display animals, trees and number charts.

There are also a woodwork and art room and a well-stocked sickbay with two beds.

"Sometimes the children get ill at school. The sick bay is very important," says Mooney.

In the kitchen is a freezer donated by a local organisation, while food is donated daily by local businesspeople.

"The children stay here from about 8am to 2pm and are given two meals a day. Their parents don't pay anything because they are mainly from very deprived areas."

In the diningroom the children take turns to learn to eat at a table.

"It used to be a problem at the beginning. It was difficult for some of the children to accept that they could sit and eat at a table like other people. This is really where they start receiving their human dignity."

Mooney feels this important learning process for the children is being affected by the failure to get a subsidy from the Department.

"There is a need for this school in the South Cape. Before we started, there was only a similar school for whites."

Last month a school linked to the Labour Party opened in a spare room in the Bridgton library.

"The new school is not following the procedures set down by the Department, but will probably be accepted because of its Labour Party links," says Mooney.

"They have tried to give the impression that their name will be chosen by the community by having a competition in which people must select one of three names. Kairos is not included in the three.

"They say our name is not acceptable to the community, yet we have collected 4 000 signatures in Bridgton and Bhongolethu in support of the name.

"The petitions will be handed soon to the Director of Education, Mr Awie Muller.

"Our name has nothing to do with the Kairos Document. We had chosen a few names from the Bible and eventually decided on Kairos because it means an opportune time and a vital part of the body.

"It summed up that this was the right time to open the school and described what we wanted to do."

Mooney says he does not mind being associated with the Kairos Document.

A friend from Cape Town had sent him a copy of the document after he had heard about the school's problems.

"I read the Kairos Document and found nothing wrong with it," he says.

Kairos members Mr Gert Mooney and Mr David Piedt outside the school

South

11 17/12/88

299

Mr Gert Mooney in the junior class

Disabled muster for action

299

By Janine Simon

Disabled people are set to take action, if necessary by litigation and public demonstration, against discrimination.

Repeated reports of discrimination — for example of a quadraplegic Cape Malay girl denied access to services because a major white hospital refused to admit her to intensive care — have fired Disabled People South Africa (DPSA) into action, the chairman, Dr William Rowland, said this week.

A three-tier procedure for dealing with complaints was devised and a watchdog group, "Discrimination Watch", established.

"We aim to be responsible, not emotional."

Discrimination Watch would first negotiate with the offending party. If unsuccessful, it would enter into public debate through the media.

If that did not work, it would resort to legal action and public demonstrations — principles which had proved successful overseas, Dr Rowland said.

"Disabled Americans staged a 28-day sit-in — that country's longest — to protest that regulations relating to the 1973 Rehabilitation Act took three years to formulate. It took a lot of organising, but it shows public demonstrations are viable," he said.

Employment and access were Discrimination Watch's major concerns.

The Industrial Court had ruled favourably in two of three cases of unfair dismissal on the basis of disability already brought before it though it was not clear how denial of employment on those grounds would be viewed.

Employment in education, for example, was a particular problem as some education authorities flatly refused to place blind people in teaching positions they commonly held in the United States and Europe.

"Their arguments on supposed problems of marking, classroom discipline and visual presentations are not valid," said Dr Rowland, who is also the executive director of the South African National Council for the Blind.

Regarding access to buildings, Discrimination Watch would take legal action should any new buildings not comply with the access features stipulated in the 1986 National Building Regulations.

Medical aid bites sharply

Own Correspondent

DURBAN — Contributions to medical aid schemes over the past eight years have risen at almost twice the rate of salaries — and members hit hardest have been blacks and coloureds.

Mr Jeff Slome, managing director of Medicaid Administrators, an organisation which administers 18 schemes in South Africa said contributions from black members in that period, on an annually compounded basis, have increased by 26,6 percent. Contributions by white members went up 19,2 percent.

'ALARMING TREND'

"The contribution by coloureds has risen by 21,5 percent against salary increases of 12,1 percent," said Mr Slome, "and an alarming trend is that some members of schemes who believe they are paying in more than they are claiming, are asking their employers to allow them to withdraw. This must be resisted. If it is allowed, medical schemes will suffer in that most members will be those who claim often, resulting in further contribution rate increases."

Mr Slome said an education programme was needed to raise the awareness of sceptical members. "They should realise that medical aid is not a bottomless pit that pays for all medical expenses. It should rather be regarded as an insurance for the days when they incur a major medical expense.

"Disgruntled members should also view escalating contributions in the light of the soaring costs which medical practitioners say are making it difficult for them to make ends meet. The needs of doctors should not be ignored."

The cost of prescribed medicines has also risen way ahead of inflation. In 1987 medicine costs rose by more than 30 percent, and this year increases are expected to be between 18 and 23 percent.

Mr Slome added that the scope of medical aid schemes needed to be continually developed and refined, and there was a greater need for flexibilty.

CHEAPER RATES

He said more flexible packages needed to be worked out for medical aid members. "For example, for a person who earns say R8 000 a month, being treated at an an institution that costs R100 a day is not a problem, but for the person who earns R800 a month it is a problem. Good facilities at cheaper rates should also be open to negotiation."

298 SMM 299 29/2/88.

Sowetan 1/3/88

Rape victims need clinical care

299

By BRENDA ROBSON

I HAVE been asked by a friend to discuss another problem that occurs all the time in our community. This is the problem of rape.

Rape is something that I have been told happens too often. One of my friends has a niece and she was on her way home from school when she was attacked, raped and stabbed. When I asked what we could do about this, he said that they were scared that we might identify the rapist and this would put his niece into further danger.

I have thought long and hard about this. I do not know what we should do to protect the lives of our young. The part that really worries me is not the physical rape. This is something that can be overcome with surgery if necessary. It is not the stabbings though that do put the child's life in danger. The psychological problem is what worries me.

I have spoken to a number of children who have been raped. They all say that they never feel clean again. They all complain that the smells of the rapist worry them for years.

There are nightmares and horrific dreams. This we cannot solve unless we all as a community find a way of bringing all these people to task. We have got to make the community safe for all the children.

I have been into this problem and discussed it with many people all over the world. The same problems exist here as any where else in the world.

Many of the large hospitals in America have got a crisis clinic. This is staffed by people from the community. It cannot be run by the hospital. They are not members of the community. They also have not got the time to sit and be available to the young when they are needed. This centre we must organize with understanding people from the community.

The specialists are freely available and we can find them anywhere. These are gynaecologists or the surgical people. They can make right the physical damage but we, the community must give the victims the support they need.

In Atlanta I spent many hours with a group of people who run the rape clinic. They give time every week to sit in the hospital and they are there when the victims need them. They are the counsellors. They give them support until they are better. We can never say cured because this attack takes years to heal.

I am sure that many of the clergy would also be available to help. It will take a lot of very dedicated people. I am sure that we could put together the best team possible made from caring members of the Soweto society. The one thing we need is time and this is so valuable. We have to be there whenever the rape victim needs someone to talk to. They need many hours of loving, listening to and getting out all the fears and worries before they can cope with this type of trauma.

I have often worried about the children who have been raped and for some reason fear to tell anyone about their problem. They must live with this huge problem. If they had someone who they could go to without fear of retaliation, it would help enormously.

I am throwing this challenge out to all people of Soweto. This would be something that we could show how much the safety of our children means to us and also help many young people. Again please, can I have any thought that you have on this subject.

Helping stroke victims

Star 23/5/88 — 299

By Toni Younghusband
Medical Reporter

The chance of a South African suffering a stroke is comparatively high, but there are few facilities for his long term rehabilitation.

In an attempt to combat this lack, a group of volunteers assisted by the University of the Witwatersrand's speech and hearing clinic have set up therapy groups in Johannesburg under the auspices of the Stroke Aid Society.

One of these operates from a church hall in Norwood and each session is attended by about 50 people.

Professor Claire Penn, of the Department of Speech Pathology and Audiology at Wits, told The Star that while a patient was given excellent treatment in hospital during the initial stages of a stroke, once discharged they were often without the long-term care and rehabilitation they so desperately needed.

A stroke happens when the blood flow to the brain is blocked for a period of time, depriving the brain of oxygen. Strokes are particularly prevalent among the black population because blood pressure is not properly monitored, said Professor Penn.

Feel lonely and discarded

Alone at home, their once-productive lives hampered by mental and physical disabilities brought on by the stroke, sufferers are frequently depressed, lonely and feel worthless and discarded.

They need the company of others who are enduring similar hardships and need a thorough rehabilitation programme to restore their lives to what it once was.

The Stroke Aid Society has about 700 members in the Johannesburg area and was recently granted an official welfare number enabling it to launch aggressive fund-raising schemes.

Members attending the weekly therapy sessions spend a morning playing bridge, cards and board games, learning new arts and crafts or reading.

They also undergo speech therapy and physiotherapy and are counselled by trained volunteers.

There is no pressure on members to take part in any particular activity. The morning's session is designed to provide a relaxed, happy outlet where stroke sufferers can enjoy the company of others and if they would like to, can learn new skills. And spouses are welcome to join in.

Regain self respect

A common problem is that it is often the breadwinner in a home who is incapacitated after a stroke.

This may make him feel useless, guilty and unwanted.

By joining the Stroke Aid Society's group sessions, he can regain his self-respect and learn new skills which may provide him with an income for his family.

The Stroke Aid Society's growing membership has meant that more volunteer workers are needed. Should you be able to help or should you require further information about the society contact Maurice Hetz at 646 9744 or Shirley Abrams at 786 8749.

Factor launches non-smokers' club — with big perks

Star 2/3/88

By Toni Younghusband, Medical Reporter

Johannesburg discount king Mr Tony Factor declared war yesterday on smokers and vowed that South Africa would be smoke-free by the year 2000.

He was speaking at the launch of the country's first anti-smoking club which has been established in Orange Grove.

The club, which is aimed at all sectors of the population whether they be smokers or non-smokers, will entitle members to discounts on purchases, rentals and other consumer commodities.

"The club will encompass not only the means for an intensive research programme and the dissemination of information, but also a wide variety of recreational activities and personal benefits for those who choose to join the club," said Mr Factor.

According to statistics released at the launch, smoking claimed three lives every two hours and 34,5 percent of all white men in the country died from tobacco-related causes.

CIGARETTE ADDICTION

South Africa has the highest percentage of smoking per capita in the western world — 22 billion cigarettes were bought annually by the South African consumer, Mr Factor said.

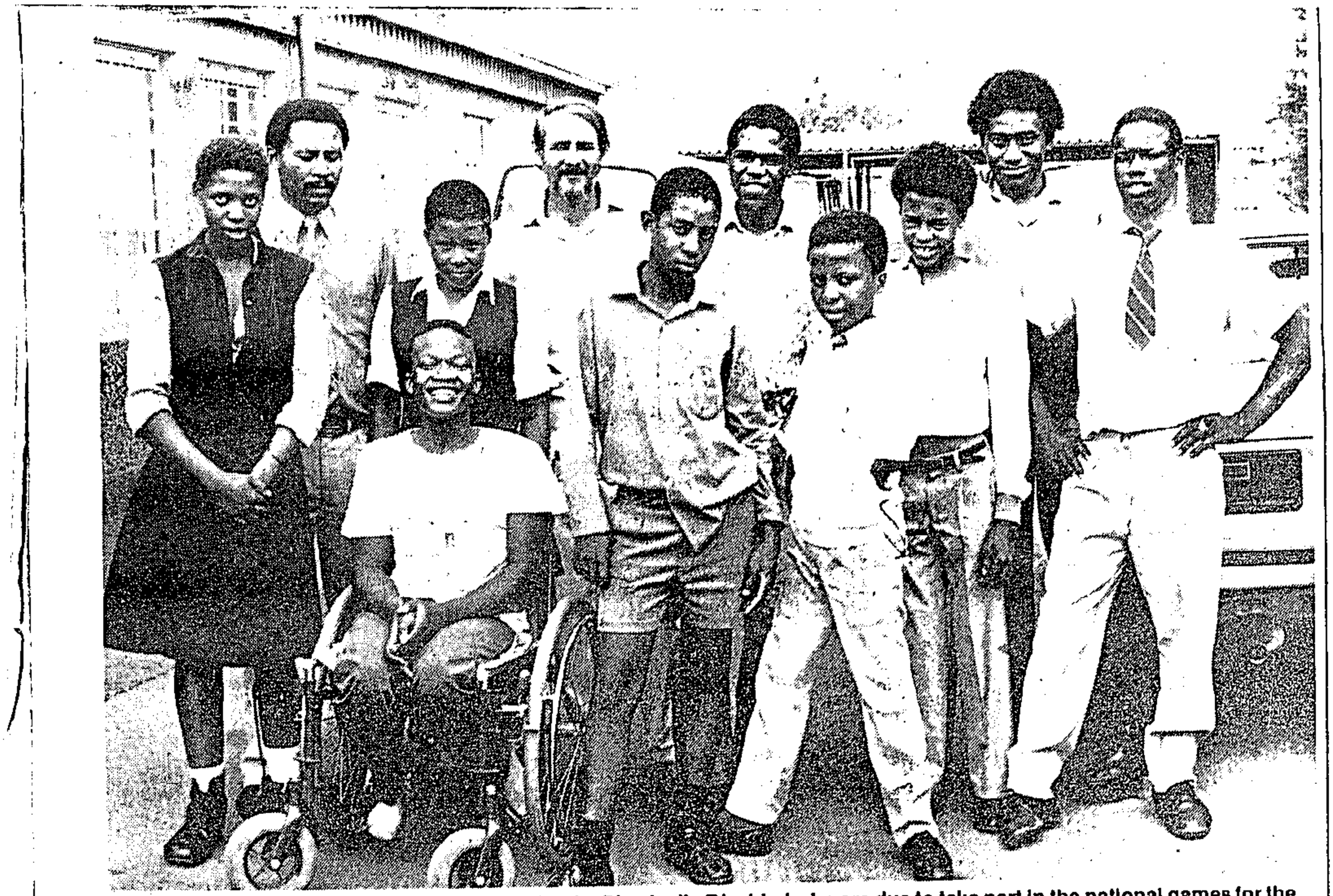
Statistics showed that more than 12 million South Africans were addicted to cigarette smoking.

Mr Factor praised South African Airways for its smoking ban on domestic flights, saying he was pleased it had had the guts to take a stand.

Mr Factor's decision to establish an anti-smoking club came after years of cigarette addiction, two heart attacks and a by-pass operation.

He gave up the habit last year and has now decided to devote the rest of his life to "the plight of the victims of smoking".

To join Mr Factor's club, a non-smoker must pay R75 per annum and potential non-smokers R95 per annum.



NINE of the 11 pupils of J C Merkin School for the Physically Disabled who are due to take part in the national games for the disabled in Stellenbosch next month. Also in the picture in the back row are, from left, Mr Mandla Mwelase, a staff member, and Mr Danny Schoeman, the principal.

Sowetan 3/3/88

HELP US PLEA

299

Disabled kids dream trip in danger

ELEVEN pupils of J C Merkin School for the Physically Disabled in Soweto may see their dream of participating in the South African National Games for the Physically Disabled (juniors) evaporate unless a Good Samaritan comes to their rescue.

By NKOPANE MAKOBANE

Mr Danny Schoeman, the principal of the school, said they were faced with a task of raising R7 000 for the trip to Stellenbosch for the games from April 3-7. The funds are needed for uniforms, petrol and accommodation.

He said although they knew well in advance that they would be taking part in the games, they had been let down by a man he believes is a trickster.

The man, who calls himself Mr Boniface Mthimunye (35), had introduced himself to the school last October. He said he worked for a company that does fund-raising for charity organisations.

Promise

"This man promised to get the 11 pupils and the five teachers, who would be accompanying them, a sponsorship. Although at first we did not take him seriously, he took us into his confidence when he managed to get a sport company to sponsor our soccer team with a new outfit.

"Since October, we have been waiting to hear from Mr Mthimunye but all in vain. We tried to get hold of him at addresses and telephone numbers he left us, but were unsuccessful.

"Last week out of desperation, I contacted the company that he said would sponsor us. The company confirmed that they knew him, but said it knew nothing about the sponsorship. In fact it was embarrassed about the whole thing," he said.

Concerned

According to Mr Schoeman, the school is concerned that he may be using the school's name to enrich himself. He had taken pictures of the school and they think he may be using them to collect funds.

"We are only left with a month to raise the R7 000 for the trip. We are appealing to companies and individuals to help us. If we cannot raise the amount between now and date of departure, the trip will fail," he said.

The 11 children from the school will form part of the 71 members of a team to represent Southern Transvaal in the games.

They will take part in all field and track events that include discus, long jump, club, wheelchair racing, flat race, shot putt, javelin as well as table tennis.

Mr Schoeman can be contacted at 984-4209.

Lions' white cane blitz will aid blind

Star 4/3/80 (299)

Lions clubs nationwide are attempting to break a world record in a White Cane Day fund-raising venture, which started yesterday and ends tomorrow.

The record, of selling 1 million white canes, was entered into the "Guinness Book of Records" by United Kingdom Lions last year.

But their South African counterparts are anxious to better this and will be blitzing shopping centres and street corners around the country in an attempt to do so, says Lions.

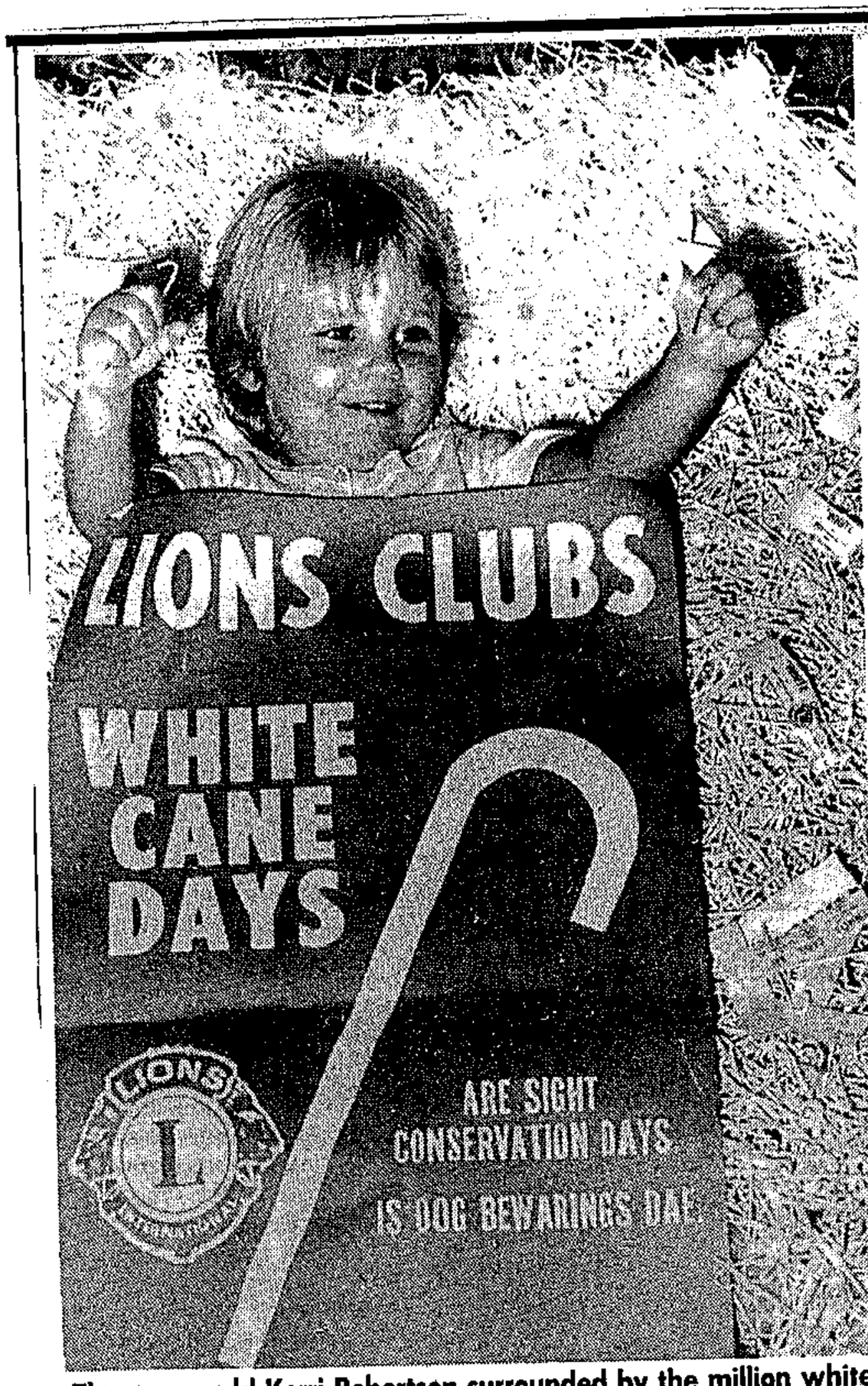
MORE FUNDS

"We would like to break the record purely because it would mean more funds to help our special sight-saving projects," says spokesman Mr Peter Schmolke.

Lions has been involved with serving the blind and visually impaired since 1925.

Funds from the white-cane collection will benefit guide-dog training schools, eye banks, research and rehabilitation centres, printing of braille books and the operation of sight-conservation clinics.

Operation Brightsight, the Lions' project to recycle used spectacles to indigent people, will be a special beneficiary, says Mr Schmolke.



Three-year-old Kerri Robertson surrounded by the million white canes Lions hope to sell.

It's a war against fags

JOHANNESBURG businessman, Mr Tony Factor, has declared war on smoking.

At the launch of his anti-smoking club in Orange Grove Mr Factor said he held cigarette companies and vendors responsible for the "tragic deaths" of close to 36 people from smoke-related diseases daily.

He vowed to do everything at his means to see that the smoking of cigarettes stopped and promised he would never die until he did.

"Cigarette smoke is the number one killer in South Africa," Mr Factor said.

"Apart from the great loss of lives, the costs of tobacco addiction in South Africa are astronomical. Twenty two billion cigarettes are bought annually by the South African consumer.

He said that five percent of the black population dies of tobacco-related diseases every year. There was a great likelihood that the number will increase since blacks were the target group of the cigarette manufacturers.

"We should educate them and make them aware of the dangers of smoking to stop the percentage going up. We all can live without cigarettes. Addication is all in the mind. All we need is motivation," he said.

Operation

Mr Factor, who has had two serious heart attacks and a heart bypass operation as a result of cigarette addiction, offers an incentive as a way of motivation to people who want to stop smoking.

His club will offer personal benefits to members. They will automatically qualify for discounts at selected car rentals, recreation centres, academic institutions and health spas on the Rand.

The aims of the Tony Factor Anti-Smoking Club are:

- To organise people who have stopped smoking into a group;
- To form through their collective efforts a pressure group engaged in fighting smoking in public;
- Protecting the interests of non-smokers where passive smoking is concerned and demanding legislation to complement the present laws regarding smoking.

The objectives of the club, which charges R75 for non-smokers and R95 for potential non-smokers a year as a membership fee, hopes to see a smokeless South Africa in 12 years' time.

Deaf-aid breakthrough

Star 5/3/88

(299)

SARA MARTIN

South Africa is soon to manufacture its own bionic hearing aids, says the surgeon who pioneered bionic ear implants here two years ago.

"It will be a combined effort of private and academic enterprise," said the surgeon, who may not be named for professional reasons.

"At present, we import the hearing aids from Germany, the United States and Australia. Soon they will be locally manufactured at half the price."

A German company has offered to make the parts using expertise developed at the University of Pretoria.

This will cut the cost of bionic ear implants by almost half.

The South African model will be one of the most modern in the world.

Bionic ear transplants cost between R15 000 and R35 000, depending on whether the model has one or many channels.

The surgeon has performed more than 31 bionic implants at the Garden City Clinic in the past two years, and many more are booked for the next few months.

His patients include the youngest bionic ear recipient in the world and the oldest in South Africa.

A bionic ear is not a hearing aid. It is an electronic system which amplifies sounds and transforms them into stimuli.

The surgeon said the hearing aids improved both communication and the user's quality of life.

Tanya

Demand for transplants 'not being met'

By Toni Younghusband
Medical Reporter

The problem with organ donation in South Africa is that doctors are not informing the public of donor potential, claims Professor J A Myburgh, head of the department of surgery at Johannesburg Hospital.

Professor Myburgh says there seems to be a general belief that relatives of potential donors refuse to give permission for transplantation. "But the real reason for the shortage of donors is that doctors are not asking relatives for consent," he says.

The reasons for this reluctance on the part of doctors are many.

Speaking at a function last week to herald the 1 000th kidney transplant performed at Johannesburg Hospital, Professor Myburgh said that while there was a sense of gratification in the success of the hospital's renal unit, there was no reason for complacency.

"We are not fulfilling what the population requires. We have done 1 000 transplants; we should have done 4 000," he said, because only a quarter of the demand for transplants was being met.

LONGEST SURVIVOR

The first kidney transplant performed in South Africa was carried out at Johannesburg Hospital in 1966 and the longest-surviving patient, Mrs Anita Meyer, died last year.

The 1 000th patient to receive a transplant is Miss Elsie Makhawana (35) of kwaNdebele.

Professor Myburgh said another myth about organ donation was that blacks, for religious and cultural reasons, would not consent to organ donation.

"A study done at Ga-Rankuwa Hospital (near Pretoria) showed that two-thirds of the relatives of possible organ donors will give their consent. A lack of facilities and patient care is the real reason for the shortage of black donors," Professor Myburgh said.

The lack of funds for adequate facilities was a serious problem facing Johannesburg Hospital and other medical centres.

According to Professor Peter Thomson, of the hospital's paediatric renal unit, the last seven patients he has tried to get into the paediatric intensive care unit could not be admitted because no beds were available.

"And there are no beds because there is not enough nursing staff," Professor Thomson said.

Professor Myburgh slammed kidney transplant critics. "I get very angry when people say why bother with kidney transplants when there is malnutrition. You cannot achieve success by breaking down what already is," he said.

Argus 8/3/85

299

Sats medical aid running dry

The Argus Correspondent

DURBAN. — The South African Transport Services' 100 percent medical aid gravy train is running dry and the 140 000 members, pensioners included, will have to pay 25 percent cash for most services from April 1.

The move is apparently aimed at cutting down on unnecessary visits to doctors.

Now the all-white membership Transmed, which used to pay 100 percent for all consultations, operations in consulting rooms, out-patient treatment, house visits — including the material used, all pathologic, radiologic (diagnostic) and physiotherapy, any tests rendered inside or outside a hospital and maternity services, will stop doing so from the end of March.

However Transmed will still pay 100 percent for hospital treatment, nursing homes, accommodation in a general ward, theatre fees, operations, operation procedures and treatments, blood transfusions, medicines and dressings.

Members angry

Circulars have been sent out to doctors telling them to take 25 percent of the fees for the above services and the balance will be paid when they (the doctors) submit their accounts to Transmed.

Members are angry at the changes and claim that the reason why they are being forced to pay part of their bill is because Transmed is soon to be opened to people of other race groups.

One man said that he saw no reason why the present membership, which included pensioners, should have to pay for other people.

But a spokesman for Transmed, Mrs Sandra Gertenbach, who confirmed the changes, denied that it had anything to do with the fact that Indians and coloured people are to be included in the membership.

"People of other races will be admitted in about two years time. But this is not the reason why it has been introduced. We have done this to improve our members' benefits and also to make them aware of the cost of medical care."

Medical-aid fees outpace pay rises

MEDICAL-aid scheme contributions have risen by more than double the rate of salary increases in the past eight years, and the trend is set to continue this year.

By Robyn Chalmers

Increases of 20% to 30% are expected in subscriptions.

Jeff Slomes, managing director of Medicaid Administrators, says blacks and coloureds have been particularly hard hit. Contributions by blacks in the past eight years rose by 26,6% compounded annually, but pay increases were only 13,95%.

Coloured members' contributions increased by 21,5% against pay rises of 12,1%, and white members' contributions by 19,2% against 11,3% in salaries.

Medicines

Mr Slomes says the reasons for high increases in the black and coloured subscriptions include:

- ☐ Improved facilities and better use of them.
- ☐ Availability of more facilities.
- ☐ Increase in the number of members.
- ☐ Poor Government and provincial health services.

Other reasons contributing to the increases are a huge rise in the cost of prescribed medicines — way above the rate of inflation; schemes being hampered in designing their own benefit packages; a steep rise in provincial hospital tariffs — 100% in some cases; members abusing use of the schemes; and practitioners overservicing patients.

Mr Slomes says: "Medical aid should be seen as an insurance for the days when there will be a major expense. At present, members who think they are paying more than they claim in a year wish to withdraw from their schemes.

Statutory scale

"This would result in schemes consisting mainly of sick people. That must be resisted as subscriptions would rise even higher."

Medical aid is governed by the Medical Schemes Act of 1967 which provides, among other, for guaranteed payment to all suppliers of service who render their accounts at the statutory scale of benefits.

This system allows the suppliers to "write their own cheque" as they determine the treatment for each patient. The general practitioner is the gateway to the system, he says, and once the member has passed through his hands the subsequent tests are unlimited and out of control of the medical systems.

The guaranteed payment system is a major reason why medical costs have soared.

Coupled to this is the Act's insistence that all schemes provide a minimum level of benefits.

The minimum is 70% of the scale of benefits and 50% of the cost of prescribed medicines. Mr Slomes believes the provision lifts costs as schemes have no power to formulate packages which would force people to contain costs, such as co-payment by the member at the time of receiving treatment.

The first insolvency of a scheme was in 1986, mainly because of its low reserves. The Registrar of Medical Schemes has recommended that they have reserves equal to 25% of annual contributions, but Mr Slomes believes this is too high.

"We have recommended that schemes try to retain reserves of about 17% of annual contribution income".

Flexibility

Mr Slomes does not expect susbcriptions to rise by more than 30% this year — provided there are no huge increases in medicine costs and provincial hospital tariffs.

"There is an urgent need to educate the public about schemes and change legislation. Scehemes should have flexibility. Provisions relating to guaranteed payments and minimum benefits should also be altered.

"Once this is accomplished, contribution increases will level out, and the health care needs of the population will improve immensely."

299 (5) SML 14/3/88.

Higher fees for pharmacists may hit medical aid

Medical Reporter

Proposed new fees for South Africa's pharmacists could push up medical aid subscriptions, the Representative Association of Medical Schemes (Rams) says.

The key element of the proposed package is a sharp increase in dispensing fees. "The proposals contain elements of cost escalation that medical schemes, their members and employee groups will simply be unable to cope with at the current medical aid subscription levels," a Rams spokesman said.

"Our information is that the proposed new professional dispensing fee could be pitched at between R4 and R6,35 an item — a sharp increase on the current level of R1,30 an item — while the proposed mark-up on medicines may be as high as 40 percent," said the spokesman.

"If these figures are correct, the proposals are way out of line and fly directly in the face of President Botha's efforts to contain inflation."

The spokesman said that if the gross incomes of pharmacists were to remain the same, the future dispensing fee should be no more than R4,22 an item.

Medicines account for 40 percent of the benefits paid by medical schemes so the impact of any increase would be huge.

EDUCA

Plight of disabled athletes

Sowetan 14/3/88.

299

THE J C Merkin School for the Physically Disabled in Soweto still has to raise R6 647 of the R7 000 needed for a school trip to Stellenbosch next month.

Eleven pupils of the school are set to take part in the South African National Games for the Physically Disabled (juniors) in Stellenbosch.

Represent

They are part of a 71-member team to represent Southern Transvaal in the championships.

Early this month, the schools' principal, Dr Danny Schoeman, told the *Sowetan* that the children's dream to take part in the games would be shattered unless a good samaritan helped them.

He said they needed R7 000 for uniforms, petrol and accommodation.

"I am disappointed that we have so far had a poor response. We have only managed to raise R353."

The R300 was raised by the school through a street collection at the double-header between Cosmos-Chiefs and Swallows-Pirates at Ellis Park on March 5.

The R53 was donated by the Atlantic City Youth Club of White City Jabavu.

Mr Schoeman said the school would have made proper arrangements for the trip had a man not promised them a non-existent sponsorship.

"We are once more appealing to companies and individuals to help us," he said.

The 11 pupils will take part in all field and track events, including discus, long jump, club, wheelchair racing, flat races, shot putt, javelin and table tennis.

Mr Schoeman may be contacted at 984-4209.

National health service call

Staff Reporter

A SINGLE national health-care structure — or national health service — was necessary to solve the inadequacy of South Africa's present health services, the 6th biennial general practitioners' conference heard yesterday.

Mr Cedric de Beer, co-director of the Centre for the Study of Health Policy at the University of the Witwatersrand, said the country's health service lacked equality, efficiency and universal, comprehensive primary care.

The country's health services were "sadly deficient" due to the combined effect of fragmentation and private fee-for-service care. Thus market forces allocated health resources according to ability to pay rather than need.

Health care was fragmented into 17 health departments — 10 in the homelands, three "own affairs" and one "general affairs" department and the state, province and local authorities. There were also public and private health sectors.

Medical aid schemes should 'build reserves'

SM 16/3/88 Medical Reporter (599)

It was essential that medical aid schemes built up reserves in order to provide stability and to keep down contribution rates, Mr Jeff Slome, the managing director of Medicaid, a medical aid administration group said yesterday.

Mr Slome said that for too long South African schemes had had insufficient reserves. This meant that when there was an unforeseen surge in claims, hikes in contribution rates were the only solution.

"It is essential that medical aid schemes build up reserves in order to provide stability. Reserves are conservatively invested to generate additional income for schemes, creating further stability," Mr Slome said.

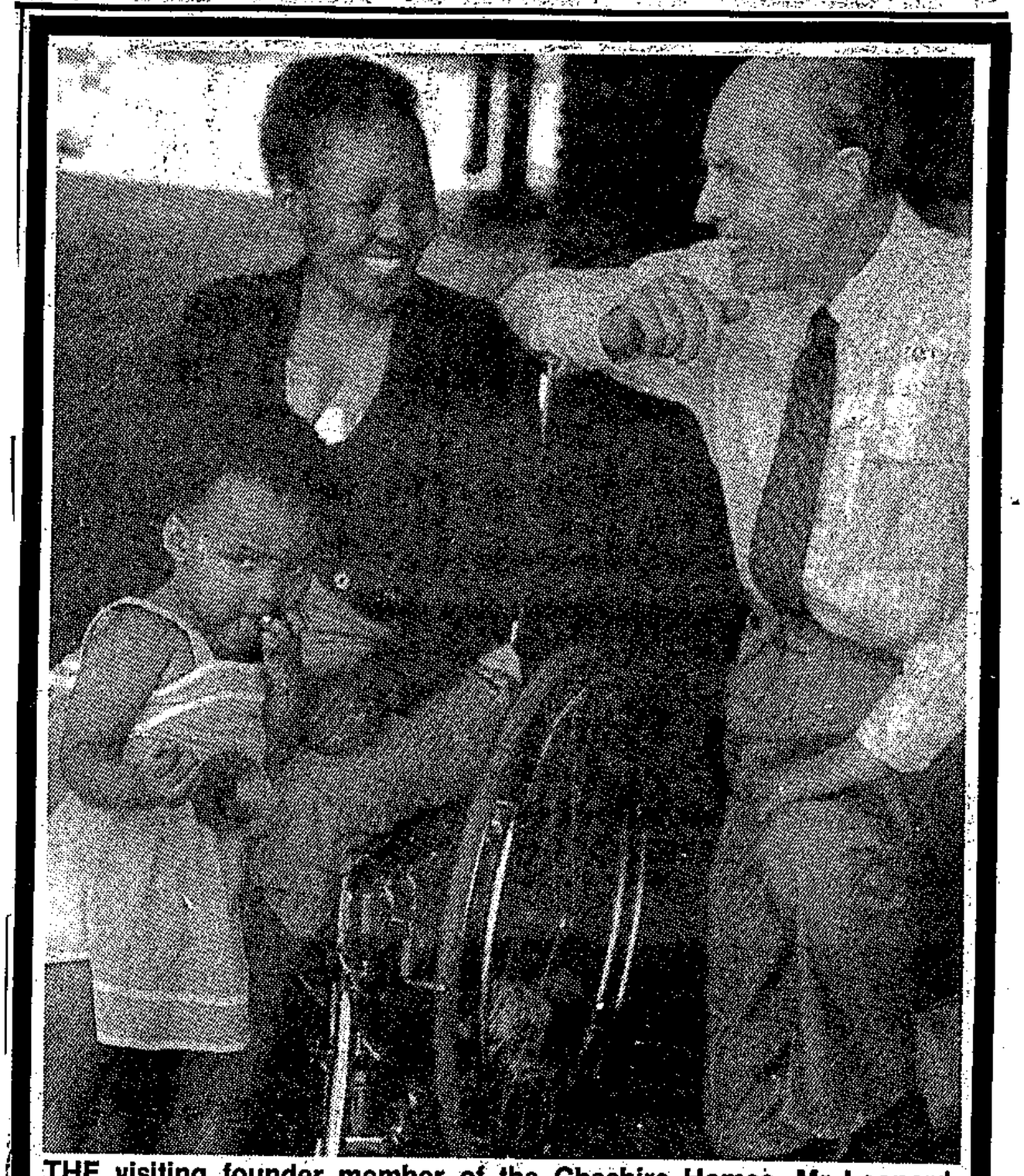
According to Mr Slome, significant surpluses for 1987 had been recorded by the six open medical aid schemes within the Medicaid Administrators Group, which during the year had paid out more than R125 million in claims for the 65 000 members of these schemes.

He said one scheme within the group, which has 17 000 members, achieved a surplus of R4 million. Another scheme had registered a surplus of R3 million.

Mr Slome attributed the group's success to a strong communications drive through which members were educated on wide-ranging aspects of home health care and cost awareness.

"Other factors included prudent budgeting, tighter claims control and accurate forecasting through careful monitoring of statistics," he said.

Of the R125 million paid out in claims — medicines accounted for R36 million (28 percent) and hospitals for R27 million (22 percent).



THE visiting founder member of the Cheshire Homes, Mr Leonard Cheshire, with an employee of Self-Help Association of Paraplegics, Miss Poppy Buthelezi. The little girl is Banana Mavuso. Her father, Mr Friday Mavuso, is chairman of SHAP.

Sowetan 16/3/88 (299)

Disabled people to get R1-m home

A NEW R1-million home for physically disabled adults is to be built near Moroka, Soweto.

By JOSHUA RABOROKO

At a sod-turning ceremony in Soweto yesterday, the founder of the International Cheshire Homes, Group Captain Leonard Cheshire, said many handicapped people were forced to attempt to survive in "appalling conditions."

The Cheshire Homes project aims to help disabled people and was started by Captain Cheshire in Britain in 1948.

There are 260 such homes throughout the world.

Mr Cheshire, who arrived in South Africa from Britain this week, said it had been his "burning desire" to help disabled people worldwide.

He said: "The project in Soweto is an important milestone for our organisation. Despite the size of Soweto, no organised communal accommodation for the physically disabled adult exists."

The new home is expected to accommodate more than 40 people.

It will be funded by the local community and the private sector.

The chairman of the Self-Help Association of Paraplegics, and chairman of the Soweto Cheshire Home steering committee, Mr Friday Mavuso, who is himself a paraplegic, said the new home would help many disabled people.

He was also involved in the running of a workshop for physically disabled people in Soweto.

He hoped that the project would be supported by many people who would be expected to raise funds for "this giant venture."

● The mayor of Daveyton, Mr Tom Boya, has allocated a site in the township for the building of a Cheshire Home.

Seminar on drugs in EL

DD 16/3/88

299

Daily Dispatch Reporter

EAST LONDON — A drug awareness seminar will be held at the Teachers' Centre here today and tomorrow.

The seminar, hosted by the Beacon Bay Lions Club, aims to help curb drug abuse and inform the public about the effects thereof.

Drug awareness is an international Lions project, which hopes to prevent drug abuse by holding seminars such as this.

Guest speakers today include Dr Colin Bouwer (advisor to the President's Council on drug abuse) from Cape Town, Dr Ian Wiseman (associate professor of pharmacology at the University of Port Elizabeth), local representitives from the medical, social science, teaching and religious fields and a speaker from the Border South African Police narcotics branch.

The seminar is expected to be attended by members of the medical, pharmaceutical and educational professions, but all members of the public are invited to attend the lectures, which are free of charge.

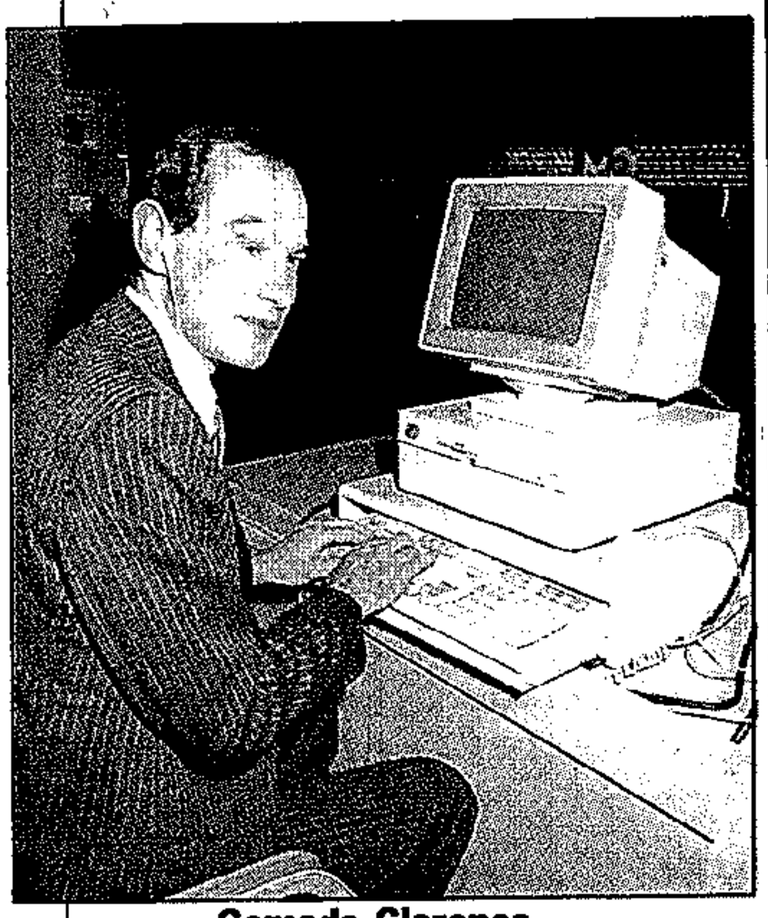
Lectures will be held from 8.30 am to 9 pm today, and a drug awareness workshop will be held from 8.30 am to 11.30 am tomorrow.

DISABILITIES

Fighting back

SA's disabled are battling with "ancient technology", while US companies have a large range of computerised equipment to suit almost any disability. So says a South African who was blinded in the Pretoria bomb blast in 1983.

Neville Clarence was a lecturer in air traffic control theory before he lost his sight. He has spent the past five years researching computer systems for the blind and disabled



Comads Clarence .. helping the disabaled

and is now chairman of a company dedicated to assisting disabled persons in finding precisely the right equipment to fit their needs.

Given a chance and the right technology, blind people are highly employable because they give total dedication to their jobs and their employers, since they are so grateful for the employment, he says.

Hi-tech equipment for the disabled includes braille keyboards; voice synthesisers which read the characters as they are typed, or words or sentences on command; synthesised voice document scanners, which will read in English or Afrikaans; control key pedal adaptations for people with only one arm; and many more special aids for people with different disabilities.

Following the blast which blinded him, Clarence says he found "there was nobody to whom I could turn for information on computer equipment for the blind or partially sighted." Accordingly, he began writing hundreds of letters and in the past five years has gathered information from all over the world. Besides getting himself equipped to live a highly productive life, he has condensed this information to the point where his company, Computer Aid for the Disabled (Comad), can design a system for a person with any disability within a couple of hours.

The US is the greatest source of equipment for the disabled and is also a source of valuable information, he says, as there are about 50 companies there which specialise in systems for disabled people.

Comad now supplies systems tailored to any disability and trains disabled people to use the equipment. Further, it gives information and advice to anyone who needs it.

One piece of equipment which Comad supplies is a voice synthesiser from Germany, which does an adequate job of reading Afrikaans. This system — consisting of computer, synthesiser, keyboard and printer — costs about R4 000. It is interesting to note that there are 10 blind South Africans in senior computer programming positions, thanks to innovations in speech synthesis. Kobus Swart, at the UBS in Johannesburg, is in charge of his department and Garth Long, at Eskom, uses a scanning device which reads documents into a computer. Long can listen to the document over and over again, thus giving it his total concentration and no outside aid is needed for its operation. A text enlarging program is also available and is said to be of exceptional value for the partially sighted.

Clarence believes that the 67 000 blind people in SA should know how their horizons can really open up through computer science. To this end, Comad currently sends a newsletter to about 600 blind and partially sighted people. A quarterly newsletter tape is also sent out, advising the blind on new equipment and its availability.

□ For more information telephone Neville Clarence in Pretoria at (012) 312-2142 or Ian Unite in Johannesburg at (011) 442-9337. ■

Medical scheme tightens screws

Jeff Slome ... reserves the key to stability

MEDICAL aid schemes are getting tough with members who abuse their benefits. Transmed, the SA Transport Services scheme, is leading the way to change.

Transmed is excluded from the Medical Schemes Act, and will introduce a restructured programme at the beginning of April. Other schemes under the Act are striving to achieve a similar system.

Transmed members will have to pay 25% of all consulting fees immediately.

Other schemes are precluded from enforcing this discipline on members because they are registered under the Medical Schemes Act of 1967.

Transmed members will pay 25% of their bill for consultations to doctors, radiologists, pathologists and physiotherapists. Transmed will pay the supplier of the service the remaining 75% directly.

Cancelled

Transmed manager Retha Ross says the scheme was changed to make members aware of the cost of medical services, and to stop them

By Robyn Chalmers

from using them recklessly.

"Too often we have discovered members making too great a use of the service because they are not responsible for the end payment. Similarly, we have found that doctors will 'overservice' a patient, costing us a a great deal of money."

Transmed has cancelled all its contracts with chemists and dispensing doctors. Members will either be allowed to use one of Sats chemists or one of their own choice.

Costs increase

Members using their own chemist will have to pay the full amount of the bill and will be refunded 75% by Transmed. If they use a Sats pharmacy, they will have 25% of the bill deducted from their pay cheque.

"We believe that it is up to the individual member to negotiate with the doctor or chemist for good prices and tariffs. We also believe that they will do so now that it is in their best interests.

"This is a positive move for medical aid schemes in general. I hope that other schemes will be allowed to do the same. We expect objections, but it is a good decision and will work well."

Medical aid schemes throughout SA are moving towards this way of thinking. Medicaid Administrators managing director Jeff Slome says co-payment at the time of service is "a real disincentive to members to contain costs".

The recently released results of the six member schemes of Medicaid showed that 68% of the R125-million paid out in claims in 1987 went on medicines, hospitals and specialists.

This was because of the increased cost of medicines, provincial hospital tariffs and members making excessive use of benefits.

Medicaid also reported surpluses for the six schemes, amounting to more than a month's subscriptions from members. Mr Slome says a surplus is essential to provide stability for a mnedical aid fund.

"For too long SA schemes have held insufficient reserves. As happens from time to time, if there is an unforeseen surge in claims, susbcription rates have to be increased."

299 B/day 23/3/88

5% rule undermines other rebates

Medical aid tax relief loss hurts earners

GOVERNMENT's scrapping of medical aid deductions significantly wipes out the benefits obtained from other concessions, Aiken and Peat partner Pat McGurk says.

In terms of the Budget, contributions for medical-aid schemes will only be tax deductable if they exceed 5% of taxable income.

Commenting on the effect of the scrapping, McGurk said that it "undermines the concessions granted through an increased primary rebate and threshhold level.

"An income-earner of about R80 000 a year will only be better off this year by R490 when compared with last year, despite the increased concessions — because he will lose on the deduction for medical-aid contributions."

McGurk said there was a need for clarity on whether the deduction for contributions in excess of 5% of taxable income was a full deduction — although this might encourage the taxpayer in a borderline case to spend an extra R100 to qualify for the whole deduction.

Discretion

"The scrapping of the deduction could encourage non-contributory medical-aid schemes where the employer bears the full cost of contributions. Discretion would be needed to check the rules permitting this however, so problems relating to fringe-benefits' tax do not arise."

Price Waterhouse partner Chris Frame said the scrapping was a retrogressive step from a social point of view, though the "fiscal

HELEN CHAPPEL

reason" was in line with government's rationalisation policy towards allowances for private expenditure, as compared with those regarding income-generating activity.

"Essentially it would be nice if the money could be diverted to assist the poor and meet their medical expenses in a more direct way. Small sums are more important to the small earner and the relief formerly obtained was more vital to the smaller income group.

Concession

"The 5% concession will only assist the upper-income groups in extraordinary medical expenditure."

Representatives' Association of Medical Schemes (RAMS) executive director Rob Speedie said: "A substantial burden is already falling on employers to contribute to medical-aid schemes — they pay at least rand-for-rand in most schemes, up to R1,50 a R1 in others — and the scrapping of the deduction can only exacerbate the situation.

"It is difficult to quantify the effect but the man-in-the-street will most likely be hardest hit."

Speedie said as prices increased, contributors would more quickly approach the expenditure level of 5% of taxable income, and to this extent "it could be argued the allowance-level is encouraging cost-increases".

HOUSE OF DELEGATES

†Indicates translated version.

For written reply:

299

Own Affairs:

Disability grants cancelled

10. Mr M RAJAB asked the Minister of Health Services and Welfare:

(1) Whether any disability grants administered by his Department in respect of physically disabled, mentally retarded and aged persons were cancelled in (a) 1986 and (b) 1987; if so, (i) how many, and (ii) why, in each case;

(2) whether any such grants have been reinstated since then; if so, (a) how many, and (b) why, in each case?

The MINISTER OF HEALTH SERVICES AND WELFARE:

(1) (a) Yes.

(b) Yes.

(i) 983 in 1986 and 420 in 1987

(ii) The beneficiaries had been assessed medically and not found to be disabled.

(2) (a) 225 in 1986 and 103 in 1987.

(b) Additional medical evidence submitted justified the reinstatement of these disability pensions.

Sites in Lenasia South: construction of houses not yet completed by developers

13. Mr M RAJAB asked the Minister of Housing:

(1) Whether, with reference to his replies to Question No 2 on 3 September 1987 and Question No 91 on 24 September 1987, certain developers have not yet completed constructing homes on the sites allocated to them in Lenasia South; if so, (a)(i) how many and (ii) what are their names and (b)(i) at what price was each of these plots allocated to each such developer and (ii) how many plots were allocated to each;

(2) whether his Department intends instituting claims for damages against any of these developers; if not, why not; if so, against which developers;

(3) whether any properties in other areas have been allocated to these developers; if so, (a) where and (b) how many plots were allocated to each developer;

(4) whether any of these developers will again be considered by his Department when allocating sites for development; if so, why?

The MINISTER OF HOUSING:

(1) Yes.

(a) (i) 2

(ii) Dashanya Residential Development; Bazaria Housing Utility Company.

(b) (i) R18,00 per square metre.

(ii) Dashanya Residential Development: 90.

(ii) Bazaria Housing Utility Company: 100.

(2) This will depend on an acceptable explanation being advanced as to why the contract could not be completed within the stipulated period and whether it is decided to take steps against such defaulting developers or not.

(3) No.

(a) Falls away.

(b) Falls away.

(4) See (2) above.

Transfer of assets of former Department of Community Development

14. Mr M RAJAB asked the Minister of Housing:

(1) Whether any assets of the former Department of Community Development in the form of (a) land, (b) buildings and (c) cash have been transferred to his Department; if so,

(2) (a) on what date or dates, (b) what is the (i) location and (ii) book value of the (aa) land and (bb) buildings and (c) what amount in cash was so transferred?

The MINISTER OF HOUSING:

(1) (a) No.

(b) No.

(c) No.

(2) (a) Falls away.

(b) (i) Falls away.

(ii) (aa) Falls away.

(bb) Falls away.

(c) Falls away.

Construction of schools in Phoenix: criteria for assessing tenders

16. Mr M RAJAB asked the Minister of Housing:

Whether, with reference to the reply of the Minister of Local Government, Housing and Agriculture to Question No 13 on 25 April 1986, the criteria for assessing tenders for the construction of schools in Phoenix still apply; if so, to what extent; if not, why not?

The MINISTER OF HOUSING:

Yes. Fully.

State housing sale campaign: houses sold

24. Mr K CHETTY asked the Minister of Housing:

How many houses were sold by his Department in each province under the State housing sale campaign during the latest specified period of 12 months for which figures are available?

The MINISTER OF HOUSING:

Natal: 13

Transvaal: 27

Cape Province: 0

From 1 February 1987 to 31 January 1988.

The place of hope

Playing the communication game. A pupil at Siswile "listens" intently as Brother Gerard Cox speaks to her.
Photograph by Herbert Mabuza.

R20-m plan to expand school for Soweto's deaf children

By Winnie Graham

Sizwile, the only school for deaf children in Soweto, is to be expanded at a cost of almost R20 million.

Work on the three-year project starts in Dobsonville soon.

Mr Dave Jackson, the school's management consultant, said this week that plans included the building of hostels for both primary and high school pupils, additional classrooms, storerooms, workshops, an arts and crafts centre, a community centre and laboratories.

The diagnostic centre and auditorium alone, he said, would cost more than R1 million. Equipment for this division would cost R180 000.

"The project is geared to create career opportunities for disabled children," Mr Jackson said. "Education starts in the pre-school and will continue all the way through until employment is found for the pupils."

BROTHERS OF CHARITY

The school is administered by a Catholic order, the Brothers of Charity, who, with the Bishop of Johannesburg, the Rt Rev Reg Orsmond, have already met Mr Sam de Beer, the Deputy Minister of Education.

Mr Jackson said the Minister had been "extremely sympathetic" and had commented that there was no doubt the school was needed.

"In projects of this nature the Government is usually committed to meeting certain costs," Mr Jackson noted.

Of the R19,7 million needed, the Government would pay R11,4 million. The rest had to be found by the school. A sum of R94 000 had already been promised by a German group known as the "Children's Mission".

Mr Jackson said the children raised money at Christmas by singing carols in the streets — specifically for needy missions.

MULTI-PURPOSE FACILITIES

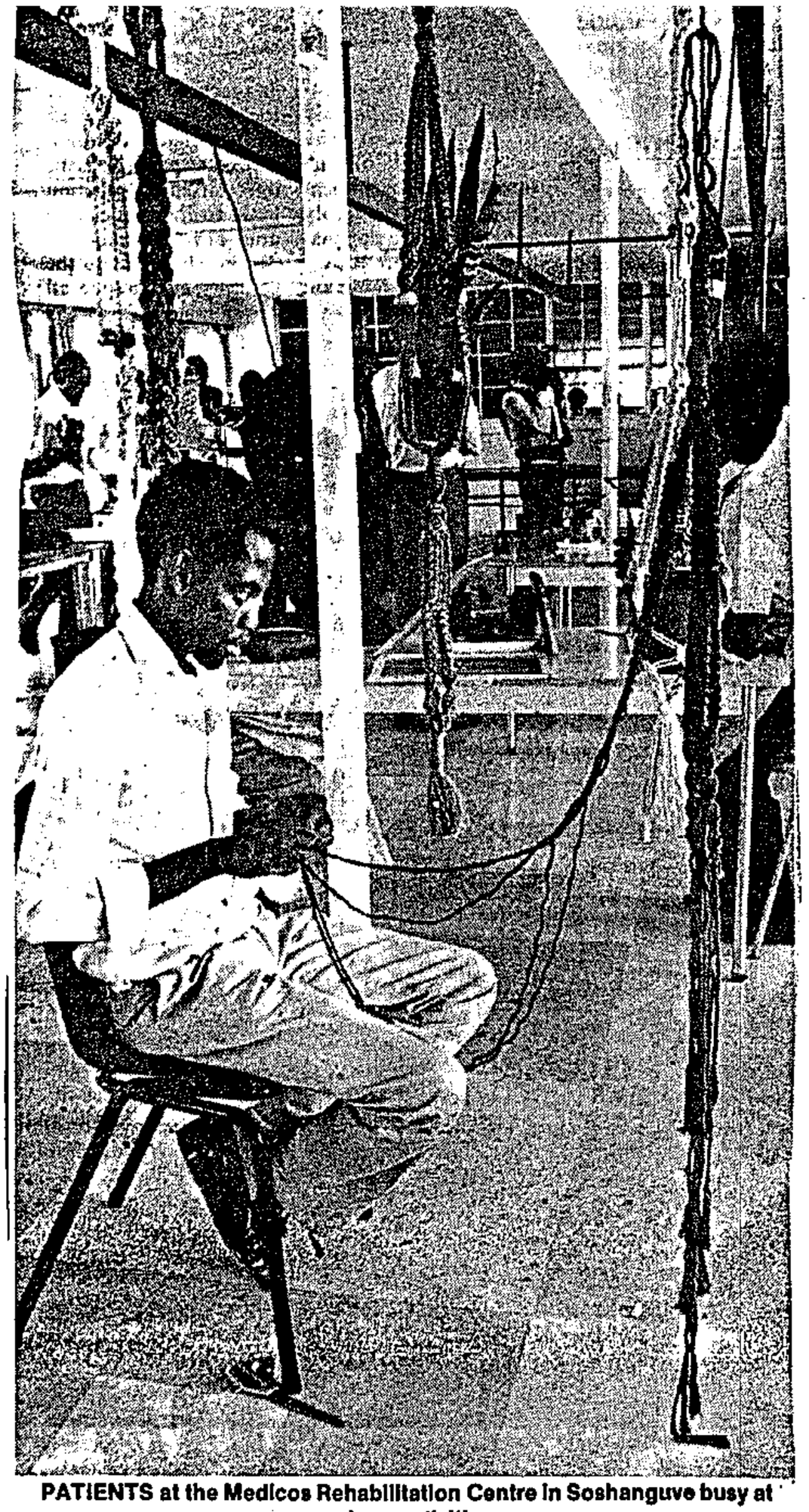
Brother Gerard Cox, the principal of Sizwile, who came to South Africa from Indonesia in 1982 to run the school, said the Dobsonville Council had donated a piece of land 6,5 ha in extent for multi-purpose sports facilities. These facilities would be used not only by disabled people but also by the community.

Brother Cox has arranged for senior pupils to use workshops at the Mezodo Technical Centre until such time as the school's workshops have been built.

He is hopeful that the provision of expanded facilities will open new doors for deaf pupils.

"One in every 1 000 children born is disabled through deafness," he said. "Yet hardly any facilities exist for them.

"Once the school for the deaf has been built, we hope to start a school for the blind on an adjacent piece of land."



PATIENTS at the Medicos Rehabilitation Centre in Soshanguve busy at various activities.

Medunsa casts net wide

Sowetan 24/3/1988 299

By NKOPANE MAKOBANE

TO many people the Medical University of Southern Africa is known as an institution that provides training for black health professionals.

But in the last four years this university has not only trained medical practitioners, dentists and veterinarians, but also to make this training relevant to the needs of the community.

To help achieve these aims, the Medunsa Institute for Community Services (Medicos) was established within the Department of Community Health in the Faculty of Medicine.

This department is responsible for planning training programmes, research and for health services.

The Medicos recently invited the media to its centre in Soshanguve to obtain first hand knowledge of the role it plays in services rendered to the community.

Giving a broad outline of the activities of Medicos and its history, Professor E L Karlsson, Medunsa's vice principal, said since its inception the overriding objective had been to improve the quality of life of those most in need.

He said it had also aimed to co-ordinate, promote and facilitate medical, dental, teaching, research and associated services in the community. He said with limited private sponsorship they obtained to initiate the Medicos programme, this programme had concentrated on two main activities.

The first programme is called the Rural Outreach Programme which involves sending of specialist staff, both medica and dental, on a regular basis into rural hospitals and clinics.

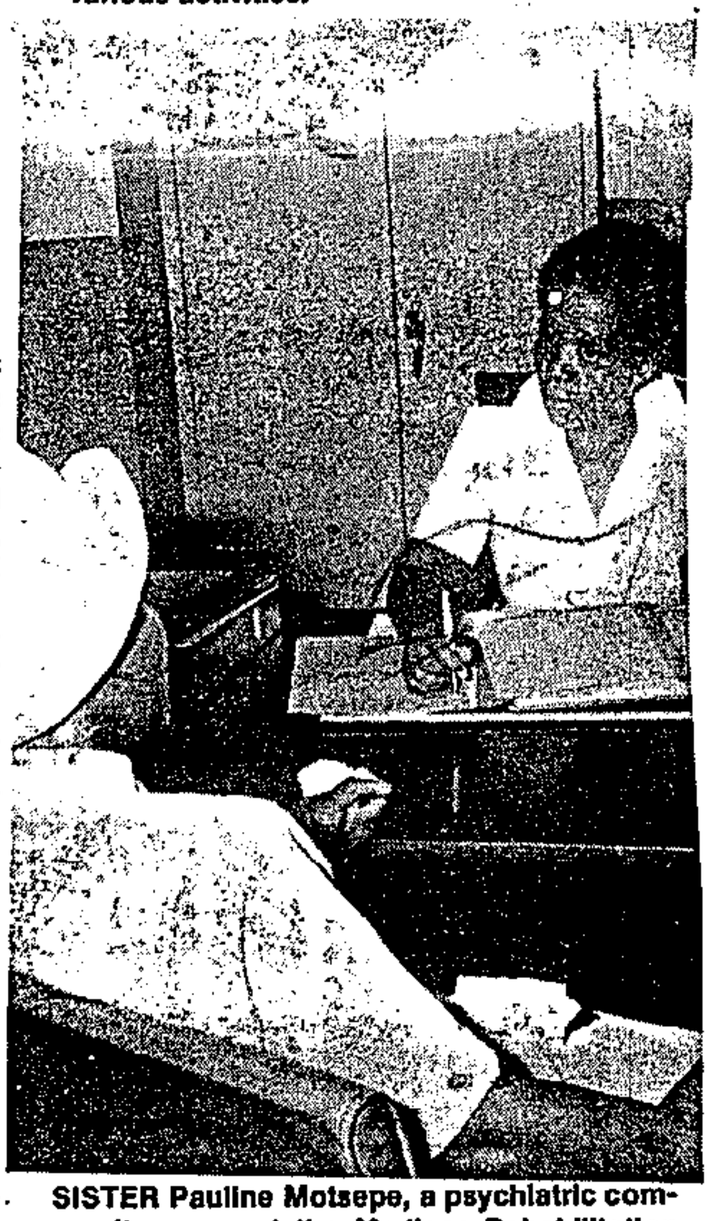
Specialists

"These specialists not only examine, operate and treat patients, but also spend considerable time and effort in teaching sessions with doctors and nurses," Prof Karlsson said.

Among the features of the centre is a large hall where rehabilitation of psychiatric and physically handicapped patients takes place on a day care basis. Services here are rendered by the departments of occupational therapy, physiotherapy, psychiatry and clinical psychology.

There is also a Day-Care Centre for mentally handicapped children which presently houses 40 inmates. Although there is a waiting list of more than 200 children, a sponsorship has been obtained to build two classrooms which would accommodate about 70 children in the near future.

Those who would like to assist the programmes financially are asked to contact Mr C W Berndt, the acting director of Medicos, at (012) 58-2844 Ext 2222.



SISTER Pauline Motsepe, a psychiatric community nurse at the Medicos Rehabilitation Centre in Soshanguve attending to a patient.

It's a war against fags

Sowetan 24/3/88

299

LOCAL authorities and the central government would be petitioned to introduce anti-smoking legislation, Mr Tony Factor, businessman and anti-smoking organiser, said yesterday.

Mr Factor was speaking after a meeting of what he called "people dedicated to the cause of making South Africa a tobacco-free society."

Convened by Prof S A Strauss of the University of South Africa, a meeting of experts representative of societies such as the Medical Association of SA, the Medical Research Council, the Universities of the Witwatersrand and South Africa, the Heart Foundation, the National Council for Health and Smokng, the Brain Research Institute, the SA National Council on Alcoholism and Drug Abuse (Sanca) and various other concerned bodies, reached unanimous agreement to form an alliance of "people who will not rest until South Africa has become a tobacco-free society."

Celebrities

Drafting the support of well-known celebrities from every walk of life — including business, the arts, entertainment and sport — the alliance will be pressing for tough legislation to fight the tobacco industry, including:

- The initial inclusion of a warning of the dangers of smoking in all cigarette advertising and eventually a total ban on any form of advertising;
- Much heavier taxation on smoking — to force the smoker to pay for the heavy costs of smoking to the economy and relieve the non-smoker of the burden to subsidise smokers;
- Pressing local authorities to change existing by-laws and ordinances to outlaw smoking in public and at the workplace;
- Legislation to stop the selling of cigarettes to children and the total banning of vending machines;
- Legislation to introduce compulsory legislation on the dangers of smoking to children in schools; and
- Legislation to have nicotine declared a registered and banned (or illegal) drug.

Mr Factor also reminded the public that April 7 was worldwide No Smoking Day. — Sapa.

Finding by the South African Institute of Race Relations released today

HEALTH CARE FOR BLACKS DECLINING

Sowetan 25/3/88

299

BLACK access to adequate health facilities appeared to be declining in the fourth quarter of 1987, according to the South African Institute of Race Relations' *Social and Economic Update* released today.

Noting that the deputy Minister of Law and Order, Mr Roelf Meyer, had identified housing, education and health as areas which needed upgrading if the "revolutionary onslaught" was to be countered, *Update* reports that this commitment had resulted in efforts to eliminate backlogs in some areas, especially education and housing.

It points out that substantial spending on infrastructure in black areas also continued during the quarter and suggests that this might increase if regional services councils raise loans to fund township development.

But it also points out that these trends are uneven.

"Areas such as electricity — where the Escom plan still awaits implementation — and water enjoy lower priority and in at least one area, health, black access to adequate facilities appears to be declining.

"Spending on infrastructure is also uneven: while substantial sums are being allocated to others and which have been sites of unrest, far less has been allocated to other and less still to rural areas. And even in the areas accorded priority — education and health — there are still major constraints eliminating backlogs".

Dilemma

The publication says that there were also no signs during the quarter under review that unused white health and education facilities were being allocated to blacks.

The need for public health services was outstripping the Government's willingness to fund them. It said that the State President's recent speech at the opening of Parliamen' suggested that the Government regarded its new economic strategy as a way out of this dilemma.

Mr Botha said that money saved or raised through privatisation would be used to fund infrastructure in "developing" areas.

But it was by no means certain that the Government would use its new economic strategy to improve infrastructure and black access to services, the Institute said. The extent to which the Government did so would be a gauge of its commitment to removing racial backlogs.

Solution

In its detailed examination of health services, *Update* quotes official spokesmen as saying that while they are committed to improved black health services, they cannot improve existing facilities because funds are not available.

It also quotes a health researcher who says that black patients find it difficult to obtain public transport to health care facilities during working hours.

Turning to the desegregation of public hospitals, the publication reported that of the 17 unutilised wards at Johannesburg Hospital, three were being converted into accommodation for trainees at white nursing colleges and the rest were not being used due to "staff shortage and lack of funds" according to the Minister of National Health and Population Development, Dr Willie van Niekerk.

The Institute said pressure on the Government to improve black access to health care was bound to grow as private health care was likely to remain out of reach of most black people.

While the Government was looking increasingly at the privatisation of hospitals as a solution to the problems confronting it, the attempt to reduce the state's responsibility for health care was eliciting fierce opposition from doctors and critics.

They charged that the public health service was deteriorating sharply and was increasingly out of reach of low income earners.

The Institute also noted that the portion of the gross national product spent on health care was higher than the minimum figure suggested by the World Health Organisation. Nevertheless, access to health care appeared to be decreasing in the light of higher tariffs in state hospitals and persistent overcrowding.

"This suggests that a disproportionate part of the funding is still being allocated to facilities for higher income white patients — as evidenced by racial disparities in spending on hospitals — and on medicine appropriate to them".

Social and Economic Update is available from the Publications Department of the South African Institute of Race Relations, P O Box 31044, 2017 Braamfontein, at R8,43 inclusive, (R6,50 cover price, plus 78c GST, plus R1,15 postage and packing).

118

Dread disease benefits combat soaring health costs

Modern medicine has revolutionised the treatment of many illnesses — at a cost. The amounts now spent on sophisticated and sometimes lengthy treatments are often far higher than medical aid benefits.

Western society still has its health scourges such as heart attacks and cancer. Treating these illnesses requires the use of the latest technology. While it is often effective, it can be frighteningly expensive.

Treatment following a coronorary thrombosis, for example, if it involves bypass surgery, can cost tens of thousands of rands. This could impose an intolerable financial burden on the person having the treatment and the family.

Until recently, people had to make whatever arrangement they could to pay these medical bills. Medical aid schemes usually pay only part of these amounts, leaving the patient to find the balance.

In addition, money is needed both to meet the costs of recuperation and to help adjust to a new and possibly less active lifestyle.

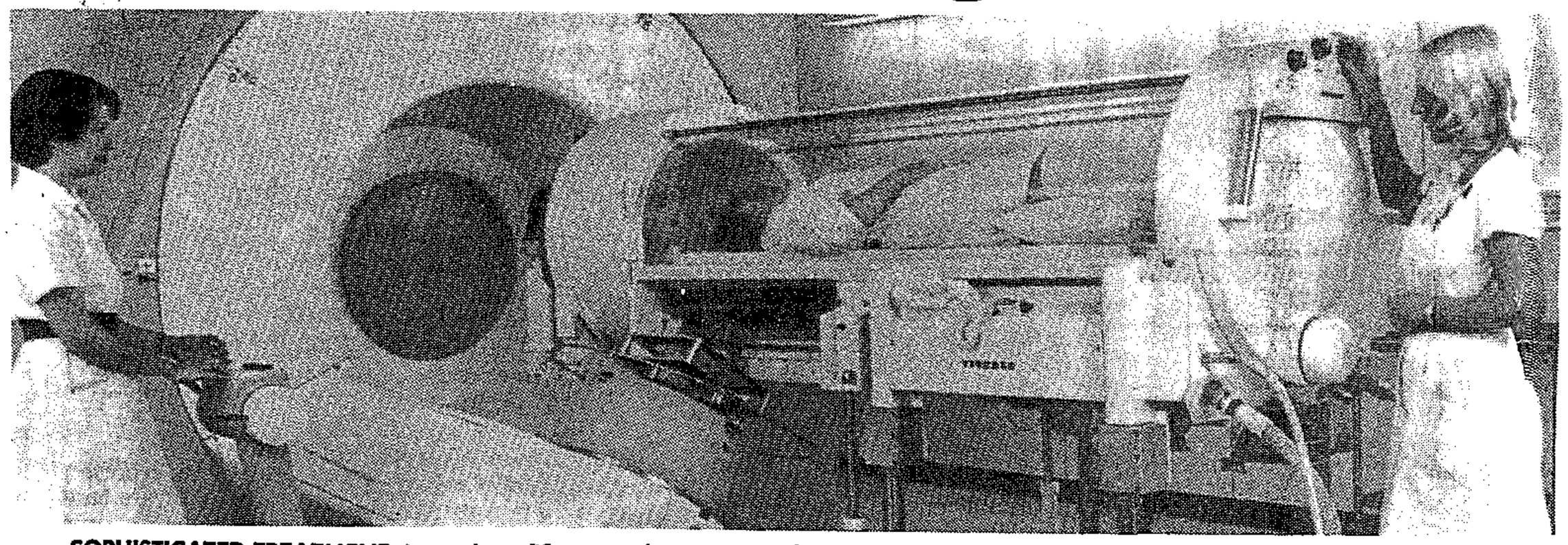
Through an important extension to their range of products, several life assurers have introduced a dread disease benefit.

The benefit provides for the payment of a lump sum should the policyholders suffer from a specified dread disease.

While the diseases covered by various assurers may differ, those most usually covered are cancer, stroke, heart attack, kidney failure, coronary artery surgery, major organ transplant, blindness and paraliegia.

Through such a policy, the anticipated medical costs can be covered, even if they are as high as R50 000 and more.

By Michael Belling, general manager, marketing communication, at Sage Life



SOPHISTICATED TREATMENT: it can be a life-saver, but at a crippling financial cost. Now a new insurance benefit offers a solution.

The full amount of the benefit is paid immediately the dread disease, as defined, is diagnosed.

The benefit is usually linked to a life policy, providing both death and dread disease cover.

There is a limit to the amount of cover that may be obtained, but the available cover should suffice to pay for almost all anticipated treatment.

This limitation is logical as it is unlikely that the medical care would cost more than R40 000 to R50 000 at most.

The type of life policy to which dread disease benefits may be attached varies among the assurers.

Some companies only attach them to term policies.

Others offer the facility of these benefits with other policies, such as universal life, so that the cover under the basic policy and the dread disease benefit can increase from year to year to counteract the effects of inflation.

Some companies also make dread disease benefits available for group funds, such as pension or provident funds.

They may be added to these funds as an extra benefit.

The importance of dread disease cover is evident from medical statistics which show that each year more than 50 000 people in South Africa suffer a heart attack and 80 percent survive their first attack.

More than 60 000 people a year are stricken with cancer — many of them live for many years afterwards and some are cured.

The new benefit is a valuable addition to the range of disability insurance.

It adds to the "living assurance" products, broadening the scope of benefits offered before death and helping to meet the needs of the public more effectively.

It adds a new dimension to life and disability policies.

Previously they paid out on death or permanent disablement. Dread disease cover pays out even if you recover.

Hungry line up for food

Soup relief for Cathcart's poor

by DAVE MARRS

EAST LONDON — More than 850 residents of the Cathcart township were fed on the first day of a soup kitchen sponsored by Operation Hunger this week.

The Operation Hunger regional director, Mrs Linda Murray, said the Cathcart Residents' Association (Cara) had approached her to provide soup as a result of the high level of unemployment in the area.

She said she had been "appalled to see the state of some of the children due to malnutrition".

"I just hope that the soup that is being provided will make a difference. Some of the children were showing typical symptoms of malnourishment, including reddish-coloured and thinning hair."

A Cara spokesman, Mr Kenneth Sigidi, said although many of the 10 000 residents of the poorly-serviced township were qualified in a profession, there were no jobs available in Cathcart and people were desperately poor.

Old and disabled people had no source of income and were forced to wear tattered clothing and borrow blankets to keep warm at night.

"Only 350 people living in Cathcart have work, while experienced teachers, nurses and mechanics are unemployed," he said.

Many of them had been waiting for over a year for their unemployment insurance cards in order to receive compensation, while others had given up in disgust.

Mr Sigidi added that residents had requested that Operation Hunger introduce its self-help schemes and provide seed for home gardens.

The schemes include beadwork, knitting, brick making, fence making and sewing, and products are sold to provide a limited income.

Mrs Murray said her organisation hoped to work closely with the Cathcart community, as well as continuing its feeding schemes in Cathcart schools, where more than 1 000 children were fed daily.

Mr Sigidi appealed to businessmen and authorities in Cathcart to make available any covered premises that could be used in the self-help schemes.

● Allegations of indirect pressure being applied on Cathcart's "Old Township" residents to move to the new Katikati village further out of town, have been renewed after several families, whose homes were damaged during recent heavy rains, were housed in tents by the local authority.

Residents say they were promised homes in the new township if they left their leaking mud houses, but have not had any response from the town committee to requests for new housing.

MRS MURRAY . . . appalling

A spokesman for the Katikati town committee could not be contacted for comment yesterday, although the committee has consistently denied that residents are being forced to move.

The Supreme Court in Grahamstown recently ordered the Katikati town committee to re-erect the home of an elderly woman who was left homeless when her house was demolished.

The order came after an urgent application, brought by Mrs Eunice Nomakula Pupa against the committee, was upheld by the judge.

Other residents have accused the town committee of withdrawing virtually all services to the old township and preventing any further development there, in an attempt to force people to move without having to evict them.

They say despite the superficial attraction of Katikati, there are good reasons why people do not wish to move.

These include the close and supportive spirit within the old community that would be destroyed if they had to move, the price of houses in Katikati being higher than they can afford, the distance of the new township from the commercial centre and the lack of churches or clinic facilities in the new town.

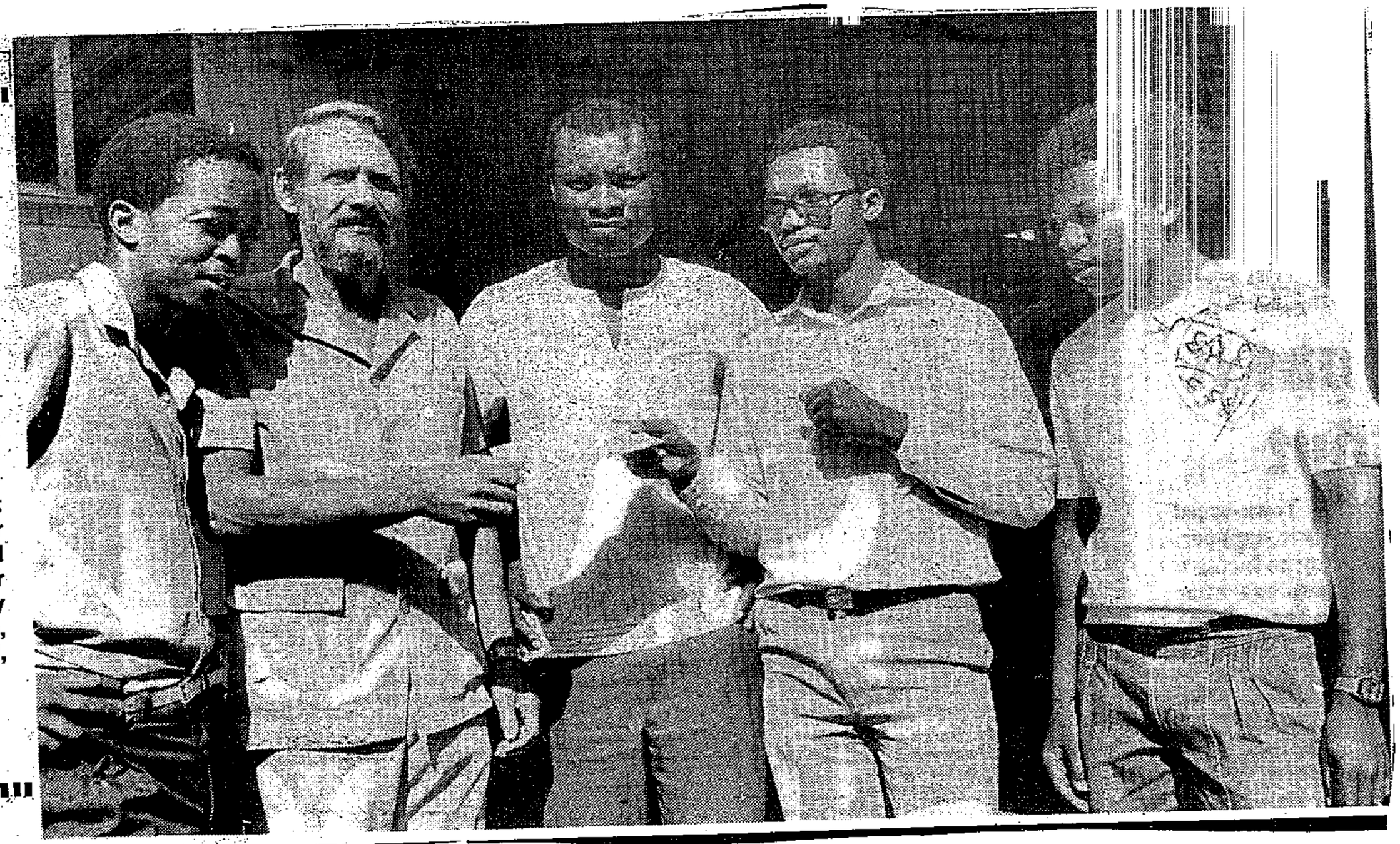
Mr Sigidi said Cara did not bar the way of those residents who wanted to go to the new township, but was against people being "forced to destroy what they built years ago and having to start afresh at a cost they cannot afford".

Sowetan 7/9/88

299

Youth club to the rescue

ISIBONELO Youth Club which operates from the Ipelegeng Community Centre in White City Jabavu, Soweto, is one of two black organisations which rallied to the plight of 11 pupils of the J C Merkin School for the Physically Disabled in Soweto when they desperately needed funds to go and take part in games of the disabled in Stellenbosch. Mr Danny Schoeman, the principal of the school (second from left), receives a cheque for R465,30 from club members (from left), Danny Kekana, the club's PRO, Mr Nema Tshabalala, a teacher at the school, Sipho Ngubeni, chairman and Mr Lekgoro, the treasurer.



Mrs Miriam Buchalter presents the principal of the Bethelsdorp Training College with a Cripple Care accessibility symbol. With them is Mr Wellington Williams, a paraplegic student.

Disabled man beats handicap

9108148

by JUDY SPARG

EAST LONDON — Life took a twist for Mr Wellington Williams of Parkside when a stab wound transformed him from an active youth to a wheelchair-bound paraplegic.

The human spirit is adaptable, however, and Wellington, 22, was determined to transcend physical and psychological barriers and carve out a new life for himself.

"I decided to look on the bright side, and to set an example to other disabled folk," he said.

That was four years ago, and Wellington took a big step towards independence when he enrolled as a full-time commercial student at the Bethelsdorp Training College, East London, earlier this year.

"It's opened up a whole new world for me, as I will stand a far better chance of becoming self-supporting when I qualify," he said.

299

"The N1 course will equip me for a clerical position, and the syllabus includes office practice, typing, commerce and accountancy.

"Full-time study seemed an impossible dream until Cripple Care and Bethelsdorp Training College helped me overcome practical problems such as transport, accessibility to the building, and social adjustment.

"The college had no wheelchair ramps when I enrolled, but they built four ramps at the request of Cripple Care.

"They were so open and welcoming, and have even adjusted their timetable to enable me to attend certain classes," he said.

A Cripple Care social worker, Mrs Miriam Buchalter, praised college staff and said she was "delighted with Wellington's progress".

"It is good to see him so happy and motivated, as he has been through a difficult time," she said.

"He was in and out of hospital for years after his accident, and was obliged to move in with his mother as he could no longer hold down a job.

"He tried to do a correspondence course at one stage, but he was in hospital so often that it did not work. He also struggled with isolation, and he was unable to visit the Parkside library as it was inaccessible to wheelchairs.

"Wellington's story illustrates how important it is for public buildings and amenities to be physically accessible to the disabled.

"Cripple Care has presented Bethelsdorp Training College with a symbol of accessibility in recognition of their efforts to open their premises to Wellington.

"They have literally opened the doors of learning to Wellington and others who may attend the college in future," she said.

"I would like to thank the principal, Mr Barry de Swardt, for encouraging Wellington to prepare himself for a clerical position, thereby assisting in his total rehabilitation.

"We are very grateful for his wholehearted co-operation in removing physical and psychological barriers, and making it possible for Wellington to attend the course.

"We have also launched a three year accessibility project as part of our Easter Stamp Campaign to educate the public," she said.

in health arena

D/D 19/4/88 (299)

Hope for more government control

CAPE TOWN — South Africa's welfare administration is to be restructured in order to strengthened the relationship between the government and the private welfare sector.

This was announced by the Minister of Health, Dr Willie van Niekerk, at a press conference yesterday.

He also said that the government would shortly release a policy document containing important directives on social welfare policy and structures.

The document would describe the responsibility of the state, the principles, aims and objectives of welfare delivery and the status of voluntary welfare organisations.

It would also emphasise that the government assumed responsibility for the prevention of social or physical suffering among its citizens and give special recognition to the role and functions of voluntary welfare organisations.

A national welfare policy council would be set up as part of a mechanism in which the two sectors could deal with social welfare policy.

The private sector would be able to participate in welfare through local committees, the existing regional boards, new advisory boards and a modified South African Welfare Council, which would communicate with the policy council.

The privatisation of welfare services had been referred to the inter-departmental consultative committee on welfare matters for further investigation, Dr Van Niekerk said.

"Although I am of the opinion that welfare service in its present form is already fully privatised, it may be necessary to establish a clearer definition of the various roles and functions of the private and public sectors."

The cabinet had instructed the Welfare Council to organise a national welfare conference as soon as possible, he said.

Further details of the new structure and policy would be announced by the three own affairs ministers in their budget debates.

Dr Van Niekerk added that the cabinet had approved a national plan to combat and control drug and alcohol abuse.

The plan would promote an "education for life" programme in schools and among young people, co-ordinate the prevention and treatment of alcohol and drug dependency, and would help collect and publicise information.

A sub-committee of the Department of Health had been appointed and the cabinet had decided that health departments should give the implementation of the plan priority.

Dr Van Niekerk said the loss of productivity as a result of alcohol abuse was reckoned at R530 million a year.

With the related costs of alcoholism in terms of health, motor accidents, violence, crime and social programmes to combat alcoholism, the total cost of alcoholism was R1,1 billion in 1985.

He added that there was wordwide agreement that dagga had greater addictive properties than alcohol and that it posed greater health hazards than any legal drug.

DR VAN NIEKERK

Meanwhile a call for Aids carriers to be isolated from the community was made yesterday.

This follows an admission by a Durban prostitute that she was still plying her trade a year after she admitted having the disease.

The call was made by Progressive Federal Party health spokesman, Dr Marius Barnard.

Dr Barnard also criticised the Department of Health for not taking adequate steps to prevent the potential spread of the disease.

Dr Van Niekerk said yesterday that the woman had been tested again and had been shown to be 'negative'.

However, he added that further tests were now being conducted to establish whether she really had Aids or not.

When it was disclosed last year that the self-confessed prostitute, Miss Sharmaine van Loggerenberg, had Aids, Dr Van Niekerk said attempts would be made to rehabilitate her.

However, newspaper reports at the weekend disclosed that she was still in business.

Dr Barnard said the government would urgently have to do three things to stop the spread of Aids:

- Overhaul the present inadequate regulations;
- Make Aids a notifiable disease, and;
- Isolate Aids carriers in the same way tuberculosis carriers are isolated.

Dr Barnard said the case of Miss Van Loggerenberg was proof that current measures were not working.

"New mechanisms are urgently required. She cannot be locked away but some means of isolation must be found," he said.

- Durban's Medical Officer of Health, Dr Muriel Richter, said yesterday that a new list of notifiable diseases was being discussed by the government, and health authorities were hoping that Aids would be one of them.

As Aids was not a notifiable disease, little could be done to control carriers, she said.

"I would appeal to all those who have the disease not to spread it."

- A foreign seaman at the weekend told Durban police of his horror at being told by a woman with whom he had sex on board his ship that she had Aids.— Sapa

School

(279)

Sowetan 21/4/88

THE Red Cross is to open a school for mentally retarded children in Evaton and has invited parents to register them today and tomorrow.

A spokesman for Red Cross, Mr Peter Mahlatsi, said the parents could apply at the Red Cross Centre, next to the Santa Clinic, in Evaton, between 9am and 1pm.

Volunteers are needed to work for disabled

The Transvaal Association for the Physically Disabled has appealed to the public to become involved in a planned volunteer programme to extend its social work services.

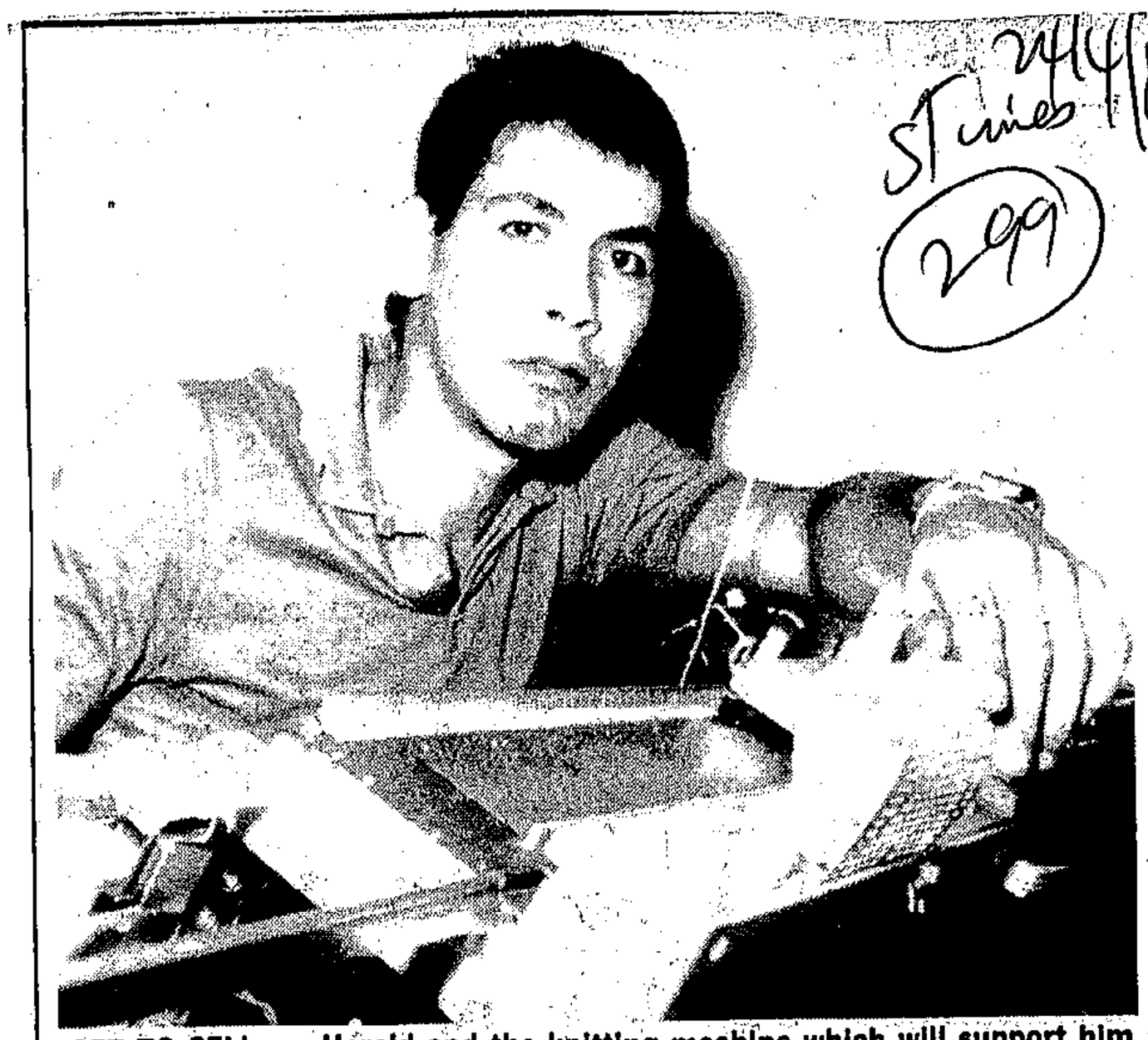
Volunteer work ranges from direct contact with clients, such as taking them on outings, supportive casework, sporadic transporting and shopping, to indirect contact, such as street collections, fund-raising and occasional clerical or committee work.

Suitable applicants will attend a nine-week training course, beginning in August, to orientate them to the organisation and the field of physical disability.

The course will involve increased self-awareness, knowledge and skills in this specialised field.

For information telephone social workers Bertha Cohen or Chareen Grobler (011) 646-8331.

ST Times 24/4/88
299



SET TO SELL ... Harold and the knitting machine which will support him

Harold goes plain and purl

A PARAPLEGIC whose salary has been cut by more than half because of his disablity has resigned from his job to make jerseys for an income.

"My self-worth has been undermined and I am prepared to take a chance rather than earn just R600 a month," Mr Harold Nicholson, 25, of Durban, said this week.

Mr Nicholson, who joined the South African Transport Services in 1981 and was earning about R21 000 a year until a car accident confined him to a wheelchair, is not a bitter man.

"These things happen, I

By TERRY VAN DER WALT

have got used to my disablity," he said at his mother's modest Greyville home where he stays with her and his two brothers.

He returned to work in April last year and was found a job in a plant hire centre.

He continued to get his artisan salary until January this year, when he was officially appointed as a tradehand with a salary of R600.

"I was quite prepared to take the cut, which worked out at about R400, but when they put me on the new salary scale, it was just not acceptable," Mr Nicholson said.

Mr Nicholson handed in his resignation at the end of March and will stop work at the end of this month.

He has made plans for making a living by selling jerseys he is to make on his mother's knitting machine.

"It has been sitting here unused, so I thought 'why not make money from it'.

"My sister is doing a fashion design course in Johannesburg and I am going to ask her to give me some ideas," he says enthusiastically.

Big lack of mental facilities

A mentally ill black child has to wait five years before being admitted to an institution because of a lack of facilities, Dr Cliff Allwood, senior psychiatrist at Baragwanath Hospital and the department of psychiatry at the University of the Witwatersrand, has said.

Dr Allwood was interviewed by the assistant director of the South African Institute of Race Relations for an article published in the latest edition of *SAIRR News*.

He said facilities for mentally ill blacks lagged far behind the provision of other medical facilities.

INADEQUATE

In Soweto, the facilities for mentally ill people were not yet adequate, and there was an overwhelming need for facilities to care for low-functioning mentally handicapped children.

"As it stands at present, there is a five-year waiting list for any child that we may need to place and there's just nothing that one can do to help these unfortunate families when urgent problems arise."

Santa condemns delay in issue of grants

299

PORT ELIZABETH — Some tuberculosis patients had to wait for more than a year before applications for disability grants were processed by the Department of Home Affairs.

This was revealed at the Eastern Cape regional Santa conference which took place in Port Alfred yesterday.

Santa's Port Elizabeth publicity chairman, Mrs A. Ossher, said the delays in processing the applications were "shockingly bad" causing much hardship for the families.

The national director of community education, Dr Theo Collins, told the conference that the matter had come before Santa's medical committee in July last year.

He said he had written to the person concerned with the matter in the Department of Home Affairs, in care of the Director General.

"However, I received no reply. Two months ago, I sent a copy of the letter under cover of another letter to the Director General himself. I have still had no reply," he said.

Dr Collins said the medical commitee would meet again soon and preparations would be made to send a letter to the Minister of Home Affairs.

"And if we get no reply this time, we will write to the State President himself," he said. — DDC

The MINISTER OF LAW AND ORDER:

See reply to Question No 774 on 26 April 1988 (col 1183).

Post of private secretary: restrictions in regard to period of service

783. Mr C J DERBY-LEWIS asked the Minister of Defence:

Whether the appointment of persons to the post of private secretary in the South African Defence Force is subject to any restrictions in regard to period of service; if so, what are the relevant details; if not, (a) what procedure is followed in (i) assessing such officials for promotion purposes and (ii) granting them promotion and (b) what are their prospects for promotion?

The MINISTER OF DEFENCE:

See reply to Question No 774 on 26 April 1988 (col 1183).

Post of private secretary: restrictions in regard to period of service

784. Mr C J DERBY-LEWIS asked the Minister of National Health and Population Development:

Whether the appointment of persons to the post of private secretary in his Department is subject to any restrictions in regard to period of service; if so, what are the relevant details; if not, (a) what procedure is followed in (i) assessing such officials for promotion purposes and (ii) granting them promotion and (b) what are their prospects for promotion?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

See reply to Question No 774 on 26 April 1988 (col 1183).

Transfer of local government functions

890. Mr M J ELLIS asked the Minister in the State President's Office entrusted with Administration and Broadcasting Services:

(1) Whether, with reference to the reply of the Minister of Education and Culture to Question No 58 on 14 August 1987, the transfer of local management functions has been concluded; if not, (a) why not and (b) when is it anticipated that it will be completed; if so,

(2) whether the identification and functioning of provincial public libraries have been finalized; if not, why not; if so, (a) which provincial public libraries have been identified as White own affairs, (b) why have they been so identified (c) when were they transferred to his Department and (d) who took the decision in this regard;

(3) who will be responsible for (a) ordering and (b) buying books for such libraries?

The MINISTER FOR ADMINISTRATION AND PRIVATISATION:

(1) No.

(a) The investigation is extensive and complicated.

(b) As soon as the investigation has been completed and the procedural requirements of the Constitutional Act, 1983 (Act 110 of 1983) for the transfer of functions have been complied with.

(2) Provincial administrations do not have provincial public libraries. Provincial administration do, however, provide professional support and supply stocks of books to libraries of local authorities. The Cabinet has decided that the afore-mentioned service should be continued by the provincial administrations as a general affair and that the own affairs administrations may decide whether they want to continue utilising the service and to what extent. A library of a local authority may, depending on its clientele group, be an own affair for that group.

(a), (b), (c) and (d) Fall away.

(3) Falls away.

Privatization of hospitals/health facilities

897. Dr M S BARNARD asked the Minister in the State President's Office entrusted with Administration and Broadcasting Services:

(1) Whether it is the intention to privatize in the current year any hospitals or other health facilities falling under the provincial administrations; if so, (a) how many and (b) which (i) hospitals and (ii) other health facilities;

(2) whether he will make a statement on the matter?

The MINISTER FOR ADMINISTRATION AND PRIVATISATION:

To questions No. 897, 898 and 899.

(1) Privatisation possibilities in respect of hospitals and other health services can only be determined after the investigation in this regard, with which Dr W J de Villiers is still busy, has been completed and his recommendations have been considered by the Committee of Ministers on Privatisation and Deregulation.

(a), (b)(i) and (ii) Fall away.

(2) No.

Privatization of hospitals/health facilities

898. Dr M S BARNARD asked the Minister in the State President's Office entrusted with Administration and Broadcasting Services:

(1) Whether it is the intention to privatize in the current year any hospitals or other health facilities falling under the Department of Health Services and Welfare of the House of Assembly; if so, (a) how many and (b) which (i) hospitals and (ii) other health facilities;

(2) whether he will make a statement on the matter?

The MINISTER FOR ADMINISTRATION AND PRIVATISATION:

See reply to Question No 897 on 26 April 1988 (col 1188).

Privatization of hospitals/health facilities

899. Dr M S BARNARD asked the Minister in the State President's Office entrusted with Administration and Broadcasting Services:

(1) Whether it is the intention to privatize in the current year any hospitals or other health facilities falling under the Department of National Health and Population Development; if so, (a) how many and (b) which (i) hospitals and (ii) other health facilities;

(2) whether he will make a statement on the matter?

The MINISTER FOR ADMINISTRATION AND PRIVATISATION:

See reply to Question No 897 on 26 April 1988 (col 1188).

Employees: extra employment/own businesses

905. Mr C J DERBY-LEWIS asked the State President:

(1) Whether employees in his Office are permitted to (a) take on extra employment and (b) participate in any type of business of their own; if so,

(2) whether this permission is granted subject to any conditions; if so, what conditions?

The STATE PRESIDENT:

See reply to Question No 906 on 26 April 1988 (col 1190).

Employees: extra employment/own businesses

906. Mr C J DERBY-LEWIS asked the Minister in the State President's Office entrusted with Administration and Broadcasting Services:

(1) Whether employees in his Department are permitted to (a) take on extra employment and (b) participate in any type of business of their own; if so,

(2) whether this permission is granted subject to any conditions; if so, what conditions?

The MINISTER FOR ADMINISTRATION AND PRIVATISATION:

To question 906, as well as on behalf of the Ministers concerned to the similarly phrased questions concerning General Affairs Nos. 905, 907, 908, 909, 910, 911, 912, 913, 914, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 928 and 929 and concerning own Affairs Nos. 108, 109, 110, 111, 112 and 113.

(1) (a) and (b) Individual officers and employees as well as members of the Services Departments may, in terms of the statutory provisions applicable to them, ask for permission to do additional work or to participate in any business undertaking of their own, other than their work in the Public Service Departments. Such applications are considered by the Minister of the department concerned or his delegate in the Department.

Home has desperate need (299) for funds

By Janine Simon

Star 27/4/88

Woodside Sanctuary, a home for profoundly mentally handicapped children, will have to close in March 1989 if its financial position does not improve drastically, says the manager, Mr Danie de Villiers.

The home, in Auckland Park, Johannesburg, provides 24-hour care for about 80 children handicapped by congenital defects during birth, in road accidents or by a spread of factors — such as revival after a swimming accident — which caused severe brain damage.

"Fund-raising and parent contributions have not kept pace with running costs, forcing us to dip into our invested capital. As a result it dropped from R891 000 in November 1985 to R320 000 in February 1988," Mr de Villiers says.

"If the trend continues we will have to close in March 1989, or at best, in January 1990."

The sanctuary, which opened in 1955, has a waiting list of more than 60 but it cannot accommodate them because it has no funds to furnish its new wing.

SMALL GRANT

Besides its commitment to taking in new admissions from all race groups, irrespective of financial status, Woodside has also to care for young adults who survived the rigours of a handicapped childhood.

Monthly costs per child are R760, subsidised in most cases by a small Government grant and parental contributions averaging about R72 of the R200 they are requested to pay, Mr de Villiers says.

Woodside's estimated costs for the year ending March 1988 are R800 000 and the estimated shortfall about R245 000.

New appeals have been made to parents, companies and the public for clothes, furniture and funds.

Anyone able to help should contact Mr de Villiers at (011) 726-7318/9 or Mrs Audrey Haselum at (011) 726-2912.

Flu vaccination plan: employers attempt to reduce staff illnesses

D1 D 27/4/88

299

Daily Dispatch Correspondent

JOHANNESBURG — Businesses around South Africa are attempting to prevent man-days lost through winter illnesses by having their staff vaccinated on the premises against three strains of the influenza virus.

The manager of Mediclin, Mr David Crockart, said thousands of employees have been, or are to be vaccinated against the three strains — commonly known as A-Taiwan or Singapore, Leningrad and Ann Anabor — through their various mobile vaccination teams.

The vaccination is effective from two weeks after it is given and lasts up to one year. The vaccination comprises elements of the virus which allows the body to build up an immunity.

Mediclin's demand this year has been far greater than last year, said Mr Crockart. He added the vaccination should not be given to very young children, pregnant women, those with an allergy to eggs and anyone with a cold.

Professor Barry Schoub of the National Institute for Virology said people suffering from "flu" were not necessarily suffering from the influenza virus.

He said the virus changed every two to three years and while there were similarities, there were also important differences.

The Department of National Health said in December that the only influenza viral strain isolated in 1987 was A-Taiwan.

● Flu is also taking a heavy toll of runners preparing for the Comrades Marathon.

One Durban doctor has treated 15 cases in the last week. He and other sports medicine experts renewed their warning to runners not to continue training while they have flu.

A record number of 12 073 entries have been received for the May 31 event and the final total could reach 12 200.

The Durban doctor, who cannot be named for professional reasons, said flu was hitting runners harder than usual this week.

He had treated about 15 Comrades runners with severe flu in the past 10 days.

"This is the time when flu strikes hardest — when runners put in an increased mileage at an increased rate.

"In order to lose weight to improve their performances, they eat less and they eat protein as opposed to carbohydrate.

"The carbohydrate gives you energy — so they are eating food that doesn't have the ability to produce energy at a time when they are expending more energy and that makes them more liable to infections of any sort.

Medical aid for accident injured urged

Star
27/4/88
(299)

Medical Reporter

Legislation on motor vehicle accidents should be amended so that medical aid schemes are compelled to cover their members for injuries, says Dr Nic Lee, editor of *The South African Medical Journal*.

In an editorial in the latest edition, Dr Lee says accident victims covered by medical aid may well be under the impression that if they are injured in an accident they can send the accounts to the medical aid society.

"If they do they are in for a nasty shock since, according to the Medical Schemes Act, medical aid societies are not liable for any medical costs incurred in an accident unless the claim has already been repudiated by the third-party insurer involved."

In fact, says Dr Lee, under present legislation, even if a scheme is prepared to pay the medical costs of an accident victim it cannot do so since only providers of services, such as hospitals and doctors, can claim directly from a third-party insurer.

"The question of who pays for the medical care of an accident victim has now become urgent because of the proliferation of private hospitals, most of which refuse to admit accident patients unless they agree to be responsible for their own accounts."

Dr Lee says the solution is simple.

He feels legislation should be amended so that medical aid schemes will be compelled to cover their members.

MEDICAL AIDS

Healthy attitudes

Government has indicated its willingness to accept a more flexible medical aid system.

Medical aid societies and pharmaceutical manufacturers alike favour plans to move away from all-encompassing cover and towards an insurance-style system allowing members a choice.

A recent Government Gazette suggested "a registered medical scheme may determine a scale of membership fees in accordance with the extent of the cover afforded to the member."

A weakness of the present system is that many payouts are for non-essential, "pocket money" items that could be paid by the patient. These bills drain society funds and limit money available for major medical costs.

Adcock Ingram MD Don Bodley sees the moves to offer a choice as essential. "If medical aid was treated like any other kind of insurance, people would get what they paid for. For example, instead of first rand cover, other benefits — including catastrophic cover and not much else — might be available."

He says such choice would lead to greater awareness of medical costs and, in the long-run, to savings. However, other savings are needed. Private hospital fees are a favourite target for critics of health costs.

Clinic Holdings MD Barney Hurwitz says the cost of health care has not increased disproportionately. "For example, an appendectomy used to entail a 10-day stay in hospital but now means three days. As constant care and attention is provided, our charges compare favourably with hotels."

He argues that the medical aid system itself leads to inefficiency. "There are more than 250 medical aids in this country, compared to three or four in most other industrialised nations. There is little economy of scale."

SA's pharmaceutical manufacturers aren't prepared to cut medicine costs if it means a dilution of research. Says Noristan MD Hugo Snyckers: "We must do our own research so that multinationals can cross-fertilise with us rather than treat us as franchisees for their products."

The health care industry is holding fire on government's plan to end tax deductibility on most medical aids. Representative Association of Medical Schemes executive director Rob Speedie says it will make people realise that health care isn't a free ride and that it is, effectively, a redistribution of wealth away from the well-off. ■

Deaf people face more than silence

Star 29/4/88 249

BREAKING BARRIERS: Dr Robert Simmons makes a point to teacher of the deaf, Mrs Claude Goddard.

By Marika Sboros
Options Editor

Living in an eerily silent world is not the only obstacle facing people who are deaf — the treatment meted out to them by those blessed with the sense of hearing can be just as distressing.

People shout or pull hideous faces when confronted with a person who is deaf, or they walk away in embarrassment, leaving that person feeling unutterably lonely, alienated, rebuffed.

Deaf people are often dismissed as stupid because of the difficulty they may have in making articulate sounds.

But Dr Robert Simmons of Johannesburg is a shining example of how really perfectly normal (and in his case brilliant) such people are.

He has a doctorate in medical science, neuroanatomy and microbiology and lectures in these departments at the University of the Witwatersrand's Medical School.

Visual aids

He makes use of teaching and visual aids and writing on the blackboard; his lectures are always typed out in full for students who have difficulty understanding him.

Soon he will give a specialist course in neurology, with small classes of up to 10 people.

He just wants to be treated like an ordinary person, he says, "because I am".

To say things have not been easy for him is an understatement. But thanks to support from a man of vision and tolerance, Dr Simmons has been allowed to break personal and societal barriers.

That man is his guide and mentor, Professor Philip Tobias, dean of the medical faculty at the University of the Witwatersrand, who employed Dr Simmons despite criticism from students and parents.

"I owe him an immense debt of gratitude," says Dr Simmons. "He always had faith in me and knew that I could teach hearing people despite my hearing impairment."

Another person who has taken the trouble to see further than Dr Simmons' "invisible handicap" is Mrs Claude Goddard, a teacher of the deaf.

When people told her he must be stupid because he spoke so oddly, she had only one word to say, "Rubbish!".

She saw his potential.

Dr Simmons' life story is a documentation of determination and triumph over adversity. It is a heartwarming story of how much can be achieved when people with a handicap receive the love and moral support that is their birthright.

Dr Simmons was born deaf and attended St Vincent's School for the Deaf. He studied in the United States at Columbia university, an achievement in itself, because he had to lip read to hear what his lecturers were saying. Lip reading, as Dr Simmons says, is an arduous task.

Listening to Dr Simmons articulating the loneliness and the prejudice he has faced may be a slow process, but it is a rewarding one. He makes it easy to understand why the great Helen Keller said that if she had her life over again and had to choose between blindness or deafness, she would choose blindness because blindness cuts you off from things. Deafness cuts you off from people.

The greatest problem he has faced in life is "communicating with people".

"Most deaf people do not have clear speech, and this embarrasses hearing people," says Dr Simmons.

Patronised

They either walk away, give the wrong answer or smile meaninglessly or worse still, patronisingly.

"The person who is deaf doesn't get embarrassed," says Dr Simmons. "He or she needs a chance to understand and to be understood."

He was married, to a woman who is deaf, but the marriage failed. The failure has nothing to do with their being deaf, Dr Simmons says.

But while he has been blessed with opportunities to develop his talents, he is all too aware that the majority of people who are deaf are denied them.

How to deal with the deaf

Here's what you should do when you meet someone who is deaf:

- Don't be shy or frightened.
- Be patient; if you don't understand them the first time, let them go on and on; give them plenty of opportunities.
- Speak slowly and clearly (not loudly).
- Stand away from the light and let the person who is deaf stand with the light behind him.
- Learn sign language.

Mrs Claude Goddard, a teacher of the deaf, says South Africa is backward in its treatment of people who are deaf.

She would like to see this country emulate the American and British progressive attitudes.

"American fire-fighting departments have people who can use sign language.

"We must train people as interpreters so they can bring hearing people and those who are deaf closer together."

Mrs Goddard suggests that news broadcasts and important announcements and programmes on television could be captioned.

Cook-and-sip happening

Book now for Angela Day's demonstration, "Cooking with fortified wines", on Wednesday May 11. Some of the unusual dishes you can learn about are seafood in muscadel and terrine with port. There will also be a wine-tasting conducted by Ms La Rein Muller of KWV.

The happening, in the Angela Day auditorium, The Star, 47 Sauer Street, Johannesburg, will run from 10 am to noon. Entry is R5. Telephone 633-2582 to book.

For Better or For Worse® by Lynn Johnston

publica...

DIP 4/5/88

Double trouble for smokers?

299

JOHANNESBURG — Smokers, already faced with the grim news that they may not be entitled to sick leave if their habit causes illness, could be in for another blow.

Draft regulation is presently being considered which, if passed, will entitle medical aid schemes to rate members according to risk and smoking will certainly be taken into consideration.

According to the executive director of the Representative Assocation of Medical Schemes, Mr Rob Speedie, South Africa, however, will not follow British medical aid schemes in refusing to pay for treatment for smoking-related illness.

"Under present regulations, a medical aid scheme is only excluded from liability if the claim relates to willful self-inflicted injuries," he said.

"I think to say smoking is a willful self-inflicted injury is probably going too far.

"With life assurance, smokers usually pay higher rates and I think this pattern will be followed by the medical aid schemes." he said. — DDC

Clarendon pupils give blankets and clothes to children's home

Daily Dispatch Reporter

EAST LONDON — A Clarendon Primary School project group of standard four and five pupils gave away clothes, blankets, foodstuffs and toys to Khayalethemba Children's Home in Mdantsane yesterday.

A teacher who accompanied the group, Mrs B. Taljard, said the group was often given projects to work on and the one they were currently working on was "disability".

She said the importance of this project was that pupils be made community-aware, so that they could grow to be concerned adults.

"As part of the project, we first collected clothes and food for Khayalethu in Duncan Village and gave some to Parkside.

"Then we heard about Khayalethemba and the girls were interested."

She said the pupils heard about the conditions of the home and its inadequacies from the negative publicity it received as a result of a misunderstanding between the trustees of the home, Mfesane and the staff.

The pupils organised an inter-house competition for collecting clothes, blankets, foodstuffs and toys.

Yesterday the pupils, accompanied by two teachers, took their boxes of clothing items, blankets, foodstuffs and toys to the home.

The pupils said that they appreciated the fact that they had been able to deliver the goods themselves.

After seeing the home for themselves, they felt they had learned a great deal.

Mrs Taljard said that the pupils would "definitely" visit the home again.

Last week, the Hudson Park High Inter-act club, visited the home with similar donations.

One of the club's members, Kelly Blake, said that the club was involved in various community projects to help the needy.

She said that in the choice of foodstuffs they had chosen protein-rich food because the diet at the home was mainly starch.

After seeing the "scratchy and thin" blankets at the home, the group left with promises to return with blankets to give the children some warmth during the winter months.

TWINS' FUND SWELLS

EARLY last year *Sowetan* staffers heard the bizarre story of two babies at Baragwanath Hospitl who were, by some quirk of nature, joined at the head.

The *Sowetan* staffers immediately went into a council of war and the upshot was the gem of an idea from the then News Editor of the *Sowetan* (he is now Senior Assistant Editor), Mr Thami Mazwai, to adopt the twins. In fact adopt the family.

A relationship was struck up with Miss Sophie Mathibela and *Sowetan* reporters went to see Mpho and Mphonyana. They were beautiful babies and everybody seemed to have fallen in love with them.

The *Sowetan* readers were in the meantime sending in money, clothes and presents for the twins.

Residents of Soweto took the matter in hand and under Mrs Maggie Nkwe formed a committee consisting of Mrs Nkwe (chairlady), Mr Aggrey Klaaste, Miss Sonti Maseko, Mrs Florah Mollo, the Reverend Otto Mbangula and the Rev John Tau, Mirriam Mazibuko, Mary Mothoane, Belede Mazwai, Lindi Myeza, Nobantu Mofokeng and Amanda Nkosi.

As the committee was not entitled by law to accept donations and collect funds for the twins, an approach was made to the African Bank who supplied their own legal team and set in motion the Mpho and Mphonyana Trust Fund.

To date the Trust Fund has more than R60 000 in the bank and after the operation separating the twins, the money has been pouring in.

The Trust Fund was launched at Soweto's A Train night club and was attended by more than 300 invited and uninvited guests. The launch party was sponsored by the *Sowetan* and the African Bank.

The establishment of the Trust Fund meant donations could be accepted and these were put into an account at African Bank.

The trustees are Mr Aggrey Klaaste and Mr Gasewabone Kotsi (senior trustees representing the *Sowetan* and African Bank), Mrs M Nkwe, Nobantu Mofokeng, Belede Mazwai, Amanda Nkosi, Lindi Myeza, Florah Mollo, the Rev John Tau and the Rev Otto Mbangula, Mirriam Mazibuko, Masontaha Maseko, and later Mrs Thandeka Gxashe. Mrs Mary Mothoane has pulled out of the Fund.

The Trust Fund has a lengthy document which is open to public scrutiny.

Apart from administering the Fund the trustees are at the moment buying a house for Sophie Mathibela and the twins in Klerksdorp, their home town.

According to the Fund a beneficiary is described as: "The Mathibela Siamese Twins (Mpho and Mphonyana) and that person or persons who may from time to time be selected by the Trustees in their entire and absolute discretion to be a beneficiary or beneficiaries in respect of the income or capital or both under the Trust, by virtue of their unique physical and mental disability for which specialised medical care and treatment may be required as in the case of the Mathibela Siamese Twins.

Beneficiary shall also include the guardian of a beneficiary."

The African Bank donated R5 000 to launch the Fund. The *Sowetan* donated R1 000.

The principal objective was to create a special fund for Mpho and Mphonyana. The objectives were made wide enough to include children born under similar unique circumstances as Mpho and Mphonyana. The objective in the document reads: Providing the Mathibela Twins and children born with similar disabilities the necessary medical treatment and care and maintenance."

The Trust Fund document is bulky and the public can read it. It is in the hands of Mr G Kotsi, the legal representative of the African Bank.

THE general manager of the National Soccer League, Mr Cyril Kobus (right), yesterday presented a cheque for R1 000 to the Editor of the *Sowetan*, Mr Aggrey Klaaste. The NSL's cheque is a donation to the *Sowetan*/Mpho-Mphonyana Trust Fund. The twins underwent the final operation to separate them at Baragwanath Hospital on Tuesday.

Fraud is rife in many health schemes

Millions ripped off medical aid

Star 9/5/84 (299)

Own Correspondent

DURBAN — South African medical aid schemes are being racked by fraud of millions of rands — and members are having to bear the cost in the form of increased fees and reduced benefits.

The swindles are often extremely difficult to detect, and almost impossible to stamp out.

A source who has intimate knowledge of the workings of several medical schemes says fraud has become the rule rather than the exception.

He also describes aspects of some schemes as "licences to print money".

Several leading figures in the industry say the schemes are wide open to fraud, and ways to prevent abuse are being looked at.

There have been many types of swindle, some involving collusion between doctors, pharmacists and patients.

There have allegedly been instances where doctors have set themselves up as virtual "loan sharks", giving patients prescriptions which are exchanged for cash, or other goods such as baby food, at a pharmacist.

One of the commonest rackets is the "bottom-line script" in which an extra item is added to a prescription.

This is sometimes not given to the patient, but is claimed from the medical aid fund. It helps to cover the levy fee.

Unsophisticated

Also common is fraud by medical aid fund members. This takes many forms, but a common one is to allow someone to pose as a relative.

The doctors and pharmacists involved in these rackets tend to prey on unsophisticated patients who often do not read their prescriptions and medical bills.

Sources also claim that a major problem is that many medical aid schemes are not prepared to go to the trouble of legal action. They say the schemes are non-profit organisations and there is therefore no motive for them to police themselves.

"They are quite happy just to push up the fees to cover the losses," says one source.

Mr Trevor Jackson, spokesman for one of South Africa's major medical schemes, says fraud is rampant.

"I would suspect that it is far more substantial than anybody realises.

"One big problem is that it is very difficult to investigate, and come up with anything concrete and get a conviction."

He says the money being lost by schemes is forcing them to push up fees or reduce benefits — or both.

Even smaller medical aid schemes have reported fraudulent activities running into thousands of rands. Several sources say the losses nationwide would amount to millions.

Higher recall rate

For many years it has been known that doctors tend to treat patients on medical aid more often than those who pay cash. The Representative Association of Medical Schemes found recently that doctors who "serviced" patients from medical aid schemes had a 22 percent higher recall rate than those who treated mainly patients outside schemes.

Opinion over solutions to the problem is fairly divided. One source is adamant that the first priority should be a powerful inspectorate that examines pharmacies routinely.

Others feel sentences for offenders should be toughened.

A spokesman for the Pharmacy Council, a statutory body that has the power to strike pharmacists from the register for unacceptable practices, says there had been "quite a number of complaints in recent years".

"We have suspended and erased from the register a number of pharmacists," he says.

Mr Nico Prinsloo, registrar of the South African Medical and Dental Council, says there has been a general increase in this type of crime in recent years.

A spokesman for the Pharmaceutical Society of South Africa says that despite the presence of fraud, "those involved in terms of the pharmaceutical profession are a minority — the amoral element that one finds in any walk of life".

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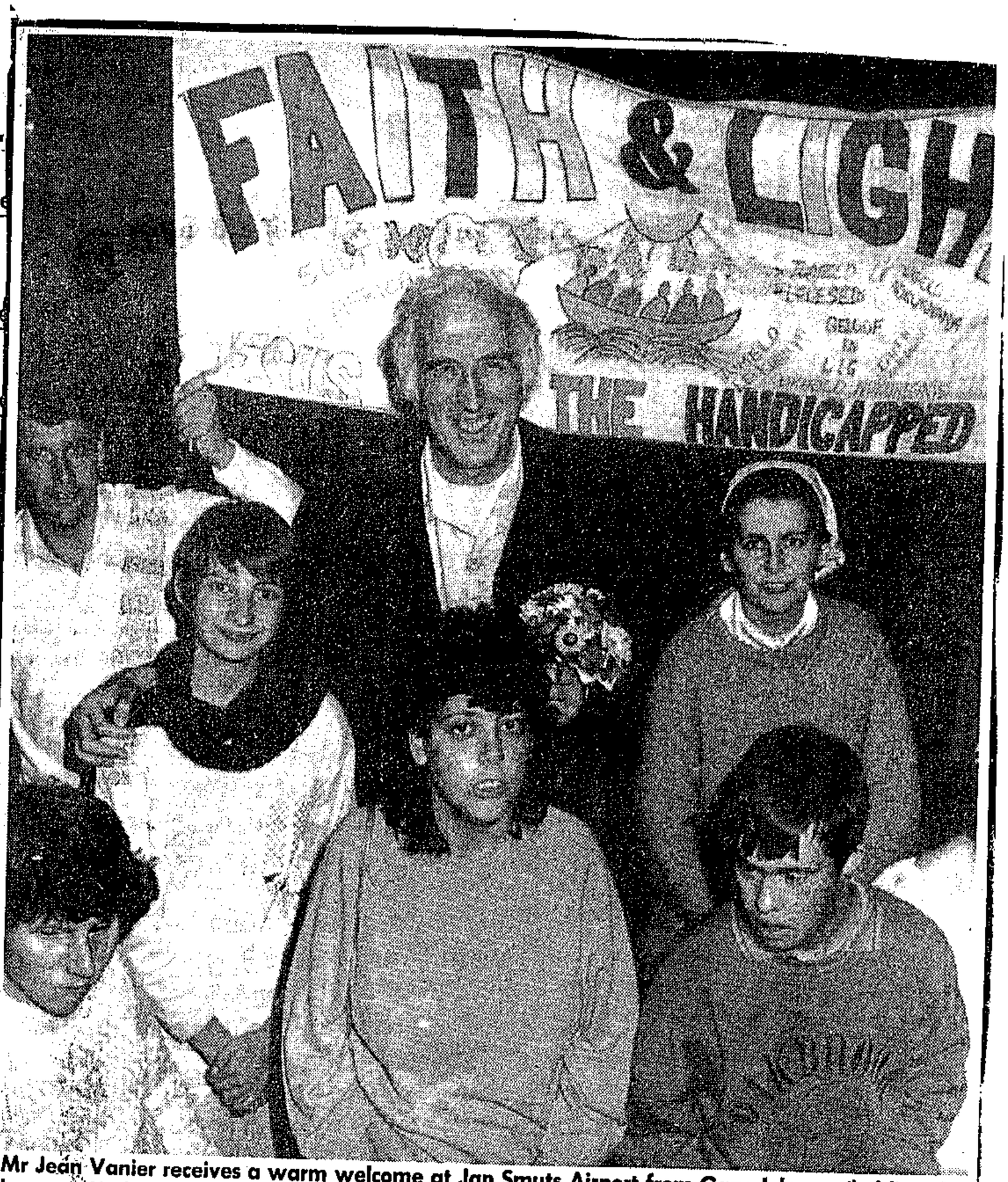

Mr Jean Vanier receives a warm welcome at Jan Smuts Airport from Gary Johnson (holding the banner), Kathrine Shine, Anna-Paula de Freitas, Ingrid Ross, John-Gavin Toweel and Ms Terese de Bertodano, the Faith and Light group's zone co-ordinator for Africa. ● Picture by Ken Oosterbroek.

299 Stars 9/5/88

Patron of mentally ill is in SA

By Winnie Graham

Mr Jean Vanier, a man who has become known as "the Mother Teresa of the mentally retarded", believes there would be no war, rivalry, competition or oppression in the world if all people had the sense of the mentally handicapped.

BEAUTIFUL

Speaking at Jan Smuts Airport last week at the start of a short lecture tour of South Africa, he described retarded people as "beautiful people who could teach us much if we would only learn from them."

Mr Vanier, a Canadian, founded the first l'Arche home for mentally handicapped people in France in 1964. Since then more than 90 have been opened worldwide.

He also started the Faith and Light community support groups for families with children with mental handicaps. Today there are more than 700 such groups.

He said mentally retarded people looked only for friendship.

"Normal people know about sexuality, violence, oppression, rivalry. Normal people are sad, burdened down by problems relating to sickness, family life, love and hate, but the mentally handicapped know none of these heartaches."

Mr Vanier, who lives with mentally handicapped people, said they are much easier to live with than "normal" men and women. Life, to them, is a "celebration", an ongoing source of joy.

He told a story about a normal man who was describing his domestic problems and heartaches. In the middle of the discussion a youngster with Down's syndrome walked, laughing, into the room.

"The man turned to me and said: 'Isn't it sad to be mentally handicapped?'" Mr Vanier recalled. "He couldn't see that the youngster was happy but he was the one bowed down with anxieties."

Mr Vanier's interest in the mentally handicapped was born after he took up a teaching post at the University of Toronto and started visiting hospitals and mental asylums.

He was appalled at the oppression he found in these institutions — so he started the first l'Arche home in a French village with two retarded men.

In no time the community had grown to 400.

"If we are opened to the tenderness, the delicacy of feeling of mentally retarded people, the world could be transformed," he said.

Mr Vanier was given a warm reception by a group of boys and girls from the Casa do Sol school in Johannesburg.

Whether a certain person, whose name has been furnished to the South African Police for the purpose of the Minister's reply, is currently in the employ of the Police; if so, (a) in what capacity is he employed, (b) for how long has he been employed, (c) what is his rank, (d) what are his functions and duties, (e) where is he stationed at present and (f) what is his name?

The MINISTER OF LAW AND ORDER:

No, not as far as could be ascertained.

(a) to (f) Fall away.

Damages arising out of civil cases brought by detainees: payable by policemen found guilty

*15. Mrs H SUZMAN asked the Minister of Law and Order:

Whether members of the South African Police have been informed that any damages arising out of civil cases brought against them by detainees will henceforth be payable by the policemen found guilty by the courts; if so, (a) (i) in what manner, (ii) when and (iii) why and (b) what are the details of the information so conveyed to them?

†The MINISTER OF LAW AND ORDER:

No. However, at the time of their employ and from time to time thereafter, the attention of members of the Force is drawn to the contents of Chapters W3.1 and 4.1 of the Treasury Instructions as contained in the Financial manual for Government officials.

After payment of a civil claim by the State, the matter is referred to the State Attorney who decides whether or not the member/members of the Force concerned must be held responsible for the expenditure of the State.

Such recoveries from members of the South African Police are made in terms of the provisions of section 34 of the Exchequer and Audit Act, 1975 (Act 66 of 1975).

Rooi Els/Betty's Bay/Kleinmond: proclamation as nature area

*16. Mr R R HULLEY asked the Minister of Constitutional Development and Planning:

Whether, with reference to his reply to Question No 6 on 28 July 1987, his Department or the Cape Provincial Administration still intends to proclaim the Rooi Els/Betty's Bay/Kleinmond area as a nature area; if not, why not; if so, (a) what are the boundaries of the proposed nature area, (b) what steps (i) have been and (ii) remain to be taken in this regard and (c) when is it anticipated that the proclamation in question will be issued?

The DEPUTY MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING:

This information was furnished by the Cape Provincial Government:

Since the reply to Question No 6 for 28 July 1987 the Cape Provincial Government has renounced its intention to reserve the Rooi Els/Betty's Bay/Kleinmond area as a Nature Area. The reasons are:

(a) Provision is made in clause 16 of the Draft Bill on Environment Conservation as published under Government Notice 353 of 1987 for the declaration of "Protected Natural Environments". If this concept is accepted, it will result in a better dispensation for private landowners, which is supported.

(b) After the Environment Conservation Act (presently in the form of a Draft Bill as mentioned above) is promulgated, the area in question will be declared as a "Protected Natural Environment".

Mr D J N MALCOMESS: Mr Speaker, arising out of the hon the Deputy Minister's reply, does the fact that he prefaced his answer by saying that the information was supplied by the provincial administration mean that the hon the Minister washes his hands of all responsibility for the correctness of the answer?

Spouses of Black members of SAP: membership of Polmed

*17. Mr L DE BEER asked the Minister of Law and Order:†

Whether the spouses of Black members of the South African Police Force who are married according to the provisions of the Republic's legislation on marriages, qualify to be members of the medical aid scheme of the South African Police (Polmed); if not, why not?

†The MINISTER OF LAW AND ORDER:

No, unfortunately not yet at this stage. Black members of the Force receive a monthly allowance for this purpose. However, in-depth negotiations with the Commission for Administration and the Secretary to the Treasury are in progress to bring about the provision of comprehensive medical benefits for Black members of the Force.

Defence Force vehicle: transportation of personnel

*18. Mr S S VAN DER MERWE asked the Minister of Defence:

Whether the South African Defence Force owns a vehicle with the registration number R113-912; if so, (a) what is the make of the vehicle and (b)(i) for what purposes and (ii) where is it being used?

The DEPUTY MINISTER OF DEFENCE:

Yes.

(a) Isuzu KB 21.

(b) (i) For the transport of personnel.

(ii) Mamelodi, Soshanguwe, Atteridgeville and KwaNdebele.

Eskom: under control of Department

*19. Mr M J ELLIS asked the Minister for Administration and Privatisation:

(1) Whether Eskom now falls under the control of his Department; if so, (a) why and (b) to what extent;

(2) whether any other statutory corporations or institutions have been referred to his Department with a view to privatisation; if so, which corporations or institutions?

†The MINISTER FOR ADMINISTRATION AND PRIVATISATION:

(1) Yes. The Ministerial responsibilities for Eskom, as set out in the Eskom Act, 1987 (Act 40 of 1987) have however been entrusted to me by the State President.

(a) Because the Government has decided to investigate the possible privitisation of Eskom.

(b) As indicated above.

(2) The Ministerial responsibilities for Iscor and Foskor have also been entrusted to me with a view to the possible privatisation of these corporations.

Prohibition of issues of 8 and 22 April 1988 of Scope

*20. Mr J J S PRINSLOO asked the Minister of Home Affairs:†

Whether the distribution of the issues of 8 and 22 April 1988 of a certain magazine, the name of which has been furnished to the Minister's Department for the purpose of his reply, was prohibited recently; if so, (a) in terms of what statutory provisions, (b) what is the nature of the material in each of these two issues on the grounds of which they were prohibited and (c) what is the name of the magazine concerned?

The MINISTER OF NATIONAL EDUCATION (for the Minister of Home Affairs):

Yes.

(a) to (c) The hon member is referred to *Government Gazettes* Nos 11256 and 11271 of 11 and 19 April 1988, respectively, in which notice was given that the 8 April 1988 and 22 April 1988 issues of *Scope* had been found undesirable within the meaning of section 47(2)(a) of the Publications Act, 1974. In terms of that section a publication is deemed to be undesirable if it contains matter which is indecent or obscene or is offensive or harmful to public morals.

*21. Mr J H VAN DER MERWE — Public Works and Land Affairs. [Reply standing over.]

Njongo Primary School, Khayelitsha: petition from parents of pupils

*22. Mr K M ANDREW asked the Minister of Education and Development Aid:

Whether the Department of Education and Training recently received a petition from parents of pupils at the Njongo Primary School in Khayelitsha; if so, (a) on behalf of how many persons was the petition submitted and (b) what was (i) the purport of the petition and (ii) his response thereto?

The DEPUTY MINISTER OF TRANSPORT AFFAIRS (for the Minister of Education and Development Aid):

Yes.

Two contradictory petitions were received on 20 and 29 April 1988 respectively.

(a) According to preliminary indications there are serious doubts concerning the degree to which these petitions reflect the views of *bona fide* parents.

'Public will pay dearly for health privatisation'

By Jo-Anne Collinge Stev 10/5/05

A sombre warning that the public will pay dearly if it meekly accepts the privatisation of health care services has been sounded by Professor Dingie van Rensburg, head of the department of sociology at the University of the Free State.

"Health and care are not commodities. They are not simply an individual responsibility and a privilege reserved only for certain people. It borders on the immoral to make a profit out of health care," Professor van Rensburg says in an article in his university's journal, *Acta*.

"Privatisation of health care is in the interests of many other groups, but it is in many respects not in the interests of the most important group — the patients.

"The broader community, which consists of patients, will pay heavily for uncritically accepting the privatisation of health care services — the poor with privation and those that can comfortably afford it for the profits and wastage that necessarily can take place."

Professor van Rensburg says that a simplistic economic model of free enterprise has been generalised to health care, whether it suits that purpose or not.

A power elite of politicians and businessmen has set the nation on course for privatisation wherever possible — and the layman has uncritically bought the idea that it must be in everyone's best interests if health services were to become a private initiative.

In doing so, the public accepts a whole package of principles and practices — "the good, the less good and the bad".

"With the privatisation of health care, South Africans have accepted the more serious side-effects of the free enterprise system and of capitalism. These include possible problems concerning inequality in health provision; financial exclusion; a second class health system; first and second class health services and first and second class patients; profit-seeking, monopoly interests and even exploitation."

KwaZulu urged to adopt Indian plan to cut mortality

Star 10/9/85

By Jo-Anne Collinge

Senior health care workers in kwaZulu are urging the authorities to adopt a community service patterned on a programme in India, which caused the infant mortality rate in the targeted region to drop dramatically.

Dr Pat Garde, a community obstetrician in Natal, gave details of the plan at a conference of trainers of primary health care nurses held near Johannesburg this week.

She explained the Indian programme was based on a continuous chain of health workers of various degrees of expertise.

The basic link was an ordinary housewife, trained as a "home health worker" to motivate 10 other women in her neighbourhood to reach out to secure better health. She would liaise with a facilitator.

The facilitator would, in turn, liaise with a co-ordinator, who would be a trained nurse.

She stated that the Indian model programme had reduced infant mortality rates to 40 per 1 000 births in the target region as a whole and had further reduced them to 20 per 1 000 births in the families directly reached by the health care network. The norm in India was 100 per 1 000 births, she said.

How had they done this? By gearing their health network to tackle such diverse matters as nutrition, literacy, rehabilitation of the disabled, sanitation and training in the use of herbal remedies.

She pointed out that maternal malnutrition, drug use, infection and anaemia were known to carry a 'high risk' of harming the foetus. Conditions like diabetes and the habit of smoking could also impair the development of the unborn child.

DD 11/5/84

Programme for blind school children praised

299

Daily Dispatch Reporter

EAST LONDON — A school-readiness programme for blind children here has been described as successful in the latest National Council for the Blind magazine, Imfama.

The programme, which began in 1986, was created because there was no school for blind children in this area.

The nearest school was in Port Elizabeth, which meant that children had to go away from home to school at an early age, and be with their parents only twice a year.

"This deprives them of the opportunity of growing up in a family unit during their formative years, which is vital to emotional well-being. Both parents and children must be prepared beforehand to adjust to this programme," Imfama said.

Social workers hold informal and relaxed sessions with the children and their parents, helping them to deal with the problems of adjusting to school.

Last year's group consisted of five children aged between 5 and 12 years.

R250 000 needed to build home for blind

By Sue Valentine

In spite of the gift of almost half the building costs, Services for the Blind and Visually Handicapped still needs to raise almost R250 000 to finance nine new accommodation units in Coronationville.

Mr Daniel Petersen, trustee of the organisation, said the building would house about 30 people who are employed in the services' nearby workshop.

"We provide one cooked meal a day for all blind people who work at the various jobs taken on by the workshop," said Mr Petersen.

"They weave baskets, assemble hose clips, string labels and stitch pillows.

"We welcome any contractual work that blind people can do."

He said the site had been donated and the builders, Duvack construction company, had agreed to foot part of the construction bill.

An architect and director of Duvack construction, Mr Alan Duval, said his company had done a lot of work in the area.

Although the organisation receives a grant from the Department of Manpower and the City Council, they rely on money from trusts, donations and fund raising activities to supplement the income of workers and to support the blind.

Anyone interested in assisting the association can telephone Services for the Blind and Visually Handicapped at 27-1565, or they can write to PO Box 42181 Fordsburg 2000.

Visitors to the workshop are welcome.

The workshop is on the corner of Riversdale and Fuel streets, Coronationville.

Women's campaign

Sowetan 16/5/86

THE Imbeleko Women's Organisation is to launch a national campaign against the privatisation of health services, a Mamelodi seminar was told at the weekend.

The one day seminar also looked into the role of women in the struggle

By MOKGADI PELA

and in trade unions.

Delegates came from as far afield as Lenyenye, Kuruman, Langa in Cape Town and Ka-Ngwane.

Speaking at the seminar, the co-ordinator of Imbeleko, Miss Nomonde Jafta, said the struggle for national liberation and the struggle for women's emancipation had to run concurrently.

A speaker from the East Rand, Mr Mandla Nkosi, said by privatising health services the Government would follow the example of Ronald Reagan and Margaret Thatcher in their countries.

He said by introducing this law, black people would be forced to go to private hospitals which were expensive.

Campaign for better health care in N Transvaal

Star 18/3/87

299

A public campaign is to be waged in the rural areas of the Northern Transvaal to pressurise the authorities for more hospitals, more doctors and better equipment and supplies in existing facilities.

Spearheading the campaign is the Northern Transvaal People's Congress (Nospeco), which has collected hundreds of survey questionnaires from people living in the area to gauge their views of the present health system.

"We emphasise the urgency of improved health care in the rural areas which have hither to been neglected," a statement of the organisation said.

"We have noted the Government call for the privatisation of health structures. This is viewed as an attempt by the Government to shirk its responsibilities and to pass them on to the private sector.

PRIVATISATION CRITICISED

"The principle behind privatisation is far from addressing the inequities in the health system. It does not address the genuine needs and the priority of equal distribution of health resources. Its motivation is profit. The health care industry under privatisation would render profits for a few.

"The unemployed, the aged, the disabled and the poor will be denied access."

Nospeco believes budgeting priorities need to be reconsidered and that defence spending should be reduced and reallocated to services, such as health.

The organisation urges that people be educated to understand what decent health care constituted — so that they could make demands in their own best interests.

It also calls for the creation of "people's health centres" where lay people can be trained in basic first aid and nursing and people will be able to obtain supplies necessary for home care of the ill.

Tingas looks after 1/2-m people

14/5/88 sowetan

NACTU health and safety officer Vusi Tinga.

BEING shouldered with the responsibility of ensuring the health and safety of about 300 000 workers in an unenviable task, and even worse when those people are scattered all over the country, writes MOKGADI PELA.

Mr Vusi Tinga (30), Nactu health and safety officer for the National Council of Trade Unions, gave a picture of what his work entails. He also gave a spine chilling statistical picture of the dangers workers faced in their daily lives.

"In 1986 alone about 347 170 employees were injured in work-related accidents. Of these 28 620 were accidents that led to disablement and 2 900 led to death. The rest were just classified as 'other injuries'," Mr Tinga said.

Compensation

Regarding compensation for injuries suffered at work, Mr Tinga said: "Compensation to an injured person is calculated on 75 percent of his salary.

"The schedule for the compensation for injuries sustained at work says that if a person is injured at work, for instance an arm, below an elbow and shoulder, it is identified as 65 percent injury He will be paid according to the degree of the disablement."

If a person loses a finger, it is regarded as four percent disablement and he will be paid accordingly, he said.

He outlined some of the objectives of his unit as:

- To embark on a health and safety training programme on all aspects directly or indirectly affecting workers;
- To avail a continuous health service and advice to all Nactu affiliates;
- To conduct health and safety surveys to determine the effectiveness of the health and safety campaigns and future needs of unions in the field; and
- To collect health and safety information nationally and internationally and disseminate it to Nactu unions.

His department's influence within trade unions is reflected by the fact that most unions today have entered into agreements with management on matters of health and safety.

The man who is popularly known as "Tingas" said the Machinery and Occupational Safety Act instructs managements to appoint safety representatives.

"Our position is that these representatives should be elected by our members at all our plants, to that end there is no compromise."

Mr Tinga is a globe trotter, having addressed various international gatherings. He is married and has one son, Mthunzi.

Ezibeleni school wins acclaim in contests

Sowetan 19/5/88

299

THE sun is finally shining for the physically disabled children schooling at the Ezibeleni school for crippled children in Katlehong near Alberton.

Recently the school competed in the Transvaal United African Teachers' Association (Tuata) choir competitions and obtained third position.

By ALI MPHAKI

Pitted against normal children from eleven schools from Katlehong, Thokoza and Vosloorus, the Ezibeleni choir, under the baton of Mrs Deborah Vilakazi, was awarded the trophy for the best choir, as well.

The school also participated in the SA National sports championships for the physically disabled (juniors), in Stellenbosch and the seven athletes from the school, performed magnificently.

They brought back nine gold medals, eight silver and two bronze medals.

Pretty Mzileni set a new South African record in the javelin, Steven Mokoena did on high jump and Philadelphia Vilakazi on discus.

The seven athletes have also been awarded Southern Transvaal colours.

Ezibeleni is uniquely situated next to the Natalspruit hospital. A gate between the school and the hospital opens on to a walkway which leads to the casualty section of the hospital.

All pupils at Ezibeleni are registered patients of the hospital and are accorded preferential treatment in case of an emergency.

In 1981, the school became a special school under the juristiction of the Department of Education and Training's (DET) section for special education after an agreement with the Germiston Cripples Care Association.

The school is subsidised by DET.

The principal, Mr Joseph Durand, said through the help of God everything could be achieved.

Mrs NOKUTHULA Xulu (left), with six of the seven athletes from Ezibeleni school for the physically disabled who performed well at the SA National Championships.

WOMAN

Gem of Alexandra

Sowetan 20/5/88

By PHANGISILE MTSHALI

FRANZ Sebolayi, a jeweller who did not let his handicap make him a beggar.

IN the back streets of Alexandra township a handicapped father of two, designs and makes jewellery with glittering Tiger Eyes stones to maintain his family.

Franz Sebolayi (50), did not let his physical handicap force him into the streets, begging to support himself and his family. His right hand side was paralysed in a knife fight 20 years ago and Franz still depends on his hands to make a living.

"I love making jewellery and it is my only source of income," he said.

This experienced and talented jeweller did not have any formal training. He learnt the skills and the know-how from a factory where he worked from 1959 to 1973.

"When I was retrenched in 1973 I took the skills I had gained and used them to my benefit," Franz said. "I was not going to get another job easily with my handicap."

He has been self-employed ever since and his designs are becoming fashionable and accepted by his community. He makes earrings, rings, necklaces, bracelets and sometimes brooches which accessorise for traditional attires.

He works hard from his single crowded room but finds problems in making his products known and in selling them.

Family

"I rely on my wife to sell the jewels," said Franz.

"I am the breadwinner but when she gets temporary jobs she sells them at her work place. Otherwise she goes from door to door."

Franz and his family were just managing to keep their heads above water until he joined *Progress Through Employment*, an organisation promoting self-help among the handicapped and the unemployed of Alexandra.

"The organisation offers basic business management skills," said Franz.

"I have just joined it but it has already offered me opportunities to show my jewellery to the public."

He recently participated in a recent fashion show and he has a stand at this year's Matchmaker Fair.

Medical-aid subs could be lowered

By Robyn Chalmers

MEDICAL-aid scheme members could pay lower subscriptions if changes to the Medical Schemes Act are implemented.

The societies have long campaigned for greater flexibility, and the Representative Association of Medical Schemes (Rams) has welcomed the proposed changes.

A notice in the Government Gazette says: "A registered medical scheme may determine a scale of membership fees payable per member in accordance with the extent of cover afforded."

If the recommendations are accepted, medical schemes will have some freedom to base their contribution rate on a member's:

- **Income, age and the geographic area they live.**
- **Number of dependants.**
- **Period of membership and claims experience.**

Medicaid Administrators managing director and Rams spokesman Jeff Slome says this means schemes will be able to offer lower subscriptions to members with a more positive claims experience and different levels of cover.

Mr Slome says: "One possible problem with the changes is that the membership base of a scheme could be so fragmented that there will be insufficient spread of risk within an option selected.

"The Registrar of Medical Schemes has indicated, however, that he will not allow registration of the different options unless he is satisfied that there are enough members in each group."

Members should look at cover as an insurance for the days when there will be a major expense, and not use their scheme for petty ailments.

The societies and pharmaceutical manufacturers welcome the move from rigidly regulated schemes.

22/5/88
299
Star

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Cash shortage may hold up St Giles home expansion plan

Lack of funds could hamper plans by the St Giles Association in the Transvaal to build a desperately needed home for the newly injured.

The association needs R500 000 to house 33 people in St Giles Home-in-the-Valley.

The Transvaal association's first home, St Giles Home-on-the-Hill in Observatory, Johannesburg, was officially opened last Wednesday.

The home accommodates 19 and serves as a day-care centre for others, but is not nearly large enough to house the stream of disabled people desperate for accommodation, said Sister Karen Stilwell, the association's public relations officer.

The second home, in Dewetshof, will concentrate on rehabilitating the newly injured and returning them to society as soon as possible.

Man escapes from custody

One of three men arrested near Tarlton in connection with an alleged R2 million fraud case has escaped from police custody in Pretoria.

Police said 31-year-old Mr Piet Ras, a member of the so-called Boere Mafia, could be on his way to Botswana.

Anyone with information should contact the Brooklyn police station in Pretoria. — Sapa.

Ex-Ministers questioned

UMTATA — The chairman of Transkei's Military Council, General Bantu Holomisa, confirmed at the weekend that an undisclosed number of former Transkei Cabinet Ministers, some of whom were forced to resign by the army, were detained briefly and questioned about a trip they undertook to Cape Town last week. — Sapa.

Bus disaster toll rises to 35

EAST LONDON — The Cathcart bus disaster toll has risen to 35 with the death of an unidentified woman in Frere hospital yesterday.

The medical superintendent of the hospital, Dr Peter Mitchell, said the woman, who had suffered head injuries, died in the intensive care unit. — Sapa,

WOMAN

Imbeleko will fight Govt plan

THE Government's intention to privatise health services has led the Imbeleko Women's Organisation to launch a campaign against the move before it comes into operation.

By MOKGADI PELA

Explaining her organisation's campaign, Miss Nomonde Jafta, the co-ordinator of Imbeleko, said: "In keeping with the popular expression namely, *mme oa ngoana o tshoara lehare ka bohaleng* which loosely translated means that a mother will use her bare hands to hold the blade of a sword in order to protect her offspring, we felt we could not let this government do what it wants without being challenged."

The 29-year-old Miss Jafta, from Wattville said: "In order to understand the motive behind the proposed privatisation of health services, it is essential to realise that South Africa is both a racist and capitalist state."

Miss Jafta said: "Privatisation will only inerease the misery of black people. Only the rich sections of our community will afford privatised health services, because they can afford the already expensive Medical Aid schemes.

Education

"If this move succeeds, infant mortality rates will soar, the high pregnancy rate among our youth is not going to be reduced by privatisation, but by proper health and sex education.

"From a brief look, it is clear that for the past five years, hospital fees have been rising unbelievably. Government's intention has been to slowly condition the masses to this coming privatisation," she said.

She said those who were going to be particularly hit by the move were pensioners and lower income groups. She said Imbeleko wanted health services to be accessible to all.

"One of the reasons why workers are taxed is for provision of health services, instead of our money being wasted in bantustans like Lebowa. One wonders what is going to happen to billions of rands the Government claimed to have reserved for health services once these are privatised," Miss Jafta said.

She added that Imbeleko, in conjunction with other organisations, intended conducting health clinics throughout the country.

The decision to launch a campaign against privatisation was reached at a seminar in Mamelodi, Pretoria, last week where delegates came from areas such as Lenyenye, Kuruman and KaNgwane, Miss Jafta said.

The co-ordinator of Health 2000, Dr Abu Asvat, said: "The impending privatisation of health services does not augur well for the man in the street. Access to health, which is a basic human right, will in future be available on payment of money — the more you pay, the better the service."

He said the poor would suffer and the World Health Organisation's dream of providing health to all by the year 2000 would be an unattainable proposition.

MISS Nomonde Jafta, co-ordinator of Imbeleko.

CITY/NATIONAL

Fraud is costing medical schemes millions of rands

MK(u) 25/5/88 299

The Argus Correspondent

DURBAN — Medical aid schemes are being hit by fraud amounting to millions of rands and members are having to bear the cost in the form of increased fees and reduced benefits.

The swindles are often extremely difficult to detect and virtually impossible to stamp out.

An array of swindles have been used, some involving collusion between doctors, pharmacists and patients.

There have allegedly been instances where doctors have set themselves up as virtual "loan sharks" giving customers prescriptions which are either exchanged for cash or other goods, such as baby food, at a pharmacist.

One of the commonest rackets is the "bottom line script" in which an extra item on a prescription is not given to the patient in exchange for dropping the patient's levy fee.

Pose as a relative

Some pharmacists and doctors also allegedly give patients cheaper medicines than those prescribed while claiming for the more expensive medicine.

Also common is fraud by members. A common method is allowing people who are not on the member's medical aid to pose as a relative.

The doctors and pharmacists involved in these rackets tend to prey on unsophisticated patients who often do not read their prescriptions and medical bills. These patients are also often reluctant to get involved in legal action or make very poor witnesses.

Difficult to detect

Mr Gideon Barnard, general manager of Cape Medical Plan, said they had caught some people "but it tends to be luck when we do catch them. It is impossible to say how widespread it is because it is so difficult to detect.

"People think up all kinds of ways of ripping off medical aid societies.

"We have for instance been told about a dispensing doctor in a country town in the Western Cape who has a patient who submits huge bills for drugs he allegedly hasn't received from the doctor. We have heard that they allegedly share the money after we pay the bills.

How to prove it

"The trouble is, how do we prove it? We aren't there to compare drugs actually dispensed with the claims made."

It was honest members who lost out.

"I believe that the answer is to bring in payment at source. Members would be reluctant to go the doctor unnecessarily if they had to pay a portion of the bill in cash on the spot. It would also make them more aware of how expensive medical treatment is.

"Another way of solving the problem is to levy medical aid subscriptions according to usage. This would stop some of the heavy claims and reduce abuse."

Mr Barnard said medical aids were prevented by law from using either of these systems.

The words spell W E L C O M E — on the cards and in sign language — as children from Sizwile School for the Deaf greet guests at the opening of their school yesterday.

© Picture by Frank Black.

School for Deaf on the road to success

Star 31/5/88 By Paula Fray

The Sizwile School for the Deaf — the only institution in the PWV area for black children with hearing disabilities — was officially opened in Dobsonville yesterday.

The director general of the Department of Education and Training, Dr A B Fourie, representatives from foreign embassies and multi-national companies, and the Dobsonville mayor were among dignatories at the opening.

The principal, Mr Gerard Cox, told the more than 500 guests and schoolchildren that the completion of this first phase was a milestone in the school's history.

The school now provides pre-primary and primary school training. It will go on to take students up to matric.

Mr Cox said deafness was one of the worst of handicaps as it "cut out a person socially".

Yet the children were eager to develop to the limit of their capabilities. The school was there to help them become useful members of their communities.

Future growth involves a R20 million capital development programme over five years.

Among projects planned are hostel, kitchen facilities, secondary classrooms, a diagnostic centre and auditorium, a community sports complex, and an arts and crafts centre.

Palsy children at home with 'Mama Jackie'

Star 1/6/88

299

Keamogetsoe Xaba undergoes her half-hour of physiotherapy under the careful guidance of Mrs Heather Baxter.

By Sally Sealey

The small hands reach out, the eyes light up, a little girl rushes over, arms outstretched to "Mama Jackie", who picks her up, holds her closely, and whispers, "my butterfly".

Ms Elizabeth Jackson, better known as "Mama Jackie", works at the Paul Kushlick School for Cerebral Palsy Children in Soweto. Here 199 children of all ages are loved, cared for and educated.

Her ambition is to make all "her children" independent, to give every child a sense of dignity.

"So many of them come to us apologising for being alive, I want them to know that they are loved and that they have every right to be glad they are alive," says Ms Jackson.

The school prepares children for the classroom, and to make them as independent as possible.

"Only four of our children are in wheelchairs, the rest get about on bicycles or on their own two legs," she says.

Before 1982 there was no school in Soweto for children suffering from cerebral palsy. "God alone knows what they did then," says Ms Jackson.

Coping with rejection

"Most of the children were kept in a world of darkness or institutionalised where they were fed and cleaned but offered no mental stimulation or education."

Often the children have to cope with rejection from their families and from the community.

"One little boy tried to hang himself five times because his mother rejected him," said Ms Jackson.

"One of our little girls, my 'butterfly', is cared for by her 15-year-old sister; often the sister goes out and forgets to feed the little one."

The school staff consists of teachers, housemothers, physiotherapists, occupational therapists, speech and hearing therapists and remedial teachers.

"The physiotherapists try to prevent gross deformity by giving the children treatment as early as possible. Ideally each child should be given half an hour of physiotherapy daily but the most we can provide is three times a week," said one of the physiotherapists at the school.

Ms Jackson says although the work is fulfilling it is often frustrating especially when the parents reject the child. Many fail to report the illness because they are afraid or in many cases, ashamed.

Ms Jackson says it is important to remember that cerebral palsy is not a disease and is not hereditary. It is caused by brain damage, before during or after birth or by an accident.

The school has a three-fold task, she said, the first being education. "We educate the children to be as independent as possible and we educate the parents to accept their children to understand them and to love them."

Ms Jackson's dream is to have a boarding facility at the school.

"My dream is to have a place for the children, particularly those that have been abused, a home where they will be loved and cared for. A home for my 'butterfly' and the many like her".

Solly Rabambo (6), nicknamed "Spoggy" by the staff of the Phillip Kushlick School for Cerebral Palsy Children in Soweto, takes his first tentative ride on his bicycle, under the watchful eye of staff members.

© Pictures by Alf Kumalo.

Intelligence

The earlier the children come to the school, the better their chances. "The children are far more intelligent than the average person thinks. At our school we have two children who have very high IQ's but because of their physical disabilities they may never realise their potential", she says.

The occupational therapist at the school says : "We work in the functional, educational, personal and work sphere. We teach the children to have self respect and help them become employable."

The school offers a variety of skills to the children, from basket weaving, woodwork, metalwork to domestic science.

"The children feel that we are their real parents", says teacher, Mr Cecil Moruthanae.

Soweto deaf get new school

Star 11/6/58 (299)

The Director General of the Department of Education and Training, Dr Brand Fourie, says his department has embarked on 29 building programmes for disabled children during the current financial year.

Speaking at the official opening of the Sizwele School for the Deaf in Dobsonville, Soweto, Dr Fourie said the building of Sizwele School involved R1 291 million, and that 95 percent of this amount had been subsidised by the DET.

The schools are expected to admit their first pupils later this year. — Sapa.

WOMAN

Twins shook world

299

Soweten 6/6/88

WOMAN'S FORUM

EVERY expectant mother prays to God that she gives birth to a normal child. How should a mother handle the situation when she gives birth to Siamese twins.

Should she accept it as a gift from God and be happy? Or should she seek medical advice and have the children separated so they can be like normal human beings?

Write to the Woman's Forum and tell us how you feel about this issue. Remember you stand a chance of winning R25 if you write the best letter. The closing date for letters is June 23.

Your letters should be addressed to the Woman's Forum, Box 6663, Johannesburg 2000.

THERE was a very unusual occurrence in South Africa between 1986 and 1987 when three sets of Siamese twins were born to three black mothers within a period of 12 months.

By SIZA KOOMA

The now world renowned Mpho and Mphonyana, who were joined at the head, were born of a domestic worker, Miss Sophie Mathibela, of Klerksdorp in December 1986.

Ten months later, while the whole country's attention was still focussed on this unusual set of twins, another set, Nozipho and Siphokazi — joined from the chest to the abdomen — were born of a Transkeian, Mrs Thobekile Qakama in September.

It was within the next three months when in December, Motho and Mothoana were born of 25-year-old Mrs Adeline Hlalele, of Botshabelo in Bloemfontein. These were joined from the breast to the abdomen.

Although this miracle shook the whole country and set temperatures of most expectant mothers soaring, it was not the first time it occurred. The birth of twenty such twins had been recorded in world history already. Science explains this very rare occurrence — about 0.6 to a million — as a result of an egg splitting partially after fertilisation.

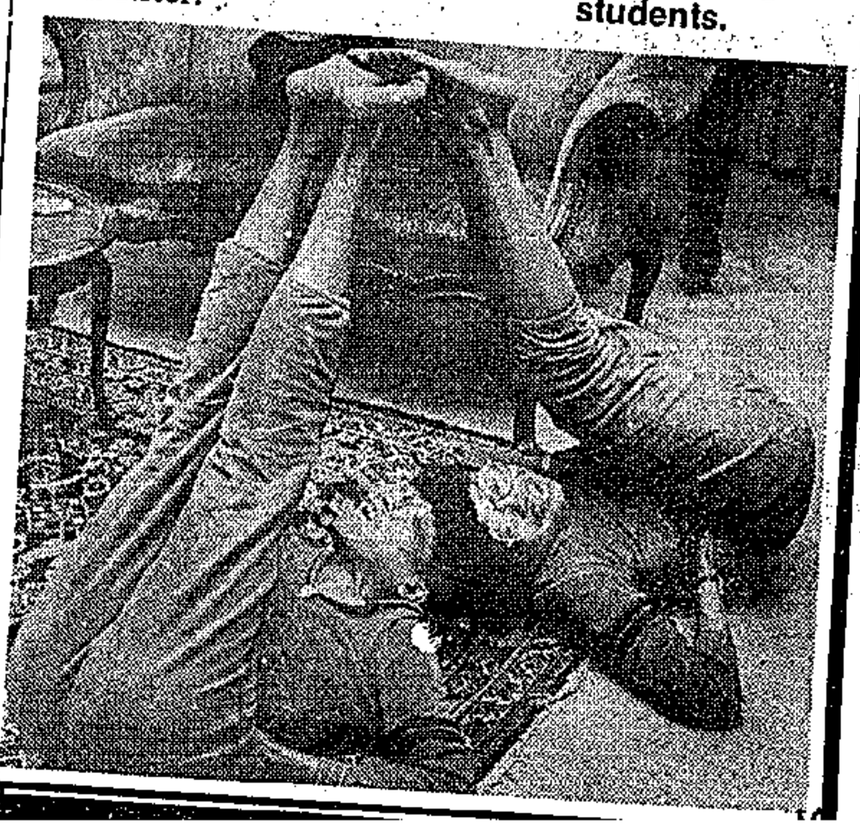
All three mothers said they were shocked at the first sight of their strange babies and they consented to the carrying out of operations to separate them.

When they were 57 days old, an 11-hour operation was performed on Siphokazi and Nosipho at Durban's King Edward VIII Hospital. They died within a few hours of each other. Motho and Mothoana were operated on at Pelonomi Hospital when they were four days old by a team of 10 doctors. Motho died within two months of her twin sister.

Mpho and Mphonyana, who won the hearts of the community and also attracted a lot of overseas attention, went through the third phase of a complicated and risky operation when they were 17 months old. The gruelling operation at Baragwanath Hospital, headed by Professor Robert Lipschitz, lasted seven-and-half hours. Mpho and Mphonyana survived the operation and both are well on their way to recovery with Mphonyana, the weaker of the two, recovering at a slower pace.

Many Siamese twins have been successfully separated by surgery. But there are also some mothers who have decided their children would rather live with the strange physical disability than undergo an often risky operation. The most famous pair are Chang and Eng who were born in Siam, now Thailand, in 1811. They were joined by a short piece of flesh in the abdomen. They married English sisters and between them, had 21 children. They died aged 63.

YVONNE and Yvette McCarter have been joined at the head for 38 years. Like normal healthy adults, they have left the seclusion of their home and are enrolled at a college as students.



Shap needs more funds

Soweton 1/16/88

299

THE Self Help Association of Paraplegics in Soweto needs an additional R460 000 to furnish phase two of their new complex to be built at the end of June.

The chairman of the association, Mr Friday Mavuso, said it was necessary to extend Shap in order to cope with the growing number of disabled people who want to be accommodated at the centre. He also said there was a need for more room, as some other work areas inside the centre were overcrowded.

At present the centre provides 100 disabled people with jobs and there are already over 500 other disabled people in Soweto who need help.

Mr FRIDAY Mavuso

Dress warmly — the cold can kill

Soweton 10/6/88 (299)

THOUSANDS of people are crippled or killed each year because they underestimate cold weather hazards.

It does not require sub-zero exposure before inner organs lose their precious warmth, reports the June *Reader's Digest.*

Many cases of hypothermia, a potentially deadly loss of warmth in the body's core, occur in moderately cold temperatures.

Particularly vulnerable are small children, whose bodies lose heat faster than adults' bodies do; the elderly, who are often undernourished or on medications that alter the body's temperature response; people with underactive thyroids; the unusually slender; dieters and alcoholics.

Here, from the magazine, are six steps you can take to avoid hypothermia.

1. Eat properly. Dieters and extremely thin people are more susceptible to the cold because they do not have the insulation that fat cells provide. Moreover, their bodies contain less fuel — either food or body fat to convert to heat. Carry high kilojoule snacks if you expect to be out long.

2. Prevent dehydration. Fluid loss from perspiration and from breathing dry air can substantially reduce your blood volume. Drink extra fluids before prolonged outdoor activity, and take along a hot beverage.

3. Avoid alcohol. Alcohol gives the illusion of warmth because it dilates blood vessels and brings a rush of blood to the skin. But this also takes blood away from core organs, rapidly depressing body temperature.

4. Know the effects of drugs. Some medications such as drugs to control blood pressure, antidepressants and certain heart medicines affect the body's response to outside temperature changes. Check with your doctor.

5. Wear appropriate clothing. Remember the three L's: light, loose and layered. A thin outer shell can prevent wind from penetrating. Loose, multiple garments trap layers of air, providing additional insulation, and give you the ability to add or shed clothes as conditions change.

Essential are a hat and scarf, because up to one-third of a body's heat loss comes from the head and neck. For the hands, experts suggest water-resistant mittens to provide an "envelope" of warm air; for feet, loosefitting shoes with thick woolen socks.

The groin should be protected by not too snug underwear and windproof outer clothing.

Toy library helps disabled children develop via play

Star 13/6/88 299

By Kaizer Nyatsumba

Does your child have enough time to play — and with the right kind of toys?

That, according to a South African Inherited Disorders Association (Saida) toy library director in Johannesburg, is a question every parent has to answer, because many people are not aware of the importance of play to all children.

"We live in an age where play has actually become a dirty word. The truth is, we learn a lot when we are playing; through playing children learn basic skills," said toy library director Mrs Angela Frankel.

Non-profit service

Established in 1979, the toy library is a private, non-profit and non-racial community service, which caters for individual pre-school children and their parents on a regular basis, and runs a mobile service to areas around Johannesburg.

Said Mrs Frankel: "We take knowledge and toys on the road to educate, stimulate and help those families with handicapped children who have more pressing needs in troubled times."

The library, which is "as much for parents as it is for the child," caters for handicapped and non-handicapped children.

It has also intitiated mobile services or trained parents and nursing sisters at Natalspruit Hospital in Katlehong, Baragwanath Hospital in Soweto, Nokuthula Centre in Alexandra, Harvey Cohen Training Centre in Eldorado Park and Milsight Hospital in Randfontein.

Every two weeks the toy library organises activity groups "for pre-school children to encourage social interaction and emotional maturity, (while) their parents relax, meet others and choose their children's toys at leisure." These support groups are run by social workers.

Situated at the Transvaal Memorial Children's Hospital in Parktown, the Saida library is the biggest of the 18 toy libraries in South Africa.

The first toy library, said Mrs Frankel, was opened in Scandanavia in the early '60s, in response to "the recognition of the need to help and stimulate mentally and physically handicapped children by supplying toys to aid their development".

A Saida statement says: "Toy libraries exist to promote the principle that play does matter for the developing child.

"By offering a befriending, supporting service to parents, and by making available and lending appropriate toys, they extend the opportunity for shared play in the home."

The library charges a nominal R48 annual membership fee. If parents cannot afford this amount, the library arranges sponsorship for the child.

Mrs Frankel can be contacted at (011) 643-2913 or (011) 643-6311 for either questions or donations.

first adventure into the world of business. A small boy can imagine great things with a toy till. ● Pictures by John Hogg.

Great benefit to disabled child — and mother too

Star 13/6/88 299

Two-year-old Ryan Davis is an avid user of the Saida toy library. Every morning he asks his mother: "Mommy, is the toy library open?"

Little Ryan, paralysed from the waist down, looks forward to going to the library, and "is very keen to be here", according to his mother, Ms Jean Davis.

Ms Davis, a single parent is full of praise for the toy library, of which she has been a member for two years.

"The toy library has been a great benefit to Ryan. I couldn't get him the sort of toys and help he gets here, where we have an occupational therapist paying special attention to him," said Ms Davis.

When she first heard about the toy clinic, her son was attending the spina bifida clinic at Johannesburg Hospital. She said that when she first made inquiries she did not know she was eligible, "because I thought the library was for under-priviliged people only".

She said going to the library has taught her to play with Ryan, "which I think in today's world is very necessary and important for parents to do with their children. Since I work during the day, I must have quality time for Ryan."

Her son, she said, "enjoys the imaginative type of play; most of the innovations he has come up with are quite amazing".

Mrs Mary Burgan is mother to six-year-old Justine who has a speech problem "which made him insecure and unsure of himself". The toy library, she said, has done wonders for her son.

Justine was three years old when his parents first realised he had a problem. The situation worsened when two years later he could not "pick up a pencil to write or draw, because he had no confidence in himself," his mother said.

When Justine started using the toy library two years ago, an occupational therapist made him solve four pieces of puzzles, and now he can solve about 100 of them.

"I don't think the average member of the public realises that playing has a therapeutic effect," Mrs Burgan said.

A colourful world of make-believe provides a good foundation for the real world ahead. Toys and helping hands give children a good start in life.

SQUATTERS PLIGHT

Sowetan 14/6/88 (299)

HEALTH 2000 conducted a survey at the Chiawelo emergency camp at the weekend.

Dr Abu Asvat, co-ordinator of Health 2000, said: "We found that there were 25 families living in tents with no end of their plight in sight.

"The threat of removal to Rietvallei still looms large on them. Therefore few people have money for brick structures. They also feel that the R27 they pay for rent is exorbitant," Dr Asvat said.

Many cases of upper respiratory problems were found as a result of the recent cold spell and poor quality of their structures, he said.

Health 2000 found a number of cases of previously undetected high blood pressure and referred them to the Chiawelo clinic.

They also found a case of one teenage mother who had no source of income and having two underfed children. She was referred to the social workers for assistance.

Dr Asvat said they distributed soup and bread as well as clothes obtained from well wishers. Health 2000 also made a call to the community to bring along old clothes and blankets to house No 2065 at Moroka, Soweto for distribution.

Mrs Domitilla Hyams of Little Eden home holds little Rainer and Martina. ● Picture by Stephen Davimes.

'Miracles' happen at Little Eden

Star 14/6/88

299

By Paula Fray

A child holding a toy would normally not evoke any reaction, but when the child is severely mentally handicapped this brief show of concentration is regarded as nothing less than a "miracle".

And at Little Eden in Edenvale — a home for children who are severely mentally handicapped as a result of infections, difficult births, child-bashing and accidents — "miracles" still happen.

Here, 178 people of various ages, races, and religions are given the chance "to live in a peaceful, healthy environment and in the hope, however small, of a slight improvement", says Mrs Domitilla Hyams, Little Eden's driving-force.

Italian-born Mrs Hyams met her South African husband, Danny, during the war.

Lot of Work

Grateful for her new life, and wanting to serve others, Mrs Hyams started Little Eden in June 1967 when she was the mother of five daughters and one son.

It was nearly not to be when she visited her family in 1965 who asked her to stay. However, says Mrs Hyams, "I literally heard a voice telling me to return."

And, until she opened the school, she says she felt unsettled. She says after seeing a vision of the Madonna, she believes Little Eden is the result of Divine Providence and likens herself to a pair of scissors with God, the tailor.

So, with R10, three children and an empty hall she started Little Eden.

After 15 years of moving from property to property the home settled down on land given by the Edenvale municipality.

Today Little Eden has seven wings, a kitchen, laundry, therapy centre with three jacuzzi's, a theatre, games hall and workshop.

The children are divided according to age and physical abilities.

While Little Eden will never close, the finances are strained. Government grants make up two-thirds of their income, parents give one-sixth and the public gives the remaining one-sixth.

Debts paid

The outstanding debt of R160 000 for renovation is paid from fund-raising and donations.

The home exists from month to month with the public's help as parental support varies from total involvement to none at all, says Mrs Hyams.

The school's long waiting list decreases only when a child dies. There are now 60 adults over eighteen, and this has led to an urgent need for more space.

To fill this need, Mrs Hyams wants to build an agricultural centre on the 43 ha of serviced land in Bapsfontein, which the home owns.

The soil has been tested by agriculturalists and Pecan nut trees have been planted. The home's occupants will all help earn money for its upkeep.

The initial cost for the 100-bed centre is estimated at R2 million. The home needs helpers and donations for their October Mardi Gras at Germiston Lake when they celebrate Little Eden's 21st anniversary.

Little Eden can be contacted at (011) 609-7246 or Box 121 Edenvale, 1610.

HEARTBREAK

Anguish of having to turn away fellow paraplegics

Sowetan 15/6/88

299

THE co-ordinator for Self Help Association of Paraplegics Centre in Soweto, Mr Friday Mavuso, has appealed to paraplegics all over the country to inform him in time before they come to the centre in Soweto.

By MATSHUBE MFOLOE

"It breaks my heart as a disabled person for the Self Help Association of Paraplegics, to have to send some of my colleagues back home," he said.

Mr Mavuso said this in reaction to the inflow of disabled people from outside Soweto who approach him for help.

Although SHAP was established to cater for the disabled in Soweto, disabled people from as far as Queenstown, Swaziland and Parys in the Free State, come for help, Mr Mavuso said.

Already, the centre is housing three disabled people from outside Soweto. "I cannot send them back because they are in need of help," Mr Mavuso said.

Mr President Maki (35), who is confined to a wheelchair after an accident, travelled alone by train from Queenstown, eastern Cape, to Soweto, seeking help from Mr Mavuso.

Mr Maki said life for him was "unbearable at home," as nothing was done "to make life meaningful" for him.

A University of Swaziland B. Comm graduate, Mr Mduduzi Zwane, arrived at SHAP centre after he could not find a job at home. Mr Zwane said that his arm was amputated at an early age.

Gratitude

"I enjoy my stay here at SHAP, and my deepest gratitude to Mr Mavuso, who has been so kind to everybody," he said.

Miss Patricia Tilotsana from Parys, heard of SHAP centre and read about it in the *Sowetan*.

"I was told that the centre was for the disabled in Soweto only," but I found SHAP to be the only centre to make life meaningful to me," said Miss Tilotsana.

"There are a lot more of us at home (Parys), and our community at home seems not to care for us. We hide ourselves and only come out when necessary. People do not regard us as people," she sobbed.

Mr Mavuso, who is also manager of the SHAP centre, said it "frustrates" him to send cripples from outside Soweto back home.

"I feel the Soweto community will criticise me for housing outsiders while many Soweto cripples are still on the waiting list," he said.

Meanwhile, Mr Mavuso appealed to relatives and families to make applications for their disabled people, rather than "dumping" or sending them alone to the centre.

THE co-ordinator of the Paraplegics Centre in Soweto, Mr Friday Mavuso (extreme right), with some of the paraplegics who came to Soweto without having informed him. (From left) they are: Miss Patricia Tilotsana from Tumahole in Parys, Mr President Maki from Queenstown in the Eastern Cape and Mr Mduduzi Zwane from Swaziland.

housebreaking with intent to steal and theft, (g) robbery, (h) theft of (i) motor vehicles and (ii) cycles, (i) malicious damage to property, (j) illegal possession of fire-arms and (k) possession of drugs were reported and investigated at police stations serving Riverlea and Riverlea Extentions 1 and 2 areas in Johannesburg in (aa) 1987 and (bb) 1988 as at the latest specified date for which information is available;

(2) (a) how many of these cases in each category (i) have been solved and (ii) remain to be solved and (b) in respect of what date is this information furnished?

The MINISTER OF LAW AND ORDER:

(1) and (2)

Riverlea and Riverlea Extensions 1 and 2 fall within the Langlaagte police station area. Separate records of crimes committed in these areas are not kept, therefore the required information cannot be furnished.

SAP training college, Bishop Lavis: Ranks of lecturers

33. Mr W J MEYER asked the Minister of Law and Order:†

(a) What are the ranks of the lecturers at the South African Police training college at Bishop Lavis, (b) how many (i) White and (ii) Coloured persons hold each of these ranks and (c) in respect of what date is this information furnished?

The MINISTER OF LAW AND ORDER:

(a) Lance Sergeant to Major

(b) (i)	Major	1
	Captain	1
	Lieutenant	1
(ii)	Lieutenant	1
	Warrant Officer	8
	Sergeant	10
	Lance Sergeant	15

(c) 16 May 1988

Own Affairs:

Old-age homes

33. Mr P J MÜLLER asked the Minister of Health Services and Welfare:

(1) Whether any new old-age homes are envisaged by his Department for (a) Port Alfred, (b) Grahamstown and (c) Kirkwood; if not, why not; if so, (i) when is it anticipated that building operations will (aa) commence and (bb) be completed, and (ii) what is the total amount allocated for this purpose, in each case;

(2) whether he will make a statement on the matter?

The MINISTER OF HEALTH SERVICES AND WELFARE:

1. (a) No, (b) No, (c) No, because it is the policy of my Department not to establish Old Age Homes. This is left to the initiative of Welfare Organisations while the Department contributes in the form of subsidies.

(i) (aa) Fall away

(bb) Fall away

(ii) Fall away

2. No.

Johannesburg: rehabilitation centre

36. Mr T R GEORGE asked the Minister of Health Services and Welfare:

(1) Whether his Department intends to establish a rehabilitation centre in the vicinity of Johannesburg; if not, why not; if so, (a) where will it be located, (b) when is it anticipated that building operations will (i) commence and (ii) be completed and (c) (i) what is the estimated total cost of the project and (ii) in respect of what date is this estimate furnished;

(2) whether he will make a statement on the matter?

The MINISTER OF HEALTH SERVICES AND WELFARE:

1. No, my Department is presently in the process of doing a need assessment investigation as regards the establishment of a Government rehabilitation centre for the northern Provinces.

(a) The location can as yet not be determined.

(b) (i) Fall away

(ii) Fall away

(c) (i) Fall away

(ii) Fall away

2. No.

Riverlea/Riverlea Extension 1: organization/persons involved in clinics

40. Mr T R GEORGE asked the Minister of Health Services and Welfare:

Whether he will furnish information on the organization and persons involved in the administration and operation of the clinics in Riverlea and Riverlea Extension 1; if not, why not; if so, (a) what (i) is the name of the organization, and (ii) are the names of the persons, so involved and (b) what are the positions held be each of these persons?

The MINISTER OF HEALTH SERVICES AND WELFARE:

No information can be given on the organization and persons involved in the administration and operation of the clinics in Riverlea and Riverlea Extension 1 as these clinics do not fall under the jurisdiction of the Department of Health Services and Welfare.

(a)

(i) Fall away

(ii) Fall away

(b) Fall away

Riverlea: organization/persons involved in crèche

41. Mr T R GEORGE asked the Minister of Health Services and Welfare:

Whether he will furnish information on the organization and persons involved in the administration and operation of a certain crèche in Riverlea, the name of which has been furnished to the Minister's Department for the purpose of his reply; if not, why not; if so, (a) what (i) is the name of the organization, and (ii) are the names of the persons, so involved, (b) what are the positions held by each of these persons and (c) what is the name of the crèche in question?

The MINISTER OF HEALTH SERVICES AND WELFARE:

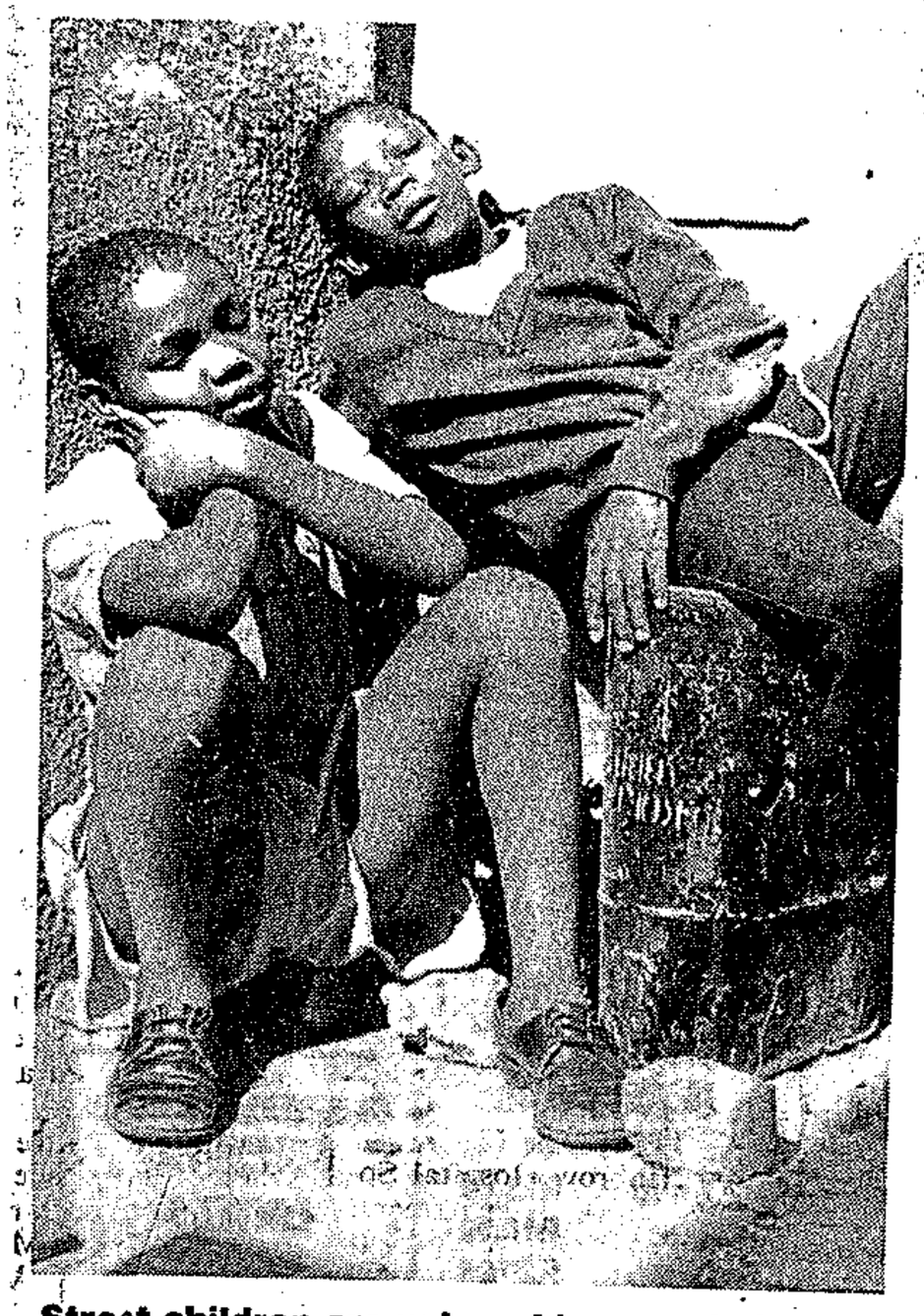
(a)

(i) Riverlea Social Services Institute

(ii) Information as regards private welfare organisations are not made available.

(b) Fall away

(c) Witsco Crèche



Street children are vulnerable sexual abuse.

New shelter for street children

(29) Chron 19/6/88

By VASANTHA ANGAMUTHU

DURBAN'S street children are to get a new home, following the gutting by fire of their shelter, Khaya Lethu, last week.

The Durban City Council this week voted in favour of demolishing Khaya Lethu, landscaping the site and requesting the Durban African Child and Family Welfare Society to identify alternative premises for a shelter with council assistance.

Councillors Gys Muller and Lew Phillips voted against the third proposal.

Muller said the council was harbouring sodomites and criminals by providing money for a shelter for the more than 100 children.

He said the children should be sent to a place of safety as it was not the council's responsibility to look after them.

Councillor Margaret Winter said present costs to the city would be nothing compared with the costs if nothing was done about the street children.

Chairwoman of the management committee, Sybil Hotz, said the grant given to the welfare soceity to look after the children was the smallest given to any child welfare organisation.

Winter said Muller was right when he said the children were exploited for sexual reasons and were being used to peddle drugs.

"But don't think that rounding them up will make any difference.

"There is no organisation for blacks like there is for the other race groups – there is only one place of safety in Durban and it is grossly overcrowded.

"We have to face the problem and deal with it," she said.

Meanwhile, the children continue to sleep in the disused back room of their burned-out Khaya Lethu.

To ward off the cold they wrap themselves in blankets donated to them after the fire.

Khaya Lethu, their home of eight months was gutted after a fire broke out in an upstairs room.

Unless alternate accommodation is found for them, they will have to go back to sleeping in storm-water pipes, buses and shop entrances.

Sorting out medical aid confusion

COMPANY managements expect widespread confusion when amendments to the regulations governing medical schemes are introduced.

A multitude of flexible packages are likely to be offered, blurring the perception of various scheme advantages.

Keith Hollis, managing director of Medscheme which pays out more than R360-million a year in benefits, says his company has established Medscheme Consultants to provide comparisons of all medical schemes in the country, detailing differences in benefits, claim levels and member subscriptions.

Business Times Reporter

Using Medscheme's mainframe data base, the company has for some years captured details of all competitive medical aid schemes. In the past this has been been offered freely to companies, but the success of the operation has encouraged the company to establish its consultant company.

Medscheme Consultants' assistance will be useful to companies with large workforces, experiencing pressure from down-the-line employees wishing to gain membership.

This pressure has often been reinforced by trade unions demanding improved benefits for the members as well as those wishing to offer black employees medical aid.

Medscheme Consultants is able to offer an economic array of options for evaluation by the company which could be compared with competitors' benefits.

Medscheme Consultants will charge an investigative fee for information, but this will be waived if a Medscheme package is used.

Growth of Medscheme itself has been tremendous and it now has a membership of 300 000 and an estimated 975 000 dependents. It has offices Johannesburg, Cape Town, East London, Durban, Vereeniging Swaziland and Windhoek and new branches are being planned in Benoni, Port Elizabeth and Pretoria.

Doctors' fees plan rejected

JOHANNESBURG. — South African medical schemes have decided to reject the Medical Association of South Africa's proposal that doctors should be allowed to charge what they like for services, while still enjoying the 100% guaranteed direct payment from medical schemes in terms of the medical schemes scale of benefits.

In a statement Mr Rob Speedie, the executive director of the Representative Association of Medical Schemes (RAMS), said this was a significant deviation from the present system in which doctors who charge at the RAMS scale of benefits are guaranteed payment direct from medical schemes, while doctors who charge at above the benefits scale do not enjoy the right of guaranteed benefit.

Instead, members claim the applicable benefit from their schemes and are personally responsible for payment of their doctor's accounts. "The MASA proposal that doctors be allowed to charge at above the scale of benefits could well create problems. RAMS cannot go along with it." — Sapa

men started last Monday.

MASA in row over fees

Sowetan 20/6/88

SOUTH African medical schemes have decided to reject the Medical Association of South Africa's proposal that doctors should be allowed to charge what they like for services, while still enjoying the 100 percent guaranteed direct payment from medical schemes in terms of the medical schemes scale of benefits.

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Instead members claim the applicable benefit from their schemes and are personally responsible for payment of their doctor's accounts.

Problems

"The MASA proposal that doctors be allowed to charge at above the scale of benefits — collecting the guaranteed payment from the medical scheme and the excess from the patient — could well create more problems than it would solve. RAMS cannot go along with it."

He said RAMS would be making a counter proposal to MASA soon, in the hope of reaching agreement.

While RAMS welcomed MASA's reported decision to keep increase in tariffs to below 10 percent next year, the decision to possibly introduce additional services and MASA's recommendations on unit values applicable to each medical service, the overall increase in medical fees could well be more than 10 percent.

(1) How many South African Airways flights between (a) Durban and Cape Town, (b) Durban and Johannesburg and (c) Durban and Port Elizabeth (i) arrived and (ii) departed late during the week which ended on 13 May 1988;

(2) what percentage of the total number of South African Airways flights to and from Durban during this week does this represent?

The MINISTER OF TRANSPORT AFFAIRS:

(1)	(i)	(ii)	
(a)	Particulars are not readily available and it will take much time and expense to gather such information.	10	Both directions
(b)		24	
(c)		2	

(2) 13,6 per cent.

As weekly statistics are kept from Monday to Sunday particulars are in respect of the week 9 to 15 may 1988. In the case of Question No. 1126 it was from 2 to 8 May 1988.

SAA flights: late arrivals/departures

1193. Mr R J LORIMER asked the Minister of Transport Affairs:

(1) How many South African Airways flights between (a) Johannesburg and Durban, (b) Johannesburg and Cape Town and (c) Johannesburg and Port Elizabeth (i) arrived and (ii) departed late during the week which ended on 13 May 1988;

(2) what percentage of the total number of South African Airways flights to and from Johannesburg during this week does this represent?

The MINISTER OF TRANSPORT AFFAIRS:

(1)	(i)	(ii)	
(a)	Particulars are not readily available and it will take much time and expense to gather such information.	24	Both directions
(b)		29	
(c)		20	

(2) 20 per cent.

As weekly statistics are kept from Monday to Sunday particulars are in respect of the week 9 to 15 may 1988. In the case of Question No. 1127 it was from 2 to 8 May 1988.

Major transport facilities: withdrawals

1230. Mr C J DERBY-LEWIS asked the Minister of Transport Affairs:

(1) Whether any major transport facilities were withdrawn in (a) the Transvaal, (b) the Orange Free State, (c) the Cape Province and (d) Natal over the latest specified five-year period for which information is available; if so, (i) what facilities, (ii) when, (iii) why, and (iv) what savings were effected as a result, in each case;

(2) whether any major transport services currently operated in each of the provinces are uneconomical; if so, (a) what services and (b) at what cost to the taxpayer, in each case?

The MINISTER OF TRANSPORT AFFAIRS:

(1) Yes, rail and road transport services. Full particulars as requested by the hon member are not readily available and it will take much time and expense to gather such information.

Transport Services, like any other organisation, evaluates its services on a continuous basis and adjustments are made where necessary.

Various suburban and intercity passenger services have been withdrawn as a result of poor patronage and an annual saving of R108 536 093 was effected. Uneconomical rail services over various branch lines have also been replaced by road transport services after efforts to improve the economy of the rail services have failed. In the financial year in which the various services were withdrawn the following savings were effected:

	Million R
Fort Beaufort — Seymour	0,387
Molteno — Jamestown	0,540
Bowker's Park —Tarkastad	0,611
Estcourt — Weenen	0,654
Umlaas Road — Mid Illovo	0,204
Donnybrook — Umzinto — Madonela	2,805
Port Shepstone — Harding	4,745

(2) Yes. Rail passenger services and various branch line services are operated uneconomically. Particulars of the contributions by the Central Government in respect of losses on railway passenger services for the 1986/87 financial year are contained in the Report of the Auditor-General on the Accounts of the South African Transport Services which was tabled on 18 April 1988.

Losses in respect of uneconomical branch lines do not affect the taxpayer as Transport Services bears its own losses.

Officials: overseas journeys

1235. Mr J J S PRINSLOO asked the Minister of Transport Affairs:†

(1) Whether any officials who fall directly or indirectly under the South African Transport Services undertook any overseas journeys during the past two calendar years; if so, (a) (i) what are their names and (ii) what posts did they hold at the time of these journeys, (b) what was the (i) purpose, (ii) duration and (iii) cost of each journey, (c) when was each journey undertaken, (d) who paid the travelling and subsistence expenses in each case and (e) who gave approval for these journeys;

(2) whether any of these officials were accompanied by their wives; if so, who paid the travelling and subsistence expenses of these wives?

The MINISTER OF TRANSPORT AFFAIRS:

(1) Yes. Senior officials of Transport Services undertake overseas journeys from time to time, *inter alia*, to attend conferences of international railway organisations, investigate the feasibility of new systems under South African conditions, monitor contracts concluded with companies abroad and for the normal execution of their duties. Each visit is subject to my approval except in the case of employees of SA Airways where authority is granted by the Chief Executive (Airways). All subsistence and travelling expenses are borne by Transport Services.

Full particulars as requested by the hon member are not readily available and it will take much time and expense to gather such information.

(2) Officials are sometimes officially accompanied by their wives in which case Transport Services accepts responsibility for the subsistence and travelling expenses.

Transmed members: contributions

1237. Mr J J S PRINSLOO asked the Minister of Transport Affairs:†

Whether the contributions of Transmed members to (a) doctors' fees and (b) the cost of medication were increased in the past three calendar years; if so, (i) what was the percentage increase, and (ii) on what dates were these increases introduced, in each case?

The MINISTER OF TRANSPORT AFFAIRS:

1 January 1985 to 31 December 1987.

(a) No.

(i) and (ii) Fall away.

(b) Only in respect of pensioner members.

(i) Partial payment of the cost of medicine was increased from 10 to 20 per cent.

(ii) 1 April 1986.

First-year students

1251. Mr K M ANDREW asked the Minister of Education and Development Aid:

With reference to the reply of the then Minister of National Education to Question No 1114 on 4 July 1984 how many full-time equivalent first-year students were (a) enrolled and (b)

'Many medical services overcharge patients'

Overcharging and billing for services not rendered is common practice among certain elements that provide medical services, says Mr Pat Corbin, the chairman of the Witwatersrand Chamber of Commerce and Industry's (WCCI) medical aid fund.

He says the medical aid fund, which has 6 500 principal members, finds it necessary to keep a tight rein on all payments and all claims are carefully vetted before being settled.

"This reaps us a rich harvest in saved overpayments," he says.

MANY CLAIMS ADJUSTED

"We find overcharging in at least 50 percent of the claims submitted to us by certain providers of services and we see to it that they are adjusted accordingly, in some instances quite substantially.

"Instances where fictitious services are charged for are fairly common. We have referred such matters to the Medical and Dental Council who consistently declined to tell us whether any disciplinary action had been taken or not."

Mr Corbin said it was quite apparent to the WCCI that there were some people among those providing medical services who tried to take advantage of patients's ignorance and charged for services not rendered.

This was worsened by the seeming indifference and closed-shop attitudes of many who were involved.

"Experience has taught us that many members of the medical community don't really understand how a medical aid scheme operates. This results in confusion and an added administrative burden for us," he says.

"Furthermore, many employees don't seem to realise that medical contributions are regarded by their employers as part of their salary packages and that it is therefore in their interest not to misuse their funds. Because in the end they are the ones who foot the bill.

HEALTH CARE NEWSLETTERS

"I also believe that not enough is being done on the preventive side of medicine and we are currently arranging to issue newsletters on health care to all our members."

The WCCI's tight financial and administrative controls over its medical aid scheme has made it one of the top performers in the industry. It has consistently maintained the prescribed 25 percent reserves of annual subscription income, a feat few other societies have been able to emulate.

'Health services must be free'

THE Government's idea of privatising health and social welfare services once more received all-round condemnation — this time from the Centre for Enrichment in African Political Affairs, writes Mokgadi Pela.

More than a month ago, the Imbeleko Women's Organisation launched a national campaign against the programme.

At the weekend, various speakers in Soweto reiterated that the provision of houses, health facilities and education was the responsibility of the State.

A thread which ran through their speeches was that tax was deducted so that citizens could benefit from among others, free health services.

They further said that only when a total transformation of society took place, would black people enjoy basic necessities?

Mr Ish Mkhabela, the acting co-ordinator of the Witwatersrand Network for the Homeless, said: "Privatisation is not on our agenda, it is on the agenda of the State and big business. In this country, housing is another means of control and oppression."

He said as long as there was capitalism, housing would remain a problem.

A social worker from the South African Council of Churches, Miss Fikile Mazibuko, said privatisation of health and welfare services did not auger well for the man in the street. The lower income groups and pensioners would be hardest hit.

Mrs Amelia Jones, a social worker from Cape Town, who delivered a paper on the dilemmas faced by social workers, said the impact of apartheid was a reality faced by all her colleagues.

The two-day seminar, which was held at the Dube YWCA, was attended by a wide cross section of people.

Preparing people to help others

Sowetan 30/6/88

299

A ST JOHN nursing sister seen with children at one of the community projects administered by the organisation.

ST JOHN is a first aid organisation which prepares children and adults to help the sick and injured.

Its aims are to serve and care for the community regardless of race, class or creed. The Order of St John started almost 1 000 years ago in Jerusalem. Today St John operates in over 40 countries and has over 250 000 volunteer workers who help others in their free time.

St John volunteers are trained in first aid. This makes them able to help in the home, at an accident or even in a national emergency. They are trained to save lives.

St John members serve the community in the following ways: ambulance transport, first aid duty at events such as soccer and other sport functions giving life-saving help at road accidents and training others to save lives. These are just a few examples of the worthwhile work that St John does.

Children and young people may join the cadets where they are offered a wide range of activities and events. They also learn first aid.

Last year over 9 000 St John people in South Africa spent over 90 000 hours of their time providing help to others without receiving payment.

St John also co-ordinates community projects. These projects include soup kitchens, child care, care of the aged, eye clinics, home nursing and the provision of wheelchairs and crutches.

Aims

Two of the main aims of St John are to provide the community with skills to improve the quality of life and to serve all people of South Africa.

It concentrates on areas of health care and basic health education. This is an important step in treating disease at an early stage. If it were not for the volunteer workers in the various communities many of the problems in these areas would not be discovered, and these people would not get the help they need.

By means of first aid training every person could be prepared in case of emergencies like drownings, burns, poisonings.

People who are interested in giving a few hours a week to helping others and to learn first aid or nursing can join the St John Ambulance Brigade (Telephone: 403-4227).

R20-m medical bill for 'over-servicing'

MEDICAL aid society members may soon have to pay most of the first-time consultation fee for visiting a doctor.

Experts believe the plan will help staunch an industry-wide cash crisis caused by general practioners over-servicing their patients.

A Sunday Times investigation has revealed that the administrators of one of SA's biggest medical aid schemes are losing at least R2-million a year from this practice.

Excessive

The total over-servicing bill for the country's medical aid schemes could be a staggering R20-million. Members and employers will have to pick up the bill.

Affiliated Medical Administrators (AMA) found that GPs receiving direct guaranteed payments did 34 percent more consultations per patient than contracted-out doctors charging at the scale of benefits.

Said AMA executive chairman Mr Tony Leveton: "The guaranteed payment system must be changed. GPs who are paid directly clearly have no real interest in cost containment and it's just a credit card system for them."

But the doctors' Medical Association of South Africa (Masa) hit out at the suggestion that "tariffmanship" was rife in the profession.

Said Masa chairman, Dr Bernard Mandell: "We know that certain doctors are over-

By HAMISH McINDOE

servicing, but we have an effective committee to deal with this problem."

The Representative Association of Medical Schemes (Rams) and Masa are scheduled to meet on July 19 to discuss proposed changes to a wide range of medical care issues.

And the agenda is expected to include a Rams proposal that would effectively scrap guaranteed medical scheme payments for consultations.

Industry sources say the proposed payments scheme would make the patient pay between 50 to 70 percent of the consultation fee.

Meanwhile, attitudes are also hardening against the private hospitals that flesh out their accounts causing medical schemes to pay millions of rands for careless accounting and, in some cases, blatant dishonesty.

AMA post-payments audit on private hospital accounts managed to recoup a staggering R250 000 from members' accounts last year.

Several hospital bills shown to the Sunday Times tell a dismal tale of overcharging, massive price differences on agreed costs for medicines and equipment and charges for non-chargeable items.

New deal won for working parents

By KERRY CULLINAN

THE Commercial, Catering and Allied Workers Union this week took a historic step when it signed the first-ever parental rights agreement with Pick 'n Pay.

According to Ccawusa organiser Jeremy Daphne, the agreement, which directly affects about 24 000 people, is geared towards eliminating discrimination against women by making childcare more of a joint parental responsibility.

In terms of the agreement, if both parents work for Pick 'n Pay, they can share 11 months' parental leave, nine of which is paid.

A father may take eight days' leave when his baby is born, as well as one day off a month to take his child to the clinic.

Women are given nine months' paid maternity leave, and are guaranteed their jobs back on their return. Pregnant and nursing women are exempted from working overtime, at night, or in dangerous areas.

"One of the principles underlying the agreement is the acknowledgement that men and women have the right to hold a job, lead a normal family life, work under healthy and safe conditions and give their children the necessary care and attention," the union said, adding that it hoped the agreement would make an important political contribution.

"The political questions of equality between women and men and gender roles have not received sufficient attention, and this agreement makes concrete contributions in this area," added Daphne.

Clifford 3/7/89

299

(299) S/Times 3/7/88

Medical-aid schemes returning to health

By Robyn Chalmers

THE marked improvement in trading results of most medical aid schemes is mirrored by Meddent, a Johannesburg-based scheme.

Meddent, which has more than 18 000 members with 36 000 dependants, achieved a surplus of R3,1-million from income of R38,7-million in the year to December 1987.

Chairman Don Boddington told the annual meeting of the society that the surplus was a 600% increase over the R405 000 in 1986.

"Surplus improvement was a direct result of the timeous adjustment of contribution rates. The reserves of the society are now well on the way to achieving the levels recommended by the Registrar of Medical schemes.

"Reserves are vital for stability," he said.

Representatives of the medical-aid movement have long campaigned for greater reserves to achieve this as well as to bring contribution rates down.

Paraplegics need finance

Star 4/7/88 (2nd)

By Stan Hlophe

The Self Help Association of Paraplegics (Shap) is expanding because of the huge demand for its services in Soweto.

Work on a new building, which has already started, is expected to be completed next January at a cost of R1,5 million.

The centre's chairman, Mr Friday Mavuso, has already raised R850 000 towards the building from overseas companies. A further R660 000 is needed for equipment, transport and running costs.

Mr Mavuso was full of praise for Anglo American, JCI and SA Breweries for their contributions towards building the first phase of the project.

Sanctuary needs money to fill beds

Star 5/7/88

(249)

By Paula Fray

While it has more than 60 children on its waiting list, the Woodside Sanctuary in Auckland Park has 12 empty bedrooms — each able to accommodate four beds — which cannot be used because it does not have the necessary finances and furniture.

The sanctuary has been hit by a decrease in contributions, but has been fighting back with massive fund-raising campaigns, says the chairman of the Woodside committee, Mr R G Nicholson.

Apart from launching an appeal for contributions by sending out more than 100 000 letters to private individuals, the home received a R25 000 contribution from running veteran Wally Hayward.

The Woodside Sanctuary provides 24-hour care for about 80 children handicapped by congenital defects during birth, road accidents or by a spread of factors which cause brain damage.

Mr Nicholson said: "With the completion of the extensions to the sanctuary during 1987, Woodside was in a position of offer further care to many more children and hence relief to their parents,".

The extensions meant 16 rooms were built to house an additional 64 children.

Already 16 children from the home have been given the chance to live where they have more privacy and space, with their own beds and recreational area.

However, only four rooms could be filled with the contributions received.

Article is 'vindictive' — SACBC

The Southern African Catholic Bishops' Conference (SACBC) hit out today at an article by political analyst Aida Parker in the latest edition of her newsletter.

In a statement, the SACBC said Ms Parker was continuing her "vitriolic campaign" against the Church in her recent article "The priests take on Pretoria".

She had singled out various church leaders for a particularly venomous attack, the SACBC said.

The statement said: "Her reasoning is simplistic and her argument is emotional and vindictive."

The SACBC reaffirmed its belief in the dignity of all human beings, who were created in the image and likeness of God.

"Knowing Aida Parker as we do, we await with great interest to see whether she will attack the Pope himself.

"And he (the Pope) has expressed his support for the efforts of the SACBC in the area of justice and peace," the statement concluded. — Sapa.

Which used

1988-198

Welfare bodies battle without multinationals

By Winnie Graham

Hard-hit welfare organisations in South Africa, doing vital work among the poor and handicapped in this country, had lost an estimated R100 million since the withdrawal of multinational companiess, Mr David Jackson, a community management consultant, said.

He was commenting on the critical financial problems being experienced by most welfare societies.

He said it was time the Government provided firms which contributed to the day-to-day needs of the under-privileged community with the same tax incentives as those received by companies sponsoring international cultural, educational or sporting events.

These firms received a 90 percent after-tax subsidy from the Government. Sker 22/7/88

Mr Jackson said that while the multinationals were in South Africa many of the Signatories Association companies gave between 12 and 15 percent of their after-tax profit to community projects.

Those taken over by South African interests were now donating only about 0,5 percent after tax. (299) (~~297~~)

The physically disabled, the deaf, blind, mentally handicapped and, perhaps, the animal welfare societies remained the "Orphan Annies" of society.

"Some kind of tax incentive must be found to help these organisations," Mr Jackson said.

He suggested these organisations get together not only to lobby the Government, but also to coordinate their fund-raising activities.

Parents of oesophagus sufferers form group

Medical Reporter

Children born with abnormalities of the oesophagus need specialised tube-feeding until they are able to undergo corrective surgery.

Mrs Lynne Lonsdale, whose daughter was born with a malformed oesophagus, would like to set up a support group to help the parents of these children.

She told The Star: "These children need extra care and parents must know what types of food to give them and how to feed them through tubes.

"They are often fed through tubes which are inserted into their stomachs. In the black population this condition is problematic because the child is sent home but the parent has no idea how to tube-feed the child and in some instances the child dies."

The condition is easily corrected by surgery but the operation is not always done immediately after birth.

Anyone wishing to join Mrs Lonsdale's support group can contact her at home at (011) 683 9872.

continue

Caring for the disabled

25/7/88

299

By Mokgadi Pela

HAVE you ever imagined that someone could accept a hospital bed as his permanent home? This is the case with paraplegics at the TEBA Rehabilitation Centre in Welkom.

A talk with some of them recently revealed the emotional trauma they have had to go through in trying to adjust to this type of life. Firstly thay had to accept their condition and secondly acceptance by the society, and the family was a problem on its own.

Patients with all kinds of disabilities recounted accidents which landed them at the Rehabilitation Centre.

RIGHT: Paraplegics going through an exercise.

Some explained that they had lost the support of their children who seemed not to realise that they sustained those injuries trying to make a living for them.

"Lack of gratitude destroys my soul, I do not know why God spared me. I am haunted by day and tormented by night," said Mr Frans Stuurman (49), a former mineworker at the Amanda Belt in Thabazimbi.

Some patients complained that they were not properly compensated in terms of the Workmen's Compensation Act. Most of the injured were members of the National Union of Mineworkers.

The superintendent of the centre Dr Jerome Boule explained that the hospital was well equipped. It also had physiotherapists, occupational therapists, neurosurgeons and various specialists in their fields.

Chamber

The centre is controlled by The Employment Bureau of Africa Ltd., the labour wing of the Chamber of Mines. Officials were reluctant to reveal the total number of paraplegics throughout their mines.

"It will give us a bad name," one official said.

He further said they had established a family training section to improve the relationship between patients and their families. A clinical psychologist conducts lessons in which patients are taught how to have sex with their wives.

He also said every disabled person was capable of a sexual relationship of some sort.

Dr Boule said the centre faced daily cases of alcoholism and dagga smoking. He said: "All the Lesotho guys say dagga is their cigarette."

Table

A walk around sections of the hospital gave us an insight into their lives. Mr Molahlegi Motsebane (48), a former mineworker at Matla Colliery, Witbank, said: "I was working when a table fell over me. I was unconscious until I found myself at the Rand Mutual Hospital in Johannesburg."

He kept himself busy with handwork and knitting jerseys. His wife was next to him the whole day. She had been with him for weeks.

"It proves that she meant it when she made a vow that she would love me until the end of time," said Mr Motsebane.

25/7/88
Soweton
299

Mr Stuurman, former worker from Vryburg, Northern Cape, said he was hit by an underground trolley in September 1986. He injured his spine, broke his right leg and lost his left arm.

Mr Vuyisile Nomsopo, from Tsolo in Transkei, said he was injured while dipping his cows. He sustained spine, hips and leg injuries. He was married with two wives and 11 children.

Mr Seabata Nkoko (38), from Prieska, Cape said he had one child. he complained that after his injury he was given R2 600 instead of getting a bigger amount which he believes he was entitled to.

NUM

He also said his monthly income at the centre was R153. "I cannot support my family, I cannot even take my son to school.

The Compensation unit of NUM said the only reason black workers were discriminated against was because of their skin colours.

Compensation officer, Miss Nomsa Nkwanca, said: "The compensation workers receive makes it **difficult for them to support themselves and their families."**

She added that most of the workers who get injured at work were sent home under the pretext of what was called *Medical Repatriation.*

In that regard, NUM advised its members to elect safety stewards on all mines to ensure that all injuries were monitored, she said.

Centre for disabled expands in Soweto

By Stan Hlophe and Sue Olswang

Building of the R1,5 million second phase of facilities for the Self-Help Association of the Paraplegics (Shap) started in Soweto this week.

The building, which will cater for 120 people, is scheduled to be completed in January next year.

The first phase, which caters for 100 disabled people, was built in 1983 at a cost of R500 000.

The centre's chairman, Mr Friday Mavuso, said the huge demand from the disabled as afar afield as Swaziland and Bophuthatswana had forced them to expand.

"What we do here is train them, help them to organise initial funds and send them back to their respective places where they are encouraged to start their own self-help centres."

The enormous demand for such facilities led Mr Mavuso to campaign for funds internationally and locally. He got a "favourable" response from South African Breweries, Gold Fields, Anglo American and JCI.

Offers are still pouring in and the latest donor is the director of Eyethu Cinema, Ms Dombolo Tshabalala, who has pledged all the proceeds of the internationally renowned "Cry Freedom" gala night show to be held at the cinema on Friday evening.

Mr Mavuso urged other black businessmen to follow suit.

Anyone interested in buying tickets for the gala night can contact Eyethu Cinema at 982-1086 or Mr Mavuso at 982-1036.

Mr Mavuso was shocked late last night when The Star informed him of the Minister of Home Affairs' direction to the Publications Appeal Board in Pretoria to reconsider the approval of the "Cry Freedom" film on Steve Biko's life.

Front row: Mr Friday Mavuso, chairman of Self Help Association of Paraplegics (Shap), Miss Poppy Buthelezi, Shap secretary, and Mr Johannes Nhlapo. Back row: Mr Thomas Thekiso, Shap's engineer, Ms Dombolo Tshabalala, who will donate the proceeds of the film, "Cry Freedom", and Mr Fanie Gambu, a supervisor at the site of the second phase.

● Picture: Herbert Mabuza.

Star 26/7/88

29/7 = 4/8/83

'Strange, the way people think that because we are disabled we are mere shells'

Losing the use of their limbs is only part of the tragedy for Soweto's disabled. The real problem is the way the ignorance of those around them cages the disabled in helpless, dependent roles

JO-ANN BEKKER reports

Picture: STEVE ROTHENBURG

Hurt by a stereotype ... disabled man at a Soweto help centre

"PEOPLE only see our shell," a disabled Soweto resident said. "They think the shell is empty. They think there is nothing we can do."

Wits University sociology lecturer Dr Jacklyn Cock quoted this statement in her paper, "Life 'inside the shell': a needs survey of spinal cord injured wheelchair users in Soweto".

In spite of Baragwanath's overcrowded and inadequately staffed wards, many disabled people wanted to remain there rather than return to a society which shuns them, Cock told the Association of Sociologists in Southern Africa's conference in Durban last week. Her paper was based on interviews with 88 people.

Several people interviewed confirmed that patients re-opened their pressure sores with blades to avoid discharge. One young man committed suicide by hanging himself in the toilet, rather than leave Baragwanath.

Almost a third of the sample, 27 people, reported they had wanted to commit suicide. A total of 12 had actually tried, using sleeping pills and pain killers. "When I returned home from hospital I tried to kill myself by eating ground glass," one interviewee recalled.

"Anywhere I go people stare as though I am from the moon."

Another said some people did not want him inside their houses and when he went to a shebeen he had to sit outside and drink his beer.

"In a racist society like South Africa, often the sterotype of disability interacts with a stereotype of racial inferiority in which attributes of stupidity and childishness are dominant," Cock said. "There is a danger that this stereotype acts as a self-fulfilling prophecy caging disabled people in helpless and dependent roles."

Few people interviewed enjoyed an independent family life. Seventy-one of the 88 were single, five were divorced, one separated and one widowed. Only 10 were presently married. Most were living with their parents or with other relatives, an arrangement which places family relations under considerable strain.

The majority of single people interviewed had a girl or boyfriend, Cock said. But 51 percent reported they had difficulties with sex, and several reported they had not had sexual intercourse since their injury. Very few received any counselling on how to overcome these difficulties. "This is anchored in the general perception of the disabled as asexual," Cock said.

Most of those interviewed said they spent weekdays alone. Leisure time was spent on watching television, drinking — 48 percent reported they drank a lot — and listening to music. One person said: "I just sleep."

Apartheid was the cause of most violent incidents which result in physical disablement in townships and the barrier which prevented black disabled people from living full and productive lives, Cock said.

Many were the victims of criminal violence fostered by poverty and unemployment. Forty-two percent of the sample interviewed had been stabbed. A further 11 were injured in shooting incidents which did not involve the police. One had been thrown from a train by *tsotsis*.

"Life here is fast," one interviewee explained. "Two people living near me were stabbed in a fight over a dog. Life here is too fast. It is because people are squeezed."

Cock said a third of the sample interviewed were stabbed or shot by lovers when they tried to terminate a sexual relationship.

Cock said: "Such patterns of behaviour have to be contextualised in a social atmosphere in which male dominance and violence are accepted cultural themes. They also have to be tethered to the social context of Soweto which exhibits many of the characteristics of disadvantage and deprivation that are typical of South Africa's black urban townships."

Many disabled black South Africans were the victims of the "direct repressive violence of the state", according to Cock. A total of 77 percent of the 88 people interviewed had received their spinal cord injuries in a violent assault and almost a quarter were the victims of police shootings.

Some had been shot by police accidentally or during political violence. Others were shot while they were engaged in criminal activities. Five of those interviewed were shot by police during the 1976 Soweto uprising.

A number of disabled people were victims of "reactive violence". One person interviewed was shot by guerrillas after her father resigned from the African National Congress.

According to Cock, black disabled people were the victims of "structural violence" against both black and disabled people in South Africa. All blacks were discriminated against in housing, transport and health care services — and disabled black people suffered double the discrimination.

Only 17 percent of Cock's sample received compensation for their injury. One person who was shot in the 1976 riots said: "My father tried to fight for compensation but they told him that as I was a student maybe I was involved in those things."

In addition, Cock said "State pensions paid to all disabled people discriminate between the racial groups with Africans receiving about half that of whites." Only 49 people interviewed were receiving a disability grant — the maximum amount was recently increased from R97 to R117.

Black disabled people were also discriminated against in the area of employment, Cock said. The Department of Manpower operates sheltered workshops for white disabled, but none for blacks. Almost half the sample, 42 people, were in employment at the time of their injury; now two-thirds of the sample are unemployed. The majority of those employed worked at the Self Help Association of Paraplegics (Shap), a "self-help factory" started in August 1983.

"Many factors — transport difficulties, employer prejudice and architectural barriers — coalesce to exclude such spinal cord injured people from productive employment," Cock said.

There are few opportunities for Soweto's disabled to further their education. Of the 88 people interviewed for Cock's research, the average level of education achievement was Standard 5 and six people had received no schooling. Only 15 had any other kind of training or qualification. Although 90 percent of the sample were keen to acquire skills, many were blocked by educational authorities from returning to school. The only school in Soweto for the physically disabled goes up to Standard 6 and caters for 150 pupils.

The shortage of adequate housing for black people is another serious problem for disabled people. One person interviewed said: "I sleep in the kitchen, I have to wait for them to finish eating and washing before I can go to sleep."

Cock said many interviewed complained that transport was expensive, inaccessible and infrequent. Fifty percent said they had to rely on private taxis. "Sometimes they just pass if they see you in a wheelchair," said one.

Health services were also inadequate, although Cock points out Soweto offered better facilities than most townships. In all 42 percent had not seen a doctor for a year and 10 percent had not seen a doctor since being discharged. Only 24 percent said they were visited by a district nurse and 15 percent saw a social worker.

'Anywhere I go, people stare at me as if I am from the moon'

Where disabled are assets at work

By Shehnaaz Bulbulia

Goodwill Industries of Johannesburg, a private welfare organisation which employs handicapped people, celebrates its silver jubilee this year.

"We established a work-oriented rehabilitation facility which utilises the work experience and related services to assist handicapped people to progress towards a normal life," said Mr Alan Flint, manager of Goodwill Industries.

The objective of establishing protected workshops, he said, was to give the handicapped a feeling of independence.

The workshop has four departments where 100 workers, most of whom are mentally handicapped, are trained to pack toys, food, nuts and bolts.

The non-racial organisation accommodates up to 150 people but requires more work orders.

Depending on the job description, workers may be trained for a a few hours or for as long as a month.

EMPLOYED

After passing a one month probationary period they are then permanently employed.

"Those employed must have a disability grant and in addition they receive meals, free transport and a weekly wage ranging from R9 to R20," said Mr Flint.

"Society either shies away from the mentally or physically handicapped or dishes out sympathy which people don't want. They should not be rejected but made to feel as if they are assets to our community," said Mr Flint.

Mr Dennis Daly, of Bedfordview Rotary Club, which assists Goodwill Industries, would like to extend the project in the East Rand area.

If you are disabled or know of someone who is, please write to Rotarian Harold Thompson, Director of Vocational Services, Rotary Club of Bedfordview, Box 121, Bedfordview 2008, or telephone Mr D Daly at (011) 534780.

Group instils confidence, respect and independence

Helping handicapped turn disability into advantage

Star 1/8/88

299

By Kaizer Nyatsumba

So you are handicapped, cannot do anything for yourself and other people look down at you, making you lose confidence in yourself and you feel lonely, unloved and uncared for — the whole world is turned against you, right?

Wrong, says the Independent Living Centre (ILC), which believes that a handicap should not put handicapped people at a disadvantage for the rest of their lives.

Handicapped people, the ILC believes, should be able to live satisfying lives, just as other people do, without feeling sorry for themselves.

So, what is the magic formula?

The answer, says the ILC, lies in the everyday interaction of others with the handicapped, and how that interaction occurs.

The handicapped should be treated with respect and be encouraged to think independently to reach decisions for themselves.

Reliance on institutional care should be reduced.

The ILC, which was founded five years ago, is situated at the corner of Loveday and Wolmarans streets in Braamfontein, Johannesburg, and recently opened a branch in Mfolo, Soweto.

This was done "to curb transport problems experienced by people with disabilities staying in Soweto, who have indicated the need for ILC services," a spokesman said.

The organisation was aimed at "promoting independent living among people with disabilities".

This independence does not necessarily mean living without any physical assistance, if and when needed.

"It means independence to take decisions about one's life and taking responsibility on the course one's life is to take."

Founded in April 1983 — two years after the International Year of Disabled People — the ILC "offers a free service where people of any race, age or income group, who have physical, mental or dual disabilities, can obtain optimum and comprehensive information covering every aspect related to reducing or eliminating the handicaps imposed by their impairment and by society."

The ILC also helps families of handicapped people as well as professionals and volunteers involved in the care of the handicapped.

The organisation intends to "reduce institutional care and promote independent living in the community by providing support and assistance, when requested by disabled people, rather than by imposing preconceived concepts, upon them as to their role in society."

In April 1986 the ILC adopted a new constitution which ensured that the "ILC will always be an organisation run by people with disabilities, for people with disabilities." This was in line with the organisation's philosophy, that:

- "All people visiting the centre are individuals with a right to make decisions on anything that effects their own lives";
- "Integration at all levels, as opposed to segregation, is a prerequisite to the preservation of self-esteem, dignity and independence";
- "Using people with disabilities as an information source and for sharing of solutions to problems"; and
- "The ILC works with people with disabilities, not for them, or through a third person as far as referrals and problem-solving are concerned. No decisions are taken which will affect the person with the disability without his/her active involvement and consent."

A spokesman for the organisation said it was financed by public donations and trust funds alone, and "no Government subsidy is received".

(299) B Daily 8/8/88

Rams wants talks

THE Representative Association of Medical Schemes (Rams) has asked for an urgent meeting with the Medical Association of SA (Masa) to discuss impending medical cost increases that could result in a R150m increase in subscription rates for members of medical schemes.

Rams said at the weekend the impending cost increases resulted from two factors:

☐ The proposed introduction of dispensing fees for doctors who dispense medicines directly to patients; and

☐ A move to increase general practitioner consulting fees by 33,3%.

Rams executive director Rob Speedie said Rams had written to Masa in the interim urging that the dispensing fee be reconsidered "in the light of its very serious implications".

He also said a computer analysis of a group of medical schemes with more than 170 000 members had shown the effects of the proposed fee changes would be "catastrophic".

The people likely to be hardest hit by the Masa dispensing fee move would be "pensioners and underprivileged people", particularly in the black and coloured communities, as they were the greatest users of the services of dispensing doctors.

He said the computer analysis showed coloured medical-aid members would face a 29% increase in the cost of medical aid if the dispensing fee were introduced.

Black members would have to find an additional 27% in subscriptions.

"If the proposed increase in general practitioner consulting fees is added to the planned dispensing fee, coloured medical aid members will face an increase in subscriptions of no less than 58%," Speedie said.

Black members would have to pay 55% more for medical care if fees were raised. — Sapa.

Call for urgent meet on medical fees plan

CM Times 8/8/88 299

JOHANNESBURG. — The Representative Association of Medical Schemes (RAMS) has called for an urgent meeting with the Medical Association of SA (MASA) to discuss proposals on medical fees.

The proposals include the introduction of dispensing fees for doctors supplying medicines directly to patients and a 33,3% increase in consulting fees for general practitioners.

RAMS executive director Mr Rob Speedie said that members of medical aid schemes faced a R150m increase in membership fees this year if the proposals were implemented.

The chairman of the federal council of MASA, Mr Bernard Mandell, said it was a pity that RAMS had made a statement about increases in medical fees when negotiations on the proposals had not yet beeen finalized.

Mr Mandell also said his association was opposed to dispensing fees for doctors, but he said if this could help keep down the cost of medicines, his association could not but support it.

Mr Mandell added that a 33,3% increase in consulting fees for doctors was highly unlikely. What was being considered was a 10% increase in the medical scale of benefits.

● Government's firm policy was to privatize health services as far as practically possible, Deputy Health Minister Mr M H Veldman said at the weekend.

Speaking at a medical fund function in Randburg, he said socialized medicine had never figured in official policy.

Mr Veldman said he failed to understand the logic of some medical schemes, which provided no benefits for preventive health-care services.

Some schemes would not cover anti-malaria drugs, yet they covered the cost of treatment of the disease.

Most schemes failed to cover contraceptives, yet they would pay costs incurred for pregnancies and confinements.

Medical men drop bedside manner

B Day 9/8/88

299

PRETORIA — The Representative Association of Medical Schemes' (Rams) pre-emting of a possible increase in medical scheme benefits and blaming Masa, the Medical Association of SA, for the proposed dispensing fee for doctors, was a breach of confidence, Masa federal council chairman Bernard Mandell said.

He added that Masa had been confident good progress was being made by a joint Masa/Rams liaison committee on possible amendments to the Medical Schemes Act and was, therefore, shocked to learn of a Rams news release last week that they and Rams were "locking horns".

Rams said an urgent meeting had been held with Masa at which the proposed fee for dispensing doctors, and an increase on GP fees of 33%, were discussed.

Mandell said government had decided the costs of prescription medicines was too high.

GERALD REILLY

To counter this it was suggested that profits on medicines should be abolished and that doctors and pharmacists should get a fee for handling medicines. It was misleading to imply that doctors would use this to raise their incomes.

The public had also been misled by guesses that GP tariffs would rise by a third and that medical schemes members would, as a result, have to pay an additional R150m.

Masa pointed out that Rams' scale of benefits was 50% lower than Masa's guideline fees for doctors.

The third increase in GP consultancy fees would mean the schemes raising their benefit for consultancy fees from R15 to R20.

Possible amendments to the Medical Schemes Act were still being negotiated and these could have a decisive influence on schemes payouts.

out to judge their health". — UPI

Masa slams Rams for 'confidence breach'

CM-Times 9/8/88 299

Own Correspondent

PRETORIA. — The Representative Association of Medical Schemes (Rams) pre-empting of a possible increase in medical scheme benefits and blaming Masa for the proposed dispensing fee for doctors was a breach of confidence, the Medical Association of South Africa (Masa) federal council chairman, Dr Bernard Mandell, said here yesterday.

Masa, he said, had been confident good progress was being made by a joint Masa-Rams liaison committee on possible amendments to the Medical Schemes Act.

Masa was, therefore, shocked to learn of a Rams news release last week that the two associations were "locking horns in yet another disagreement".

Rams said an urgent meeting had been held with Masa at which the proposed fee for dispensing doctors, and an increase on GPs' fees of 33,3%, were discussed.

Dr Mandell said that the government had decided that the costs of prescription medicines was too high.

RAMS in bid to avert medical fee rise

299

Staff Reporter 10/8/88

THE Representative Association of Medical Schemes (RAMS) will meet the Minister of National Health and Population Development, Dr Willie van Niekerk, in a bid to stave off a huge rise in medical fees.

This move follows an urgent meeting with the Medical Association of SA at which the proposed medical fee increases were discussed.

These include the introduction of dispensing fees for doctors supplying medicines to patients, and a 33,3% increase in consulting fees.

RAMS executive director Mr Rob Speedie said the fees rise threatened to have "catastrophic" effects on the poor.

11/8/88

Job security for pregnant women guaranteed

New agreement will give workers the right to parental benefits

The struggle for parental rights in South Africa has received a boost through a precedent-setting agreement between the Commercial, Catering and Allied Workers' Union (Ccawusa) and leading retailer Pick 'n Pay which employs 18 000 people. However, the majority of South African workers still have a long way to go before they can enjoy parental and child care benefits as a right, writes Labour Reporter MIKE SILUMA.

The parental rights agreement between the Commercial, Catering and Allied Workers' Union (Ccawusa) and Pick 'n Pay — which comes into effect this month — has placed the issue on the social agenda at a time when most South African working women have yet to win the right to have children without jeopardising their jobs.

The agreement is based on a set of principles, which include the notion that women and men should have equal opportunity to combine employment with family life under safe conditions.

The agreement includes the following innovations:

- The right for women employees to take 11 months' parental leave, for nine of which they will be paid 75 percent of their wages. Fathers are entitled to share the remaining two months' unpaid leave provided they work for Pick n' Pay.
- Eight days' paid leave for fathers during their partners' confinement or when adopting a child. Fathers are also entitled to a total of 10 days unpaid leave until their children are 12 years old, plus an additional paid day off each month during a baby's first six months.

No discrimination

The agreement also guarantees job security for pregnant women and outlaws discrimination on the basis of pregnancy. In addition, women will be entitled to paid leave in accordance with a doctor's recommendation in the event of a stillbirth or miscarriage.

The Ccawusa-Pick 'n Pay agreement, followed closely by a less generous one between the Amalgamated Clothing and Textile Workers' Union and James North Africa in Natal, is the result of growing pressure among the black union movement for improved parental rights for South African workers, itself the culmination of years of campaigning for maternity rights.

The first comprehensive maternity agreement was signed in 1983 between Ccawusa and OK Bazaars. It included a year's unpaid leave and job security. This was followed by agreements with other employers in the retail and distributive trade and other sectors.

According to Ccawusa spokesman Mr Jeremy Daphne, many women earning low wages were forced to return to work too soon after childbirth because of financial difficulties. The Unemployment Insurance Fund (UIF) only provided for six months' pay at 45 percent of a woman's wages.

He praised Pick 'n Pay for being "reasonably open-minded" in their approach to the whole issue of parental rights.

"We believe that Pick 'n Pay were in the best position to negotiate an enlightened agreement because they were accustomed to the union ... and were, more importantly, financially in a position to agree to our proposals," said Mr Daphne.

Pick 'n Pay's industrial relations general manager, Mr Frans van der Walt, acknowledged that the company's comparatively strong financial position might have been crucial to management's approach.

According to Mr van der Walt, Pick 'n Pay believes it has a role play in helping employees with parenting.

It was impossible, said Mr van der Walt, to predict the exact cost of implementing the agreement because the number of people who would make use of the facility was unknown. But he did give a "guesstimate" of between R1,2 million to R2 million a year.

"We will now have a clear-cut policy (on the parental rights issue) and this could have a positive effect on industrial relations in the company," said Mr van der Walt.

Ccawusa regards the Pick 'n Pay agreement as an important first step and hopes it will be a precedent in providing for the parental and child-rearing needs of all South African workers, according to Mr Daphne. The union plans to table proposals similar to the Pick 'n Pay agreement to all companies where it is recognised.

The same proposals have been submitted to the industry's wage board, which sets minimum standards for wages and working conditions for retail workers.

But while Ccawusa has its sights set on a comprehensive parental rights programme, the vast majority of employees in both the public and private sectors have yet to attain maternity rights, let alone child care facilities or paternal rights.

Thousands of farm and domestic workers are not covered by the Labour Relations Act, and do not, therefore, qualify for UIF benefits.

Maternity rights

According to the Institute for Industrial Relations, central Government and provincial departments have no provisions for either maternal or paternal benefits. Pregnant women are allowed to take unpaid leave for up to six months, which may be increased depending on circumstances. However, where a replacement is necessary, a woman going on maternity leave would have to resign.

Employees of some municipalities are covered by industrial council agreements which provide guidelines for maternity rights.

A recent snap survey by management consultants P E Corporate Services showed that only 20 percent of Johannesburg companies approached were prepared to grant three months' unpaid maternity leave; 50 percent gave three months' paid leave and 20percent gave up to six months' unpaid leave. Only 10 percent would give a year's unpaid leave.

All companies arranged that there be no loss of pension benefits during maternity leave. All the companies also gave women returning from such leave the same position as before if they returned within an agreed time. Only 10 percent offered child care facilities and 100 percent considered women for professional appointments on the basis of ability and qualifications for all positions.

Regarding paternity leave, companies were willing to give a day's compassionate leave at the time of childbirth. If the father wanted longer time he would have to take it from his annual leave. The survey concentrated on professional and skilled employees.

P E Corporate Services' remuneration division manager, Ms Naomi Brehn, said the figures showed that paternity leave and the provision of child care facilities were not common.

"While these are big issues in the United Kingdom, Europe and United States, (they are) things we still have to pay attention to if we are to draw women into the workforce. The only way we can do that is to provide means of child care."

She said State and private child care facilities were not easily accessible and could only be afforded by high in come earners.

Disabled are taught to start home businesses

Staff Reporter

There were smiling faces yesterday when 15 physically disabled women graduated in their self-made gowns after attending a five-week sewing course at the Foundation for Entrepreneurship Development's (FED) training centre in Johannesburg.

The women, all from Tembisa township, were previously unskilled and were doing menial assembly work.

Now they are well on the way to making money after completing the first leg of the FED's Cottage Industry Development Programme.

VIABLE

The programme aims to create a viable cottage industry sector in southern Africa.

Sponsored by a local company, the women have learnt to make a variety of clothing and will now move on to the second phase of their training, called Cottage Industry Development Unit.

In the four-month course they will be taught how to manage their own cottage operations.

Dr Dennis Wolmarans, founder and executive director, said the FED's main aim is to motivate and develop self-employment among unskilled and deprived people.

299

Healthy glow for medaid schemes

THE medical-aid industry is returning to glowing health after a turbulent 1986 when two major schemes folded.

By Robyn Chalmers

Reporting on the progress of the six schemes under the Medicaid Administrators Group for the six months to June, managing director Jeff Slome says their reserves will probably soar.

"By the end of the year I expect all of the South African schemes to have reserves approaching 20% — equal to more than two months' contributions.

"This is a healthy position. Adequate reserves are essential for the stability of the industry. They provide a buffer against the need for contribution increases when there are adverse claims experiences.

"Big tariff increases for providers of medical services are expected in January next year and they will have to be met by an adjustment of contributions rates."

Mr Slome points to Medicaid's KWB scheme as an ideal example of how the industry has turned around.

"In September 1986, KWB had used up almost all of its reserves. They now stand at more than R5-million, or 19% of annual contributions income. The trading surplus for the first six months of this year was R1,3-million.

"The turnaround has been achieved by prudent and timeous monitoring of trends against budget and strict management of the scheme's risk profile."

The schemes in Medicaid Administrators report large surpluses after paying more than R59-million in claims from 65 000 members.

The schemes have boosted total reserves to more than R23-million.

Concern

Flagship scheme Multimed's surplus is R1,8-million and Meddent also tops R1-million.

Mr Slome says that although the overall results are pleasing, some areas of expenditure particularly for pathological and radiological services and private hospitalisation are over budget and cause of concern.

"Private hospital costs have increased ahead even of the rise in fees implemented at the beginning of the year. We also expect overall claims to be higher until September as a result of the colds and 'flu of the winter months."

Jeff Slome ... strong reserves protect us

Cost of medicine causes concern

Cape Times 20/8/88

299

Political Staff

DURBAN. — South Africans could no longer afford to get sick or to get old, Dr Willie van Niekerk, Minister of Health, said yesterday.

The government was extremely concerned about the rising cost of medicine in the country, he told delegates the Natal NP congress.

He was concerned too that the government had not been able to increase civil pensions in the face of rising costs and inflation.

Some medicines had increased by 230% and more in a short time, for a variety of reasons, including higher salaries due to union pressure in multi-national companies.

An investigation had been launched some time ago and a report was due before the end of the year.

"We may have to look at price fixing as we had before. Nobody can afford to get sick any more," he told the congress.

People relying on civil pensions also could not afford to get old and it was even worse for women because they got only half of the husband's pension, and lived longer.

He jokingly said they lived longer because men looked after them better than they looked after the men.

● PW and Naspers showdown soon — Page 3

Cost of medicine causes concern

Political Staff

DURBAN. — South Africans could no longer afford to get sick or to get old, Dr Willie van Niekerk, Minister of Health, said yesterday.

The government was extremely concerned about the rising cost of medicine in the country, he told delegates the Natal NP congress.

He was concerned too that the government had not been able to increase civil pensions in the face of rising costs and inflation.

Some medicines had increased by 230% and more in a short time, for a variety of reasons, including higher salaries due to union pressure in multi-national companies.

An investigation had been launched some time ago and a report was due before the end of the year.

"We may have to look at price fixing as we had before. Nobody can afford to get sick any more," he told the congress.

People relying on civil pensions also could not afford to get old and it was even worse for women because they got only half of the husband's pension, and lived longer.

He jokingly said they lived longer because men looked after them better than they looked after the men.

● PW and Naspers showdown soon — Page 3

21/8/88 (294) Chron

Soweto project to help epilepsy

By SIMPIWE NCWANA

A GROUP of women in Soweto have formed a self-help group to teach epileptic people various handwork skills.

The 10 women run the Soweto Epilepsy Self-Help Organisation free of charge.

Voluntary worker Pinki Zikalala said the organisation was formed to keep the epileptics busy and to enable them to make some money.

"We discovered that epileptic people are the most neglected in terms of special facilities," she said.

"Mostly, they end up just staying at home doing nothing. The medical treatment they get from clinics helps them a lot, but they also need to be socially and economically fulfilled.

"It is not very easy for them to get proper jobs or attend normal schools.

"Most of the time the children fail, not because they are stupid, but because they are far behind with their school work. It is then difficult for them to catch up by themselves.

"They end up pitying themselves and feeling useless. There is a great need for them to have special schools with special teachers who will understand their problem.

"The Soweto Epilepsy Self-Help Project helps them come together and instils a feeling of responsibility in them. They look forward to the next day because they know they have some work to do. It also makes them feel good to know they can produce lovely things that are needed in the community," said Zikalala.

The Soweto project has 40 epileptic members. They do not yet have a proper centre, but meet every Thursday at house 3100 in Rockville, the home of Daisy Maakwe, a voluntary worker on the project.

The epileptics are taught skills such as knitting, sewing and shoe repairing, but the project is hampered by lack of funds and materials.

"We appeal to the community to support us. People can provide us with wool, cloths, shoes for repairs and any other material," said Zikalala.

The group intends organising a fund-raising project at which the goods will be sold to the public.

The group has organised a seminar on abuse of epileptic patients. It is to be held at the Diepkloof Hall on August 27.

Rise in GP fees bad for patients, good for doctors

Star 299 24/8/88

By Toni Younghusband, Medical Reporter

An increase in general practitioners' consulation fees would be disastrous for the patient, says Mrs Joy Hurwitz, vice-president of the Housewives League. But PFP health spokesman, Dr Marius Barnard says an increase would be well-deserved by doctors who have to cope with high costs.

Mrs Hurwitz said an increase would be particularly hard on consumers struggling with the high cost of living.

"To have the added burden of worrying whether you can afford to be ill or not is disastrous," she said.

Dr Barnard said general practitioners were battling to cope with their own high costs.

"They have had unbelievable increases in costs lately. Their own living costs, office rentals, the cost of equipment has gone up, drugs are more expensive ... the list goes on.

"A 10 percent increase (as has been proposed by the Medical Association of South Africa) would be well below the inflation rate," he said.

Their remarks come in the wake of the recent announcement by the Representative Association of Medical Schemes (Rams), which claimed that Masa was proposing a 33,3 percent rise in general practitioners' fees.

Masa said the Rams statement had been a breach of confidence and was speculation.

Masa and Rams were engaged in talks over proposed increases and a Masa spokesman said anything that came out of the talks was sub-judice.

"In June a 10 percent fee hike was announced for doctors who have contracted out of medical aid but nothing further has been decided. Private doctors make up between 10 and 15 percent of all GPs in this country."

Mrs Hurwitz said everybody in health services seemed to be at loggerheads. She said it was a pity these people were fighting among themselves when what they should be doing was bringing down medical costs.

"My concern is the patient. Something must be done to bring down costs.

"The State is finding it increasingly difficult to carry patients not on medical aid and those who do belong to medical aid schemes are having to pay higher and higher subscription fees."

Dr Barnard did not think the problems in the country's health services should always be laid at the door of the doctor.

"It seems that the Government has closed its eyes. The whole health care spectrum must be looked at," he said.

2 classes for the disabled

Pretoria Bureau

A private company has donated two classrooms valued at R40 000 to the Medunsa Institute For Community Services (Medicos) to be utilised for handicapped children.

The presentation ceremony was held at the Medicos Centre in Soshanguve this week.

The classrooms will be occupied by handicapped children attending the Children's Day Care Centre at Medicos Centre, which is situated at the entrance to the township.

Medicos is a multidisciplinary institution within Medunsa and is entirely dependent on private grants.

The classrooms would alleviate the great demand for the admission of more children at the Medicos Day Care Centre, according to the authorities.

Currently the Day Care Centre accommodates 40 children who are either mentally handicapped or have learning disabilities.

Spokesman for Medicos said "the idea is to meaningfully occupy the children, assist them to overcome their problems and where possible, provide those with insurmountable handicaps with the skills necessary to enter sheltered employment".

299 Press 28/8/88

New drug, alcohol centre for Reef

A CENTRE for the treatment and rehabilitation of alcohol and drug-related problems is to be erected north-west of Johannesburg by private health care organisation the Lifecare Group.

"Our market research has shown that there are more than 750 000 people in South Africa suffering from some form of alcohol or chemical dependency," said Lifecare chairman David Tabatznik. "Only a tiny minority are receiving the treatment they need, leaving an enormous gap in health care. The existing general hospitals are unable to provide the appropriate therapy and offer no rehabilitiation programmes."

Said Dr Sylvain de Miranda, a leading expert on the treatment of alcohol and drug-related problems: "We are sorely in need of such centres to provide a holistic treatment."

The centre, which will hopefully admit its first patients early next year, will be built on 14 hectares in a rural setting bordering on the Jukskei River. It will initially cater for 72 patients and be staffed by professionals trained at Phoenix House and the Centre for Alcohol and Drug Studies in Johannesburg. All race groups will be admitted. – Sapa

Star 20/9/88 (299)

Disabled cost SA millions in welfare payments

Pretoria
Correspondent

The disabled in South Africa are costing the State millions of rands annually in welfare payments, mainly because they are unaware of the training facilities and job opportunities available to them.

This is one of the findings of Human Sciences Research Council (HSRC) education specialist, Mr Peet le Roux, who co-ordinated a nationwide survey into the training and placement of the disabled.

The survey was launched at the request of the Minister of Manpower as one of the projects for the 1986 Year of the Disabled.

"Only 10 percent of South Africa's three million disabled have permanent jobs," Mr le Roux said.

"While, admittedly, there are employees who are wary of employing a disabled person, this situation is mainly due to the fact that so few of our disabled really know about the training facilities and job opportunities available to them.

"As a result they cost the State millions of rands in welfare payments every year," Mr le Roux said.

The investigation, which was done in co-operation with the National Training Board, will conclude with a symposium on Tuesday, October 19, at the Tuks Aula.

The symposium will give disabled people or those who deal with the disabled a chance to make recommendations on the current circumstances of and facilities for the disabled.

Registration must be completed by September 20.

All those interested groups or individuals needing more information should contact Mr le Roux at 202 2547.

'Millions a day' get frittered on medicine

By RENEE MOODIE
Medical Reporter

SOUTH AFRICANS spend about R2 000 million a year — or almost R5,5 million a day — on medicines, it was said at the launch of a new medical publication yesterday.

Professor Peter Folb, chairman of the Medicines Control Council and head of the UCT department of pharmacology, was speaking at the launch in Pinelands of the "South African Medicines Formulary", which was compiled by members of his department.

He said there was a "worrying tendency" to over-prescription of drugs in South Africa, which had been documented by medical aid societies and hospitals.

The "Formulary", the first comprehensive medicine-prescribing guide for use by health professionals in South African conditions, was published by the Publications Division of the Medical Association of South Africa (MASA) in association with the Pharmaceutical Society of South Africa.

Prof Folb said that while spending on medicines in South Africa fell in an intermediate range internationally, white South Africans probably spent about as much as North Americans. Black South Africans probably spent as much as that spent per capita in countries like Nigeria.

Twenty percent (R400 million) of money expended on medicines was spent by the pharmaceutical industry on promoting their products.

"Much of this information is fair and accurate but it is also likely to be motivated by self-interest. The aim of the "Formulary" is to provide medical people and the public with objective information in the public interest," he said.

Dr John Straughan, co-editor with Dr Elizabeth Conradie of the "Formulary", added that over-prescription was part of a social ethos.

Prof Folb said the "Formulary" aimed at promoting a rational, cost-effective and objective use of medicines.

"There is the prospect that unless we use medicines carefully, the continued availability of essential drugs cannot be guaranteed in the future.

"Having essential medicines depends on local and international infrastructure and industry, governmental attitude to that industry, the resources of a country, systems of distribution and the amount of money available.

"In most countries — except advanced nations — people do not have access to critical medicines like penicillin," he said.

In the foreseeable future, South Africa would not be self-sufficient in essential medicines. "We do not have the technology or the expertise," he said, adding that as yet the country had not suffered from sanctions in this area.

D. 299 Star 30/8/88

Fragmentation causing 'wastage of resources'

Health service unity needed

By Toni Younghusband, Medical Reporter

The only way South Africa could successfully control the spread of disease was through the unification of its health services, Professor Solly Benatar, head of Cape Town University's medical department, said yesterday.

He told delegates at a medical congress in Sandton that "if we fragment our health services rather than unify them then we are not going to successfully combat disease, no matter what we do".

Infectious diseases were responsible for the second highest mortality rate in South Africa, Professor Benatar said.

Whatever medical milestones had been achieved in this country were being ignored by colleagues overseas.

"Whatever our achievements have been, they are being seen as of little importance in the face of our politics.

"The rest of the world has set us on a path of destruction and will not stop until there are equal rights for all in this country," he said.

Professor Benatar said what was needed was a great deal of co-operation between the peoples of South Africa.

"I would like to say that if South Africa is going to succeed in all areas we are going to have to unify rather than allow fragmentation to occur".

South Africa was divided into 14 independent geographical and political areas for the purposes of health-status monitoring and health-services provision, Professor Benatar said

Dr Carel Ijsselmuiden, of the department of community health at Wits University, said this was further complicated by the fact that the prevention of infectious diseases in so-called white South Africa was the responsibility of more than 800 local authorities and of the Department of National Health and Population Development.

"There is no binding mechanism for the centralised setting of standards, for the monitoring of infectious diseases or for the evaluation of the activities aimed at their prevention.

"This fragmentation not only makes for operative ineffeciency and lack of co-ordination, it also promotes an enormous wastage of resources which could have been used to combat infectious diseases," Dr Ijsselmuiden said.

Prevention better than cure

The redistribution of South Africa's health budget would dramatically improve health conditions, delegates at a medical congress heard yesterday.

Dr Derek Yach, of the Medical Research Council at Tygerberg Hospital, said the shift from curative spending to preventive spending would make a dramatic impact on health care.

Good living conditions vital to health

Medical Reporter

Advanced medicines would do little to improve health conditions in South Africa if the current socio-economic climate remained unchanged, Dr Carel Ijsselmuiden, of the Department of Community Health at Wits University said yesterday.

He said that this century improvements in socio-economic conditions had been more important in reducing infectious diseases than medical care.

He said poverty and a lack of adequate resources, such as housing, education and sanitation, all contributed to an increased incidence of disease.

"In South Africa a lack of adequate housing and overcrowding have shown to be related to an increased incidence of tuberculosis and have recently again been associated with an increased incidence of measles.

"Poor education, inadequate water supply, malnutrition and civil unrest all work against the control of infectious diseases."

Dr Derek Yach, of the Medical Research Council in Cape Town, said that within racial categories, diarrhoeal incidence was strongly related to social and economic factors.

(299) B/day 28/9/88

Policy breaks new ground

DURBAN — A new medical aid policy to be introduced by the National Medical Plan (NMP) from next year will provide cover mainly for major "in-hospital" medical expenses with members paying directly for normal doctor's bills.

Announcing this in Durban yesterday, CE Rob Basson said many firms and their employees had not been able to afford the comprehensive medical aid packages medical aid societies were obliged to provide in terms of the Medical Schemes Act.

He said many medical aid members who were healthy and fit complained about having to subsidise other members who ran up large consultation and prescription costs all year.

These people would far rather foot the bill for ordinary medical expenses out of their own pockets "if this meant a reduction in premiums, provided they were covered for major in-hospital medical expense items such as heart by-pass operations which can cost from R15 000 to R20 000".

Own Correspondent

NMP's new "Calamity Cover", which comes into effect on January 1, would provide policy-holders with R50 000 cover for a monthly premium of R22,50, while a member with four dependents could get up to R125 000 cover for a monthly premium of R160.

Basson said the onus was on employers to decide whether or not this option was suitable for their particular firm, and whether they wanted to include two or three policies running simultaneously, thus leaving the choice of policy to the individual employee, or have a standard policy for all employees.

Average medical script is R40

Cpt Times 8/10/88

Medical Reporter

THE average South African consumer of medicines — or his or her medical aid — can expect to pay about R40 for any prescription filled at a pharmacy.

A medical doctor and former chairman of the Family Practitioners Association of the Western Cape, who cannot be named for ethical reasons, said yesterday that the current cost of an average prescription ranged from about R35 to R49 but averaged about R40 and contained an average of 3,4 items.

"This covers prescriptions for colds and flu and also more expensive medicines for things like cardiac conditions," he said, adding that the average cost of a prescription last year had been about R35, with a range from R30 to R40.

From year to year medicine prices were about 2% higher than the cost-of-living index, and had risen sharply in 1985 to be 9,7% higher. He said he thought the medicine price index would not go above 3% higher than the cost of living this year.

Over-prescribing

Mr Rob Speedie, executive director of the Representative Association of Medical Schemes (RAMS), said yesterday that medical schemes spent about 35% — or over R1 000m a year — on medicines dispensed in hospitals and by private doctors or pharmacists.

"The slice of the pie attributable to medicines has been growing and is a cause for real concern. We have established a committee to investigate both the causes and possible solutions," he said.

Professor Peter Folb, chairman of the Medicines Control Council, this week said the high cost of medicines was largely caused by over-prescribing by doctors. Figures from medical aids showed that following a doctor's consultation, 88% of patients received a script of one kind or another.

Squatters receive medical treatment

By Jovial Rantao

A team of volunteers, operating under the auspices of Health 2000, conducted a free health clinic at a squatter camp between Finetown and Grasmere south of Johannesburg yesterday. Star 11/10/88

The camp, which started a year ago, is occupied by about 500 homeless people.

The health team was made up of eight people from Lenasia, Eldorado Park and Soweto.

Dr Abubaker Asvat, who heads Health 2000, said about 60 adults were treated.

One case of high blood pressure was detected.

Five people who had urinary problems were treated.

One child who was greatly underweight was referred to hospital for further treatment.

People living in the area, supported by outside groups, provided water and other necessities for the team.

"People were apprehensive about the proposed Squatter Act. They felt that if they were left where they were, they would improve their modest structures and upgrade their limited facilities," Dr Asvat said.

Sporting greats get top honour

NEW YORK — Olympians Willye White, Margaret Murdock, Irinia Rodnina and Aileen Riggin Soule have been named to the Women's Sports Hall of Fame.

White, the only American-born athlete to compete in five consecutive Olympics (1956 to 1972), won two silver medals in the Games.

Rodnina of the Soviet Union dominated international pairs figure skating from 1969 to 1980, winning three gold medals.

Murdock became the only American woman to win an Olympic medal in open shooting competition when she took a silver at the Montreal Olympics in 1976.

Murdock won 21 gold medals in international competitions.

Soule, the oldest living Olympic medalist of the 1920 Games, won a gold medal in diving at the age of 14. — Sapa-AP.

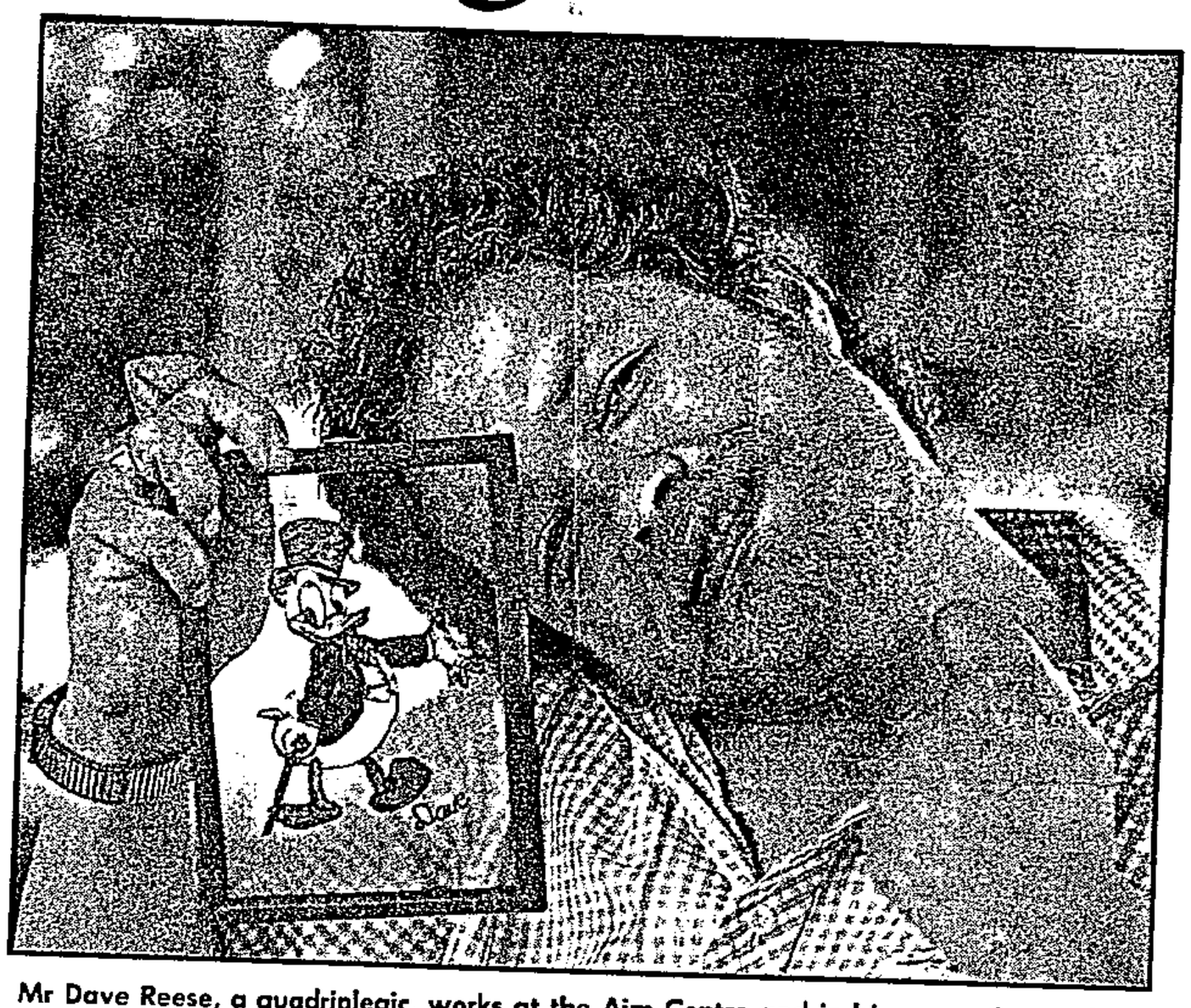
SALLY SEALEY reports on a centre offering constructive employment to the physically disabled.

StarStyle

Giving disabled purpose in life

Star 12/10/87

299



Mr Dave Reese, a quadriplegic, works at the Aim Centre and in his spare time paints Disney characters on glass and frames them. ● Picture by Sean Woods.

A thoughtful and a loving environment, a place where people can feel whole again. That's how the Advancement to Independence through Motivation (Aim) project has been described.

The workshop under the guidance of Mr Dick Grix offers employment opportunities to 26 physically disabled and head injured people at the Avalon Centre in Dewetshof, and to nine people at St Giles.

Mr Grix says the workshop is basically geared for packing.

"We do, however, fit inserts into envelopes, lenses into protective goggles and one of our latest orders has been to put rubber stoppers on the top of eye and ear droppers."

The money received for fulfilling these contracts is not always a great deal, but all the money made is divided among the workers, he says.

Expansion

The centre offers constructive employment as well as an atmosphere in which workers can move forward to an independent life.

"When we first started out we had to instill in our workers that this was a working environment; this is something that most people take for granted but we had to teach people that they could not just leave whenever they fancied."

The project is not State-subsidised and can only succeed and expand with the assistance of the community and business sector.

"We rely on the business sector for funds and with the money we purchase machines and oth aids to assist in the packing and assembling of various orders we receive.

"Everyone has a place in society; individual potential just needs to be utilised properly.

"Many of the workers are without the use of their hands but this does not stop them. One ma has developed a technique of putting rubber stoppers on eye and ear droppers with his palm Another has only the use of one arm. A special gadget has been made to enable him to put labe on bottles."

One of the workers at the Aim centre, Mr Dav Reese, paints Disney characters on pictures and frames them despite being a quadriplegic.

Mr Grix says that the men and women at the centre work hard, but they are faced with prejudice from the public who write them off as useless.

"This workshop has given us a wonderful opportunity. Many of us have been sitting around for 20 years and now we have a goal in life," says one Aim member.

Workers are given incentives to produce and many double their pay by taking home a bonus.

The centre needs contracts to keep going. Anybody interested in helping, should telephone Mr Grix at (011) 616-5041.

Aim is to hold a Golf Day at the Glendower Golf Club on November 8. The organisation is still looking for players to participate in the betterbal stableford. If you are interested, please call Mrs Shirley Warne (011) 646-5171.

Win with real

For Better or For Worse®

by Lynn Johnston

Higher medical aid subs for better benefits

By Lloyd Coutts

An increase in medical aid subscriptions is likely following an agreement to an upward adjustment in certain scales of benefits by South Africa's medical aid schemes.

Subscription rates will probably go up by considerably more than the increases in benefits announced on Wednesday by the Representative Association of Medical Schemes (Rams).

Payments to doctors, dentists and physiotherapists will go up by an average of 10 percent in 1989.

Rams said in a statement the last adjustments were granted at the beginning of 1988 when the medical, dental and physiotherapy professions received pay-out rises of 17,5 percent, 15 percent and 12 percent respectively.

Earlier this year the Medical Association of South Africa (Masa) said it would increase its 1989 recommended tariffs by no more than 10 percent.

A Rams spokesman said this responsible attitude was welcomed.

The spokesman said the Rams decision was also influenced by an intensive investigation into the economy, the ability of employers and employees to meet increases in subscription rates, utilisation levels, and average rates being charged for services.

The impact of the adjustments would differ from scheme to scheme, depending on the membership mix and claims experience of each scheme.

Some benefits are to be increased more than others.

For instance a R15 benefit for a consultation in rooms by a general practitioner will increase by nearly 17 percent — to R17,50.

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Higher medical aid subs for better benefits

(299)

Star 14/10/88

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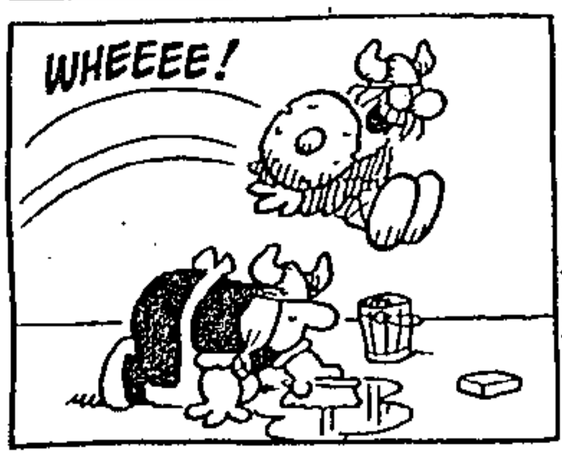
HÄGAR the Horrible



They're committed to uplifting the people

Star 14/10/86

297

Two companies have received awards for their efforts in developing human potential. **WINNIE GRAHAM** looks at the achievements of the two innovative firms.

Janssen Pharmaceutica was last night presented with the Mayor of Sandton's Human Resources Award in recognition of the numerous schemes it has introduced to develop human potential "demonstrating imagination, flair and dedication in creating opportunities for greater employment".

The same firm shared with another international company — Steinmuller Africa — the mayor's second award "for company commitment to developing human resources measured by the proportion of company time and resources spent on training, education and advancement programmes".

Black advancement

When Sandton mayor Peter Gardiner initiated community investment awards in association with The Star and the Sandton Chamber of Commerce, he did so because he believed the usual business awards acknowledging merely financial feats were no longer relevant in South Africa.

The time had come, he said, for the white business sector to do more than just "devote increased sums of money to black advancement". Much more was required in terms of time, energy and managerial resources.

The two companies that received the awards last night show a commitment to the community that must be difficult to match in South Africa.

They were selected by a panel comprising Mr Colin Adcock, chairman of the Sandton Civic Foundation; Mr Harvey Tyson, Editor-in-Chief of The Star; Mr Gaby Magomola, chief executive of the African Bank; and Mr Gardiner.

Janssen has concerned itself with unemployment, labour relations, education, health and nutrition, housing and residential segregation, political rights and community development.

Concern at black unemployment prompted it to initiate a programme designed to generate income for the unemployed and destitute. The programme collects people off the streets and offers them basic motivational training and the opportunity of working at the firm's manufacturing premises for a day. Steps are then taken to place them in the job market.

Janssen has also made efforts to raise the wages and conditions of employment of thousands of office cleaners in the Sandton area.

Seven years ago it pioneered a programme to ensure every school in Alexandra was supported by a company. After canvassing support, this objective was achieved and the Alexandra Schools and Sponsors Association was formed. This body has continued to play a vital role in confronting the DET with alternative educational concepts.

The severe housing shortage prompted the company to re-assess its strategy and look at ways and means of alleviating the chronic housing shortage. It has initiated "pilgrimages of pain" (townships tours) and facilitated meetings between black and white South Africans.

Janssen has contributed to youth leadership forums at various levels and has become involved in an outreach programme to Afrikaner decision-makers. It takes an active interest in old age homes, creches, handicapped children, self-help schemes and various training schemes.

Steinmuller Africa, which shared the Human Resources Development Award, allocates over 10 percent of its annual overhead costs and specialist personnel to training and development. It believes in the philosophy of equal opportunity and the recognition of ability and performance.

An average of 110 apprentices of all races are trained by the company each year. The emphasis is on the training of blacks, and Steinmuller apprentices have twice won the Seifsa Apprentice of the Year award.

The training of specialist technicians is ongoing and the provision of supervisory and management skills training is undertaken at all levels for all race groups. Basic literary and numeracy skills training is undertaken on a voluntary basis by a fully trained staff member.

The company sponsors several high school students at St Barnabas, a multiracial school in Bosmont, and has granted bursaries to several students for undergraduate education.

Its social community projects include support for the Alexandra Clinic, the Anti-TB Association, the African Children's Feeding Scheme and Kinderstrand (for underprivileged children).

The company also operates a housing scheme for employees with a total of R1,5 million available to staff for the purchase of property.

Subscriptions set to go up

Medical aids raise doctors' benefits scales

GERALD REILLY

PRETORIA — The Representative Association of Medical Schemes (Rams) has agreed to raise its scale of benefits for doctors by 10% from January, but it is expected subscription rates will probably be increased by considerably more than the percentage increases in benefits.

Nonetheless, the medical profession claims the increase falls short of adequately compensating doctors for higher practice and other costs.

The increases were announced after a meeting on Wednesday between the executives of Rams and the Medical Association of SA (Masa).

Masa federal council chairman Bernard Mandell said doctors had to cope with spiralling living costs like all other sections of the population.

It was estimated, for instance, that doctors' practice costs had risen from 52% of gross income last year to 64% this year.

Currently 80% of doctors adhered to the Rams scale of benefits, but with the "inadequate" 10% fee hike announcement, it was likely many more would opt to charge Masa's guidelines fees.

Masa announced earlier this year it would raise its guideline tariffs by 10% from January.

The Rams increase, Mandell said, meant the gap between the Rams scale of benefits and Masa's guideline fees would remain at about 50%.

GPs will get about 8% of the Rams increase, which means a hike from R15,60 a consultation to R17,50. Surgeons will get 4,7%.

Masa's recommended GP consultation fee will rise to R33 in January.

Mandell said the Rams "unit" in the scale of benefits would increase from R1,67 to R1,75. Masa's recommended unit from January would rise to R3,30.

Rams executive director Rob Speedie said the impact of the adjustments would differ from scheme to scheme depending on the membership mix and claims experience of each scheme, Sapa reports.

It was expected that subscription rates would have to be increased by considerably more than the percentage increases in benefits, he said.

University becoming more accessible to handicapped

Breaking down barriers for disabled at Wits

Star 18/10/88 299

By Zenaide Vendeiro, Education Reporter

During his second year of law studies at Wits University, Mr Brian Mashiele completed an examination paper in his allotted time only to have the invigilator discover that all but one of the pages were blank.

Mr Mashiele, who is blind, had been alone in the exams room because the noise made by the typewriter he uses to "write" his exams would distract other students. There was no one to tell him that the ribbon on the typewriter had shifted and that nothing was coming through on the paper.

This problem was solved by asking invigilators to enter the exams room regularly in future to check that all is well. But disabled students face many other obstacles . . .

Mrs Penelope Aarts, co-ordinator of the Disabled Students Programme (DSP) at Wits, says it is difficult for an able-bodied person to envisage some of the daily frustrations and problems experienced by the disabled.

"At Wits, for example, simply to cross busy Yale Road from the east to west campus is an ordeal if you are blind or in a wheelchair — especially if your wheelchair motor is temperamental and gives up in the rain!"

DESIGNED

Mrs Aarts says the university, which has 22 students with major disabilities, is almost barrier-free, with ramps for wheelchairs, low-level lift buttons and specially designed rooms to accommodate wheelchairs in the Barnato Hall and Sunnyside residences.

This is largely due to the efforts of Kathy Jagoe, the disabled rights campaigner who formally initiated the DSP in 1986.

But the removal of architectural barriers is an ongoing programme.

Malcolm Anderson, a third-year B Sc student confined to a wheelchair, says most lecture halls are accessible but visiting lecturers in their offices is a problem in some buildings.

He also complains that lifts are often out of order and that in many buildings only one side of double doors are opened so that he can't get his wheelchair through.

"Barnato Hall, which was supposedly built with the disabled in mind, is built on a split level. After first year, my friends moved from the accessible part of the building to the side that is not . . . but I had to stay behind."

TRANSPORT

Unlike Malcolm, Patrick Nkosi, a quadriplegic student in his second year of study towards a BA Ed degree, does not live in residence. He says his "biggest hassle" is transport between the university and his home in Klipspuit, Soweto.

"I have a temporary transport arrangement but I need someone who commutes from Soweto to Braamfontein to give me a lift. I also need the community to help me contribute towards the cost of petrol," he says.

As Wits has six blind and three partially sighted students, an important aspect of the DSP's work is to put study guides, prescribed books and research material on tape. "We are building up a very comprehensive collection, so that our blind students have access to the best university audiotape collection in the country," says Mrs Aarts.

"We are trying to raise funds to buy a personal computer with a braille printer, text scanner and voice synthesiser. This will enable a student to preselect material for audio recording or braille printing."

The DSP is also concerned with preparing disabled students for the "outside" world. "To leave the relative security of the university and cope with a full-time job is a major hurdle that has to be overcome," she says.

Brian, who is in his final year, is having problems finding a firm where he can serve his articles although he is a model student, has passed all of his 25 BA and LLB courses first time and has been awarded the J & B Rare Achievement Award.

"Companies are a bit nervous of taking on blind people," he says.

Mrs Aarts says Wits firmly believes that physical disability should not interfere with the opportunity to gain a degree. "We welcome disabled students who qualify for tertiary education and do our best to help them lead a fulfilling university life."

● If you able to help Patrick Nkosi with daily lifts, please contact him at home on 938-4942 or leave a message at the DSP on 716-3211.

Mr Brian Mashile and Mr Patrick Nkosi . . . overcoming their disabilities. ● Picture by Alf Kumalo.

Medical aid payout rises

MEDICAL schemes are to increase their payout to private hospitals and day clinics by 12% from next year.

The Representative Association of Medical Schemes (Rams) said yesterday that changes to the scale of benefits applicable to private hospitals and day clinics, resulting in an overall increase of around 12%, would be implemented on January 1.

Rob Speedie, executive director of Rams, said substantial increases had been approved for operating theatre and ward fees. However, the payout on consumable items such as drugs and medicines, would be reduced by 10%.

Speedie said members of medical schemes and their employers would be relieved by the relatively low increase in the scale of benefits itself. But he warned that various factors would result in the pay-out by medical schemes to private hospitals and day clinics being substantially higher than 12%.

He said that the utilisation of private hospitals by members of medical schemes was showing a strong upward trend which was expected to continue next year, as increasing numbers of patients were moving away from provincial hospitals to the private sector.

599 B/day 20/10/88

Aggravating

Another aggravating factor which had to be taken into account was a substantial rise in the prices of medicines and other consumables which were largely imported. An increase in the prices of these items of around 25% could be expected for next year.

Private hospitals receive about 18% of the total pay out made by medical schemes. "This year our total pay-out is expected to be in the region of R3,5bn, about R650m of which will go to private hospitals," Speedie said. — Sapa.

21/10/88

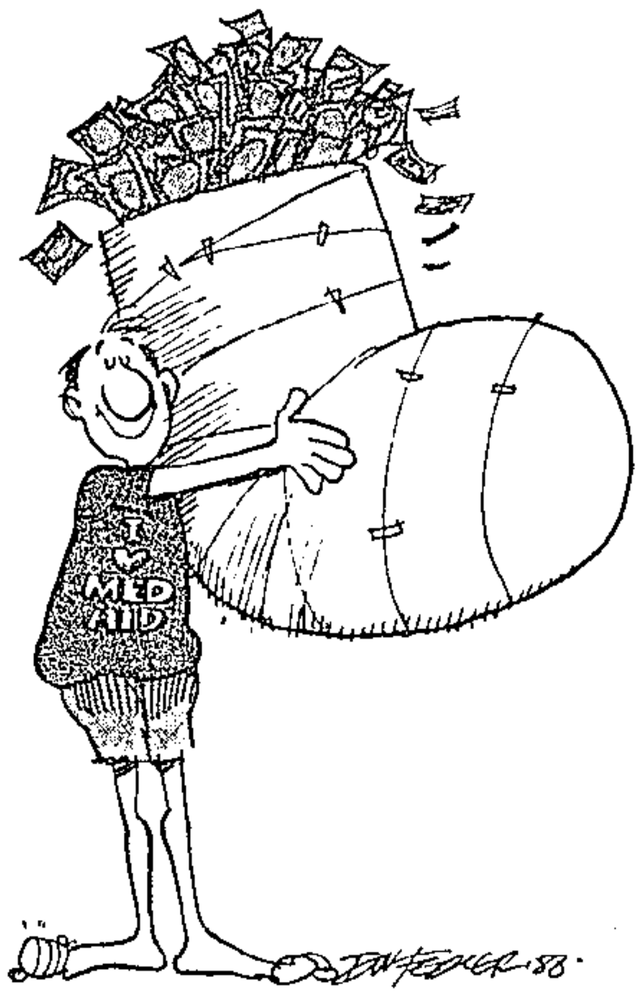
MEDICAL AID 299 FM

Use and abuse

The spiral of medical costs is exacerbated by considerable abuse from pharmacies, hospitals, doctors and members, claims a leading medical scheme administrator.

Jeff Slome, MD of the 83 000-member Medicaid group, says at least R102m — or just over 5% — of the R2bn paid out by medical schemes goes to fraudulent accounts. Accounts have been sent to medical schemes for such patently non-medical items as the grooming of pets, prescriptions for sunglasses and electric toothbrushes.

A common abuse is for members to hire out their cards or claim for the illness of servants. And doctors have been known to ask patients to sign blank accounts which they fill in later. Among the more imaginative cases, a dentist charged for pulling out 46 teeth, even though human beings have only 32 teeth; another charged a four-year-old boy for a full set of dentures.



The single largest contributor to abuse is alleged to be private hospitals, in which "finger errors" or mistakes on bills are said to be worryingly common. Coincidentally, they never lead to undercharging.

Private hospitals also often charge for non-chargeable items listed in the *Government Gazette*, such as savlon, spray bottles, glass syringes and surgical spirit. Or they charge for a whole band of elastoplast when only a small amount is used.

Hospitals have stepped up self-regulation since the National Association of Private Hospitals (Naph) was formed this year.

But Representative Association of Medical Schemes executive director Rob Speedie says Naph is an entirely voluntary body and can only exert peer pressure on members. "Private hospitals need a statutory body with disciplinary powers on the lines of the Central Council for Medical Schemes or the Medical and Dental Council."

Legislation has been tabled to form a National Council for Private Hospitals, but Speedie says the first draft provides for an investigative and advisory body with no disciplinary powers.

Many forms of abuse are within the law, thus impossible to prevent. Says Medicaid claims manager Ben Reichgelt: "If doctors over-prescribe, we aren't in a position to question them. In some cases, rather than giving conventional X-rays, costing maybe R100, they might take patients to a new MRI scanner where the cost is more like R2 500."

For medical schemes, sniffing out fraud is an enormous task. Medicaid, with two full-time investigators, processes 18 000 claims a day. It also employs former theatre sisters to check complex hospital bills. ■

Give disabled a chance, expert urges SA employers

Star 25/10/88

299

Dr Rowland ... "Government should have a policy on disabled".

By Paula Fray

South Africa should consider "incentive legislation" to enhance job creation for disabled people, Dr William Rowland, executive director of the SA National Council for the Blind, said last week.

Dr Rowland has just returned from the second general assembly of the World Blind Union which was held in Madrid last month, where, as a member of the "Committee of Three Blind Doctors", he made recommendations on employment for the blind.

More than 600 people from over 80 countries attended the conference.

The committee — made up of Dr Rowland, Belgian lawyer Dr Juan-Paul Herbec and retired West German federal judge Dr Horst Stolpe — was assigned by the union's Committee on Rehabilitation, Training and Employment to study the employment of the blind worldwide up to the year 2000.

Dr Rowland said the group conducted an international survey to find out about employment possibilities for visually handicapped people were.

Although only 29 countries participated they were representative of western countries, the eastern bloc and the Third World.

They found that employment for the blind in developing countries was limited to two or three occupations, but in Europe and America there were up to 500 different occupations.

South Africa, said Dr Rowland, did not have a problem with the variety of jobs but rather unemployment.

The committee made 21 policy points which will be circulated to the governments of the member countries and certain United Nations agencies.

"We believe every government should have a policy on the employment of disabled people. Presently, there is a world trend towards the quota system whereby a percentage of jobs are set aside for disabled people.

"In South Africa there is no legislation on the employment of disabled people. The Government should seriously consider international models of legislation. Because of the high unemployment there may be resistance to the quota system."

Apart from possible tax exemptions, Dr Rowland would not comment further on the legislation he favoured until the council had consulted legislative experts.

He said the committee also stressed that training should be made available. This included incorporating blind people into general training and making special training available.

Another aspect was technology.

"When technological aid is made available the variety of employment increases greatly," Dr Rowland said.

In South Africa the national training board and the Human Sciences Research Council has just completed a study on the training of disabled people, he said.

Another favourable perception which Dr Rowland brought home was that the "blind are governing the blind".

Not only was there the "Committee of Three Blind Doctors", but there was a high percentage of blind delegates, he said.

The South African delegation of four was well received and there was no talk of them being expelled. They were accommodated free of charge by the Spanish National Organisation of the Blind.

DISABILITY CONQUERED

Physical handicaps overcome at Wits

PHYSICAL disability should not interfere with the opportunity for individuals to gain a university degree, says Ms Penelope Aarts, co-ordinator of the Disabled Students Programme at Wits University.

By NKOPANE MAKOBANE

According to her, to be disabled — deaf, blind or confined to a wheelchair — means that a "normal life", as experienced by most people, is impossible.

"But with training and support, many major disabilities can be overcomed or conquered. We at Wits are proud that the campus is almost barrier free.

"We have ramps for wheelchairs, low level lift buttons, and specially designed rooms to accommodate wheelchairs in the Barnato Hall and Sunnyside residences," she said.

Ms Aarts said at the moment, Wits had 22 students with major disabilities. A growing number of students with lesser disabilities such as partial hearing and sight and speech disorders are also seeking assistance.

They come from all over the country and study everything from law to computer science.

"There are seven blind students, and volunteer readers put study guides, prescribed books and research material on tape. We are building up a very comprehensive collection, so that our blind students have access to the best university audio-tape collection in the country.

"Brian Mashile is one of the blind students who makes use of the blind reading programme. He is in his final year of study towards an LLB degree, and is a model student who has passed all of his 25 BA and LLB courses first time.

"Our disabled students are very resourceful, and most achieve good academic results. However, it is difficult for an able-bodied person to envisage some of the daily frustrations and problems," she said.

JOBS FOR 50 000

DR BEN VOSLOO

THE Small Business Development Corporation created 50 000 job opportunities last year and the corporation had granted loans worth R461,2 million to 19 429 entrepreneurs since its inception eight years ago.

This was said by the managing director of the SBDC, Dr Ben Vosloo, this week at a Press conference held in Johannesburg to review the past financial year.

Dr Vosloo said, during the past year 6 107 loans valued at R114 million were made to entrepreneurs. He said his corporation had given information and advice to a number of small businesses since April 1985 and further enquiries were being received at a rate of 24 000 a month.

He said hundreds of

Local 'stand-up' wheelchair launched

299

Star 3/11/85

Medical Reporter

The first locally-manufactured "stand-up" wheelchair, which enables paraplegics to stand upright for extended periods of time, is being built in Johannesburg.

The wheelchair, originally designed by Mr Ken Smith for a paraplegic friend, enables its user to stand up and cook, work at a workbench, reach the top of a cupboard or even play golf or darts.

Mr Smith developed the wheelchair when his paraplegic friend, Mr Johan Heefers, complained of bedsores from sitting all the time.

Mr Heefers was unable to sit and work because of the sores and needed something to prop him upright.

The specialised wheelchair looks like any conventional mechanism and can be used as such. However, a pump handle can be attached to the front of it and by pushing this handle up and down the chair straightens out, pushing the user into a standing position. He is held up by means of a thick strap buckled across the chest.

The chair costs in the region of R2 800 and is being manufactured on Mr Smith's behalf by Elwood Manufacturers, a Marlboro, Johannesburg-based company.

Mr Heefers told The Star the chair also had many medical benefits. "By being able to stand, you improve your blood circulation and your kidney and bladder function".

Computers help disabled young

(299)

Few people think about the difficulties disabled children have playing with toys designed for able-bodied children.

However, Interface, a project which uses computer technology to create opportunites for disabled people, has managed to convert many of today's battery operated toys into playthings for disabled children.

The project was started in Cape Town four years ago and has gradually spread. There are now branches in Durban and Johannesburg.

Two occupational therapists who work for Interface (they cannot be named for ethical reasons) say there have been a number of advances in commerce and industry recently and this knowledge needs to be applied to people.

The therapists have been actively working with a number of children suffering from cerebral palsy.

"People tend to forget that children suffering from cerebral palsy find it difficult to play with conventional toys," said one.

"We have to set up a system which will best suit the children. Battery operated toys cannot be used by cerebral palsy sufferers as they find it difficult to turn the switch on and off.

By Sally Sealey

"We have devised a method whereby these children can use the toys. We attached a long lead to the toy with a much larger switch which responds to touch.

"Toys are important for a child's development," said one therapist. "Normally the children are passive recipients of anything we do for them. Here they have a chance to be actively involved in playing with the toys," says the therapist.

This method can also be used for tape recorders so children respond to music.

The therapists appealed to the business and public sectors who have computer know-how to come forward and help.

The use of computers for the disabled is new to South Africa but organisations here are catching up on British and US counterparts.

Interface is not only for children but for adults too, as it advocates a policy of total communication for the disabled. The organisation believes that opportunities can be created for disabled people through the use of computer technology. It is presently setting up a resource centre as a base of operation which can help the disabled.

One child, Natasha (10), has been involved in the Interface programme for about four months and has showed great progress. She cannot speak or move her limbs. The only part of her body over which she had some control, is her head.

"We adapted a helmet for Natasha in which we inserted a mercury switch which activated a computer terminal.

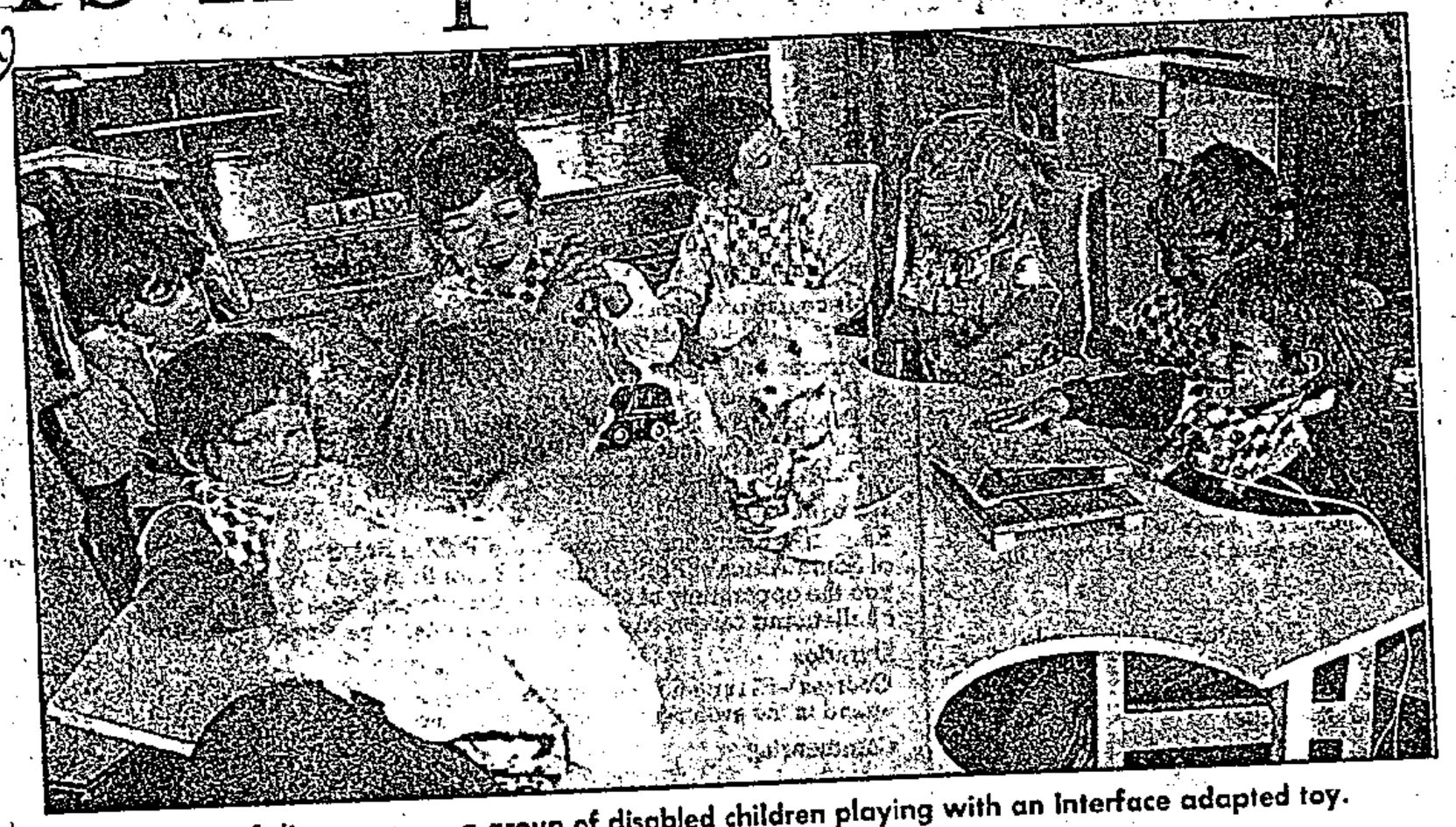
"Natasha has been able to play a whole series of games with this method."

One of the games involves the spotting of a cloud which is hidden behind a gate or in the grass. Once the cursor points in the right direction, Natasha nods her head and the cursor moves in the direction she has indicated. If she is right she is congratulated by a hearty computer laugh.

"This is just the beginning; eventually we will teach her to use a scanner and hopefully in time we will be able to set up a system where she will be able to exercise control."

For more information on Interface contact the Independent Living Centre on (011) 724-3225.

● Interface will be holding a cheese and wine information demonstration Thursday November 10 at the Forest Town School at 6 30pm.



The joy of discovery . . . a group of disabled children playing with an Interface adapted toy.

Help yourself, druggist tells SA patients

Star 14/1/88

299

Medical Reporter

Substituting visits to the doctor with self-medication could effectively control spiralling medical costs, says Mr A M Karis, the managing director of the SA Druggists health care group.

Responding to the 20 percent rise in medical aid fees next year, Mr Karis said the increase was due chiefly to an increase in general practitioners' fees, but if patients curtailed unnecessary visits to their doctors these costs could hold steady.

"There is an attitude held by many patients that, since the medical aid pays, 'let's go to the doctor'.

"This is short-sighted. The more medical aids have to pay out to doctors for unnecessary visits, the higher go medical aid subscriptions," said Mr Karis.

In a recent issue of the *South African Medical Journal*, two University of the Witwatersrand economists argued that wider application of a policy of self-medication could bring about a significant reduction in the national health bill.

They called for a wider range of medicines to be made available to pharmacists.

The Browne Commission of Inquiry into Health Services in South Africa estimated that 90 percent of all primary health care provided by medical practitioners could probably be handled by self-medication.

Aid for those with defective speech

Sun 10/11/88 (299)

Although acknowledged as a world leader in office automation, Canon is equally committed to communications technology.

An aid for adults and children with gross speech impediments arising from cerebral palsy, multiple sclerosis, motor neuron disease and muscular systrophy is now availabe in SA.

Developed by Canon Office Automation, it is being hailed as a major breakthrough in communications therapy.

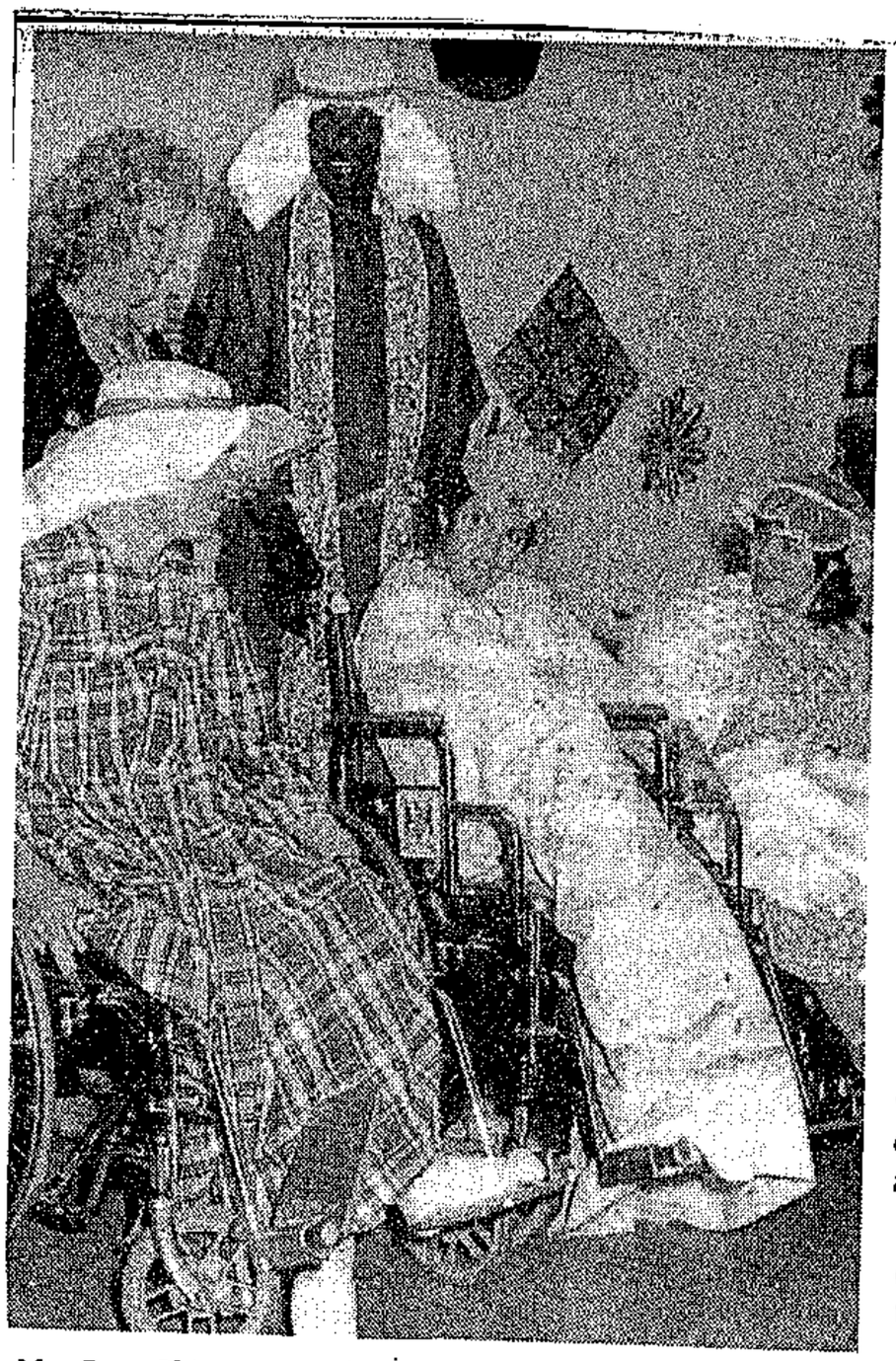
Mr Dermot Murtagh, director, Canon SA, says: "This is a low-profile area of group activities since products developed for the disabled are marketed on a low or non-profit basis. This contributes to Canon's social responsibility effort, rather than to turnover.

"It is, however, a natural and important extension of the technical skills employed in business."

The Cannon Communicator M is a battery-charged, hand-held computerised mini-typewriter that can be used to type messages. Up to now, electronic communication by the disabled has been limited by the fact that equipment is electrically powered and not portable.

Weighing only 250 g, the communicator consists of a 26-word keyboard, with the distinction between vowels and consonants made by colour differentiation to simplify operation. Messages are printed on tape in standard size or in easily selected enlarged print.

An interface unit enables two-way private communication.



Ms Pat Skinner and orderly Mr Richard Netshivhazwaula help children to prepare for their Christmas tableau at Johannesburg's Woodside Sanctuary for the mentally and physically handicapped.

Woodside: Need for funds urgent

Star 14/11/88 (299)

Woodside Sanctuary, one of the few homes for severely mentally and physically handicapped children in the Johannesburg area, is in urgent need of funds.

Woodside, home to more than 80 youngsters ranging in age from just a few months to over 20 years, requires specialised nursing care and therefore sees a high ratio of staff to patients, making the cost of keeping a child exceptionally high.

"Woodside is a loving home for handicapped children," said Ms Audrey Haselum, fundraiser for the sanctuary. "It gives families essential relief from the enormous burden of caring for these children."

HOLIDAY CARE SERVICE

"Although the State provides a small disability grant to each child and some parents are able to contribute towards the fees, we are dependent on the generosity of the public to make up the balance."

Woodside Sanctuary also offers a holiday care service for handicapped children to allow families the chance to spend more time with each other and to get away from home.

But, the sanctuary cannot cope properly with the demand for its services and is also in need of assistance with expansion.

People who would like to assist Woodside over the Christmas period may address their contributions to: Woodside Sanctuary, P O Box 91299, Auckland Park, 2006, Johannesburg.

The registration number is (01-100147-000-6).

Call for urgent inquiry into soaring medicare

Star 15/11/88

299

By Toni Younghusband
Medical Reporter

246

South Africans were in a crisis situation as far as medical care was concerned and the entire medical system had to be investigated urgently, the past president of the Housewives' League, Mrs Joy Hurwitz, said today.

Mrs Hurwitz, who is conducting an in-depth investigation for the league into medical costs, was responding to the disclosure in The Star yesterday of the State tender system of purchasing medicine.

By purchasing on tender, the State was buying its medicine as much as 80 times cheaper than the private patient.

Mrs Hurwitz said it was "absolutely alarming" to see by how much the price of medicine had gone up in the last year. "The cost to the private patient is astronomical. It cannot go on.

"The more the price of medicine goes up, the higher the medical aid fees until eventually you won't have anyone able to afford medical aid. They'll all become State patients and then where will the State be. It says it has no money to pay for the patients it has," Mrs Hurwitz pointed out.

The Minister of Health, Dr Willie van Niekerk, yesterday rejected accusations by the Pharmaceutical Society of South Africa that the Government was responsible for the high price of medicine. He said the society wanted "protected free enterprise".

Mr Jack Bloom, chairman of the Southern Transvaal branch of the society, said Dr van Niekerk had failed to address the real issues at stake.

"The argument concerns the tender system. It is the tender system which pushes up the price of medicine. Dr van Niekerk has not answered anything at all," Mr Bloom said.

Mr Bloom pointed out that pharmacists were already "protected" and what they were looking for was not protection for themselves but for the paying consumer.

"We are the interface with the public and they get terribly rattled when they have to pay high prices for their medicines. We cannot blame them.

"It is a totally crazy situation," Mr Bloom said, adding that he and other society members have called for a concerted consumer protest.

School for handicapped children gets R1 000

The Pumelela Training Centre for handicapped children received a shot in the arm when it received a donation of R1 000 from the Soweto Woman's Chamber of Commerce and Industries (SWCCI) yesterday.

The donation was described as worthwhile by the centre's principal, Mrs R J Leoka, during a ceremony attended by the staff and representatives of the SWCCI who were entertained to dancing by the pupils at the centre's headquarters in Senaoane, Soweto.

Mrs T Makgata, chairperson of the SWCCI, said her organisation had decided to adopt the centre three years ago to show their commitment to helping needy and less

16/11/88 By Stan Hlophe

privileged children.

"We felt this would be a way of showing our gratitude to the community which supports us and moreover, as mothers of this country, it is incumbent on us to put our money where our responsibilities are."

Mrs Leoka, who heads a staff of 22, expressed gratitude to the SWCCI.

She said that the donation could not have come at a better time and that it would help ease the centre's problems. She then appealed to both the community and the private sector for help in financing further building operations at the centre.

She said four new classes and a toilet were started last year but these could not be completed due to a shortage of funds.

"As most of our children are mentally handicapped, while others suffer from cerebral palsy and epilepsy problems, they encounter difficulty in running to the toilet which is about 800 m away from the classes. Things become worse during cold weather conditions.

"We have a waiting list of another 100 children and we need 10 more classrooms and a comprehensive block which will consist of a pottery, weaving room, a workshop and a domestic science class," she said.

CITY NATIONAL

Medical costs at crisis level

The Argus Correspondent

JOHANNESBURG. — South Africa was in a "serious crisis" concerning medical care and the whole system had to be investigated urgently, said Mrs Joy Hurwitz, the past president of the Housewives' League, today.

Mrs Hurwitz, who is conducting an intensive investigation for the league into medical costs, was responding to the disclosure in the Star, sister newspaper of The Argus, yesterday about the state tender system of purchasing medicine. By purchasing on tender, the state was buying its medicine as much as 80 times cheaper than the private patient.

Mrs Hurwitz said it was "absolutely alarming" to see by how much the price of medicine had gone up in the past year.

"The cost to the private patient is astronomical. It cannot go on. The more the price of medicine goes up, the higher the medical aid fees — until eventually you won't have anyone able to afford medical aid. They'll all become state patients and then where will the state be? It says it has no money to pay for the patients it has," said Mrs Hurwitz.

She also slammed the general sales tax and import duty slapped on medicines.

Import duty

"Why should we have 12 percent GST on medicine or, for that matter, why is there import duty? Medicines are not luxury items, you cannot avoid being ill," Mrs Hurwitz said.

She said while the government had promised to "look into" the medical situation in South Africa, little had been done.

Mrs Hurwitz will meet the Minister of Health, Dr Willie van Niekerk, on November 23 to discuss medical costs.

Dr van Niekerk this week rejected accusations by the Pharmaceutical Society of South Africa that the government was responsible for the high price of medicine.

He said the society wanted "protected free enterprise".

Mr Jack Bloom, chairman of the Southern Transvaal branch of the society, said Dr van Niekerk had failed to address the real issues at stake.

"The argument concerns the tender system. It is the tender system which pushes up the price of medicine. Dr van Niekerk has not answered anything at all," Mr Bloom said.

"Totally crazy"

He pointed out that pharmacists were already "protected" and what they were looking for was not protection for themselves but for the paying consumer.

"We are the interface with the public and they get terribly rattled when they have to pay high prices for their medicines. We cannot blame them. It is a totally crazy situation," Mr Bloom said.

He and other society members have called for a concerted consumer protest. A press advertisement had received widespread reaction, said Mr Bloom, both from consumers and the medical profession.

"The phone started ringing as soon as the newspaper appeared on the streets. Members of the public felt it was time something was done," he said.

The manufacturers of generic medicines have pointed out that the substitution of generics for brand name products would substantially decrease the price of medicines.

However, here pharmacists were to blame, one manufacturer said. Pharmacists were reluctant to recommend generics because lower prices meant lower profits for the chemist.

Medical care in SA 'critical'

Sowetan 16/11/88

299

SOUTH Africa was in a "serious crisis situation" as far as medical care was concerned and the entire medical system had to be investigated as a matter of urgency, the past president of the Housewives' League, Mrs Joy Hurwitz, said yesterday.

SOWETAN REPORTER

Mrs Hurwitz, who is conducting an in-depth investigation for the league into medical costs, was responding to the disclosure on Monday of the State tender system of purchasing medicine.

By purchasing on tender, the State was buying its medicine as much as 80 times cheaper than the private patient.

Mrs Hurwitz said it was "absolutely alarming" to see by how much the price of medicine had gone up in the last year.

"The cost to the private patient is astronomical. It cannot go on. The more the price of medicine goes up, the higher the medical aid fees until eventually you won't have anyone able to afford medical aid.

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"Why should we have 12 percent GST on medicine or for that matter, why is there import duty? Medicines are not luxury items, you cannot avoid being ill," Mrs Hurwitz said.

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Mrs Hurwitz is meeting with the Minister of Health, Dr Willie van Niekerk, on November 23 to discuss medical costs.

(299) Star 17/11/86

Drug manufacturer urges use of generics

Call to cut medicine costs

By Toni Younghusband, Medical Reporter

Medical aid societies could effectively "force down" the price of medicine by recommending the use of generics rather than ethical drugs, a Johannesburg drug manufacturer has pointed out.

Generics, which are copies of an ethical drug for which the patent has run out, can cost up to 60 percent less than their ethical counterparts.

"If medical aid societies insisted on paying only as much as the generics cost, the price of medicine would come down considerably," said Mr Norman Fleminger, a director of the Safimed Group. Medical aid schemes should tell their members they would pay generic medicine rates only and any extra charges brought by using ethical drugs would have to be borne by the patient, he advised. Mr Fleminger said some societies had already taken this stand.

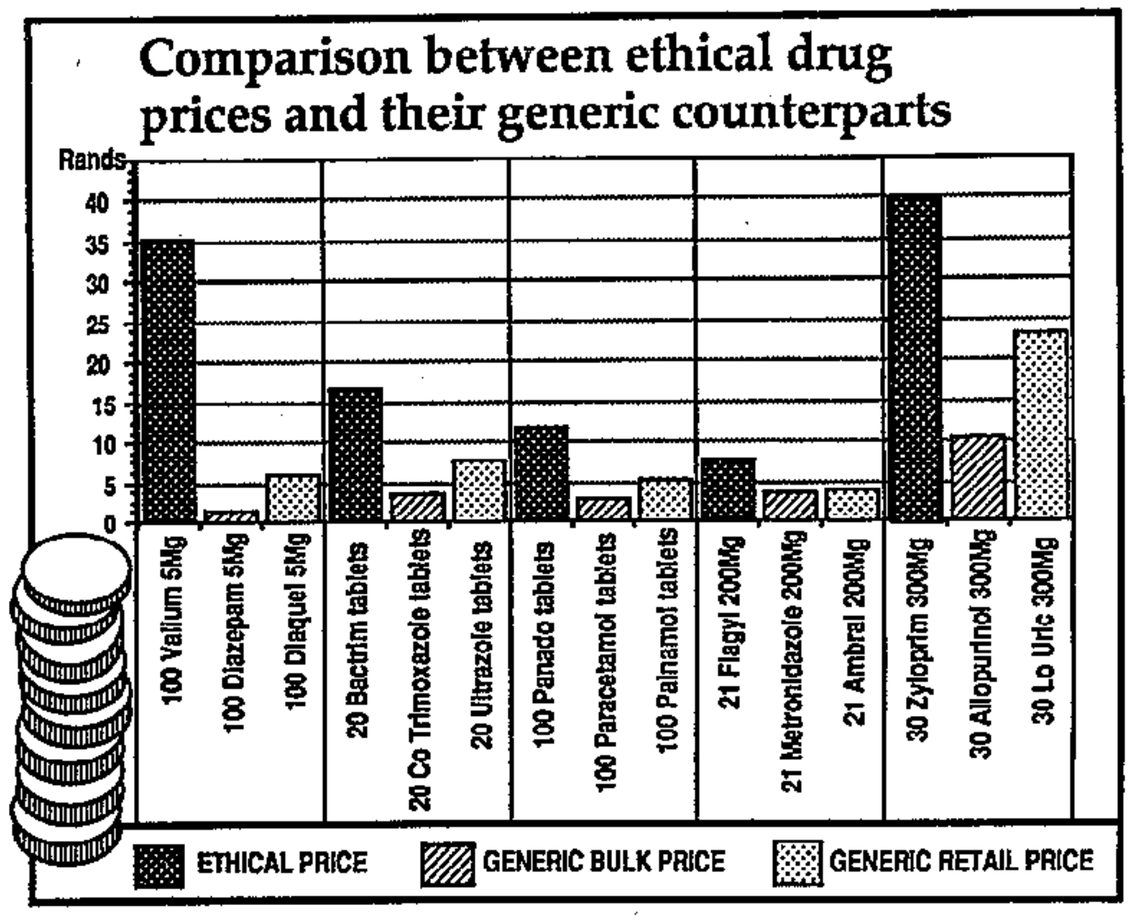
Spiralling medicine costs are effectively pushing drug prices beyond the reach of the private patient and a further 33 percent increase is expected next year.

Mr Fleminger said unfortunately pharmacists were reluctant to dispense generics because the markup on a generic was less than on an ethical. Legislation in any case, Mr Fleminger pointed out, prevented them from recommending generic substitution. They were forced to follow a doctor's prescription.

Doctors too have had a negative attitude to generics. Many of the older doctors are suspicious of generics while others are easily persuaded to stick to ethicals by ethical manufacturers.

General practitioners interviewed by The Star said they were "more comfortable" with ethical companies and "had known them for a long time".

It has been suggested that many doctors are "persuaded" to stay with an ethical manufacturer "in exchange for favours".



Calls for probe of high medical costs renewed

299 ST Times 29/11/88.

A NEW row over the cost of medicine could result in far-reaching reforms to the entire medical payments system.

Reacting to reports that private patients are paying up to six times more for medicine than State hospitals do, all sectors of the medical profession call for an investigation of medical funding.

One outcome could be that all medical-aid members would have to pay for 25% of their consultation, medicine and other fees.

Another could be the introduction of a private tender system similar to the State's.

The Pharmaceutical Manufacturers Association believes the Government, together with the private sector, should consider designing a new health-care strategy.

Exemption

The Medical Association of SA has made representations for GST and surcharge rates to be abolished in an attempt to curtail costs to the patient.

SA Pharmacy Council president Kosie van Zyl believes a private tender system would go a long way to solving the problem.

"Wholesalers must get together and introduce a tender system based on quantity. We must ask why hospitals can tender and get what they want, yet even if they do not tender, they still get medicines up to 20% cheaper than the rest of the private sector."

Possibly, manufacturers are reluctant to allow private-sector tenders for fear of profit cuts.

Mr Van Zyl questions how manufacturers, which claim to make profits of between 17,5% and 20%, can afford to give away up to 15% of them through discounting when their overheads can amount to 11%.

By Robyn Chalmers

The State buys up to two-thirds of all medicines at cut-throat prices, so manufacturers are making up their losses on private-sector sales. For example, the drug Tegretol sells to the State for about R12 a unit and to the wholesaler for R40.

The wholesaler adds 20% to this, the pharmacist puts on 50%, a 10% break-bulk fee, a 15% dispensing charge and 5% for a photostat of the prescription. The price to consumer after 12% GST is R74,14.

Fingers

One spokesman, who has been in the profession for many years, believes it is unfair to point fingers only at the State, saying the factors involved in rising prices are multiple.

"We have to look at medical schemes, which virtually give members a credit card to spend, and balance their books at the end of the year by increasing prices.

"Doctors often do not take account of costs when they make out prescriptions."

He says manufacturers are also to blame because they can manipulate the market.

"We need a single exit price for the State and the private sector based on volume. Manufacturers' claims that this is not feasible are nonsense."

Representative Association of Medical Aid Societies executive director Rob Speedie says the regulations provide for schemes to implement a 25% disincentive, but they are dictated to by their customers.

"Medical-aid schemes reflect the wishes of their members, and if they refuse to have this provision implemented we cannot do it.

"For us, one of the solutions would be to employ our own pharmacists and run our own dispensaries. This was recommended by the Browne Commission a few years ago."

Focus on jobs for disabled

Sowetan 21/11/88

299

By NKOPANE MAKOBANE

THE Greater Soweto Liaison Committee for the Physically Disabled has organised a one-day seminar to focus on the employment facilities and opportunities for the disabled people.

Mrs Bertha Mafoko, chairman of the committee, said the seminar would be held at Funda Centre tomorrow from 8,30am.

Its theme is "Employment for the Physically Disabled Leads to Greater Independence."

She said various expert speakers have been lined up to address the seminar on the importance of giving disabled people an opportunity to work.

"There is an attitude in the community that disabled people are unemployable. These people may be disabled but are mentally alert.

"It is for this reason that we have also invited some disabled people, who have been successfully placed in jobs, to come and address the seminar on how they feel to gave been given an opportunity to work in the open market," she said.

Soweto businessmen are invited to attend. Mrs Mafoko said they would be motivated to employ disabled people in their businesses.

Star 22/11/88 (299)

Medical aid schemes' limit 70 pc

Seeing the doctor set to cost more

Patients may have to pay an additional 30 percent on their medical bills if an agreement between medical representative associations is accepted by the Minister of Health.

The Medical Association of South Africa (Masa), which represents the country's doctors, and the Representative Association of Medical Schemes (Rams), have agreed in principle that in future medical schemes will no longer be obliged to pay 100 percent of the scale of benefits for doctors' consultations.

However, minimum guaranteed benefits will not be less than 70 percent.

This means that the patient will have to cough up the difference between the amount charged by the doctor and the benefits paid by the medical scheme.

Individual medical schemes wishing to pay the 100 percent will be free to do so.

By Toni Younghusband
Medical Reporter

According to a joint statement issued by Masa and Rams yesterday, the purpose of the agreement is to encourage "responsible use of consulting services and to curtail spiralling costs".

The associations hope to discourage patients from utilising doctors' services unnecessarily.

Awareness of costs

"The introduction of this disincentive to patients will make them more aware of costs and of the standard of service they are paying for," the statement said.

Mr Rob Speedie, executive director of Rams, said medical schemes could not continue to burden both employers and employees with ongoing substantial increases in subscription rates.

"It is vital that we introduce disincentives in order to contain cost increases," Mr Speedie said.

A Masa spokesman said it was not yet possible to say exactly what amounts were involved as fee increases were expected next year and the scale of benefits was to go up by 10 percent.

"Nothing is final yet. We will meet again in January to finalise details of the agreement and joint representations will then be made to the Minister of Health for the appropriate changes to be made to the regulations issued under the Medical Schemes Act.

"If the Minister gives the green light it will take some time before the new system goes into operation," the joint statement said.

And if the Minister decides the new system necessitates changing the entire Medical Schemes Act, it could take more than a year.

Change in medical scheme policy

PRETORIA — Medical schemes will no longer have to pay 100% of doctors' consulting fees, according to an agreement reached between the Medical Association of SA (Masa) and the Representative Association of Medical Schemes (Rams).

Doctors' minimum guaranteed benefits will be no less than 70%, which means scheme members will be responsible for 30% of the fees.

The agreement is aimed at discouraging irresponsible use of consulting services and to curtail spiralling costs.

The difference between fees charged for consultations and the benefits paid by medical schemes will have to be paid by the members of the schemes to the doctors concerned.

GERALD REILLY

Med aid cut

Sowetan 22/11/88 299

MEDICAL schemes would no longer be obliged to pay 100 percent of the scale of benefits for doctors' consultations, but only 70 percent or more, in terms of an agreement reached by the Medical Association of South Africa and the Representative Association of Medical Schemes.

The bodies said in a joint statement in Pretoria yesterday the measure was intended to act as a disincentive, to make patients more aware of costs. Patients would have to pay the difference.

Said Mr Rob Speedie, executive director of Rams: "Medical schemes cannot continue to burden both employers and employees with ongoing substantial increases in subscription rates.

"It is vital that we introduce disincentives — preferably with the agreement of the suppliers of services — in order to contain cost increases."

Masa and Rams would meet again in January to finalise details of the agreement. — Sapa.

1988

50c (45c plus 5c GST)

Main R

Lower benefits for medical aid

Staff Reporter

MEDICAL schemes may soon stop paying the full cost of doctors' consultations in terms of an agreement between the Medical Association of SA (Masa) and the Representative Association of Medical Schemes (Rams).

Under the agreement — which is "only the first step" in a major overhaul of the country's medical-aid system — medical-aid schemes will guarantee cover of no less than 70% of consultation fees, as laid down in the agreed scale of benefits.

The bodies said in a joint statement in Pretoria yesterday that the measure was intended to act as a disincentive to make patients more aware of costs.

Patients will have to pay the difference of 30% or less.

According to Mr Rob Speedie, executive director of Rams, medical schemes "cannot continue to burden both employers and employees with ongoing substantial increases in subscription rates.

"It is vital that we introduce disincentives — preferably with the agreement of the suppliers of services — in order to contain cost increases."

Masa and Rams would meet again in January to finalise details of the agreement, he said.

Joint representations would then be made to the Minister of National Health and Population Development for the appropriate changes to be made to regulations issued under the Medical Schemes Act.

If the minister gave the green light, it would take some time before the new system came into operation, they said.

Mr Speedie said the eventual aim is to transform the present system into one in which the the individual could purchase medical aid tailored to suit his own needs.

299

Medicine — R100 a month more?

Staff Reporter

THE average family could end up paying an additional R50 to R100 a month in medical bills if the new agreement between doctors and medical aid administrators is implemented, a Cape doctor has warned.

And a national consumer body, the Housewives' League, has reacted with "shock" to the news of the agreement in which medical-aid societies will foot the bill for no less than 70% of a doctor's consultation fees.

The Medical Association of SA (Masa) and the Representative Association of Medical Schemes (Rams) have jointly agreed on the scheme, which must still be ratified by the minister.

Patients will, if the new agreement is implemented, have to pay the difference of 30% or less.

"The cost of medical treatment is reaching crisis proportions," Mrs Joy Hurwitz, vice-chairwoman of the Housewives' League said.

According to a former chairman of the Family Practitioners' Association of the Western Cape, the average family with two or three children would "easily" be faced with having to find an additional R50 to R100 a month to spend on medical care.

In the joint statement issued by Masa and Rams, a spokesman said that both bodies had felt it necessary to introduce a "disincentive" to keep patients from visiting doctors for every minor ailment.

But according to Mrs Hurwitz, "it is wrong to victimise everyone. A major revamp is needed, and this could be done in other ways, such as paying out some form of low claim bonus".

Before the new agreement is implemented, joint representations by Masa and Rams will be made to the Minister of National Health and Population Development for the appropriate changes to be made to regulations issued under the Medical Schemes Act.

Defence objects to Bop State evidence

Own Correspondent

MMABATHO — As a general rule, the State was under no obligation to disclose evidence except factual, the Bophuthatswana Assistant Attorney-General, Mr F Elf, told the Mmabatho Supreme Court yesterday.

He was replying to objections made by the nine members of the People's Progressive Party (PPP) charged with treason following the February 10 abortive coup.

Mr C R Mailer, for the defence, yesterday examined allegations point by point to call for further particulars to enable the accused to prepare their defence and to plead.

He asked Mr Justice E A Smith to rule on an order forcing the State to give the following information:

- How many meetings were held at the Molopo Military Base when it was taken over by the rebels on February 10 and who was there.
- Who told the soldiers that the government had been overthrown?
- Who announced that President Mangope had resigned and Mr Rocky Malibana-Meitsing had been sworn in?
- Which one of the accused allegedly conspired to overthrow the government and with whom?
- What were the terms of the alleged conspiracy?
- Which of the accused incited or instigated others to commit offences?

Mr Mailer said the State had failed to set out essential particulars and the accused were entitled to a proper reply to their questions under the Criminal Procedure Act.

Mr Elf admitted the State did not have all the information, but the summary of facts in the indictment provided all the detail needed.

The hearing continues.

Step in the right direction, says chief

Buthelezi approves move to form party

By Esmaré van der Merwe, Political Reporter

The Chief Minister of kwaZulu, Chief Mangosuthu Buthelezi, has given his cautious support to efforts by the Progressive Federal Party, the Independent Party and the National Democratic Movement to form a new party on the political Left.

"I must necessarily applaud any attempt anybody could make to promote the broad principles of a non-racial, multiparty democratic order," he said yesterday.

The political situation was plagued with the fear that such a democracy could not be established, more than the fear that whites would not fare well if it was established, he said.

Chief Buthelezi, also the president of Inkatha, said Inkatha would be pragmatic about "how we go about putting intentions to co-operate into practice".

He had neither been briefed personally about the latest developments nor had he had the chance to discuss the issues with Inkatha's leadership.

The PFP, IP and NDM met last week at the house of the Transvaal rugby chief, Dr Louis Luyt, and sources have indicated that a new party could be established as early as January.

The three main issues to be thrashed out are a statement of principles, a name for the new party and the pressing issue of a leader, the sources added.

A special committee is to be announced this week to prepare a joint declaration of intent and a joint statement of principles.

Some sources said that not one of the three leaders — Dr Zach de Beer, Dr Denis Worrall or Mr Wynand Malan — should lead a new party.

They favoured a charismatic, respected and high-profiled Afrikaner "such as former newspaper editor Dr Willem de Klerk".

Others mentioned Dr Van Zyl Slabbert, the former PFP leader, and Dr Luyt himself.

Chief Buthelezi said: "Forces to the left of the National Party are divided. We cannot wish these divisions away because many of the divisions revolve around fundamentally important issues.

"We must work our way through them and if this move among white political leaders is a step in this direction, then I welcome it," he said.

Commenting on rumoured differences of opinion between the three groups about which extra-parliamentary organisations should be involved, he said it was "sad" that that should be a problem.

"The final analysis of the South African situation is yet to be made and it is not wise right now to be rigorous in the allocation of organisations into camps.

"When things move, they may well move with an awesome rapidity which will demand radical realignments in the pursuit of a non-violent transition towards a democracy," Chief Buthelezi said.

Robbers murder guard

West Rand Bureau

Robbers killed a middle-aged security guard at a Westonaria greengrocer's shop on Monday and escaped with about R7 000 in cash.

A West Rand police spokesman said Mr Teyi Mbali was on guard duty at the Drive-In Fruiterers in Suurbekom, Westonaria, on Monday night when he was overpowered and tied up.

His assailants dragged him about 50 m away and apparently suffocated him.

They then cut the fence around the shop and broke in.

They took about R7 000 in cash from the office of the owner, Mr R M Pellers.

Imported medicine to cost more

By Toni Younghusband, Medical Reporter

The registration of imported medicines is to cost drug manufacturers more next year — and consumers must expect an increase too.

The South African Medicines Control Council has proposed an increase of registration fees from R1 000 to R5 000 per medicine from January.

A spokesman for the MCC said this is the first increase in 10 to 15 years and is an attempt by the Government to make the MCC more self-sufficient.

"The MCC costs the Government an estimated R3 million a year to run. It was felt an increased registration fee would bring in more revenue and the MCC would become less dependent on State funding," the spokesman said.

All medicines must be registered with the MCC before they can be sold. The registration takes a minimum of 18 months.

Dr Gerhardus Oberholzer, of the Department of National Health and Population Development, said the MCC had failed to break even or keep up with general price increases for years.

"We are now trying to get to where we should be," he said.

Mr Johan Schlebusch, registrar of medicine control at the department, said he did not think the increase would be as high as was proposed.

Dental medicines, which in the past have not had to be registered with the MCC, will also be affected.

Mr Schlebusch said dental medicine, such as dental cement, came into direct contact with the patient and could have an effect on that patient's health and should be under MCC control.

The executive director of the Pharmaceutical Manufacturers' Association, Mr John Toerien, said the proposed increases were "enormous" and should be implemented in phases rather than all at once.

SURCHARGE, TOO

"We feel a three-year period is fair. The fees should be increased slowly over this period. Manufacturers are facing not only the fee increase but also an import surcharge on certain medicines and the declining rand.

"These additional costs have to be passed on to the consumer," he said.

Mr Toerien said the pharmaceutical manufacturing industry had protested to the department about the proposed increases.

'20 pc surcharge will push up cost of health care'

Star 24/11/82

299

By Toni Younghusband, Medical Reporter

The 20 percent import surcharge on medical supplies will result in shortages of vital medical equipment and in the cancellation of operations, Dr Marius Barnard, the Progressive Federal Party's spokesman on health, has warned.

Dr Barnard has been lobbying on behalf of surgical equipment suppliers who fear that the import surcharge, which came into effect in August, will put many of them out of business.

Mr Len Swanson, a director of Rand Medical Supplies, told The Star some equipment had doubled in price since the introduction of the surcharge.

"That is without taking into consideration the falling rand," he said.

Mr Swanson said a major concern was that some suppliers could no longer afford to buy necessary equipment and if there was a national disaster, South Africa would be in trouble.

"Because of the high costs, suppliers are letting their stocks run down. If that equipment is needed urgently, we are going to be in a lot of trouble," he said.

Mr Swanson pointed out that medical supplies were necessities, not luxuries.

"You can do without a television set or a camera but you cannot do without medical equipment," he said.

South Africa did not have the infrastructure to manufacture its own medical and surgical supplies, he said.

"The surcharge will push up the cost of health care and, in addition, will affect the whole medical profession. Necessary equipment will become extremely difficult to get hold of and, if the equipment can be bought, there will be long delays," said Dr Barnard.

Some importers who paid R15 million for their equipment before the surcharge was introduced would have to pay a further R3 million by the time the equipment arrived.

"Some of that equipment, which was ordered before the surcharge, is out at sea on its way to South Africa and when it arrives it'll cost more," Dr Barnard pointed out.

He said while suppliers could effectively pass on the 20 percent surcharge to their purchasers, many of them preferred to hold the equipment in bond until they were paid.

"Again, we are confronted with a shortage," he said.

Dr Barnard said he had worked in communist countries where there were often shortages of medical equipment.

"You are forced to use inferior equipment or cannot operate at all because there is nothing to use. South Africa is heading that way," he said.

StarStyle

Star 24/11/88 (299)

Computers helping to remove barriers

By Sally Sealey

A glove developed by a space programme and a computer that can translate braille into script are just two of the latest developments to help disabled people adapt to modern society.

Dr David Boonzaier of the Biomedical Engineering Department of the University of Cape Town (UCT) was the guest speaker at a function last week hosted by Interface, an organisation involved in developing total communication for the disabled.

Interface was founded because of the need for information about the use of micro-computers as a tool for the disabled.

Dr Boonzaier says: "There is a fundamental lack of knowledge in the area of communication intervention for the severely disabled, non-speaking adult.

"Technology is able to provide the means by which a person can be interfaced to a communication, education, vocational or recreational tool."

He says there is very little understanding of how to provide a severely disabled person with adequate communication.

Although therapists and teachers are aware of alternative communication systems, such as sign, gestural, body and symbolic languages, very few have been trained in the theory, teaching and use of these systems.

Technology enabling people without the power of speech to speak is already available.

There are telephones, some attached to cuddly bears, which can store special messages; all the person need do is press a button to communicate basic needs.

With the bear, a child can ask for a drink, call his or her parents or have the light switched off.

There are also computers available which allow disabled people to string sentences together.

Dr Boonzaier describes this as the first steps towards "free speech".

A computer can also be programmed for a person suffering from cerebral palsy to take into account his or her specific disabilities, for example how many times the person shakes in a minute.

This can be programmed into the computer and it can then act accordingly.

So if a person hits the keyboard erratically, the computer will not automatically download. Because the person's disabilities are known to the computer it will act accordingly.

For a disabled person doing clerical work, the computer can be programmed to compensate for errors. Should the person mistakenly ask for computer file "Smjth" instead of "Smith" the computer will go through the records and will pull out the file closest to "Smjth".

Some computers have been programmed to set the user a test so that it can assess the user's ability and act accordingly.

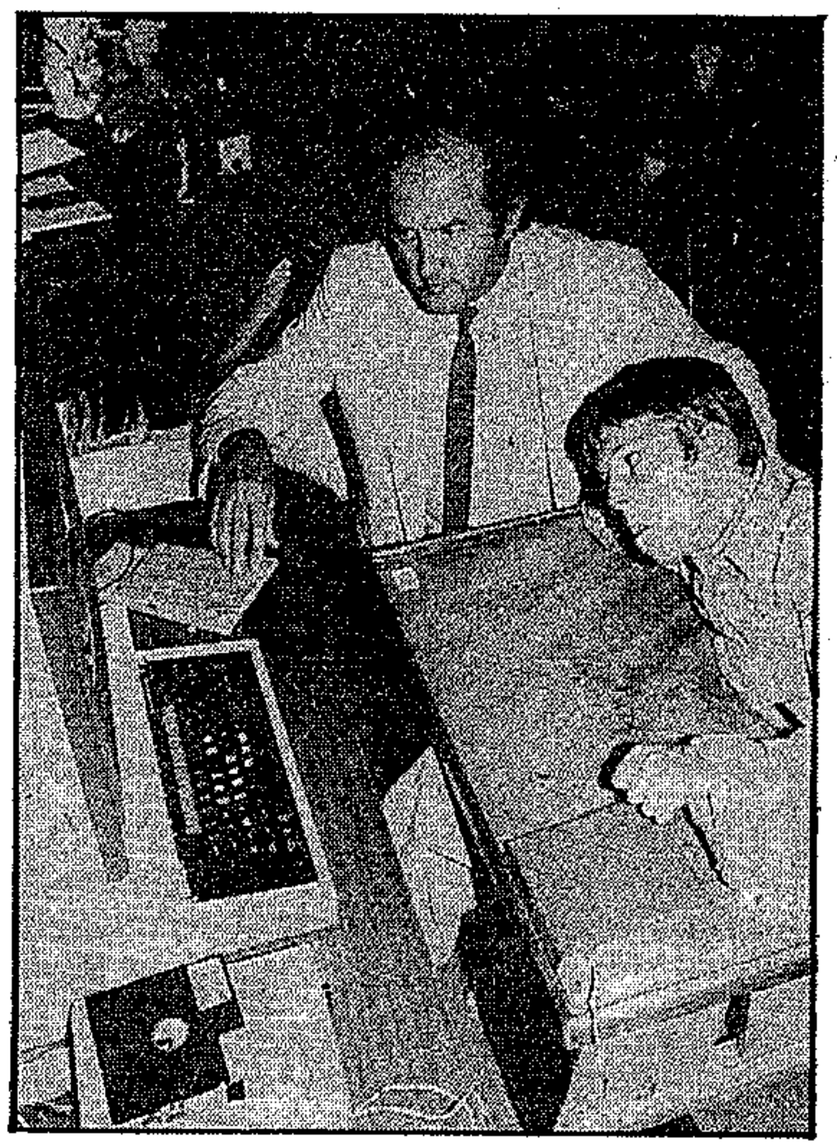
Others have a series of alternatives. With a booklet, a disabled person can inform the computer of a disabilty. For example, each disabilty has a corresponding letter of the alaphabet. When that letter is pressed the computer will then compensate for whatever disability that letter represents.

A glove that was developed during the course of the space programme has helped disabled people communicate over the phone.

The person is able to finger spell with the one hand. The glove interprets this and transmits the message through the phone to the person on the other side.

A metal hand, which interprets words into finger spelling, has also been developed. The disabled person covers the metal hand with his own and hearing people who do not know how to sign can communicate through it.

Dr Boonzaier says a time will come when all prosthesis will be treated like glasses which today are not even considered a handicap.



Doctor David Boonzaier of the University of Cape Town and Richard van der Merwe (14) at one of the computer terminals specially designed for the disabled. ● Picture By Stephen Davimes.

Disabled are given boost in age of of new technology

STV 24/11/85 (299)

Alternative to medical aid schemes put forward

Medical aid membership will fall dramatically over the next 10 years as subscription fees soar in line with increasing medical costs. One solution, delegates at a pharmaceutical congress heard yesterday, was the establishment of Health Maintenance Organisations. TONI YOUNGHUSBAND, The Star's Medical Reporter, examines the HMO concept.

Growing medical costs have forced medical aid schemes to increase their membership fees substantially over the past year. Further increases are expected next year.

Pensioners, in particular, have been hard hit. Medical schemes say pensioners' claims are excessive and their fees must be brought in line with those of other scheme members. One comprehensive medical insurance company has increased its pensioners' subscriptions by R94 in one month.

If subscriptions go up, membership falls.

In a report compiled at the request of the Department of Health, Dr John Cowlin recommends the establishment of a system which is becoming increasingly popular in the United States.

A Health Maintenance Organisation (HMO) combines the financing and provision of health care services in exchange for a pre-negotiated monthly premium paid on behalf of a member and his family.

Any excess income over expenditure is distributed as a bonus for cost-effective practice on the part of the health care professional, as well as to provide dividends for the financiers and shareholders.

Furthermore, such excess of income over expenditure can be re-distributed to members of the scheme by means of no-claim bonuses on future premiums.

"It is quite obvious," says Dr Cowlin, "that such an arrangement provides a very effective deterrent against over-servicing by both the patient and the doctor. In South Africa, medical benefit schemes operate in a similar way but do not distribute 'profits' to shareholders, staff or investors in the same way as an HMO does."

Dr Cowlin believes HMOs, with their proven record of cost-effectiveness, are the ideal vehicle to provide workers who cannot afford medical aid-type schemes with quality health care.

ADVANTAGES

The HMOs are cost-effective in six areas:

- The profit motive: In the South African context it is estimated that 80 percent of health care costs are initiated, ordered and controlled by the general practitioner. By allowing the health care professionals a share in the savings achieved through the HMO, they will be motivated to practise economically thus re ducing the costs to the HMO.

Over-servicing, Dr Cowlin points out, will be a thing of the past.

- Dispensing: By operating their own dispensaries, HMOs avoid the 17 percent mark-up from manufacturer to wholesaler and the 50 percent mark-up from wholesaler to retailer.
- Hospitals: Many HMOs run day hospitals which cater for primary health care and minor procedures. Hospital space can be leased from the State.
- Preventative medicine: Under the existing medical aid schemes in South Africa, doctors are not paid to practise preventative medicine. However, doctors who stand to gain financially by controlling costs in their HMO will certainly practise it.
- Home care: In many instances it is not necessary for a patient to occupy an expensive hospital bed and many HMOs provide home nursing.
- Control of abuse: In order to control abuse of the facilities by the patient, a no-claim bonus is introduced where subsequent premiums are reduced from the incremental basis.

The HMO is ideal for workers who cannot afford medical aid schemes.

"Unfortunately, it is the ethical rules of the South African Medical and Dental Council which is the greatest HMO stumbling block," said Dr Cowlin.

Fraud drains medical aid

B/day
24 11 88 KAY TURVEY 299

MEDICAL aid schemes were losing about R20m a year through fraud and abuse of the claims system, Priceforbes Federale Volkskas group's Medicaid MD Jeff Slome said.

He said the variety of abuses was endless, although the alteration of dates and initials to lodge claims for non-dependants was fairly common.

Medscheme group marketing manager Malcolm Wilson said it was difficult to quantify the extent of abuse, which often involved collusion between doctors and patients.

Affiliated Medical Administrators executive chairman Tony Leveton said it was possible the newly announced agreement, whereby medical aid schemes would no longer have to pay 100% of doctors' consulting fees, could reduce over-servicing.

Representative Association of Medical Aid Schemes (RAMS) executive director Rob Speedie said the agreement between Rams and the Medical Association of SA (Masa), aimed at containing spiralling costs, would take time before implementation.

He said doctors' minimum guaranteed benefits to full members would be no less than 70%.

SOUTH AFRICAN TRANSPORT SERVICES

No. R. 2351 **25 November 1988**

TRANSMED REGULATIONS.—SCHEDULE OF AMENDMENT

Under the powers vested in me by section 25 of the South African Transport Services Conditions of Service Act, 1988 (Act 41 of 1988), I, Eli van der Merwe Louw, Minister of Transport Affairs of the Republic of South Africa, do hereby approve of the Transmed Regulations published in Government Notice R. 34 of 7 January 1983, as amended, being further amended as follows with effect from 1 April 1988:

REGULATION 21

Substitute the following for paragraph (3):

(3) A member/beneficiary who resides or is on holiday outside the Republic of South Africa by own choice or who is outside the Republic of South Africa due to official duties, shall be entitled to the benefits which Transmed is liable for in the Republic of South Africa. The member shall settle the account and thereafter claim a refund as prescribed in regulation 25. A refund of 75 per cent of the total cost shall be made by Transmed.

Delete paragraph (4) and renumber paragraphs (5) and (6) to (4) and (5) respectively.

REGULATION 22

Substitute the following for paragraph (1):

(1) No membership fees shall be payable by a member, but a serving member shall contribute R10 per month. These contributions are paid into Transmed's Working Account from which grants are made and against which moneys that deceased members were owing to Transmed are written off.

REGULATION 23

Substitute the following for paragraphs (1) (a) (i) and (1) (a) (ii):

(1) (a) (i) Transmed shall pay as follows for the services of a general medical practitioner or specialist for consultations in consulting rooms, at outpatients' departments of hospitals and at residences:

All members: 75 per cent of the tariff of fees. Members shall make a partial payment of 25 per cent, based on the tariff of fees, direct to the supplier.

(1) (a) (ii) Transmed shall normally pay as follows for the services of a general medical practitioner or specialist for treatment, small operations or other procedures in consulting rooms and for surgical dressings and injections, including the material used in consulting rooms. Surgical dressings and injections (insulin injections excluded) are not supplied on prescription. The medical practitioner can claim the costs thereof on his account:

All members: 75 per cent of the tariff of fees or of the costs of the surgical dressings, injections or material used. Members shall make a partial payment of 25 per cent, based on the tariff of fees or the costs of the surgical dressings, injections or material used, direct to the supplier.

In paragraph (1) (a) (iii), in the *second last sentence* substitute "75 per cent" for "50 per cent".

Substitute the following for paragraph (1) (b):

(1) (b) Transmed shall normally pay 100 per cent of the tariff of fees for the services of a general medical practitioner or specialist for operations and surgical procedures in hospitals, institutions or theatres registered in terms of the Health Act, 1977 (Act 63 of 1977).

SUID-AFRIKAANSE VERVOERDIENSTE

No. R. 2351 **25 November 1988**

TRANSMED-REGULASIES.—WYSIGINGSLYS

Ingevolge die bevoegdheid aan my verleen by artikel 25 van die Wet op Diensvoorwaardes vir die Suid-Afrikaanse Vervoerdienste, 1988 (Wet 41 van 1988), verleen ek, Eli van der Merwe Louw, Minister van Vervoerwese van die Republiek van Suid-Afrika, goedkeuring daaraan dat die Transmed-regulasies gepubliseer in Goewermentskennisgewing R. 34 van 7 Januarie 1983, soos gewysig, verder soos volg gewysig word met ingang van 1 April 1988:

REGULASIE 21

Vervang paragraaf (3) deur die volgende:

(3) 'n Lid/voordeeltrekker wat uit eie keuse buite die Republiek van Suid-Afrika woon of met vakansie is of wat weens amptelike pligte buite die Republiek van Suid-Afrika is, is geregtig op die voordele waarvoor Transmed in die Republiek van Suid-Afrika aanspreeklik is. Die lid moet die rekening vereffen en daarna 'n terugbetaling eis soos bepaal in regulasie 25. 'n Terugbetaling van 75 persent van die totale koste word deur Transmed gedoen.

Skrap paragraaf (4) en hernommer paragrawe (5) en (6) onderskeidelik na (4) en (5).

REGULASIE 22

Vervang paragraaf (1) deur die volgende:

(1) 'n Lid betaal geen ledegeld nie, maar 'n dienende lid dra R10 per maand by. Hierdie bydraes word in Transmed se Bedryfsrekening gestort waaruit toekennings gedoen word en waarteen gelde wat afgestorwe lede aan Transmed verskuldig was, afgeskryf word.

REGULASIE 23

Vervang paragrawe (1) (a) (i) en (1) (a) (ii) deur die volgende:

(1) (a) (i) Transmed betaal soos volg vir die dienste van 'n algemene mediese praktisyn of spesialis vir konsultasies in spreekkamers, by buitepasiëntafdelings van hospitale en by wonings:

Alle lede: 75 persent van die geldetarief. Lede moet 'n gedeeltelike betaling van 25 persent, gebaseer op die geldetarief, regstreeks aan die leweransier doen.

(1) (a) (ii) Transmed betaal normaalweg soos volg vir die dienste van 'n algemene mediese praktisyn of spesialis vir behandeling, klein operasies of ander prosedures in spreekkamers en vir chirurgiese wonddekkings en inspuitings, met inbegrip van die materiaal wat in spreekkamers gebruik word. Chirurgiese wonddekkings en inspuitings (insulieninspuitings uitgesluit) word nie op voorskrif verskaf nie. Die mediese praktisyn kan die koste daarvan op sy rekening eis:

Alle lede: 75 persent van die geldetarief of van die koste van chirurgiese wonddekkings, inspuitstof of materiaal gebruik. Lede moet 'n gedeeltelike betaling van 25 persent, gebaseer op die geldetarief of die koste van die chirurgiese wonddekkings, inspuitstof of materiaal wat gebruik is, regstreeks aan die leweransier doen.

In paragraaf (1) (a) (iii), die *tweede laaste sin*, vervang "50 persent" deur "75 persent".

Vervang paragraaf (1) (b) deur die volgende:

(1) (b) Transmed betaal normaalweg 100 persent van die geldetarief vir die dienste van 'n algemene mediese praktisyn of spesialis vir operasies en chirurgiese prosedures in hospitale, inrigtings of teaters wat kragtens die Wet op Gesondheid, 1977 (Wet 63 van 1977), geregistreer is.

REPUBLIC OF SOUTH AFRICA
REPUBLIEK VAN SUID-AFRIKA

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Vol. 281 PRETORIA, 29 NOVEMBER 1988 No. 11607

NOTICE 832 OF 1988

DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

REPRESENTATIVE ASSOCIATION OF MEDICAL SCHEMES.—SCALE OF BENEFITS IN RESPECT OF PHYSIOTHERAPY SERVICES

The Representative Association of Medical Schemes, in terms of section 29 of the Medical Schemes Act (Act 72 of 1967), as amended, hereby determines the scale of benefits for physiotherapy services as set out in the Schedule hereto. The said scale of benefits shall come into effect on 1 January 1989, and replaces the scale of benefits which was published in Government Gazette No. 11507 dated 11 December 1987.

N. J. J. VAN RENSBURG,
Chairman: Representative Association of Medical Schemes.

SCHEDULE

General rules governing the scale of benefits

001 Unless at least two hours' notice of cancellation of an appointment has been given, the relative

KENNISGEWING 832 VAN 1988

DEPARTEMENT VAN NASIONALE GESONDHEID EN BEVOLKINGSONTWIKKELING

VERTEENWOORDIGENDE VERENIGING VAN MEDIESE SKEMAS.—VOORDELESKAAL TEN OPSIGTE VAN FISIOTERAPIE DIENSTE

Die Verteenwoordigende Vereniging van Mediese Skemas, kragtens artikel 29 van die Wet op Mediese Skemas (Wet 72 van 1967), soos gewysig, bepaal hierby die voordeleskaal vir fisioterapie dienste soos in die Bylae hiervan uiteengesit. Die genoemde voordeleskaal sal op 1 Januarie 1989 in werking tree, en vervang die voordeleskaal wat in Staatskoerant No. 11507 van 11 Desember 1987 gepubliseer was.

N. J. J. VAN RENSBURG,
Voorsitter: Verteenwoordigende Vereniging van Mediese Skemas.

BYLAE

Algemene reëls betreffende die voordeleskaal

001 Tensy ten minste twee uur kennis gegee is van die kansellasie van 'n afspraak kan die

Workers for the blind honoured

Star 30/11/88

299

By Paula Fray

The Society to Help the Civilian Blind honoured its volunteer workers at a function in Roseacres, Johannesburg, today.

Dr William Rowland, director of the National Council for the Blind, spoke on the partnership of the community of volunteer workers and the welfare organisations.

Social worker Miss Maria Longley said 30 volunteer workers, many of them skilled pensioners, had been trained to do various jobs this year.

They befriended the blind, visiting them in their homes, teaching them mobility skills and basic daily living skills.

Miss Longley said the volunteers performed an excellent service and were a high point in the lives of the blind people they helped.

She thanked the helpers and various service organisations, including branches of Lions International.

'Disabled doesn't mean unable'

C/Press 4/12/88

299

"We are happy to be able to do something useful, rather than sit around at home feeling sorry for ourselves," says a blind group.

Pics: ANDRIES MCINEKA.

By LULAMA LUTI

DISABLED does not mean unable.

This has become a popular saying among disabled people, who appear to have graduated from self-pity and are now fighting for recognition and upliftment in all spheres of life.

City Press recently visited the Itereleng/Ezenzeleni Workshop for the Blind in Wadeville, Germiston, which employs about a hundred blind people who would otherwise have been sitting at home with nothing to do.

One of the men, Tsidi Maphike, 38, said: "We are here to prove that we are capable of doing work as well as sighted people.

"We are not just dumped here. We have been provided with something to do and that is a motivation to other handicapped people."

Most of the work is assembly of a large assortment of articles.

Various companies in Germiston and nearby industrial areas send their products to the factory, where the blind people assemble and prepare them, sorting and sealing them.

Instructor Irene Nkuna, who together with Edward Mashao is responsible for relaying instructions to the assistants, explained how work was done and how it was divided among the people who worked with instructors and aides at both factories.

"At Factory 1 they assemble and strip boxes for the nearby Nampak company in preparation for packaging.

"Those working at Factory 2, which is the gluing section, do packaging for a firm in Elandsfontein and also sort out sticky tape according to grading for the same company."

She said most of the workers came from East Rand townships like Daveyton, Vosloorus, Kwa-Thema and Natalspruit.

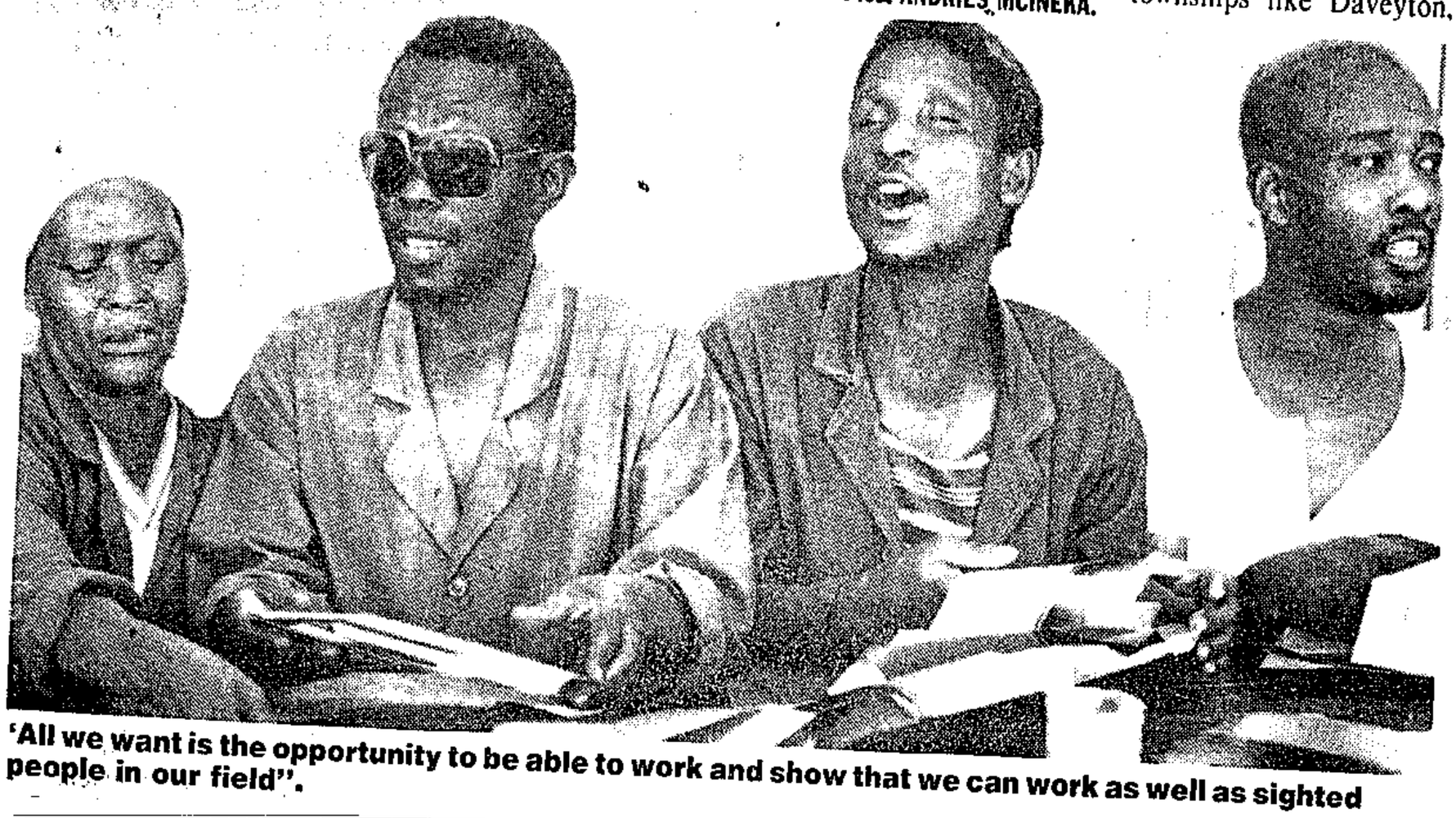
Asked which periods of the year was the busiest, she said these were during winter, when they assembled fruit boxes, and when most companies were closing for vacation.

Susan Ntsapi, a 64-year-old mother of seven from Katlehong, said her eye problems and severe headaches began in the late 60s and ended in her going blind in 1972.

Single with one child is Lenos Nyathi, 35, who has been blind for the past 16 years.

He said his eyesight was affected by smoke at a Wadeville factory and that he was not compensated.

Everyone agreed that they were happy to be at the workshop with something to do.



'All we want is the opportunity to be able to work and show that we can work as well as sighted people in our field".

Plucky paraplegics make history

Own Correspondent

WELKOM — Three paraplegics from Teba Rehabilitation Centre in Welkom have completed courses at the Northern Free State Training Centre.

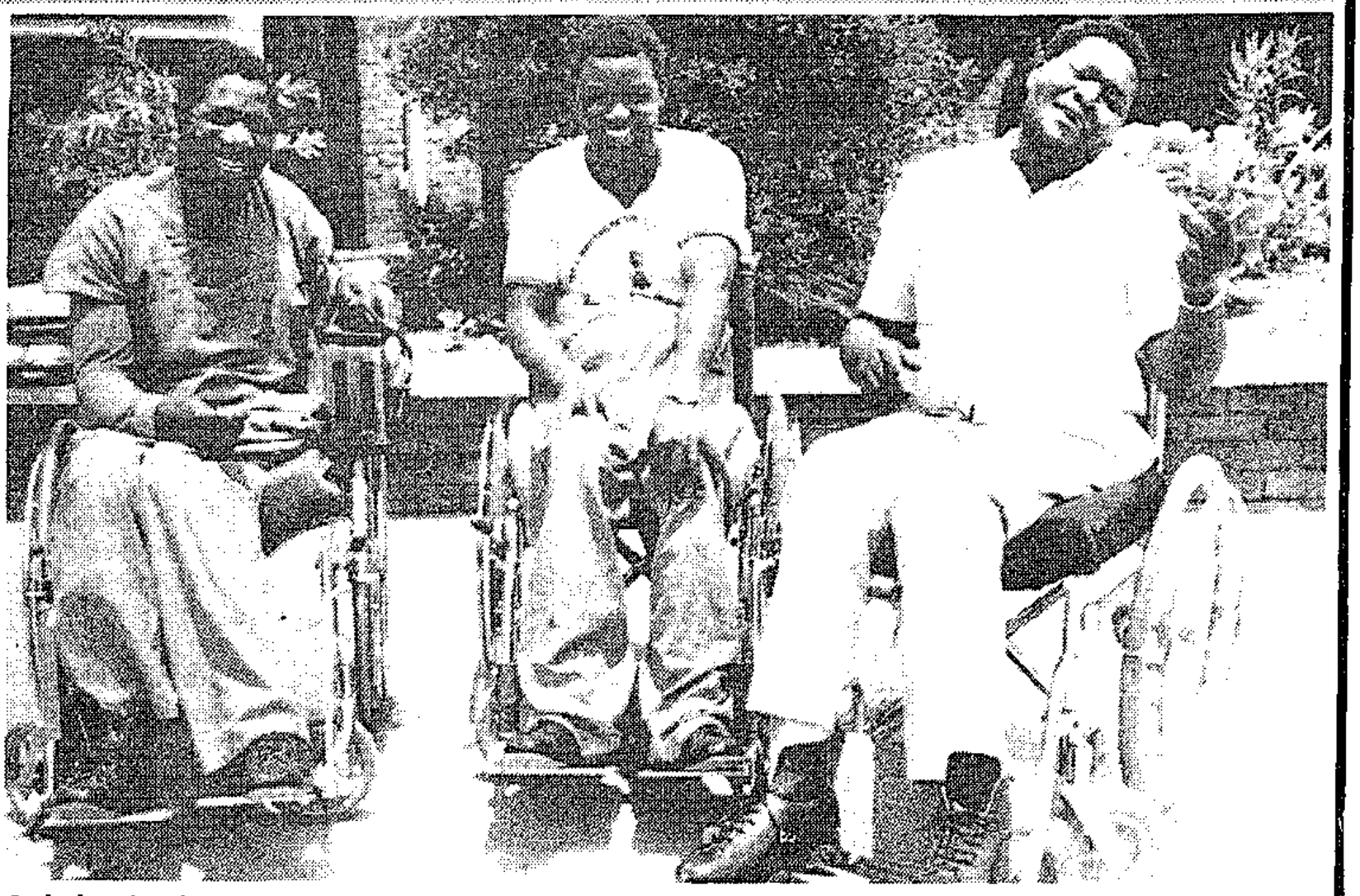
Mr Raphael Julai, Mr Zacharias Khetshana and Mr Simon Theko were the first disabled men to attend the non-racial training centre, which offers basic courses in many skills for work-seekers as well as rebate training for industry.

Previously employed on the mines, the three have been part of the Teba programme since being transferred from Rand Mutual Hospital in Johannesburg, where they were initially treated after the accidents that left them paralysed.

At Teba the men are taught the skills necessary for reintegration into society — and by coping successfully at the training centre, where they were resident for the duration of their courses, Mr Julai, Mr Khetshana and Mr Theko have proved they are ready for the next step: re-employment.

NFS Training Centre director Mr Japie de Wet said that only minimal adaptations had had to be made to accommodate the paraplegics.

"We constructed two ramps," he said, "but Raphael, Zacharias and Simon were so independent that we soon forgot that they were in wheelchairs. At first, some of them tried to help by pushing the chairs but the paraplegics insisted on wheeling themselves."



Delighted to have completed their courses . . . Mr Zacharias Khetshana, Mr Raphael Julai and Mr Simon Theko now hope for re-employment in the mining industry. ● Picture: Barbara Frost.

Raphael, who did welding, and Zacharias, who was on the electrical course, had no problems but there were a few anxious moments for Simon, who did basic training as a supervisor and storeman.

"He had to attend lectures upstairs but volunteers soon solved the problem and carried him and his chair to the first floor," Mr de Wet said.

Dr Jerome Boulle, who has been in charge at Teba since last year, said it was not only the certificates the men had earned that were important.

"The realisation that they can manage in the normal community is vital not only for the disabled but also for potential employers," he said.

Str 6/12/88

First time for Transvaal children

New school for visually impaired

(299)

A fully-equipped nursery school for visually impaired children, which complements an existing therapy stimulation unit, will be opened in Johannesburg early next year.

The entire institution will be the first of its kind in the Transvaal and will assist children from as far afield as Sasolburg, Nigel and Bethal in the Free State.

Mrs Beth Nielsen, a social worker with the Society to help the Civilian Blind, said the institution will be called The Moonbeam Centre for the Advancement of Visually Impaired Children,.

Miss Mary Anne van der Velder, a phsysiotherapist who works with the unit at the Johannesburg Hospital, said stimulation therapy for the pre-school visually impaired child had been decidedly lacking in the Transvaal.

By Paula Fray

Miss van der Velder said the Transvaal Memorial Institute for Child Health (TMI) has been running a therapy-stimulation unit for pre-school visually impaired children since 1983. The ages of the children range from birth to about 5½.

However, said Mrs Nielsen, the needs of the children had far outstripped the help the stimulation unit was able to give.

Now, with the help of the Society to help the Civilian Blind, it would be able to open the full-time nursery, manned by professional staff, at the end of February next year.

Mrs Nielsen said the institution would cater for nursery school children and others who needed stimulation.

The staff will include a physiotherapist, an occupational therapist, a speech and hearing therapist, a social worker, a nursery school teacher and administrative staff.

AID TO COST-CUTTING

Companies are wasting millions of rands a year on unsuitable medical aid schemes because they aren't aware of the alternatives, says medical aid consultant Lyn Blignaut.

She says that despite the Medical Schemes Act, which is intended to ensure uniformity in medical aid packages, there is considerable variation in cost and services. Some companies could save more than R1m a year and increase benefits at the same time.

She says company directors "often don't realise the range of options available. The scheme they join may not be best for the members." As companies grow, schemes can offer them more attractive packages but often these companies are unaware of the option to upgrade benefits.

Representative Association of Medical Schemes (Rams) executive director Rob Speedie says: "There is a significant variation in patterns, depending on the profile of the membership. There are non-statutory services available such as paediatry and speech therapy, which aren't brought to the immediate attention of members."

Blignaut says schemes are being reassessed. The 100% scheme, in which medical aids pay the entire bill, will become less common. Rams and the Medical Association of SA have agreed that medical aid societies should be given the option of paying doctors only 70% of fees, leaving the patient to pay the rest.

599 FM MAIL 9/12/88

Tembisa businessman aids charities

By SELLO SERIPE

TEMBISA businessman Joe Tuba, owner of Tuba Kentucky Fried Chicken and a confectionery and bakery, this week gave R800 to two local charities.

The Association for the Physically Disabled and the Society for the Care and Welfare of the Aged each received R400.

Most of the organisations' income comes from donations from businesses.

APD chairman Pescod Tindleni said the R400 donation would be used to buy equipment. He added that the town council had allocated APD a site for a permanent centre to be used by the disabled.

Patricia Modise said the money donated to the SCWA would be used to help feed the aged who met for lunch and discussions each Tuesday and Wednesday.

She said the town council had given SCWA a site to build an old age home.

Tindleni and Modise also appealed to the community to give more money to the organisations as they did not have enough money to build the centres.

Tuba said: "It is my responsibility to sow what I have reaped from the community.

"I would be nowhere without their support."

Tuba challenged other local businessnmen to give money to the two organisations.

Disabled Jerry Khumalo accepts a donation.

Big medical increases 'unavoidable'

Cape Times 14/12/88

299

Own Correspondent

PRETORIA.—Increases of between 17% and 25% in medical schemes' subscriptions seemed unavoidable in the new year, Representatives Association of Medical Schemes (RAMS) executive director Mr Rob Speedie said yesterday.

Costs had risen across the board in the past 12 months, exerting tremendous pressure on the resources of schemes, and the trend was certain to continue into the new year, he said.

The weakened rand would also cause a big increase in the prices of drugs and medicines.

Doctors and dentists fees would also rise from the beginning of the year.

Another important reason for the escalating costs was an over-utilisation of medical services.

Over the past few years this had increased at a rate of 5% a year, Mr Speedie said. It included unnecessary visits to doctors and consequent costly prescriptions.

This year the average cost of a prescription, which normally included two ot three items, was R50.

Cut back on doctors, says medical aid chief

ARGUS 14/12/88

The Argus Correspondent

PRETORIA. — An increase of between 17 and 25 percent in medical scheme subscriptions is regrettable but necessary, according to Mr Rob Speedie, executive director of the Representative Association of Medical Schemes.

Medical costs had risen and the cost of medicine was expected to continue rising, partly due to the weakened rand, he said.

Patients could help by cutting back on consulting doctors for minor ailments and making more use of pharmacists.

Medication on the advice of a pharmacist would reduce the number of consultations and expensive prescriptions.

Mr Speedie said the average prescription had increased from two to three items. The use of generic equivalents would result in substantial savings.

Patients and doctors needed to be made more aware of costs.

Medical aid subscriptions set to rise by 17% or more

GERALD REILLY

PRETORIA — Increases of between 17% and 25% in medical-scheme subscriptions seemed unavoidable in the new year, Representative Association of Medical Schemes (Rams) executive director Rob Speedie said yesterday.

Costs had risen across the board in the past 12 months and the trend was certain to continue into the new year.

The weakened rand would cause a big increase in the prices of drugs and medicines — biggest components in pay-outs.

Doctors' and dentists' fees would also rise from the beginning of the year.

Another important reason for the escalating costs was an over-utilisation of medical services.

Over the past few years this had increased at a rate of 5% a year.

It included unnecessary visits to doctors and consequent costly prescriptions.

A greater use of self-medication in consultation with pharmacists would save medical schemes substantial amounts, Speedie said.

A break-down of medical-scheme pay-outs showed about 30% went to doctors and specialists, 22% to hospitals, 12% to dentists, one or two percent to supplementary services such as physiotherapy, and more than 40% to drugs and medicines.

Speedie said it was estimated the 210 schemes associated with Rams would pay out between R3,2bn and R3,5bn this year.

UCT sets up a Disability Unit

Sowetan 14/12/88 (299) (582)

THE University of Cape Town has established a Disability Unit to help disabled people on campus who face both physical and attitudinal barriers in gaining access to the university's facilities.

A spokesman for the university said the aim of the unit is to raise awareness of the needs of disabled people in the university community.

This included, advising students or departments, architects, builders and the maintenance department on how best to meet the special needs of disabled people.

The spokesman said parking is already a sensitive issue and an appeal has been issued to all who park at UCT to show consideration and refrain from parking in bays reserved for disabled people unless they are entitled to do so.

A number of parking bays at strategic points on campus have been specifically allocated for use by students or staff with a disability. There are two kinds of bays:

- numbered bays that have been allocated to individuals for their sole use, many of which are clearly identifiable by the international access sign; and
- unnumbered but signposted bays indicating that they may be used by any persons with a disability.

Sight problems prevent children realising potential

Undetected vision problems prevent many children from achieving their scholastic and sports potential, says a spokesman for the SA Optometric Association.

Parents should let their children take more than a new uniform and satchel when they start school next year, by making sure that their vision — the sense that collects 80 percent of their information — has been professionally assessed.

Visual problems can drastically affect the quality of children's lives and could be the root of learning problems and poor ball co-ordination, the spokesman says.

"Eyes don't cause pain like teeth, so often they are ignored. Children should have regular dental and pediatric check-ups, as well as eye tests," he says."

The spokesman says that many parents believe that their children see as well as they do.

"This may be so. But only a thorough eye examination can make sure that there is no problem."

Many schools arrange eye screenings for pupils. Although this does aid in detecting eye problems in some children, it in no way replaces a professional eye examination.

Eye care should begin in the cradle, with parents noticing whether their baby's eyes appear squint (not working together). If eyes haven't righted themselves by the time the baby is six months old, an eye care professional should be consulted.

Parents should be aware of the signs of possible vision problems.

Some signs are:

- Continuous frowning or rubbing of eyes.
- Continuous tilting of the head.
- Difficulty with ball games.
- Toddlers walking into objects that they should have noticed.
- Grabbing at toys, but missing.
- Frequent headaches.
- Continuous blinking.
- Doing school work with a hand covering one eye.
- Squinting to see.

The problems that children may have can range from seeing a blurred blackboard to reading difficulties.

Decision on medical aid fees condemned

DRUGS 19/12/88 299

By a Cape Town general practitioner

IT is with extreme dismay that one reads in these times of high inflation that the Representative Association of Medical Schemes, in conjunction with the Medical Association of South Africa, has agreed to pay only 70 percent of the consultation fees to the doctor, leaving the member responsible for the remaining 30.

The claim by the medical aids that this would benefit employers and employees financially by reducing contribution costs is a load of drivel.

This move, besides hitting people of the lower socio-economic areas hardest, would drastically affect members in the affluent areas who are fast losing their affluent identity because of this country's unbridled and apparently unstoppable rate of inflation.

Thirty percent in terms of rands and cents for GP consultations could add up to quite a phenomenal sum for a family of four, depending on which side of the social scale they belong.

For members of the lower socio-economic group wh se doctors accept the contracted in rates, this would work out at R18 while for the affluent patients whose doctors are contracted out this could add up to R78.

Either way both groups are going to be hard hit.

In a medical practice, disincentives never work when they entail collecting money from patients because:

● Doctors make bad debt collectors, and

● Doctors are compelled to see patients in need of their services irrespective of whether patients can afford their services or not.

The spiralling rise in health care can easily be attributed to the fact that this country with its "medical aid" population of four million (one million blacks and three million whites) has 240 medical aids — which is far too many.

America, with a population of 220 million, has only four medical aid societies for the entire country. The simple deduction is that this country has about 210 medical aids too many.

Vast sums of patient contribution is being guzzled in salaries for the directors, administrators and employees of these excess medical aids, which are really poor duplications of the few well-run medical aid societies in this country.

Medical aids have come to the rescue of the ailing State health services, which failed to provide decent medical facilities for the underprivileged claiming that it (the State) was bankrupt.

The State offered tempting perks to the employers by allowing them a tax deduction on the 50 percent they contributed for their employee to a medical aid scheme.

Employees were often forced to join these medical aids in terms of their contract even though they couldn't afford to do so. Medical aids went out of their way in vying for the custom of big employers.

It is not surprising therefore to find many of them in a state of imminent bankruptcy.

The medical aids should come out in the open and make it quite clear that their membership is no longer for sale to all and sundry. People belonging to the lower socio-economic group should rightly be the responsibility of the State and not the private sector.

The employee should have a direct say as to whether he wishes to opt out of a medical aid or not, just as his medical aid assumes the "automatic" right to change the laws as it suits itself without consulting its members.

The sad thing about all this is the resigned manner in which the affluent accept whatever is dished out to them without any protest because they can afford it. What about the poor?

If the affluent used their clearly heard voices, there is little doubt that the medical aids would not have landed themselves in the financial mess that they have.

The medical association's support of such a scheme can only reinforce the doubt in the minds of many of its former and present disenchanted members — namely, their major concern falls within the constraints of those who can afford.

Wouldn't they like to speak for those who can't afford as well?

To them one can only say — turn a sick man away today and tomorrow he will return with the epidemic. How else can one explain the rising rate of TB and measles in the country?

The medical aids have failed to solve the health care needs of the underprivileged, so they should accept that fact, bow out gracefully and return the responsibility to the State.

Soweto hostel for disabled

The Association for The Physically Disabled (Transvaal) has just completed a new hostel, believed to be the first in a black township, for its J C Merkin School in Jabavu, Soweto. Star 19/12/84

Mrs Shelley Shorten, chairman of the governing body, said the new hostel can accommodate 90 children who are so severely disabled they cannot get to and from ordinary day schools. (299)

"Accommodation at school is the only solution because of the lack of transport," Mrs Shorten said.

The new hostel opens on January 16 and a start will soon be made on the second phase, which consists of a kitchen, dining hall, study and recreation room at a cost of R500 000.

Iscor fraud suspect found hanged in cell

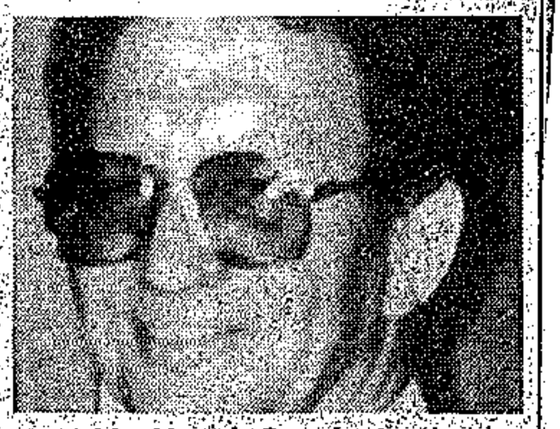
The Argus Correspondent

PRETORIA. — Mr Karel Daniel Oosthuizen, the accountant accused of defrauding the Iscor Medical Aid Fund of R4,5-million, died today in what appeared to be suicide.

In a statement, the Prisons Service announced "that an awaiting trial prisoner of the Pretoria Central Prison apparently committed suicide last night after he had hanged himself from a cell bar".

Mr Oosthuizen, 49, previously of River Road, Lyttelton Manor, was refused bail on Tuesday. No charges were put to him and he was to remain in custody until January 4.

Magistrate Mr M C de Witt said on Tuesday that Mr Oosthuizen's behaviour did not convince the court that he would come back for trial if granted bail.



Mr Karel Oosthuizen

Mr Oosthuizen's former mistress and co-accused, Ms Cornelia Pistorius, who was conditionally granted R6 000 bail, could not be reached for comment.

The incident was being investigated departmentally and by the police, the statement said.

INSIDE: Weather 2, Women 18, Financ

Forgotten people spend Christmas alone

By KURT SWART 299 ST Times 25/12/88

ALL the "forgotten" people of Cape Town's hospitals would like for Christmas is somone to care enough about them to come and take them home.

Dubbed the "forgotten people" by hospital staff, they lie in hospital wards sometimes not knowing who they are or where they have come from.

Their faces and a few bits of information about them appear intermittently in local newspapers. The headline is normally : Do you know these people?

Mrs Maureen Kruger, social worker at Victoria Hospital, said : "These patients are usually people who have suffered head traumas through motor vehicle accidents or assaults and are admitted with diminished levels of consciousness

"No one seems to know they are here and no one seems to care."

Some of them have suffered strokes, many can't speak at all and others are so disoriented and don't know who they are.

"We make every effort to identify them — sometimes another patient may give us a clue, or the patients may have scraps of information about themselves when they are admitted," said Mrs Kruger.

"But we have no way of identifying some of them at all."

She said social workers were very successful in tracking down the relatives of some of the patients.

"Our problem is what to do with those that are not identified."

Many are sent to the Conradie Hospital, which has a long term and geriatric unit — the only one of its kind in the Western Cape.

The ward has 61 beds for patients under 65 and another ward is available for the over-65s.

According to statistics at least 90 percent of the "forgotteen" patients are men, mostly in their 30s or 40s.

Mrs Tertia McKie, social worker at Conradie Hospital, said: "It can be a very sad experience when a family looking for a lost relative enters a ward full of hope only to find that the patient is a stranger.

"Not knowing whether a loved one is alive or dead is a very traumatic experience," she said

Year of medical successes

Star 29/12/88 299

A fairytale come true is how the mother of Siamese twins Mpho and Mphonyana Mathibela described one of South Africa's greatest medical triumphs — the separation of her children on May 3.

When the twins were born at the Tshepong Hospital in Klerksdorp two years ago, Sophie Mathibela did not want them. Her babies were joined at the back of the head and their deformity frightened her.

But thanks to dedicated teams of nurses and doctors, Miss Mathibela learnt to love her babies and eventually to celebrate their surgical separation.

Congratulations poured in from all over the world when Professor Robert Lipschitz and his team announced at Baragwanath Hospital in Soweto that the twins were at last two separate beings.

Their separation involved three complex operations and many hours of pain and suffering but, for them, 1988 heralded a new beginning and, for South Africa, a medical victory to be proud of.

The past year has featured many stories of children, their happiness and heartaches.

Media attention focused repeatedly on the Johannesburg Hospital's Ward 294 — a day clinic for terminally ill children. Their faces racked with pain, the children fought on against the illnesses destroying their bodies.

BY TONI YOUNGHUSBAND, Medical Reporter

Rotary's Reach for a Dream project did much to brighten the lives of the children, and media reports on the project evoked widespread sympathy and offers of financial assistance.

Yet another Rotary project, the All Africa Trust Fund, paid for heart surgery for six-year-old Gladys Nakazwe. The hole in Gladys's heart was repaired at the Morningside Clinic in Sandton. She flew home to Lusaka in time for Christmas.

Thirty-three other South African children had reason to celebrate 1988. They were all conceived as a result of the test-tube techniques practised at the Sandton Clinic's in-vitro fertilisation unit, which celebrated its third birthday on November 21.

While many prefer to remember 1988's success stories, there is no denying the country's health system is ailing.

Newspaper headlines said it all: "South African medical system at crisis point"; "Private patients suffer"; "Seeing the doctor set to cost more"; "Imported medicine to cost more" and so it went on.

The strongest protest against soaring medicine costs came from the pharmacists, who claimed they were tired of taking the blame.

They launched a national campaign calling on consumers to protest against increased prices, pointing out that it was the State tender system of buying medicine, and not the pharmacist, that was to blame.

A 33 percent increase in medicine prices is forecast for the new year.

Medical aid subscription fees are also set to go up in January. According to the Representative Association of Medical Aid Schemes (Rams), patients could pay up to R15,50 for a visit to the doctor.

According to a joint statement by the Medical Association of SA (Masa) and Rams, the purpose of this is to encourage "responsible use of consulting services and to curtail spiralling costs".

However, while costs soared there was some relief for overcrowded provincial hospitals. Baragwanath Hospital opened a new maternity section, relieving the burden on the old unit, and provincial officials agreed to the erection of temporary buildings for the Department of Medicine.

The controversial Lenasia South Hospital, which stood empty for two years, was also granted a reprieve.

The 98-bed hospital was never opened because of a lack of funds but in November the Minister of Health Services and Welfare in the House of Delegates, Mr Raymond Bhana, announced that budget savings in his department would provide funding for the hospital's opening. It is scheduled to open in January.

One of medicine's greatest mysteries, the Aids virus, continued to threaten populations worldwide.

The terrifying consequences of this modern plague prompted the World Health Organisation to declare December 1 World Aids Day in the hope that all countries would join together in the fight against the killer disease.

Education on lifestyles is being encouraged in most countries, and not just with the Aids issue in mind.

Politics reared its ugly head in the medical profession once again. Dr Jocelyn Kane-Berman, Groote Schuur Hospital's chief medical superintendent, was transferred to the post of western Cape regional medical superintendent after her lighthearted remarks in a newspaper article which mentioned Nelson Mandela as a possible prime minister.

A storm of protest from hospital staff and other medical professionals followed and Masa agreed to back Dr Kane-Berman should she decide to take court action.

Mpho (left) and Mphonyana . . . a fairytale come true for their mother, So was frightened of their Siamese-twin condition and rejected them at birth. South African doctors make 1989 a year for the twins to look fo

30/12/88 Soweta 299

Helping hand for disabled

By THEMBA MOLEFE

A KAGISO businessman who is concerned about the plight of the disabled in the West Rand township has put up R1 300 towards building a self-help factory for afflicted people.

Taverner Mr Carter Manake said his donation to the Itsoseng Disabled People of Kagiso was a challenge to all businessmen in the township to join hands in the venture.

The organisation, which has acquired land from the Kagiso Town Council, needs R500 000 to erect the factory, a school and a sports field.

Mr Manake has also donated 75 percent of a weekend's takings towards the project and has pledged to do so again in future.

Chairman of Itsoseng, Mr Peter Mabuse, said the building of the centre would alleviate problems of the disabled, who lacked facilities and had to travel outside Kagiso to work or study.

He pointed out that schools in the township discriminated against disabled children who then had to travel to the two schools in Soweto which cater for afflicted children.

The factory, Mr Mabuse said, would enable the 54-member organisation to establish industries and create a sense of self-reliance.

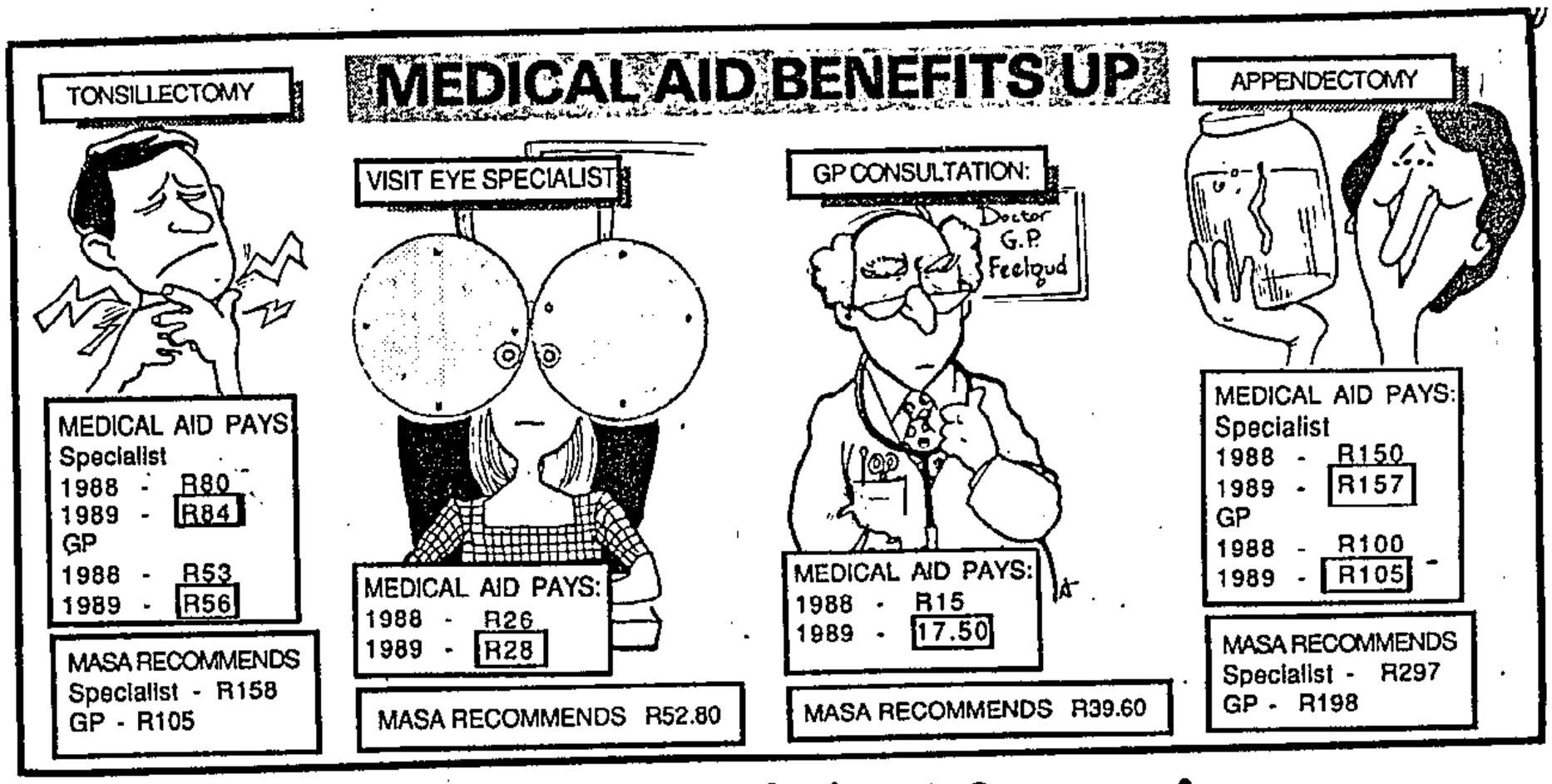
Mr Manake said: "My donation is small but I vow to work with the disabled until they reach their goal. I also appeal to the Kagiso business community to lend a hand in the project."

MR Carter Manake (extreme right) hands over the R1 300 cheque to Itsoseng's treasurer, Mr George Mokgothu, while Mr Peter Mabusa (chairman), Mr Abram Medupe (PRO), and Mr Fanyana Seloke (vice-chairman) look on.

SOCIAL SECURITY
~~SUBJECT~~ ~~SELECTOR~~ MEDICARE

1989

JANUARY — JUNE



Masa unhappy with 10 pc increase

299 Star 4/11/89

By Toni Younghusband,
Medical Reporter

Medical aid schemes have increased their overall payouts for doctors' services by 10 percent.

The increase, which was announced by the Representative Association of Medical Aid Schemes in October last year, came into effect on New Year's Day.

The overall increase means benefits for general practitioner consultations will go up by more than 16 percent but for most other services the increase will be less than five percent.

Last year, medical aid schemes paid out R15 for a general practitioner's consultation. This year, they have increased their payout to R17,50.

A tonsillectomy performed by a specialist has gone up from R80,20 to R84 and by a GP from R53,40 to R56.

Despite the increase, the Medical Association of South Africa (Masa) says there will be no meaningful improvement in the remuneration position of the vast majority of doctors.

Dr Bernard Mandell, chairman of the Federal Council of Masa, said the increase would be a major disappointment to those doctors who charged medical aid rates. The Association believes doctors should be paid out a lot more.

"It is anticipated that more doctors will have to consider charging the recommended Masa fees in order to maintain viable practices," Dr Mandell said.

Masa has recommended that general practitioners charge a maximum of R39,60 per consulation.

As a result of the increased benefit payouts, membership fees are also expected to rise, possibly by as much as 20 percent.

PIC: ROBERT MAGWAZA

School for handicapped gets 100 percent pass

299

Sowetan 5/11/89

By MONK NKOMO

THE Filadelfia Secondary School for the handicapped in Soshanguve near Pretoria set a record when all 22 of their Standard 10 pupils passed the final examination last year.

Mr Aldert Dill, principal of the school, yesterday said the 100 percent pass was obtained by 14 physically handicapped and 8 blind pupils — six of whom obtained first class passes.

The pupils wrote the examination as other matric students under the Department of Education and Training.

Among those who passed was Caroline Visser, a Tswana-speaking girl from Kimberley who is physically handicapped and was very sick throughout the year, according to Mr Dill.

"I am glad that she too made it despite the problems she encountered during the year," said Mr Dill.

Distinctions

Those who obtained first class passes are:

- Solomon Bokaba, a blind student from the West Rand who obtained a distinction in Biblical studies and symbol B in English;
- Ellen Mdau obtained a distinction in English and B symbols in accountancy and business economics;
- Noria Molokoane of Mafikeng scored a distinction in Biblical studies and B symbols in history and Tswana;
- Nelson Dawetsi from East London got B symbols in English and business economics;
- Andries Moetsi from Soweto obtained a B symbol in English and;
- July Thwasa from Hanover near Colesburg got a B symbol in Biblical studies.

Mr Dill lauded the students for their hard work and dedication despite their handicap. He also praised his teachers for having patience throughout the year. Mr Dill said he expected the same results for the 45 matric pupils this year.

Eureka talking computer is latest aid to the blind

Star 11/11/89 (299)

By Paula Fray

A portable talking computer — with the latest technology for visually handicapped people — has come to South African shores, says Mr Geoff Hilton-Barber, director of the Natal Society for the Blind.

The Eureka A4 computer was described as an innocent looking dynamite package by Mr Hilton-Barber, in the latest *Infama*, the bi-monthly South African National Council for the Blind journal.

Mr Hilton-Barber, who is also blind, told The Star the advantage of the computer was that it had not been specifically created for visually handicapped people. It was adapted from computers created for sighted people.

● For brochures, tapes, and demonstrations, contact the Natal Society for the Blind, 194 Unbilo Road, Durban, 4001 or telephone (031) 21-4229.

Star 11/11/89 299

Nature trail for disabled

Own Correspondent

DURBAN — The combined efforts of a group of people dedicated to serving the needs of the handicapped are soon to be rewarded with the opening of an especially adapted nature trail at the Kenneth Stainbank Nature Reserve in Yellowwood Park.

The concept was initiated more than three years ago and a co-ordinating committee of the disabled was formed under the chairmanship of a senior ranger naturalist of the Natal Parks Board, Mr Roland Goetz.

The committee consulted representatives of the various associations of disabled people in the Durban area to find out exactly what type of facilities were most in demand.

The result was the first trail in the country designed with disabled people in mind, including wide concrete pathways for wheelchairs and handrails for the blind. Much of the funds and materials needed for the project were raised through the efforts of the Lions Club of Port Natal and the Durban/Umgeni Rotary Club.

In addition to parking areas for vehicles adapted to be driven by the disabled and easy-access ablution and braai facilities, prominent relief signs and maps have been erected by the officer in charge at the reserve, Mr Christo Grobler and his team.

Medical aids boost payout — and fees?

The Argus Correspondent

JOHANNESBURG. — Medical aid schemes have increased their overall payouts for doctors' services by 10 percent.

The increase, announced by the Representative Association of Medical Aid Schemes in October last year, came into effect on New Year's Day.

The overall increase means benefits for general practitioner consultations will go up by more than 16 percent but for most other services the increase will be less than five percent.

Last year, medical aid schemes paid out R15 for a general practitioner's consultation. This year, they have increased their payout to R17,50.

A tonsillectomy performed by a specialist has gone up from R80,20 to R84 and by a GP from R53,40 to R56.

Despite the payout increase, the Medical Association of South Africa (Masa) says there will be no meaningful improvement in remuneration for the majority of doctors.

Dr Bernard Mandell, chairman of the Federal Council of Masa, said the increase would be a major disappointment to those doctors who charged medical aid rates. The association believes doctors should be paid out a lot more.

"It is expected that more doctors will have to consider charging the recommended Masa fees in order to maintain viable practices," Dr Mandell said.

Masa has recommended that general practitioners charge a maximum of R39,60 per consulation.

As a result of the increased benefit payouts, membership fees are also expected to rise, possibly by as much as 20 percent.

Heart-related death rate climbs

By Carina le Grange

Nine Aids-related death claims were received by Old Mutual last year, according to findings of research into death claims received from 1985 to 1988 by the insurance company. The findings were released today.

These were the first Aids-related claims received by the company.

But the most disturbing factor of the survey into causes of death over the last three years was the high incidence of heart-related deaths, according to general manager Mr Bobbie Jooste.

"The alarmingly high death rate caused by heart disease among the country's most productive age group (41 to 60 years) is cause for great concern," he said.

Over the past three years heart-related disease was responsible for 50,2 percent of death claims by the company's policy holders.

Heart-related deaths in the 42 to 60 years age group increased by almost 24 percent over that of the under-40 age group.

But in the under-40 age group, motor accidents outnumber all other causes of deaths. As many as 35,5 percent of policy holders in this group died on the road compared with 11,8 percent in the over-40 age group.

In all, violent causes of death — such as accidents, drownings, fire and military deaths — in the under-40 age group exceeds that of any other group.

Baha'i in

Intensive search

Hospital group to dump medical aid

Ogle Times 14/1/89 299

Medical Reporter

AT LEAST one big private hospital group is contracting out of medical aid schemes — a move which means medical aid patients will have to pay for items not covered by their schemes.

Mr Graham Anderson, the executive director of Clinic Holdings, the country's largest private hospital group, said yesterday that his group was contracting out from February 1 because of dissatisfaction with the latest tariffs set by the Representative Association of Medical Schemes (Rams).

The new tariffs amount to roughly a 12% increase for private hospitals.

Mr Anderson said Clinic Holdings — which controls City Park Hospital — had decided that it would be unable to continue providing services for patients after the increase, which did not cover the costs of providing the services and did not cover the recent 15% increase for nursing salaries.

He said accommodation and theatre fees would not be affected, since these were fully covered by medical aid schemes.

"Historically there have been certain items for which medical aids do not pay, and over the past 12 months these items have been increasing. We simply cannot continue to bear these costs — we would go bankrupt," he said.

The items included the use of certain types of equipment, surgical items and disposable items such as syringes.

The items would probably comprise about 10% of the average patient's bill, he said.

Patients whose medical aid schemes are prepared to undertake to pay their share of the bill would probably be asked to pay a 10 to 15% deposit and the balance would be obtained from the medical aid.

"But if a medical aid will not make this undertaking, the issue of payment would have to be settled on admission," he said.

It was reliably understood yesterday that the country's other two major hospital groups would also be contracting out, but spokesmen for the two groups were not available for comment.

A spokesman for the independent Jan S Marais Clinic in Bellville said yesterday the clinic would stay contracted in.

A spokesman for the MediCor group, which owns the MediCity hospitals in Somerset West and Worcester, said that the group would also stay contracted despite "tightly squeezed margins".

Dr John Steer, chairman of the Cape Western branch of the Medical Association of South Africa (Masa), said yesterday the move would mean higher costs for patients.

"One appreciates that hospitals operate at enormous cost, but Clinic Holdings recently reported a profit of 77% — I don't know how they justify contracting out," he said.

Medics in a tizz over indemnity cover

ST Times 15/11/89

299

PRICEFORBES Volkskas subsidiary Medical Liability Services of SA has shaken the medical and dental professions by introducing an alternative form of professional indemnity protection.

Competition is considered healthy, but this new product is causing considerable tension. The Medical Association of South Africa is pragmatic in its acceptance of the scheme, but the Dental Association objects to it. The executive director of the Dental Association sent a four-page letter to members urging them to reject the cover.

Reasons

David Campbell, director of Medical Liability Services, explains some of the reasons for the resistance.

"Up to now the cover, also known as malpractice protection, has been available only through the various medical and the dental associations which arrange the insurance with two friendly societies in the United Kingdom. These two societies have had a monopoly for 102 years.

"The medical and dental associations receive a brokerage or handling fee which contributes to their running expenses. There is no limit of liability to these schemes — providing the funds are availale.

However, no insurance policy documents are supplied and claims are settled on a discretionary basis.

Business Times Reporter

The arrangement has proved satisfactory, but two Johannesburg doctors invetigated why premiums were increasing each year.

Fear

They questioned whether the premiums reflected South African claims or whether they were based on the experience of European and other First World countries. Last year in Britain a court awarded a claim exceeding £1-million.The investigating doctors bewlieve SA's medical profession is supplementing a global claims experience.

One says: "There is a growing fear among doctors that the friendly societies, which are not insurance companies, could run out of funds if claims and awards increased at their present rate."

In addition, the doctors fear buying foreign cover with weak rands. There is also the worry that claims funds might be blocked by sanctions should there be a change in attitudes and policies in Britain.

The two doctors approached PFV with a view to providing the SA medical profession with cover at realistic rates and with a policy document that is legally binding.

The cover is underwritten by an SA insurance company and reinsurance is provided by companies with funds in this country.

Without access to all SA claims data, including those settled out of court, the company has decided to peg premiums at the same rate as those charged by the friendly societies last year.

Computer

With the aid of the PFV computer facility, premiums may be paid annually or monthly. The liability limit is retricted to R5-million a claim, which is more than double any kown malpractice claim in SA. Other benefits are similar to those offered by the friendly societies — legal costs and advice.

A similar competitive scheme has been running successfully in Australia for a year and a firm of Lloyd's brokers has been asked to obtain cover for a professional indemnity product for the medical profession in the UK.

Algae killer

A SWIMMING-POOL product, which is claimed to be a world first in the control of algae, has been developed in SA.

Called Spalsh, the purifier reduces the need for chlorine and does not stain pool walls. It is produced by Universal Coatings.

Splash, which has been tested for two years, has attracted attention in America and Australia.

...makes extensively ... manager

Happier days at work

By Robyn Chalmers

THE percentage of workers who suffer disabling injuries (DI) has dropped from 2,4% to 1,8% in the past 10 years — representing 10 000 injuries prevented.

This claim is made in the annual report of the National Occupational Safety Association (Nosa). Nosa is a non-profit organisation established in 1951 on the initiative of then Labour Minister Ben Schoeman.

Nosa's aims are to reduce the injury rate of workers. It promotes the prevention of occupational accidents and diseases.

S/Times Stars 15/11/89

Nosa president Don Carroll says most of the credit for the reduction in injuries is due to its training programmes.

"With more audits and surveys, more training on all levels, more contact generally with employers and employees, the DI percentage a year will come down to 1,5%."

To assist managers with safety procedures, Nosa has developed a five-star grading system. It identifies weaknesses and strengths of any safety programme and gives recognition to management and the work force for reaching certain high standards of achievement.

A one-star grading indicates a weak accident prevention operation and a five-star rating means great safety in the plant.

Nosa managing director Bunny Matthysen says figures from the Workmen's Compensation Commissioner show that the percentage of the work force suffering disabling injuries each year has dropped from 4% in 1951 to 1,6%.

He mentions:

- The upgrading of management skills — in the past 17 years 300 000 people have attended Nosa courses;
- The guidance that members of the various Government inspectorates have given to employers;
- The Workmen's Compensation Commissioner and his staff keeping the claims costs and overheads at an optimum level.

Fresh (249)

Mr Matthysen praises the Machinery and Occupational Safety Act of 1983, saying it is bringing about a fresh awareness of occupational safety in all sectors of the community.

Since its inception in 1984, Nosa has brought about greater management and employee involvement in safety.

He says an aviation safety co-ordinator has been appointed as a result of a R75 000 annual grant for five years from the Directorate of Civil Aviation.

Nosa has embarked on the development of programmes incorporating road safety.

... managem

CAPE TIMES 17/1/89

Private city clinics to contract out of medaid

299

Medical Reporter

ANOTHER private hospital group which controls four Cape Town clinics has announced it will contract out of medical aid schemes — and the National Association of Private Hospitals (NAPH) is to hold a meeting on the issue tomorrow.

The issue will also come up for discussion at a meeting of the Representative Association of Medical Schemes (RAMS) tomorrow.

The country's largest private hospital group, Clinic Holdings, last week announced its intention to contract out of medical aid schemes, a move which it said meant patients would have to pay for items not covered by their schemes.

Yesterday a spokesman for Medi-Clinic Corporation — which controls Panorama Medi-Clinic, Constantiaberg Medi-Clinic, Medipark Clinic and Leeuwendal Nursing Home — said a decision had been taken in principle to contract out of medical schemes.

He said he could not give a date for the move or any other details.

Mr Graham Anderson, executive director of Clinic Holdings (which controls City Park Hospital in Cape Town), said the decision to contract out followed dissatisfaction with the 12% tariff increase granted to private hospitals by RAMS.

Subscriptions set to rise by 18%

B/Day 18/1/89

Medaid paid out R3,5bn last year

299

GERALD REILLY

PRETORIA — Medical schemes paid out between R3,25bn and R3,5bn in benefits last year — at least 20% up on the 1987 payouts, Representative Association of Medical Schemes executive director Rob Speedie said yesterday.

He said he expected this year's increase to be no less and members' subscriptions to rise on average by around 18%.

Against a background of a weakening rand, the price of medicines and drugs would continue to escalate at between 20%-26% this year.

There was little comfort for medical schemes in the rand's likely international purchasing power in the months ahead. A large percentage of medicines, drugs and raw materials for their manufacture were imported.

Speedie said of the total payout last year about 40% was on medicines and drugs. Another 34% was paid on doctors. The balance went to dentists, private and provincial hospitals and paramedical services.

In the interest of cutting back on spending, efforts were being made to persuade members to make a more judicious use of benefits. The abuse of benefits was an important reason for the pressure on schemes' finances.

Doctors, too, could contribute by dispensing cheaper prescriptions, which could include generic alternatives and by guarding against over servicing.

□ Sapa reports that NBC Medical Aid Society general manager Richard Rowe called on medical schemes to "close ranks and act with one voice".

His call followed a letter recently circulated to medical schemes emanating from Clinic Holdings in which notice was given the group intended to raise additional charges above those indicated in the scale of benefits.

Rowe said the group indicated it would endeavour to keep the same format as the scale of benefits applicable to accommodation and theatre fees where possible. Additional charges would also be raised on certain equipment.

'88 medical aid payouts up by 20%

Cape Times 8/11/89

299

Own Correspondent

PRETORIA. — Medical schemes paid out between R3,25bn and R3,5bn in benefits last year — at least 20% up on the 1987 payouts, Representative Association of Medical Schemes (RAMS) executive director Mr Rob Speedie said yesterday.

He expected this year's increase to be no less and members' subscriptions to rise on average by around 18%.

Against a background of the weak and weakening rand, the price of medicines and drugs would continue to escalate at between 20 and 26% this year. And, Mr Speedie said, there was little for the comfort of medical schemes in the rand's likely international purchasing power in the months ahead.

A large percentage of medicines and drugs and raw materials for their manufacture were imported. Mr Speedie said that of the total payout last year, about 40% was spent on medicines and drugs.

Another 34% was paid on doctors. The balance went to dentists, private and provincial hospitals and for para-medical services.

In the interest of cutting back on spending, efforts were being made to persuade members to make a more judicious use of benefits. The abuse of benefits was an important reason for the pressure on schemes' finance.

Doctors too, he added, could contribute by dispensing cheaper prescriptions and by guarding against over-servicing.

Meanwhile, a National Health Department spokesman said the development of medical insurance within the framework of three criteria may be permitted by the government and the Central Council for Medical Schemes.

To this end amendments to the Medical Schemes Act could be considered. The spokesman said accusations had been made that the act was too rigid because it disallowed insurance companies from performing the functions of medical schemes.

The three criteria are: Suppliers of services and insurers of medical expenses must negotiate with each other on the prices of services and goods; the government must not become involved in determining tariffs for private health services, and amendments should not diminish cover for medical expenses to an extent where there was a dependence on state support. They should not cause an escalation of state expenses.

To comply with the criteria, insurance for medical expenses would have to include prescribed minimum benefits. It was not acceptable to insure for medical catastrophes only.

Insurance should not be suspended because an insured person had a high-claim profile and insurance had to continue after retirement, he said.

New management, coupled with a new ... decided to "sti...

Psychologists 'face bias from schemes'

B/Day 19/11/87 BRONWYN ADAMS (299)

THE medical profession was partly to blame for the bias in medical aid schemes which led to patients being inadequately refunded for visits to clinical psychologists, Masa spokesman John Olivier said yesterday.

He said the psychology profession was discriminated against despite the fact that it was a member of the association and controlled by a professional board.

Olivier said the medical profession dictated the tariffs and the principle that only medical complaints be compensated by medical aids.

He said the ceiling on clinical psychology claims had been instituted in an attempt to "put the brakes" on the extended treatment of patients by psychologists.

Jeff Slome of The Medical Administrators, representing 25 medical aid schemes in SA, said most schemes did include a provision for clinical psychology treatment in accordance with the Representative Association of Medical Schemes' recommendations.

He said this was merely a financial control. Patients needing attention beyond the R600 recommended per ailment, could apply for an additional benefit.

'Co-operation ignored'

'Medical aids must act on new fees'

Star 19/1/89 (299)

Medical Reporter

Medical aid schemes should close ranks and act with one voice, according to Mr Richard Rowe, the general manager of the NBC Medical Aid Society.

Mr Rowe's call for solidarity follows the withdrawal of a private hospital group from the scale of benefits laid down by medical aid schemes.

The Clinic Holdings Group recently sent a letter to medical schemes indicating that its fees would go above those prescribed by the scale of benefits.

Mr Rowe said the hospital group had suggested it would be in the members' "best interests" if the medical scheme's portion of the account was paid directly to the hospital.

Mr Rowe said: "The implications of this action appear to be obvious and one really only needs to look at the situation that has arisen between medical practitioners and the medical schemes.

"The differential between the recommended fee put out by the Medical Association and that of the scale of benefits, which is the fee on which the medical schemes base their refunds, is purported, in some cases, to be as much as 100 percent."

BURDEN

Should medical schemes agree to refund to the hospital that amount which the hospital determines is the medical schemes' portion and allows hospitals to bill the medical scheme member with the difference, it will not be long before the difference takes on significant proportions and the burden placed on the individual becomes of concern to all, said Mr Rowe.

"With the increasing differential, pressure will be brought to bear on medical schemes to close the gap and the situation could quite easily arise that private hospitals will now dictate the hospital tariff to the medical schemes industry," he said.

Mr Rowe said the Representative Association of Medical Schemes was believed to be meeting the National Association of Private Hospitals and the Clinic Holdings Group of Hospitals.

RMAL 20/1/89

INSURANCE — 1 299

Alternative cover

Medical practitioners in SA and in the UK now have new sources of malpractice cover, previously available only from the Medical Defence Union (MDU) and Medical Protection Society (MPS) — both London-based. Priceforbes Federale Volkskas has launched Medical Liability Services of SA (MLS) and this month the Practitioners' Medical Malpractice Scheme (PMM) will start operations in the UK.

MLS is underwritten by Standard General Insurance, PMM by Lloyd's and the London short-term insurance market.

Though SA claims experience is not as adverse as in the UK and US, claims against all professionals have risen substantially in both number and amount (*Economy* August 19). Says Robert Vivian, professor of insurance and risk management at the University of the Witwatersrand: "In the past three years SA courts have granted R2,5m for a brain injury, R1,4m for a paraplegic case and R330 000 for loss of sight."

Escalating claims pushed premiums up by 33% to an average annual R480 in 1988. MLS director David Campbell believes they would have increased by "as much as 50% this year" had MLS not entered the market.

MLS's 1989 rates are R73,22-R485 a year. Campbell claims that once start-up costs are covered, its cover will be cheaper than that available offshore. The MLS view is that the high incidence and cost of claims in the UK will ultimately weaken the "overall position of MDU and MPS, necessitating increases in all their rates."

Dr Hendrik Hanekom, acting honorary secretary of the MDU and MPS in SA, disagrees. "These societies have been in operation for over 100 years and will continue providing stable premium rates according to SA claims experience."

MLS offers:

- ☐ Fully retroactive cover with an indemnity limit of R5m, including legal and other costs;
- ☐ A 24-hour medico-legal and ethical advisory service;
- ☐ Cost of legal representation at professional disciplinary hearings and inquiries of up to R250 000; and
- ☐ The security of a legally enforceable policy document.

PMM offers similar benefits and rates but will concentrate on low-risk business. MDU and MPS also offer similar benefits and rates — with the additional advantage of unlimited indemnity. However, a Lloyd's broker points out: "In reality, indemnity is strictly limited by reserves." He believes a long tail of claims could soon reduce that reserve significantly.

"MDU and MPS are not insurance companies," he says, "but simply friendly societies offering protective cover."

This means they have discretionary power over paying out claims. "They don't have to pay if they don't have funds, and they have the right to call on members to contribute an extra year's subscription in the case of a shortfall." But MLS and PMM "offer legally enforceable insurance contracts for specific indemnity limits and premiums are not subject to supplementary calls."

Hanekom points out, however: "Neither MDU nor MPS has ever imposed additional levies — though such a right exists — as both are adequately reinsured by Lloyd's." ■

CAPE TIMES

riday, January 27, 1986

299

Probe starts on troubled SA med-aids

Own Correspondent

JOHANNESBURG. — The Competition Board is to investigate the activities of South Africa's troubled medical aid system.

Competition Board chairman Mr Pierre Brookes said the inquiry would be made on the basis of previous investigations and continuing complaints about "anomolies" in an increasingly monopolistic pharmacy network.

The investigation also comes in the wake of controversy surrounding the decision of several private hospital groups, led by Clinic Holdings and Afrox, to contract out of medical aid schemes.

The National Association of Private Hospitals (NAPH) had accused the Representative Association of Medical Schemes (Rams) of consistently lagging behind real costs and being blind to the increasing cost of running private hospitals.

According to NAPH chairman Mr Dick Williamson, the "unsatisfactory" Rams increases of 12% had left private hospitals in a "worsening financial situation".

Today's Government Gazette said the board was undertaking the investigation in terms of the provisions of Section 6(1)(a) of the Maintenance and Promotion of the Competition Act of 1979.

A statement by the board said the investigation would include negotiation between medical schemes and the renderers of health services, the role of the scale of benefits, restrictions on certain medical schemes to render health services and the role of medical schemes compared with those of state and semi-state institutions.

Reacting to the decision, managing director of Medicaid Administrators Mr Jeff Slome said: "The investigation would be welcome if it provided any relaxation in legislation governing aid schemes."

The Medical Association of SA (Masa) welcomed the move, saying they accepted that the investigation was intended to bring cost-effective private health care within the financial reach of as many people as possible.

Medical aid schemes to be investigated

Medical Reporter

The Competition Board is to investigate South Africa's medical aid schemes following complaints and queries from both the public and other medical institutions.

According to a board spokesman, the complaints were received over a number of months.

"The public and other medical institutions have many questions about medical aid schemes including why Transmed, the South African Transport Services benefit scheme, should not be privatised?

He said the board would also look at the role of the scale of benefits in determining fees granted to medical personnel and private hospitals.

Notice of the investigation was published in the *Government Gazette* today.

'Blindaba' magazine a boost for black youths

Star 27/1/89

299

By Jovial Rantao

A braille magazine — the first in South Africa — was launched yesterday to coincide with the 60th Diamond Jubilee celebration of the South African National Council for the Blind (SANCB) in Pretoria.

Dr William Rowland, SANCB executive director, said *Blindaba* will fill a gap in the range of existing braille publications.

During 1988, research by the SANCB's committee of consumers — which vets services and products for the blind — and input from several community members showed current braille publications sidestepped the special needs and interests of black readers aged between 16 and 24.

SPORT, POP MUSIC

The expressed wish of many young blind people was to be able to to read for themselves information on sport, pop music, people and politics, said Dr Rowland.

The first copy of *Blindaba* was presented to its first reader, 16-year-old Michael Maseko from Siloe School for the Blind in Pietersburg.

According to Dr Rowland, Michael was chosen for this role after he sent a letter and photograph of himself holding a birthday cake with his entry to the magazines's "Find-a-Name" competition.

The competition was however won by Miss Leah Mangope from the Itireleng Self-Help Industries. For coming up with the name "Blindaba", Leah won a R60 prize.

Presenting Michael with the first copy of the magazine, a teacher from the Philadelphia School for the Blind, Mr John Ngubeni said: "Touch the words and the words will touch you and give you the information."

The magazine will be edited by Mrs Vanessa Bell. Mr Ngubeni and Miss Thelma Ngema are contributing editors.

According to Mrs Bell, more than 600 youths, some from as afar afield as Zambia, Malawi and Zimbabwe, are already on the *Blindaba* mailing list — double the readership of most existing braille magazines.

Govt to probe medical aid system

GOVERNMENT is to launch an investigation into the activities of SA's troubled medical aid system.

Competition Board chairman Pierre Brookes said the inquiry would be made on the basis of previous investigations and complaints about "anomolies" in an increasingly monopolistic pharmacy network.

● BROOKES

BRENT MELVILLE

Negotiation between medical schemes and the renderers of health services, the role of the scale of benefits, restrictions on certain medical schemes to render health services and the role of medical schemes to those of state and semi-state institutions will be investigated.

Brookes said: "The extremely central position of medical aid is of concern, and the board's wide-ranging investigation will concentrate on med-aids' control over pharmacies, provision of medical

● To Page 2

Govt probe into medical aid system

● From Page 1

services and tariff determination."

The investigation comes in the wake of controversy surrounding the decision of several private hospital groups, led by Clinic Holdings and Afrox, to contract out of medical aid schemes.

Brookes said the decision by some private hospitals to opt out of medical aid schemes was a factor, as it affected the final cost to the consumer. But the investigation was not strictly on that basis.

The National Association of Private Hospitals (NAPH) had accused the Representative Association of Medical Schemes (Rams) of lagging behind real costs and being blind to the increasing cost of running private hospitals.

Today's Government Gazette stipulated the board was undertaking the investigation in terms of the provisions of section 6(1)(a) of the Maintenance and Promotion of the Competition Act of 1979 into the activities of medical schemes including those of state and semi-state institutions.

Medicaid Administrators MD Jeff Slome said: "The investigation will be welcome if it provides any relaxation in legislation governing aid schemes."

Medical Association of SA (Masa) welcomed the move, saying it accepted the investigation was intended to bring cost effective private health care within the financial reach of as many people as possible.

Aids poser for med schemes

By DICK USHER
Business Staff

SOUTH Africa's R3,5-billion medical aid industry faces crucial decisions to cope with the spread of Aids.

Some experts said that medical aid schemes faced "astronomical" costs allied with the spread of the disease, while another opinion was that it would have to be treated in the same way as other problems and the costs built into medical aid payments on a historical basis.

At present medical aid societies are protected from some implications of Aids because many patients are treated at provincial hospitals.

But there is a belief that if the disease spreads as projected this may become too expensive for the State to bear and other measures may have to be found, which could throw the burden on to medical aid schemes.

Insurance companies have already taken measures, which industry spokesmen decribe as "interim", to protect themselves by requiring new policy holders to take an Aids test or accept an exclusion clause for cover over certain limits.

But many medical aid schemes have no limits on benefits and treatment of the disease, for which there is no cure, is extremely expensive.

An infected person can take up to five years before displaying early symptoms, and death can take between two and five years from the development of "full-blown" Aids, depending on the victim's general health.

Because Aids lowers and finally destroys the body's ability to resist infection, those infected become prey to a wide range of illnesses. Members of medical aid schemes would expect their societies to pay benefits in respect of these.

Drugs alone for treatment in the later stages of Aids could cost up to R1 000 a month, and the average length of time spent in hospital by an Aids victim in the United States is 168 days.

Mr Bob Speedie, director of the Representative Association of Medical Schemes (Rams), said the association had considered the question of protection in great detail some time ago.

He said the financial implications of Aids were quite serious for medical aid schemes and it had been decided that each scheme should decide for itself what steps to take.

He pointed out that schemes were controlled by members and it was quite feasible for them to place limits on benefits for people with Aids.

Mr Les Hollis, deputy managing director of Medscheme, which administers about 30 schemes for about 300 000 members, said the costs of Aids were potentially astronomical.

"The concern comes when there is no annual maximum on benefits. It may be necessary for schemes without limits to consider placing a limit on benefits for Aids sufferers," he said.

Gradual increase

"But at this stage the feeling is one of compassion, that a person is desperately ill and the scheme has to make life reasonable within the limits the scheme can afford."

Mr Rod Hallowell, MD of D & E Administrators, said nobody really knew what the situation with Aids was.

It was not a problem at this stage and had not started "denting budgets".

"We have to live and learn with this problem and in the end members will have to decide what to do.

"I think there will be a gradual increase in the incidence of Aids and schemes will build in their costs on a historical basis."

Bargain-hunters go over the top

Business Editor

BARGAIN-HUNTING frenzy often drives bidders into paying too much, says Wynberg auctioneer Robin Mills.

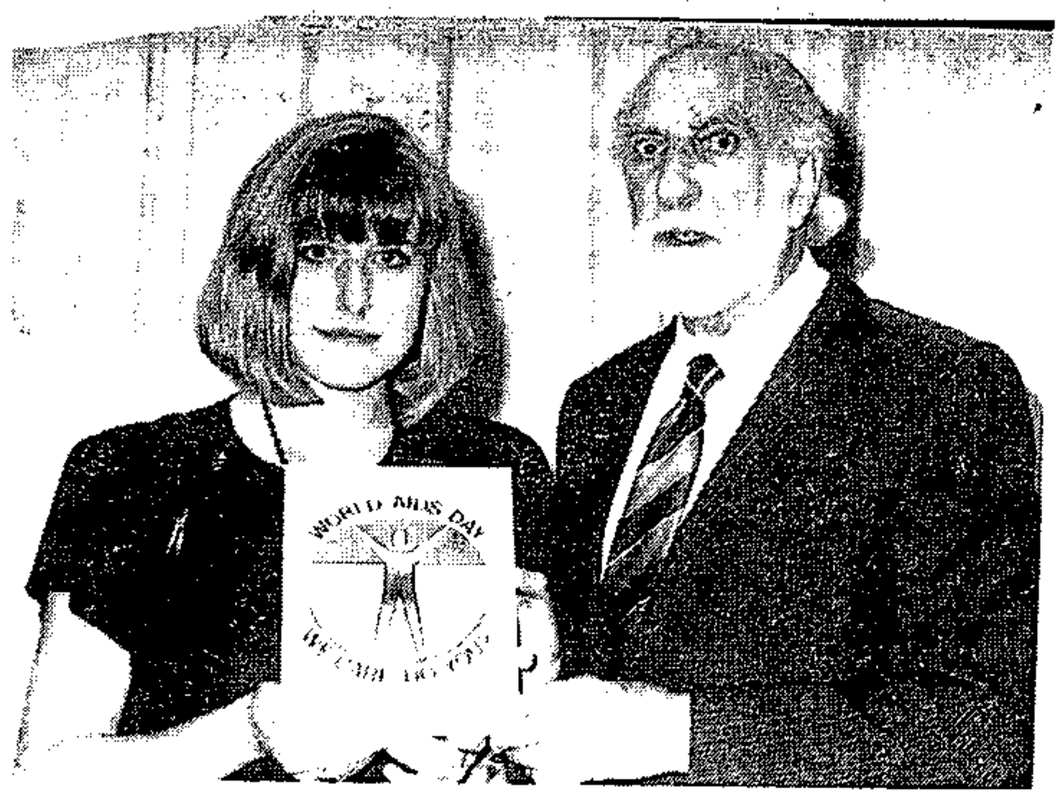
Some items, such as old hand tools, now fetch practically the same as new tools.

One seller handed in 10 attractive knife sets he bought retail at R29,95 each and the prices were bid up to R70 a set.

"People could have gone across the road the bought them in a supermarket," said Mr Mills. "People pay big prices if the goods look good."

There is now a huge demand for electrical appliances and a shortage of supply because of the high cost of new appliances.

"It is now difficult to value goods before an auction. Something we believe is worth R50 could go for R100."



DR Ruben Sher and Ms Heather Gomes displaying the Aids logo.

SOPHIE Mathibela with twins Mpho and Mphonyana.

UGLY PART OF HEALTH SCENE

Hospitals are usually dirty, overcrowded and facilities are poor

FOCUS

THE health scene in South Africa during 1988 was a mixture of the good, the bad and the ugly.

For the sake of recording our medical history it is important to highlight some of the events which made news last year.

As far as the good news is concerned the case of Mpho and Mphonyana Mathibela tops the scene. The two-year-old Siamese twin sisters who were joined at the head were separated on May 3 at Baragwanath Hospital after a gruelling $7^1/_2$ hour operation.

On that day the world was united in prayer for the success of the operation. Indeed, God listened to His children and the operation was successfully completed.

By MOKGADI PELA

The world sighed with relief.

The National Union of Mineworkers also tasted success in its protracted battles with the mining bosses against the use of Polyurethane.

Before then the industry and the Polyurethane Association of South Africa had vehemently defended the material saying it had no substitute in terms of efficiency.

It was used underground to insulate pipes in order to keep them cool. The union said about 208 black workers had died from the material, the Kinross mine disaster, being the best known case.

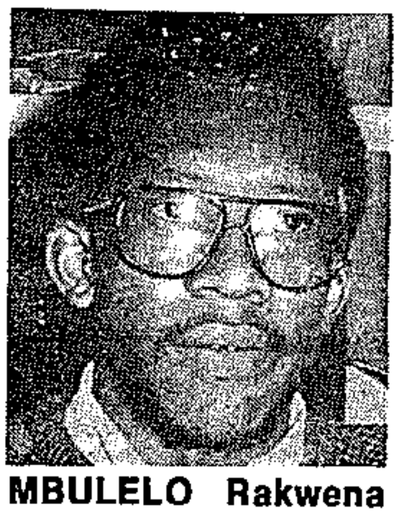
When people talk about the bad events of 1988 there is no way they can ignore Aids — Acquired Immune Deficiency Syndrome. Last year this deadly killer registered itself firmly on the South African medical scene.

This country has recorded 166 full blown HIV carriers.

Advice has come from many quarters. People should either change their sexual behaviour or die. As simple as that.

The acting head of the Department of Immunology at the South African Institute for Medical Research, Dr Ruben Sher, repeatedly informed the public that

HAZZY Sibanyoni of NUM.



MBULELO Rakwena of Bamcwu.

in the Northern Transvaal and the Northern Cape has ruined the lives of many people.

Victims of the dust particles cough continuously and, literally speaking, die a slow death.

In the Northern Transvaal area of Taung in Lebowa, the community recently told the *Sowetan* that they were allocated sites next to uncovered asbestos dumps. The disease resulting from the inhalation of these dust particles is called Asbestosis.

In the forefront against the continued mining of the mineral has been the Black Allied Mining and Construction Workers Union.

The sad part of it is that South Africa continues to mine the mineral despite the deadly nature. Bamcwu has said it would fight for the closure of the asbestos mines in the country in line with other parts of the globe.

5/1/89

Soweton

299

Aids would infect anyone, given the right circumstances, i.e., sexual contact.

When the year started the Government announced plans to sell hospitals to the private sector. The reason, the authorities said, was lack of funds on their part. The move was roundly condemned.

Opponents of the move said the poor sections of the community would be the hardest hit because they could not afford high medical bills.

It was in the light of these factors that the Imbeleko Women's Organisation launched a national campaign against the privatisation of health services to ensure that the move was stillborn.

Another factor contributing to the bad side of the health picture is the asbestos dust. This fine dust which is mined

When we talk about the ugly part of the medical scene in South Africa we refer to black hospitals whose conditions leave much to be desired.

The hospitals are usually dirty, overcrowded and the ablution facilities inadequate.

The consequences of such conditions are that patients do not receive proper care and are discharged prematurely.

Hospitals such as Baragwanath, Philadelphia and Limpopo Messina, to name but a few, can never hope to escape our attention and resultant condemnation. One does not need to be a genius to know that dirt and health are like north and south.

But perhaps after the exposure of these conditions the medical fraternity will improve them. When that happens we will be the first to praise them for having done the obvious.

5 CT hospitals to leave aid schemes

CT-Times 11/2/89

299

Medical Reporter

FIVE Cape Town hospitals are to contract out of medical aid schemes in mid-February, a move which means patients will pay an average R17,50 a day extra for medical care.

Dr Edwin de la H Hertzog, managing director of the Medi-Clinic group, which controls the five hospitals, said yesterday that Medi-Clinic had already announced its intention to withdraw from medical schemes but had not previously given details.

Three major private hospital groups — including Medi-Clinic — have announced their intention to withdraw because of dissatisfaction with the average 12% increase recently granted by the Representative Association of Medical Schemes (RAMS).

Medi-Clinic controls Constantiaberg Medi-Clinic, Panorama Medi-Clinic, Leeuwendal Nursing Home, Medipark Clinic and Mitchells Plain Private Hospital.

Dr Hertzog said in his statement that this move would take place only in mid-February because many medical schemes had taken longer than expected to indicate how their patients' accounts should be handled and because computer and administrative adjustments had to be made.

He said an average bill, including accommodation, theatre and drug costs, was R350 a day, and that patients would now have to pay about 5% of this. During an average three-and-a-half-day stay, a patient's bill would amount to R1 225, of which R61,25 would be paid by the patient.

First hostel for disabled pupils in township

By Jovial Rantao

A hostel for disabled pupils — the first of its kind in any township — was opened yesterday at the J C Merkins School for the Disabled in White City, Soweto.

In his opening speech, the director of the Association for the Physically Disabled (APD), Mr Guy Houghton, said the building of the hostel was a milestone for the association and it would ease the transport problem encountered by APD.

"The hostel will cater for pupils who stay far from Soweto.

"This is a breakthrough for us, this is first hostel of its kind in any township," Mr Houghton said.

According to the school's headmaster, Mr Danny Schoeman, the school will accommodate 100 pupils.

CME Times 8/2/87

Med scheme refuses higher fees demand

299

Staff Reporter

THE Federation of Medical Schemes (FMS) has refused the demand by some private hospitals for more than the approved 12% increase in fees this year — and criticised certain hospital groups for excess profits and unwarranted expansion of facilities.

According to Mr Nic van Rensburg, FMS chairman, the approved 12% increase in private hospital fees was "realistic" and FMS will join the stand taken by the Representative Association of Medical Schemes not to accede to the demand for higher fees.

Mr Van Rensburg slated the role of certain private hospitals, saying that "profits of certain hospital groups" and the rate at which more beds were being provided by the private sector were "inconsistent with an industry experiencing financial problems".

want to know the size of the field, the technical problems and the technicalities of bringing the gas ashore to assess the field's viability.

"If it's viable it will be a tremendous boost for the Namibian economy."

Harvey Storm, GM of BP in Namibia, says he is not involved in exploration. And a Total SA spokesman gives a simple "no comment," when asked if his company is interested in the project. ■

MEDICAL AID SCHEMES

Under the knife

The Competition Board's (CB) investigation into the country's 200 medical aid schemes has forced schemes on the defensive. At the same time it has re-opened debate on private hospital tariffs, the role of pharmacists in dispensing medicine and the high level of medical fees.

Schemes are forbidden by the Medical Schemes Act to set their own tariffs, or to offer individual members a choice of packages. The CB will consider whether it's time to allow more flexibility — as schemes, doctors and private hospitals have been arguing for some years.

But, more ominously for the medical aid movement, the CB will also determine whether the present system of benefits is in the public interest from the point of view of promoting competition.

Medical aid subscription rates have been rising faster than tariffs for many years, which goes against the schemes' claim to curb medical inflation. This year, for instance, there was an average 20% increase in subscriptions compared with 12% in tariffs.

The schemes are putting a brave face on the investigations. Representative Association of Medical Schemes (Rams) executive director Rob Speedie says: "We've got nothing to hide. Subscriptions had to go up because of greater use by members and not just higher tariffs. This can be fully accounted for."

A working party, chaired by Stability Medical Aid's John Ernstzen, has been set up to formulate a reply. Ernstzen says the medical aid system complies with free market principles.

"Though there are compulsory benefits, schemes compete on extra benefits such as chiropractors and homeopaths. We also have a range of options on the proportion of benefit we pay doctors and for prescription medicines."

Schemes are not allowed to pay more than the scale of benefits — "but this was forced on us by doctors and pharmacists who are reluctant to negotiate with individual schemes as they're afraid we could flex our muscles."

CB chairman Pierre Brooks says the board was first made aware of the central role of schemes when it investigated restrictive practices in the dispensing of medicine. As a

result of that investigation the CB recommended that allowing doctors and pharmacists to make a profit on prescription medicine was not in the public interest.

The ownership of pharmacies by schemes, as recommended by the Browne Commission will also be addressed. "It may be something of an anomaly that certain State and semi-State medical benefit societies are allowed to run dispensaries but the private sector is unable to do so," adds Brooks.

Brooks says the investigation will touch on related fields such as private hospitals, pharmacies and doctors. There is still a considerable amount of restrictive practice in the medical and pharmaceutical professions.

Says Medscheme MD Keith Hollis: "At present pharmacies have excessive control in the dispensing of medicine to the private sector. If this control was broken free market forces would operate and drive costs down."

Replies Pharmaceutical Society executive director Boet van der Merwe: "The patient has the right to choose his own pharmacy and to do so without penalty. In cases where schemes ran dispensaries, members were obliged to obtain their prescription requirements from the medical scheme dispensary."

Doctors and private hospital groups also say the schemes have steadily eroded the scale of benefit in real terms, which has led to lower standards.

Schemes reply that the healthcare sector must learn to live within its means, and can't expect a blank cheque. But Hollis says 80% of medical practitioners operate within the tariff — which suggests that there is satisfaction with the present tariff and guarantee system.

While more heat than light is being revealed, the CB investigation could highlight important issues affecting the pocket of the end-user — the long suffering patient. ■

MEDICAL AID SCHEMES (299)

Under the knife

FM/AC 10/2/89

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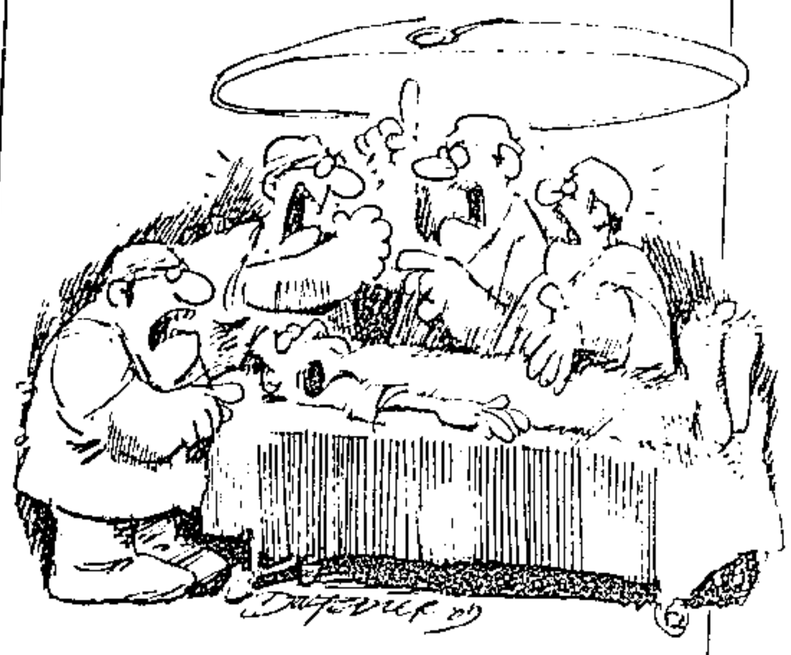

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Helping the blind to see a future

Mr Ian Hutton, a slim, wiry man with only three percent vision, is working to create a new way of life for the blind people of Gazankulu.

For the past seven years the almost sightless director of the Rivone Society for the Blind near Louis Trichardt has devoted all his energies to making the centre's workshop self-sufficient.

Not only that, but he is determined to help mobile blind people in the area keen to establish their own self-help projects.

His is a marathon project, but Mr Hutton believes with the assistance of marketing specialists his vision for Rivone need not be a pipe dream. He has the support of the centre's employees who, he says, are democratically involved in the running of the workshop.

To achieve the centre's goals, Mr Hutton has enlisted the aid of the International Executive Services Corps (IESC).

Mr Arnold Nelson, a semi-retired engineer who worked in the gold and uranium divison of Johannesburg Consolidated Investments until two years ago, is now trying to get work for the Rivone workshop.

Needs work

He said this week: "Rivone is not looking for handouts, but if it is to be self-sufficient it needs work providing a regular income. Perhaps its greatest handicap is its distance from Reef markets, but the potential is there."

Working closely with Mr Hutton, he is approaching a number of firms to ask for contracts.

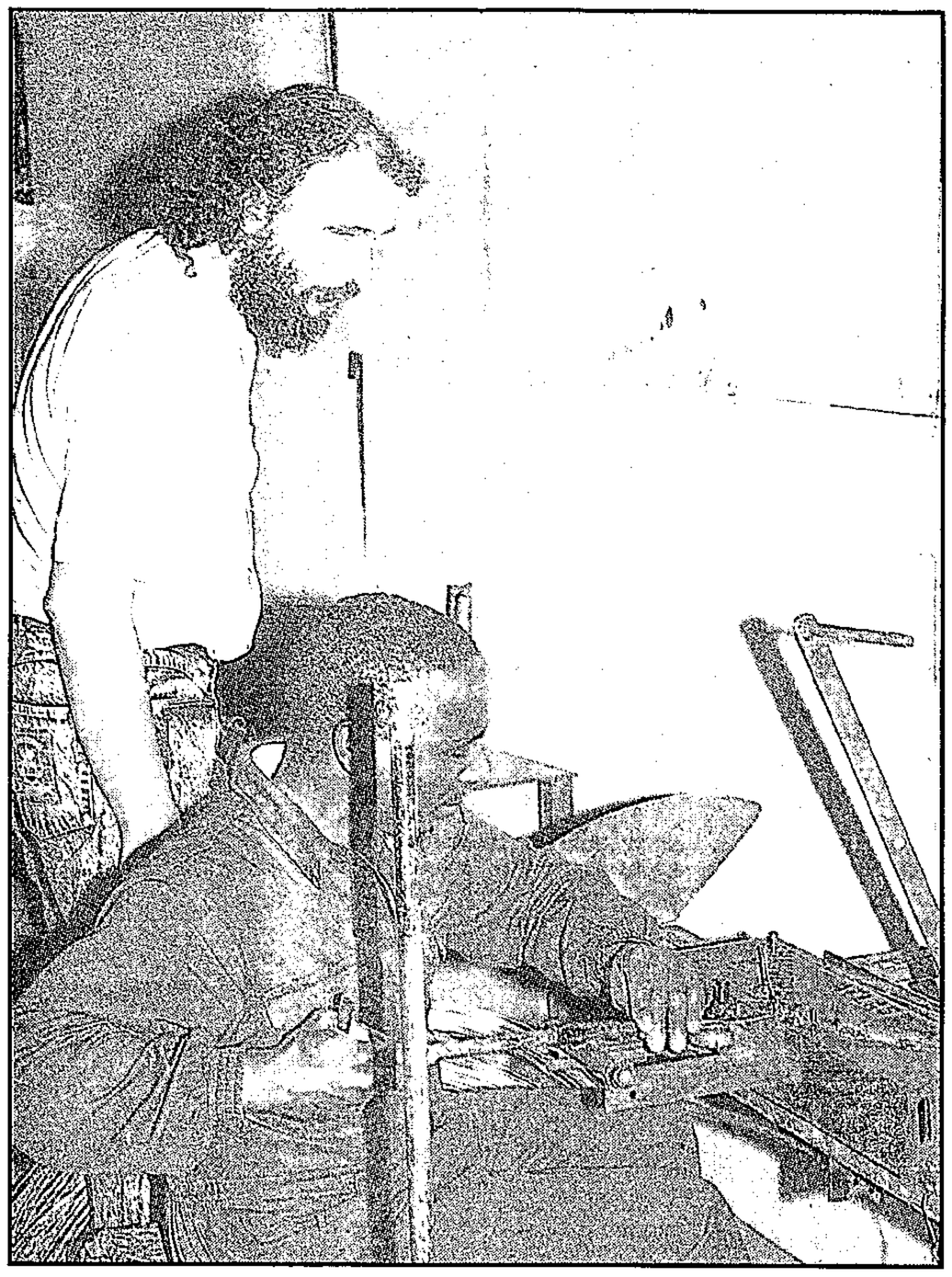
Mr Hutton, now in his early 30s, obtained his LLB degree at the University of Natal and was at the Bar for 18 months before accepting the challenge of working in Gazankulu.

He found the infrastructure at Rivone already established. The blind people had a number of projects in hand, including the manufacture of bible covers, weaving, woodwork and the sale of chickens.

The International Executive Services Corps (IESC) — an organisation comprising retired business executives who devote their time to helping emergent black businesses get started — holds its first annual meeting as a South African company, not for gain, at the Carlton Hotel, Johannesburg, at 6 pm today.

Details of a loan scheme, to be operated by the African Bank in conjunction with IESC, to cater for the needs of business in the disadvantaged sector of the South African economy, are to be announced by the chairman, Mr Gaby Magomola. IESC's newly appointed board of governors, headed by Mr Gavin Relly, will be at the meeting.

In this article, WINNIE GRAHAM highlights the type of work being done by IESC.



Mr Ian Hutton, director of the Rivone Centre in Gazankulu, watches a blind worker make wire coathangers — one of their best selling lines.

The society, however, was not generating enough income and, in an area where blindness is endemic — largely as a result of trachoma — it was soon apparent more job opportunities had to be created. This could only be done if the workshop become less dependent on subsidies.

Mr Hutton estimates there are roughly 2 000 blind people in the area. He speaks proudly of three blind villagers who have started a self-help project making diamond-mesh fencing.

"In our rural environment, no one can be guaranteed employment," he said this week. "So when blind people are sufficiently rehabilitated to start something like this, they need our support in finding markets."

Rehabilitation is all-important to Mr Hutton. Even before blind people can think of self-help schemes, they need to be mobile — and that takes training.

Apart from the workshop, Rivone has an old farmhouse it uses as a training centre and blind men and women come from miles around to acquire "mobility".

Within a few weeks they are making vegetable gardens, caring for babies, cooking and cleaning.

They acquire a freedom many have never experienced.

"It is something for a blind person just to find his way to the nearest shop," Mr Hutton explained.

Once they have completed their training, the blind are hopeful of finding work — but work is virtually impossible to come by.

If, however, the Rivone workshop can run profitably, more jobs can be created.

Mr Hutton has asked the IESC for assistance in identifying products and for help in marketing these.

One of the first products the Rivone workers are beginning to market profitably is wire coathangers — much needed by dry-cleaners. Mr Nelson found unused machines at the Associated Fibreglass Industries (AFI) factory in Springs. One was modified and is now being used to produce more than 800 coathangers a day at Rivone. Local firms are snapping up the hangers as fast as they can be produced.

Efficiency

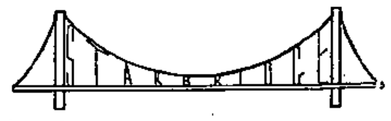
Rivone workers still make bible covers, but that division of the workshop is to be investigated to see if it could be run more profitably. The weaving and woodwork divisions, too, need to become more cost effective.

Mr Hutton looks forward to the day when Rivone becomes profitable, when the society does not subsidise blind workers.

"We don't expect miracles but with the right kind of advice much can be achieved," he says.

Learning to walk without assistance. Mr Libert Ndzovela goes through his paces with the aid of Miss Sharline Msimeki, mobility training officer.

Mobility taught to those who live in darkness



He stood, hand outstretched, ready to make his way across the lawn.

Miss Sharline Msimeki, a mobility trainer at the Rivone rehabilitation centre for the blind near Louis Trichardt, gave quiet instructions. The young man went through his paces, his face wrinkled in concentration.

The demonstration complete, Mr Libert Ndzovela, a young man from Letaba in the eastern Transvaal, turned towards the watching group.

Miss Msimeki said "very good" and he smiled.

"How did he become blind?" I asked the young trainer, but before she could answer Mr Ndzovela responded.

"I was working for the mines in Carletonville in 1980 when my eyes started troubling me," he said. "I had operations which left me blind."

He did not know what had caused the blindness, nor had he received a pension when his lost eyesight forced him to return to his home in the eastern Transvaal — immobile and unproductive.

He had spent the past eight years in darkness, unable to move far without help. Then he heard of the mobility "course" Rivone offered and he came to learn to "walk" again.

He said: "Now I can go alone to the shop for my mother. And perhaps I will be able to find work."

But jobs are hard to come by — even for a young man who can speak English and has a newly-acquired mobility. However, Mr Libert Ndzovela has taken his first steps — and he lives in hope.

Private hospitals 'do not expect to get complaints'

By Toni Younghusband,
Medical Reporter

Private hospitals did not expect adverse reaction from patients to their contracting out of medical aid, hospital spokesman said.

Mr Jeffrey Hurwitz, a director of the Clinic Holdings Group of hospitals, said since his group had contracted out, patient reaction had been positive and most had been happy to pay "upfront".

Last month, private hospitals announced that they would be contracting out of medical aid as a result of the "unacceptable" 12 percent increase in the scale of benefits granted to them by medical aid schemes. The hospitals were demanding at least 17 percent to "cope with increased running costs and the escalating rate of inflation."

Administrative hitches prevented all hospitals from contracting out immediately. This week, two Johannesburg hospitals belonging to the Medi-Clinic Group, will contract out.

Mr Enzo Bernabei, marketing manager for Medi-Clinic, said patients were being told of the current situation by their doctors and leaflets explaining exactly what the patient would be liable for were available.

"We have also provided information desks at our hospitals for patients," he said.

He said the decision by some medical aid schemes to refund the patient and not pay the hospital direct was "in the hands of the medical schemes".

A large percentage of medical schemes have refused to pay hospitals direct. As a result, patients are having to pay the full cost of their treatment before admission to hospital.

Although official policy of the Transvaal Hospital Services is to treat any patient, it is well known that medical aid patients are turned away from State hospitals purely for economic reasons.

However, both State and private hospitals have said they will treat emergency cases whether they be medical aid patients or not.

Private hospital spokesmen said yesterday there had been no marked drop in admission rates since the announcement that they would contract out.

However, members of the public who telephoned The Star yesterday complained bitterly.

Patients who must produce a full cash payment before admission could face the following fees as they walk through the door: R680 for a tonsillectomy, R850 for an ulcer and R1 100 for a coronary.

A woman having a baby will have to fork out R2 000.

The Representative Association of Medical Aid Schemes has indicated that it will continue talks with private hospitals in an attempt to settle the current deadlock.

"There is an earnest desire on all sids to see a resolution to the current problem," Mr Rob Speedie, the executive director of Rams said. He said he was sure those medical schemes who refused to pay hospitals directly, would discuss the matter with scheme members who were finding it difficult to pay upf)ront.

Medical fees to go up

Sowetan 21/7/89

299

SOWETAN Correspondent

THOUSANDS of medical aid scheme members will have to pay hundreds of rands in advance before being admitted to private clinics.

This comes as a result of the dispute between medical aid societies and private clinics over the annual increase in the scale of benefits. Most of the country's private clinics have contracted out of medical aid and increased their fees above the offered 12 percent.

Call to stop excessive costs

Hospital, medical aid deadlock angers patients

299

By Toni Younghusband, Medical Reporter

Members of the public are far from happy about the bills they are having to pay at private hospitals, callers to The Star said yesterday.

In response to reports carried on Monday concerning the dispute between private hospitals and medical aid schemes, callers telephoned the newspaper complaining of "extraordinarily" high bills and poor medical aid administration.

On January 1, medical aid schemes granted a 12 percent increase to private clinics which were demanding at least 18 percent.

As a result, most of the country's private clinics have contracted out of medical aid and increased their fees above the offered 12 percent.

Medical aid members are now liable for the amount in excess of the scale of benefits. Patients are now being asked to pay a deposit (covering the tariff excess) before being admitted to hospital or pay the whole amount beforehand and claim from their medical aid.

Many medical aid societies have refused to pay the hospital direct and will only refund the patient.

One man said he was having to come up with more than R4 000 for a simple operation performed on his wife's nose.

"She had a small hole in the cartilage of her nose. The doctor's bill was R800 and the bill for the clinic (she spent only one night there) was more than R2 500. When I asked for a detailed account, I saw that the drugs bill alone was R1 400.

"This operation had to be done but I am not prepared to pay something like this. We have got to put a stop to these high costs," the man said.

A Johannesburg butcher said he had to fork out R1 000 extra for the part of the private hospital bill not covered by medical aid.

Emergency cases

"I have good medical insurance cover but I still had to come up with an additional R1 000," he said.

A plastic surgeon, who cannot be named for ethical reasons, said doctors' practices were also being affected by the deadlock.

"People want to know from us why, as contributors to medical aid societies, they must still pay excess fees.

"The private hospitals say they will treat emergency cases regardless of whether or not the patient can pay, but that is purely at the whim of the person at the reception desk.

"I know of cases that have been turned away," the surgeon said.

An apprentice to a printing firm has called on medical aid members to strike. "Stop these companies taking us for a ride. I suggest every medical aid member should resign and rather put the money into a savings account to draw interest."

He had been told a back operation would cost him in excess of R4 000 but his medical aid scheme refused to pay the hospital direct.

Beauty firm ordered to pay over R2-m

A South African company, International Cosmetics & Fragrances (Pty) Ltd (ICF), has been ordered to pay more than R2 million to the US company Max Factor or its local subsidiary, RGI Beauty Products (Pty) Ltd.

The order was granted in the Rand Supreme Court yesterday by Mr Acting Justice P E Streicher.

ICF must also pay interest and costs.

An amount of R2 828 378,82 was payable in terms of an agreement dealing with the importation of Halston fragrances, Orlane and Max Factor products, and the payment of royalties.

BUSINESS

Patients pay more, hospitals earn less

Raising rates hasn't brought in much more revenue for hospitals. Too many people can't afford even the lowest charges

MAKING people pay for treatment in state hospitals is an important part of the government's policy of "privatising" health care, reducing its funding of the hospitals. But hospitals which have introduced new charges on this basis have added only marginally to their revenue — because most black people can't afford even the lowest subsidised rates.

The vast majority of black people depend on state hospitals. Although the number of blacks belonging to some kind of medical scheme more than doubled between 1975 and 1986, by 1986 only about four percent of Africans were covered.

Provincial hospitals in Natal and the Cape adopted new "user-pay" systems in April last year but have found that cost-recovery is not much higher than it was before.

This is according to the latest Social and Economic Update (SEU), published by the South African Institute of Race Relations.

While current government strategy is that users should pay the cost of services as far as possible, "the scope for recovering costs from patients is extremely limited", writes SEU researcher Elaine Cosser.

Cosser reports that a representative of the Cape Provincial Administration noted that around 75 percent of hospital patients were in the minimum tariff category. The new tariffs introduced last year had added to revenue, but only six percent of hospital services were being recovered.

In Natal, revenue recovered from patients has increased from six percent of expenditure to eight percent since the introduction of the new formula, which has increased health costs for most low-income patients. Under the new Natal formula, free services were withdrawn and all patients had to contribute to costs according to their income level.

Where previously those earning R200 a month were treated free, now the minimum charge is R2 in cash for any treatment. Those who can't pay cash pay more — a R22,50 minimum account fee instead of the R2 cash fee.

In-patients, for example, pay R6 a day in cash or R24 a day on account. These rates are heavily subsidised. All patients earning up to R900 pay fees at subsidised rates, with fees rising as income rises. Beyond R900 they pay the full medical aid rates for their treatment.

While officials interviewed by Cosser said people would not be refused "essential" care if they couldn't pay, the Health Workers' Organisation in Durban has alleged that people have been refused treatment and that the new tariffs are beyond the means of most people.

Meanwhile in the Transvaal, cuts in the central government grant to the province last year were so severe that they led to a significant decline in the quality of services — the government was forced to acknowledge adequate services could not be maintained, Cosser reports.

The "user-pays" system is likely to be introduced in future in the Transvaal and the Free State, in line with government policy of reducing its expenditure on health services.

The SEU report concludes: "The vast gap between the costs of the current health service and what most patients can afford casts doubt on the viability of a key government health strategy — privatisation ... the level of cost-recovery in black provincial hospitals confirms that none can be run on a profitable basis."

It adds: "The government therefore faces a choice between increasing its funding of health care for low-income patients (the vast majority of whom are black) and allowing black access to even basic health care to decline even further."

Caught in the crossfire

Row between hospitals, medical aid hits patients

TONI YOUNGHUSBAND
Medical Reporter

PRIVATE hospitals and medical aid societies are both ripping off the sick, according to angry patients.

A dispute between the hospitals and medical schemes over a Scale of Benefits increase has left people fearful they will not be able to afford to become sick.

As a result of the dispute, many clinics have contracted out of medical aid and some medical aid societies have refused to pay the hospital direct. Patients are being asked to fork out hundreds of rands before admission.

A Johannesburg woman needing a small hole repaired in nose cartilage was horrified at having to pay more than R4 000. She spent just one night in a private hospital.

Her overnight stay in the clinic cost her R234, the theatre fees were in excess of R500 and the drugs used in theatre totalled R1 391.

A few smaller items added in and her total bill for the hospital came to R2 500.

"By the time I had paid the doctor and the anaesthetist, and for the medicine I had to take home, the bill was more than R4 000.

"I am not on a medical aid and when I went to the hospital they asked me for a deposit of R750.

"When I explained that my husband is retired and we do not have medical aid cover, the receptionist said she was sorry but we would have to pay a deposit.

"They estimated my bill for the clinic would be about R1 800. In the end it was R2 500. This is what really shocked me. When you expect one thing and get something like this it comes as a tremendous shock," the woman said.

An elderly Berea pensioner had to withdraw R8 000 of her savings to pay for a hip operation because her medical aid would only cover R2 500.

"God knows what would have happened had I not had the savings. It is ridiculous to think that for the 50 years I worked I contributed at least R72 a month to medical aid but when I need them, they can only give me R2 500.

"I could have gone to the Johannesburg Hospital but they told me they had a waiting list and were short-staffed.

"If I delayed the operation I would have been confined to a wheelchair and it would have been too late," she said.

Another patient said his hospital bill was "an absolute rip-off".

"I called the hospital in December last year and asked how much I would have to pay as I am not a medical aid member. They told me it would cost me R120 a day.

"I went into hospital in January and was asked for a deposit of R1 200. When I queried the amount they said their fees had gone up to R156 a day — that's a 30 percent increase."

A woman who went into a clinic for a minor operation was asked to pay R110 deposit — more than the doctor's fee for the surgery.

An apprentice to a printing firm has called on medical aid members to strike.

"Stop these companies taking us for a ride. I suggest every medical aid member should resign and rather put the money into a savings account to draw interest," he said.

The man said he had been told an operation on his back would cost him in excess of R4 000 but his medical aid scheme refused to pay direct.

"Where is an apprentice supposed to find that kind of money?" he asked.

He was unable to get either a bank loan or building society advance because he did not earn enough as an apprentice.

● SEE PAGE 10.

Presmed stays contracted in

MEDICAL REPORTER

A PRIVATE hospital group has announced that it will not contract out of medical aid despite a decision by the majority of the country's clinic owners to do so.

Most private clinics have already contracted out of medical aid schemes as a result of a dispute over the annual Scale of Benefits increase.

The Representative Association of Medical Aid Schemes (Rams) granted private clinics a 12 percent increase from January 1. This was rejected by the majority of clinics which were demanding at least 18 percent to cope with escalating costs and inflation.

Mr Carl Grillenberger, the managing-director of the Presmed Group, said on Thursday it had been a difficult decision for his company to remain contracted in.

"The cost increase in the provision of hospital care is probably 50 percent more than the increase granted by medical aid societies," he said.

However, his company had decided to stay contracted in and would take measures to tighten further internal control at its hospitals and day clinics to narrow the difference between cost and tariff increases.

"Staying contracted in and invoicing medical aid societies directly instead of patients, simplifies financial control. We shall concentrate our efforts on running our hospitals and day clinics in the most cost-effective way possible without sacrificing the quality of service and equipment," he said.

He pointed out that it was not up to the hospitals alone to curtail costs.

"It is essential that patients become more discerning in demanding quality health care at a reasonable price.

"General practitioners can accommodate patients opting for lower medical treatment costs by referring such patients to specialists who operate in day clinics and contracted-in hospitals," said Mr Grillenberger.

Amid the pomp and ceremony another story

As leaders from around the world gathered for the day-long funeral of Emperor Hirohito, not everyone in Tokyo was in mourning. Police (above) had to rush out into the street at one point to restrain two demonstrators who attempted to disrupt the funeral procession. Despite 32 000 policemen being on extra duty, only 15 minutes before the motorcade passed another point enroute to the cemetery, an explosion, believed to have been a bomb, showered dirt and debris over the highway. While Emperor Akihito was saying in his eulogy: "The people will remember him forever", police said there were 11 anti-emperor demonstrations denouncing Hirohito as a war criminal.

● SEE PAGE 10.

Speak Out!
ON SATURDAY

Clinics, Sta aids all outr

The man in the street feels hard done by and even risks losing out on medical attention thanks to the decision by private hospitals to contract out of medical aid schemes. Furious callers to *Speak Out* lambasted this decision, saying

ministration. shocked to se contributions taining ineffi

Mrs Diane a nursing sist is very danger die. Most pe

Sorting sacks is just one of many projects this group of mentally retarded young adults has tackled.

Making a plan

Star 27/2/89

Young mentally retarded men and women on the East Rand are being given the chance to prove their worth as productive individuals. 299

In a workshop in an abandoned primary school near Kempton Park these young adults are providing services for the community.

They do gardening, make coat hangers, sort sacks, restore old furniture, and will tackle any project.

The director, Mrs Wilma Basson, says the mentally retarded have difficulty in finding work. She can be reached at 979-1707 between 8 am and 1 pm or 976-5971 in the afternoons and evenings.

do so because the implication is . . . [Time expired.]

Mr J B DE R VAN GEND: Mr Chairman, what really concerns us on this side of the House is that if one looks at the evidence of the Harms Commission, it reads like a Who's Who of top Government officials and of Cabinet Ministers, and one really wonders why these people were involved when the man was so patently dishonest for a considerable period of time.

Dr de Kock of the Reserve Bank actually conducted an official opening of one of Vermaas's game farms on which he lavished favours on his important and no doubt useful friends including our Ministers. Both the departments of Defence and of Foreign Affairs have used Mr Vermaas' businesses, hiring an aircraft at, I believe, considerably well above the going commercial rates. Our Minister of Foreign Affairs has admitted that he and Mr Vermaas are close friends of many years standing and that they were involved in joint strategies to circumvent what he refers to as international sanctions. Did our Ministers really not see through this man? Were his criminal and other shady dealings not so patently obvious to at least demand caution?

Dr M S BARNARD: Have they woken up?

Mr J B DE R VAN GEND: It would appear not. On Sunday, 20 November 1988, the very day before the commission was due to commence its investigations into Vermaas, his close friend the hon the Minister of Foreign Affairs arranged through the hon the Minister of Finance for Vermaas to receive the help and advice of Mr Van Greunen, a top Reserve Bank official—on that very same night, Sunday night, as a matter of urgency—presumably in connection with his fraudulent foreign exchange dealings. Why else would Vermaas run for help the night before the commission is due to start its hearing? Why did it have to be conducted on a Sunday night? Was it that urgent?

Even after failing to submit tax returns for 10 years, there was no investigation let alone a prosecution. This meant a potential R44 million loss in tax to the Receiver of Revenue, let alone all the money this country is going to lose through his foreign exchange dealing. [Time expired.]

Mr D J DALLING: Mr Chairman, I believe that whatever is said about this matter, the intervention by the hon the Minister in the decisions of this Attorney-General is an unprecedented one. I believe that a precedent has been created in this. I want to say immediately that I think that the hon the Minister acted correctly in intervening as he did. Previously, when the hon the Minister has been questioned about what an attorney-general has decided, said, done or what he should do, he has always pleaded that an attorney-general is independent; that the Minister has no power to intervene; that the decisions made are those of that Attorney-General and not of the Minister. The question I have to ask has a bearing on his administration of justice and that is, is an attorney-general independent or is he not; and, if he intervened, under what powers did he so intervene? [Time expired.]

The MINISTER OF JUSTICE: Mr Chairman, there really is a peculiar relationship between the hon member for Sandton and myself because he asks the right question at the right time which enables me to make a policy statement. I can assure hon members that I have not arranged this with him beforehand. However, let me first say, he is so predictable. That is the point.

If the hon member for Groote Schuur had held forth outside Parliament as he has been holding forth in this House, he would have rendered himself liable to prosecution under the Commissions Act because he has now sat as a commissioner. He has evaluated the evidence. He has come to a conclusion—a finding. [Interjections.] He has levelled a charge. He is the commissioner, he gave evidence again and he interpreted the evidence. It is patently not applicable to this case. He does not have the power and it is most inappropriate.

According to the Criminal Procedure Act, an attorney-general exercises his authority and performs his functions under the Act, subject to the control and directions of the Minister of Justice. This is what section 3 says.

Successive governments and Ministers of Justice have interpreted this provision to mean and applied it in such a way that attorneys-general are recognized and respected as fearlessly independent and must be seen to be so. In my experience, attorneys-general exercise their discretion to prosecute or not in a professional and objective manner and they should be allowed to continue to do so without being subjected to undue pressure from whatever source.

The relationship between attorneys-general and the Minister of Justice is indicative of the whole approach to criminal justice in our country. Our courts and our judicial functionaries dispense justice fairly between man and man and they do so independently of executive control or pressure. [Time expired.]

Debate concluded.

QUESTIONS

†Indicates translated version.

For oral reply

General Affairs:

Criticism of Goverment prohibited

*1. Mr S S VAN DER MERWE asked the Minister of Law and Order:

Whether any persons or organisations were prohibited from issuing or making statements critical of the Government in 1988; 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? B137E

The MINISTER OF LAW AND ORDER:

(a) to (e)

In respect of persons — no

In respect of organisations I refer the hon member to *Government Gazette* numbers:
11340 and 11344 dated 10 June 1988
1148 dated 24 August 1988
11561 dated 25 October 1988
11569 dated 31 october 1988
11592 dated 11 November 1988
11623 dated 8 December 1988
11627 dated 13 December 1988
11655 dated 29 December 1988
11671 dated 16 January 1989.

Persons arrested for attending illegal gatherings

*2. Mr S S VAN DER MERWE asked the Minister of Law and Order:

How many persons were arrested by the security forces in 1988 for allegedly attending gatherings prohibited in terms of (a) section 46 of the Internal Security Act, No 74 of 1982, and (b) the emergency regulations? B138E

†The MINISTER OF LAW AND ORDER:

(a) 194 persons

(b) 3 persons

SADF pensioners: medical arrangements

*3. Mr D J N MALCOMESS asked the Minister of Defence:

(1) What medical arrangements are made for South African Defence Force pensioners who require operations;

(2) whether such pensioners are obliged to have operations at military hospitals; if not, what are the relevant details? B139E

The DEPUTY MINISTER OF DEFENCE:

(1) and (2) The medical expenses of members of the Permanent Force who retire with pension, is borne by the Permanent Force Medical Continuation Fund. These members must, where possible, make use of the facilities of Military Hospitals. If this is not possible, for example in areas where no Military Hospital exists, Provincial Hospitals may be used and the cost will be borne by the Permanent Force Medical Continuation Fund.

Military pensioners who receive a pension in terms of the War Pension Act, receive their medical treatment at the expense of the Department of National Health and Population Development at their nearest Provincial or Military Hospital.

Mr D J N MALCOMESS: Mr Chairman, arising from the reply given by the hon the Deputy Minister, is he aware that in some instances Defence Force pensioners, not the second category he mentioned but the first category, have been told they have to go for operations to No 1 or 2 Military Hospital, when they are in fact resident in Port Elizabeth and that under those circumstances they are in a strange community with nobody to visit them in hospital? Could he investigate the situation with the view to preventing it in future?

The DEPUTY MINISTER: Mr Chairman, I want to point out that they do have a choice. If the hon member will make this information available to me, I will certainly investigate the matter.

WOMAN

Creche opens for handicapped children

THE Civilian Blind Association has opened a Centre For Visually Impaired Children.

The multi-racial creche is housed at the Transvaal Memorial Institute Building in Joubert Street. The creche takes children aged three to five years old.

"Most children who are visually impaired are protected from their environment," Mrs Beth Nielsen, who runs the creche said.

"We intend for them to learn to touch, explore and know their environment. We will also introduce them to braille."

The centre offers other services like a stimulation unit, physiotherapy, occupational therapy and speech and hearing therapy. All this is available to parents with blind children.

The centre is open from 8am to noon and costs R150 a month.

"We can only take 15 children as they need individual attention. We also try to find bursaries for those who cannot afford the fees," Mrs Nielsen said.

For more information contact Mrs Nielsen at 642-7554.

Health care becomes everyone's property

Star 6/3/89

294

By Jo-Anne Collinge and Sally Sealey

Health care shed its white-coat image yesterday when the South African Health Workers' Congress was launched in the Johannesburg City Hall to the accompaniment of freedom songs, traditional dancing and endorsements from scores of community organisations and trade unions.

Sahwco, with an estimated membership of 2 000, draws together doctors, nurses, para-medical and auxiliary health staff and lay people whose interest lies in the improvement of health facilities.

The second day of its inaugural meeting was open to the public and drew a crowd of well over 1 000. Mr Krish Vallabjhee was elected president.

"The exciting thing is that it's the people at this launch who are talking about health. We've allowed the professionals to control health, to take it out of our hands," said Dr Ivan Toms, who was active in community health projects in the Cape Peninsula long before his objection to military service brought him national prominence.

Dr Toms said Sahwco could play a vital role in "demystifying" health.

Medical knowledge, shared with the people, could save lives. Health workers should revise their concept of themselves, should see themselves as part of a team "passing on their skills and empowering other people".

Speakers emphasisedthe link between economic systems and the health of the people. They referred to poor health having its roots in landlessness, homelessness and unemployment.

Father Smangaliso Mkhatshwa, general secretary of the Institute for Contextual Theology, pointed to the uphill job of health workers in a context of increasing poverty and "brutal and terrible stress" caused by repression.

Health authorities to thrash out differences

299

Star 6/3/89

By Toni Younghusband,
Medical Reporter

Health authorities are being invited to thrash out their differences and discuss possible solutions for South Africa's crumbling health care system at a conference later this year.

The conference, the brainchild of Wits University's Centre for the Study of Health Policy, has been organised in the wake of widespread dissatisfaction over escalating health costs and inferior health service.

Medical aid societies and private hospital owners, who have been locked in battle over tariffs, will be encouraged to attend the conference and to present papers.

High drug costs, another explosive issue which had pharmacists, manufacturers and the Government at loggerheads earlier this year, will also be on the conference agenda.

WHOLE SYSTEM THREATENED

"Health care costs are going through the roof. Some people blame private doctors and hospitals, others blame the medical aids. Yet others blame the multinational drug companies or the Government.

"Spiralling health care costs affect everyone and threaten the whole health care system. We would like to host an academic conference where the causes of escalating costs can be identified and short-term solutions found," conference organiser, Mr Cedric de Beer said.

Mr De Beer said the conference would be open to anyone involved in health care to attend.

The conference will be chaired by economic and health economy experts who will comment on each topic.

A date for the conference has not yet been set as the organisers are trying to get hold of an overseas speaker.

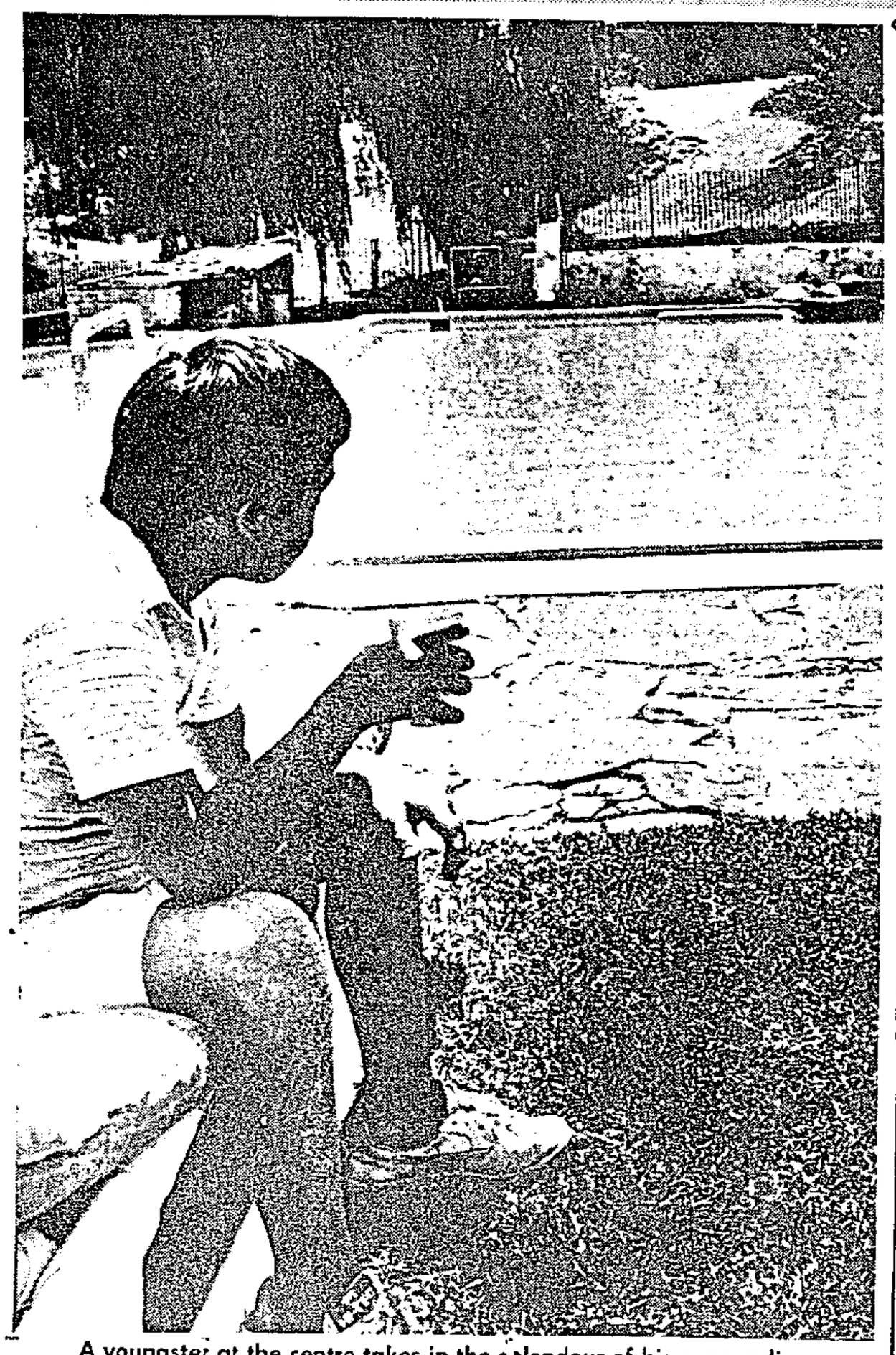
it out of our hands," said repression.

River.

The Federal Energy Depart- Press

tion with

Here the mentally handicapped find peace



A youngster at the centre takes in the splendour of his surroundings.

Star 6/7/89 299

By Toni Younghusband, Medical Reporter

The majestic Magaliesberg mountains provide the backdrop for a very special holiday camp where retarded people of all ages are able to enjoy the outdoors and get to grips with nature.

Camp David, situated deep in the bush about 60 km from Johannesburg, was the brainchild of Mr Jack Shapiro, executive director of the Selwyn Segal home for the mentally handicapped.

The camp, which looks more like a luxury hotel, was built at a cost of more than R2-million, every cent of which was donated by well-wishers.

The buildings and furnishings are bright and ultra-modern but built for comfort. The camp, built chiefly for Jewish people, has a kosher kitchen.

The lounge and dining area have huge glass sliding doors opening on to the lawns and for the energetic there is a swimming pool and a tennis court.

Residents sleep in dormitories and a special activity programme is planned each day. In between swimming and sports there are hikes up nearby koppies, braais, games and competitions. Some mornings the residents eat breakfast on the river banks or take a long walk to the town of Magaliesburg.

There are fulltime nurses, aides and social workers on hand to help out.

Groups stay at Camp David for between three and eight days at a time and for each period there is a theme.

"We have had South Africa as a theme and China. We get dancers to perform for the residents and have traditional food and costumes. It's great fun and a learning experience at the same time," Mrs Loren Einstein, a camp co-ordinator, told The Star.

The camp is available not only to retarded people but also to schoolchildren who might enjoy a few days away from the big city.

Nat MP in Boksburg row over rezoning

304 A

SK 6/3/89

The role of Boksburg National Party MP Mr Sakkie Blanche in obtaining government approval for the rezoning of two portions of land in Windmill Park Extension 4 in 1986 has drawn the ire of the town's Conservative Party-controlled management committee.

Mr Gideon Fourie, chairman of the management committee, said he had requested the Acting State President, Mr Chris Heunis, to launch an investigation into Mr Blanche's involvement.

After Boksburg businessman Mr Larry Barnett had a protracted battle with the previous town council, Mr Blanche assisted him in obtaining approval from the Minister of Constitutional Development and Planning to establish industrial plant on the land. — Political Reporter.

ve dicussed the problem.

early 1920s?

Plea for action over soaring medical costs

Star 6/3/87 — Medical Reporter (299)

The Housewives League has called on Minister of Health Dr Willie van Niekerk to take immediate action against escalating medical costs.

League past president Mrs Joy Hurwitz said last week in a statement that members of the public were far from happy about the increased medical costs at a time of high inflation and lower living standards.

"Our concern is so great that the league has organised a petition to the Minister of National Health and Population Development appealing to him to act. This petition has been drawn up to give expression to the great dissatisfaction of South Africans regarding the enormous increases in this field."

Mrs Hurwitz said the public could not control this aspect of their lives, as illness could strike at any time without warning. "When it does, our immediate concern is: can we foot the bill?".

hon the Minister's reply, was there any stage that our ambassador in Ciskei declined to give the people of East Peelton assistance with their problem?

The MINISTER: Mr Speaker, I am not aware of that at all but what I am very well aware of is that our ambassador went out of his way to facilitate provision of the necessary protection at all times. He involved himself personally and he visited President Sebe on this matter personally. I can given the hon member the assurance that that was the attitude of our ambassador throughout this situation.

Statutory bodies abolished

22. Mr R R HULLEY asked the Minister of Economic Affairs and Technology:

Whether it is his intention to abolish any of the statutory bodies falling under the control of his Departments in accordance with the Government's stated policy of privatisation and deregulation; if so, (a) which bodies and (b) when; if not, why not?

B306E

The MINISTER OF ECONOMIC AFFAIRS AND TECHNOLOGY (Reply laid upon the Table with leave of House):

(a) and (b): In the case of the Department of Trade and Industry it is considered to abolish the Travel Agents Board and to repeal the Travel Agents and Travel Agencies Act, 1983 (Act 58 of 1983). This matter is now being considered by the board and their proposals will be submitted to me at the end of May 1989.

No other statutory bodies which are linked to the Departments of Trade and Industry and of Mineral and Energy Affairs are ear-marked for abolishment or lend themselves thereto. However, investigations are continuously being conducted, where necessary in close consultation with the Ministry for Administration and Privatisation, to establish whether, in the spirit of privatisation and deregulation, specific activities could possibly be transferred to the private sector with advantage. A number of activities which have been identified are on their way to privatisation or have been privatised already, as follows:

(i) *The Industrial Development Corporation of SA Ltd (IDC)*

There is no intention to privatise the IDC as such, because the Corporation has to assist in implementing the Government's policy in respect of industrial development, import replacement, export promotion and small business undertakings. However, the privatisation of the following industries which are controlled by the IDC for its own account on behalf of the State is receiving attention:

— Foskor: The privatisation of Foskor in its entirety is being withheld until the company's results and market conditions make it possible.

— Alusaf: The transfer of and control over Alusaf to and by private sector interests and the quotation of the company will take place as soon as circumstances are favourable.

— Sorghum beer industry: Good progress has been made in preparing the extensive sorghum beer industry for merging into a unit which can be privatised. The follow-up actions are aimed at arousing the interest of the private sector, in which the consumer will hopefully also be represented.

(ii) *The Council for Scientific and Industrial Research (CSIR)*

The CSIR itself is not ear-marked for privatisation. However, certain functions of the CSIR have been privatised already or are in the process of being privatised, namely:

— The South African Inventions Development Corporation (Saidcor) will ultimately be replaced by a private company in terms of legislation now before Parliament.

— The motor vehicle fleet of the CSIR has been sold and is now operated by a private leasing company.

— The design office of the CSIR had been underutilised and has been taken over by the office personnel. By also undertaking private work, besides the work which is now being done for the CSIR, the work can be done on a more cost-effective basis. In this way the cost to the CSIR has been reduced appreciably.

— The training function at the CSIR is now also being undertaken by a private company which, too, is contracting for work from outside. Accordingly, the training aspect of the CSIR is done on a more cost-effective basis.

(iii) *The Atomic Energy Corporation of SA Ltd*

The high precision mass production facility of the AEC is now on the road to privatisation.

Maternity benefits of wives of national servicemen

23. Mr R J LORIMER asked the Minister of Defence:

Whether the wives of national servicemen are entitled to the same maternity benefits and medical care as are the wives of members of the Permanent Force; if not, why not?

B307E

The DEPUTY MINISTER OF DEFENCE:

No, this is a service condition for Permanent Force members. Sufficient provisioning is normally made for the majority of families of National Servicemen by their own medical schemes in the private and public sectors. In addition, there are not enough personnel and facilities in the SA Defence Force available to cope with the extra load and it will also place an additional burden on the SA Defence Force budget.

Mr R J LORIMER: Mr Speaker, arising out of the hon the Deputy Minister's reply, does he believe it is fair to discriminate against national servicemen like that?

The DEPUTY MINISTER: Mr Speaker, I can reply to that. We do not see that as discrimination. As I have already pointed out national servicemen can make use of their own medical schemes. Further to that question I must point out to the hon member that in cases where certain circumstances arise Treasury approval may be granted for those cases to be handled by the South African Medical Services.

Mr R J LORIMER: Mr Speaker, further arising out of the hon the Deputy Minister's reply, if I draw cases of hardship to the attention of the hon the Deputy Minister is he in a position to do something about it?

The DEPUTY MINISTER: Mr Speaker, yes, provision is made for those specific cases.

Control of pesticides

24. Mr M J ELLIS asked the Minister of Agriculture:

Whether he is considering introducing legislation to amend the Fertilizers, Farm Feeds, Agricultural Remedies and Stock Remedies Act, No 36 of 1947, in order to transfer control of pesticides to the Minister of Environment Affairs; if so, when will such legislation be introduced?

B308E

†The DEPUTY MINISTER OF AGRICULTURE:

No.

*25. Mr M J ELLIS ÷ AGRICULTURE. [Withdrawn.]

Latin: abolishment as requirement for admission in Supreme Court

26. Mr D J DALLING asked the Minister of Justice:

Whether he intends to introduce legislation in 1989 to abolish the requirement of a qualification in Latin for admission as an advocate in the Supreme Court; if so, when; if not, why not?

B313E

The MINISTER OF JUSTICE:

Last year the hon member for Sandton also asked me about the possible abolition of Latin as a prerequisite for persons wishing to practise as advocates and attorneys. On 8 March 1988 I pointed out in this House that before I exercise my power in terms of section 1 of the Admission of Advocates Amendment Act, 1987 (Act 17 of 1987), to determine a date on which the concession granted in terms of that Act is to cease to apply, I require the viewpoint of the advocature. According to a majority resolution of the General Council of the Bar of South Africa it is proposed that Latin be abolished as a requirement. The various Bars were, however, not unanimous in this regard, and several representations on behalf of individual Bar Councils were once again received advocating the retention of Latin as a requirement for admission as an advocate.

I have, in the meanwhile, had the benefit of a wide range of views, in the course of which the following factors have emerged as most relevant —

(a) certain provincial division of the Supreme Court of South Africa have held that a special university course in Latin is suffi-

Posmed members agree to keep PO medical aid white

Pretoria Correspondent

Star 8/3/89

A majority of 57 percent of Post Office officials belonging to the whites-only medical aid scheme, Posmed, have rejected a move to include non-whites in the scheme.

A secret ballot was conducted by the Post Office among Posmed members last month to gauge the feeling of the possible admission of non-whites to the scheme. 299

The investigation was backed by senior officials of the Post Office, following questions in Parliament during the 1988 session.

Medical aid scams cost members millions

DOCTORS and pharmacists countrywide are being investigated in connection with a massive medical aid fraud estimated to involve R30-million. And as a result of widespread fraud, South Africans could be paying as much as seven percent more on medical aid contributions than they should.

The shocking disclosure by the Association of Med Scheme Administrators that 28 doctors and pharmacists are being investigated follows police action this week against an East Rand pharmacy suspected of being involved in medical aid fraud.

Toiletries and other goods were allegedly offered at the pharmacy instead of medicine on prescription. Medical aid schemes were then billed for "medicine" dispensed.

After staking out the pharmacy in Benoni, police swooped and copies of prescriptions made out in the past three months were seized.

Amsa provides a service that monitors fraud and abuse for the 62 schemes under its control.

All in all there are 216 medical schemes in South Africa generating annual transactions estimated at R3,5-billion.

Hardship

The association, which has been conducting an undercover investigation for more than a year, says the entire medical scheme movement in South Africa could be losing as much as R175-million a year to false claims.

The figures are based on reports from the massive Blue Shield and Blue Cross Medical Plans in the United States where fraudulent claims and similar malpractices represent between five and 10 percent of all claims.

Amsa says that at suspected levels of fraud, members' contributions are calculated to be seven per cent higher than they need be. The actual level varies from scheme to scheme.

Says chairman Keith Hollis: "Fraudulent practices create financial hardship for all members and inevitably cause medical aid scheme contributions to rise."

By MANDLA TYALA

Mr Gordon Waugh, a retired assistant commissioner in the British South Africa Police who is heading the Amsa investigation, told the Sunday Times how the crooks operate.

Methods

"A doctor dispenses medicine to a medical aid member, then issues the patient with a prescription. The patient is then referred to a particular pharmacist where she is offered toiletries or any other goods.

"The medical aid scheme is then billed for the medicine dispensed by the doctor as well the 'medicine' from the pharmacy.

"The claims are in most cases higher than the amount of the goods that were sold to the patient against his prescription," said Mr Waugh.

He believes it will take another three to four months before the next case is cracked.

Mr Hollis said: "Investigations of this nature are difficult to conduct. In the United States an 'army' of ex-FBI and former Internal Revenue Service investigators took many years to bring its first culprit to the courts.

Convicted

"In South Africa, Gordon Waugh, chief investigator for Amsa has done considerably better with a far smaller staff and 28 major cases are now under investigation."

● Last year a Nelspruit pharmacist, Abrie Wiid, was convicted on 381 counts of medical aid fraud, fined R25 000 and ordered to pay back R22 000.

He was found to have dispensed medicines to clients on 201 occasions on false prescriptions. On another 180 instances he had altered prescriptions to dispense more medicine to his clients.

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Clinic opts out for your good

Business Times Reporter

SOUTH Africa's largest private hospital group, Clinic Holdings, has launched a spirited defence of its decision to opt out of the medical aid societies scale of fees.

Chairman Barney Hurwitz says in the company's first annual report since it was listed on the JSE that it has no option but to contract out if it is to maintain standards of medical service.

"To continue with our policy of widening the range of clinical services and upgrading existing medical and surgical facilities in order to maintain standards equal to and surpassing the best in the world, it is essential to keep up with the latest technology advances.

"While it is costly, the equipment required to maintain this standard often reduces the stay in hospital and lessens the need for protracted medical care."

In spite of high costs, the company — one of the biggest 1987 listings — exceeded its prospectus forecasts for turnover and earnings in the year to September 30.

Turnover increased by 34% against a forecast 29% and earnings were 21,5c a share. The forecast was 20,5c.

Mr Hurwitz says a comparison of the increase in private health care costs with the economy as a whole provides an insight into Clinic's decision to opt out of the medical aid schemes.

Slower

A study by Unisa School of Business Leadership professor of management economics Jan Hupkes for 1983-1987 shows that the cost of medical services increased at a slower rate than other sectors.

The all-items consumer price index rose by 78,5% from the 1983 base in the four years. The CPI for services increased by 71,1%; pharmaceutical, surgical, medical and allied products increased by 96,2%; and the cost of medical services increased by 49,7%.

In a First World economy the price of service would generally rise faster than inflation. This occurred in SA in 1984-1985, but then the general graph rose faster, says Mr Hurwitz.

The likely reason is that the rand's fall hit the cost of goods more severely.

Row over bid to sell cut-price medicine

ST Times. 1/3/87 299

By GWEN GILL

A GROWING number of pharmacies are cutting the costs of prescription medicines.

Medical aid members in many parts of the country could be paying 20 percent less for these within months, said Mr Kosie van Zyl, managing director of a new group, Medicine Distribution Corporation.

He said this week at least 50 pharmacists had approached him to join in the discounting since details of his operation were revealed two days ago.

Since last October, a large Pretoria pharmacy, Pharmarama, has been quietly cutting prescription prices by 25 percent.

But a huge row is brewing in pharmaceutical circles over what the professional bodies see as support for a commercial venture by Minister of Health Dr Willie van Niekerk.

Mr Van Zyl has been on the Pharmacy Council for 25 years, the last five as president.

He said: "Mediscor's operation will be like a franchise.

"Our aims are to bring down the cost of drugs, improve the standard of pharmaceutical practice in South Africa and enable medical aid members to enjoy the full benefits of the expertise of the pharmacist.

"We are expecting between 500 and 1 000 of the country's 2 700 pharmacies to join us. We should be able to buy in massive quantities at a discount. That's how we'll be able to cut the price of prescription medicines."

Unpleasant

Selling prescription drugs at discount prices breaks an ethical rule of the pharmaceutical industry and could result in pharmacists not being allowed to practice.

Mr Gerhard Slabbert, a director of Pharmarama, said this week: "Consumers are flocking into my store to see what's going on."

Though it welcomes moves to cut medicine prices, a spokesman for the Pharmaceutical Society of South Africa this week slammed the Minister of Health's "use of his privileged position" to draw the public's attention to Mediscor.

The Deputy Minister of Health Services in the House of Assembly, Dr Michael Veldman, moved on Friday to cool down the row.

He appealed to all parties to end the "unpleasant war of words" between pharmacists and the Government in a "responsible manner".

Industry sources warned that cutting prices could mean many pharmacists going out of business.

"A survey last year showed that if prescriptions were discounted by five percent, 40 percent of pharmacies would have to close. The figure rose to 80 percent if a 15 percent discount were given."

However, neither Mr Slabbert nor Mr Van Zyl believe it will be necessary for pharmacists to lose their jobs.

Medical scheme fraud put at R175m

JOHANNESBURG. — Fraud is costing medical scheme members R175 million a year, according to the chairman of the Association of Medical Scheme Administrators (Amsa), Mr Keith Hollis.

In a statement yesterday, Mr Hollis said this had come to light as the result of a probe by East Rand police into alleged malpractices involving an Actonville pharmacy. Initial investigations had been done by Amsa.

He said the R175-million estimate was based on reports from the massive Blue Shield and Blue Cross medical plans in the United States. Fraudulent claims and similar malpractices represented between five and 10% of all claims in the US.

Applying the lower figure of 5% to the South African medical scheme movement of which 216 medical schemes generate annual transactions of R3,5 billion, the value of false claims was likely to exceed R175 million a year. — Sapa

ance that I have been acting strictly in accordance with the terms of the relevant Act and that we have been giving the matter proper and serious attention.

†Prof S C JACOBS: Mr Speaker, further arising out of the hon the Minister's reply, I should like to ask him whether his department has recently received a letter from a legal firm in regard to these by-elections.

†The MINISTER: Mr Speaker, the answer is yes, I did receive the letter. [Interjections.]

Business interrupted in accordance with Rule 180C(3) of the Standing Rules of Parliament

Monitoring standards: produce

*17. Mr M J ELLIS asked the Minister of National Health and Population Development:

(1) Whether produce for consumption on the local market is subject to the same monitoring standards in terms of controlling the abuse of pesticides as are produce for consumption on the export market; if not, (a) why not and (b) what standards apply in each case;

(2) whether produce for the local market is monitored at the market place; if not, why not;

(3) whether the same monitoring standards apply in each province; if not, (a) why not and (b) what are the differences?

B376E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) Yes, except in extraordinary cases,

(a) generally there is an agreement between the monitoring standards of different countries, as most like the RSA, base their standards on the Codex Alimentarius of the World Health Organisation and the Food and Agricultural Organisation. Occasionally countries may in specific cases, however, differ from the requrements of the RSA, and in such instances, the exporter must conform to these specific requirements,

(b) the most recent set of monitoring standards for the RSA has been published as Government Notice R2160 of 2 October 1987, as amended by R1939 of 23 September 1988. Regarding the export market, exporters must themselves determine what the requirements of the importing country are. The Department of National Health and Population Development does not keep copies of these requirements;

(2) yes;

(3) yes, (a) and (b) fall away.

Misuse of pesticides

*18. Mr M J ELLIS asked the Minister of Agriculture:

How many cases of (a) agricultural and (b) domestic misuse of pesticides were reported to the Registrar of Pesticides in 1988?

B377E

The MINISTER OF AGRICULTURE:

(a) Four; and

(b) seven

Portugal: shipment of cycads

*19. Mr R J LORIMER asked the Minister of Constitutional Development and Planning:

Whether, with reference to his reply to Question No 8 on 28 February 1989, the shipment of cycads to Portugal from the Cape Province in 1988 was for Madeira; if so, (a) what was the nature of the shipment, (b) what species of cycad were included in it and (c) who applied for the permit for the shipment?

B378E

The MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING:

This matter vests in the Administrator of the Cape Province and he has furnished the following information:

Yes. Cites export permit — Cape Province: 133/1988 dated 19 September 1988; Portugal Cites import permit LI-191/88

(a) Private collection of cycads legally acquired for donation to the Botanical Gardens, Madeira.

(b)

Encephalartos altensteinii	20
E. caffer	29
E. arenarius	29
E. cupidus	9
E. cycadifolius	17
E. eugene maraisii	20
E. ferox	17
E. frederici-guilielmi	20
E. ghellinckii	25
E. heenenii	6
E. horridus	21
E. humilis	10
E. inopinus	13
E. laevifolius	7
E. lanatus	8
E. latifrons	31
E. lembomboensis	28
E. lehmannii	17
E. longifolius	26
E. natalensis	16
E. ngoyanus	12
E. paucidentatus	9
E. princeps	32
E. transvenosus	13
E. trispinosus	41
E. umbeluziensis	8
E. villosus	12
E. manikensis	12
E. pteragonus	1
E. muschii	7
E. concisus	5
E. lehmanniiariensis	2
E. gracilis	2
E. elizabethalensis	1
E. hildebrandtii	2
E. altensteinii x E. latifrons	4
E. altensteinii x E. trispinosus	27
E. altensteinii x E. villosus	11
E. altensteinii x E. arenarius	16
E. altensteinii x E. princeps	8
E. altensteinii x E. spp (uncertain)	13
E. arenarius x E. trispinosus	19
E. eugene-maraisii x E. spp. nova	6
E. ferox x E. natalensis	4
E. horridus x E. longifolius	7
E. horridus x E. spp. (uncertain)	1
E. horridus x E. lehmannii	13
E. latifrons x E. trispinosus	4
E. latifrons x E. longifolius	2
E. lehmannii x E. longifolius	8
E. woodii x E. natalensis	2
E. longifolius x E. arenarius	1
E. longifolius x E. spp. (uncertain)	1
E. longifolius x E. trispinosus	1
E. laevifolius x E. sp. nova	1
Strangeria eriopus	16
E. natalensis x E. villosus	2

(c) Mr J M R Berardo

Ozone layer

*20. Mr R J LORIMER asked the Minister of Foreign Affairs:

(1) When is it anticipated that South Africa will sign the Montreal Protocol on Chlorofluorocarbons to the Vienna Convention for the Protection of the Ozone Layer (1985);

(2) whether, with reference to his reply to Question No 5 on 12 April 1988, South Africa has acceded to the Vienna Convention; if not, when is it anticipated that it will do so?

B379E

The MINISTER OF FOREIGN AFFAIRS:

(1) As soon as the administrative requirements have been completed by the Department of National Health and Population Development, my Department will proceed with the necessary steps to accede to the Montreal Protocol.

(2) No. As soon as the Department of National Health and Population Development completes the necessary administrative requirements, my Department will proceed with the necessary steps to accede to the Vienna Convention. The Vienna convention and the Montreal Protocol will be acceded to simultaneously.

Medical Schemes Act: representations for amendments

*21. Dr M S BARNARD asked the Minister of National Health and Population Development:

(1) Whether he has received any representations for amendments to be effected to the Medical Schemes Act, No 72 of 1967; if so, (a) from whom and (b) what was (i) the purport of and (ii) his response to each such representation;

(2) whether he will make a statement on the matter?

B380E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) Yes, subsequent to those mentioned in my reply to question 2 on 23 June 1987, representations from the following parties were received:

(a) (aa) The Medical Association of SA

(ab) A????

(ac) The Representative Association of Medical Schemes

(ad) The National Association of Medical Benefit Schemes

(ae) The Association of Medical Schemes Administrators

(af) The SA Federated Chamber of Industries

(ag) AECI Ltd

(ah) Mediclinic Corporation Ltd

(ai) Dr G Marais, MP

(aj) Mr S G Bloomberg, MP

(ak) Mr J R Jewel

(al) Mrs I C V Bourgeois

(am) Mrs M Baird

(an) The Sunday Tribune

(b) (i) and (ii) In the same order as in (a) above, respectively;

(aa) Purport:

Amend the Act to prohibit benefit schemes from touting for members, advertising and from exploiting medical practitioners.

Response:

The proposal is not consistent with the principle of free enterprise and deregulation.

Purport:

(1) That the existing relativities between consultative services and other services be separated but that the relativities amongst the services within each of these two categories of services be retained;

(2) that for consultative services direct guaranteed payment of benefits as stipulated in the scale of benefits, be effected irrespective whether practitioners render accounts for such services in excess of amounts stipulated in the scale of benefits for such services. The balance of the account shall be paid to the doctor by the patient;

(3) that the same system as mentioned in paragraph 2 above would apply for all other services. This point could, however, be negotiated on;

(4) that the guaranteed payment for consultative services be set at 70% of an overall increased scale of benefits for 1989, provided that no payout for any service will be less than those in force for 1988, plus the increase for 1989. No medical scheme must be allowed to pay out more than 70% of the applicable scale of benefits for consultative services;

(5) that direct payment of benefits by medical schemes to their members may only be effected upon presentation of a receipt from the doctor;

(6) that for services other than consultative services, medical schemes shall have the right to provide greater benefits over and above those determined in the scale of benefits but, in such cases, the benefit in excess of the scale of benefits shall not be paid to the practitioner;

(7) a practitioner may elect not to accept direct payment of any amount from medical schemes;

(8) the Medical Schemes Act will provide for different systems of guaranteed payment in respect of medical practitioners, dental practitioners, physiotherapists

and private hospitals, as agreed between RAMS and the relevant suppliers of services.

Response:

That consensus first be reached between the parties concerned on the matters of mutual interest.

(ab) Purport:

Amend section 32 to phase out guaranteed payment.

Response:

Negotiations between the parties concerned are still under way on the matter.

(ac) Purport:

Expand the definition of a medical scheme to widen its scope of cover to all services;

amend section 2(2A) to make section 23A(6) and section 26 applicable to non-registered schemes;

delete section 20B (4);

amend section 23A by decreasing the number of schemes in subsection (2) to 10 in respect of benefit schemes; by increasing the number of members to 500 000; and by altering the number of constituent bodies to more realistic numbers;

proposes consensus decisions on the deletion of section 32(2), (3) and (4);

expand section 39A(4) to allow Council to impose monetary penalties too; and expand subsection (6) to allow other parties to engage legal representatives too.

Response:

The proposals will be considered along with others received.

(ad) Purport:

Amend section 23A to entrench recognition of the Association by decreasing the number of schemes;

delete section 32(2), (3) and (4) dealing with guaranteed payment to suppliers;

amend section 20B(2) to qualify the provision in respect of benefit schemes so as to exclude equipment used by benefit schemes to provide medical and dental serices.

Response:

The proposals will be considered with others received.

(ae) Purport:

Amend section 32 to provide guaranteed payment equal to 70% of the scale of benefits; Provided that schemes may guarantee more if they wish;

allow schemes more flexibility.

Response:

The matters will be considered with others received.

(af) Purport:

Allow schemes more flexibility;

schemes should not be compelled to pay an account in full, but to pay according to its particular benefit schedule i.e. 70%.

Response:

The matters will be considered with others received.

(ag) Purport:

Removal from legislation of guaranteed payment.

Response:

The matter is under consideration along with others.

(ah) Purport:

Allow schemes more flexibility;

membership fees and benefits should be lowered i.e. dependants need not be covered;

the state ought to subsidise membership fees of certain groups;

measures should be introduced to promote competition between schemes.

Response:

The proposals will be considered with others received.

(ai) Purport:

Amend section 33 to allow insurers to provide health care cover according to insurance principles.

Response:

The minimum requirements prescribed in the Act are of cardinal importance in health care cover. Insurers have not come to the Department with firm suggestions regarding amendments to the Act in respect of health care cover.

(aj) Purport:

More flexibility is required which should include catastrophic costs and sudden chronic illness;

the state should cover the chronically ill and the poor under a new system;

present system is curative orienated rather than preventive;

a government scheme, like workmen's compensation is advocated.

Response:

Those who only insure for catastrophe may in many cases become a burden to the state for their day-to-day health care;

the state assists indigent people. Government spending should, however, not be caused to increase as a result of the proposed developments in the medical schemes movement;

medical schemes insure their members against sickness. Preventive cover is, however, not the prime objective of a sick fund;

a national scheme cannot be supported because of the cost involved and all the possibilities of abuse.

(ak) Purport:

A social health scheme is proposed and the privatisation of schemes rejected.

Response:

A social scheme cannot be afforded by means of taxation levied on the relatively small proportion of the economically productive population.

(al) Purport:

Amend section 20(a)(f) to compel an employer to continue paying contributions in respect of retrenched workers for a period.

Response:

The Medical Schemes Act cannot be utilised to regulate conditions of employment.

(am) Purport:

Amend section 38(2) to allow a married woman to join a scheme of her choice without having to be registered as her husband's dependant under his scheme.

Response:

The provision is aimed at the protection of the rights of a member's dependants therefore, the proposal is not acceptable.

(an) Purport:

No claims bonuses and package deals are proposed.

Reponse:

Payment of no-claims bonuses would mean that the sick and elderly will have to subsidise the young and healthy's bonuses;

package deals may compel persons to call upon state facilities for treatment in respect of conditions or services not covered under such deals;

(2) yes.

there are several interested parties playing large roles in the medical schemes movement. Their inputs in amendments to the Act, are of real importance.

Government policy is that the most important of these parties much reach consensus on their differences before amendments to the legislation can be considered. These parties have not yet reached agreement on all the aspects that may be involved in amending the legislation. For instance — the Medical Association of SA and the Representative Association of Medical Schemes issued a joint press release recently regarding the matters on which they are still negotiating.

Management bodies for schools

22. Mr K M ANDREW asked the Minister of Education and Development Aid:

With reference to his reply to Question No 7 on 21 February 1989, (a) what are the names of the persons serving on the management bodies at (i) Intshukumo Comprehensive School, Guguletu, and (ii) Malizo Secondary School, Khayelitsha, (b) when were they elected and (c) what are the names of the temporary teachers not re-appointed in respect of each of these schools?

B382E

The MINISTER OF EDUCATION AND DEVELOPMENT AID:

(a) (i) and (ii) In the view of the current circumstances and possible pressure on and intimidation of the members of the management bodies, I do not consider it desirable to make their names known.

(b) (i) Intshukumo Comprehensive School, Guguletu
7 August 1988

(ii) Malizo Secondary School, Khayelitsha
5 February 1989

(c) (i) Intshukumo Comprehensive School, Guguletu
P L Gagu
L Mafa
M P Kula
B W Mdingi

(ii) Malizo Secondary School, Khayelitsha
Mr X Lupuwana
Mr L J Sali
Miss T Majola
Miss N Y Nguga

Fezeka High School: Geography results

*23. Mr K M ANDREW asked the Minister of Education and Development Aid:

Whether the 1988 matriculation pupils at Fezeka High School, Guguletu, have received their Geography results; if not, (a) why not and (b) when is it anticipated that they will receive them; if so, (i) when did they receive them and (ii) what (aa) was the nature of and (bb) were the reasons for the delay in this regard?

B383E

The MINISTER OF EDUCATION AND DEVELOPMENT AID:

Yes;

(a) and (b) fall away.

(i) Results were made available on 4 January 1989.

(ii) (aa) and (bb) fall away.

Tax: deductibility of moneys for educational purposes

*24. Mr R M BURROWS asked the Minister of Finance:

(1) Whether he or his Department has initiated further investigations into the deductibility of moneys paid by individual taxpayers for educational purposes at school or college level; if not, why not; if so, (a) what matters are being investigated and (b) by what body;

(2) what is the current tax policy regarding individuals and/or companies who make donations to (a) tertiary institutions and (b) schools;

(3) whether there have been any changes in the above policy during the past five years; if not, why not; if so, what changes?

B384E

The MINISTER OF FINANCE:

(1) Yes.

(a) The provision of tax relief in respect of donations to primary schools.

(b) The Office of the Commissioner for

'98% of accidents can be prevented'

350 000 injured in workplace yearly — expert

GERALD REILLY

PRETORIA — More than 350 000 disabling injuries resulting from work place accidents occurred every year, National Occupational Safety Association's Ron McKinnon said yesterday.

He told the Association of Societies for Occupational Safety and Health symposium that more than 2 000 people were killed in the accidents.

Of those injured, 27 000 resulted in permanent disability, 145 000 in temporary disability, 7 000 in traumatic amputations and 900 people were blinded.

Serious

McKinnon stressed the figures represented only the tip of the iceberg.

For every accident that resulted in one serious injury there were 10 others resulting in minor injuries, and 30 others that resulted in some form of loss in property damage or business interruption.

It had been proved that 98% of such accidents were preventable.

Haggie Rands' M D Baker said legislation on occupational medicine was long overdue.

Unfortunately, the issue had been the victim of a number of problems including inter-departmental wrangles, lack of support from industrialists, government departmental inertia and others.

It was obvious in the early '70s that the state of occupational health in the industrial work force was poor.

Witwatersrand University lecturer Anne Patrick Hilton stressed the needs of working women were largely neglected in general as well as in occupational health.

In certain sectors such as the health, clerical and garment industries women accounted for most of the workforce.

Government mining engineer J B Raath said the accident rate in the mining industry had dropped in the past decade in spite of some severe accidents resulting in multiple fatalities.

He said the accident rate a 1 000 workers a year declined from 1,28 in 1977 to 0,97 in 1987.

The rehabilitation of waste and tailings dumps at abandoned asbestos mining areas in the northern Cape and north-eastern Transvaal was being given intensive attention.

I love you all: Disabled kids are told

THE mayor of Soweto Mr Sam Mkhwanazi yesterday visited the J C Merkin School of the disabled. He was given a big ovation when he told the children and teachers that he loved them all and that they were not the forgotten people in the community. He promised that he will attend to all their problems and would consider expanding the school or move them to a bigger venue. He is pictured holding little Muzi Pooe who was born without limbs.

249

Sowetan 16/3/89

Pic: PAUL TSHABALALA

Cape Times 16/3/89 299

'Collusion' is costing med-aid

By MEG BRITS

THE most common form of medical aid fraud — which is costing schemes an estimated R175 million a year — is collusion between members and suppliers of services.

The next most frequently occurring misuse of medical aid benefits is the lending of membership cards to non-members.

Mr Keith Hollis, chairman of the Association of Medical Aid Scheme Administrators, said yesterday that although there were no established fraud figures for SA, investigations over the past five years had indicated that they might correspond to those for the US.

These showed that fraud and other irregularities could account for between 5% and 10% of all medical aid claims. SA has 216 medical aid schemes generating claims worth about R3,5 billion a year, which means that false claims could total a minimum of R175m.

In fact, false claims — and the cost of eliminating them — have this year boosted medical aid subscriptions in SA by 7%, or around R16 a month for the average family.

Mr Hollis said it was possible for medical aid members, with the collusion of suppliers of health care services, to submit claims for services which had never been rendered or to submit inflated accounts.

Mr Rob Speedie, executive director of Rams, the Representative Association of Medical Aid Schemes, has said overuse of health care facilities, overtreatment and overprescription are among other factors which helped raise medical aid fees by 18% this year.

MEDICAL AID

Patients get the needle

Doctors are all set to follow private hospitals by rejecting tariffs offered by medical aid societies.

If no agreement is reached, medical aid patients of SA's 15 000 general practitioners (GPs) may soon be forced to pay the full consultation fee direct to the doctor.

It will be a further blow to patients already caught in the crossfire between medical aids and private hospitals. Following hospitals' rejection of medical aid benefits, patients are having to pay the difference.

In the latest health rumpus, talks between the Medical Association of SA (Masa) and the Representative Association of Medical Schemes (Rams) have broken down on the issue of the scale of benefits that medical aids are prepared to offer GPs. If agreement is not reached at the next meeting in April, patients will immediately feel the effects in their pockets.

About 80% of GPs currently adhere to the Rams scale of benefits, which allows them to charge R17,50 a consultation, to be paid by medical aid.

Medical aid societies announced late last year they had agreed with Masa that societies would in future pay only 70% — or R12,25 — of the R17,50, leaving patients to pay the difference themselves.

The decision was seen as a step towards discouraging unnecessary consultations, reducing medical aid payouts and therefore members' premiums. As GP consultations account for some 20% of medical aid costs, it was estimated the change could lead to savings of 6% on medical aid subscriptions.

But the Rams announcement has turned out to be premature. Says Masa general secretary Marais Viljoen: "Masa believes if the 70% is to be implemented, there should be a gradual phasing-in, so that doctors and patients will experience the least possible inconvenience."

Also, instead of Rams offering 70% of R17,50, Masa wants the R17,50 itself to represent 70% of an increased benefit. It wants the tariff to be pegged at R17,50 until that sum represents 70% of the overall benefit, and for tariffs to be 70% from then on.

Viljoen says an immediate reduction in the scale of benefits could force doctors in less affluent areas out of practice because their patients would not be able to afford the payments.

However, Affiliated Medical Aid executive chairman Tony Leveton says medical aids should be able to offer flexible packages to members and encourage them to pay a portion of their bill if it helps bring down subscriptions.

He wants the guaranteed medical aid-GP payment to be abolished, in favour of the patient paying his GP and claiming the money back from medical aid. He argues that once a financial relationship has been established between a patient and doctor, it acts as a disincentive against overservicing.

Clinic Holdings chairman Barney Hurwitz, who led the private hospitals' move to contract out of medical aid benefits, says it's time medical aids stopped penny pinching.

"The result of lower tariffs in real terms, whether for private hospitals or doctors, is inevitably going to be a lower level of service. If the tariff can't keep up with the rising cost of living, we have to make up for the lost income in other ways."

So far, the main beneficiary of the breakdown of medical aid negotiations has been insurance companies and a variety of hospital insurance packages. Hurwitz says these schemes will become increasingly important as medical aids no longer provide complete cover.

Crusader Life joint MD Bob Rowand says: "Early indications are that the media attention to medical aid disputes has highlighted the need for our packages in a very favourable way."

FINANCIAL MAIL MARCH 17 1989

CHESHIRE Homes is to build a home for the disabled in Daveyton with the help of a R250 000 donation from JCI. Seen here at the presentation ceremony are (standing) Mr S S Sinaba, the Mayor, and Mr Tom Boya, a councillor; and (seated) Mr Friday Mavuso, Mr Patrick Mabunda and Mr Jerry K Nkeli

Star 23/7/89 299

Cases of permanent damage reported

Anger over delay in skin cream ban

By Toni Younghusband, Medical Reporter

Studies conducted in the PWV area have shown that between 30 and 40 percent of black women using skin lightening creams have permanent skin damage.

Dr Marius Barnard, the PFP spokesman on health, said in Cape Town yesterday there was growing bewilderment and anger in medical and pharmaceutical circles at the Minister of Health's apparent reluctance to immediately ban skin lightening agents. Dr Barnard said had the creams been affecting white women, they would have been banned years ago.

Surveys conducted by doctors in Johannesburg and Pretoria estimate that up to 42 percent of women suffer permanent damage.

The creams contain a harmful substance called "hydroquinone" which, if used long enough, actually darkens the skin. The skin becomes coarse, with small raised bumps which eventually join together to form larger raised areas. These changes are permanent and irreversible.

In a recent newspaper interview, one manufacturer said all evidence of the damaging effects of skin lighteners was from cases prior to 1983 when the amount of hydroquinone was cut from around five percent to two percent.

However, a Pretoria University dermatologist says in the latest edition of the British *Journal of Dermatology* that 46 percent of women using the low dosage creams show skin damage.

The skin-lightening industry is believed to be worth about R80 million a year.

Dermatologist

A Johannesburg dermatologist said a study she conducted at the Hillbrow Hospital in the gynaecological outpatients department showed that 28 of 100 women examined had skin damage as a result of these creams.

The doctor, who may not be named, pointed out that the study was done on a random sample of patients.

Dr Nick Hardwick, formerly of the University of Pretoria and now living in London, found in a recent survey that 35 percent of all black people examined at the outpatients department of a Pretoria hospital showed signs of hydroquinone damage.

Of 142 women examined, 60 had damaged skin. Of the men examined, 15 percent showed signs of permanent damage.

Consumer organisations and the medical and pharmaceutical professions have made repeated calls on Dr Willie van Niekerk to ban the creams. They were to have been banned on July 1 this year but Dr van Niekerk announced he would grant manufacturers a "three-year phasing-out period".

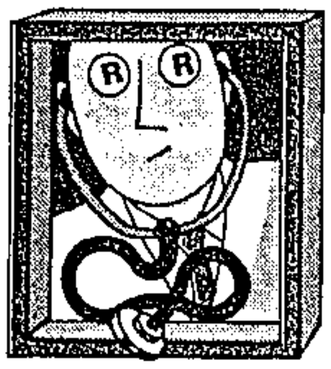
(299)

Continue

MEDICAL COSTS

Crisis in the offing

The solution lies in facing unpleasant reality



Medical aid has traditionally been regarded as a standard employment benefit. In fact, it's fast becoming a luxury — as soaring premiums and high excess payments demonstrate. Is the system at fault — or the doctors? Is there a way out of spiralling costs?

Subscriptions have been increasing at a compound rate of 20% since 1981, substantially above inflation. If this continues — and there is no reason to believe it won't — by the year 2000 the average subscription will increase from R120 to R890 a month, and the top rate from R300 to R2 200, which represents a 740% increase. A compound inflation rate of 15% would mean an increase of 465% in the CPI.

The schemes were devised to assist companies and individuals to provide security and peace of mind and were based on normal health insurance criteria — affordability and balancing the books were the *sine qua nons*. Now the cost equation has become seriously unbalanced.

Existing members feel growing resentment at high subscriptions. Sales manager of Mapp medical aid brokers Bryan Sidders points out that there is a great disparity in the value for money provided by schemes. "While the life assurers offer almost parity products, this is far from the case with medical aids," he says. "Most medical aid schemes have an annual limit on benefits, which means that they don't pay out medical expenses in full when you need them."

And just as rates are skyrocketing, they are becoming progressively less comprehensive. Many private hospitals now charge more than the maximum benefit allowed and medical aids may soon have to pay only 70% of the tariff applicable to the cost of visiting a general practitioner.

Meanwhile, more than a fifth of GPs have contracted out of the scale of benefits and often charge twice as much. Of course, that is their right. You don't *have* to go to them. Their justification is that even though medical aid subscriptions have leaped, they claim their living standards have been eroded.

Certainly, medical inflation has increased much faster than general inflation. Drugs, which will increase in cost by at least 25% this year, have been particularly prominent in the cost factor, because of the need to import primary ingredients and the increasing cost of research. Or so it is argued by the pharmaceutical companies.

Afrox chairman Peter Joubert argues that the remuneration of hospitals and doctors has gone down in real terms. Legislation allows the medical schemes to set tariffs, after discussion with the suppliers of services, but there is no real negotiation. Indeed, Joubert describes the Representative Association of Medical Schemes (Rams) as a "co-operative control board ... Medical aids like to take the moral high ground but their income consists of a guaranteed percentage of turnover, so they're sitting pretty."

Joubert adds that the medical aids haven't taken cognisance of the expense involved in importing new equipment — and if the hospital groups don't get a return they won't be able to bring it in, and SA's standard of health care will rapidly regress.

Little could have been done to contain this expenditure — especially given the often extravagant demands of the white health consumer. But *some* costs can be contained.

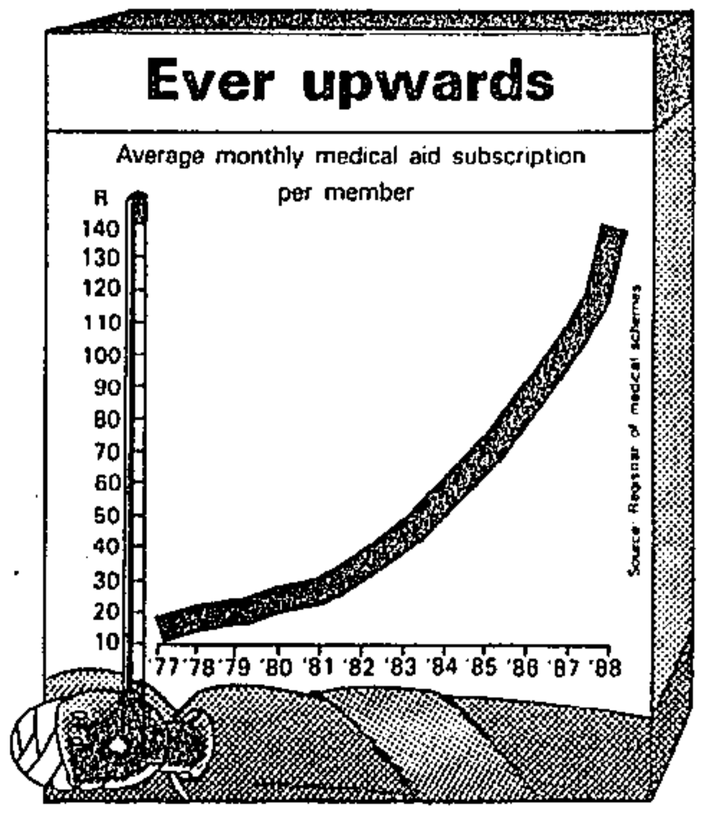
As healthcare consultant Dr John Cowlin points out, the current structure of the medical-aid industry encourages over-servicing — over-prescription, unnecessary referrals — not only by the suppliers and patients but also the medical-aid administrators.

"The administrators' fee is based on a percentage of up to 8% of their subscription income, so when subscriptions rise their fee increases," he says.

Rams executive director Rob Speedie says patients and doctors should learn to be more responsible about the use of benefits. Instead of taking the view that "I've paid for health care already, I'll use it whenever I can," the patient should remember that less use of primary health care will bring subscriptions down in the long run.

Some hope, many would argue. Indeed, Speedie himself says: "There is unlikely to be a reduction in unnecessary visits to the doctor unless there is a proper financial disincentive. At the moment, some schemes have a kind of disincentive as they only pay 80% of the consultancy fee — but the balance isn't charged to the member at the time of the consultation, but later on through a payroll deduction, and so it isn't as powerful a disincentive as it could be."

But there is nothing that the medical-aid schemes, run by financiers and not medical practitioners, can do to prevent patients from going to their doctors for whatever reason.

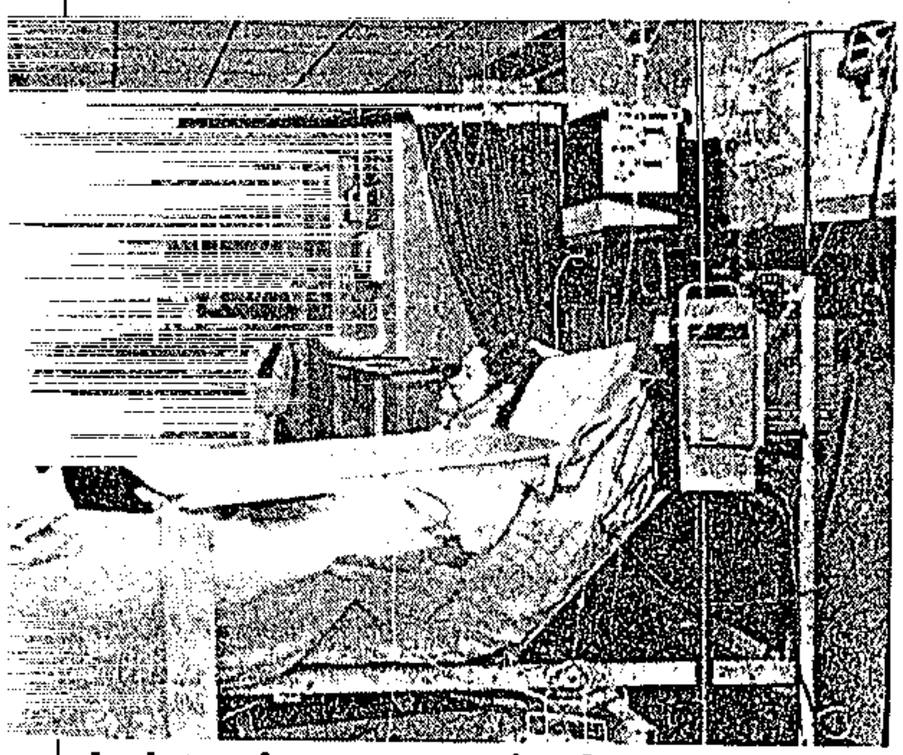


This does give enormous discretionary powers to the doctors who can prescribe the drug of their choice — too often the latest state-of-the-art antibiotic when a more conventional medicine or even a generic would be suitable.

Some doctors appear to process patients as if on a production line. If a GP charges within the scale — now R17,50 a visit — the schemes are obliged to pay him direct. A GP who charges more, or contracts out, gets the money from his patient, often upfront, and then the scheme pays out its portion.

Speedie says the tendency to over-service, or raise incomes by increasing volumes, is far stronger for doctors who charge within the scale of benefits. "Acres of statistics have shown that for every visit to a doctor who contracts out, we are paying for 1,33 visits to doctors who enjoy the guaranteed payment. Obviously, the patient who pays R25 for a consulation in (Johannesburg's) northern suburbs will take more interest in getting value for money; and, similarly, the doctor will take more care as there is a direct financial relationship between doctor and patient."

But the secretary general of the Medical Association of SA (Masa) Marais Viljoen considers the guaranteed payment to be an



In intensive care ... hard on the wallet

essential safeguard, even though it is well below its own recommended tariff: "Masa makes no excuses for its efforts to see to it that doctors are adequately remunerated for their services and that they should enjoy financial security.

"Unfortunately, many doctors are forced by circumstances, such as the risk of bad debts and the socio-economic conditions of their patients, to adhere to the scale of benefits — which is now barely more than half of Masa's own recommended tariff."

That is a comparison over which some scepticism is advisable: the recommended tariffs would in the normal world of commerce be regarded as restrictive trading.

But Joubert says Rams must accept that if the practitioners don't get the increases they need, then they're going to make up for this by pushing for greater volumes.

Offer a range

Affiliated Medical Aid executive chairman Tony Leveton says the medical aids are expected to provide a Rolls-Royce service even to those who don't want or need it. They should be allowed to offer a range of options.

To most healthy young people medical aid subscriptions seem high. But the schemes are not allowed to offer discount premiums for healthier individuals, such as non-smokers, and they aren't allowed to give no-claims bonuses. The only factors that are permitted to determine subscriptions are the patient's income, and the number of dependants.

Moreover, the type of medical aid and the administrator is chosen by the employer and the employee has no other option. Leveton says: "Options tailored for individual employees should be a prospect in the future, though we would have to watch our underwriting very closely."

Leveton hopes SA will learn from overseas experience — medical aids must turn from being passive financiers to active providers. But, "the trouble is, we still have archaic guild rules in the pharmaceutical and medical professions. These prevent group practice, which makes it impossible for a medical aid to employ its own healthcare team."

Speedie says the schemes are keen to look at Health Maintenance Organisations (HMOs). Under this system, for a set monthly fee, and no more, the member will obtain the services of those medical practitioners who have contracted to the scheme.

Masa has two reservations about HMOs. It is worried that they could relegate the standard of service to motives such as productivity and time efficiency. It also says HMOs could monopolise health services in specific areas so that patients won't have any free choice of services.

However, as Speedie notes: "The complete freedom to see the doctor of one's choice would be eliminated but there would have to be a trade-off to reduce costs. If there were any savings they would be shared among the members by reduced subscriptions. And a healthcare professional would be charged with ensuring that standards aren't sacrificed for the sake of saving money."

Cowlin says that if they're properly marketed, HMOs could fulfil a major role in financing health care for the poorer employed sectors, especially blacks. "The stark reality facing the bulk of workers is the overworked township GP and overcrowded State hospitals. Medical aid in its existing form is totally out of reach."

The immediate priority for medical aids is undoubtedly medicine costs. Speedie says that even before HMOs are set up, medical schemes should have the right to run their own dispensaries, enabling them to sell medicines to their members virtually at cost. At the moment there is a 17,5% mark-up for wholesalers and a 50% mark-up for retailers. The rules of the Pharmaceutical Society do not allow pharmacists to advertise prescription medicine prices. The Pharmarama in Pretoria, owned by former SA Druggists executives Gerhard Slabbert and Malcolm Abramson, first broke ranks.

It offers a 25% discount on prescription medicines, though it never advertised this, and has been hounded by the society which has brought complaints against it on behalf of the bulk of pharmacists. Pharmacists blame the "greedy" multinationals for profiteering and high prices — a familiar protectionist argument — while doing nothing to reduce prices at their own level.

The private hospital groups also have a profligate image, as any visitor to these ultra high-tech marble-floored, fountained palaces can testify. But, of course, they exist in response to the demands of the market and as Dick Williamson, GM of Afrox Healthcare, says: "No other industry is told what equipment it should buy and when. We aren't allowed to compete on price, so we have to compete on services and facilities."

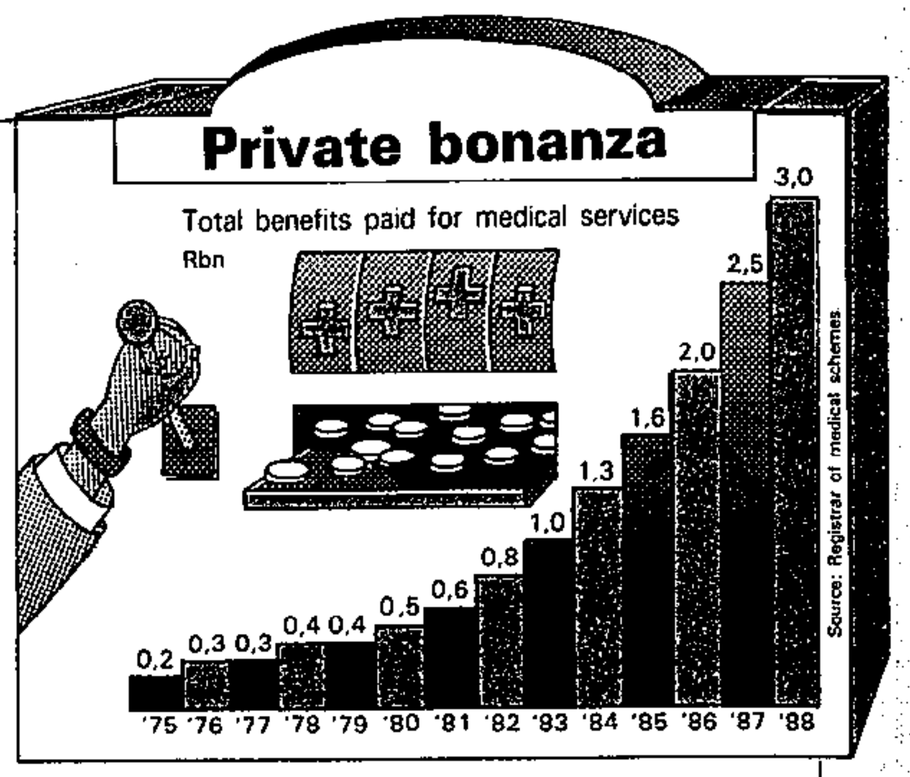
The industry likes to compare itself to the hotel sector, and says it offers value for money in comparison. But, perhaps, just as with hotels, there is a surfeit of upmarket hospitals and a lack of budget facilities. One group attempting to be a no-frills "City Lodge" of private hospitals is Medicor. Executive chairman David Horwitz notes: "In the past two years Medicor has led the decentralisation of hospitals away from metropolitan areas. The demand for hospitalisation in SA in the future will be of a Second- and Third-World nature. We believe that government regulations require urgent redrafting to enable the private-hospital industry to provide services to these sectors."

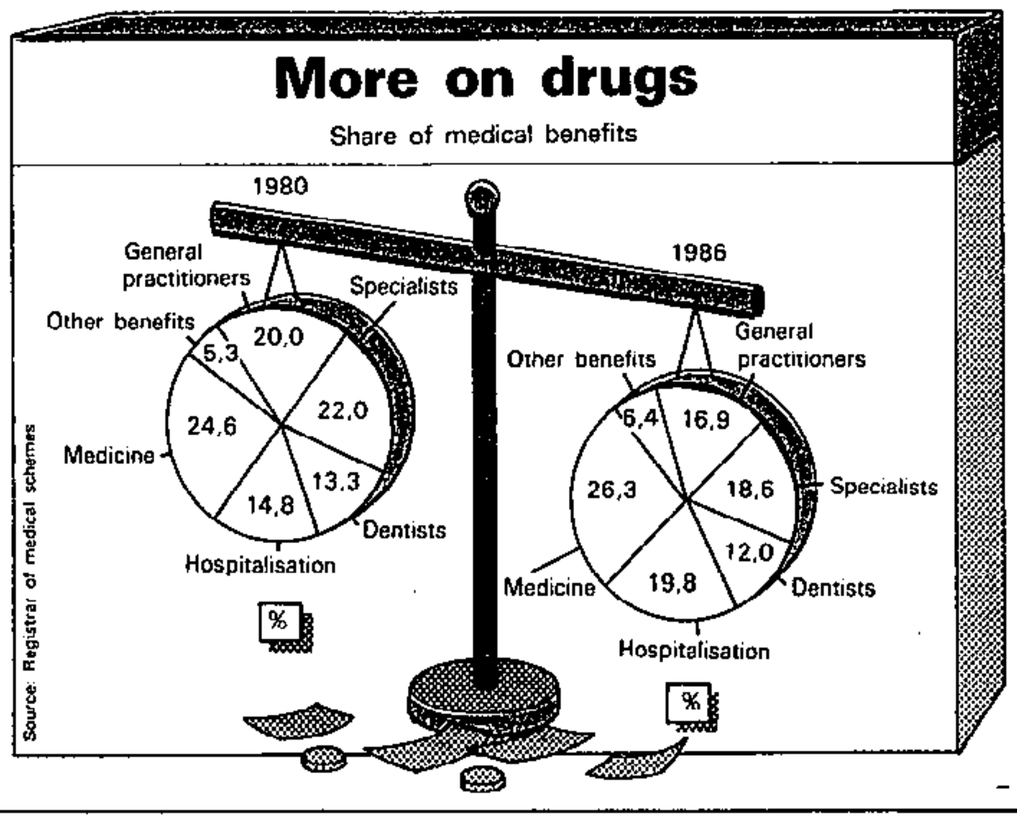
Healthcare cost escalations are a worldwide phenomenon. In Europe and North America the main problem is the "greying" of the population — an ever higher proportion of old people living longer. This is also true of the white population in SA, who still make up 64% of medical aid members.

Little can be done in the short term to reduce the cost of equipment and medicine itself — certainly not through further control and regulation — but a great deal can be done to reduce wastage. In the age of deregulation, both the trade practices of doctors and pharmacists warrant at least an economic review. Greater recognition of this by the medical aid schemes — and more effective lobbying to have archaic laws changed — could lead to more innovative approaches. That applies to doctors and pharmacists, too. Their tendency to levitate above commercial motive, while desiring its fruits, reduces their ability to face realities.

American statistics show that the greater part of an individual's health costs generally occur in the last six months of his or her life. Medical science can now prolong life for a short period — but at enormous cost. As long as society regards this expensive prolongation as everyone's inalienable right, there is going to be upward pressure on health costs.

Medical science has not yet reached a stage at which the cost of its application is irrelevant. Perhaps in due course that will happen. But until it does, prosperity, even in the most advanced countries, is both relative and finite — and insufficient to keep every one healthy. Medical insurance needs to be designed around that reality. ■





Govt asked to limit legal drugs on market

BY HELEN GRANGE

As South Africa is fast becoming one of the highest alcohol and drug consumer countries in the world, there is only one method to control abuse effectively — limit the availability of legal drugs.

This is the opinion of Professor Thomas Neslund, executive director of the International Commission for the Prevention of Alcoholism and Drug Dependency, who is currently visiting South Africa as a guest of the South African National Council on Alcoholism and Drug Dependence (Sanca).

"Consumption of alcohol and drugs in South Africa is increasing at an alarming rate, with each drinker consuming R947 worth of liquor per year.

"In 1985, South Africans spent R4 168 million on alcohol. The revenue derived from the sale of alcoholic beverages, in the form of sales tax and excise duty amounted to R1 163 million," said Professor Neslund.

Statistics

Further, statistics showed that there was a minumum of 353 000 alcoholics in South Africa, which meant there were 24 alcoholics out of every 1 000 adults. This proved South Africa to be in the top five alcohol consumer countries in the world.

A Sanca survey showed that urban black males had the most serious drinking problem and that males betweeh the age of 16 and 18 consumed relatively high quantities of alcohol.

Professor Neslund points out that the money spent worldwide on alcohol and drugs could feed and house every individual adequately.

The main solution to cutting down alcohol and drug dependence, says Professor Neslund, is to reduce the availability of legal drugs.

"There is a strong relationship between the use of alcohol and tobacco, just as there is a strong relationship between smoking and the use of other drugs. Seventy-eight percent of smokers are drinkers and a substantial percentage of smokers are found to use marijuana and other illegal drugs.

Gateway drugs

"Smoking and alcohol are gateway drugs to other drugs, and the answer is to limit these legal drugs. In addition, the use of drugs has proved to be strongly related to crime," says Professor Neslund.

Professor Neslund says the South African Government should further address the problem by raising the legal drinking age to 21; limiting the outlets for alcohol and drugs; increasing prices and tax on alcohol and cigarettes; reducing television and media advertising of the items.

He also suggested reducing alcohol content in each beverage by 50 percent.

"Taxes from drugs should be injected into organisations like Sanca so that more can be spent on prevention strategies such as education, and media campaigning," he said.

"By simply making drug busts, only the surface of the drug problem is addressed. Governments also tend to have a fatalistic attitude to the ever-increasing demand for drugs and alcohol, believing that it is the public's responsibility to reduce demand.

"I believe it is the government's responsibility to educate the public and reduce the supply," he said.

government's recent stand on the ozone layer issued and urging more support for the UN environment issue.

Star 3/4/89

Sign language dictionary to help deaf cross barriers

294

A Johannesburg speech pathologist has found a way to cross the many racial and cultural barriers which limit communication between deaf people.

Professor Claire Penn, Associate Professor of the Department of Speech Pathology and Audiology at Wits, is compiling South Africa's first sign language dictionary of about 3 500 words, reflecting the signing variations used by all deaf groups throughout the country.

"One of the greatest misconceptions hearing people have of sign language is that it is, or should be, universal and therefore understood by the deaf throughout the world.

"Sign language is subject to the same regional, cultural, social and racial influences that affect any other language.

"There is no reason why deaf individuals from different races, countries or cultural groups should understand each other any better than hearing people of equivalent groups," says Professor Penn.

She heads a Sign Language Board which will meet seven times during the year.

The board has representatives of all races, cultural backgrounds and languages who discuss and compile the sign variations of each group.

Professor Penn says the compilation of the dictionary is "going wonderfully. We have our first 420 words and are now looking for a publisher to put them into print.

Professor Claire Penn

"The words and their accompanying graphics are on computer but we would like to print about 55 000 copies.

"We are now concentrating on words used by pre-school and primary school deaf children and will progress from there."

The board will meet again in June to compile the next group of words.

Sotheby's wanted the

299

Ageing population adds to crisis

SA health services 'can only get worse'

Pretoria Correspondent

Long-term prospects for health services in South Africa are bleak.

This was said at a South African Nursing Council meeting in Pretoria yesterday by the Director-General of the Department of National Health and Population Development, Dr C F Slabber, who added that a decrease in student nurses and poor distribution of registered nurses was a "double problem".

"With an ageing population and a declining birthrate, the situation can only get worse," he said.

However, he believed South Africa's health services' personnel had the expertise and dedication required to meet the country's needs in the future provided they worked in close co-operation.

South Africa, with 13 other countries, fell within the lowest range of middle-income countries, said Dr Slabber.

Funds in the Republic for health services were limited and would remain so in the "foreseeable future".

The country could not afford First World health services. The quality of services ranged from standards comparable with the best in the world in urban areas to "problematic" in the rural areas.

For his department to provide an affordable health service of an acceptable standard to all South Africans in the future, the service would have to be based on primary health care.

"The nurse is essential to the planning, implementation and evaluation of primary health care in the RSA," Dr Slabber said.

However, despite an increase in nursing personnel of 31 524 since 1980, the country did not have enough nurses in the "right categories, at the right time and in the right places".

Dr Slabber said many problems related to a lack of a national health policy.

The National Health Policy Council (NHPC) had reaffirmed a need for planned primary health care, he said, adding that the Health Matters Advisory Committee would meet in May to determine national health goals and priorities and to develop a national health plan and a broad implementation strategy.

Other issues that needed attention were the definition of the roles of the different health professionals and an improvement in the working and living conditions of nurses.

Prevention the only cure – experts

Star 8/4/89

299

PREVENTIVE health measures would do much to bring down South Africa's infant mortality rate and promote a stronger economy, the Department of National Health and Population Development has pointed out.

In its World Health Day message yesterday, the department said South Africa could not afford to let its children or the economically active die from preventable diseases. It was time for each and every individual to learn preventive health measures.

MEDICAL REPORTER

The World Health Organisation (WHO) has encouraged health authorities to promote health rather than discuss disease. "Every man, woman and child should be in a position to choose a healthy way of life," said Dr Hiroshi Nakajima, the director-general of the WHO.

He said in order for preventive health measures to be effective, each person had to be aware of how to promote a better way of life. It was for this reason that the WHO had chosen "Let's talk health" as this year's World Health Day theme.

To promote healthier lifestyles, the department has, in conjunction with other organisations, arranged a number of activities focusing on prevention rather than cure.

These include an exhibition at the Rand Afrikaans University where blood pressure and cholesterol levels will be measured, exhibitions at public libraries throughout the country and lectures at Potchefstroom University on low blood pressure and correct eating.

● See Page 10.

Braille computer needed

Star 11/4/89 299

Medical Reporter

A young Johannesburg man, who was blinded during a township assault 10 years ago, is trying to raise money to buy a braille computer which will help him complete his legal studies.

Mr Brian Mashile (25) completed his law degree at Wits and is currently serving his articles with a firm of city attorneys.

As an articled clerk Mr Mashile does not earn a high salary. He also has to pay for secretarial assistance as he is unable to perform certain tasks due to his sight handicap.

He is now trying to raise R50 000 to buy a personal computer with a voice synthesizer and a braille keyboard. The computer is able to read and will enable Mr Mashile to read his mail and conduct necessary legal correspondence.

For further information contact the fund administrator, Rev Roger Wiles (011) 726-4535.

Experts' plan against abuse of substances

By Toni Younghusband, Medical Reporter

Experts on alcohol and drug abuse met in Johannesburg yesterday to discuss implementation of a nationwide plan to combat the growing incidence of drug abuse in this country.

At a press conference after the meeting, Dr Wallace Anderson of the Department of Health, said every member of the community had to become involved in the plan.

"We need doctors, teachers, nurses, welfare organisations and even parents. The whole community must become involved if we are to find a solution to this growing problem," he said.

STRESS

Accurate statistics are not available on drug and alcohol abuse in South Africa but it is estimated that there are at least 353 000 alcoholics nationwide. During 1985, South Africans spent more than R4 million on alcohol.

One area of great concern to health authorities was the growing incidence of stress-related drug abuse. More and more women were taking tranquilisers to cope with stress while alcoholism was on the rise among urbanised men.

Dr Sylvain de Miranda, a director of the South African National Council on Alcohol and Drug Dependence, said if any preventative plan was to work there had to be a unification of all groups dealing with drug and alcohol treatment.

R20-million vaccine facility to make SA self-sufficient

Star 14/4/89

By Toni Younghusband
Medical Reporter

The South African Institute for Medical Research has commissioned a R20 million vaccine production facility which it hopes will make this country independent of imported vaccines.

At the launch of the institute's 75 th anniversary celebrations last night, Professor Jack Metz said the new serum and vaccine production facility was one of the most modern in the world.

"For very many years now the institute has produced almost all the bacterial vaccines used in this country.

"With the commissioning of the new facility we will increase both the scope and amount of our vaccines with the aim ultimately of making South Africa independent of imported vaccines and also to compete on the international market," said Professor Metz.

Professor Metz said during the anniversary year there would also be much development in the Aids field.

"Last year the institute established the first Aids Training and Information Centre in the country.

"We have this year received additional funding for the centre from the private sector and we will double the present number of staff," he said.

He said the institute had also just opened a new molecular biology laboratory and one of the major programmes in this laboratory would be fundamental studies on certain enzymes of the Aids virus as targets for the development of therapeutic drugs against the virus.

Professor Metz expressed the hope that all private organisations who had financially supported the institute in the past would continue to do so.

40 000 to help cancer drive

Star 14/4/87 299

By Toni Younghusband,
Medical Reporter

The National Cancer Association launches one of the country's largest volunteer-based campaigns tomorrow in a bid to raise over R4-million.

About 40 000 volunteers — or "toktokkies", as they are known — will be visiting homes countrywide until the end of June to distribute information leaflets on cancer and to collect funds.

Cancer in one form or another kills more South Africans each year than any other illness except heart disease.

However, if treated early enough 50 percent of patients can recover.

"There was a time when a diagnosis of cancer was considered a death sentence — but that has changed.

ACTIVE LIVES

"Cancer in its early stages is one of the most curable of all serious diseases. Thousands of South Africans who have cancer and receive prompt treatment could be pronounced cured and go on to live active, productive lives," NCA president Professor J D Anderson points out.

But members of the public must know what early warning signs to look for, and the information supplied by the "toktokkies" will tell them.

The NCA is not government sponsored, yet the demand for the free services it offers to cancer victims and their families has mushroomed.

Expenditure on services rendered to cancer patients and their dependents has increased from R2,25 million in 1986/87 to R6,18 million in the 1987/88 financial year. The budget for the 1988/89 financial year is forecast to be in the region of R12 million.

44 225 were repatriated in terms of section 16.

(ii) (aa) WHITES

United Kingdom	6
Portugal	2
Greece	1
Italy	2
Germany	1
USA	1
Zimbabwe	1
	14

BLACKS

Lesotho	34
Swaziland	6
Bophuthatswana	4
Botswana	2
Venda	6
Zimbabwe	4
Mozambique	33
Transkei	68
Ciskei	7
Malawi	2
	166

(bb)

Zimbabwe	3 527
Mozambique	33 446
Botswana	757
Tanzania	7
Lesotho	4 400
Swaziland	1 839
Ghana	1
Malawi	248
	44 225

HOUSE OF ASSEMBLY

QUESTIONS

†Indicates translated version.

For written reply:

General Affairs:

Internal Security Act: persons detained under section 31(1)

254. Mrs H SUZMAN asked the Minister of Justice:

(1) How many persons in each race group were detained in terms of section 31(1) of the Internal Security Act, No 74 of 1982, (a) in 1988 and (b) as at 31 December 1988;

(2) for how long had each such person been detained as at 31 December 1988?

B559E

The MINISTER OF JUSTICE:

(1) (a) and (b). The information as far as the race groups are concerned, is not readily available.

(2)

Number of persons	*Period*
1	3 days
1	17 days
1	23 days
4	1 month 5 days
3	1 month 15 days
1	3 months
2	7 months 21 days
1	7 months 29 days
2	9 months 6 days

Own Affairs:

Remedial teachers

299

44. Mr R R HULLEY asked the Minister of Education and Culture:

(1) (a) How many qualified remedial teachers were employed at schools falling under the control of his Department, and (b) what was the (i) pupil: remedial teacher ratio and (ii) school: remedial teacher ratio at such schools, in 1975 and 1988, respectively;

(2) whether the (a) number and (b) ratio of remedial teachers varies from province to province; if so, (i) what are the differences and (ii) why;

(3) whether there are any schools falling under the control of his Department which cater specifically for children requiring remedial teaching; if not, why not; if so, (a) which schools and (b) where are they situated;

(4) whether the training and employment of remedial teachers for schools falling under the control of his Department is regarded as a top priority by his Department; if so, what steps are being taken in this respect; if not, (a) why not and (b) what is regarded as having higher priority?

B515E

The MINISTER OF EDUCATION AND CULTURE:

(1)

		1975	1988
(a)	Cape	19	154
	Natal	63	127
	OFS	23	109
	Transvaal	**	300
*(b) (i)	Cape	7813,7 : 1	836,2 : 1
	Natal	790 : 1	432 : 1
	OFS	3033 : 1	684 : 1
	Transvaal		979,59 : 1
(ii)	Cape	40,2 : 1	3,9 : 1
	Natal	3,05 : 1	1,5 : 1
	OFS	9,5 : 1	1,8 : 1
	Transvaal	**	2,36 : 1

* based on primary schools in the main stream and schools which admit pupils with specific learning disabilities; remedial education specialists attached to educational aid services are not included

** not available.

(2) (a) Yes,

(b) Yes,

(i) see (1) (a) and (b),

(ii) each province makes provision for children with learning problems according to its own needs;

(3) yes.

(a)	(b)
NATAL	
Biggarsberg Primary	Glencoe
Maritzburg Model	Pietermaritzburg
Glen Park	Pinetown
Livingstone	Durban
Zululand Remedial Unit	Empangeni
Browns School	Durban and Pietermaritzburg
Kenmont School	Durban
Open Air School	Durban
OFS	
Martie du Plessis School	Bloemfontein
TRANSVAAL	
Hope School	Johannesburg
Forest Town School	Johannesburg
Frances Vorweg School	Johannesburg
Transvalia School	Pretoria
New Hope School	Pretoria
Pretoria School	Pretoria
Prospectus Novus School	Pretoria
Meerhof School	Hartbeespoort
WK du Plessis School	Springs
Protea School	Springs
Murial Brand School	Brakpan
West Rand School	Krugersdorp
Lantern School	Roodepoort
School of Achievement	Germiston
CAPE	
Elizabeth Conradie School	Kimberley
Jan Kriel School	Kuilsriver
Cape Receife School	Port Elizabeth
Paarl School	Brackenfell
Vista Nova School	Rondebosch
Tafelberg School	Cape Town

(4) Yes, in the main stream pupils receive remedial teaching individually, in groups or in remedial classes. Child guidance clinics give specialist aid to pupils, parents and teachers. Apart from the schools for the neurally handicapped indicated in 3(a), all schools for specialised education and all child care and reform schools have full-time posts for remedial education. The Department offers programmes for the in-service training of remedial teachers as well as diploma courses in remedial education and provides bursaries for this study field.

HOUSE OF DELEGATES

QUESTIONS

†Indicates translation.

For written reply:

Own Affairs:

Universities: cuts in budgets

4. Mr M RAJAB asked the Minister of Education and Culture:

(1) Whether cuts have been made in the budgets of universities falling under his Department in respect of the 1988-89 financial year; if so, what cuts;

(2) whether he will make a statement on the matter?

D53E

The MINISTER OF EDUCATION AND CULTURE:

(1) No.

(2) No.

Expenditure per school

5. Mr M RAJAB asked the Minister of Education and Culture:

What was the average expenditure, excluding expenditure of a capital nature, per school falling under the control of his Department in 1987 and 1988, respectively?

D54E

The MINISTER OF EDUCATION AND CULTURE:

1987: R802 769 (excluding special schools)
1988: Not available as yet.

Average expenditure on Indian school pupils

6. Mr M RAJAB asked the Minister of Education and Culture:

What was the average expenditure, (a) including and (b) excluding expenditure of a capital nature, on Indian school pupils in each province of the Republic in the 1986-87 financial year?

D55E

The MINISTER OF EDUCATION AND CULTURE:

(a) and (b) Figures not maintained according to provinces.

Schools: changes in financial assistance

7. Mr P T POOVALINGAM asked the Minister of Education and Culture:

Whether schools falling under his Department were advised of specific changes in the financial assistance that they would receive in respect of (a) 1987 and (b) 1988; if so, when in each case?

D56E

The MINISTER OF EDUCATION AND CULTURE:

(a) No.

(b) Yes.

On 13 May 1988, State-aided Schools were advised of revised rates in maintenance subsidies through their respective grantees.

Teachers: applications refused

8. Mr P T POOVALINGAM asked the Minister of Education and Culture:

Whether any applications from suitably qualified (a) primary and (b) secondary school teachers for posts at schools under his control were refused by his Department in 1988 and 1989, respectively; if so, (i) why, (ii) how many, (iii) in which departmental regions, and (iv) in respect of what date is this information furnished, in each case?

D57E

The MINISTER OF EDUCATION AND CULTURE:

(a) 1988 and 1989: Yes.

(b) 1988 and 1989: Yes.

(i) Applications received from foreigners and White South Africans were refused as the Department has a number of applications from suitably qualified Indian educators on record.

(ii)

	PRIMARY	SECONDARY
1988:	2	3
1989	2	4

Patients may now ask for cash discounts

Doctors are now permitted to offer patients discount for cash.

The South African Medical and Dental Council ruled yesterday that doctors be permitted to offer cash discounts provided they do not advertise this practice in advance.

They are not restricted in the amount of discount they may offer.

This is the first time the SAMDC has permitted discounting.

Star 20/4/89

No abortion on demand – Minister

297

CAPE TOWN — The Government would not allow abortion on demand, and "that is final", the Minister of National Health and Population Development, Dr Willie van Niekerk, said in Parliament yesterday while replying to the health vote.

Earlier in the debate Mrs Helen Suzman (DP Houghton) had appealed for a new commission of inquiry into the working and efficacy of the Abortion and Sterilisation Act.

She had said the existing population development programme should be backed by a more liberal abortion law.

CONCERNED

In reply, Dr van Niekerk said it was extremely effective to kill foetuses. "Why not kill off babies?" he asked.

He said the Child Care Act was under review but proposed amendments would not be able to be submitted to Parliament during the present sitting.

Dr van Niekerk said he was extremely concerned about child abuse and every effort was being made to combat it.

On the question of unequal treatment of patients of colour as compared to that afforded to whites, he appealed to members to bring any such incidents to his attention. — Sapa.

Children enjoy an ACC workshop

By VICTOR METSOAMERE

TWO groups of abandoned and mentally handicapped children had a fun-filled day during an arts workshop conducted by the Afrika Cultural Centre in Fordsburg.

The children came from the Ngubane Centre for Abandoned Children in Kliptown and the Harvey Cohen Training Centre for Handicapped Children in Eldorado Park.

They went through improvisation classes, mime, music and art workshops. Benjy Francis, ACC director, conducted the classes with Ngubane's Rafik Badat and Harvey Cohen's Yunus Cassim. Acting students at ACC assisted in the workshops.

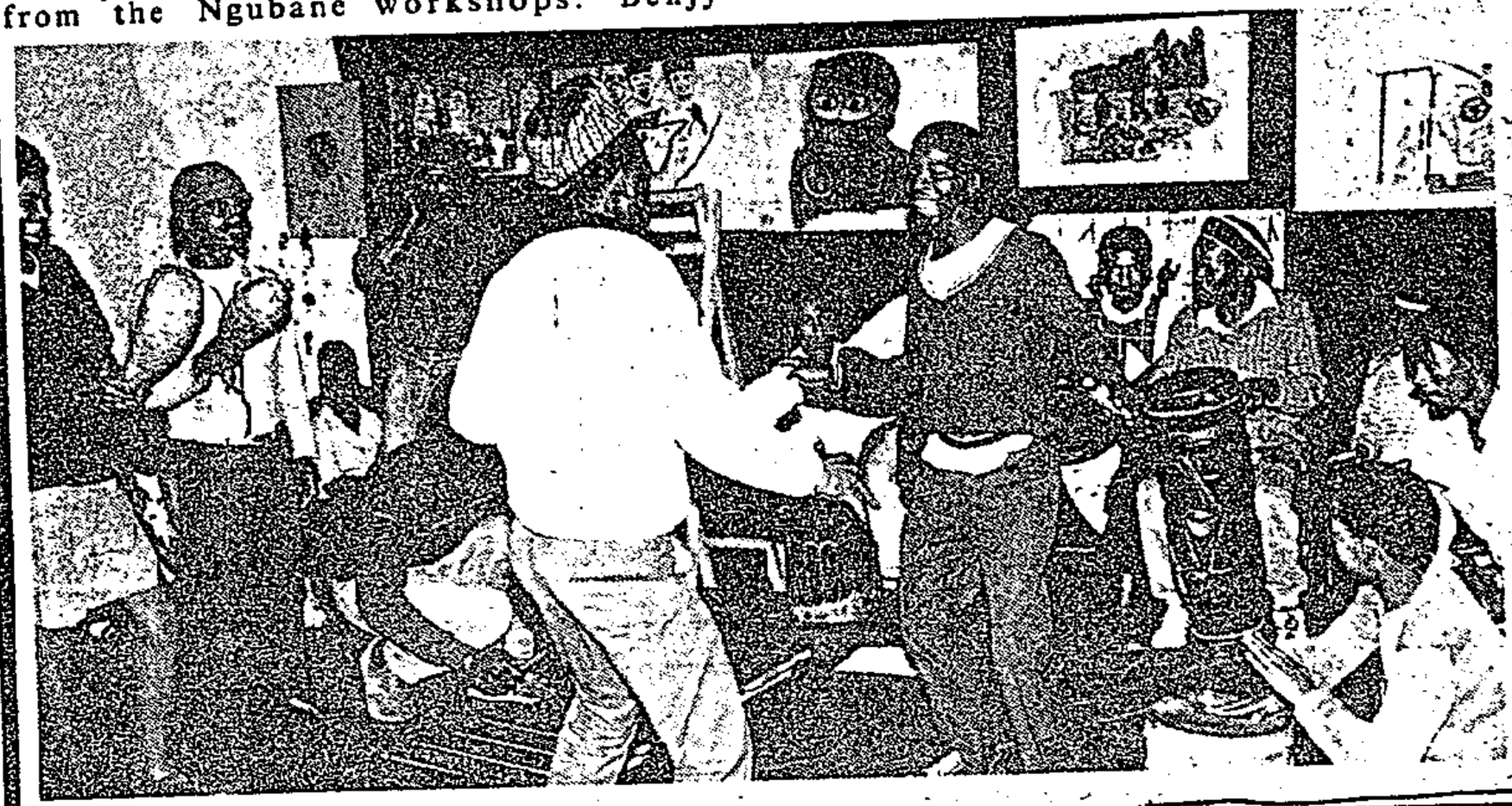
Both Badat and Cassim were thrilled to have taken the two groups on such a stimulating outing.

Badat said: "The children at Ngubane are rarely given such a treat. Most of them come from broken homes due to economic reasons. This occasion gives them a chance to feel wanted and it boosts their morals".

Cassim said: "We have a number of activities at the Harvey Cohen Centre. But the children need to be brought to art centres to see different arts activities and to mix with 'normal' children."

Some had an opportunity to play drums and various other musical instruments, while others danced and did all sorts of creative things like drawing and painting. Their bright faces confirmed their happiness.

Francis said the workshops will be held regularly with an emphasis put on leading "forgotten people on a way to self-discovery". Community organisations and art centres interested in taking their children to the ACC's art workshops can telephone (011) 838-3034.



DANCING time: There was fun all around as drums were pounded, people danced, sang and ululated no end.
Pics: MBUZENI ZULU

Closing date for

Pill for under-age girls 'acceptable'

Karen Stander

CAPE TOWN — Prescribing the "pill" for girls under the age of consent was legally acceptable, medical law expert Professor S A Strauss said in Stellenbosch recently.

He advised doctors not to inform parents against the child's will.

Professor Strauss told a family planning congress at Stellenbosch University's medical school that the doctor was sometimes in a better position than a parent to judge what was in the child's best interests.

Young girls often consulted a doctor rather than discuss the matter with their parents because they feared the ramifications.

Professor Strauss referred to a case in Britain in which a Roman Catholic mother of 10 children, Mrs Victoria Gillick, sued the department of health in a campaign for the right of parents to be consulted before contraception was prescribed to under-age girls.

Her case was initially dismissed, then upheld on appeal, but finally overturned by the House of Lords, the country's highest court.

Professor Strauss said that in South Africa it was widely accepted that doctors could prescribe contraceptives for under-age children.

Doctors should counsel these children and encourage them to inform their parents. However, doctors should not inform the parents against the child's will as this could cause "disturbed family relationships".

The benefits derived from oral contraceptives far outweighed the possible risks, according to Dr Gerhard Lindeque, head of the oncology unit at Tygerberg Hospital's department of gynaecology and obstetrics.

He said studies indicated that while there appeared to be a slight increase in cervical cancer in women on the pill, there was no effect on the incidence of breast cancer.

Disabled have great transport difficulties

299

Star 25/4/86

By Jovial Rantao

Disabled people often find it difficult if not impossible to make use of public transport, says the chairman of the Association for the Physically Disabled (APD), Mrs S Shorten.

Mrs Shorten said transport for disabled people had to be from door to door and this was incompatible with normal public transport operations.

With every project introduced for disabled people by the APD, transport and accessibility emerged as essential factors.

Transport of people with disabilities should be the Government's responsibility, not that of fund-raising organisations.

"It hardly seems correct that a person with a disability should have to depend on the uncertain results of fund-raising for his transport," she said.

Campaigns

APD has 11 branches, mostly in townships, and 21 organisations are affiliated to it in the Transvaal.

In 1986, the Year of the Disabled, the APD had launched a variety of projects to promote the problems of the disabled and also to attempt to assist them, she said.

One of its functions is to find jobs for disabled people in the open labour market.

Through its awareness programmes, the APD campaigns for accessibility to buildings and facilities — which is essential for disabled people who hope to gain independence.

The APD maintains a fleet of specially equipped buses and carries more than 30 disabled people daily to and from work, school, hospital, clinics and training and recreation facilities.

Mrs Shorten said: "Rapidly escalating costs have made it increasingly dif ficult to support this service which receives no state, provincial or local authority funding.

In consequence, the vast majority of disabled people rely completely on the Association's fund-raising for their mobility.

Qualified

APD drivers are now attending courses with the institute of Advanced Motoring and seven have qualified. Specialist training on loading methods has been given to drivers by the Association's occupational therapist.

To add to the Association's problems, a number of their kombis which are specially adapted for the disabled have been stolen. Mrs Shorten said that as a result the Association was considering buying other kinds of vehicles.

StarStyle

Treat the blind with sensitivity

Staff Reporter

Sight is a gift many people take for granted until the devastation of losing it. The deprivation of sight is hard enough to cope with, without the added burden of insensitive treatment from sighted people.

Anyone who is not familiar with blind people and how to behave when meeting them, should take a look at a leaflet titled "When you meet a blind person", distributed as part of a consumer programme developed by a supermarket chain.

The pamphlet gives the following advice:

Talk normally to people who are blind. Don't talk "down" to them or speak as though they were not there. Never speak to a blind person through a third party if you can speak directly to him or her, and don't be afraid to say "Nice to see you". Blind people say that too.

TOUCH THEM

The phrases that should be avoided are the ones that are pitying or sentimental, such as: "Oh, poor thing, what a terrible affliction."

Tell a blind person who you are when you approach to greet them — don't rely on them recognising your voice. Touch the person on the arm to let them know you are speaking to them, if you find you cannot remember the blind person's name.

Also tell the blind person if you intend moving away after speaking to them. It can be embarrassing for blind people to find themselves talking to an empty space.

Blind people do not want to be "carried" when walking in the streets so try, instead, to "guide" them. Many will prefer to hold on to their guide's arm, but this is not always the case so make a tactful enquiry about the blind person's preference.

DINING OUT

It is vital to be scrupulously accurate when giving directions to a blind person.

When dining out, guide the blind person to your table in the restaurant and place their hand on the back of their chair. Outline the table setting briefly and describe where the different food items are placed on the table and side dishes when the meal arrives.

Motorists should remember that a white cane is a universal symbol of blindness, or at the very least, impaired vision.

Drivers should exercise special caution approaching a person carrying a white cane with two red bands. This indicates a hearing problem.

For more information or a copy of the leaflet, please contact (011) 28-1028.

Parents puzzled by disorders

Medical Reporter

The parents of children suffering genetic disorders are grossly ignorant about their children's condition and are unsure about how to deal with them, a recent survey has shown.

A study by the Human Sciences Research Council (HSRC) has revealed that nearly half the parents of children with genetic disorders are unaware that the problem is hereditary. More than 70 percent of those questioned believed that the disorder would improve and could be cured.

The purpose of the study was to identify the specific needs of genetically impaired children and what educational measures could best meet these needs.

According to the survey report, published in the *South African Medical Journal*, an alarmingly high number (83 percent) of parents needed more information about the genetic handicap of their child. Well over 80 percent were in favour of a national genetic counselling service.

MEDICINE COSTS (299) FM/ML 28/4/89

Health vs wealth?

Pharmacists and drug manufacturers are heading for a showdown over attempts to discount medicine prices.

The Pharmacy Council, responsible for monitoring the pharmaceutical profession, has published new rules to push back the tide of discount pricing. The upshot is that drug manufacturers have accused it of meddling in retail activities, instead of concentrating on professional matters.

The council is already on a collision course with its former president, Kosie van Zyl, who heads Mediscor, a fledgling discounter of prescription medicines.

Mediscor has told medical aids it will offer discounts of up to 25% on standard medicine prices and, eventually, will tender for medicines. Van Zyl has strong support from medical aid schemes keen to break the spiral of price increases in pharmaceutical products.

Representative Association of Medical Schemes executive director Rob Speedie says there's little incentive for the public to shop around for the best medicine prices. He hopes the advent of Mediscor will encourage patients to use a discount pharmacy rather than a full-price one.

In an extraordinary act of re-regulation, however, the Pharmacy Council has decided to strengthen its ethical rules against discounting.

It is now contrary to ethical rules to grant bonuses or promotional discounts, or to accept them. If Mediscor continues in its present form, it will be in contravention of the rules.

Predictably, pharmaceutical manufacturers are unhappy. The Pharmaceutical Manufacturers' Association is scheduled to meet shortly to formulate a reply to the new rules.

Council president Professor Antoon Goossens says the council's executive is aware of the unhappiness over the rule change and has decided to give interested parties another chance to comment. However, the rule hasn't been withdrawn in the meantime.

Registrar of Pharmacy Pieter Traut says the council won't act on any complaints concerning the new rules until all comment has been received by May 25.

But he adds:"We are acting against discriminatory pricing and want manufacturers to charge the same price, subject to volume, to each customer." He says Mediscor would certainly contravene aspects of the new rule.

Says Adcock-Ingram CE Don Bodley: "The ethical rules should be concerned with professional matters, not with the business of retailing. If we're going to bring down the cost of medicine, competition must be encouraged."

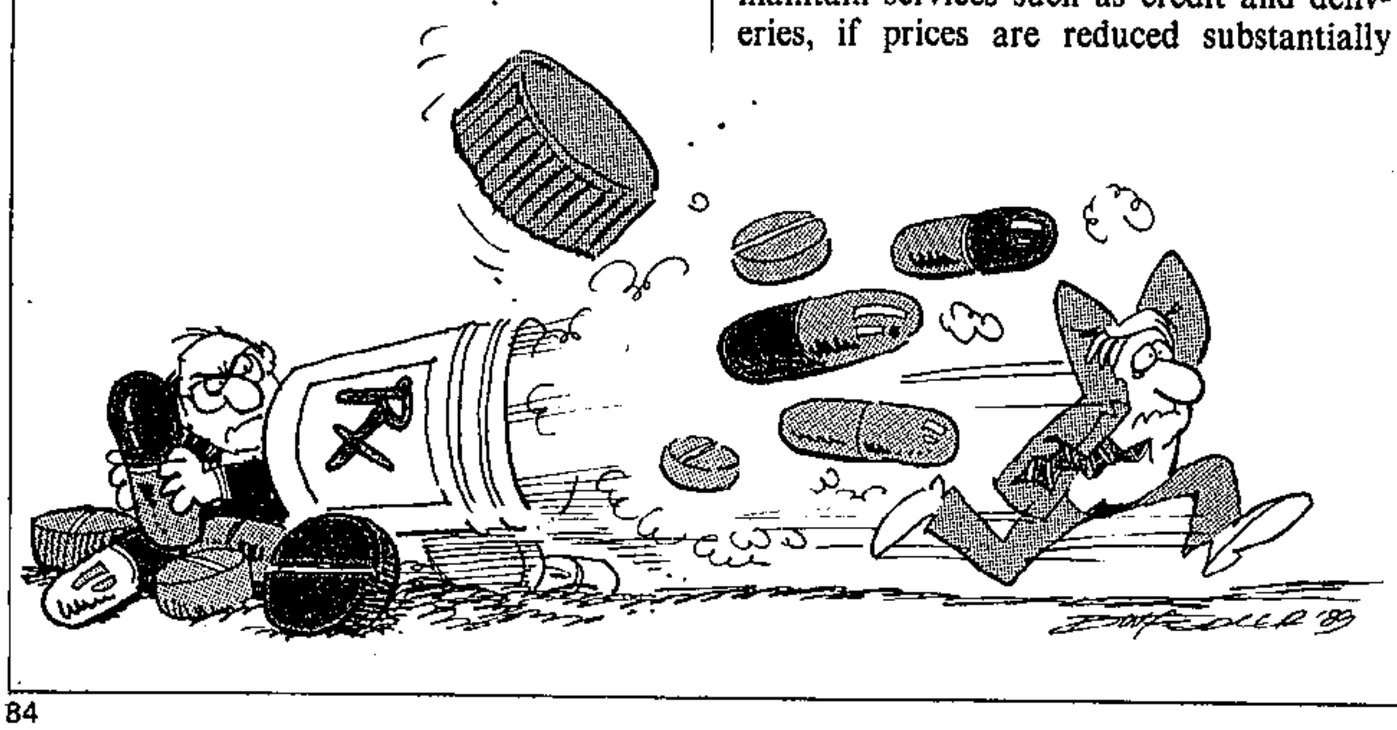
Retail pharmacists suggest the Mediscor chain won't get off the ground. SA Association of Retail Pharmacists executive director Dave Pleaner says it will be impossible to maintain services such as credit and deliveries, if prices are reduced substantially across the board.

None of the three existing major chains — Allied's Plus, SA Druggists' Link or Adcock-Ingram's Family Circle — have yet unveiled a formal discount strategy. But some of their affiliates, such as Link's Daelite pharmacies, are already offering discounts.

SA Druggists MD Tony Karis says prices can't be brought down substantially until generic substitution is allowed and much cheaper equivalents could then be used.

Retail pharmacy still has a long way to go to back up cost-cutting words with deeds. Transmed scheme manager Rita Ross says though the oft-quoted 50% mark-up on medicines is merely a guideline, it's difficult to find variation in price on pharmacy shelves.

"A repeat prescription used in Johannesburg, Cape Town and Durban will usually get identical prices." ■



Health consultant takes the heat off asbestos

EDYTH BULBRING

A HEALTH consultant predicts one in every 100 000 people will die of an asbestos-related disease.

Brian Gibson added in an interview yesterday, however, the rate was 75 times higher for those having annual X-ray check-ups.

Gibson was responding to statements by DP councillor Clive Gilbert that Johannesburg City Council had a slack approach to monitoring of buildings and workplaces containing asbestos.

Questions to the council last week were not answered to the satisfaction of the DP caucus and resubmitted.

Gibson said: "All of us are breathing in asbestos. It's everywhere you care to look."

He considered levels of asbestos in the air no danger to the average citizen. Over half of the fibre was a result of natural forces and not man's activities.

Gibson said products containing asbestos — like brake pads, roofing sheets and room partitions — were made from high-density materials and the release of signifiacnt quantities of asbestos fibre did not occur.

He believed legislation controlling occupational exposure was satisfactory.

"Of course asbestos should be treated with respect but, to introduce local government legislation to monitor the enviroment, would be overkill," Gibson said.

He added disclosure that asbestos-coated filtration bags were used at Bushkoppies sewage works should not alarm the public.

Asbestos fibre was only a potential risk if breathed and could not do any harm if consumed in water.

During the past few years many countries have greatly tightened up laws covering asbestos.

SPEC 28/8/84 · (299

New ways to finance health in SA needed

Staff Reporter

Alternative sources of funding for health services should be urgently considered to relieve the financial and staff burden placed on the public sector, says Dr George Watermeyer, executive director of Cape Hospital and Health Services.

Speaking at the National Society of Community Nurses congress in Cape Town, Dr Watermeyer told delegates greater involvement by the private sector could bring about a great improvement in health services. He said the private sector served only 15 percent of the population while the public sector was responsible for the other 85 percent.

Dr Watermeyer attributed the major costs of health services to salaries and training of staff and the importing and maintenance of expensive equipment.

"Doctors and nurses are trained to use first world technology in circumstances where such technology is not always suitable.

"In addition, expensive new pharmaceutical medications are used where cheaper, and less, medication can achieve the required results", he said.

Dr Watermeyer said greater co-operation should also exist between local authorities and business organisations which provide in-company primary health-care services.

MEDICAL CARE (299) From

Seeking alternatives

The present system of medical aid will never be affordable to most of SA's population, so alternative funding methods must be investigated.

Although this statement by Potchefstroom economics professor Hentie Boshoff may seem an indictment of medical aid, it was accepted enthusiastically at the Representative Association of Medical Schemes (Rams) conference in Kimberley last week.

Says Boshoff: "I found delegates extremely receptive. Medical schemes have been looking at alternatives such as Health Maintenance Organisations (HMOs) and Preferred Provider Organisations for some years.

"The major obstacle to their implementation isn't the schemes themselves but the legislation which outlaws doctors, pharmacists and nurses from forming a group practice together."

Boshoff says only 20% of the population is covered by medical aid. With subscription costs rising, this figure won't change much, he predicts.

"A few people who aren't members yet will be able to afford to join the schemes, thanks to economic growth and wealth redistribution, but not many. Medical services have increased in cost faster than the rate of inflation this decade and this is unlikely to change because of the increased cost of medical technology."

He says the HMO is a better way of keeping costs down as it involves a single, all-inclusive subscription paid directly to the providers of medicine, who have no other source of income.

"HMOs have an incentive to keep costs down. There is an emphasis on preventive medicines in HMOs since it's cheaper than curative medicine in the long run. Blacks will be more likely to afford to join HMOs than the present medical aids."

Costs could also be saved through a basic list of, say, 400 medicines instead of the more than 2 000 now on the market. He argues that standards wouldn't be reduced in an HMO, only overservicing.

Transmed scheme manager Rita Ross told the conference one man on her scheme was receiving 14 injections a month when he needed two. HMOs would monitor servicing very closely.

Boshoff says at least 80% of the functions performed by doctors could be performed by a trained nurse and a pharmacist. If group practice were allowed, these functions could be delegated, leaving the doctor time to concentrate on more serious illnesses. ■

FINANCIAL MAIL MAY 5 1989

(299) From 5/5/89

Sister Doreen Malekane, founder and manager of Tshepong Stimulation Centre for Mentally Handicapped Pupils.

Sowetan 11/5/84

Dream comes true

299

SOUNDS of trumpets and drums marked the opening of a new school for mentally handicapped children of Katlehong on the East Rand.

Tshepong Stimulation Centre for Mentally Retarded Pupils is the brainchild of Sister Doreen Selekane.

Selekane, who manages the school, is assisted by three teachers.

The school consists of two classrooms, a kitchen and a toilet. It has 24 pupils whose ages range between six and 12 years.

"We thank all the people who made this venture a reality," said Sister Malekane at the function.

She urged the community to keep a vigilant eye on the building, "because it serves not only the handicapped children, but the community at large".

Paralysed Vaal girl (14) is helped by Evaton Council

299

Sowetan 12/5/94

A 14-YEAR-OLD paralysed, deaf and dumb Vaal Triangle girl, who has been bed-ridden since birth, has been offered help by the Evaton Town Council after her plight became known through the *Sowetan* this week.

By JOSHUA RABOROKO

Melta Motaung has been confined to her bed for 14 years and her destitute family could no longer afford to care for her needs, despite pleas from organisations for financial assistance.

The council's public relations officer, Mrs Louise van Aswegen, yesterday told the *Sowetan* that the council will also assist her poverty-stricken mother, Mrs Maria Motaung, to maintain her other seven-year-old child.

She said this after officials of the city council visited Mrs Motaung following an article which appeared in the *Sowetan* on Monday.

Mrs Motaung had explained her plight which culminated in her being jobless. She spent a lot of money in an attempt to make her child live a normal life. "I am almost destitute," she said.

Mrs van Aswegan said the council will apply for a maintenance grant from the government to support the children.

She conceded that Mrs Motaung had earlier applied for a disability grant, but because of her age the application was unsuccessful.

"Melta needs to be 16 years old before she can get the disability grant," she said.

However, she said the council will, after consultation with social workers, apply for a maintenance order for the two children.

"The grant will continue until Melta is 16 so that she can apply for disability benefits. The council's welfare department will assist Mrs Motaung in all possible ways.

"Apparently Mrs Motaung also applied at other institutions for some form of assistance, but it is not exactly clear which of these institutions turned her application down," she added.

She said Melta stayed in a well-ventilated room due to the fact that she could not move around easily. Her mother provided her with the necessary medication obtained either from the Sebokeng Hospital or private doctors.

She said Mrs Motaung's husband has apparently left the family and the social workers and the council will assist her in any possible way.

Dentists may charge twice med aid rates

By MONICA GRAAFF

DENTISTS have been advised to charge fees of up to 100% more than the amount medical aids are prepared to pay — and patients will have to pay the difference.

Thus if a dentist charges the new recommended rate of R28 for an ordinary filling when medical aids are only prepared to pay R14,70, the patient will have to pay the R13,30 difference.

This recent Dental Association of South Africa (Dasa) recommendation was made because the scale of benefits determined by the Representative Association of Medical Schemes (Rams) had not kept pace with the increasing costs of dental practices, the Dasa director, Dr Helmut Heydt, said yesterday.

Dentists had therefore been advised to follow the guidelines of Dasa's annually-updated National Schedule of Fees which recommended rates that were more-or-less 100% higher.

These guidelines recommended annual increases in excess of the annual average cost of living increase as they took the increasing costs of imported dental products and other factors like the education of dentists' children into account.

"While we understand that it will be difficult for Rams to improve the scale of benefits, we cannot advise our members to charge Rams rates," he said.

The chairman of Rams, Mr Nic van Rensburg, declined to comment yesterday on whether his association would consider increasing the amount medical aids would be prepared to pay.

Charging more than the Dasa rate is illegal, but dentists are under no legal obligation to inform their patients that their rates are higher than what the medical aids will pay.

But a pamphlet explaining the necessity of the increased rates to patients has been sent to all Dasa members for inclusion with their accounts.

It tells patients that they "are personally responsible for professional services rendered" regardless of whether they are members of a medical scheme.

"Fees are usually charged by dentists and dental specialists according to individual circumstances and you are free to discuss this matter with your dental practitioner," it adds.

Health care the US way

RESPONSIBILITY for the provision and financing of the bulk of health services should be returned to the State to solve the crisis in private sector health care, Dr Jonathan Broomberg, of the Centre for the Study of Health Policy, said today.

In a paper presented to the National Medical and Dental Association conference in Johannesburg, Dr Broomberg said the trend was however increasingly moving towards privatising health services and it was therefore necessary to look for alternatives within the present medical aid schemes.

Rising costs

The cost of private sector health care services has escalated rapidly in recent years, far outstripping wage increases over the same period.

The average monthly contributions of all members to medical aid schemes (black and white South Africans), showed an increase from R17,72 in 1977 to R112,43 in 1987. "A recent projection suggests that by the year 2 000 the monthly contribution will vary from R849 to R2 200."

Dr Broomberg said an increasing number of black South Africans were using private medical aid schemes, partly because of the deterioration in standards of care at public facilities, and the rising costs of using such facilities.

JANET HEARD

In 1977, 0,9 percent of blacks were covered by schemes, whereas in 1987, the figure increased five-fold to five percent.

Outlining the shortcomings of the present private health care service, he said all providers were reimbursed on a fee-for-service basis, which encouraged providers to increase the supply of services. "In health, consumers are not able to 'shop around', and this results in the excessive use of health care services."

Dr Broomberg said rising costs would soon mean only the wealthiest of workers would be able to afford medical aid. In the light of this, he proposed an alternative scheme based on one in the United States called "managed care".

He stressed that because of the inevitability of privatisation, it was necessary for the progressive movement, and the labour movement in particular, to intervene to ensure some form of control over its operation.

Managed care, he said, differed from the existing scheme because the functions of financing and providing health care services were integrated under one body.

"Once it is fully developed, the scheme will collect monthly contributions from members and employers, and in return, will offer members and their dependents, a wide range of health services. It will do this by employing its own doctors and other professionals, and by contracting with clinic and hospitals to provide services to its members."

The GP's, specialists, and other professionals employed would operate out of health centres, at which members would be able to obtain a comprehensive range of preventive and primary curative services.

The scheme had to provide services to each member at a pre-determined, fixed rate, which would be a strong incentive to ensure that its costs per member did not overrun its income from contributions. Doctors and other providers would be paid a salary, removing the fee-for-service incentive.

The cost savings would be passed on to members in the form of lower contribution rates, said Dr Broomberg.

'BLACK' CP MEMBER: Staunch Conservative Party member Mr Robert Sargent is fed up with the jokes being made by his wife and black colleagues. ● Photograph: Stephen Davimes.

Storm over R100 000 win by SABC worker

STAFF REPORTER

A R100 000 HOME offered as a prize in a competition run on SABC-TV has been won by an employee of the corporation which now insists he forfeit the prize.

The dream-in-a-lifetime win by Mr Elias Molane, who works in the record library of the corporation, has sparked a row between the sponsors, the Maize Board and Wimpey Homes, and the SABC.

The SABC says that according to its regulations staff were not eligible to enter the competition.

But a spokesman for the promoters, Mrs M Rowland, said Mr Molane was the legitimate winner.

Mrs Rowland refused to comment about the SABC's decision to disqualify Mr Molane, saying she would not like to "cross swords" with the corporation.

The R100 000 house, donated by Wimpey Homes, will be built in Spruitview, on the East Rand.

Wimpey spokesman Mr Bob Gregory, said the SABC had no right to disqualify Mr Molane.

The corporation had not run the competition.

d rvise1The chairman of the Maize Board, Mr H P de Lange, said: "As far as we are concerned, Mr Molane still remains the winner, with or without their approval. He is their employee, not ours."

Mr Molane said yesterday he was hopeful the matter had been resolved, and said he had already consulted legal advisers on the matter.

Black day for a CP supporter

JANET HEARD

BLACK colleagues have been taking the micky out of an ardent Conservative Party member after discovering he was mistakenly registered black.

Mr Robert Sargent, (43) a mechanic who lives in Marister, received his unemployment insurance card from his former employers from Halfway House last week. His wife, Marie, was shocked to see the word "black" on the card, and then he saw the identification number "008". Whites are "008".

Mr Sargent said black workers at the construction firm where he is presently employed have been laughing at him and calling him "brother".

"It's a joke, but I am starting to get annoyed at the cracks coming my way. My wife also rocks me sometimes and I don't appreciate it".

He said his former employers requested he return the card to them to rectify the error, but he is first seeking legal advice.

Change means one man one vote, Gandhi tells SA group

SALLY SEALEY

NOTHING short of universal adult suffrage in a single parliament for all South Africans would satisfy India that South Africa had changed, Indian Prime Minister Rajiv Gandhi told a visiting South African delegation yesterday.

Representatives of the Transvaal Indian Congress, the Natal Indian Congress and the Congress of South African Trade Unions (Cosatu) met the Mr Gandhi yesterday to discuss a wide range of issues relating to the struggle against apartheid.

International campaign

The delegation, which included TIC president Mr Cassim Saloojee, Mr Reggie Vandeyar, Mr Charm Govender, Mr Yunus Carrim and Mr Fred Gona of Cosatu, have been in India for the past seven days.

Mr Gandhi reaffirmed India's commitment to the international campaign against South Africa and said the country was prepared to do everything possible to bring about a peaceful resolution to South Africa's problems.

He said: "The struggle for independence in India was born in South Africa. Who knows, if Mahatma Gandhi had not been exposed to the shock of apartheid, Indian history might have taken a very different course."

Mr Gandhi expressed concern over the continuing state of emergency in South Africa and the plight of detainees on hunger strike.

The delegation told him of the harsh restrictions imposed on many of the ex-detainees.

He said he was disturbed to learn that some ex-detainees were restricted to their homes for up to 20 hours day to their homes and were expected to call at the police station twice daily in the four hours they were allowed outside.

Mr Gandhi said he would raise the issue in international forums.

The talks are expected to end early next week with the issuing of a joint statement covering the major issues discussed.

Health care the US way

Star 13/5/89

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Loss-plagued Medi-Clinic back in black

AFTER two years of losses Medi-Clinic Corporation is back on its feet with a 95% increase in income before debenture interest.

For the year to March, net income before debenture interest increased from R6,3m to R12,3m, largely as a result of increased bed occupancy in bigger hospitals and because no new hospitals were commissioned.

Debenture interest of R8,6m reduced net income to R3,6m compared with a R2,4m loss in 1988 after debenture interest of the same amount.

Earnings a share increased from a 2,7c loss in 1988 to 4c earnings in 1989. After the conversion of debentures, earnings a share show an increase from 3,7c in 1988 to 7,2c.

279 EDWARD WEST

31 May 1989

Doctors 'should remain impartial prescribers'

Pharmacists losing out to physicians, congress told

THE full, comprehensive pharmaceutical service rendered by pharmacists was becoming non-viable in many parts of SA because of the loss of services to the trading doctor, Pharmaceutical Society of SA (PSSA) president Willie Kock said yesterday.

Opening the PSSA's annual conference in Johannesburg, he said a doctor should remain an impartial prescriber and not have a vested interest in the cost of medicine prescribed.

With the increasing demand for health services in SA, Kock said, a larger group of medicines had to be made available for dispensing by the pharmacist, which would allow him to relieve the financial burden on medical schemes.

The PSSA had helped fight health costs by implementing the Maximum

DIANNA GAMES

Medical Aid Price system, self-medication schemes and discounts of about R35m allowed to medical schemes, between June 1987 and 1988.

Kock said it was hoped new legislation regarding the control of medicines, expected next year, would allow pharmacists more discretionary powers over a list of medicines for which alternatives could be substituted.

Role

He said pressures on the community pharmacist had increased, resulting in a discount war and, although it benefited the patient, a pharmacy could not continue providing full services if discounts were pushed over 25% on present prices.

Pharmacy Council president Prof A Goossens said the pharmacist would play an important role in SA's health services if government successfully implemented the privatisation of health services.

He said the single greatest criticism of the private pharmacist was that he was too expensive.

Goossens asked for reflection on the cost of abuse, misuse and wastage of medicines if supplied outside the controlled environment of a pharmacy, bypassing the professionals who were specifically trained for this work.

The cost structure of the total distribution chain, from manufacturer to retail pharmacy, had to be taken into account rather than just the price of medicine paid by the public.

Kock also reiterated the strong objection by the PSSA and SA Association of Retail Pharmacists to the registration of hydroquinone, used in skin lightening preparations, as a medicine.

Travel agents, pharmacist launch health campaign

BDay 16/5/89

THEO RAWANA

RENNIES Travel and pharmaceutical company Smith Kline and French have launched a joint immunisation awareness campaign to protect travellers' health.

The main aim of the campaign is to emphasise those vaccinations necessary for travel to different parts of the world, an article in The Rennies Traveller says.

Charts indicating which diseases occur in what areas and what precautions can be taken are displayed at Rennies Travel outlets and books on the subject are also available.

Special emphasis is placed on the disease Hepatitis B, which is caused by a virus resulting in an unpleasant, sometimes fatal, illness, with fever, nausea, vomiting, jaundice and extreme lethargy.

The report says the prevalence of Hepatitis B is very high in parts of Asia and Africa and also commonly occurs in Latin America, the Middle East and Southern and Eastern Europe.

But it warns South Africans do not have to travel that far to be at risk, as carriers are also found in SA.

CARING FOR THE DYING

Hospice plans to open a centre in Soweto

By PHANGISILE MTSHALI

THE Hospice Association, Witwatersrand, which sprung from a small band of volunteers who got together 10 years ago to help terminally ill people and their families, today cares for 8 000 dying people a year.

It has gained recognition from the public and medical circles.

This week has been declared the Hospice Week on the Witwatersrand as the organisation celebrates its 10th birthday.

As part of its projects for 1989 Hospice plans to open a centre in Soweto which will provide day care and home care facilities. Plans to open centres in Krugersdorp and Eldorado Park are also in the pipeline.

"Hospice does not quarantine the terminally ill," said its chief executive officer and founder member, Mr Stan Hennen.

"It provides the dying with a home-from-home care and it also looks after their families, morally, emotionally and psychologically.

"It aims at helping the living more than the ill. Its objectives is to improve and uphold the quality of life.

"All services are provided on the basis of need only without regard to race, creed or religion. We take our service where it is needed."

Hennen continued: "Soweto needs our services as the Aids menace increases. It is proved that in every 300 pregnant women one is HIV positive. This means that in every 900 people we have at least three Aids victims.

"We have been allocated a site to build a centre there. We are only waiting for the Soweto City Council's approval to start building," said Hennen.

Hospice is a non-profit making organisation which depends on donations and fund-raising programmes. It has branches all over the country which work independently of each other.

They have an in-patients department for those who are seriously ill; home care and day care facilities for those whose families can afford to look after them partially.

It also helps their families to come to terms with the reality of losing the loved one. Support for the family continues after the patient has died.

Hospice defines a terminally ill person as a person who is beyond medical care. This includes Aids sufferers, cancer patients, those with genetic diseases that shorten the life span and those suffering from motor-neuron disease.

"Everyone who is at an advanced stage of illness and when the doctors think there is nothing that can be done to help him is welcomed by Hospice," said Hennen.

The Witwatersrand branch has 47 professional staff including a doctor, 14 nurses and three social workers. There are also volunteers who are trained at the Hospice Learning Centre.

The association can be contacted at (011) 728-7023/4 and the contact person is Stan Hennen.

Help for the terminally ill should be sought by members of the nuclear family of the ill, the patient, his doctors or welfare personnel.

31 fatal heart attacks daily

High death rate due to 'pig-like living'

Star 18/3/89 299

By Winnie Graham

Thirty-one people died of heart attacks in South Africa each day, Dr Marius Barnard, the heart surgeon, said at Sun City this week.

Speaking at Convention 89, a conference organised by a direct selling organisation, he estimated 45 000 people in South Africa would have a coronary thrombosis this year. About 11 000 would die of heart-related diseases.

He estimated there would be 70 000 new cancer cases this year, of whom 6,5 percent would die.

Science had made enormous strides in preventive medicine since the turn of the century and had literally taken people "from the grave". People, however, were not looking after themselves.

Man had become a walking disaster because he had started "living like a pig".

In 1900 heart attacks were responsible for 8 percent of all deaths. This figure had grown to 48 percent in the eighties. Then, cancer killed 3,7 percent of the population. Today it kills 20,9 percent.

"Humans must be the only mammals which continue to provide milk in their diet after weaning. They guts all the chops and boerewors they want when a piece of fish would be so much better for them.

"And, worst of all, there is too much smoking. Smoking causes heart disease, cancer, baldness, ingrown toenails — everything possible that is bad for you."

He described it as the biggest health hazard in the world.

Medicine discount war looms

B1 Day 18/5/89

299

DIANNA GAMES

A DISCOUNT war could develop between pharmacists and medical schemes if some pharmacies agree to contract exclusively to certain schemes outside the Pharmceutical Society of SA.

Lex Tannebaum of the National Wholesale Drug Association warned delegates to the PSSA national conference in Johannesburg yesterday that certain medical aid schemes were forming Preferred Provider Organisations.

These expected pharmacists to contract with them for medicine supplies at discounted prices in return for exclusivity.

However, the association was strongly in favour of the PSSA contract system, which allowed every member to benefit from contracts.

Tannebaum said if some medical schemes succeeded in squeezing big discounts, the industry would have to give big discounts to all private medical aid schemes, which it would not be able to afford.

SA Association of Retail Pharmacists (SAARP) president Gary Kohn said certain medical scheme administrators and medical aid schemes were trying to induce pharmacies to offer unrealistic discounts on prescription medicines.

He said there were attempts to create an impression prices should be reduced by retail pharmacists based on "excessive profits", while the real intention was to get additional discounts.

Enforceable

The problem to be addressed was that retail pharmacists were only able to get medicines at already inflated prices. He said even if they gave medicine at cost, it would still exceed prices available on tender.

He also said it was essential an enforceable end price from manufacturers, based solely on volume, be introduced soon by the Competition Board, with disciplinary action taken against those not complying with it.

The PSSA conference resolved this week to ask the board to declare such a practice regarding buyers in the private sector, and that its national executive investigate implementation of the same, including government's tender system.

Kohn said among the reasons SAARP had declared a no-confidence motion in Health Minister Willie van Niekerk was his failure to address problems created by manufacturers' discriminatory pricing policies.

Coupled with this was his demand that the retail pharmacist bear full responsibility for reducing medicine prices.

He said it was a matter of urgency that the Medicines Control Council introduce a list of generic substitutes. This would help reduce costs.

☐ Willie Kock was voted in for a second term as PSSA president yesterday.

Sinah's haven

DISABLED people of Alexandra have found a haven in the Self-Help Association of the Disabled.

Shadex, as it is popularly known in Alexandra, was started by Sinah and John Gwebu in 1986.

The centre employs 45 men and women and has other members who are too feeble to work. It is an independent organisation which has restored its members' pride.

"Shadex began after my husband was shot. After treatment in hospital, nothing was done to rehabilitate him," says Mrs Gwebu.

"He started a workshop in our backyard and soon had four helpers. I joined the group when John had to go back to hospital. We realised that we had to move when the group increased to eight.

"The City Council gave us a site but it was not suitable. It was too small and situated behind a bar. We did not get on with the patrons and decided to move," she said.

Shadex rents a warehouse which was vacated after the 1976 riots. Mr Gwebu visited several companies looking for casual work.

Mrs Cleanor Anderson, an executive member of the Alexandra Clinic, gave Shadex a converted minibus which had belonged to her late husband who was disabled. This solved a great problem of moving members to and from the centre.

Mrs Gwebu goes around the township looking for disabled people. "I compile a list from which we choose those who can work. The rest are carried as members. We support one another and do not rely on handouts.

Woman of the Week

Sinah Gwebu

"The companies we deal with train some of our workers who come back and teach others. We make grills, control panels, parts for air-conditioners, fans, number plates, elements, booties, toys, battery terminals and irrigation cables.

"I intend starting a wing for women as they encounter many problems outside the centre. We must all work together to solve them. We will affiliate to the Disabled People of South Africa.

Shadex formed a burial society after one of the members could not be buried by his family. Discussion groups were formed to discover ways of easing the plight of the handicapped.

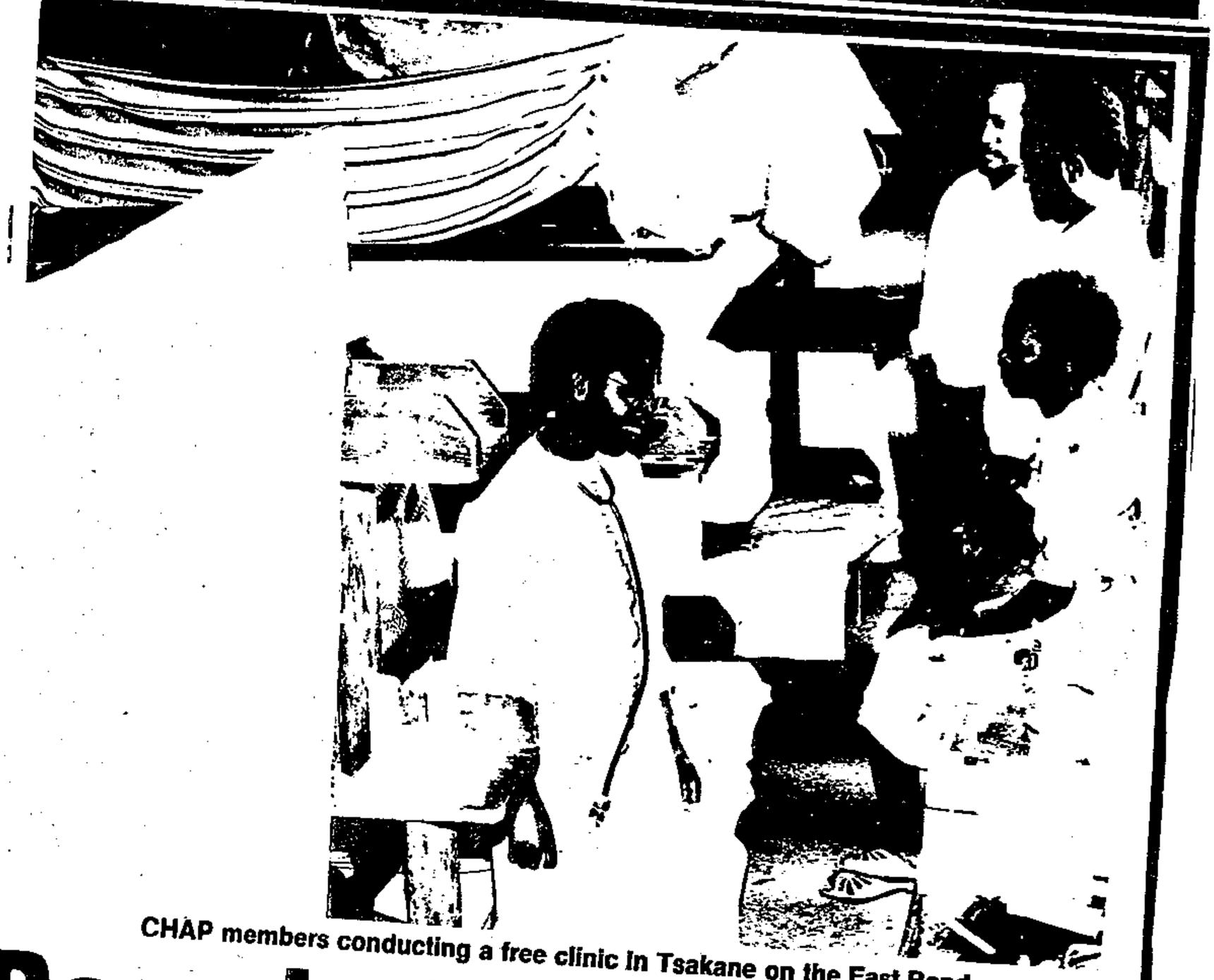
Shadex raises money through selling chickens and eggs. The group used the money for trips to Mandeville for sports outings, a holiday in Durban and occasional trips to the cinema.

"We have acquired a site to build a Shadex village. It will house single and married people. It will have workshops, conference rooms and a hall.

"I am aware of the problems of the physically handicapped because of my husband's injury and because I am partially disabled myself."

Mrs Gwebu is a member of the Alex/Sandton Kopano meeting, an executive of the creche division of the Child Welfare Society and an executive member of the Women's Bureau.

She was awarded the Otis Community Team Activity award in February.



CHAP members conducting a free clinic in Tsakane on the East Rand.

Parade to spotlight awareness of TB

Sowetan 19/5/89

299

THE Wattville Clinic will have a float parading through the streets of Actonville and Wattville tomorrow to create awareness of tuberculosis.

There were 459 cases of TB in Benoni in 1988; of these, 166 people died. TB of the lungs was most common (431); others contracted TB meningitis, TB of the glands, kidneys, bones, and spine.

The recent increase in TB cases is partly due to overcrowding.

There is a great deal of overcrowding," said Mrs Sheila Eland, the senior community nurse of the clinic.

"People from the homelands are flocking to the towns. Some have had TB for some time.

"They then spread the disease in towns. Others default on treatment. There is a belief that TB is a form of witchcraft-*sejeso.* They seek help from a sangoma and later die.

"People are apprehensive about treatment because they have heard stories that TB patients swallow tons of pills. This is no longer true. There is a new drug on the market that is a combination of curative drugs.

"The maximum amount a patient can take is five pills a day. The number can be less depending on the weight of the patient," she said.

When a person visits a clinic because he thinks he may have contracted TB, a history of his symptoms is taken i.e. a persistent cough, loss of weight and night sweat even when the weather is cold.

X-rays and sputum are taken and if both are positive, treatment starts immediately. The very ill or destitute are transferred to hospital. Usually treatment lasts 120 days.

"We make home visits if a patient defaults treatment. If he persists, we take him to hospital. There is a possibility that a defaulter may build up resistance to the drug and be unable to get well," Mrs Eland said.

"TB can be cured unlike sugar diabetes or high blood pressure," she said.

Patients receive a ration of fat, mielie meal, beans and skim milk once a week. There are support groups to help them overcome the social stigma and ostracism of the society.

HEALTH

RAU for the gap?

The supreme irony of turning Johannesburg's J G Strijdom (JGS) hospital into a white Own Affairs institution is that hundreds of the hospital's white patients stand to lose essential services.

The future of the services and of more than 50 University of the Witwatersrand physicians and medical students was due to be clarified this week following more than a month of negotiations between the Wits medical school and government on the hospital's new status.

Government officials maintain the hospital's status — which would permit only 5% of its patients to be black — does not disqualify it from being used as a teaching institution. But Wits academics say the law prevents them from teaching in anything but General Affairs health centres.

Caught in the crossfire are 750 JGS patients — 95% of them white — who rely on specialised services such as intensive care and haemodialysis manned by Wits staff. Government says if Wits pulls out, it will advertise for replacements. But that promise

Services shutdown . . . J G Strijdom faces apartheid realities

has done nothing to set JGS officials at ease. Even Transvaal MEC in charge of hospital services Daan Kirstein admits the search will "not be easy."

"Under normal circumstances, a search to replace one or two specialists would take about two months," says hospital secretary Johannes Visagie. "These circumstances are not normal and a search for 50 specialists would definitely be the largest I have ever heard of."

So far, one physician has resigned in protest against the hospital's status change. Ten more have asked for transfers to other city hospitals. Further resignations will force even more paitents to seek services elsewhere and could spell trouble for Johannesburg's four remaining General Affairs hospitals, according to JGS spokesman Mariaan van Kaam.

While a General Affairs hospital can accept as many blacks as it can serve, a whites-only hospital must seek government approval to exceed the 5% limit on black patients required by law. That restriction, combined with a decline in specialised services, could force many JGS patients to larger, more crowded centres like the Johannesburg Hospital.

The 20-odd Wits medical students who pass through JGS each day would also have to begin studying in other hospitals. Black medical students have already refused to work in a hospital which would not accept them or their families as patients.

National Health Deputy Minister Michael Veldman told the *FM* the potential "academic boycott" by Wits staff is "unethical." "Those people should read the Hippocratic oath. Strijdom has always been a segregated institution and Witswatersrand's medical school has been part and parcel of it since its first days," he argues. "Incorporating the JGS under white Own Affairs is the start of putting what we have in mind — an eventual separation of services among blacks, whites, coloureds and Indians — into practice."

One solution to the problem might see non-academic doctors combining their private practices with hospital duties at the JGS. But Van Kaam says such a move would damage the "neighbourhood feeling" at suburban Strijdom.

Much more to the hospital's liking would be the establishment of a medical school at neighbouring Rand Afrikaans University (RAU). JGS opened its doors in 1969 partly to provide a future medical facility for RAU. Financial constraints have thus far prevented the opening of that faculty, but RAU's nursing students train at Strijdom and show no sign of pulling out with their Wits colleagues.

Van Kaam says she has heard no official talk of RAU stepping into JGS but adds such a move would "make a lot of sense." ■

MEDICAL ADVICE MOSTLY NEEDED

'Patients ignore treatment'

THE failure by many patients to comply with medical treatment is a result of inadequate advice from doctors.

So says the Community Health Awareness Project (CHAP). Projects co-ordinator for CHAP, Dr Oupa Mpe said patients suffering from illnesses requiring life-long medication were being repeatedly admitted in hospitals because of "failure by health professionals to educate their patients about the importance of regularly taking treatment

"The fact that treatment is life-long means that a patient has to be psychologically prepared. Because of that we appeal to doctors to go out of their way and educate the patients to observe treatment."

Doctors

Among diseases that require life-long treatment are: asthma, hypertension, epilepsy and diabetes.

CHAP, however, acknowledged that there were some patients who ignored treatment deliberately. It pleaded with them to stick to doctors instructions.

MEDICAL AID (299) Fmail 19/5/89

Healing the rift

The medical aid movement wants to sort out its tariff differences with private hospitals and doctors before the rift becomes too wide to heal.

Since January 31, private hospitals have charged for many previously non-chargeable items. Medical aids aren't paying for these, so hospitals are asking for payment from patients.

Afrox Healthcare GM Dick Williamson says the average patient is directly liable for an estimated extra 4% on the bill.

Most private sector medical aids have taken a pragmatic line so far and paid private hospitals directly for their portion of the bill. But Williamson says quasi-government schemes have taken a harder line and argue that if private hospitals don't stick to medical aid tariffs, they can't expect medical aid societies to guarantee payment.

The alternative is to pay the patient and let him settle the bill — and the difference.

Other medical schemes could soon adopt a similar hard line. Says Medscheme MD Keith Hollis: "We are evaluating how much each of the hospital groups is charging above tariff. We want the principle maintained that charging at or below tariff is necessary for guaranteed payment.

"If we don't confront the problem now, there'll be a bigger and bigger gap which the patient will have to pay."

But Medi-Clinic MD Edwin Hertzog says the contracting-out of hospitals will be beneficial to both hospitals and medical scheme members in the long run. "Different hospitals should be charging different tariffs due to different standards of service and facilities.

"The fact that patients have to pay a small portion of the account themselves leads to greater cost awareness. This also leads to a greater awareness as to what benefits their medical schemes offer them."

However, Representative Association of Medical Schemes (Rams) chairman Nic van Rensburg says private hospitals should look at their own cost structure.

"Groups each want to have their own MRI scanner, even if another hospital has one a few kilometres away. Once it's installed, they have to make it pay even if it's underused. In some areas, there's overprovision of services."

(299)

There's also still no agreement between Rams and the Medical Association of SA (Masa), which represents doctors. Patients will have to pay consultation fees direct to their GPs if the situation doesn't change soon.

Doctors are still guaranteed payment if they charge the R17,50 Rams tariff. Medical aids want to change the minimum guarantee to 70% of tariff — something Masa will consider only if the current R17,50 immediately becomes 70% of an increased tariff.

Van Rensburg says Rams will keep on negotiating and lines of communication will be kept open. But if agreement isn't reached on both this and the dispute with private hospitals, he warns the entire scale of benefit system may have to be reviewed. ■

Workshop appeals for support

By NTHABI MOREOSELE

MANAGER of the Soweto Workshop for the Blind, Mr Denver Berry, has appealed for support from black businessmen.

"They can also talk to big business for us and get us work. They can also sub-contract some of their work to us," he said.

The Soweto Workshop for the Blind opened in 1987 in Devland. It started with 15 people but now has 125 workers.

Blind

The workshop accepts adults who are capable of working. The work involves assembly of industrial components.

"This is the type of work which the blind can do or learn to do.

"We want our people to become so skilled that they can find work in the open market."

Some of the people who came to the centre at the beginning had never worked. They had to learn skills and the responsibility of working in an open market as the concept of working was totally new for them.

Problems

They also receive mobility instruction at work and in their homes.

A social worker sees them once a week to help them with their problems.

They get tea and bread in the morning and their transport needs are partly subsidised.

"One of our biggest problems is that we are looking for work that can be done by blind and partially sighted people. The people here are willing to work.

"The worst thing you can do is try to treat them differently. They are not different. They only have a handicap. When I am in the workshop, I see people who are similar to me."

(291)

Cardiac disease a major cause of deaths in SA

HEALTH GUIDE

By MOKGADI PELA

Heart disease is the major cause of deaths in South Africa, a seminar organised by the South African Institute for Medical Research was told this week.

Professor Harry Seftel, an expert on the disease, said some of the causes of arterial rot include smoking. "It needs to be stressed that there's no such thing as moderate or excessive smoking. Smoking is dangerous, irrespective of the rate."

He said he often advised cigarette manufacturers that if they continued advertising their products, they would end up not having customers because smoking kills.

• The high consumption of cholesterol (through over-eating animal fats and red meats) causes heart failure.

• High Blood Pressure: Statistics, he said, showed that HBP was very common among adult urban blacks. One out of every four urban blacks suffered from this disease. He added that 22 percent of the whites in the country face the HBP threat.

• Sloth or allergy to movement (lack of exercise) contributes a very high percentage of heart disease.

• Obesity (fatness) is dangerous and must not be taken lightly.

Professor Seftel said South African women were the fattest in the world.

• Diabetes: It also accounted for a large number of heart incidence ailment in the country. Whites suffered a 5 percent rate while blacks had 10 percent of this killer disease.

Professor Seftel said the ways to end the high incidence of heart diseases include moderate eating and drinking, exercises, relaxation by sleeping, especially lying down.

He advised people to maintain an ideal body weight. People had to move from eating red meat to fish, chicken and fibre as well as vegetables.

If people could stop smoking coronary heart disease (CHD) could be reduced by 50 percent, he went on. CHD has fallen markedly in the West and increasingly it's a disease of the ignorant and obstinate.

• Rheumatic heart disease has largely disappeared in the West except in underprivileged communities.

Prevention better than cure

IF it's true that prevention is better than cure, it might be safer to live in the country than in the urban jungle.

Statistics show that hypertension or high blood pressure is more prevalent in urbanised black communities than in rural areas.

In a recent paper by Coronation hospital specialist, Dr Joe Veriava, he attributed the high mortality rate among urban blacks from this disease to social, economic and political stresses.

Dr Veriava said one out of every four black people in urban areas suffered from this disease which was often called *The Silent Killer*.

He said 22 percent of the white population suffered from hypertension. The prevalence of hypertension in rural communities stood at 10 percent, he added. The difference in the prevalence of hypertension between rural and urban blacks was attributable to dietary patterns.

Salt Intake

He said the salt intake was higher among urban blacks than rural ones. "The tendency for higher blood pressure in urban blacks begins in childhood."

"Evidence exists that low potassium intake protects against hypertension. Calcium has also been proved to correlate with blood pressure.

"Blacks as a rule eat less calcium and this may be a contributory factor in their hypertension," Dr Veriava stated.

"It is important to emphasise that food rich in potassium and calcium is often expensive, accounting for the low intake in the poorer sections."

Heavy alcohol intake has also been associated with hypertension.

Dr Veriava said the hypertensive death rate in urban blacks was probably four times greater in all age groups and in both sexes than whites. Most of these deaths are due to cardiac (heart) failure, brain damage or kidney failure.

Back pain suffering

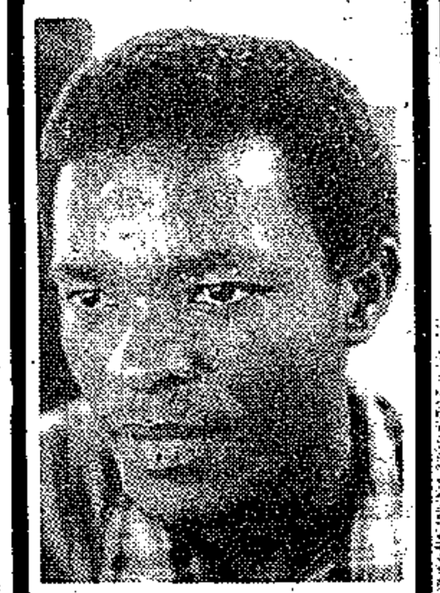
STATISTICS supplied by the South African Back Pain Association show that 80 percent of people in South Africa suffer from back pain at some time and a massive 90 percent of these become chronic sufferers.

This was one of the findings of medical practitioners who addressed the problem at the congress of the South African Society of Physiotherapy in Durban.

299

Cardiac disease a major cause of deaths in SA

HEALTH GUIDE



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9/Times 28/5/87

Insurers to rescue of medical aids

INSURERS have moved into health care with a product which will have highly beneficial effects on the beleaguered business.

By Robyn Chalmers

Crusader Life will officially launch its Total Health Care package in soon. The package was formulated by Dick Slingsby, who designed the Dread Diseases policy, together with Marius Barnard and other Crusader executives.

It is believed to be the first of its kind in the world, and was developed in response to a need for health care.

Solvency

A study by Jan Hupkes, professor of management economics at Unisa's School for Business Leadership, found that insurers would have to move into health to rescue medical aid schemes.

The report expressed reservations about the future solvency of some medical-aid schemes. It said it was clear that the average margins of schemes were too thin to maintain solvency.

"It is obvious that medical schemes' membership fees will have to increase drastically in the foreseeable future, even independent of the cost of medical services.

"It is clear that private insurance companies should be considered a welcome partner in the funding of healthcare delivery systems in SA. They should be allowed to coexist with current medical-aid schemes, and to complement, augment and supplement the activities of the latter."

Endowment

Although legislative barriers exclude insurance firms from providing medical-aid services, the report suggested they could provide schemes for people to insure themselves for major diseases only. They should not reimburse patients who went to doctors for treatment of minor ailments.

Total Health Care package does this by combining three Crusader products — Hospitalplan, Major Medical Expenses Plan and Dread Diseases. Underlying this package is an endowment policy which means that the insured will have an amount invested at the end of 10 years.

Dread Diseases now provides 10 benefits, Hospitalplan pays a maximum of R250 a day while in hospital either from day four or day one of an accident and the Major Medical Expenses Plan provides cover of more than R5 000 for anything related to a surgical or medical procedure.

Marketing

Crusader executive marketing director Brian Peters says the marketing of the package is important.

"Our new method of marketing this product, which is sold on a coupon basis, means that once the proposed insured has agreed to the sale with the consultant, he immediately obtains his policy document together with the terms and conditions.

"We have had the backing and endorsement of First Bowring. The product is now to be placed in each Bowrings office countrywide as well as in each First National Bank branch."

BRIAN STEPHENS

The product was developed over about two years, and coincides with Professor Hupkes' report which described present health services as being in a sorry state.

"Demographic trends mean that an increasingly larger segment of the population will need health care and escalating health expenditure has not been arrested as medical technology grows increasingly expensive with no end in sight."

04

'Blindness can be avoided'

294

SW 29/5/87

Staff Reporter

More than half the 103 000 blind and partially-sighted people in South Africa would not have lost their sight had they been aware of ways to prevent blindness.

This is according to the director for the Prevention of Blindness, Mr Sarel van der Walt, who says 50 percent of blindness is preventable through avoiding eye infections which may impair sight.

In a bid to increase awareness among South Africa's youth, a large supermarket chain, together with the South African Council for the Blind, is to host a national school's essay competition.

Pupils wishing to enter are required to record an essay, prose or play on a cassette tape on the topic "If I were blind ... how would my world change" — and send it in to Checkers Head Office, care of Mandy Matthews at Box 1264, Johannesburg 2000.

The closing date for entries is the last post of Saturday September 30.

Entry forms are obtainable from Checkers stores countrywide.

Cancer care centre opens

Star 20/5/89

299

Medical Reporter

The country's first cancer care centre, which offers cancer sufferers and their families psychological and educational support, opened in the Western Cape last week. The cancer care centre is the realisation of a dream by Mr Doug Eyre who died of cancer last year.

Mr Eyre started the "Flight for Hope" project which involved the construction of a light aircraft to raise funds to help fellow cancer patients. The care centre will follow a holistic approach, dealing with the whole person rather than just the disease.

The emphasis will be on stimulating a positive attitude, helping patients to live with cancer and to help them to become involved in their own healing process.

Patients will be encouraged to make use of the therapeutic, educational and supportive services offered at the centre as well as the emotional support staff members will provide to newly-diagnosed sufferers and their families. The cancer care centre is situated in Mowbray.

Star 29/5/89

Warning of blood shortage at depot

299

By Julienne du Toit

Johannesburg's main transfusion centre has practically run out of blood and is running on a day-to-day basis.

Wednesday's public holiday has sparked fears of a shortage.

Mr Bill Nortman of the South African Blood Transfusion Service in Hillbrow claimed one of the causes of the severe shortage in recent years had been the increase in sophisticated surgery.

"Ten years ago, cardiac bypass surgery was very rare. Now they do dozens a week."

A liver transplant operation, for example, used up to 40 units in 72 hours.

Another reason for the diminishing of supplies was the high population density of Johannesburg, said Mr Nortman.

DEMAND

The transfusion centre had found that the higher the population density, the lower the level of social awareness. The demand for blood in Johannesburg was huge, and supplies had to be supplemented from the less-busy East and West Rand branches.

"A number of people think they can get Aids from donating blood," said Mr Nortman. "This is impossible, since the centre uses only new sterilised equipment, all of it disposable.

"Every single unit of blood is tested for Aids, syphilis and hepatitis."

He said the centre needed an additional 1 500 donors a week to catch up with the demand.

Consumer will save if chemists 'buy better'

System change mooted

DIANNA GAMES

PHARMACIES could not afford to discount medicine prices to medical aids unless the system was changed to allow pharmacists to "buy better" and pass the final saving to the consumer.

That was the view of SA Association of Retail Pharmacists (SAARP) president Gary Kohn, who said the average net profit for a pharmacist was only 5%, and to increase discounts in this situation would be unrealistic.

Kohn was responding to the possibility of increasing numbers of medical aids contracting exclusively to pharmacies in return for major discounts in the wake of MDS Mediscor's innovative discounting scheme of at least 22% of prescribed medicines.

He said last year pharmacies had paid out R53m in discounts. It was estimated 29% of their expenses were dispensing costs.

Kohn said a pharmacist would have to be guaranteed volume if he contracted directly to a medical aid.

A resolution on the discounting issue was taken at a closed session of the Pharmaceutical Society of SA (PSSA) conference this month, to be discussed at a pharmacists' meeting next week.

He said medical aids working on squeezed margins obviously wanted to lower their medicine costs, which comprised 26% of the total medical aid bill. Subscriptions would be unaffordable by the year 2 000 at their present rate unless the structures were changed.

Mediscor GM Kosie Van Zyl said he was negotiating contracts — expected to be in operation from September — with a large number of medical aids. Mediscor, established earlier this year, acts as an intermediary between medical aids and retail pharmacies to which it sub-contracts and negotiates discounts on medicines to medical aid members, starting at 22%.

This is considerably higher than the average PSSA discounts of between 7% and 15% to member pharmacies. Mediscor is not a member.

Van Zyl said while large discounts could affect profit margins initially, this would be compensated for by the volume of business such discounts would draw. "I believe in free enterprise, private initiative and competition," he said.

He said a future possibility was that Mediscor would further bring down the cost of medicines by tendering its medicines directly.

Van Zyl said a prescription could amount to several hundred rand, with the average price of one prescription medicine being around R70.

StarStyle

Star 1/16/89

SA group's objective is to help the hard of hearing

299

By Sally Sealey

Fifteen percent of South Africans are hard of hearing as opposed to being completely deaf, says Ms Carla Zille of the Self-Help Association for the Hard of Hearing (SHHH) — a non-racial organisation started in response to the need for hearing-impaired adults to come together.

Ms Zille, founder member of SHHH, says hearing loss is not visible and often goes unnoticed.

SHHH focuses on the problems of the hard of hearing and also serves as an information and resource centre to educate the public about the needs of people who are hard of hearing.

Hard-of-hearing people in South Africa are still "in the closet", she says. "We still grow our hair over our ears in an attempt to conceal hearing aids, whereas in Europe hearing aids are fashionable. They are bright in colour and are worn like any other accessories."

Ms Carolyn Fedler, a micro-biologist who lost her hearing as a baby, says it's important to involve young people. "We have organised a couple of social evenings and they have been very successful."

Ms Zille says: "We have members who have suddenly acquired hearing loss and others who have experienced a gradual or progressive hearing loss.

"Often hearing loss can end in unemployment. Even if this doesn't happen, it's hard for hearing people to know how to respond to a new set of circumstances.

"We would like to stress that we are not a welfare organisation. We want to educate people and to remove prejudice."

SHHH hopes in the future to campaign for sub-titles on television and to raise funds for "hearing dogs". These are dogs who can actually communicate to a hard-of-hearing person that someone is at the door or that a child is crying.

The dogs are trained not to bark, but to attract attention by touching the hard-of-hearing person on the arm.

Ms Fedler says that SHHH meets twice a month and social events are arranged at least once a month. Anyone interested in joining SHHH can telephone Myra on (011) 646-3935.

299

ect e tables kers

Right: The Transvaal Association for Blind Black Adults had cause to celebrate when the National Beverage Services gave them a cheque for R20000. Mrs Eunice Sibiya (in jersey) presented the money to Mr Seadom Tlotleng, Mrs Ruth Machobane and Mrs Elda Oliphant.

Residents get together to fight widespread ailments

Staff Reporter

A health clinic has been opened in Lenasia by the Extension 10 Residents' Association (FRA) and the the Lenasia branch of the South African Health Workers' Congress (SAHWCO) at the weekend.

The reason for opening the clinic is the common occurrence of high blood pressure and sugar diabetes in the community.

Often people go around unaware that they are suffering from these two diseases, hence they are considered silent killers," said a spokesman for the FRA.

With the type of tests available at the FRA clinic, cases will be detected early. Patients will be advised on what foods to eat and what exercises to perform.

The service is open to all the residents of Lenasia and is free of charge. The clinic will run once a month at the L M A Mosque and School Complex in Volta Street, Extension 10.

The next clinic will be run on Sunday June 18. For information telephone (011) 854-4260.

Barrow pusher raises R70 000

87=Y
21/6/89

By Dirk Nel,
Northern Transvaal Bureau

The "barrow for marrow" project to collect money for the treatment of leukaemia sufferers, spearheaded by marathon barrow pusher Mr Derric Lang, has raised R70 000.

Mr Lang, who was back at his business in Pietersburg this week after walking from Beit Bridge to Johannesburg in six weeks, is confident the target of R100 000 will be reached soon.

Mr Lang left Beit Bridge on April 14 and reached the Johannesburg Hospital on May 25, where he was met by the mayor and members of the hospital's leukaemia unit.

The money raised will be used for the establishment of another leukaemia unit and research.

Mr Lang made a special effort to acknowledge donations personally. He particularly appreciated the generosity of the people of Messina, who gave R3 000, and the efforts of pupils from two Pietersburg schools, who gave a total of R5 000.

Anyone still wanting to make a donation can telephone Mr Lang at (01521) 7-4718.

CHAP outlines patients' rights

Sowetan 8/6/89 (299)

HEALTH GUIDE

By MOKGADI PELA

IN keeping with their objective of raising public health awareness, the Community Health Awareness Project has released a paper outlying the rights of patients.

CHAP says in recognition of the chaos created by "apartheid medicine", black patients have suffered many humiliations, often because they were not aware of their rights.

On top of the list CHAP says is the patient's right to considerate and respectful care irrespective of his social and economic status.

The patient has the right to obtain from his physician complete current information concerning his diagnosis, in simplified terms.

The patient has the right to receive information from his physician when this information is necessary to consider consent prior to the start of a procedure or treatment.

Alternative

Where medically significant alternatives for care exist or when the patient requests information concerning alternatives, the patient has the right to such information.

He also has the right to refuse treatment to the extent permitted by law and to be informed of the consequences of his action.

Privacy concerning his medical care programme is one of the rights CHAP stresses. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly.

All communication records pertaining to a patient's care shall be treated as confidential.

The patient has the right to expect that within its capacity, a hospital must make reasonable response to his request for services.

Urgency

The hospital must provide evaluation, service and referral depending on the urgency of the case. When medically permissible a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to which he is to be transferred.

The patient has the right to medical care in a hospital of his convenience irrespective of racial or ethnic and economic considerations.

CHAP added that it would work tirelessly towards the achievement of these goals before the year 2000, the deadline for "health for all" as decreed by the United Nations.

SA 'can't afford first world health services'

Star 7/6/89

Medical Reporter

South Africa could not afford first world health services or to spend as much as developed countries on health, the Minister of National Health and Population Development, Dr Willie van Niekerk, said today.

Speaking at a conference in Johannesburg, Dr van Niekerk said per capita expenditure on health in South Africa was R242 or 5,8 percent of the Gross National Product.

The World Health Organisation's (WHO) target for the year 2000 was 5 percent. "We have passed the target," he said.

"We must accept that South Africa is not a first world country; we are a third world country with a small first world component," Dr van Niekerk said.

He said the country had other major needs such as education and housing to consider.

According to the WHO, South Africa, together with 13 other countries such as Algeria, Mexico, Panama and Portugal, fell in the lowest range of middle-income countries.

"The obvious conclusion is that funds within SA are limited and will remain limited

have been on strike for more than a week. 58 cents increase on the minimum hourly rate. the workers' dema

Health relief

299 South 8-14/6/89.

Gawu plans unique centre

By CHIARA CARTER

AS garment workers gear up this month for the industry's annual Living Wage campaign, a unique plan for a Workers' Health Centre has been submitted to employers.

Gawu has already submitted proposals to employers for changes in the sick fund and maternity benefits as part of its annual negotiations.

Included in the proposals drawn up by a sub-committee is the plan for a Workers' Health Centre (WHC), which would be formed in four stages over a period of five years.

As a starting-point, the committee recommended that existing health services be extended to the dependents of sick fund contributors.

The scheme provides for a mobile doctor to operate from consulting rooms in residential areas. The doctor's services would later be supplemented by a mobile clinic operating from a kombi.

This will be followed by opening workers' health centres in several residential areas.

In addition to the services of a doctor and nurse, the scheme makes provision for specialist services at several centres.

The committee has also recommended that the existing sick leave be scrapped in favour of the provisions of the Basic Employment Act.

This would mean workers could take a maximum of 30 days paid sick leave over a period of 36 months.

Gawu has also asked for a maternity leave payment of 25 percent of wages for a period of six months.

There is also a proposal for a national sick leave fund.

The union will be trying to get May 1, June 16 and March 21 as paid holidays.

The Living Wage campaign is a prelude to annual wage negotiations between the 112 000 strong Garment and Allied Workers' Union (Gawu) and clothing employers' associations.

Negotiations in the Western Cape are due to begin at the end of next month.

Gawu kicks off its campaign this month with discussions around the programme of action in all locals and factories.

This will be followed by a rally at the Goodwood showgrounds next month at which the proposals coming out of national wage seminars will be submitted to workers for a mandate.

lks on transfer

A Samwu spokesperson said "high-handed baaskap action" would plunge township municipal services into a crisis similar to that experienced in Soweto last year.

He said the union assumed the ultimatum had been suspended pending the meeting with the CPA on June 21.

Samwu wants the CPA and Ikapa to negotiate workers' status, job security, wages, conditions of service and other related matters.

The union is not recognised by the CPA.

METALWORKERS OF SOUTH AFRICA

Aid for disabled for easier life

SOWETAN Friday June 9 1989

By PHANGISILE MTSHALI

PHYSICALLY disabled people must be able to do daily, simple chores themselves to make their lives easier, a social worker for the newly opened Independent Living Centre, Mrs Nomsa Mashigo, said yesterday.

"The ILC works towards liberating the disabled by making appliances like wheelchairs, especially designed spoons and handles available to them," she said.

Legal

"Welfare services and everyday gadgets, such as cushions for pressure sores and urine bags for the incontinent, are given out free of charge to those who cannot afford.

If they want to buy things like wheelchairs, hearing and speech aids, we order for them at a 10 percent discount."

The ILC opened its office in Mofolo South, Soweto, last July. Its purpose is to make disabled people self-sufficient and to make them aware of their legal and civil rights.

It also compiles reports for people disabled through accidents or violent incidents so that civil lawyers can make claims.

Mrs Nomsa Mashigo, Independent Living Centre's social worker, demonstrates appliances used by the disabled daily.

"Our people have lost a lot of money that is rightfully theirs because of ignorance. If you were paralysed after a vehicle accident or assault you must report to us or lawyers within six months. That will allow enough time to prepare for your case. You can get compensation if you report the matter in time," said Mashigo.

The centre also assists in drawing housing plans for the disabled — bathrooms are wide, plugs lower than normal positions and there are fewer passages. They also have contact with driving schools to teach the disabled and with companies to modify their cars.

"Disabled people have certain privileges that they do not know. There are traffic discs that allow them to park at places where normal people cannot," said Mashigo.

On Wednesday ILC runs a first aid clinic where pressure sores are treated and dressed, those using incontinence bags are attended to and where the disabled are given self-sufficiency tips.

For more information contact Mrs Mashigo at (011) 982-1017.

MEDICAL AID Fm. 9/6/89

299

Doctoring the bill

Failure by medical aid societies and doctors to agree on payments is threatening to delay reform of the Medical Schemes Act.

At present, doctors who charge the Representative Association of Medical Schemes (Rams) tariff of R17,50 enjoy guaranteed payment direct from the patient's medical scheme.

Rams and the Medical Association of SA (Masa) agreed in principle at the end of last year that only 70% of tariffs needed to be guaranteed but failed to agree on new tariff levels.

National Health DG Coen Slabber says an amendment will have to be tabled before the end of October if parliament is to amend the Medical Schemes Act on schedule.

He says: "We don't want to act unilaterally. It would be much more acceptable if agreement could be reached."

Masa's federal council agreed this week to continue negotiating with Rams. Says council spokesman Hendrik Hanekom: "This decision is based on the acceptance that Masa has a responsibility towards patients in respect of affordable and equitable insurance benefits."

Unfortunately, it doesn't seem to bring agreement any closer. He adds: "We wish to state unequivocally that the consistent unrealistic increase in benefits offered by medical schemes has been making it increasingly difficult for doctors to render a high standard of service at medical scheme rates."

Masa says it will oppose any attempt to remove guaranteed payment from the Medical Schemes Act. It also opposes introduction of Health Maintenance Organisations (*Business* May 5), in which patients pay lower premiums but are limited to participating doctors. "Masa believes patients have a right to a free choice of doctor."

Although Masa supports the entry of private insurers into the healthcare arena and greater flexibility in the Act, it says minimum benefits should be preserved but maximum benefits removed.

There seems little likelihood, though, that any medical aid or insurance company will pay the full Masa recommended fee, which is 60% above the current Rams scale of benefits. Masa would like its existing fee to be the starting point for any negotiations.

Rams executive director Rob Speedie replies: "It isn't our job to decide what doctors charge. We have to set tariffs at a rate which is still affordable for our members." ■

MEDICAL AID (299) Fmail 9/6/89

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Best of life for disabled

(299 ST times 11/6/89

COMPUTER technology can enhance the quality of life for the disabled.

That is the view of George Freeme, chairman of the Transvaal executive of the Computing Services Association (CSA). He visited Access College, SA's first vocational training centre for the disabled.

Access College, based in Randburg, opened its doors in 1983 to 12 students and is now geared to accept as many as 60.

It has provided employment qualifications for many people of all races, allowing them to compete in the labour market at equal salaries.

The college's curriculum comprises three main courses — clerical, secretarial and business administration.

Courses include typing, accounting, business English, business methods, business calculations, self-motivation, communication and computer applications.

Self-management and employment skills, which include work habits and telephone manner, interviewing skills, self-presentation and finding leads for employment, are compulsory in all modules.

Cheaper medicine in sight

299 Argus 12/6/89

The Argus Correspondent

PRETORIA. — Cheaper medicines are in sight for members of some medical aid schemes.

A contract signed in Pretoria will result in medicine bills of members of the Statutory Organisations Medical Scheme (Soms) being slashed by at least 22 percent.

The agreement was reached by Soms and the brokerage firm MDS Mediscor, and other medical aid schemes are likely to join the scheme soon.

MDS Mediscor negotiates with retail pharmacies on behalf of medical schemes and with medicine suppliers on behalf of pharmacies, to push down the price of medicines.

Contracting pharmacies, called MDS pharmacies, will dispense medicine to the members of medical schemes at substantial discounts.

At the same time, MDS Mediscor will negotiate for the supply of medicines to pharmacies at the lowest possible prices.

According to a statement by MDS Mediscor the scheme has been opposed by "certain groups" in the Pharmaceutical Society and by wholesalers with "vested interests in the cartels which dominate the pharmaceutical trade".

300 PHARMACIES

The statement said, however, that support from medical schemes and the public was growing and a substantial number of pharmacists wished to take part in the system.

The company plans to start the scheme in Pretoria, the Witwatersrand and the Vaal Triangle on September 1 this year.

About 300 pharmacies will take part and the turnover is expected to represent at least 30 percent of the medical bill of all medical schemes combined.

A medical scheme member who buys medicine from MDS pharmacies will pay only his member's contribution and will receive a discount of at least 22 percent on this amount.

Pharmacies will claim the balance from the medical aid scheme, via the central clearing office, and receive payment within 28 days of supplying the medicine.

The scheme should be operating throughout South Africa and the TBVC countries by the middle of next year, according to Mr Kosie van Zyl, general manager of MDS Mediscor.

Savings by contracting medical aid schemes and their members should amount to about R50-million a year, he said.

The scheme was first disclosed in March this year when Dr Willie van Niekerk, Minister of National Health and Population Development, mentioned it in an address to the House of Representatives.

Blind workers help Soweto homeless

Star 13/6/87

By Winnie Graham

Blind men are doing their bit to ease the problems of the homeless in Soweto.

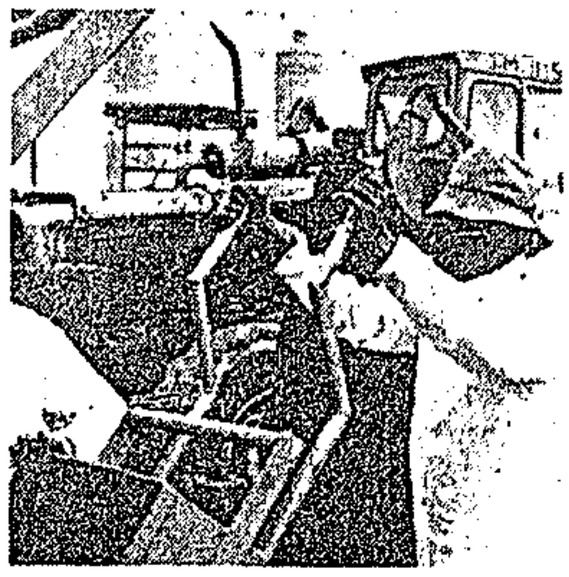
A brick-making project initiated by the Transvaal Association of Blind Black Adults (Tabba) in Soweto, in co-operation with a number of companies, is producing thousands of bricks a month — bricks being snapped up by local people anxious to build their own homes.

When the project was opened last week by Mr Dean Norton, executive director of the Portland Cement Institute, the blind brickmakers were churning out bricks at a rapid rate.

Mr Colbert Sobopha, a worker and one-time member of the Moroko Swallows who lost his sight in a stabbing incident, was running barrowloads of the brick mixture — cement, ash, sand and water — to the brick-making machine.

"It's good to be involved," he said. "Everyone wants a house, so there is a big demand for our work."

Mr Enos Motirapula, a former clerk in the Supreme Court who lost his sight in 1976, was equally enthusiastic.



Mr Colbert Sobopha, a blind brickmaker, tips the mixture into the brick-making machine.

"Look at the beautiful bricks we are producing," he enthused. "They are selling like hot cakes."

Nearly three years ago, Mrs Ruth Machobane, secretary of Tabba, aproached PCI and asked that blind men be trained to make bricks, not only to provide jobs for them but to fill the need for bricks in the community.

"She showed all the elements of entrepreneurship," Mr Norton said.

Thirty men were trained to mix concrete, compact it into moulds and to produce concrete building blocks. No concessions were made to the regular training programme.

"Our training team was very impressed with the enthusiasm of the group and its ability to produce bricks every bit as good as those made by sighted people," Mr Norton said.

A Soweto woman, Mrs Dolly Mokoko, impressed by the group's initiatve, offered to raise funds. With the money she collected a hand-operated block-making machine was bought.

PPC, a cement-producing company, donated 400 bags of cement to build a flat slab — essential to the production. National Beverages provided financing for the clearing and levelling of the ash site, as well as for electrification and renovation of the offices.

BP donated an electrically operated brick-making machine capable of producing 2 000 bricks a day. Operation Hunger provided wheelbarrows, hose pipes, industrial brooms and shovels. Crown Cork financed a cement mixer, a crusher, a conveyor belt and other equipment.

Mr Norton added: "The blind brickmakers have had the courage to focus on their abilities rather than on their disability ..."

Discount medicine scheme: Details released

C. Times 14/6/89

299

Staff Reporter

DETAILS of the new discount scheme for medicines have been disclosed.

The discounts will apply to almost 2,5 million people who will soon be able to claim a 22% discount on prescription medicines.

Mr J D van Zyl, general manager of pharmaceutical brokerage MDS Mediscor, said yesterday negotiations with some medical schemes were complete and those with others, which would give a total of almost 2,5 million members and dependants, were nearing completion.

The contracts will mean that a medical scheme member who buys prescription medicine from an MDS-linked pharmacy will, at most, have to pay his member's contribution, on which he will receive a discount of 22%.

The balance will be claimed from the medical scheme direct, via a central clearing office to be established by Mediscor.

The company, formed in March, last week signed its first deal with a medical aid scheme, the Statutory Organisations Medical Scheme, which has some 100 000 members and dependants. The members work for such organisations such as the Medical and Dental Council, the SA Pharmacy Council and most of the universities.

Retail pharmacies

The company has now completed negotiations with a group of 26 medical aid schemes administered by one Cape Town company. Members and dependants of this group total more than 500 000.

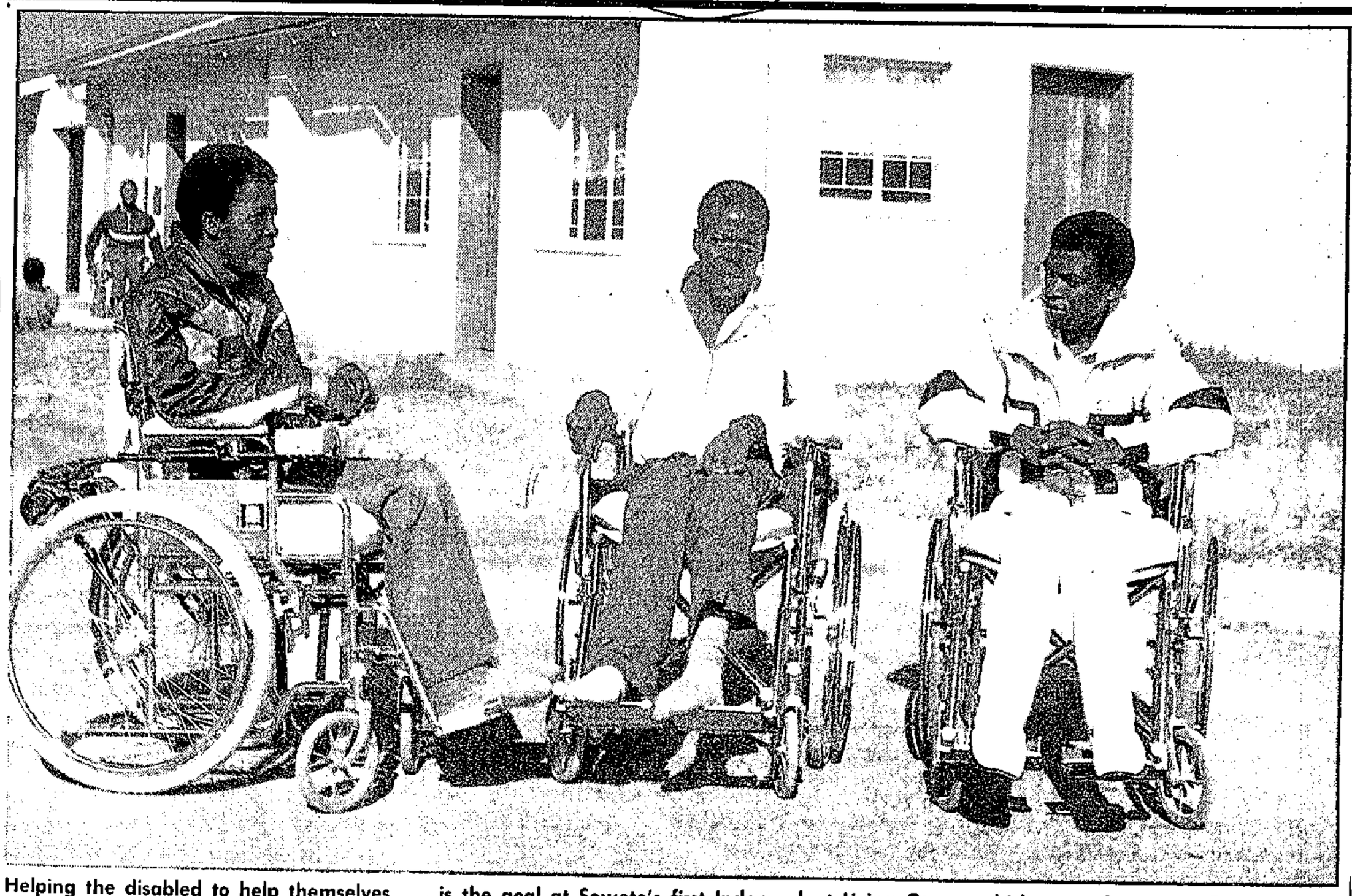
It has also opened negotiations with retail pharmacies and has already signed up several in the PWV area. It intends to kick off on September 1 with 300 pharmacies in Pretoria, the Witwatersrand and the Vaal Triangle, representing 30% of all medical schemes.

The medicine distribution system proposed by Mediscor was disclosed in March by Health Minister Dr Willie van Niekerk and it has gained increasing support from the public, medical schemes and pharmacies.

The company operates as a brokerage, which negotiates with retail chemists on behalf of the medical schemes and with suppliers of medicine on behalf of the retail pharmacies.

Contracting pharmacies undertake to dispense medicine to members of contracting medical schemes at a discount of at least 22%, made possible by the channelling of larger volumes of business through those pharmacies. Mediscor also intends to use its bulk-buying muscle to the benefit of these pharmacies — and the consumer.

Star 14/6/89 (299)



Helping the disabled to help themselves . . . is the goal at Soweto's first Independent Living Centre which opened recently. From left are Clement Madlala, Samson Fulela and Lizwi Memela.

● Picture:Alf Kumalo.

Soweto's first Independent Living Centre is launched

By Stan Hlophe

The first branch of Independent Living Centre (ILC) — which helps the disabled — has opened in Soweto.

The centre provides help and information for the disabled and displays equipment available locally and internationally.

It is based at the Self Help Association of the Paraplegics (Shap) in Mofolo.

There is a huge demand among the disabled for such a facility in the township.

The centre is run by a social worker Mrs Nomsa Mashigo. She emphasised the ILC's motto: "Working with people and not for them."

"This involves active choice-making on the part of the person with a disability," she said.

The ILC, with headquarters in Johannesburg, was funded by public donations, trust funds and companies, she said.

No government subsidy was received and the centre in Soweto is in need of funds, she added.

The objective of the centre was to offer services to help the physically disabled.

It also helped to create links between disabled people in their areas and to enable them to achieve and maintain the highest possible standard of independence, she said.

"We also liaise with other organisations working with disabled people."

The centre also helped in preparing MVA reports in the case of accidents and had lawyers who gave legal advice.

"We encourage people to lodge their claims within six months if they are involved in an accident so as not to lose their claims."

A parking concession was offered by the centre in conjunction with the Johannesburg Traffic Department in the form of a disc which allowed the disabled to park in certain restricted areas.

The centre also assisted in drawing up housing plans for the disabled in which rooms were more spacious, bathrooms wider, showers accessible to wheelchairs and plugs lower.

The centre also had contacts with driving schools and companies to help the disabled drive.

On Wednesdays ILC ran a clinic where pressure sores were treated and dressed and those with bladder problems helped, she added.

Mrs Mashigo can be contacted at (011) 982-1017 between 8 am and 4 pm, on weekdays.

Discount plan for pharmacies

Own Correspondent (299)

CAPE TOWN — Almost 2,5-million people may soon be able to claim a 22% discount on their prescription medicines. B1Dan 14/6/89

In terms of contracts negotiated by pharmaceutical brokerage MDS Mediscor, members of participating medical schemes who buy prescription medicine from an MDS-linked pharmacy will, at most, have to pay their member's contribution, on which they will receive a discount of 22%.

The balance will be claimed from the medical scheme via a central clearing office to be established by Mediscor.

MDS GM J D van Zyl said yesterday negotiations with some medical schemes were complete and those with others, which would give a total of almost 2,5-million members and dependants, were nearing completion.

The company intends to kick off on Septmeber 1 with 300 pharmacies in Pretoria, the Witwatersrand and the Vaal Triangle.

Contracting pharmacies undertake to dispense medicine to members of contracting medical schemes at a discount of at least 22%.

MEDICAL AID (299)

Premium cover

The healthcare industry is debating whether insurance companies should be allowed to offer general medical cover, currently the

FINANCIAL MAIL JUNE 16 1989

(299) Fmail 16/6/89

preserve of medical aids.

Pharmaceutical Manufacturers' Association president Hugo Snyckers says if insurance companies can fulfil minimum conditions, the door should be opened. He argues there must be guarantees of continued cover for people who may run up large medical bills.

"Without these conditions, an insurance company could end a contract after a year because the patient was chronically sick, and he would fall back on the State. There would also have to be provision for retired members."

Medical aids say they would welcome competition — if it's fair. Representative Association of Medical Schemes (Rams) executive director Rob Speedie says: "If we were providing identical products, I'm sure medical aids could provide the service more cost-effectively. If companies picked the eyes out of the business and covered only low-risk patients, it wouldn't be a comparable service."

Hollandia Reinsurance senior manager Nico Fourie says insurers don't want to replace medical aid schemes, but rather to provide extra benefits. It would be impractical to provide first-rand cover for all medical eventualities.

He says: "Insurers have given names like hospital plan and dread disease cover to their packages so as not to contravene the Medical Schemes Act. This is supplementary medical insurance and insurers should be allowed to call it that so it's clear to the man in the street."

He would expect such contracts to be non-cancellable. Premiums would be assessed according to risk on the first day of policy and not arbitrarily adjusted after that.

Private hospitals like the idea of alternative medical cover — hardly surprising, since the hospitals and medical aids can't agree on

Hurwitz . . . monopolistic

tariffs and some hospital groups have opted out of the system.

Clinic Holdings chairman Barney Hurwitz — who complains medical aids "are in too much of a monopolistic situation" — says hospital insurance packages already contribute towards the shortfall in medical aid payments. He urges an end to the restriction that prevents insurance companies from paying medical expenses direct to providers of services.

(19) Fmail 16/6/89

The latest debate on insurance vs medical aid was sparked off by Jan Hupkes, Professor of Management Economics at Unisa. In a report commissioned by the Hollandia and Hannover reinsurance groups, he says if the present structure of healthcare financing is maintained, it could impose an "intolerable" tax burden in the foreseeable future.

Insurers are currently excluded by the 1967 Medical Schemes Act from paying benefits direct to providers of services.

Hupkes favours a system allowing flexibility; by getting away from the situation where medical aids must provide cover for even the smallest prescription or expense. He maintains this first-rand requirement leads to high administrative costs.

Government has indicated its willingness to consider allowing insurance companies to enter the market in force. Medical aid subscriptions are currently determined according to members' income and number of dependants. The *Government Gazette* has proposed a plan that would allow members to tailor cover and payments to individual needs.

However, when legislation to this effect might go through remains unclear. Health has never been a vote-catcher in an election year. ■

Problems in remote mine towns disturb doctors

Star 20/6/89

299

South Africans living in isolated mining towns have more psychosocial problems and consume more alcohol than the general population, a study published in the latest edition of the South African Medical Journal has shown. **By TONI YOUNGHUSBAND, The Star's Medical Reporter.**

Doctors working in remote mining towns frequently remark on the number of psychosocial problems they encounter — particularly among women.

It is this which prompted the Department of Community Health and the Department of Psychology at the University of Stellenbosch to conduct an in-depth study into three towns to discover the reasons for the inhabitants' depression, high alcohol consumption, and psychiatric disturbances.

This was the first study of its kind in South Africa, although it has been well documented that there are psychosocial problems in isolated towns in Australia and Canada.

The South African study compared three small towns with a larger diamond town 30 km from a city.

There were 1 239 respondents. The study was confined to whites.

A general health questionnaire submitted to all respondents showed that 19,9 percent were psychiatrically disturbed and 11 percent needed treatment.

The percentage of men who were disturbed was 15 percent, and the percentage of women 22,2 percent. Unemployed married women showed the highest percentages in need of treatment.

Unmarried women and unemployed married women appeared the most depressed. Married women — particularly the unemployed — also suffered from more psychosomatic illnesses.

The towns also showed marked heavy drinking patterns. The percentage of people who consumed alcohol daily was found to vary from 23,2 percent to 31,2 percent.

This is almost twice as much as in the white general population.

A questionnaire showed that people in the larger town close to the city were the most satisfied. Those in the small towns the least.

Areas of dissatisfaction are inadequate entertainment or facilities for car repairs, not enough trees and grass areas to make towns attractive, and insufficient meeting places for teenagers.

Other factors will now have to be investigated, such as whether certain personality types are drawn to such towns, or whether people change when they move to mining towns.

"The cause of the problem is undoubtedly multifactorial. Further research into causes will need to be done," the study concludes.

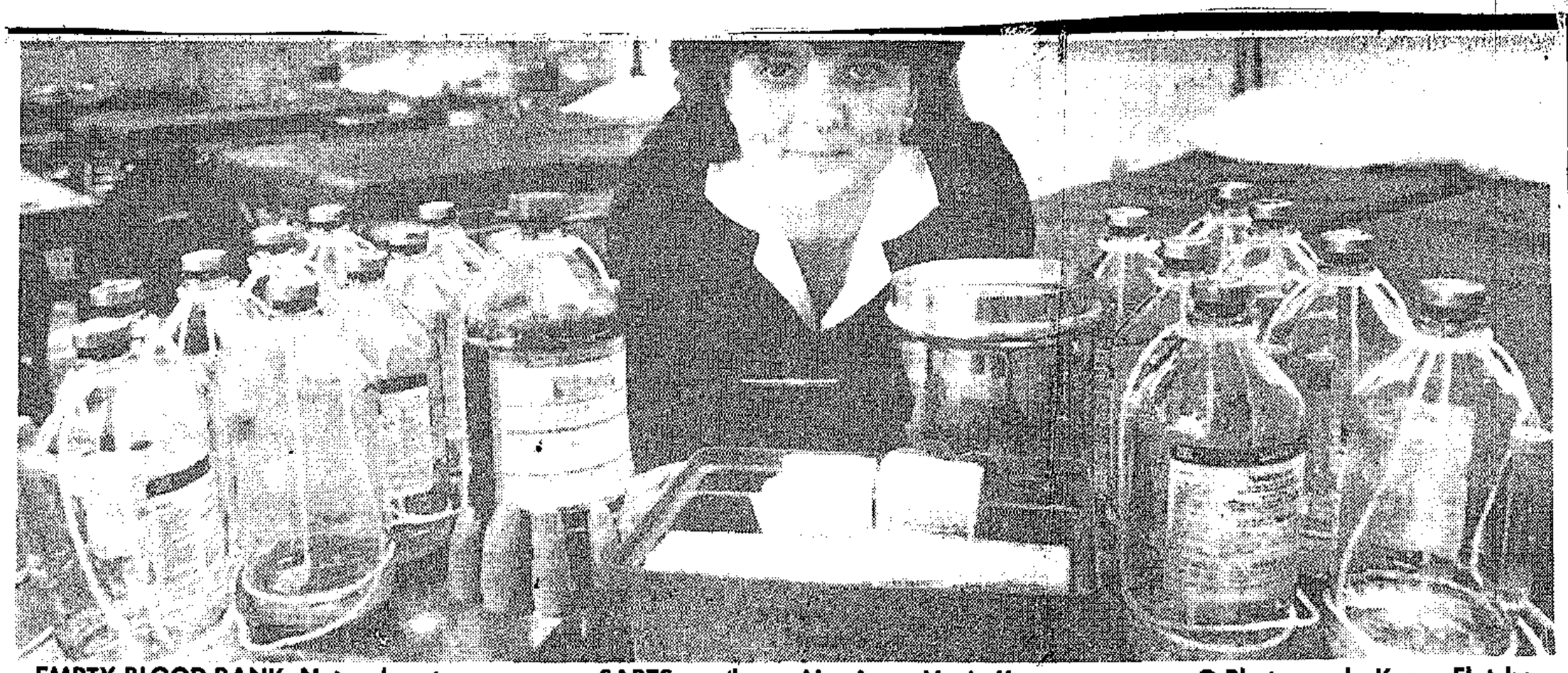
Nutrition

2/16/89 299

NEW trends and facts on nutrition and health will be discussed at the coming Southern African Nutrition Congress in Cape Town next year, a spokesman for the organisation said this week.

Covering the total spectrum on nutrition science, the congress will be attended by dieticians and nutritionists. Overseas experts in nutrition education will also attend the three-day congress starting March 19 at the Cape Sun.

Those wishing to submit papers have been asked to contact the congress secretariat at Box 4096, Old Cloak, 7537 or telephone (021) 932-0311 ext. 239.



EMPTY BLOOD BANK: Not a drop to spare, says SABTS employee Mrs Anne Marie Krynauw. ● Photograph: Karen Fletcher.

Tvl blood shortage could prove disastrous

"THERE is a fountain fill'd with blood," wrote 18th century poet William Cowper — and how the SA Blood Transfusion Service must be wishing this were true! In the Transvaal there is not a drop to spare.

Indeed, in the Johannesburg and Pretoria regions there is a critical shortage of blood — one that could have disastrous consequences if there were a sudden demand after a major accident or bomb blast.

"Although the blood shortage in all groups eased somewhat after this week's publicity and the positive public response, we are still desperate," said a spokesman for Johannesburg's Blood Bank, Mrs Claire Chowles.

She added that the drop in blood donors was inexplicable and denied it was due to a possible Aids scare. "We inform all our donors that we use new needles each time and all blood is tested for Aids.

"Every time we appeal for blood new donors come in, but they often fail to return and many regular donors have lapsed," said Mrs Chowles.

"Many blood donors seem unaware that they can donate every two months," she added.

So far, the transfusion service receives enough blood for each day, but Johannesburg and Pretoria use about 600 to 700 units daily. In the event of a major accident or bomb blast, the situation could become critical.

"We've had a drop in all our clinics. On a good day between 300 and 350 units are donated from Johannesburg and outside clinics. We send blood-donation units out to companies or factories to take blood from people working there and we want companies to do this more often. A lot of them do not want us on the premises because of tight security."

A campaign directed at black donors is in operation and the transfusion service will be holding a social event at Baragwan ath to encourage more donors.

"At the moment *all* blood groups are rare," said Mrs Chowles. "Any blood type in demand is described as rare, and right now we need all groups."

PAT DEVEREAUX

Transplant hope for Parkinson's sufferers

Star 26/6/84

299

By 1991, brain tissue transplantation could be performed in South Africa, says an optimistic Dr James Temlett.

A consultant neurologist at the Johannesburg Hospital, Dr Temlett is particularly concerned with neurological disorders such as Parkinson's disease and distonia.

It is Parkinson's disease which he believes stands to benefit the most from brain tissue transplanation and already experiments on animals are showing excellent results.

Dopamine deficiency

Parkinson's disease, which usually attacks the over-60 age group, occurs when there is a deficiency of the chemical dopamine in a certain part of the brain. The patient suffers from slowness of movement, trembles, loses his balance and may become rigid.

Eight years ago, Swedish scientists began grafting cells from the adrenal glands into the brains of Parkinson's sufferers when it was discovered that these glands contained dopamine.

Some patients showed a marked improvement but doctors failed to show conclusively that this treatment cured Parkinson's and 10 percent of patients died, due mainly to the fact that they had undergone two major operations.

Twenty years ago, brain tissue transplantation was as fictional as the Frankenstein monster but today scientists worldwide believe this may be the answer to a cure for Parkinson's and other neurological diseases. TONI YOUNGHUSBAND, The Star's Medical Reporter reports.

Dr Temlett believes scientists were so eager to prove this method worked that they failed to analyse closely enough their experimental animal data.

When this treatment showed signs of failure, scientists turned their attention to foetal tissue transplantation.

Brain cells containing dopamine are dissected from an eight to 10 week-old aborted foetus, mixed with a solution which kills off those cells not needed and injected into the brain of the Parkinson's sufferer.

Dr Temlett says he is anti-abortionist in the wider sense, but points out that in many countries where abortions are legally performed the foetal tissue is discarded. If delivered for transplantation within one hour, the tissue can be used to possibly cure Parkinson's disease.

"We are able to accurately pinpoint within 0,1 mm the area in the brain we are aiming for. The needle is pushed through a small hole drilled in the skull and the cells injected," says Dr Temlett.

This experiment is currently being performed on vervet monkeys in Dr Temlett's laboratories. "This programme is funded by the Medical Research Council and all experiments are strictly controlled by ethics committees," says Dr Temlett, emphasising that the animals feel no pain and are extremely well-cared for.

"Before we can even consider this treatment on humans we need to form a multi-disciplinary team consisting of gynaecologists, embryo experts, neurologists and neurosurgeons.

Worst sufferers

"This is not something you can do on your own. But I predict that if all goes well, we will be performing these transplants in South Africa by 1991," he says.

One of the difficulties he faces is in choosing patients for treatment. "Obviously we could not do them all in the beginning. We would offer it to the worst sufferers first," he says.

But is there conclusive evidence to show that the foetal cells work? "They have done fewer than 100 transplants in humans overseas and so far we have seen positive results in two areas.

"The foetal cells have not been rejected by the recipient (even if the cells come from another species) and the transplanted cells seem to grow.

"However, there is no evidence to show that these cells make contact with the native cells in the brain and the moment we can prove they do latch on to these native cells, I believe we have success," says Dr Temlett.

He believes that while transplantation is still in the very early stages it is important that the public is informed of the research going on behind closed doors.

"We need to tell these people that there is hope around the corner," he says.

Dr Temlett encourages Parkinson's sufferers to join the SA Parkinsonian Association which will keep them up to date, via newsletters and lectures, on the latest developments in disease cure and prevention.

Anyone wishing to find out more about this disease can write to the Association at PO Box 10901, Aston Manor, Kempton Park 1630.

Blind workers down tools

ABOUT 200 people, most of whom are blind, at the Natal African Blind Society in Umlazi south of Durban are on strike over demands for more pay.

The director of the NABS, Mr John Randles, said yesterday that the workers had been on strike since last Wednesday when they withdrew their labour and demanded more pay.

He said that the workers had been told to go back to work and await the executive committee meeting, scheduled to take place today. However, the attitude of the workers was that they would not work before then, he said.

Randles said that the committee would be able to give them money if there were any available.

He said it was illegal for the workers to go on strike, but he did not want to bring in the law.

300 000 South Africans face risk of going blind

Stev 27/6/89

299

Medical Reporter

About 300 000 South Africans are at risk of developing or passing on an eye disease which leads to blindness.

Researchers are trying to find a cure.

Retinitis pigmentosa **(RP), an incurable condition, is an inherited disease usually affecting children and young adults.**

NIGHT BLINDNESS

An early symptom is difficulty seeing at night. After that comes a reduction in side vision, and eventually blindness.

Experts now estimate that there are possibly 300 000 people in South Africa unknowingly carrying a "half-dose" of the gene for this disease. There is yet no test to identify carriers, but when two carriers marry there is a 25 percent chance that any child with have the illness.

International research to find a cure is being focused on genetic research and retinal cell transplantation, both of which require extensive financing.

To boost local research efforts, a fun cycle ride has been organised by the local RP foundation. It will be on Sunday July 9 at the Benoni Hyper at 7.45 am. The prizes are valued at more than R3 000.

Star 27/6/89 299

Dictionary of sign language a breakthrough in communication

By Noel Ndhlovu

For the millions of deaf people in this country, the hope of breaking communication barriers grew brighter as the first 1 000 words of a comprehensive sign-language dictionary were recorded in Johannesburg at the weekend.

Following the meeting of the South African Sign Language Board, visual signs used for communication by different deaf population groups in South Africa were recorded on video tapes and stored in a specially designed computer.

The computer will digitise the image of the various stored signs. The images and their meanings in words will be taught to teachers and the general public — making communication between the deaf and the hearing easier.

"Since 90 percent of deaf children are born to hearing parents, it is very important that society in general becomes more aware of sign language in order to communicate adequately with the deaf," said the project leader, Ms Claire Penn.

There was, however, a problem because sign language was not universal.

"Sign language is the natural language of many deaf people and contrary to popular opinion is not universal," added Ms Penn, an associate professor of speech pathology and audiology at Wits University.

The project, which is sponsored by the Human Sciences Research Council and the South African National Council for the Deaf, will yield the first South African Sign Language Dictionary which will contain 3 500 words.

Explaining the need for the dictionary, which will be produced over a period of three years, Ms Penn said sign language was as complex and as grammatical as any spoken language and consisted of as many words.

"We therefore need a reference text for parents and teachers to facilitate early language development in profoundly deaf children."

She added that South Africa was lagging far behind in appropriate deaf education, especially when one considered that there were 3,5 million deaf people in the country.

According to Ms Penn, unless more funds are received, the project may never be completed.

"It is strange that sport is heavily sponsored and yet a project like this is sponsored only by a few companies."

Inquiries and donations should be sent to: Sign Language Research Project, National Institute for Personnel Research, PO Box 32410, Braamfontein, 2017.

Women bring ray of hope to children

Sowetan 28/6/89

299

By SIZAKELE KOOMA

A group of professional women in Vosloorus have brought a ray of hope to the lives of mentally handicapped children in the township.

The six nurses and teachers, who call themselves Tswelopele, are setting up an education programme to cater for both special and normal children.

They are hoping to start a medically orientated day-care centre which will provide a service based on intelligence assessment.

"The situation in the black community is such that mentally handicapped children do not have special education programmes they can follow from the elementary stage," Mrs Florence Bojabotshega, president of the group, said.

"They go to the same creches and pre-schools as normal children instead of receiving a service that suits them. This is time-wasting and unfair for the child."

Bojabotshega said every child will, on admission, be given an IQ test to determine if he should join a normal pre-school programme or be admitted to the mentally disabled wing.

The normal pre-scholars will be trained on the syllabus which all creches follow while the disabled will have their own programme.

"A psychiatrist and nurse will decide what the level of disability is. There will be an educable group and a trainable group.

"Occupational therapists will be provided to work with both groups. The children will, therefore, either follow a special school programme or be trained in skills that will be useful to them in future," Bojabotshega said.

"The centre will have its own mini-clinic which will provide immunisation and also deal with minor illnesses."

She said the centre had already secured the services of local child-minders and a building site had been allocated.

WOMAN

A chat with the thinking person's nurse

299
Soweten
29/6/89

By SIZAKELE KOOMA

GRACE Dineka is the new senior nursing service manager for Soweto clinics and the first black to be appointed to the position.

This confident and articulate woman, whose academic credentials read like a college professor's has taken over responsibility of all 11 clinics in the township.

The history of the position has not made her the least nervous. She, in fact, finds comments from colleagues who ask her if she is not intimidated ridiculous.

"I have always hoped that one day I would hold this position. All these years I have been equipping myself with the knowledge that would be needed for the job," Dineka said.

"I see myself as fitting the post. I also do not know why I should be intimidated by working with my people. I am part of the community they live in. I understand their problems and know their needs. I knew what my job entailed as I have twice acted in the post. What could I therefore have to fear?"

GRACE DINEKA

Dineka already has a number of plans lined up for the upgrading of township health services. Priority goes to primary health care.

"We plan to build more clinics in the township and to extend our services to surrounding farm areas and squatters in the near future. All these areas will need primary health care nurses, who are nurses trained in duties that are performed by doctors. We need them in these areas not because of the shortage of doctors but also because of the language problem. It is very easy for patients to explain their illnesses to people who speak their language," she said.

Other plans

Other plans include opening the Mofolo Clinic, which is fully equipped but has not started operating because of a shortage of funds. Expansion of district nursing services is also in the pipeline.

These carefully thought-out plans come from a person who joined nursing not because a commitment to the health course. Dineka did nursing only because it was the fashionable career at the time. Speaking to her gives one the impression that her whole life revolves around her job.

Widowed mother

This widowed mother with one son has done most of the things that a person who is committed to her job does and her services have been recognised by her seniors. She has all the basic nursing diplomas and a BA degree in Nursing Science. She has held positions of matron grade 1, principal matron and nursing service manager.

"I attempted LLB but I dropped it because of its extensiveness. I thought it would help me gain insight into the legal system. We are living in an era of enlightenment. Patients can sue with the slightest thing that goes wrong. We therefore have to have the legal knowledge that would help us deal with such situations if they arise."

City is desperate for blood

299
some pen
29/6/89

THE South African Blood Transfusion Service is experiencing a critical shortage of all blood groups despite numerous appeals for public support.

The Johannesburg area has been hardest hit with a daily shortfall of 400 units of blood being recorded. More than 650 units of blood are needed each day and at present this area only has one day's supply of blood.

Hospital staff say the shortfall is forcing the postponement of less serious surgery and placing those patients undergoing major surgery in danger.

Doctor R L Crookes, deputy medical director of the South African Blood Transfusion Service, has appealed to business organisations to follow the example set by some companies who had instituted their own blood transfusion campaigns. — Sapa.

Nurse your loved ones at home

299

Sowetan 30/6/84

MOST women have taken on the responsibility of nursing a loved one. This can often be a daunting and harrowing experience, especially for those who have not had to cope with illness or emergency situations before.

Nursing Care At Home is a book published by the St John Ambulance Foundation. It is designed to make home-nursing techniques and strategies for coping more accessible to the public.

The book aims at helping women to become effective care-givers at home.

The manual focuses on the essentials of home nursing and emphasis is placed on involving the whole family in supportive roles.

All facets of caring for the ill are comprehensively covered. These include the patient's diet, administering medicines, changing dressings, improvising in the home and caring for the patient's emotional needs.

Written in a cheerful easy-to-read style, the book sets out clearly and factually what to do in any emergency situation which might occur in the home.

It covers the complete age range — from babies to the bed-ridden aged.

The author of the book, Elza Kritzinger, has spent a lifetime caring for the sick and has written her book for all population groups.

She has contributed many original ideas and aids for making the life of the sick more comfortable.

This book has been written with great compassion and is invaluable to anyone who has or may have to nurse family members.

At R7,50, it is an affordable must in every caring home, especially with rising medical and private nursing costs.

SOCIAL SECURITY - MEDICARE

1989

JULY — DEC.

Drive to aid smog-hit children

STAR 11/7/87

PAT DEVEREAUX

299

THEIR childrens' recurring health problems caused a number of mothers in the Vaal Triangle to band together and form an anti-pollution force which is fast becoming feared by industrial polluters.

Doctors' bills for four-year-old Helen's respiratory problems which have jammed the Mufford family's Vereeniging postbox since the day she was born were the driving force behind an anti-pollution campaign which is rapidly expanding in the area.

"Her nose has never stopped running and her cough and sinusitus are almost constant," said her mother, Mrs Jenny Mufford, an initiator of the Vereeniging-based Air Pollution Appeal Committee (Apac).

"As a baby Helen had to sleep upright in the winter months to stop her chest from clogging up completely," she said. "And the new baby, which is a couple of months old, will probably have similar problems."

Like many other families in the area the Mufford family blames its recurring respiratory health problems on the heavy industrially poisoned air that hangs over the Vaal Triangle.

Oxygen tents at the Vereeniging hospital are in huge demand for babies during the winter period when temperature inversion causes the smog to hang like a cloud over the area.

Mrs Mufford and Mrs Carol Smith joined forces with a number of mothers in the area to form Apac.

Last year Mrs Mufford waded into battle with a paper titled "Aspiration or Procrastination", which she delivered at a conference on residential air pollution hosted by National Association for Clean Air.

Since then she and Mrs Smith have attempted to establish the state of existing pollution monitoring in the area and claim the responses from Government officials have all been placatory.

"We have been fobbed off with explanations that it is not industrial smoke which is causing the problem but vehicle exhaust and smoke from the fires in black residential areas," said Mrs Mufford.

But the fight won't stop there. The group recently organised a three-day Pollution Expo in Vereeniging which was supported by Vereeniging's mayor.

Crumbling health service must be probed, says MP

299

A COMMISSION of inquiry needed to be conducted into the health services in South Africa to find ways of reducing the rising cost of health care, Dr Marius Barnard, Parktown MP and former PFP spokesman on health, said yesterday.

He was responding to the shock increases of up to 50 percent in public hospital tariffs on the Reef which were announced by the Administrator of the Transvaal, Mr Danie Hough.

The increases, which do not include community hospitals, come into effect today.

"There must be a way to make the health services cheaper, more equal and better for everyone," Dr Barnard said.

He said the Government's racially segregated policy was "unnecessary and a waste of money", and placed an added burden on rising inflation and costs of medical equipment.

The Government was unable to cope financially, and increased the price of services while at the same time, the standards of health care in public hospitals was deteriorating, he said.

"We are getting higher fees, poorer facilities and generally,

JANET HEARD

the whole service is falling to pieces," he said.

Dr Barnard said the rising costs of public hospital prices were forcing more and more people into private hospitals.

Apart from immediately opening hospitals to all races as a step towards reducing costs, Dr Barnard said private and public sector hospitals should inter-change services and co-operate with one another.

He said there was a tremendous reserve of private practice medicine available which could be used in the government sector, but there was "resistance" between the two sectors.

"Each works seperately and basically in competition with one another," he said.

Dr Barnard said the Government's policy was forcing SA into a stage were the phrase "health is now so expensive it makes you sick," became a reality.

He said ways of developing alternative funding, pooling together resources and maintaining and improving the standard of medicine and teaching facilities in the country urgently needed to be addressed.

Hospital fees hike spelt out

By SOPHIE TEMA

THE 50 percent hospital fee increase that came into effect yesterday will not affect pensioners or those with an annual income of less than R3 765.

Transvaal Administrator Danie Hough said on Friday that private patients treated in regional and academic hospitals' private wards would pay 67 percent more – R138 a day instead of R82,50.

Private patients – about 27 percent of all patients – will pay 42 percent more when admitted to a general ward.

Tariffs in community hospitals will rise from R71 to R101 a day.

The tariffs are to increase from R10 to R15 on a single admission for the H3 category, and from R20 to R30 for the H4 category. Tariffs at community hospitals will remain unchanged.

Transvaal Hospital Services MEC, Daan Kirstein, said the increases would only affect patients who were not on medical aid schemes.

The classification ceiling dividing private from hospital patients increases about 80 percent, from R5 000 annual income to R9 000 for a single person, and about 61 percent from R13 000 to R21 000 for a family of five and more.

Hough said the increases had been necessitated by the substantial rise in the running costs.

Cover for disabled pros

THE Professional Provident Society is the largest and certainly the most visible fund which provides sickness and disability benefits, group life, term cover, a retirement annuity scheme and medical aid for its 41 000 members.

Although it is registered as a pension fund, it is regarded by Inland Revenue as a sickness benefit society.

Through PPS membership, individual professional people, can obtain the same variety of benefits as those employed by large corporations.

"However, investments generate surpluses and these are paid back to the members in a tax-free lump sum when they retire.

"To attract new members, our benefits have to match those on the market," say PPS general manager Etienne Huggett.

"To augment our permanent incapacity benefits, we have introduced a partial incapacity this year.

"The need was prompted by instances where members suffered severe injuries or crippling diseases, but were trying to spend some time at their practices.

"Notable among these cases was a young professional who suffered a broken neck which rendered him quadriplegic, yet he was able to practise to a limited degree from his wheelchair."

Last year the total benefits paid to members amounted to R66,1-million — an increase of 34% over 1987.

Provincial hospital fees rise

GERALD REILLY

PRETORIA — Spiralling costs of illness will be given another major twist by substantially higher provincial hospital tariffs which come into operation from the beginning of this month.

Administrator Danie Hough said at the weekend, a big increase in hospital running costs had threatened a wide range of patient services.

Governments' commitment through big subsidies had to be reduced by generating more funds to continue rendering services for indigent patients.

In one private patient category the hospital tariffs has been raised by 67% at regional and academic hospitals — from R82,50 a day to R138.

Private patients' tariffs —representing 27% of the total — were raised by about 42% from R71 to R101 a day.

The ceiling below which a single "hospital" patient started paying had been raised by 80% from an income of R5 000 to R9 000.

For a family of five it had been raised by 61% from total earnings of R13 000 to R21 000.

Hough said increases might seem high but in January last year tariffs were not increased when the tariffs of the scale of benefits of medical schemes were raised. Hospital fees were last fixed in July 1987.

Other increases included theatre fees for private patients and radiographic services.

Danie Kirstein, in charge of hospitals, said of the 27% of all patients who were "private" 85% were members of medical schemes.

So it was only 15% of the 27% which would be hit by the big 67% tariff hike, he said.

"Many could escape this if they joined a medical scheme".

Medical aid pitfalls come under the spotlight

By MZIMKULU MALUNGA

THERE was increasing pressure in government circles for a change in regulations governing medical aid schemes, Henk Beets, assistant general manager of the Old Mutual (employee benefits), told a seminar in Johannesburg this week.

Commenting that many medical aid members were dissatisfied with the current system, Beets pointed to the following problem areas:

- The benefit structure was too rigid.
- The contribution structure encouraged cross-subsidies.
- Employee participation was often compulsory.

He said the medical aid administrators had been trying for the past six years to have the regulations governing schemes changed, but without success.

"Medical aid membership is becomingly perceived as a necessary evil to obtain work," Beets said.

Quoting from a market survey conducted early this year among medical aid members, he said about 55 percent of people wanted a "no claim bonus" on medical insurance.

Other demands included:

- The exclusion of non-essential benefits.
- Different benefits for different age groups.

Beets said benefits paid to medical aid members were increasing more rapidly than the rate of inflation. Some 1,4 million medical aid members made three million claims each month.

Forecasting future developments in medical insurance, he said there was likely to be:

- Greater flexibility in benefit options, incentives to reduce claims and contributions to match risks.
- Removal of payment guarantees for hospitals and pharmacies.
- Involvement of insurance companies.
- Formation of health maintenance organisations.

On the question of whether provident or pension funds were better, the Old Mutual general manager (employee benefits), Gerhard van Niekerk, said they met different needs.

Commenting on the union push for provident rather than pension funds, he said employers had initially been concerned that lump sum payouts would be misused.

Both Van Niekerk and Beets pointed out that increased union activity had forced employers to change their attitudes on the issue of retirement benefits.

Van Niekerk said employers had tended to act unilaterally when it came to these benefits. There was still an element of paternalism in their administration, despite the existence of jointly managed schemes, such as those falling under industrial councils.

Both speakers highlighted the need for improved communications between employers and employees concerning retirement benefits.

On the question of housing, Beets said the current crisis could be eased by diverting employees' contributions from either pension or provident funds to speed up house repayments.

After the house had been fully paid off, the employee could top up his contribution to the pension or provident fund.

"A house must be seen as part of one's preparation for retirement," Beets said, adding that a house could also provide a future investment in the sense that it could be sold to generate cash.

Van Niekerk said his company would continue to serve its customers in Namibia, even if a socialist government came to power in that country.

Responding to the suggestion that institutions such as Old Mutual had a moral obligation to take sides in the "liberation struggle", he said the only way in which such organisations could play a role was by meeting people's financial needs.

Blind could soon be hearing it like it is

Stev 4/11/84 (299)

By Jacqueline Myburgh

Blind people in the PWV area could be listening to The Star newspaper by the middle of next month.

Strange as this may seem, the talking newspaper is similar to one produced successfully in Australia and provides a valuable service to the blind community which is usually excluded from the paper market.

The Star is working on a programme whereby a week's news will be read on to tape by reporters and edited into 90 minutes of news. The tape will then be reproduced and posted to blind people who choose to subscribe to the free "newspaper" once a week.

The tapes will contain all the components of a regular newspaper — from hard news to political comment, sport, record reviews and advertisements. There will even be a comics "page" of jokes.

POST OFFICE OFFERS TO HELP

Tape Aids for the Blind, where tapes of books and plays are available to the sightless, is assisting The Star on this project and will arrange for the distribution of the taped newspaper.

The Post Office has undertaken to deliver the "newspapers" to subscribers and to return them to The Star once they have been "read". The same tapes would be taped over with the following week's news.

The Star hopes to establish a sound-proof studio where reporters would be able to read their own reports on to a master tape, and this would be reproduced on a high-speed tape recorder.

Organisers hope the project will soon be extended to the rest of the country and that an Afrikaans version of the tapes will be produced.

Soaring hospital fees will make patients wince

Star 4/7/89

The cost of running TPA hospitals has forced tariff increases of up to 50 percent. What does this mean to the man-in-the-street? **TONI YOUNGHUSBAND, The Star's Medical Reporter** reports.

	FEES PER DAY	AFTER HOURS SUR-CHARGE	WARD ADMISSION
Jan 1985	H2 - Free H3 - R2 H4 - R2 Private - R20		
Before July 1 1989	H2 - R5 H3 - R8 H4 - R12 Private - R30		
After July 1 1989	H2 - -R5 H3 - -R12 H4 - -R18 Private - R45	H2 - R7,50 H3 - R18 H4 - R30 Private - R67,50	H2 - R5 H3 - R15 H4 --R30 per day Private R138 per day
% increase since 1985	H2 - 500% H3 - 500% H4 - 800% Private - 125%		

H2 = Pensioners, unemployed, persons earning less than R3 765 annually.
H3 = Persons earning more than R3 765 less than R18 000 annually (depending on number of family members).
H4 = Single person earning more than R6 000 but less than R9 000 annually.
P1 = Staff members working at the hospital for a number of years.
P2 = Medical Aid members
P3 = Prisoners etc. State dependants.

Health care is becoming a commodity which soon only the wealthy will be able to afford.

This is the fear of the Health Workers' Association (HWA), which has been monitoring rising medical costs since 1984.

The HWA is particularly concerned about those who make up the bulk of patients: pensioners, the unemployed, and the poor.

An HWA spokesman saod: "People just won't come to hospital any more because they will not be able to afford it. The problem you will have then is that they will come only when very sick and cannot wait any longer.

"In the long term, this is counterproductive. The hospital will be spending more money caring for a very ill patient than it would have if it had seen to the patient earlier on."

Before July 1, patients paid between R5 and R12 during the day, but must now pay up to R18. If they visit the hospital after 4 pm they will be charged an after-hours surcharge, which will mean between R7,50 and R30 for treatment.

To be admitted to a ward, a patient will have to fork out between R5 and R30. They are divided into categories based on income, number of dependants, and whether they belong to a medical-aid fund. The fees are calculated accordingly.

The tariffs for private patients, who represent about 27 percent of the total number, have gone up by about 67 percent from R82,50 to R138 a day in regional and academic hospitals, and by about 42 percent — from R71 to R101 a day — in community hospitals.

Theatre fees have also gone up. But unlike private hospitals, the fees are not calculated according to the surgical procedure performed. Howevwer, the fee does increase according to the time spent in the theatre.

The Administrator of the Transvaal, Mr Danie Hough, has blamed rising running costs and expensive medical equipment for the increases. Hospitals are desperately short of money.

Johannesburg Hospital can use only 800 of its 2 000-bed capacity because it has neither the funds nor the staff to open more.

The medical and surgical wards are 100 percent full, and new admission criteria, where only the really ill are admitted, has been introduced to stem the flow of patients.

Where possible, patients are referred to other institutions, and most medical-aid members are turned away.

A Baragwanath spokesman said yesterday that an estimated 88 percent of patients did not belong to medical-aid funds.

The TPA hopes the fee increases will solve some of its difficulties.

But the HWA believes the increases will only hurt the consumer, and in the long-term worsen the hospitals' plight.

"These fee rises show that the State is abdicating its responsibility in providing a free, equal and easily accessible health care system. It is promoting the privatisation of health.

"South Africa has 14 health departments, each with its own head and administrative staff. Our hospitals are segregated, meaning we have a duplication of services at double the cost.

"If we did away with segregation and unified all health departments, an enormous amount would be saved"

Mr Hough said on Friday that there was no doubt South Africa could no longer afford apartheid in its health services.

"It is not only morally offensive, but also very expensive. As I have already urged in the past, I think there is an urgent need for a commission of inquiry to see how the escalation in health care costs can be reduced.

"I ask the Minister of National Health and Population Development to immediately appoint such a commission."

There has been no response from Dr Willie van Niekerk yet.

Hospital tariff increase slammed

By SOPHIE TEMA

INCREASED hospital tariffs are becoming too expensive for the poor and good health is becoming affordable to the rich only.

This warning was sounded by the SA Health Workers Congress (SAHWCO), who said the recent tariff increases would create serious problems for the unemployed, disabled and aged.

The organisation said the latest increase had to be seen as a further indication of the crisis in South African health services.

Unemployment and increases in the cost of living, bus fares, rentals and other charges had further aggravated the economic burden on the underprivileged.

The SAHWCO criticised Transvaal administrator Danie Hough for his statement this week that "substantial increases in the running costs of provincial hospitals made it necessary to increase the tariffs in order to maintain a high standard and wide range of services for patients".

The organisation called Hough's statement a farce, saying that while patients were sleeping on the floor at Baragwanath Hospital 1 200 of the 2 000 beds at the Johannesburg Hospital were not being used.

Hospital fees had increased by 500 to 800 percent since January 1985, the organisation said.

This meant the poor, unemployed, disabled and aged were being severely punished by the continual deterioration in the quality of health services, the congress added.

Mental Health Society needs volunteers

Sky 10/7/89 (299)

By Toni Younghusband,
Medical Reporter

The Witwatersrand Mental Health Society is searching for volunteers to help their overburdened social workers.

"We are looking for housewives and people with time on their hands who would like to help. They need not have any training in the mental health field — we will put them through an extensive seven-week training course," spokesman Mrs Sandra Greyling said.

The volunteers will train in all aspects of mental health including mental illness, crisis intervention, retardation and counselling. The training course costs R40.

She said the volunteers would be required to work at the society's head office in the city, at its regional offices and at its various centres.

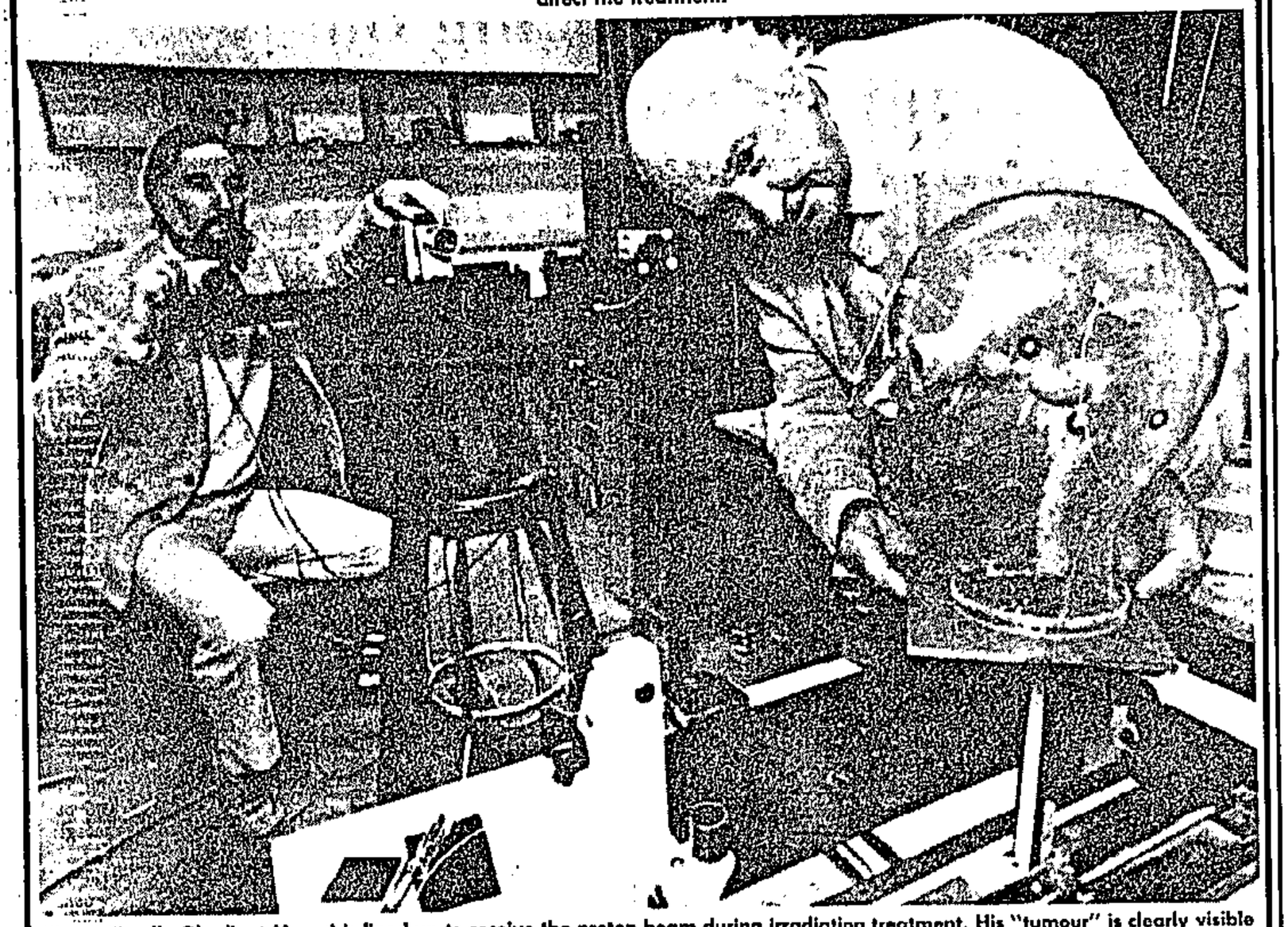
"We have a centre for people who have psychiatric problems and another one for the mentally retarded. These centres provide employment for people who are given a sense of worth and achievement".

"We need someone who is able to counsel and to offer guidance and assistance," she said.

Volunteers will receive full supervision and support from permanent staff members.

Anyone wishing to volunteer can contact Mrs Greyling at the society at (011) 331-9441 between 8 am and 4,30 pm on weekdays.

Three dimensional information is fed into a computer to calculate the position of the tumour inside "Tom's" head and thus direct the treatment.



"Tom" (Totally Obedient Moron) is lined up to receive the proton beam during irradiation treatment. His "tumour" is clearly visible in the centre of his head.

Wordgame spells success

A world breakthrough in the treatment of brain tumours has been achieved by a team from the University of Cape Town.
By KAREN STANDER, Medical Reporter

The idea which led a University of Cape Town team to a world breakthough with a new technique to line up an unseen brain tumour with an invisible proton beam began with the word "food".

The National Accelerator Centre at Faure wanted to use proton therapy in the treatment of brain tumours, commonly used elsewhere in the world but which necessitated enormous trauma for the patient with holes being drilled in the skull and the head bolted into place to prevent movement.

They had a vault for the treatment and the technology, but could not solve the problem of how to line up the patient's head with a proton beam so that only the tumour and not the healthy brain tissue was destroyed by the treatment.

The centre called in Professor George Jaros of UCT's department of biomedical engineering, who in turn called a brain-storming session of engineering and medical experts — and a sole representative of the department of surveying, Professor Laurie Adams.

In December last year the scientists met at a Western Cape hotel for the day and, led by a "master of ceremonies", started tossing ideas back and forth.

Turning to lateral thinking to force them to use the creative portion of their brains, they employed word association, a technique commonly used by psychologists, beginning with the word "food".

"When it came to my turn, I said 'microwaves', which look like monitors, and this led to computers, images and cameras ... and we had the solution," said Professor Adams.

"The breakthrough is really that South African medical experts understood that it was a measuring problem and thus called in surveyors.

"We surveyors think in three dimensions while everyone else thinks in two dimensions," Professor Adams said.

The solution was to build a chair linked to a computer in which the patient would recline while the computer calculated the correct position of the patient's head. Robotics, controlled by the computer, would move the patient into position so that the proton beam was directed precisely on the right spot.

The Cape provincial hospital authorities provided R400 000 for the research and the UCT team, led by Professor Adams and associate-Professor Heinz Ruther, began the project with the help of a plastic skull — named "Tom" for "Totally Obedient Moron" — whose pink kidney-shaped "tumour" is clearly visible through the transparent perspex.

Professor Adams explained that treatment would begin with a CT-scan or magnetic resonance image to pin-point the site of the tumour.

The relationship between the site and marks made on the patient's head was used to calculate the position of the tumour in three-dimensional space. This information was fed into the computer which could then calculate the desired position of the head in relation to the proton beam.

As the marks on the patient's head would have to remain there for the duration of the course of treatment, it had been suggested that they be tattooed on to the skin with ultra-violet ink as this could only be seen under ultra-violet and not ordinary light.

At the beginning of each session of irradiation small pieces of rubber, which would be visible on the images projected on the computer screens, would be stuck on the tattoos.

Professor Adams said one of the biggest advantages of the new system was that any head movement was constantly monitored.

Images were projected on computer screens by five or six cameras throughout the treatment, and these were closely watched by a medical technologist who had a "panic button" close at hand to stop the beam if the patient's head moved and the beam was directed at healthy tissue.

Initially radiologists would use a "shoot-through" technique of proton therapy. This would involve rotating the head into several different positions while a thin beam was directed through the brain from different angles. The beam would hit the tumour each time and eventually destroy it, but without damaging healthy brain cells with repeated exposure.

Later a more sophisticated form of proton therapy would be used in which the proton beam was set so that it's strength was concentrated on the tumour without affecting other brain tissue.

The new system was expected to be ready for use in about 18 months, Professor Adams said.

Deafness is an invisible handicap

By NTHABI MOREOSELE

THE members of a certain soccer club are frustrated because no-one wants to play with them.

The members of the football team are deaf and so the potential opposition argues that they will not be able to hear the referee's instructions.

This is an example of how deaf people in our society are prevented from socialising.

Mrs Vicky Mkhize, of the South African Association of the Deaf, says that deafness is an invisible handicap as most deaf people pass for normal.

"In 1987, the Year of the Disabled, it was found that the most common disability is hearing impairment," Mkhize said.

"But nothing was done about it. Deaf people are still lagging behind because there is no provision made for them. There is no legal provision for deafness as a disability. As a result, people are unable to get a disability pension for deafness unless it is coupled to another, visible, disability.

"There is nothing wrong with deaf people. Some of them are exceptionally bright, for example the well-known Soweto artist, Tommy Motswai."

Problem

Deaf people have a problem communicating with the rest of the world. This problem leads to complications in their lives like a lack of employment opportunities.

There is not a single high school for black deaf people — after Std. 5 they are expected to learn a trade.

"Even so, the deaf have to compete with people who can hear and have had adequate education," Mkhize said.

"Some are bright and the thought that they have to stick to welding or carpentry is frustrating."

"Available resources for training, for example from the Department of Manpower, are inaccessible to them as trainers cannot communicate with them."

No access

Another problem is lack of access to community resources. A black deaf person cannot communicate with a psychiatrist as the psychiatrist cannot communicate with him.

The deaf are blocked from socialising at clubs and church services.

• The adhoc committee for the black deaf at St Anthony's, Reiger Park, East Rand, invites other deaf people and hearing people who are interested in the aims of the committee to a meeting on August 19 at 2pm.

This is a self-help group whose aims are:

• To form an association that will look after the interests of the deaf.

• To fight for an improvement in the education of deaf people.

• To create job opportunities.

Flood of support for Boksburg clinic

By Toni Younghusband
Medical Reporter

Offers of financial assistance and legal aid have poured in for a multiracial drug and alcohol rehabilitation centre threatened with closure by Boksburg's CP-controlled town council.

Last week the council turned down an application for a concession in terms of the Group Areas Act, a move which may force the clinic to close.

The Catholic Church-run House of Mercy in South Street, Plantation, is on the border of the coloured township of Reiger Park but according to the town council is still within a white residential area. Founder of the clinic Father Stan Brennan argues that it is in a mixed area.

Father Brennan said yesterday that since a report on the clinic's plight in the Sunday Star, offers of financial and legal assistance had flooded in.

Donations of more than R60 000 had been received from companies in the area and another company had offered legal assistance in the fight against the clinic's closure. Five new patients had also come forward for treatment.

The CP has suggested the clinic move into the township itself but Father Brennan is adamant this will not happen.

"The people who come here for treatment don't want their friends and family seeing them go into an alcoholics' clinic," Father Brennan said.

Taxpayers' millions for health care go down ideological drain

Major fee increases at provincial hospitals were announced recently, increases that will result in real hardship for families with even quite modest incomes.

It is ironic that these increases come as we are reminded of crisis conditions at Johannesburg's major hospitals. Specialist units at the J G Strijdom Hospital are closing down, nurses and doctors are leaving the Johannesburg Hospital in droves, resulting in less than 40 percent of its beds being open and all but the sickest and poorest patients being referred elsewhere.

The "Beds for Bara" campaign highlights the fact that the authorities are not keeping that crisis-ridden hospital afloat.

Members of the public, whose taxes pay for the construction and staffing of these institutions, and to whom the hospital services should be accountable, are entitled to ask whether they were getting value for money before these recent increases, and what benefits will accrue to them from the substantial extra revenues that are being extracted from their pockets.

The authorities will argue that it is precisely the threatened collapse of hospital services that has necessitated these fee increases — that they will provide the funds needed to avoid complete catastrophe.

The reality, however, is that the threatening catastrophe is the result of public policies and the squandering of taxpayers' money in pursuit of those policies. Users of public health services should not accept these fee increases until those wasteful policies have been eradicated.

There are some specific questions we should be asking.

By CEDRIC DE BEER, co-director, Centre for the Study of Health Policy, Department of Community Health, Wits Medical School

How much extra does it cost the state to have 14 departments of health and four provinces all involved in the provision of health care, instead of a single authority?

No one knows the answer to that question. Logic suggests that the duplication of everything from administrative structures to stationery, the multiplication of ministerial motorcars, the need for extra staff to send accounts between departments, and the existence of three separate structures to co-ordinate between all these fragments of the health service must cost the taxpayer several million rands a year — with no benefits in terms of additional services.

There are other costs to fragmenting services this way. A simple example illustrates this. The Johannesburg City Council runs excellent immunisation and child health clinics, many with a doctor on hand. However, any child who is found to have a health problem in need of curative care, may not be treated on site, but will be referred either to the family's general practitioner or to a provincial out-patients service.

The doctor on hand may not even write a script for penicillin for a throat infection. Such events are repeated daily all over our city.

What are the costs in terms of taxpayers' money for duplicating doctors' services and to the parent for the additional transport and time wasted in standing in another queue for a service that should be readily available at the first point of contact?

Apartheid requires the segregation of hospitals and other health facilities. What are the costs? In particular what are the costs of duplicating super specialist facilities in segregated institutions?

A letter in the SA Medical Journal in January suggested that in the Orange Free State alone, nearly R37 million is wasted annually to maintain apartheid in the academic hospitals. One wonders what the total figure would be if the analysis had been applied to the whole country, and to all health care facilities and not just academic hospitals.

Given all these unanswered questions, consumers of public health care are entitled to question whether the fee increases do not amount to throwing additional funds down the sink of administrative and ideological waste. Should we not be resisting any increase until the authorities present the public with a plan that integrates all aspects of health care into a single unit that makes the most cost effective use of funds, personnel and resources already at their disposal?

Consumers of health care have, for some time, been trapped between rising prices in the private sector and deteriorating standards of care in the public sector. Perhaps the additional blow of major price increases in provincial hospitals, will jolt us into demanding a whole new dispensation in health care in South Africa. Such a demand would not be a moment too soon.

● In September, the Centre for the Study of Health Policy is organising a conference entitled "Containing costs in health care — towards affordable care for all".

299

On a high after she runs for life

OVERWEIGHT and overstressed executives are heeding the warnings of medical experts and running for their lives.

By Robyn Chalmers

A healthy, relaxed life for burdened businessmen and women is one of the biggest benefits of the get-fit Run For Life programme, which is said to be the only scientifically based multi-centred running programme in the world.

I joined the Run For Life programme grudgingly — three months seems an incredibly long time to work on one article — but it gave me an acute awareness of the importance of health.

I discovered there is no high like that of being fit. Although South Africans are slowly becoming educated in health matters, the process is a slow one.

Chances are that more than 60% of executives who believe they are relatively healthy would be unable to make it once around the block. All are prime candidates for heart attacks.

Run For Life was started in 1984 by a sports scientist at Wits University. For ethical reasons, he cannot be named. I shall call him Dr Fitness for convenience.

It began when he was approached by a Johannesburg newspaper to do an experimental project measuring the effect of running on risk factors for coronary disease.

Sedentary

When he advertised for sedentary executives between the ages of 30 and 40 to act as guinea-pigs, he received an amazing 650 applications. At the end of the experiment the chosen volunteers were so impressed with the results of their running that they did not want to disband.

So Run For Life was born. Dr Fitness says the programme started as a hobby for him, but the results he received from it — elimination of insomnia and anxiety, weight loss and reduction of high blood pressure — were so exciting, he decided to go into it full time.

"Medical practitioners often need to resort to prescriptions to treat lifestyle-related disorders — obesity, stress and high blood cholesterol — because helping patients to modify lifestyles is difficult in practice.

"We must change the lifestyle and Run For Life is an excellent catalyst to do this. In South Africa we have a fundamental problem which begins at school. At a young age children are taught sports which need co-ordination, agility, endurance, speed and leadership.

On the run to a sense of achievement

Spectators

"Children who do not have these qualities believe they are exercise drop-outs, and become professional spectators. Twenty or thirty years down the line they are overweight, stressed and unhealthy, yet they still believe they were not made to exercise."

I became a Run For Life member in April this year under the not-so-gentle persuasion of my editor. The programme is organised in groups with progressive levels of fitness. There are four beginner, two intermediate and an advanced group.

As a beginner I dragged myself around the field for five minutes, cursing the day I decided to join a newspaper. But as a colleague of mine said recently, the first day you do something it's difficult to see the point of it. Three months down the line the benefits are glaringly obvious.

Weight loss, an incredible feeling of well-being and a sense of achievement are all part of the bargain. Runners on the programme with me were of varying ages, from five years to 75, and were there for different reasons.

Businessman Pete Buchanan was taking alpha-blockers, beta-blockers, vaso dialators and cholesterol-reducing drugs as well as having suffered a suspected heart attack before he joined Run For Life.

Six months later he has lost 12,5kg, reduced his blood pressure and cholesterol level, says he sleeps better, no longer screams at idiot drivers and can run 10km three times a week without a problem.

The programme is conducted on a formulated, scientific basis. Runners receive computer printouts twice a month, monitoring their progress, assessing calorie use and fitness levels through a system of points.

From its humble beginnings in 1984 with 65 members and one branch, Run For Life now has More than 4 000 runners and walkers at 44 branches.

Dr Fitness says the target is 100 branches in the next two years, with membership reaching about 10 000. The programme was franchised about 18 months ago.

OM call for better medicaid schemes

By Michael Chester

The Government is under pressure to sweep away all red tape that hinders the launch of radical new medical aid schemes aimed at improved health care services in the face of spiralling costs.

The pressure stemmed from the insurance and pension fund giant Old Mutual in a new review of employee benefit schemes.

"Seemingly uncontrollable cost escalations in health care — in most cases in excess of the inflation rate — have been the subject of widespread public concern and much controversy," says the review.

"We believe that amendments to legislation, permitting greater flexibility in respect of the type of products which health care schemes are allowed to develop, such as cover for major medical expenses, is urgently needed."

New schemes were needed to set aim on a combination of incentives and disincentives to make them both affordable and more effective.

Scanning the scenario of benefits from medical aid to retirement schemes, especially from the angle of industrial relations, the review underscores a trend toward more negotiation between employers and employers, "rather than paternalistic hand-outs or unrealistic demands backed up by threats."

It adds: "There are growing signs of a new awareness of broader employee benefit options in the ranks of many long-established trade unions and staff associations.

"This emerging mood follows the considerable successes in recent years of a new generation of vociferous unions and union federations in negotiating more appropriate employee benefits for their members.

"We are entering a phase where employees generally, not only low-income industrialised workers, are beginning to question existing benefit structures, realising that their voices can effect meaningful change.

"It is being recognised that no employee benefit fund is 'given' any longer.

"More and more lower-income workers are looking for arrangements that will give them access to their job savings in the form of loans for housing, education and a variety of life-crisis needs. Higher income workers, on the other hand, are looking for benefit arrangements offering tax deferment.

"Many workers are beginning to realise that their retirement fund savings may amount to an asset as large in value as their homes. The question being asked is how this asset can best be utilised, not only at retirement, but also before."

Heart disease SA's biggest killer

Medical Reporter Star 19/7/88

More people die of heart disease than of cancer and traffic accidents combined, statistics released by the Heart Foundation of South Africa have revealed.

In South Africa, which has the highest incidence of heart disease worldwide, eight out of every 10 adults have a higher than normal risk of heart attack.

The Heart Foundation in conjunction with a pharmaceutical company has launched an extensive cholesterol awareness campaign aimed at lowering the incidence of heart disease which kills 31 South Africans daily, yet can be prevented.

At a press launch yesterday it was pointed out that by lowering one's blood cholesterol levels just 10 percent, the risk of heart disease dropped by as much as 30 percent.

Too much cholesterol results in fatty deposits in the arteries which may eventually completely block the artery causing a heart attack or stroke. Some cholesterol is manufactured by the body, the rest in taken in with the food we eat. (85) (299)

Stopping smoking, monitoring blood pressure and eating healthier food greatly reduces the risk of heart attack.

The Heart Foundation pointed out that many people believed because they had no physical "symptoms" of heart disease there was no need to check their cholesterol levels. This was erroneous.

299

BUSINESS

Up go hospital tariffs ... but not enough to pay

Hospital tariffs are up as much as half, but it won't make much difference to provincial budgets. A sizable number of patients still need to be subsidised, reports HILARY JOFFE

HOSPITAL tariffs have risen to levels which will take health care out of the price range of many people. But the increases are unlikely to solve the crisis in hospital funding.

The government has moved to "privatise" health care by encouraging the provincial administrations, which run the country's hospitals, to introduce "user charges". And central government grants to the provinces have been cut. But the problem is that too many people can't afford to pay the full cost of treatment and have to be subsidised.

The crisis was starkly reflected this month in the Transvaal Provincial Administration's decision to raise hospital tariffs by an average 50 percent.

The new tariffs, implemented on July 1, imposed a R7,50 after hours surcharge (for hospital visits after 4pm) and R5 ward admission fee for those in the lowest income category, H2, although it left the basic daily fee of R5 unchanged.Those classified H2 include pensioners, the unemployed and those earning less than R3 765 annually (R313 a month). In 1985, before the introduction of "user charges", they were being provided with free hospital treatment.

With the new charges, the treatment of such patients is still heavily subsidised. But the problem from the provinces' point of view, is that this category of people is hardly a minority.

According to the AMPS (All Media Products Survey) figures for 1988/89, around a third of black (African) South Africans earn less than R300 a month.

Also subsidised are those in categories H3 and H4. While H4 includes single people earning between R6 000 and R9 000 a year, H3 comprises those who earn up to R18 000 year, depending on number of dependents.

Tariffs have also been substantially increased for people in these categories. Patients classified H3 will have to pay daily fees of R12 — up from R8 before the increase and R2 in 1985. They will also be charged an R18 after-hours surcharge and R15 ward admission fee. H4 patients' tariff has been increased from R12 to R18, and they will be charged a R30 surcharge and R30 ward admission.

In percentage terms, the increases are steep. An H4 patient, for example, who would previously have paid R8 a day, could now be paying R78 if she arrived in the evening and had to spend a day in hospital — that's a 475 percent increase.

And these subsidised patients are on relatively low incomes — the most affluent of them are single people earning R750 a month or people with dependents earning R1 500 a month.

Above this ceiling, patients are classified "private" and have to pay the equivalent of (unsubsidised) medical aid rates. For these patients, tariffs have risen too — the basic daily fee, for example, has risen by 50 percent to R45.

In the case of a hospital like Baragwanath, 88 percent of the patients are reportedly not covered by medical insurance. Black medical aid membership has increased rapidly, but only seven percent of Africans were medical aid members by 1987 (compared to 68 percent of whites), up from four percent in 1985.

The Health Workers' Association has protested that the TPA's tariff increases make health care unaffordable. The result, HWA has said, will be that patients will only come to hospital when they are very sick — which is counterproductive for the hospitals.

The tariff increases will not do much to solve the provinces' cash crisis.

Only about 27 percent of the patients in TPA hospitals are "private" — the rest have to be subsidised. Earlier this year, Daan Kirstein, MEC for health services in the Transvaal, reported that only five percent of expenditure could be recovered from patients at black hospitals such as Baragwanath in Soweto, and this was a burden on the province's health budget.

And the introduction of user charges appears to have had only a marginal impact on cost recovery in other provinces where it has been introduced.

The South African Institute of Race Relations' (SAIRR) *Social and Economic Update* reported earlier this year that in Natal, the introduction of user charges increased the proportion of revenue to expenditure from six percent to eight percent. In the Cape, the move had a similarly limited effect.

Meanwhile the provinces' health budgets have not grown substantially. In the Cape, the health care budget has actually fallen by six percent in real terms, while in Natal the real increase is eight percent, according to SAIRR researcher Elaine Cosser.

The Transvaal's health care budget for all races rose this year from R1,5-billion to R1,9-billion, a 13 percent increase in real terms, according to Cosser. Health care accounts for 53 percent of the Transvaal's R3,7-billion budget for 1989/90.

Cosser reported in the most recent *Update* that provincial administrations regarded funds as insufficient.

In the Cape and Natal, officials said maintaining existing hospitals consumed most of their budgets, leaving little money for primary health care projects or for expanding facilities.

Announcing the TPA's new tariffs last month, Transvaal administrator Danie Hough blamed the increases on the rising costs of medical equipment and of medicines.

But behind the crisis in hospital funding are the costs associated with apartheid health-care — and this both the HWA and Hough have pointed out.

Hough was reported as saying that South Africa could no longer afford apartheid in its health services.

The HWA pointed to the costs of duplicating health services — for example, the country's 14 health departments.

299

Violence is the cause of trauma

HEALTH NEWS

By MOKGADI PELA

The effects of trauma on society demand that it should be prioritised in terms of preventive medicine like other preventable diseases, this is the view of Baragwanath Hospital's senior neurosurgeon, Dr Rasik Gopal.

He said in highlighting trauma there would be a need to spend more money to publicise preventive measures. The health sector would have to start a vigorous national education programme to teach preventive measures.

Dr Gopal said the medical world has correctly placed much emphasis on preventive and community medicine. Some of those programmes have included cancer screenings and immunisation against various disease. But very little is known about the incidents and effects of trauma.

"Trauma comes in various forms. Trauma from motor vehicle accidents, homicide and suicide being the major factors. Trauma research and prevention receives low priority throughout the world," he said.

Last year about 11 000 people died on South African roads. A further 40 000 people died from homicide or suicide. In addition to this horrific story for every person who died four people became permanently disabled.

Various preventive measures have been undertaken to reduce the killings on SA roads. Among them are speed restrictions especially in residential areas, checking on drinking and driving, wearing seatbelts, wearing of reflective clothing for the pedestrians, having motor cars in roadworthy conditions, having some standard in the testing and issuing of driving licences. In spite of these measures the death rate on our roads continuse to climb.

Among the homicide group were indications that most casualties were from stabbings. Recently the incidence of bullet wounds was fast increasing with most victims dying from stabs to the neck and chest. Many people become permanently disabled from head and spinal injuries, Dr Gopal added.

Factors

There were many factors contributing to this violence, he said. High on the list were low socio-economic conditions, unemployment and inadequate education. Excess consumption of liquor worsened the the situation.

Dr Gopal recommended steps that could be taken to curb the violence such as: putting restrictions on building of faster vehicles, restriction on the advertising of alcohol, finding ways of disarming people, restrictions on the sale of knives and guns, improving socio economic conditions and increasing the number of police in high-risk areas.

Check which foods are bad for you

Star 20/7/89 (299)

The Grocery Manufacturers Association is establishing a food intolerance data bank which will feature 10 of the most common substances that adversely affect some people.

The substances and their derivatives include milk, egg, wheat, soya, the anti-oxidants BHA and BHT, MSG (monosodium glutamate), sulphur dioxide, benzoate, glutamate and tartrazine.

Mr Jeremy Hele, executive director of the association, said: "The 10 substances are not the only ones that cause problems, but they are generally accepted to be the most common."

He said the bank will contain a list of brands which will be registered as free from one or more of the substances.

The food manufacturers had been asked to submit a list of brands that are free from one or more of the 10 substances to the CSIR which will then computerise the brands and produce 10 booklets.

Mr Hele stressed that these booklets will only be available to the medical profession and members of the Association of Dieticians of South Africa who in turn will make them available to the patient.

By the end of September he hoped to have a list of 2 000 products.

First 'black' scheme celebrates

B/Day 20/7/89 THEO RAWANA (299)

SIZWE Medical Fund, the first medical aid scheme designed to cater for blacks, celebrated its 10th anniversary in Johannesburg yesterday.

Started by a group of doctors and co-ordinated by Soweto's Dr Nthato Motlana in 1978, the fund is now non-racial. It has more than 27 000 principal members with 62 294 dependants, and paid out R21,1m in benefits last year.

The fund was started when the doctors wanted to open a clinic where black doctors could practise.

Kwacha (Pty) Ltd, Sizwe's holding company, has an income of R14,5m and a profit of more than R1m in the current year, on assets of R3,5m.

Less than 500 members joined Sizwe in 1979 and only R13 000 was paid out in benefits in the first year.

More than 150 companies offer Sizwe membership to their staff.

Spotlight on a killer

299
Sunday Times
23/11/87

BUSINESSMEN with high cholesterol levels run the risk of joining the thousands of heart-attack victims who have caused SA to have the highest rate of coronary heart disease in the world.

By Robyn Chalmers

A high cholesterol level is considered to be one of the major risks for heart disease. Stress is believed to be linked to raised blood pressure, increased cholesterol levels and faster heart rates.

SA executives are prime candidates for heart attacks because of high stress, and particularly if they are overweight, smoke, do not exercise, have high blood pressure or a family history of coronary disease.

A total of 31 South Africans die of a heart attack every day. Medical experts believe SA's problem of high cholesterol is one of the worst in the world.

Heart Foundation figures show that eight out of every 10 white, coloured and Asian South Africans have high cholesterol levels. The incidence is increasing rapidly among blacks.

The foundation, together with Logos Pharmaceuticals, has launched a programme to promote awareness of the danger of high cholesterol levels.

Logos medical affairs director Pierre Goosen says a concerted effort must be made to reduce cholesterol levels.

"The most important way of doing this is by helping people to adopt a healthy lifestyle. Our education programme aims to show people that the easiest way to reduce cholesterol is to improve eating habits, exercise regularly, stop smoking and reduce hypertension."

Dr Goosen says all of these are possible without major adjustments.

A Heart Foundation spokesman says more people in SA die from heart attacks and other related problems than from cancer and traffic accidents.

First black medical aid fund prospers

ST Times 23/7/89

299

Business Times Reporter

THE first black medical aid fund has developed into one of SA's most successful businesses.

When a group of Soweto doctors, aided by the established Medscheme fund, started the Sizwe Medical Fund in 1978, it paid out benefits totalling R13 000.

Eleven years later, there are 27 000 members with 6 2294 dependants. Benefits paid in 1988 amounted to R21,1-million and growth goes on. The fund is non-racial, but it aims mainly at blacks because of their different needs and claims experience.

Sizwe chairman Nthato Motlana says: "Where blacks and whites are in a medical scheme together, the blacks tend to end up subsidising the whites, who have a much higher claims pattern."

Kwacha, probably the most powerful black business group in SA with turnover of R14,5-million and a profit of R1-million on assets of 3,5-million, is the holding company.

Sizwe is owned equally by 38 doctors, only one of whom is white. Sizwe Medical Services and the modern Lesedi Clinic, which is being expanded to 218 beds, are subsidiaries.

Dr Motlana says Lesedi is the first private hospital for black South Africans. It meets a great need because conditions and discrimination in State and provincial hospitals are unacceptable.

"We have read so many stories about black business failure," says Dr Motlana. "Everyone has heard about Share World and the African Bank, but few know about us.

"We are proud of Sizwe's achievements. We have built up a reserve of R2,4-million, which is 10% of contributions — pretty good for any medical fund in 11 years."

CPA gives answers on non-payment of grants

CMC Times 25/7/89

249

Staff Reporter

THE Cape Provincial Administration yesterday responded to the non-payment of grants and pensions to Worcester's black old-age and disability pensioners, some of whom have been without income for months.

The Cape Times provided the CPA — which handles the payments — with a list compiled by the Black Sash of case studies in Zwelethemba where pensions and disability and maintenance grants were stopped.

Ms Vuyiswa Agnes Mnono received a disability grant of R194 four times a year since 1978 after losing a leg in a train accident. The grant was stopped in September last year.

A CPA spokesman said Ms Mnono was found to be medically fit by the Pension Medical Officer and payment was accordingly stopped. She is free to reapply for a disability grant, he said.

The Black Sash said a maintenance grant to Mrs Nodlunyeuana Mina Dopolo was stopped for no reason.

Her child was in Std 6 and the school had supplied a letter to confirm this. The letter had been submitted to Worcester Magistrate's Court but nothing had been done about it.

The CPA spokesman said that according to its records Mrs Dopolo received a pension but that no application for a maintenance grant had been received. She was advised to submit an application for consideration.

Sowetan 26/7/89

Parents group to help children

By NTHABI MOREOSELE

A GROUP of people in Vosloorus have organised a mental health project to cater for children in the township.

Mrs Bertha Mkhwebane, a social worker in the area, became concerned after meeting many handicapped children during the course of her work.

She founded the project which now caters for 22 children aged six to 25.

299

The project has proved to be a godsend to both parents and children.

The children are gainfully occupied while their parents are at work.

"We realised that mentally handicapped children are left alone during the day," Mkhwebane said.

"They are generally molested either physically or mentally. Some are locked out of the house when everybody is away.

"They have to fend for themselves. The worst part is that such children cannot be left with neighbours as they are hyperactive, epileptic or sometimes too dull to be tolerated by any person except their parents.

"In some cases the biological parents cannot be employed, especially the mother, because the child needs special care and attention.

"This leads to frustration and the children are the ones who suffer.

Sowetan 28/7/89 299

HEALTH CARE FACING CRISIS

SOUTH African hospitals - black and white - are facing a crisis of funding, says the National Medical and Dental Association.

Namda spokesman Dr Max Price said the response of the Transvaal Provincial Administration to the crisis was to increase hospital and clinic fees on July 1.

"The fee increases over the past four years have been up to four times higher than the inflation rate. This means it is becoming increasingly unaffordable to obtain health care.

"The fee you have to pay depends on two things: the total household income and how many people are in the house. On the basis of this a patient is classified into one of the four categories - H2, H3, H4 and P2 - as follows:

"Pensioners, unemployed. people earning less than R3765 a year or R72,40 a week are classified as H2. If you are on medical aid then no matter what you earn you are automatically classified as P2," says Price.

He said the cost of a casualty or outpatient visit to hospital had increased since January 1985:

In January 1985 H2 patients were treated free of charge. From June 1989 to date they were charged R5. H3 patients who paid R2 in 1985 now pay R12. H3 patients now paid R18 and P2 ptients R20.

The cost of admission this year for H2 category is R5, H3 is R15, H4 R30 a day and P2 is R138 a day.

"Thus for H2, H3 and H4 patients the increase since 1985 has been between 500 and 800 percent compared with the cost of living increased of about 90 percent over the same period.

"The conclusion for all this is that for the poorest patients (H category) the costs of health care now consume five to eight times more of their income than they did in 1985.

"It is hardly surprising that in order to obtain any health care. people claim they are unemployed or on very low incomes when they are questioned by the clerks at the entrance.

"The sector of the public that use the State hospitals tends to be the poorer community who cannot afford private care. The recent fee increases will lead to people staying away from medical care which they really need because they cannot afford the fees.

This is a sign of a non-caring government health services," said Price.

He said some of the reasons for the increases fell into two broad categories:

*"There is a waste within the system. One example is the duplication of high level facilities for different race groups when fewer are really needed.

"The treatment of simple medical problems in hospitals which are very sophisticated and therefore unnecesarily expensive happens because each 'race' has to have its own high care hospital.

"There is also an added burden to the costs that patients have to bear because they cannot use the hospital which is nearest to them but must travel great distances to to find a hospital of the right race group.

"Another example of waste is the duplication of bureaucratic administrations for each own and general affairs authority, the homelands and municipal authorities.

* The second reason is the Government's refusal to allocate more funds to health. The police, the SADF and the apartheid structures continue to consume an excessive proportion of our taxes.

"Of the government spending that is going to welfare, housing and education have received significant increases but not health.

"Unfortunately health issues are not high enough on the political agendas of the labour movement, the civic organisations and other progressive forces. This is the challenge to be taken up," said Price.

Annual income	Number in household				
	1	2	3	4	5 or more
Less than R3765	H2	H2	H2	H2	H2
R3 765 - R6 000	H3	H3	H3	H3	H3
6 000 - 9 000	H4	H3	H3	H3	H3
9 000 - 12 000	P2	H4	H3	H3	H3
12 000 - 15 000	P2	P2	H4	H3	H3
15 000 - 18 000	P2	P2	P2	H4	H3
18 000 - 21 000	P2	P2	P2	P2	H4
Over 21 000	P2	P2	P2	P2	P2

By THEMBA MOLEFE

Blacks lose out on medaid

5 Times 6/8/89

299

COSTS of health care are spiralling, but by 1986 only 3,66% of blacks enjoyed medical-aid cover, says Mark Colvin of Natal University's Industrial Health Unit.

He writes in the winter edition of Indicator SA that one of the weaknesses of a system based on medaid schemes is the fact that it can never provide health care to those in most need of it.

"The schemes are almost always connected to employment in some way, and even then it is usually available only to skilled workers upwards. This means that unskilled employees, the unemployed and rural dwellers will never have equivalent access to good health care."

He says, however, that the position seems to have improved since two years ago. Greater interest is being shown by companies and employer organisations in establishing schemes for blacks.

This is partly due to managements' desire to offer a more attractive package to skilled workers and so stabilise their workforces. It is also likely that large firms, especially multinationals, are under pressure to provide perks, like medical aid, without discrimination.

Mr Colvin says the reason that most workers do not and cannot belong to a medaid scheme is that it is usually prohibitively expensive. Contributions vary from 5% to 20% of a worker's pay, the lower-paid employers contributing proportionately more.

There are basically four types of medaid in SA — industrial council negotiated, company in-house, independent-commercial and trade union schemes.

Mr Colvin says that in reality, most black workers will not be able to afford a medaid scheme and will continue to rely on inadequate State services.

"A whole range of primary health care and preventive measures could be part of medical aid schemes rather than purely offering medical insurance. It remains to be seen how the Government and capital would respond.

"However, within the constraints of our existing health care system, the union movement could use its power in industrial councils or company negotiation forums to initiate alternative and progressive developments in the health care of workers and their families."

299 Shw 8/8/89

The Avril Elizabeth is a far cry from what it was 20 years ago

Home 'saved' by teddy bears

By Shehnaaz Bulbulia

Twenty years ago, Mrs Sheila Suttner founded a small two-roomed home for the care of the mentally handicapped — today the Avril Elizabeth Home for the mentally handicapped lies on five hectares of well-kept grounds on Fisher's Hill, Germiston.

The home stands as tribute to Mrs Suttner's foresight and compassion, says executive director, Mr John Rees.

Within a few years of the small home starting in Malvern, the project expanded to four homes, and in 1981 the Avril Elizabeth Home was relocated on bigger grounds on Fisher's Hill.

The move to bigger and better premises was not easy, says Mr Rees: "A few years ago, we were desperate for money. We could not even pay our rent and the home was on the verge of closing down."

But the home was saved by, of all things, teddy bears.

Says Mr Rees: "A kind man donated 100 teddies. We sold them and raised sufficient money to pay our rent. We owe our survival to the teddy."

Cuddly mascot

And in tribute, the cuddly teddy is now paraded as the home's mascot. In addition, there are teddies of all shapes, sizes and colours found in every room in the home.

"The teddy's presence just livens up this place and boosts the morale of our residents," says Mr Rees.

The home has come a long way from the time when, more than 20 years ago, many parents were desperate for proper facilities for their mentally handicapped children.

They approached the Selwyn Segal school in Sandringham without success, as the facilities catered solely for Jewish people. Administrative staff at the school were keen to help, though, and in particular one social worker: Mrs Suttner.

She was so moved by the plight of the parents, she resigned from the Selwyn Segal home to help find accommodation for the countless children.

A cottage has been named after Mrs Suttner, who was chosen as The Star's Woman of the Year in 1974 for her activities in getting the home started. She is the mother of restricted activist, Mr Raymond Suttner. Mrs Suttner emigrated to Australia a few years ago.

There are 150 residents at Avril Elizabeth Home for the mentally handicapped of whom 30 are day-care residents.

However, the residence is for whites only.

Says Mr Rees: "Because the home receives a small subsidy from the Government, we can open only our day-care facilities to all races."

But Mr Rees works firmly on the belief that all people have the right to proper facilities. With this in mind, he initiated a survey in Soweto and found that there were 15 000 mentally handicapped people in need of accommodation. Present facilities in the area accommodate only 150 people.

In an attempt to bridge that yawning gap, Mr Rees, Soweto parents and community leaders have succesfully raised money for a new home called Takalanih which can accommodate 900 residents and is expected to open in 1991.

Takalani residents will receive similar therapeutic treatment to that given to the Avril Elizabeth residents.

Says Mr Rees: "We want to break new ground in research and decided to experiment."

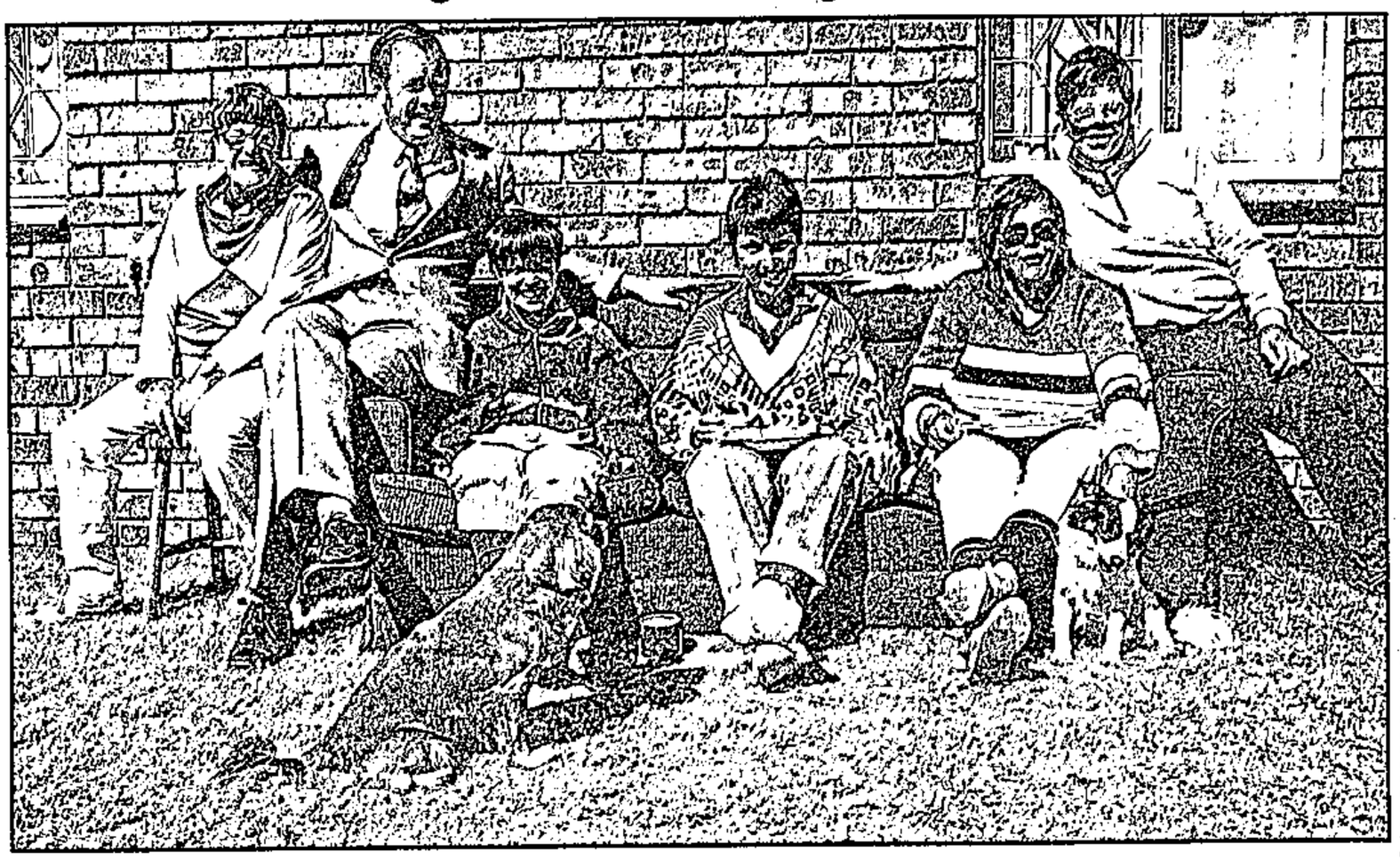
The Avril Elizabeth Home is the first home for the mentally handicapped to introduce a fully-fledged music therapy unit.

"The mentally handicapped often become frustrated and depressed because they cannot command their bodies to do certain things. We found that music has a calming effect and gets them out of their depression," Mr Rees says.

In addition, there is an animal therapy unit. It includes a bird sanctuary, ducks and four horses. Residents also exercise at the trim park daily.

For the more able residents there is a teddy-bear workshop where they pack and assemble small products which are contracted out by large companies.

"The different forms of therapy make the residents feel wanted and worthwhile," Mr Rees says.



▲ Residents of the Avril Elizabeth Home for the mentally handicapped with the executive director of the home, Mr John Rees. ● Picture by Stephen Davimes.

▲ Founder and director of the Avril Elizabeth Home, Mrs Sheila Suttner, made people aware of the needs of the mentally handicapped.

▶ Mr Rees and the home's mascot, a teddy bear, which saved the home from closing down.

MEDICINE PRICE WAR 299

Counter-attack

The Pharmaceutical Society of SA (PSSA) has unveiled its new Medikredit system — a counter-attack against the Mediscor group of prescription drug discounters.

On September 1 Mediscor will begin operations and promises discounts of at least 20% on prescription medicines from pharmacies in its network.

Mediscor is the brainchild of former Pharmacy Council president Kosie van Zyl who has been recruiting selected pharmacies into his network since March.

In response, the PSSA is offering more attractive discounts to medical aid schemes under the Medikredit name. In place of a 7% discount across the board, and 3% for settlement within seven days, it now offers a 10% discount across the board, 3% for early settlement and a 2% bulk discount for schemes which process more than 100 000 prescriptions a year. About 2m medical aid members — about half the members in SA — belong to schemes affiliated to Medikredit.

Under Medikredit the pharmacist can bill medical aids directly instead of getting payment from the member. TPS Mutual Trust MD David Boyce, who manages Medikredit in the Transvaal, says the new discount structure will save medical aid schemes R80m a year.

SA and Namibia

Boyce says 2 700 pharmacies in SA and Namibia are contracted to the scheme, so Medikredit offers an infrastructure Mediscor would be hard-pressed to match.

However, Mediscor MD Kosie van Zyl is confident Medikredit won't prove as attractive as his own organisation: "Medikredit isn't very different from the old PSSA dispensing services system. Its discounts are nowhere near our own.

"And we'll be able to operate a much more simple system out of one office in Pretoria, against their five offices across the country."

Van Zyl claims pharmacists have been threatened by wholesalers and other vested interests not to join his organisation. He says Mediscor has a strong network in Pretoria, but Johannesburg pharmacists have been subjected to arm-twisting. Now Medikredit is offering extra discounts to schemes which use them exclusively.

SA Druggists MD Tony Karis, who is both a manufacturer and a wholesaler, says Mediscor poses a serious threat to retail pharmacists. "Kosie must be very naive if he thought community pharmacy would just lie down and die."

Karis says Mediscor is only selling a promise whereas Medikredit is already up and running.

Opinions are divided in the medical aid schemes. Says Representative Association of Medical Schemes executive director Rob Speedie: "The Medikredit discounts simply aren't the most attractive on the market. We're in favour of anything that brings down the cost of medicine — and the best way to do this is to encourage new blood and competition."

So far five semi-government and six private schemes have signed with Mediscor, including the Davidson & Ewing group.

But Medscheme deputy MD Les Hollis

Medicine ... offering a lower price

says his organisation will stick with Medikredit mainly because it covers the whole country. "We won't go shopping around until something really competitive is created."

Meanwhile, patients can look forward to some benefits from the ongoing price war — provided medical aids don't use the discounts to improve their own margins. ■

Finansies 11/8/89

(299

Medaid a basket case

By Robyn Chalmers

MEDICAL aid cover is becoming an increasingly onerous burden for subscribers to schemes.

They face average premiums of almost R900 a month by the year 2000.

Only 20% of the population enjoys medical aid cover, the rest relying on State health care.

On a compound annual growth rate, subscriptions have increased by 20,1% since 1978.

Medaid schemes have been criticised because of high subscriptions, inadequate increases in the scale of benefits, lack of comprehensive cover — and for reaping huge profits.

The 1988 report by the Registrar of Medical Schemes is important to the extent that it identifies the role of medaid schemes in the health care crisis.

The Registrars' report shows that for the year to December 31, 1987, income for medaid schemes was R2,8-billion, of which R2,4-billion was paid in benefits to members.

[redacted]

Of the R400-million difference, R157,7-million went to administration costs and the rest on accumulated reserves. According to guidelines set by the Central Council for Medical Schemes, reserves equal to about 25% of contribution income are required.

A breakdown of benefits shows that 26,9% of the R2,4-billion went on medicine. The figure does not include the cost of drugs dispensed in hospitals. Another 21,2% went to hospitals, 17,7% to medical specialists, 16,3% to general practitioners, 11,7% to dentists and 6,2% for other benefits.

Representative Association of Medical Schemes (Rams) executive director Rob Speedie says the fact that most payments are for medicine is one of the reasons that health care costs have increased more rapidly than inflation.

"The depreciation of the rand has sent the price of medicines and medical equipment soaring because most of the more sophisticated apparatus is made overseas.

"Add to this overuse of benefits by members, overservicing by medical practitioners, an ageing population, changes in morbidity patterns and increasing nursing salaries, and you will find the reason for the rapid increase in the cost of health care."

[redacted]

Earlier this year, private hospitals maintained that these costs had increased to such an extent that they would have to lift their fees above those laid down by medaid societies.

Mr Speedie says that at the beginning of this year, all private hospitals operated within the scale of benefits system. When societies announced that these hospitals would receive a 12% increase in the scale of benefits, they opted out of the system.

Mr Speedie says about 70% of private hospitals have rejected the scale of benefits, meaning that members have to reach deep into their pockets to fund the additional costs.

Shortly after hospitals made this expensive decision, doctors announced they would follow suit.

Mr Speedie says the number of doctors quitting the schemes does not match the figure for hospitals, but medaid members are suffering.

"Medaid schemes have three options when a hospital or doctor opts out of the scale of benefits. It can wash its hands of the affair and the member has to pay the full amount; it can pay the whole account and recover the difference from the member; or the member can pay the sum directly and the scheme will reimburse him for the amount stipulated in the scale of benefits structure.

[redacted]

"There has not been the large-scale disruption which was feared, and there may even be some pros to the situation. Members have been forced to be more aware of the costs of health care, and not so ready to go to hospitals or doctors at the drop of a hat."

The future of health care in SA is shaky at best. Mr Speedie believes it is impossible to arrest the rise in costs unless the co-operation of all involved is attained.

No easy task, but it is essential if generations to follow are to be provided with adequate health care. Doctors and patients must become more cost conscious, the introduction of disincentives must be allowed and greater use of day clinics must be made.

The Competition Board announced in March that it would conduct an investigation into medaid schemes. A report is expected within the year.

ROB SPEEDIE

Medical aid benefit expenditure reduced

DIANNA GAMES

THE percentage of medical aid schemes' total income spent on benefits in 1987, — 86,8% — was the lowest percentage paid out for benefits since 1975, according to the Registrar of Medical Schemes' report.

The report also said during 1987 the accumulated funds of all schemes combined rose by 63,2% from R327m in 1986 to R534m in 1987.

The highest amounts paid out in 1987 were for medicines, followed by hospitalisation, specialist treatment and general practitioners.

Up to 1981, hospitalisation was the lowest payout of the four categories but had steadily risen to become the second highest.

Rob Speedie, Representative Association of Medical Schemes (Rams) executive director, said the current solvency position of medical aids was looking healthier than was generally perceived, with many of them having improved their reserve position over the past 18 months.

The level of accumulated funds has, on average, dropped since 1976 when it was 27% (as a percentage of subscriptions) to 19,9% in 1987. The average income of schemes rose to R2,7bn in 1987 from R2,1bn in 1986.

Contributions

The report said administration costs in respect of all registered medical aid schemes increased in 1987 by 23,9% (1986: 21,9%), while membership increased by only 4,1% over the same period.

Speedie said Rams was often criticised for pushing up contributions, but there had been increasing use by the public of almost every service.

However administration costs of schemes, on average, had dropped from 7% in 1982 to 5,9% in 1987.

The report, dated December 1988, said in 1978 there were 300 registered schemes. This was down to 249 at the end of 1987, the lowest in 10 years.

Speedie said one reason for the inordinately high number of medical aids in SA was that each had to gear itself for a certain market instead of being able to target many different needs.

However, it was hoped the present inflexible legislation would be changed before the year end if proposed legislation goes through. This would allow contributions to be made according to cover required.

Speedie said rising medical costs and the contracting out from medical aid of many private hospitals had led to the burgeoning of day clinics and Rams had graded 25 day clinics in the past 18 months. About 70% of private hospital beds now fell outside the medical aid tariffs, he said.

Sowetan 17/8/87 (299)

New Home will fill a big gap

By PHANGISILE MTSHALI

SOWETO's first shelter for mentally handicapped people is soon to become a reality.

The sod turning at Takalani Home for the Mentally Handicapped will take place this weekend at the Diepkloof site in Soweto in preparation for the building of the R7,6 million complex.

Takalani, which means "place of joy," will be ready for use in November next year.

The project, which is sponsored by Anglo American and De Beers Chairmans Fund, is a dream come true for the community of Soweto which has no fewer than 15 000 mentally retarded people.

"Takalani will provide the mentally retarded with a home from home setting," said the project organiser, Mr John Rees.

"It is not an institution to rid the community of the mentally retarded. The community's support and help will be appreciated and the home will be open for visits."

To give a homely feeling to the people of Takalani, the complex has been designed to resemble a village. It will cater for 750 people, 310 of them as residents.

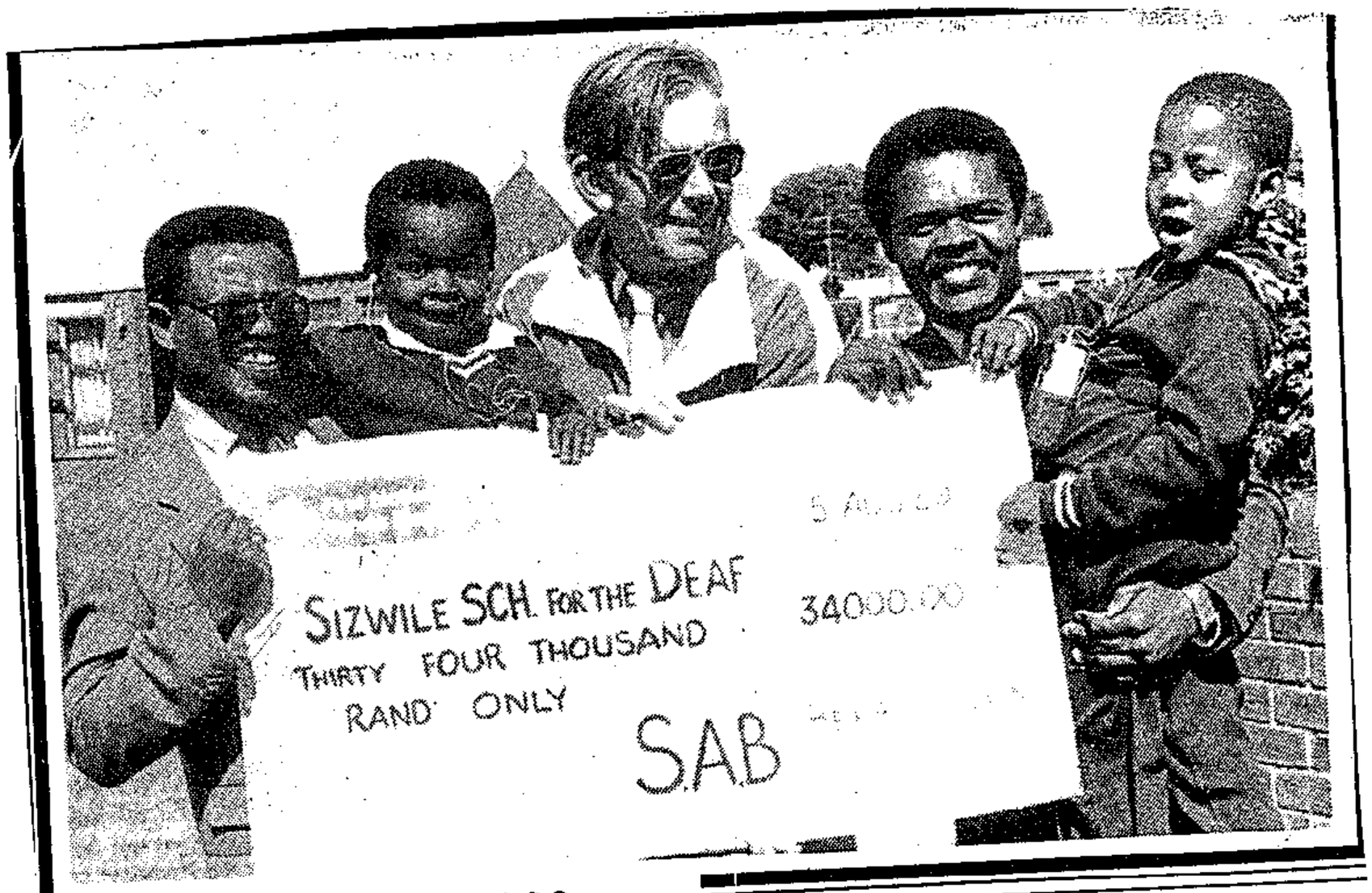
The facilities will include a 100-bed medical care centre for the severely handicapped, and a school with 14 classrooms for 350 pupils aged between six and 21.

There will be a dormetory type accommodation for 150 young people and cottages for adult residents.

A workshop for stimulation and training purposes and for protective employment will be provided

Holding the model of the multi million Takalani Home for the Mentally Handicapped are, from left, Dr Nthato Motlana, chairman of the Takalani Committee, Mrs Monica Molantoa, a social worker, Mrs Christina Sithole, committee member, Mr John Rees, organiser of the project, and Mr Michael O'Dowd, chairman of the Anglo American and De Beers Chairman's Fund.

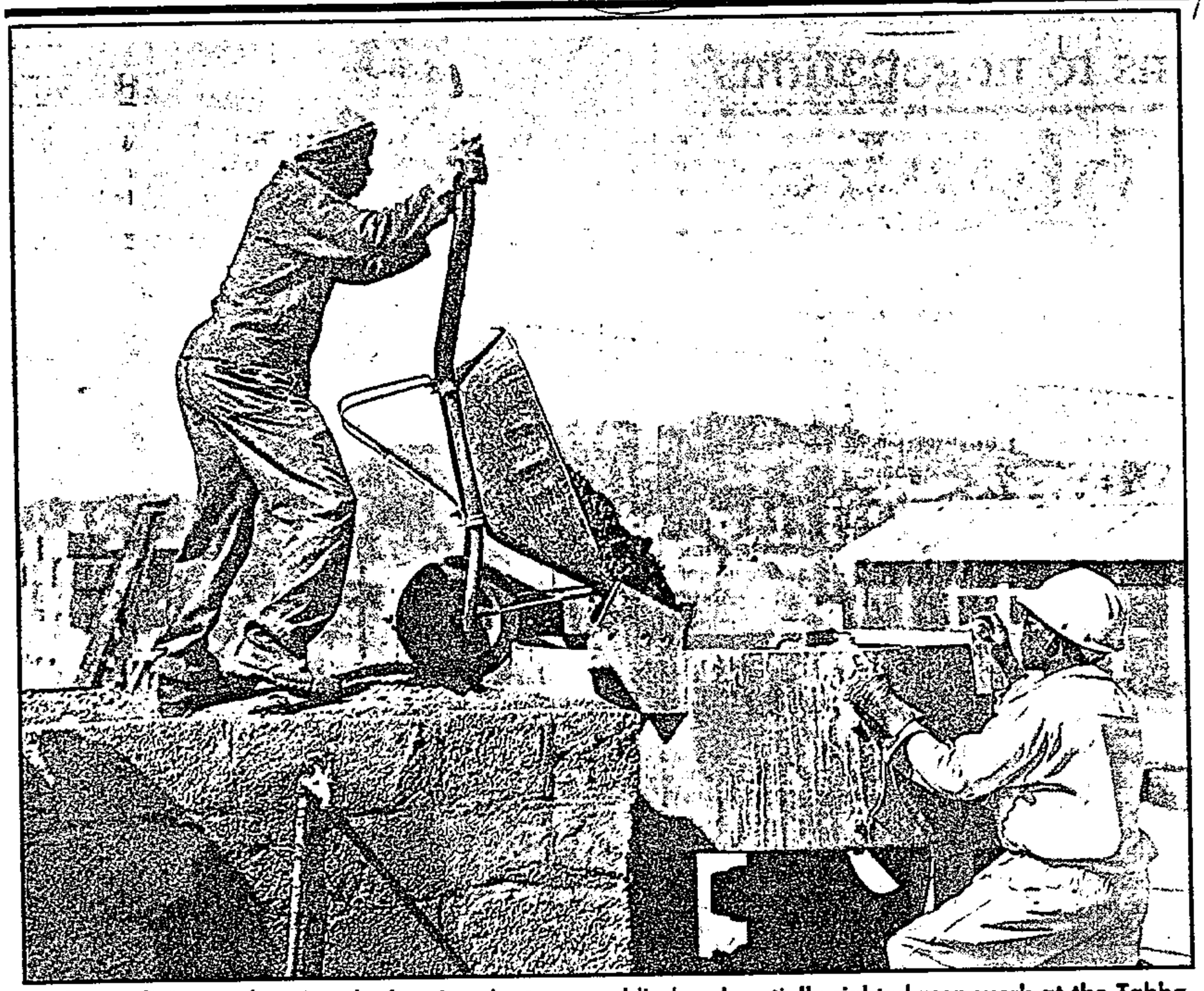
Contents



R34 000 gift for school

Mbuso Mkhize and Nomsa Mabaso of Sizwile School for the Deaf have a good reason to smile.

Their school is being presented with a cheque for R34 000,00 by the South African Breweries to assist in the purchasing of 20 hearing aids for two classes. Pictured with the two children at the presentation ceremony are, from left, Mr Sam Mosikili of the breweries, Mr Gerald Cox the school principal, and Mr Johnny Dladla of the breweries.



Making a living and easing the housing shortage . . . blind and partially sighted men work at the Tabba brick-making factory in Orlando, Soweto. ● Picture by Herbert Mabuza.

Brick-making scheme for the blind to grow

Staff Reporter

The Transvaal Black Blind Adults (Tabba) organisation, which initiated a brick-making project for blind people in Soweto, plans to expand it projects to the rural areas, where unemployment is soaring.

Tabba public relations officer Ms Eldah Oliphant says the project's aim is not to make profit but to help the blind.

"We believe we can alleviate the chronic housing shortage in our areas and simultaneously develop the skills of our blind people. At Tabba we look at the ability and not the disability of a person," she says.

The project got off the ground when a number of companies rallied to Tabba's help and now thousands of bricks, which are snapped up by people anxious to build their own homes, are produced each month.

So far 30 men have been trained by Portland Cement Industries at its Durban plant. The operation employs 10 blind and partially sighted men who produce about 350 bricks a day.

"The electrical cement mixer and brick-making machine are operated by partially sighted men while the blind men perform the manual tasks such as sifting and shovelling sand, and filling and pushing wheelbarrows," Ms Oliphant says.

A sighted supervisor, Mr Moses Moleleki, oversees the workers.

Turning the sod...founder and committee member of Takalani, Mrs Mirriam Sibeko, is helped by Tshidi Masilo, a future pupil of Takalani. Dr Nthato Motlana, Mr Michael O'Dowd and Mr Johan Ress, the organiser of the project, look on.

Sowetan 21/8/87

First sod turned at new school

299

THE birth of an institution for mentally handicapped children in Soweto was an idea that arose out of a felt need by

By SONTI MASEKO

the community and such a home would never be destroyed by members of that community, Dr Nthato Motlana said at the weekend.

Motlana was speaking at the sod turning ceremony to mark the start of the construction of a home for mentally ill children near Funda Centre in Diepkloof, Soweto.

He said black townships were experiencing a form of vandalism where children were turning against their community and actively destroying structures like schools.

"I am encouraged to think that this will not happen at Takalani because it was built by the community itself," said Motlana, who is also the chairman of the Takalani Committee.

About 300 people, including representatives of the South African National Council for the Mentally Handicapped and officials of the Diepmeadow City Council, attended the ceremony.

299

The way to better health

SOWETAN readers are showing a keen interest in the health seminar on nutrition, high blood pressure and coronary disease to be held at the Soweto campus of Vista University tomorrow at 9 30 am.

The seminar which will be addressed by Dr Victor Fulgoni of Michigan in the United States who will discuss the importance of breakfast and grain based foods in the diet.

These foods contain fibre which can prevent constipation.

Cecily Fuller, the community dietician of the Heart Foundation will speak on high blood pressure and the role that nutrition can play in keeping the family together much longer.

High blood pressure is widely accepted as one of the three major risk factors for the development of coronary heart disease together with raised blood cholesterol and smoking.

Raised blood pressure usually displays no symptoms and is often referred to as the silent killer. If uncontrolled it can damage blood vessels and increase the risk of heart attack, stroke, heart and kidney failure.

Contributory factors in raised blood pressure include hereditary factors, obesity, excessive salt in the diet, heavy drinking, stress and too little exercise.

Cigarette smoking also aggravates hypertension as it forces the heart to pump harder to get more oxygen.

Mrs Brenda Robson of the Friends of Baragwanath will discuss correct feeding habits for children under the age of three.

It is at this stage that the body develops its strengths and weaknesses, for example, teeth, eyesight and bones.

If you would like to attend the seminar telephone 673 4160 ext 143 or 706 4430 to make a reservation. A fee of R2.50 will be charged and donated to charity.

A health tea will be served and hampers of Kellog's breakfast cereals given away.

WOMAN

Christine cares for mentally ill

perience working with mentally retarded children and their families, a job she left four years ago but with which she is still heavily involved.

Sithole is director of community development with the Diepmeadow Council. She oversees and co-ordinates services for social work in the area. Her work includes planning and making decisions on youth sports and culture, health services, education, recreation and other auxiliary services.

But despite all her responsibilities this Soweto mother of three, who holds a masters degree in

By SIZA KOOMA

social work, is invo... in psychiatric services for the mentally retarded, serves on the board of the National Council for Mental Health and is vice-chairman of the committee of the Takalani School for the handicapped that is behind the construction of a school for the mentally retarded soon to be built in Diepkloof, Soweto.

"Mental health has always been my favourite occupation," said Sithole

"It was in this job that I learnt to see people in more depth and accept them as they were. It challenged my perception towards human nature and helped me grow."

Sithole said the mental health society taught her to appreciate people for what they are and respect their right to make their own decisions.

"Families of retarded children go through a lot of trauma when news of their child's condition is broken to them. You have to be patient and wait until they have accepted the fact.

299

Beliefs

"Some will attach their own beliefs to what they may think is wrong with the child. They will tell you that the child behaves the way he does because he has been bewitched or is a genius. You have to understand their behaviour and not deprive them of the right to make their own decisions," she said.

She applies her policy of letting people make their own decisions in her dealings with her staff and the community. She maintains that her present job is mental health in a broader sense.

Takalani is not the first project for the mentally retarded that she has been involved in. She was among the people who campaigned for a protective workshop for children over 16 in Soweto in 1981 and the two schools, Phumla and Phumelele.

'It was in this job that I learnt to see people in more depth and accept them as they were'

CHRISTINE SITHOLE'S involvement in the mental health service is based on her ex-

Christine Sithole. Sowetan 24/8/89

25/8/89

Medical aids: no racial splits

299 Rmail

Tony Leveton is executive chairman of Affiliated Medical Administrators (AMA), which operates the Meds and Consolidated Employers medical aid schemes.

Medical aid societies based on racial grounds are often societies without a strong financial base.

Schemes made up for the benefit of one racial group only, or of cross-subsidisation of contributions by different racial groups within the same scheme, contribute to polarisation of an already fragmented society.

At AMA we have been able to operate nonracial medical schemes since the Registrar of Medical Schemes allowed us, nine years ago, to implement a formula of differing contributions based on claims patterns — though no differentiation is made in the benefits offered.

Subscriptions of members of Meds and Consolidated Employers are calculated according to the usage patterns of the three main groups. This varies for whites and Asians, who are in the upper echelon of claim patterns; coloureds, who as a group claim less than whites but more than blacks; and blacks, who claim the least of all four groups.

This is because blacks do not have the same access to private health facilities as other groups, but, as privatisation increases and more facilities open up, this will change, as will their cost profile. The crisis in State medical facilities is forcing more and more non-whites to make use of private health facilities and their claim costs are accelerating rapidly.

Each year, AMA calculates the contribution rates for different racial groups based on their individual claim patterns. For example, a white member of Consolidated Employers in the top income bracket and with three dependants, now pays R344 a month, including his employer's contribution, while a black member of the same fund with three dependants, and his employer, contributes only R172 a month. Coloured members in the same category would pay R252.

As a result of this variation there is no cross-subsidisation in the fund by one racial group for another, and all contribute equitably to the general funding of the societies.

I see this trend, as well as the annual claim patterns within the various racial groups changing considerably in future. For example, about 12% of white members' claims are now for general practitioners, compared with 50% of black claims. In contrast, 23% of white claims are for chemist purchases, compared with only 3% of black claims.

The number of claims among blacks is steadily increasing, and, without the benefit and experience of strong finance, these changes are impossible for small or underfunded medical aid societies to absorb.

Because of superior funding, established schemes are able to ride out a run on funds in the short term. We do not, however, advocate long-term subsidies. If one group increases its use of the fund at a faster rate than the other groups, then its contributions will increase faster. The objective is for each group within the fund to be self-supporting.

The advantage to companies of the varying contribution formula is that they can install one medical aid scheme to cater for all their employees and all employees can enjoy the same level of benefit from the same scheme.

If a black member, for example, wishes to enjoy the facilities of an expensive private clinic, the medical aid will cover him or her with the same benefits as a person in any other racial group, even though his or her contribution may be considerably lower.

This has given people of all race groups access to a scheme with superior benefits that also caters to the exigencies of each racial group. The customs of racial groups are also taken into consideration in terms of benefits allowed. Blacks, many of whom traditionally have more than one wife, for example, can register each wife as a dependant.

Meds and Consolidated Employers jointly have more than 100 000 families covered, 26 000 of whom are non-white. It is the popularity of these schemes that ultimately affords members the benefits of financial stability and increased coverage. Other societies within the AMA stable are all tailored to individual company requirements and apply the same benefits across all racial groups.

THE ECONOMY

An alternative to a national health: a national insurance

A national health service sounds like a good idea, but it may not prove economically viable. A better scheme may well be one of compulsory national insurance. HILARY JOFFE reports

GREATER privatisation of health care is likely to push up health costs and cut access to health care for millions of South Africans. And a nationalised health service might not be politically feasible or economically viable.

But at a conference on health care costs this week, an alternative option began to emerge: a compulsory national health insurance system which would allow a high degree of private sector participation but would make health care affordable and accessible for all South Africans.

The conference, organised by Wits University's Centre for the Study of Health Policy (CSHP), brought together a range of health workers in the private and public sectors to discuss cost containment and equity in health care. It included community doctors and private practitioners, medical aid executives and public sector health administrators, health economists and government officials, trade unionists and employer representatives.

One of the aims of the conference, said the CSHP's Cedric de Beer, was to ensure that the vested interests in the health care debate came together to debate the contentious issues — such as equity in health provision, the funding of health care, legislative changes required, curative versus preventive medicine and the roles of different public and private sector agents.

The idea of a national health insurance system was advanced by keynote speaker Brian Abel Smith, professor of public administration at the London School of Economics, who argued that such a system would have the bargaining power to control health care costs by setting price and quality standards for private providers of health services — such as general practitioners, specialists and privately owned hospitals.

Abel Smith pointed to several interest groups which might form a constituency for a cost-effective compulsory health insurance scheme.

The low paid, who currently received inferior treatment (or none at all), would gain comprehensive health care.

Highly-paid members of medical aid schemes would gain in that the full costs of their treatment would be covered — in contrast to the current situation, where medical aid tariffs have risen but the schemes impose cash limits such that many patients have to pay in additional amounts for doctors or hospitalisation.

Progressive employers would also have an interest in a national scheme which ensured cost effective health care for their employees.

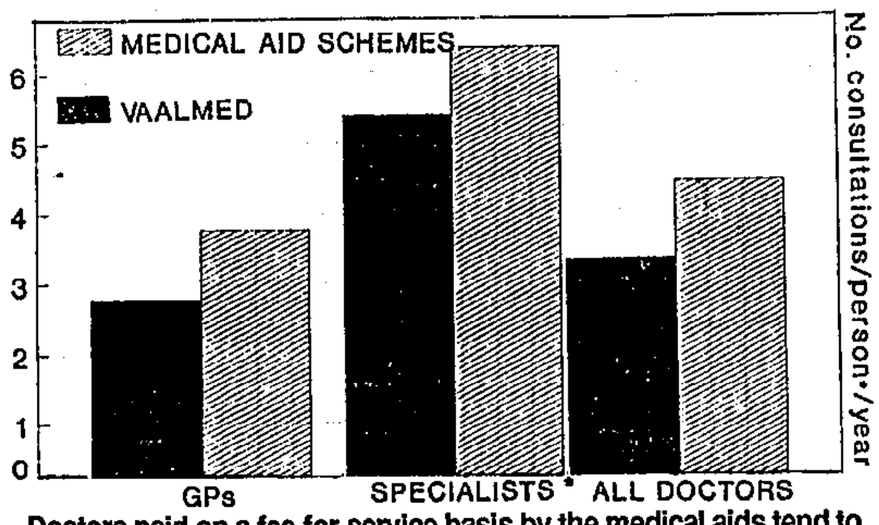
Health care for those who could not afford to pay at all — such as the unemployed or pensioners — would be funded with taxpayers' money. But funds released by the national health insurance scheme could be used for this.

The idea would be to include in the insurance scheme everyone who could afford to pay for health care; all those in formal employment would be covered, subsidised by their employers, and the scheme would also include many self-employed people. It would mean cross-subsidisation — for example, of the sick by the healthy, of the aged by the younger and of the poor by the rich. That, to some extent, is what happens in medical aid schemes at the moment.

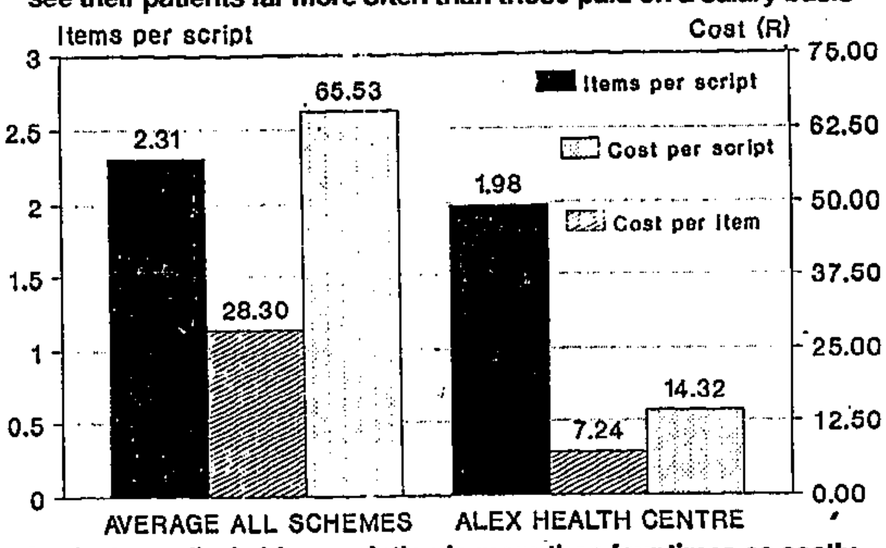
But the difference would be that a national scheme's greater bargaining power, and the controls it would exercise over providers of health care, would bring costs down substantially — it could, for example, cut drug costs by up to a third, Abel Smith estimated. It would buy only from providers who offered quality services for a good price.

It could specify that patients could visit specialists only by referral, that patients could only have one general practitioner at a time (although they would have the right to change doctors) and would have to determine what would be paid for and the methods and levels of payment.

Abel Smith said the approach he was suggesting was not necessarily in conflict with the aim of a national heal[illegible]rvice. "The essence of a national health service is that all citizens have the same rights to health care — equal rights for equal need," he said.



Doctors paid on a fee-for-service basis by the medical aids tend to see their patients far more often than those paid on a salary basis



A private medical aid prescription is more than four times as costly as one at the community-based Alexandra Health Centre

Graphs: CENTRE FOR THE STUDY OF HEALTH POLICY

The compulsory national insurance model would achieve this if tax funds were sufficient to finance the same standard of services for the non-insured as were received by the insured.

And it was more politically realistic than the alternative of eliminating the private sector. The insurance route was one many countries had used to reach universal health care rights.

He described South Africa's present medical aid system as one which benefited doctors and private hospitals rather than consumers.

The inefficiency of South Africa's medical aid system was a major theme of the conference. The medical aids themselves have acknowledged the system's role in escalating health costs, although the solutions they propose are very different from Abel Smith's. They propose to shift more of the burden of payment to patients and are demanding changes in the legislation which governs their operations.

Health economists speak of the "perverse incentive" effect of schemes like South Africa's medical aids, which work on a "fee for service" basis, guaranteeing providers payment for each service provided to a patient. Essentially there is an incentive for doctors to overtreat or overprescribe and for hospitals to run up costs.

There was dramatic evidence of this in some of the research presented to the conference. Jonathan Broomberg and Max Price of CSHP found a woman's chance of having her first baby by caesarian section was 50 percent higher in the private, medical aid sector than in a public hospital. They compared the number of caesarian sections amongst white women aged 20 to 35 having their first baby in the Johannesburg General Hospital with the medical aid figures and found the chances were 28,7 percent on medical aid and 19,5 percent in the Gen. They also found in the private sector 57 percent more deliveries took place on weekdays — implying a high rate of induced births.

In another study, Broomberg and Price found white members of medical aids visited GPs 36 percent more frequently and specialists 18 percent more frequently than comparable members of a health maintenance organisation (Vaalmed, in Vanderbijlpark) where the doctors are salaried.

In these studies, designed to compare the effects of a fee-for-service reimbursement mechanism for doctors with that of salary payment, Broomberg and Price found the average number of days in hospital per 100 members per year was 74,2 in the medical aid schemes and 64,2 in the HMO.

They concluded that "the evidence strongly confirms the international experience that fee-for-service reimbursement of doctors leads to increased utilisation of health services and interventions and consequent escalation of health care expenditure".

Research presented to the conference also showed much higher drug bills in private sector medical care compared with community or public sector health facilities.

Abel Smith suggested one option was to replace fee-for-service payments for doctors with "capitation fees" (according to how many patients they treated). This would have the advantage of creating competition among doctors: "If they gain patients they gain money, and if they lose patients they also lose money. This keeps them attentive to patients."

He also suggested doctors (and hospitals) receive incentives to undertake preventive health care work — and that their work be monitored by the national health insurer.

On cutting drug costs he envisaged a system where the national health insurance scheme would use its strong centralised buying power to push down costs, and to enforce a list of acceptable drugs it would pay for — something which has been done in most European countries.

But Abel Smith's proposals for a national health insurer ran counter to the ideas some medical aid administrators have about changing the system to make it more cost-effective. Their argument is that the Medical Schemes Act needs to be changed to allow them to provide more flexible packages — and that this would bring costs down. They also blame the doctors for escalating costs.

In his address to the conference L Hollis, managing director of Medscheme, pointed out that medical aid contributions were escalating at an annual rate of 20 to 30 percent above the general level of inflation.

He said three aspects of the Medical Schemes Act distorted market forces: minimum benefits, guaranteed payment and scales of benefits.

The schemes are obliged by law to provide a wide range of benefits and to pay at least 70 percent of the scale of benefits for each service and at least 50 percent of the cost of prescribed medicine.

"Obviously the cost of the medical package must be higher because of the statutory enforced minimum range of benefits," Hollis said. He said the medical schemes should rather offer selective packages.

Another issue is the guaranteed payment medical aids are obliged to give doctors and hospitals (other than those who have "contracted out"). While many medical aid administrators want to see this system abolished, Hollis argued instead for a partial, rather than a total guarantee, obliging patients to pay part of the cost of the service.

He said the full guaranteed payment was a massive cost escalator, encouraging abuse by both patient and supplier. "Whilst medical aids should take the financial worry out of illness we need to restore concern over cost in both the patient and the practitioner," he said.

Hollis' call for changes to legislation to provide greater flexibility for the medical aids is shared by many in the medical aid industry — as is his notion of "flexible packages".

Some in the medical aids have spoken of providing "Rolls Royce packages" which would provide comprehensive cover and, for example, treatment in luxury hospitals, as well as much more minimal packages which would be cheaper and cover only the basics.

But Abel Smith pointed to the "anti-social" irony of attempts to shift a greater proportion of the cost of health services to medical aid members, just at the point when large numbers of low income people were joining these. He asked whether medical aids saw their task as profit making insurance companies or as statutory agencies: every statutory health insurer in the world operated so as to ensure it could meet the needs of the sickest people, rather than simply to make profits.

Health economists have pointed out too that "Rolls Royce" packages would very likely be bought by the higher income, younger, healthier people — removing the element of cross-subsidisation and therefore making medical insurance even more costly for the sick and the poor.

Times when private health is less efficient

By HILARY JOFFE

THE government is encouraging privatisation in health care — by encouraging more private hospital use and supporting the principle of "user charges" in terms of which even those who use public hospitals have to pay for their treatment.

But the evidence on health care suggests that in this area, private may mean less efficient and more costly — contradicting the arguments of the free marketeers in favour of privatisation and deregulation.

And the trend to privatisation may make access to health care even more difficult and costly for the bulk of South Africa's population — in a context where the majority of black people receive only a limited portion of the country's health resources.

At a conference on health care this week, Di McIntyre and Professor Rob Dorrington of the University of Cape Town took issue with frequent government claims that the proportion of South Africa's resources devoted to health were adequate by world standards. Health care expenditure as a proportion of gross national product increased from 4,8 percent in 1971 to 5,7 percent in 1986. This is well in line with the World Health Organisation's target of five percent.

But McIntyre and Dorrington stressed the maldistribution of resources is such that national spending on health care cannot be regarded as adequate.

[illegible] majority of black people remain dependent on public sector health care even though black membership of medical aid schemes has risen rapidly. According to L Hollis of Medscheme, around seven percent of black people were covered by public and private sector medical aid schemes in 1987 — compared to 83 percent of whites.

McIntyre and Dorrington's figures show health care spending in the public sector increased from 2,7 percent of GNP in 1971 to a peak of 3,3 percent in 1986 and then decreased to 3,2 percent in 1988.

Their figures show the ratio of African to white expenditure is one to 4,3 — with R138 a year spent nationally for Africans and R597 a year for whites. Even if one assumes medical aid members make no claim on public spending, the ratio of African to white per capita expenditure would be one to 3,4.

They conclude that in fact the proportion spent on whites is equivalent to 13 to 14 percent of GNP while that spent on Africans is equivalent to three or 3,5 percent of GNP — well below the WHO target.

At the conference the South African Health Workers Congress drew attention to the rising tariffs being charged patients at provincial hospitals in the Transvaal — tariffs have risen in some cases by up to 800 percent — and described the government's support and encouragement of privatisation as "a blatant rejection of its responsibility to its people ... The shifting of responsibility to the private sector will place decent health care beyond the reach of our deprived communities".

And evidence presented to the conference showed that the cost of private medicine was much higher than that of public or community-provided medical care. State hospitals tender for drugs, and pay much less than do private users. So while 60 percent of drugs by volume are sold to the public sector, on a value basis the public sector accounts for only 23 percent of the spending, according to a paper by Syfrets investment analyst Hugh Broadhurst. Broadhurst's paper suggested the pharmaceutical industry was earning above average profits — despite industry claims of being "squeezed" by the state health sector.

Research by Max Price of the Centre for the Study of Health Policy at Wits University showed drug costs in a community clinic in Alexandra had been kept way below that for private sector medical aid patients. While the number of items per prescription was similar (2,31 for the private medical schemes versus 1,98 for Alex), there was a significant difference in the average cost of filling a prescription: R65,53 for the medical scheme patients compared with only R14,32 for the Alex patients.

299

Disabled want work

THE National Council for the Physically Disabled is to focus on promoting employment of the disabled in the open labour market as it enters its 50th anniversary this month.

The main topic of the NCPD's golden jubilee conference, to be held in Cape Town from September 18 to 20, will be how to equip the disabled to find jobs in the open market.

According to the council, there are a vast number of physically disabled people who are disillusioned and depressed by not being able to work.

A 1986 survey conducted by the Department of National Health and Population Development showed that half a million of the total population suffer from a disability and that most of them were able and wanted to earn.

The council's recent advertisment screened on SABC and which featured the physically disabled social worker, Miss Chareen Grobler, is to be followed by an advert aimed at making the black population aware of the problems disabled people face.

The advertising campaign is aimed at improving the public profile of the physically disabled and ensuring that society sees them as potential employees.

Schemes help encourage care abuse

Star 12/9/89 (299)

Full guaranteed payment by medical aid schemes is said to be a major contributor to escalating health costs as it encouraged abuse by patients and the doctors.

Studies conducted by doctors at the University of the Witwatersrand showed medical aid members visited general practitioners 36 percent more often than those who belonged to Health Maintenance Organisations (HMO) where doctors were salaried.

The chance of having a caesarian section in the private sector was also 50 percent greater.

Prof's health care proposals

Star 12/9/89 (299)

Medical Reporter

Compulsory medical aid contributions as opposed to the voluntary system practised in South Africa would do much to provide equal health care for all, Professor Brian Abel-Smith of the London School of Economics said in Johannesburg yesterday.

Addressing a health cost containment conference organised by the Centre for the Study of Health Policy at Witwatersrand University, Professor Abel-Smith said at first sight it might seem the best way to finance health services for all was from taxation carefully geared according to ability to pay.

"This may be possible where a high proportion of the working population is paid by wage or salary and where there is a sophisticated tax system.

"However, none of these requirements are met in developing countries or in countries partly developed and partly developing."

Academics criticise spending on health care

B1 Daily 12/7/89

THE essence of a national health service was that all citizens had the same right to health care, London School of Economics professor Brian Abel-Smith told the Containing Costs in Health Care conference in Johannesburg yesterday.

Cape Town University's Diane McIntyre and Professor R Dorrington outlined the extent of health care expenditure maldistribution along racial lines in SA. In 1987, more than four times as much was spent on health care for whites than on blacks.

TANIA LEVY

In total, R9 216m was spent on health, accounting for 5,7% of gross national product. About 44% of health expenditure was attributable to the private sector and 56% to the public sector. (299)

Departments of Defence, Prisons and Police account for about the same amount of health care expenditure as local government, McIntyre and Dorrington said.

Anaesthetist found guilty

Own Correspondent

CAPE TOWN — A anaesthetist was yesterday found

NATAL UNREST DEATHS

September 1987 to January 1989:	668
February 1989 — September 10 1989:	218
Past 24 hours' official toll:	0
TOTAL:	886

'Health care for aged costs SA R3bn a year'

BD 13/9/89 TANIA LEVY 299

HEALTH care for 70 000 people in institutions for the aged cost the taxpayer R3bn a year, Dr Raphael Schapera said at the Containing Costs in Health Care conference held in Johannesburg over the past two days.

He said the bill for caring for the aged in hospitals and homes could be more than R9bn a year by the year 2030, if the present style of aged care continued.

Staggering cost increases would overtake population growth estimates as well as forecasts of GNP increases, Schapera said.

However, taxpayers could be saved R800m next year if costs were to be contained at institutions for the aged. Enormous savings could be made by improved management of aged care, reduced capital costs and regulated access to institutions.

Privatisation was not a long-term solution in a population such as SA's where many of the aged lived in subeconomic conditions, he said.

Among recommendations for containing costs Schapera listed a national health insurance scheme or pension fund for the self-employed and rural blacks and increasingly flexible statutory aged care funding.

Watch what you scribble, doctor!

Star 14/9/89

299

Medical Reporter

The employee who feels he'd like a few days holiday may no longer find it so easy to obtain a medical certificate from his obliging doctor.

Patients asking their doctors for medical certificates after "a bout of flu" have had little difficulty in obtaining this document in the past.

But the apparent abuse of these certificates has alerted medical authorities, who have ordered a clampdown.

An editorial in the latest edition of the South African Medical Journal warns doctors that a medical certificate should be factually unchallengeable, medically accurate and legally correct.

"If not, the hurried, overly sympathetic, or inattentively scribbled certificate may next be seen by the doctor in uncomfortable circumstances inside a court of law," the editorial warns.

last week to take sweets and potato crisps to the children of farm workers.

Education Reporter.

Medicines obtainable at hospitals are cheaper

(299)

Star 14/9/89

'Private patients pay more'

By Toni Younghusband, Medical Reporter

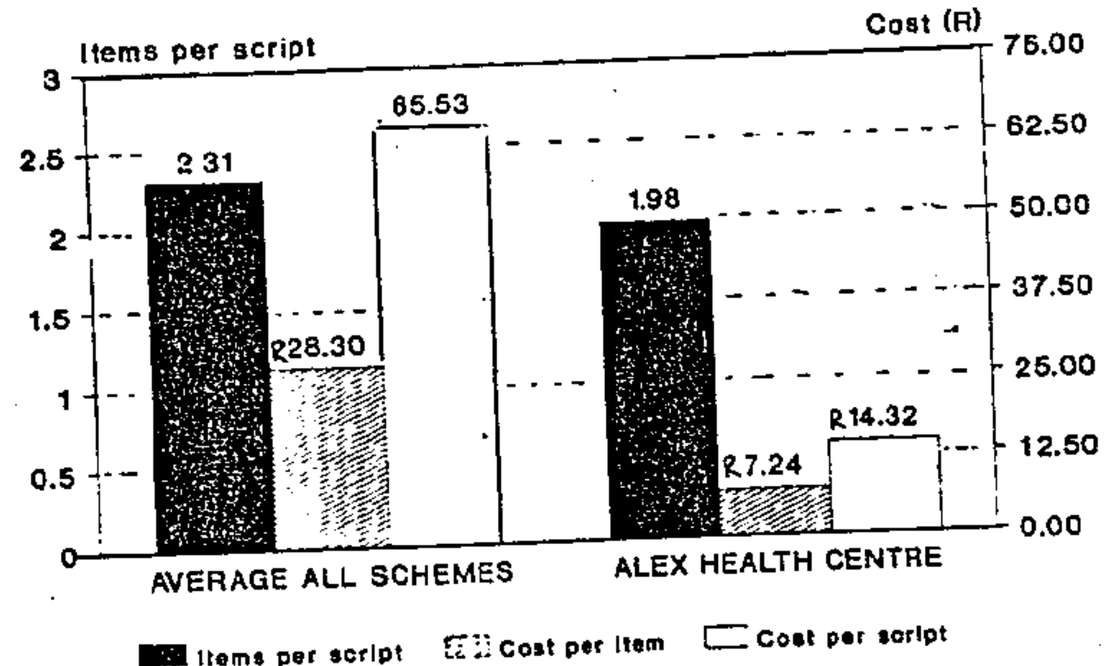
Private patients covered by medical aid pay four times more for medicine than patients who obtain their prescriptions from a hospital, a recent study conducted by the Centre for the Study of Health Policy at the University of the Witwatersrand has shown.

Dr Max Price, who compared a sample of prescriptions issued at the Alexandra Health Centre with those issued by fee-for-service doctors in the private sector, revealed at a conference in Johannesburg this week that fee-for-service patients received on average 17 percent more items on each script than clinic patients and the cost per script was 4,6 times higher.

"In the private fee-for-service medical aid sector there are no incentives or pressures on doctors to prescribe cost-effectively," said Dr Price. "The doctor does not have to bear any of the drug costs himself and believes that the patient who is a medical aid member will not have to foot the bill either.

"Doctors frequently do not even know the prices of the medicines they prescribe and are also unaware of the routine pack sizes in which drugs are sold. This often results in extra costs being charged when the pharmacist has to break a pack of which only part is used."

PRESCRIBING PATTERNS AND COSTS: MEDICAL AID CLAIMS VS. ALEX. HEALTH CENTRE, 1988



Dr Price said the absence of incentives and knowledge to prescribe cost-effectively was compounded by the enormous pressures on doctors from drug companies in the form of advertising, personal lobbying by drug representatives, and bribes, to prescribe particular brand-name drugs.

Few doctors prescribed the cheaper generic brands and pharmacists were not allowed to substitute the generic drug for the prescribed one.

At the Alexandra Clinic, clinicians prescribed medicines in pre-packed quantities, so no "broken bulk" costs were charged and cheaper generic substitutes were prescribed where possible.

He said the possibility of achieving reductions of 75 percent in the primary care drug bill if these policies were implemented in other sectors justified urgent, more detailed research.

State pays R12, you pay R100 for same muti

By Don Robertson

MUCH of the blame for rocketing medicine costs is laid at the door of pharmaceutical manufacturers.

Poor labour productivity and machinery use, the State Tender Board and controls are the main reasons for soaring prices, says a report by the National Productivity Institute (NPI).

Chemists add a 50% mark-up, so medicines are becoming too expensive for the average citizen.

For instance, 250mg of the antibiotic Amoxil, which was sold to the State Tender Board for R12,56 in January 1988 — the latest available figure — is retailed to the public at R100,19.

Rheumatism

Zyloprim (300mg), used by gout sufferers, was sold to the board for R1,30, but retails at R45,95.

Antibiotic Bactrim 500 is sold to the Government for R32, but to the public at R497,30. Rheumatism suffers have to pay R40,32 for Brufen (400mg) sold to the board for R15,35.

Naprosyn, also used by rheumatics, costs the State R35, but the public has to pay R295,61 for 250mg.

The low prices to the Tender Board are related to quantity and better bargaining, say manufacturers.

The NPI says most pharmaceutical products have risen in price by 241% since 1980. This compares with the rise in the production price index of 178% and the consumer price index of 198% in the same time.

Most pharmaceutical manufacturers concede that cheap sales through the State tender system force them to make the private buyer pay more.

About half of the participants in the survey agree that State tender prices are subsidised by the private market, and 30% will not comment. Another 17% disagree with the suggestion.

The NPI says low productivity is an important reason for rising costs. The report says that productivity has shown no increase since 1984 — as evidenced by a 5,4% decline in production volumes, but no decline in the labour complement.

It recommends that urgent attention be given to productivity to contain prices.

The NPI's research shows that average labour productivity in the industry is 51,7% compared with an acceptable 68%. This suggests that productivity could be increased by 31,5%. At the same time labour use could be increased by 13,6% and efficiency by 17,3%.

Average equipment use is only 38,9%, indicating a potential improvement in machine output of 105,7% to a figure of 80%.

The industry is currently worth more than R2-billion a year and private dosages of medical and pharmaceutical products represented 1,6% of total private consumption expenditure in 1986.

● From Page 1

Medicines

Sowetan reporter Mathatha Tsedu (right) discussed the condition of cancer patient Lucky Masuku (in bed) with a doctor at St Rita's Hospital at Glen Cowie, south of Pietersburg, on Thursday. By Friday, Masuku was dead.

Heed cancer's early warning signs - prof

No organ is free from its spread

By MOKGADI PELA

FOCUS

ALTHOUGH not the leading cause of death in this country, cancer is among the top killer diseases and possibly the most feared.

This emerged at a lecture delivered by Professor Barry Mendelow on the disease at the South African Institute for Medical Research last week.

The fear for cancer is according to Mendelow, aggravated by ignorance, conjecture and thousands who have died from this disease.

Mendelow was quick to point out that no organ was free from its spread.

"Cancer arises from the body's own cell and the basic problem is that those cells do not know when to stop growing.

"The result is that tumours will form consisting of millions of these cells which destroy the function of the organ they arrive in.

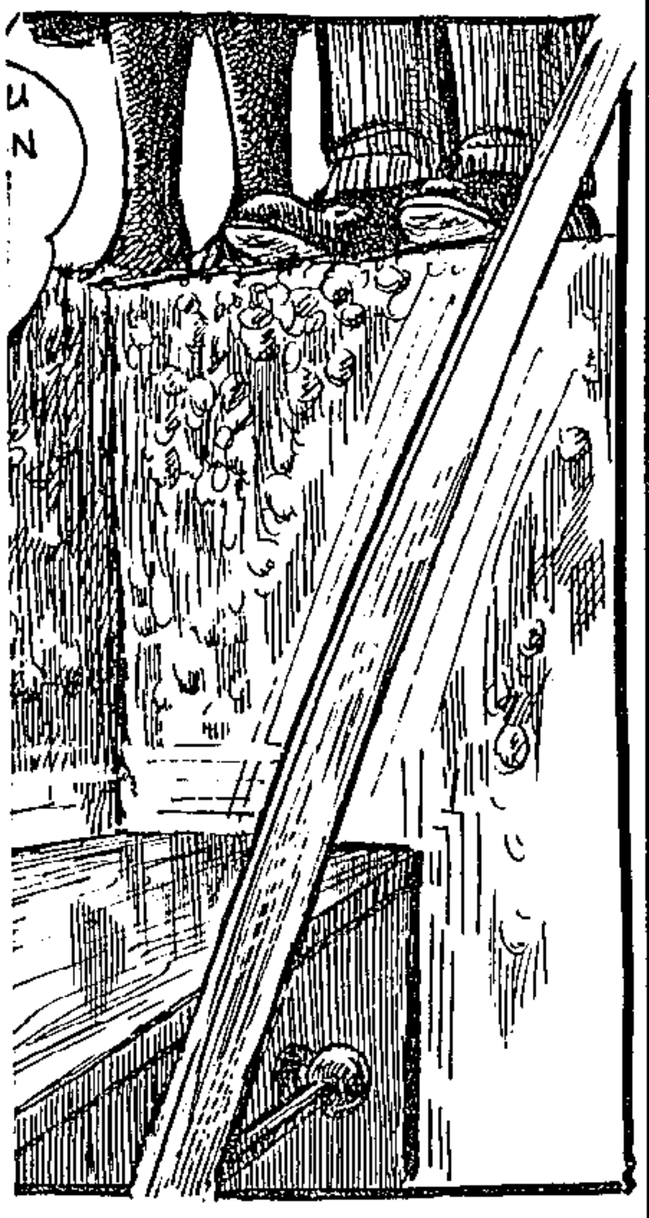
"Because they arrive in the body's own cells, the immune system does not recognise them as foreigners.

"Therefore, they are able to escape the immune system," Mendelow said.

Some kinds of leukaemia (blood cancer) are very difficult to cure while others are easier to manage.

However, because of advanced medical treatment, early detection offers hope for cure.

The most common symptoms of cancer are unusual bleeding or discharge from anywhere, a swelling, a sore that does not heal, hoarseness of the voice or cough, difficulty in swallowing or indigestion, a change in bowel or bladder movements, satellite nodules and an unexpected new lump.



The most frequent cancer conditions in the country are cancer of the skin, this is very common among white people.

Mendelow said some of the skin cancers would generally cause damage where they arrive.

Ozone

He therefore, advised against the destruction of the ozone layer, adding that the removal of the ozone layer would destroy skin tissues.

The most common types of cancers among blacks include cancer of the oesophagus, cancer of the cervix, breast cancer and bone cancer.

Breast cancer could be avoided by constantly checking whether there is a change in shape or size of their breasts.

As far as cervical cancer is concerned, the National Cancer Association (NCA) reported 2 274 cases in 1986 among the blacks.

Women

This type of cancer mostly affects women of late child-bearing age and middle-aged women who have had children in their early teens.

Early warning signs are: watery discharge generally followed by a secondary infection which becomes offensive: irregular vaginal bleeding and vaginal bleeding after sexual intercourse.

"Because these are not usually accompanied by pain, many women ignore these clues - and forget to have their pap smears-resulting in the serious, life-threatening disease which could easily have been arrested.

Cancer of the liver has claimed many lives.

SA scientists have made a great contribution in the study of this disease.

It is normally associated with hepatitis B virus, which causes jaundice.

Mendelow said a national vaccination programme was underway to try to combat its spread.

Gastrointestinal cancer is recognised by a change in bowel habits and weight loss.

Masuku

Tumours may also cause bone cancer.

The case of Lucky Masuku who died on Friday at St Rita's Hospital at Glen Cowie, about 150km south east of Pietersburg is the most recent example.

His bone cancer had reached a terminal stage that manifested itself in a 15kg growth.

Mendelow said the hallmark of cancer was the excessive unregulated growth of cells.

Mendelow said cancer's treatment lay in its removal by surgery, radio-therapy and chemotherapy.

"All these will only be possible if cancer is detected early," he said.

Political comment in this issue by Aggrey Klaaste and Joe Thloloe. Sub-editing, headlines and posters by Sydney Matlhaku. All of 61 Commando Road, Industria West, Johannesburg.

• Write to the Editor at PO Box 6663, Johannesburg 2000. Nom-de-plumes can be used, but full names and addresses should be supplied or the letter will not be published.

Cutting costs

The health-care sector could be revolutionised by the recent launch of a health maintenance organisation by a major medical aid administrator.

After three years of research Medicaid Administrators has started the Managed Healthcare Plan which it claims will reduce costs while maintaining the quality of health care.

Medicaid executive director Quentin Robinson says the scheme is aimed at low-income groups who find conventional medical aid less and less affordable. In four years, for example, medical aid contributions could be costing blacks between 17% and 25% of their wages.

The scheme's administrators will charge a monthly subscription fee that will cover each member's entire health care needs. They hope eventually to enrol 30 000 members. Break-even point is put at 12 000.

A clinic will be built on the outskirts of a major black township. Several sites are under consideration. It will concentrate on preventive care programmes, such as health education, mother care, oral hygiene and immunisation, but also provide treatment and a 24-hour emergency service. To cut costs many routine medical procedures will be carried out by nurses instead of doctors. Subscription fees will be the only source of income so the operators have nothing to gain from over-servicing — in sharp contrast to the medical aid system.

John Cowlin, the plan's medical director, says the major advantage of facilities like these is that they provide primary health care services in communities where they are scarce. "At this stage blacks may be paying medical aid subscriptions but don't have any facilities they can use anywhere near where they live."

The 1987 Browne Commission into health care and medical costs recommended that alternative delivery systems, such as health maintenance organisations, should be encouraged to reduce costs. Medicaid's announcement has not, however, been greeted with universal approval in the health care field.

Clinic Holdings chairman Barney Hurwitz warns these schemes amount to group practice which the ethical rules of the profession prohibit. "It's in the interest of practitioners to create work for each other. It is more expensive in the long run than the present system of free choice."

The Medical Association, which represents doctors, is nonetheless softening its stance on health maintenance organisations. The association has always opposed them, arguing they restrict free choice of doctors and, because they emphasise cost-containment could lead to declining standards. Its incoming director-general, Hendrik Hanekom, says the association is still weighing the pros and cons of health maintenance organisations. ■

PHARMACEUTICALS (299)

FM&T 6/10/89

Drug on the market

The war between the new drug discounter Mediscor and the established Medikredit organisation has gone to the courts.

Medikredit, which discounts prescription medicines by up to 15%, began advertising two months ago. This may have broken the ethical rules of the pharmaceutical profession which strictly forbid pharmacies from advertising or touting for business.

As the discount arm of the Pharmaceutical Society of SA, Medikredit claims that it represents the pharmacy industry and is, therefore, allowed to advertise. But Mediscor MD Kosie van Zyl says Medikredit cannot claim to represent the pharmacy industry in toto — only 65% of pharmacists are members of the voluntary society. Mediscor, which offers discounts of more than 20%, is registered as a pharmaceutical wholesaler and is, thus, bound by the ethical rules. It argues Medikredit should be subject to the same rules.

Mediscor opened for business on Monday and already has more than 50 participating pharmacists in the Pretoria area, as well as several others spread throughout the rest of the Transvaal. "We decided to kick off in Pretoria as our clearing office is there and we could more easily service any problems there," Van Zyl says.

The Medikredit advertising has already drawn complaints from medical aid schemes. They consider its headline — "What's the point of belonging to a Medical Aid if you still have to pay for your medicines" — misleading. As a result, it was modified to read "Pay up-front for your medicines."

In its defence, Medikredit says neither the society nor Medikredit is registered under the Pharmacy Act, so they aren't subject to the ethical rules.

If the courts find that Medikredit's advertising is legal, Mediscor will go ahead with its own advertising and Medikredit is not expected to object. If the courts find Medikredit's advertising illegal, then it will have to cancel a fairly expensive campaign — and Mediscor will have enjoyed the best of three falls. ■

STAR 9/10/95

No charge for patients after death

299

By Karen Stander

A private hospital group has announced that it will waive all costs incurred after death when organs are to be donated.

This decision by Afrox Healthcare — which is the second biggest private hospital group in the country with 10 hospitals, including five in the Johannesburg area — is a direct result of a case highlighted in The Star last week.

The father of 17-year-old Jacques van Wyk of Springs, Mr Willie van Wyk, was sent an account for more than R4 000 by the Princess Nursing Home in Hillbrow after he had agreed to donate Jacques's organs. The account included theatre and other costs incurred after Jacques was declared brain dead.

Mr van Wyk's medical aid paid almost R4 000 of the account, but about R240 disallowed was still outstanding. The hospital has agreed to waive this charge.

Jacques died in June after a blood clot developed in his brain. His heart, liver, kidneys and diaphragm were transplanted into five patients.

Mr Dick Williamson, general manager of Afrox Healthcare, which owns the Princess Nursing Home, said an investigation revealed that medical aid schemes were not obliged to meet the costs of any medical care after death.

His company had taken an immediate interim decision not to charge for the cost of hospitalisation incurred in the removal of organs after death.

Mr Williamson appealed to other private hospitals to follow this example.

MEDICAL AIDS F.Mail 13/10/89

More flexibility

Medical aid schemes have been given some much-needed flexibility. Amendments to the Medical Schemes Act, put forward in March last year, became law on October 1.

Medical aid subscriptions could previously be determined only by the income of a member and the number of dependants.

Now this has been extended to include the area in which a subscriber lives, his or her age, claims record, extent of cover and length of membership.

Making use of an opportunity presented by the new regulations, a new medical aid scheme for farmers, AgriMed, will base subscriptions entirely on age rather than income.

But schemes haven't been given *carte blanche*. They will still be required to honour guaranteed payments to doctors who charge according to the scale of benefits and to pay at least 50% of the cost of prescription medicines and 70% of all other medical services. They also won't be allowed to pay hospitals and doctors more than the scale of benefits.

Says Stability Medical Aid chairman John Ernstzen: "We've been given a little more flexibility and we'll be able to reward members who claim less with lower premiums.

"But until the guaranteed payment is dropped, it will be very difficult to shape different packages.

"As we have to guarantee payment to everyone who charges according to the scale, there's an enormous financial burden placed on us."

Afrox Healthcare GM Dick Williamson says the private hospital movement welcomes the changes. "Up to now, medical aids have been more socialist than capitalist as they were so heavily regulated. Now they have the opportunity to become more competitive." ▩

B/Day 18/10/89

299

HOUSEWIVES SIGN PETITION AGAINST HIGH MEDICAL COSTS

PRETORIA — The Housewives' League of SA recently handed a 54 500 signature petition to National Health and Population Development Minister, Dr Rina Venter, listing concerns about medical costs.

The league's president, Lyn Morris, yesterday said the petition expressed growing concern for the ever-increasing cost of medicines and health care in SA.

She said the petition was handed to the Minister at a meeting on October 6.

"It was a fruitful meeting and we feel sure we can look forward to changes on the medical scene."

Morris said the meeting gave the league an opportunity to discuss areas of concern in medical matters with Venter — including the prohibitive cost of medicines, private hospitals costs and the medical aid issue.

"The petition was mounted nationwide and represented many hours of manning of tables by branch members as well as considerable support shown to the project by members of the public by way of letters and telephone calls — We are still receiving petition forms and letters," Morris said.

The league would be "keeping in touch" with Venter although no date had been set for further meetings.

Venter was very knowledgeable and had a background of professional training in welfare, Morris said. — Sapa.

AIDS drug available for SA testing soon

B/Day 18/10/89

TANIA LEVY

A NEW drug being tested for AIDS treatment in the US is expected to be available for investigational use in SA early next year.

In an announcement at the weekend, the B-M Group said approval for the investigational use of Videx in SA had been sought from the Medicines Control Council (MCC).

The B-M Group is the SA subsidiary of US-based Bristol-Myers Squibb, which announced the US Food and Drug Administration (FDA) had approved protocols for the clinical use of Videx for AIDS patients who were intolerant to Zidovudine (AZT).

The B-M Group will not be direct distributors of Videx, which will only be available from the medical profession, even after approval by the MCC.

KOSIE VAN ZYL

299 W FMail 20/10/89

A maverick medicine man

The pharmaceutical establishment must be cursing its bad luck. In Kosie van Zyl, MD of MDS Mediscor, newly formed distributor of discount prescription medicines, it has found a formidable opponent.

Since opening shop at the beginning of the month, Van Zyl has shaken up the industry by offering discounts on medicines of more than 20%.

Mediscor acts as a broker between medical schemes and retail pharmacists on one hand and pharmacists and suppliers on the other. This way, members of participating medical aid schemes are guaranteed a minimum discount of 22% on medicine purchased from participating pharmacists. Pharmacists, or so the argument goes, will see turnover increase and should thus be able to reduce margins. And, because of the volumes they purchase, negotiations on behalf of member pharmacists should lead to cheaper supplies. The end result, lower prices all round — hopefully.

Kosie van Zyl... making medicine affordable

Van Zyl's initiatives have seen him denounced as a traitor to the profession in some quarters. He remains unrepentant, though. "Yes, I am anti-establishment, but it is in the public interest. If I've got the public behind me I'll go to war."

War, in fact, has already broken out. Last week, Van Zyl obtained an order in the Pretoria Supreme Court — with costs — stopping Medikredit, the discount arm of the Pharmaceutical Society of SA, from advertising in breach of the ethical rules of the profession. Medikredit discounts prescription medicines by only 15%.

There remain many battles to be fought. On the one hand, his scheme is being fiercely resisted by vested interests; on the other, he is a long way short of his own goal — signing up 750 of the country's 2 750 retail pharmacists. So far he's signed only 65. Still, early results have surpassed even Van Zyl's expectations. And contracts with medical aid schemes representing 1,75 million members — 30% of the total — is certain to attract more pharmacists.

As a youngster, Van Zyl was a lazy scholar. But the opportunity to atttend the prestigious Paarl Boys' High changed things. "I discovered what I needed: competition." His sporting talents, in particular, flourished and he became a fine sprinter. He also achieved the distinction of making the Boland rugby team, playing centre between Monty and Koffie Hofmeyr at the tender age of 19.

With age and work commitments, his sporting prowess has dwindled. Even his golf handicap has lapsed from 12 to 18. But his zest for competition remains undimmed.

Free enterprise, private initiative and competition are his new articles of faith which he frequently repeats with conviction.

Since qualifying as a pharmacist at the Cape Technikon in 1953, Van Zyl has worn most of the pharmaceutical hats available. Most of his time has been spent with the retail sector, but he's also been involved on the wholesale side and served a stint with the Department of Health.

He has held innumerable appointments on industry committees. Last year, he retired from the SA Pharmacy Council after 25 years, including a five-year stint as president.

Pharmacists often straddle an uncomfortable divide between their professional commitments and their role as businessmen. But Van Zyl seems to have addressed both with his current scheme. He has already invested a substantial sum of money and is particularly proud of Mediscor's sophisticated computer capabilities.

At the same time, though, he is trying to address an issue which has concerned him ever since spending time in Zimbabwe observing the profession there: how to achieve acceptable, yet affordable, standards of public health in Third World communities.

He points out that in 1987 medical aid schemes paid out R654m for medicine alone — 27% of the total expenditure by medical schemes that year. To cover this, schemes are forced to hike rates. With salaries often not keeping pace, a drop in the level of benefits received is often inevitable.

Van Zyl is one of those happy people whose business is also his pleasure. "I enjoy it because I know it's necessary. It's nice to do something for the public which they appreciate."

A spell as a member of a commission into drug abuse in the early Seventies made Van Zyl something of an expert in the field. He is often requested to speak on the subject.

When not embroiled in the industry, he likes to get away to the peaceful Cape west coast. Otherwise, he enjoys a game of golf and reads a lot, mostly on economics. He is married and has two daughters, both married.

Van Zyl's blend of experience, idealism, common sense and attention to detail suggest he will not easily be wished away or shifted from his chosen course. ■

'Health-care costs set to rise R800m' — Rams

CMT Trips 28/10/89

JOHANNESBURG. — South Africa's medical schemes are gravely concerned about the continued escalation in private health care costs funded by medical schemes which, according to the Representative Association of Medical Schemes (Rams), are set to rise by about R800 million in 1990.

In a statement yesterday, Rams said it had made this forecast after consultations — in terms of the Medical Schemes Act — with suppliers of health-care services, to determine statutory scales of benefits for 1990.

Rams executive director Mr Rob Speedie said the Medical Association of South Africa (Masa) had effected a number of very significant adjustments to the relative values of certain services since Rams published its 1989 scale of benefits.

"Rams is to increase the payout by medical schemes for 1990 by 15%. To this must be added the impact of ever-increasing use of medical services, which is expected to contribute another five percent to costs next year, as it has done over the past few years.

"So the total increase in payout by schemes for medical services is expected to rise by 20% in 1990, before any possible upward adjustment to the monetary value of services is considered," he explained.

He said the Masa adjustments would have the biggest impact on the less privileged medical scheme members, since Masa's latest tariffs favour the general practitioner, with whom black and coloured people consult the most. So much so that more than 50% of the costs of some schemes providing for this section of the community were for general practitioner services, he added. — Sapa

Medical aid fees to soar by 20%

Cape Times 2/11/89 299

Staff Reporter

MEDICAL AID members will have to pay an average R200 to R300 a year more in 1990 when medical scheme pay-outs will increase by 20% to R4,8 billion.

The Representative Association of Medical Schemes (RAMS) earlier this week announced increases in scales of benefits for various health services.

Medscheme managing director Mr Keith Hollis said fees would also increase by 20%.

The increase on an average R225-a-month medical aid payment would be R40 to R50, shared by the member and the employer.

Most people would have to pay between R20 and R25 extra a month, Mr Hollis said, and increases would vary from scheme to scheme.

He estimated that medical schemes would pay out a total R4 billion this year.

On average, black

To page 2

Ranger held after Kruger rhino killings

Own Correspondent

JOHANNESBURG. — The skulls of at least 25 white rhino, with their valuable horns cut off, have been found in the Kruger National Park, park warden Dr Saloman Joubert said yesterday.

A former National Parks Board employee based in the Kruger Park was arrested yesterday in connection with the matter and is expected to appear in White River Magistrate's Court today.

Dr Joubert said the rhino had been killed over a six-year period between 1983 and 1988 and their bodies hidden under bushes in the area between Pretoriuskop and Skukuza.

The suspect had been in charge of patrolling this area, he said.

The investigation, conducted by the board and the Endangered Species Unit of the police, began in September this year.

Dr Joubert said Pretoria University student Mr Danie Pienaar, who was assisting with the annual aerial census as part of his post-graduate work on white rhino, spotted rhino skulls hidden under bushes.

"He went to inspect them to collect ecological data and then he saw the bullet marks. That started our investigation."

Bullets and cartridges were found at the scene and subsequent investigations showed the animals had been killed by one specific weapon, he said.

Dr Joubert said the park's census programme was not accurate enough to detect the loss of five or six animals in a year.

The park's white rhino population was 1 200. Park officials said it was not known how many more, if any, white rhino had been killed or if any black rhino or elephant had been killed as well.

The suspect had worked for the park for about 15 years and left its service in November last year.

Parks board officials said one kilogram of ground rhino horn was worth R3 000; a single horn was worth about R1 000 a kg and individual horns could weigh up to 6kg.

From page 1

Medical aid

Cape Times 2/11/89 299

people who belonged to medical schemes would be hardest hit by the increased fees, he said.

Although black medical aid members generally paid lower fees, percentage increases in their subscriptions would be higher than that of whites. Medical aid fee increases paid by blacks would be more in the region of 25%.

Mr Hollis said this was because 60% of claims by black members were for GP visits and medicine purchases.

Doctors yesterday told the Cape Times that patients would now have to pay substantially more for health care following a "totally inadequate" one percent increase in medical aid scheme costs.

The National General Practitioners Group (NGPG), a Medical Association of SA (Masa) affiliate, yesterday described the increase for 1990 as "shocking" — and "a slap in the face to both medical scheme members and doctors".

Chairman of the NGPG Dr Johan Kruger said the "totally inadequate increase" meant that patients would have to pay more for visits to a general practitioner.

Dr Kruger also claimed that the Rams was "misleading" the public.

tising its own discounts (*Business* October 20), he has scented blood again. This time his target is pharmaceutical wholesalers.

In a complaint, Van Zyl's company, Mediscor, has asked the Competition Board to ascertain "whether any restrictive practices by, or involving, pharmaceutical wholesalers and retail pharmacies exist or may come into existence."

Van Zyl claims that some wholesalers are boycotting his network of pharmacies in an attempt to kill it.

Mediscor is offering 22% discounts on prescription medicines and Van Zyl says vested pharmacy interests are terrified that his discounts will play havoc with their traditionally high margins.

Wholesalers allegedly withheld medicine supplies from certain Mediscor pharmacies.

Board chairman Pierre Brooks says there is evidence from independent sources as well as Mediscor of the possibility that boycott actions had taken or were taking place.

He says this kind of boycott apparently did not take place before Mediscor was formed. "There seems to be a correlation between boycotts and Mediscor members, though I don't want to prejudge the investigation."

Alternate plan

Van Zyl says if wholesalers don't co-operate, Mediscor will have to buy directly from manufacturers. "This isn't the direction I want to go. I want to use the existing wholesaling infrastructure. Many manufacturers haven't been very friendly."

The pharmaceuticals sector is putting on a brave face for the investigation. Tony Karis, MD of SA Druggists, which includes the Link wholesaling group, says wholesalers have nothing to hide.

"I wish we had such power over retailers. Even those who fall under our umbrella have no difficulty buying a large proportion of their needs away from us. We've financed certain retailers through bonds but that doesn't put them in our pockets. If they are unhappy with our prices or service they can transfer their bond to one of our competitors, such as E J Adcock."

Business Dynamics MD Theo Rudman, speaking at this week's National Wholesale Drug Association conference in Somerset West, said Mediscor was given an opportunity to enter the pharmaceutical trade, thanks to the high price of medicine, and should bring much needed competition to the industry.

"Competition at every link in the supply chain is the best way of ensuring the lowest possible prices and the best possible quality and service."

He says the discount war isn't the only threat to pharmaceutical profits. Doctors, who dispense 25% of prescription medicines, get preferential discounts from some manufacturers and often a bonus of free medicine. He adds that medicine prices in the private sector will stay high as long as two-thirds of all medicine is sold to the State, often below cost. ■

PHARMACEUTICALS

Striking back

Irrepressible drug discounter Kosie van Zyl has struck again. After getting the courts to stop a competitor, Medikredit, from adver-

FINANCIAL MAIL NOVEMBER 3 1989

Medical aid cash crisis

CMH Times 13/11/89 299

Own Correspondent

JOHANNESBURG. — Medical aid schemes are beginning to crack under the pressure of medical bills running at an average of 30% over the inflation rate, according to leading medical aid organisations.

They have warned that health funding is under severe strain with ever-increasing medical costs and wage demands. Hospitals have privately warned that they need to increase their rates by at least 20% to keep afloat, but have reached no final decision on tariffs yet.

Medscheme managing director Mr Keith Hollis — Medscheme represents more than a million beneficiaries belonging to 33 schemes — said medical aid organisations had not succeeded in representations on key issues to government to modernise the method of determining medical tariffs.

One cent more

Medical aid schemes and the medical profession alike are concerned at the increasing resistance or inability of patients to pay high bills, coupled with their own rapidly rising costs. While patients with medical aids are battling to pay bills, the situation is exacerbated by the fact that 83% of South Africans have no medical aid cover.

Medical aid schemes at present pay R1,75 of each R3,30 a patient pays a doctor who follows the Medical Association of South Africa (Masa) guide to fees. But from January 1, 1990, they will pay only one cent more, or R1,76, for every R4 levied by doctors.

In addition doctors currently charge R33 for a consultation. Next year they may charge R48 per consultation, according to the Masa scale.

Medical aid schemes have been forced to raise member contributions by 20% or an average of R30 to R60 per family (to around R270 to R300 a month) as from the beginning of next year to cover the 15% raise — or R240 million — they have awarded the medical profession.

Medical societies lashed for being wastefully expensive

B/Day 15/11/89. (299)

CHARLENE SMITH

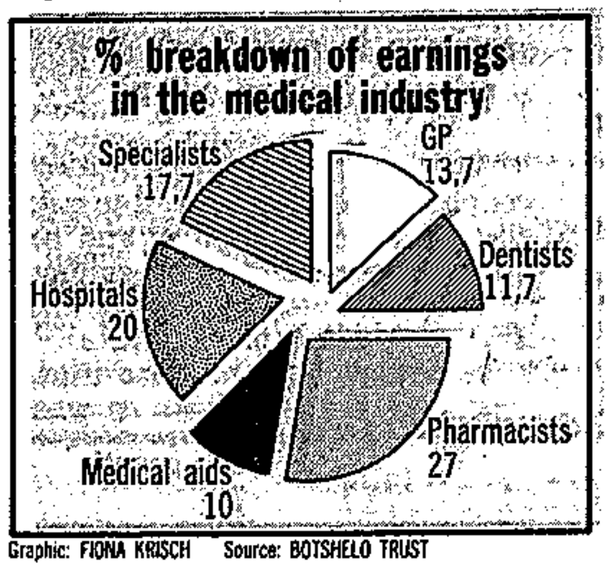
DOCTORS yesterday lashed out at medical aid societies for failing to rationalise and claimed money was being wasted on expensive bureaucracies.

"There are 240 medical aid societies in SA and only four in the US with a far greater population. What consumers don't see is they are paying for the hierarchy, plus all the costs of staff and running costs," a Benoni doctor complained. Doctors cannot be named for ethical reasons.

However, Medscheme MD Keith Hollis said administration costs for medical aid schemes were only 5,85% of contribution revenue in 1988, and this figure was expected to drop to 5,5% in 1989. This was far below that of US schemes where the cost was 10%. Hollis, whose organisation represents one-million beneficiaries, said they paid 80-million accounts every year on average, within 10 to 30 days of receipt of the account.

He rejected claims to the contrary.

A spokesman for the National General Practitioners Group, which represents 1 500 GPs said consultation fees were running below the inflation rate. He also complained that the nation's 6 500 GPs earned 2% less from medical aid societies than the 2 500 specialist doctors, who earned 19% of medical aid expenditure.



Graphic: FIONA KRISCH Source: BOTSHELO TRUST

"Most doctors charge the medical aid tariffs of R17,50 per consultation, then have to wait 90 days to get paid by the medical aid. Those that contract out have enormous problems collecting bad debts," a Randburg doctor said.

Doctors said they studiedfor a minimum of seven years and, at the end, had to pay off a R100 000 student loan at 8,5% interest within six years. To buy into a practice cost around R30 000 or R50 000 more, depending on the practice.

They saw around 40 to 50 patients a day, which brought in a monthly income of R13 200 to R16 600. From that they had to pay the costs of their consulting rooms, staff and equipment.

They criticised a system where pharmacists, who studied for three years, made 50% on medicine plus a professional fee of R1,80 per item.

A Johannesburg doctor defended the luxury cars the medical profession drove saying it was one of the few tax perks they had.

The NGPG spokesman said doctors should accept only the Medical Association of South Africa rate, which goes up to R48 per consultation next year for general practitioners.

B|Day 15|11|89

Medical aids report imminent

(299)

KAY TURVEY

THE Competition Board is set to report the findings of its inquiry into medical aid schemes before the end of the year.

Competition Board chairman Pierre Brooks said the inquiry, which included an investigation into restrictive practises embodied in the Medical Schemes Act, had attracted a wide range of spontaneous submissions from doctors, insurers and medical schemes, resulting in a lengthy extension to the deadline for submissions.

The inquiry also addresses the inter-relationship between medical aid schemes and insurers in the provision of health cover.

Insurers have increasingly been offering health cover in the form of hospital plans and dread disease cover in what is described in the industry as a "quiet revolution".

Flexibility

Insurers are forbidden from providing health care services. In terms of the Medical Schemes Act, they cannot pay doctors directly for services although they can recompense the patient.

Sanlam medical aid subsidiary Sanmed MD Nick du Preez says there is a need for more flexibility in the act so medical aids can offer a menu of benefits.

At present the Medical Schemes Act requires medical aid societies to pay a mininimum of 70% of gazetted fees and 50% of the cost of medicines.

"The biggest bane of medical aid societies is medicine," says Du Preez. Medicines account for 30% of medical aid costs, while the price of medicine is rising by 25% a year — an increase that has to be met through a 7,5% increase in premium.

Affiliated Medical Administrators chairman Tony Leveton agrees medical aids should be able to offer members different rates for different benefits.

He says insurers would be unable to compete with medical aid schemes under the present legislation, particularly if, like medical aids, they were bound to cover members and their dependants from cradle to grave, irrespective of their circumstances.

Medical aid schemes provide cover for pensioners, widows of deceased members and even terminally ill children of members — risks which insurers might be reluctant to take on.

Even given a level playing field, medical aid schemes would have the structures and experience to compete more effectively, he says.

Old Mutual GM (employee benefits) Gerhard van Niekerk said medical aid systems encouraged over usage by members and over-servicing by doctors. He said patients should be made acutely aware of costs and the professional relationship between doctors and patients restored.

Given the excessively high increases in medical services which outperformed the inflation rate and the rising cost of medical aid premiums, individuals should also be able to choose the risks they wished to cover, he said.

Medical fees hike for insurers causes clash

B/Day (299) 15/11/89

KAY TURVEY

THE Medical Association of SA (Masa) and the life insurance industry, which spent more than R50m this year on medical examinations for potential policyholders, are embroiled in a bitter clash over the proposed hike in medical fees for insurers.

Talks on the increase have reached deadlock, although the Life Offices' Association (LOA) is expected to decide how to proceed at its AGM on Friday.

Masa initially put forward an effective 77% increase for a standard medical examination by a GP, but later reduced this amount to an effective 42%.

The large life offices in Cape Town and Johannesburg employ their own doctors to conduct checkups on policyholders, but are, however, reliant on outside doctors in other centres.

LOA public relations officer Juries Wessels said the industry was prepared to meet a 20% rise this year as the rates were to be adjusted for a 15-month period.

The LOA and Masa meet annually to negotiate rates which are usually in line with the CPI.

Masa proposes rate increases in three different categories. One for doctors contracted into medical aid, another for those contracted out and a separate rate for those servicing insurers.

This year, Masa sought to adjust the manner in which fees are calculated, which would result in an effective 76% hike for a standard medical examination — specialist fees would be reduced.

However, Wessels said specialist doctors had not been represented at the talks and overall the cost increases would have been too great.

Masa acting secretary-general Hendrik Hannekon declined to comment.

● See Page 3

Medical care 'vital for rural areas'

By Toni Younghusband, Medical Reporter

It was vitally important that people living in remote rural areas had access to proper medical care — this was one area of health care in South Africa which needed careful attention, the director-general of health of the Republic of China, Dr Chun-Jen Shih, said at Jan Smuts Airport yesterday.

Addressing a press conference shortly before his departure for Taiwan, Dr Chun-Jen said his government was working on a 10-year programme which would ensure that adequate medical treatment was evenly distributed throughout the country.

"You have to get medical care to the poor, to the rural areas. That is most important," Dr Chun-Jen, who had been on a week's fact-finding mission to SA, said.

South Africa's Minister of Health, Dr Rina Venter, said there were 2 300 clinics throughout the country and 54 000 mobile medical units deployed in rural areas but these were still not enough.

"I am sure we could learn a lot from your country and we would like to investigate how you tackled the problem," she said.

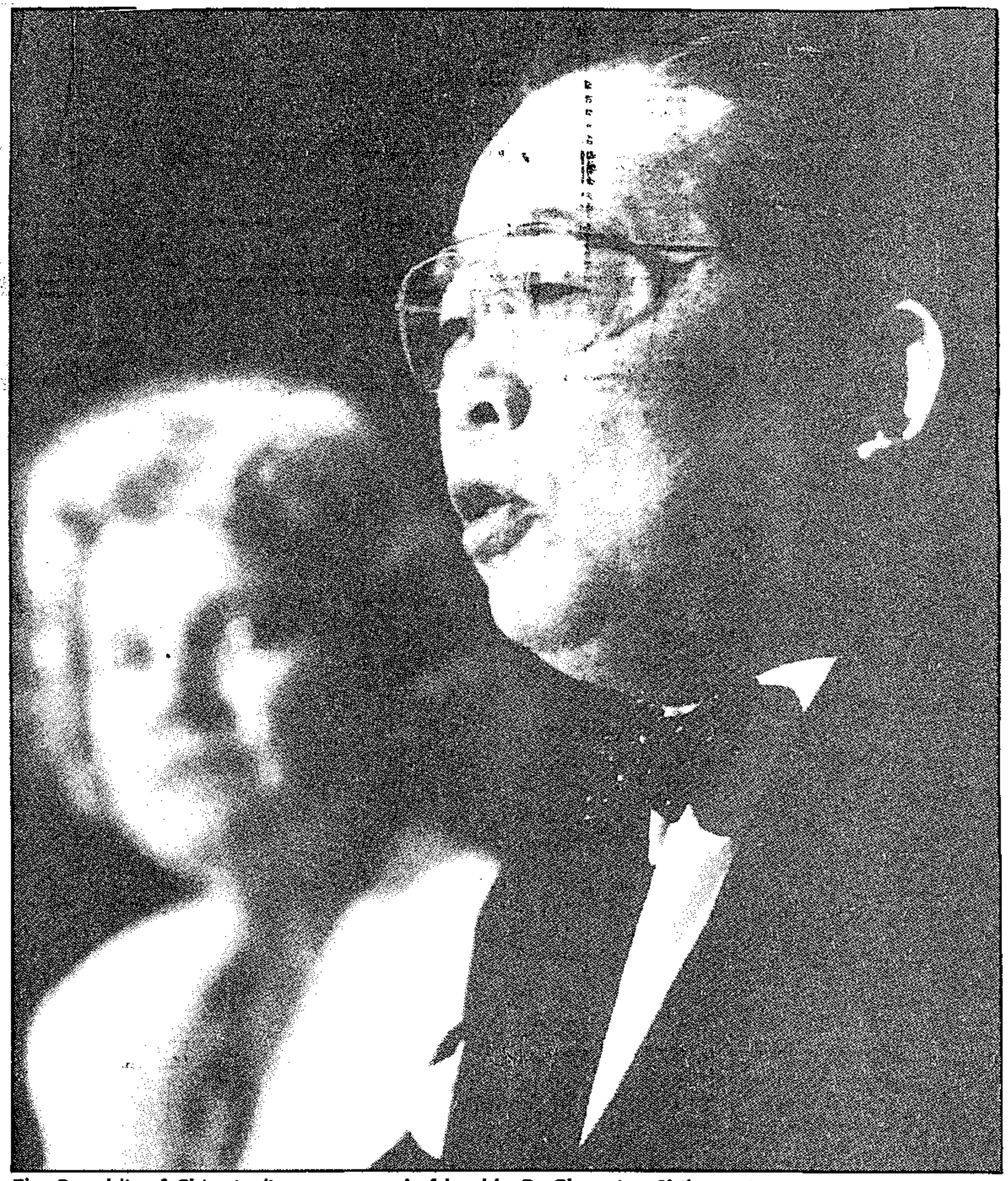
Dr Chun-Jen stressed the need for a balance between State-funded health care and privatisation. He said while private health care had the advantage of freer administration, it was essential that a government also provided medical treatment.

About 60 percent of hospital beds in Taiwan belong to the private sector and the remainder to the State.

During his visit to SA, Dr Chun-Jen visited a number of academic hospitals which he said were of the same high standard as was found in any advanced country in the world.

He said he had been most impressed by the dedication of SA's medical profession despite the shortage of manpower, a shortage which Taiwan also suffered particularly among nurses.

Dr Chun-Jen invited Dr Venter and her colleagues to visit Taiwan in the near future.



The Republic of China's director-general of health, Dr Chun-Jen Shih, at Jan Smuts Airport yesterday before his return to Taiwan after a fact-finding mission. In the background is SA Minister of Health Dr Rina Venter. ● Picture by John Hogg.

B1 p4 17/11/89

Medical hikes get attention

299

TANIA LEVY

THE inflation rate for medical costs between September 1988 and September 1989 was 22,3%, according to the Consumer Council.

This compared to 14,9% for all items in the period.

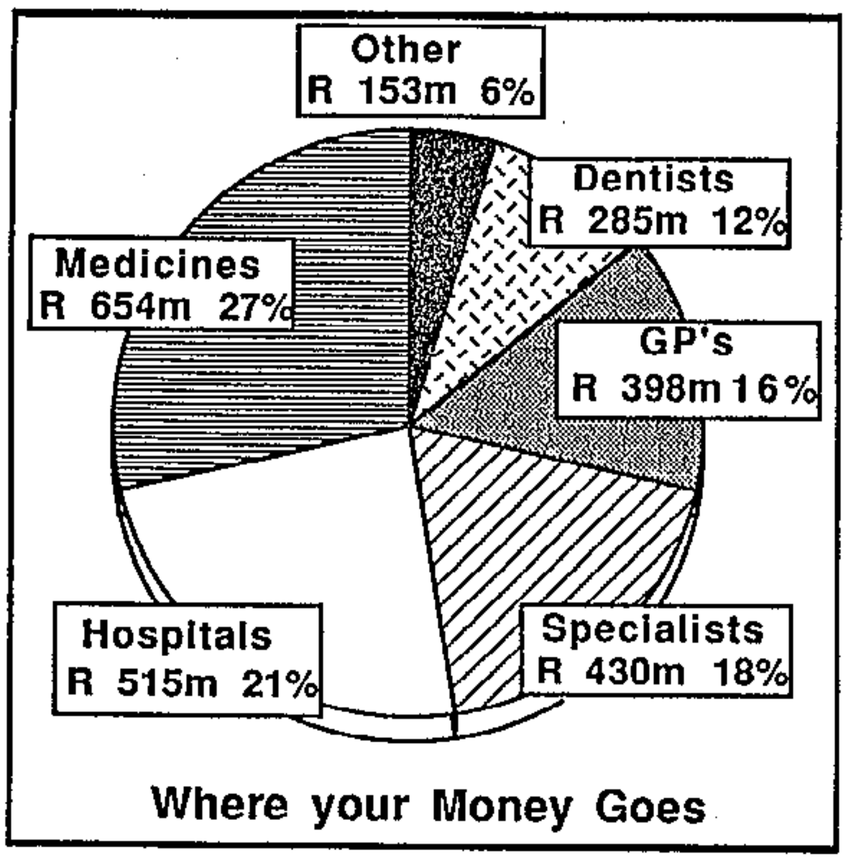
Consumer Council director Jan Cronje said in a statement yesterday the council was considering an investigation into the exceptionally high costs of medicine and medical care.

Suspected

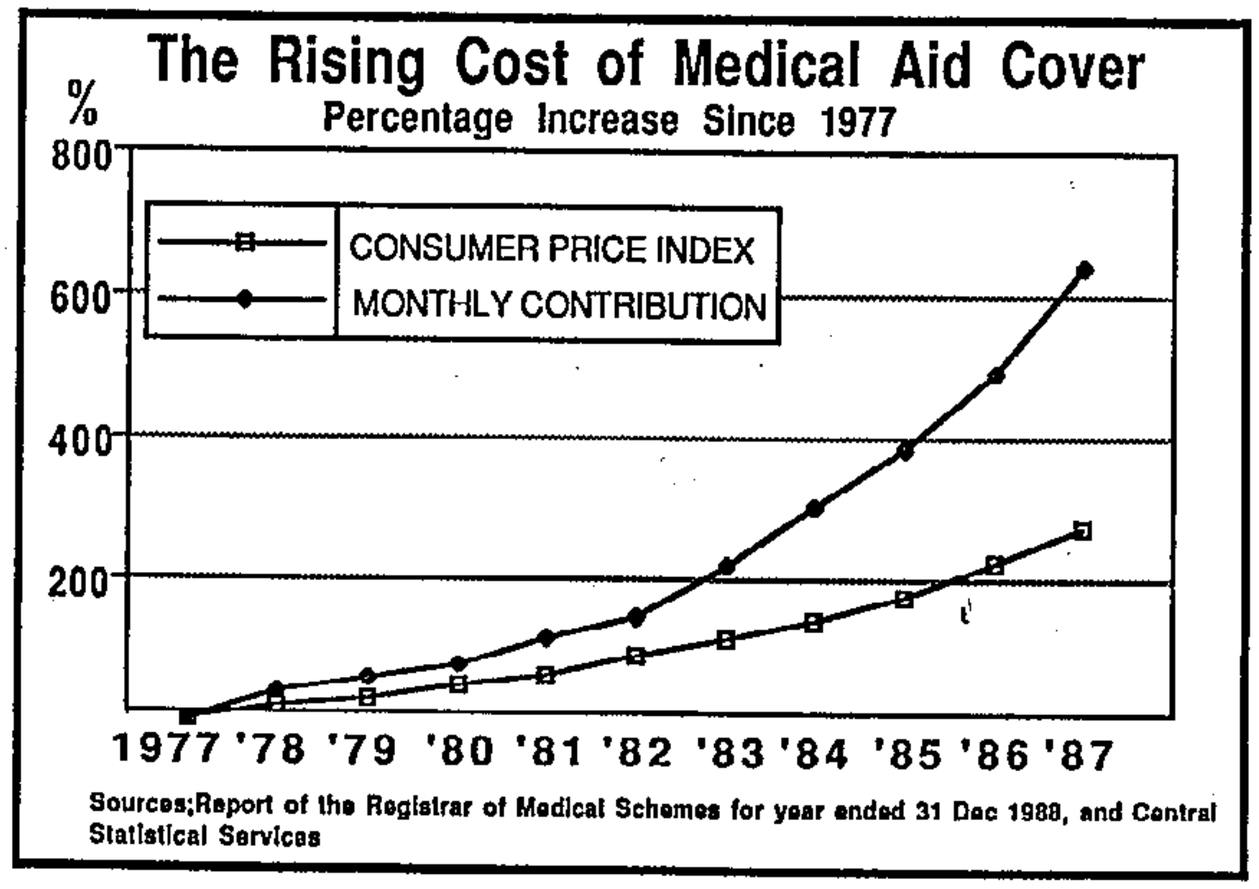
He said reports of a further 20% increase in medical aid contributions were extremely upsetting.

It was suspected that unreasonably high profit-making aided rising medical costs and that little cost absorption was done by the profession itself.

High costs were simply loaded onto the consumer.



Where your Money Goes



Sources:Report of the Registrar of Medical Schemes for year ended 31 Dec 1988, and Central Statistical Services

Wits doctor proposes compulsory health insurance scheme for SA

Medical crisis looms

Star 17/11/89

299

A dose of summer flu next year could cost you nearly R100 in doctor's fees and medicine. To have your child's tonsils removed at a private clinic will set you back more than R700 — and to have a baby, at least R2 500. Just because you belong to a medical aid society does not mean you won't feel the pinch. **TONI YOUNG-HUSBAND, The Star's Medical Reporter,** looks at rising health care costs and a possible solution to stemming the tide

Health care in South Africa is rapidly becoming a luxury which few can afford. In the past few weeks, various sectors of the health care industry have announced, with lengthy justification, their increases for the new year: increases which will necessitate a possible 20 percent rise in medical aid premiums. Even then, that will not guarantee full cover for treatment.

From January, doctors' consultation fees go up by as much as 21 percent; private hospitals are looking at an 18 percent fee increase.

The growing gap between medical aid payouts and health fees mean patients are having to fork out more and more, and in some instances are forced to pay the full amount or at least a deposit before vital medical care is given.

Dr Jonathan Broomberg, of the Johannesburg Centre for Health Policy of the Department of Community Health at the University of the Witwatersrand Medical School, blames the private health care structure in South Africa for the cost crisis.

The latest fee increases do not deviate from the trend of spiralling costs that have characterised the private health sector for more than a decade and are therefore nothing new. But how long can it go on? Is there a solution?

According to Dr Broomberg, individual health care providers cannot alone be blamed for cost escalation — rather the irrational way in which the system is structured.

The necessary conditions for a free market to operate effectively do not exist in the health sector, and therefore, rather than promoting efficiency and controlling costs, a free market in health care can aggravate the cost pressures that already exist.

The first market failure, says Dr Broomberg, is consumer ignorance. The suppliers of health care (doctors, specialists and others) have a virtual monopoly of know ledge of the services they offer.

The second market failure is the absence of true competition in the health sector. Legislative and ethical bans on advertising mean the patient is unaware of the different services offered at different prices.

"The absence of informed consumers and competitive conditions in the health sector mean the usual interactions between prices and supply and demand for goods cannot occur. This creates the potential for irrational and inefficient use of services," said Dr Broomberg.

Specific features of the private health care sector exaggerate the potential for irrationality, inefficiency and cost escalation. These include:

● Fee-for-service: The private sector's fee-for-service system leads to over-utilisation. If a doctor's income depends directly on the number of services he delivers, the incentive to over-service is created.

● Third-party payment: Membership of a medical aid scheme has meant that neither patients nor providers have any incentive to question the cost of treatment. This also leads to over-utilisation of services. Neither the doctor nor the patient is aware of the cost — the bill is paid by the medical aid scheme.

High drug bills

● Lack of a single payer mechanism: Medical aid schemes have little power to ensure that providers of health care charge according to prescribed tariffs.

Medicine prices are another cause for concern. The average prescription in the private sector costs R70 and drug bills account for 40 percent of the annual payout by medical aid schemes.

Once again, lack of awareness on the part of the doctor and patient (both of whom place payment responsibility with the medical aid scheme) means the most expensive drugs are being prescribed when generic equivalents are available.

The pharmacist may not substitute the cheaper generic for the expensive ethical, but legislation to alter this practice is pending.

Dr Broomberg believes the most serious area of cost escalation has been in the private hospital arena.

These institutions, resembling luxury hotels rather than hospitals, are making excellent profits.

"They operate on a fee-for-service basis, do not buy generic drugs and have been found to charge over and over again for the same drug or roll of plaster.

"Nobody denies the huge administration costs these institutions must bear. But again, this is the fault of fee-for-service."

The Health Policy Centre's solution? A compulsory national health insurance system (NIS).

"Everyone who is employed, including those self-employed, would have to pay a compulsory monthly contribution. These contributions go into a central pool, possibly co-ordinated by a body of medical aid schemes.

"This controlling body will negotiate a national tariff, buy drugs on tender for its members, and monitor provider practices.

"The NIS would pay for private hospital treatment, but not for the fancy accommodation. This would create competition among institutions and keep costs to a minimum."

Dr Broomberg believes there is a misallocation of resources, most of the private clinics being in wealthy areas.

"The NIS could agree to pay the cost of treatment at hospitals necessary in the area, but if a new hospital was built and there was already an oversupply, the NIS wouldn't pay. This would result in better distribution.

"Today, 46 percent of the total health care expenditure is in the private sector, which looks after only 25 percent of the population. The only way this can be redistributed is by bringing all health services together.

"The writing is on the wall for private health care in this country. The private sector is pricing itself out of the market," Dr Broomberg warns.

Medical costs hoodoo

Consumers appeal to Minister on health care

Staff Reporter

Representatives from the Housewives' League of South Africa presented a petition bearing 54 500 signatures from consumers concerned about "the ever increasing cost of medicines and health care" to Minister of Health Dr Rina Venter last month.

Mrs Lyn Morris, president of the League, said the delegation also drew the Minister's attention to other aspects of health services, particularly problems in the nursing profession and recent difficulties with the provincial hospital services, with special reference to the J G Strijdom Hospital.

She said many points discussed fell within the ambit of the Wim de Villiers Commission, a report on the rising cost of health care which is due out in the next few months and the Minister agreed to meet the group again once they had studied the report.

Mrs Morris said the League was especially concerned with the plight of the elderly who had to spend so much money on medication that they hardly had enough with which to buy food.

She said the Minister was obviously very concerned and eager to discuss the results of the Commission with the League.

"But this matter is so urgent, that if there is any delay we will ask why," she said.

Presmed's interim earnings soar 102%

ZILLA EFRAT

REMAINING contracted into medical aid tariffs, increased hospital occupancy levels and control of continually escalating costs contributed to President Medical Investments' 102% rise in earnings in the six months to August.

Earnings rose to R587 000 (R290 000) or 6,7c (3,3c) a share. The group pays a single dividend at year-end.

Turnover jumped 88% to R13,3m (R7m) on higher-than-expected occupancy levels, the result of remaining contracted into medical aid fee structures, says MD Carl Grillenberger. While the official fee structure puts pressure on margins, staying contracted-in minimises bad debt and streamlines administration, he says.

Operating margins improved to 13% (12%) through a concerted drive to promote cost-consciousness, resulting in a 102% hike in operating profits to R1,7m (R862 000).

Debenture interest rose to R174 000 (R72 000) and other finance costs jumped to R392 000 (R181 000) leading to pre-taxed profit of R1,2m (R609 000), a 93% increase.

Taxed profits improved 106% to R625 000 (R304 000) on a drop in the tax rate to 47% (50%).

While non-interest bearing debt jumped 356% to R6m (R1,3m), interest bearing debt was up 81% to R1m (R567 000).

Grillenberger says the group is developing a small, highly specialised hospital in Bedfordview which will open in 1991. In addition, plans are underway for hospitals in Welkom and Rustenburg. The board believes the 25% long-term growth objective will be substantially bettered this year.

End health care duplication — MEC

Star 4/12/89.

By Toni Younghusband,
Medical Reporter

Providing health care for all South Africans regardless of whether they can pay for it is a top priority of the Transvaal's new MEC for hospital services, Mr Fanie Ferreira.

Mr Ferreira (51), who took over from Mr Daan Kirstein on December 1, said in an interview with The Star on the day of his inauguration that he was not sure how this could be achieved but he believed sound business management would be a key to reaching this ideal.

These sound business-management principles would be applied to stringent rationalisation of health services. Although he had had little time to study his portfolio, Mr Ferreira said there was clearly a need to eliminate the duplication of services.

"At present, local-government bodies are involved, provincial administrations, community development departments ... and we are all busy with the same thing. If we could rationalise these energies I believe health services would be more effective and we would save considerable costs."

(299)

An accountant by profession, he stressed he was not a doctor and would never try to be one.

"I don't believe a doctor should be MEC in charge of hospital services. This is a position for a businessman."

A man with wide business interests, Mr Ferreira believes his involvement in local government — he served nine terms as mayor of Naboomspruit and was a member of the Provincial Council for Waterberg for five years — will serve him well.

Prevention

Asked whether Transvaal health services might expect a greater budget next year, Mr Ferreira said he was sure his department would not escape the tightening-up of Government expenditure.

"We will have to make up for that by tightening up our administration," he said. This was where his business experience would be most valuable.

Another area of cost-saving was in the promotion of primary and preventive health care.

"We must put a lot of energy into educating every parent and child in preventive health care.

"It is no use our waiting until the patients come to hospital. We must reach them before they become sick," he said.

He saw the critically short-staffed academic hospitals, groaning under heavy patient loads, becoming centres of excellence where only highly specialised medicine was practised.

The balance of patients would be catered for at clinics and regional hospitals where super-tertiary care was not necessary.

Of grave concern to him was the nursing crisis, though he did not believe the standard of medicine had suffered as a result.

"I think a more immediate question is whether we don't have too many academic beds. Again, I must emphasise rationalisation."

He would not be drawn into the issue of desegregated health facilities, saying this was the responsibility of the Government, nor would he discuss the State's privatisation policy.

Of vital importance during the next decade would be an emphasis on individual responsibility for health.

"I get the impression that we are inclined to believe our health is somebody else's problem. If we get sick we phone the doctor or go to hospital. Look at our lifestyles, at the way we eat.

"Most men in this country are kept alive by pills when they reach the age of 50. We must go back to the basics and take better care of ourselves," he said.

If health education at schools was a necessary part of this procedure, he would push for it.

Honest

A dynamic man at the helm of a thriving family business, Mr Ferreira said he hoped to encourage an honest, open relationship with the media.

"I believe in an open situation and I will gamble on trusting somebody. But if that trust is broken it will be a different story. I don't believe in trying to bluff the press," he said, adding he believed it important that he be available for comment after hours and at weekends.

Mr Ferreira is married and has two married children.

which will include a career-hool for 1 500 pupils and later a mmunity hall.

ge will offer vocational educa-ob enrichment programmes ll be run as semester-long her than requiring students to r a full year or more before qualification.

n of Barlow Rand, Mr Mike his company was delighted to with the ACE steering com-ow Rand would take an active project, participating in the support by offering vacation jobs and in-service training to college students.

General manager of The Star and chairman of the ACE steering committee, Mr Jolyon Nuttall said they were delighted by Barlow Rand's decision and their offer of providing expertise at so many different levels of the undertaking.

Another member of the steering committee, Alexandra resident, Mr Martin Ramokgadi said: "We have waited a long time for a dream to become a reality. Now our young people can't wait for the college to open."

Plea for blood donations

By Jacqueline Myburgh

The South African Blood Transfusion Service has appealed to donors to donate blood before they go away on holiday, in anticipation of a shortage of blood over the festive season.

Mr Bill Nortman, senior technical officer for the service, said an increase in blood usage was expected as a result of road accidents, shooting incidents and Christmas parties, the last ususally involving cut glass.

"Although routine surgery drops during the holiday period, these demands more than compensate.

"We are currently only just meeting our demands for blood and not replenishing the banks."

The biggest problem facing the service over the holiday period was that regular donors would be away.

Mr Nortman added that holiday-makers could donate blood at other services, but his experience was that people did not feel like donating blood while on holiday.

He said no-one had ever died because of a lack of blood, but one could not exclude the possibility.

"We came pretty close to it this year. We can always bleed staff and family, although it is not an ideal situation," he said.

For details of blood donation drives at major shopping centres later this month, or other information, contact the Blood Donors Clinic at (011) 660-6417.

rightist thinkers from all walks of life "from academics to unions" — in an attempt to start a rightist "volksbeweging" or national movement — against Government reforms.

Dept of Finance is streamlined

The Department of Finance has been restructured to streamline operations and to improve financial discipline in Government.

The Treasury and Public Finance branches have been scrapped and their functions taken over by three new branches — financial planning, financial relations and financial supervision.

One of the main aims appears to be to give greater responsiblity to the spending sections of other Government departments especialy since the Government has decided to appoint private sector expert financial administrators to improve controls.

Finance Minister Mr Barend du Plessis said the changes would enable the department to gear itself to present day circumstances and respond to new new needs, particularly the need for greater financial discipline.

scene of an arson attempt.

Med scheme pays no-claim bonus

CAM-Times 15/12/89 299

Own Correspondent

DURBAN. — National Medical Plan (NMP), one of the largest medical aid schemes in the country, yesterday announced a trend-setting annual cash bonus for members and their dependants for "simply remaining in good health" and not claiming for run-of-the-mill expenses.

As a result of the amendment of the Medical Schemes Act, NMP is able to implement the no-claim and low-claim bonus for its 60 000 members starting in January.

Mr Rob Basson, chief executive of NMP, said the first payments would automatically be made in March 1991 to "members who rightly view medical aid as insurance cover against major medical expenses and not as an excuse to incur costs for every ache and pain".

"NMP has been in the forefront of cost containment in the industry for a long time and this is one way of putting cash back in the members' pockets.

"Some members seem to think medical aid societies are cash cows and thus they claim for anything and everything. This is not the case — members create the funds."

In effect members are being provided with the incentive not to claim for "run-of-the-mill" expenses but to rather pay cash.

"The member may pay R100 in cash during the year but he stands to get 25% to 30% of his premium in return."

Mr Basson said the no-claim bonus repayment to a member with more than one dependant was R600 tax free.

"This is only elective and doesn't affect the things over which people have no control such as heart attacks, operations and cancer.

"We will still pay the maximum tariff we are allowed to by law and it won't affect their no-claim or low-claim bonus."

A new threat to the health care of SA

299

AGUS 18/12/89

By a leading Cape Town Medical Practitioner

ANALYSIS

THE medical aid funds, which have become a megabuck industry in this country, are showing signs of being unable to carry the responsibility of running private health care efficiently and cost effectively.

When the medical aid schemes established themselves in the late 1960s, they were cost effective and viable because they satisfied both the consumer and the supplier of services.

This was possible because membership was offered to people who could afford to belong to these schemes and accordingly the scale of benefits for services was in keeping with the Consumer Price Index.

Over the past decade a young breed of "enterprising" entrepreneurs has entered the field by opening new medical aid schemes which offer cheaper rates and which are aimed at the lower socio-economic group.

This has been done via the employer who has been enticed into contributing half the member's contribution as a tax saving device. The employer, in turn, has offered this medical aid cover to his employee, already suffering from the high cost of living, as an employment perk.

It is at this point that the cancer in health care set in, and it has been growing so rapidly that in the past year neither the consumer, nor the supplier of health services, has been happy with medical aid schemes.

Legislation covering medical aid schemes is so biased in favour of the medical aid schemes that it is not surprising many medical aids are operating like cartels.

The latest increase in fees by the Representative Association of Medical Aid Schemes (RAMS) to doctors is an insulting 1c per unit. Converting this to a percentage is even more insulting when one realises that the increase offered by RAMS to doctors is between .1 percent and .5 percent.

This increase has widened the gap between the scale of benefits and the suggested Consumer Price Index rates for services by 56 percent.

The question that begs to be asked is this: If medical aid schemes are paying doctors a mere .1 percent more for services, why have they increased members' contributions by a constricting 20 percent?

Quite clearly it is not the doctors, as is often believed, who are responsible for this increase. The most likely causes of the rise are the hospitals and the medical aid administrators themselves.

Unless the government decides to intervene soon, the standard of health care, particularly in the lower income group, is bound to drop considerably because patients belonging to this group will not be able to pay their doctors the suggested Medical Association of South Africa tariff for services. Doctors working among this group of patients have always been forced to accept the low scale of benefits for services on compassionate grounds.

With the new low increase for services, doctors will no longer be able to accept the low scale of benefits in 1990 and still maintain high standards.

On the other hand, patients in the lower socio-economic group, already reeling from the blow of high interest rates, will not be able to pay the huge 56 percent difference between the scale of benefits paid by the medical aids and the suggested Consumer Price Index fee.

The only way out of this impasse is for doctors to reduce the time of a consultation from about 10 minutes to three minutes, or to work longer hours at the peril of their own, and the patients', wellbeing.

The time has now come when we have to accept that the medical aid schemes are not a panacea for the government's inability to provide adequate health care for the population.

Medical aid schemes have become very money orientated and not cost effective. The latest move by one medical aid cartel — to secure a discount on medicines from doctors — illustrates the point. Doctors who were involved in negotiations for the discount, were shocked to learn that the benefit would not be passed onto the medical aid scheme members.

Medical aid schemes should be revised to offer a choice depending on the patient's income. For example, there could be three schemes offering (a) general practitioner cover for R50, (b) specialist cover for R25, and (c) hospital cover for between R50 and R100, and it should be left to the individual to choose the scheme he wishes to belong to.

Legislation should be introduced so that the difference between the scale of benefits and the suggested Consumer Price Index rate should be maintained at a minimum to ensure that patients are not burdened by huge differences to pay out for consultations.

It will not be easy to find a solution to a complex problem like this, but that should not stop us working towards a solution.

B | Day 22 | 12 | 89

Macmed offers shareholders bonus

CHARLOTTE MATHEWS

299

MACMED Health Care shareholders are being offered a bonus share or dividend on a portion of the proceeds of the sale of the Orthomed business, Macmed MD Don McArthur says in an advertisement today.

In October Macmed announced it had decided to sell Orthomed back to its original owner for R3,9m in cash.

Orthomed, which was acquired for R3,1m in August 1987, was found to be too capital intensive, and the capital base of Macmed would not allow the expansion of both businesses.

As a result of the sale the company applied to reduce its share premium account by R1,3m to remove the premium on the acquisition of Orthomed.

Shareholders are being offered the option of receiving one bonus Macmed share for every ordinary share held on the last day to register for the offer, or a dividend of 20c a share. Macmed shares closed at 32c on the JSE yesterday.

Bonus share certificates and dividend warrants will be posted on February 12.

DCM-listed Macmed makes and distributes medical consumables, capital equipment and orthopaedic supplies.

With Macmed's results for the six months to January, the directors warned that disposal of part of the business was being negotiated and that the acquisition of another operation would accompany the disposal.

Hospital benefits to be increased

Own Times 1/11/89 299

Own Correspondent

JOHANNESBURG. — Medical aid schemes are to increase benefits by 18% for private hospitals and graded day clinics.

The announcement today by the Representative Association of Medical Schemes (RAMS), says the new benefits will apply as from January 1.

The National Association of Private Hospitals (NAPH) chairman Dr Edwin Hertzog yesterday said the increase for 1990 would amount to only 13% for members who contracted out after last year's 12% increase by RAMS.

These hospitals had, on average contracted out by 5%.

Whether these members would now decide to contract back in, would be entirely up to them, Dr Hertzog said.

NAPH originally sought a minimum increase of 22% to compensate for the small increases of previous years and to cover an average 18% escalation in costs over the last year.

RAMS executive director Mr Rob Speedie said yesterday NAPH's demands had been rejected in the best interests of consumers.

He said attracting hospitals to return to a contracted-in situation was not a consideration for RAMS.

"The overwhelming consideration was the affordability of subscription rates to consumers."

Mr Speedie said the positive side-effects of certain hospitals contracting out were increased competition based on price and heightened cost-awareness among patients and the medical profession.

He said the added burden of increased use of private hospitals had been a key factor considered in coming to the increase decision.

Medical scheme payouts for across-the-board health care would rise 20% in 1990 to R4,8m — R860m of which would be absorbed by private hospitals and clinics, Mr Speedie said.

In 1989 R720m would be paid out to private hospitals.

Dr Hertzog said it was difficult to comment on behalf of all NAPH members as any increase in tariffs affected various hospitals differently, depending on patient profile and theatre/ward and pharmaceutical turnover ratios.

He said he could not comment fully on the announcement as he had not yet seen full details.

298 Sowetan 6/12/89

By PHANGISILE MTSHALI

Donations still pouring in

THE coffers of the Ikemeleng Remedial Education Centre, a school for children with learning problems, are filling rapidly as the community responds to the call for donations.

The centre, presently operating from the Youth Alive Centre in Dube, Soweto, was adopted by the *Sowetan* newspaper as part of its Nation Building campaign.

To erect a fully equipped building for Ikemeleng, R1 million is needed and the newspaper is appealing to the nation to help. To reach the required amount, 200 000 families are asked to donate at least R5 each.

New list

Here is a list of people who have responded since the last one was published:

Dr L Mhinga, Diepkloof (R750); Dr S Effa, Lesedi Clinic (R50); Dr Pooe, Jabulani (R100); Dr Motshuane, Phiri (R500); Dr B Mgulwa, Randfontein (R100); Dube Mofolo Zondi Black Housewives League (R100); Mrs L B Mvubelo, Orlando West (R20); Mrs W H Gofela, Katlehong (R20); Mrs R M Shongwe, Barbeton (R20); Anonymous, Florida (R25); Ms N Ralshikhapha, Marshalltown; Miss G Legoale, Soweto (R10); Mr J Mabaso, Jabavu (R10); Mapetla Total Filling Station (R10); Mr and Mrs Balo, Mapetla (R10); Velile P V Services, Rockville (R10); and Mr E S Khoza, Evaton (R10).

R5 donors

The following donated R5 each: Mrs J Nkambula, Orlando West; Mr R Kgobokoe, Dobsonville; the Gwebu family, Atteridgeville; Mrs E Kwadi, Mohlakeng; Miss Regina Maruping, Orlando East; Mrs Nomasonto Zwane, Orlando East; Mrs G Mabece, Protea North; G Makhubela, Orlando East; Mrs M Maleemme, Orlando East; Mrs R Twala, Orlando East; Mrs Nomsa Ngubane, Malborough; Mrs L Saltons, Horizon; Mrs Nozizwe Moledi, Rockville; Amina Marrins, Eldorado Park; Flora Seretsi, Vosloorus; Mrs E Madlala, Zola North; Thoko Radebe, Diepkloof; Mr Casy Manyama, Dobsonville; Mr Mose Serobatse, Mapetla; Mr Joseph Moloi, Mapetla; Mr A Moputwane, Mapetla; Mrs J Naphatsoe, Mofolo Central; Mrs A Pamaube, Vosloorus; Mr E Shingange, Halfwayhouse; Mr A Mothoa, Germiston; Mrs H Thubo, Pimville; Mr M I Goma, Dundee; and Mr I M Makhaya.

Address

Donations should be sent to World Vision, Box 1101, Florida,1701. Their fundraising number is 01 100007 0005. For more information telephone (011) 674 2043.

298 Sowetan 4/12/89

Children are the blessed, make them feel at home

ON THE LINE

Aggrey Klaaste

EVERYBODY has his or her Christmas story. I have two. The first is about the Mathibela twins. Being a member of the Mpho and Mphonyana Trust Fund - which was incidentally the germ for the Nation Building initiative - I am still involved in the welfare of the babies.

They are turning three this week. With the help of a subcomittee of the Trust in Klerksdorp, we have decided to throw a birthday-cum-Christmas party for the twins.

Party

We first thought we should make this a big party, the type of bash that I have promised many of my friends who were not directly involved in the Nation Buildinbg Week. But time and resources have narrowed the grand plan into a smaller if more attractive one, a Christmas party for the children of Klerksdorp.

A brilliant suggestion from Mrs Maggie Nkwe, a member of the Mpho and Mphonyana Trust Fund, was that we should make that lovable limbless boy, Muzi Pooe, the guest of honour. Most children are beautiful, but you have to meet a bouncing little boy without arms and legs, who unabashedly attempts to do all the things that children with limbs do. The charm is almost divine in a boy who, perhaps, does not realise he is disadvantaged in this terrible way, but is able to put out a magical circle of embrace to all those who come into contact with him.

Muzi is like a ray of sunshine. He is also like a little animal, nuzzling you with his mouth, his nose, making physical contact in the most arresting way, trying to hug you with arms that are not there! It is tremendous and deeply touching.

We know there are groups looking after Muzi, but the constitution of the Mpho Mphonyana Trust Fund makes him a natural beneficiary. As usual there has been a bit of competition about this type of thing, but we believe we should let the problems of the past rest.

We need to mobilise funds, first from the black community to help these disadavantaged children. I do not say we must become begggars. There are many creative ways in which funds and interest can be gathered to help.

House

After building the Mathibela family a house and generally looking after them, the funds are not as substantial as they were.

We had anticipated that these kids might grow up needing more specialised attention. That truth is coming home to us with some force, for young Mphonyana needs that type of treatment already. So we need the type of wonderful support from people we got when the twins were in the news. They are now part of the process, part of the Nation Buildinbg process, if you like.

Getting the job done now, after all the excitement is rather difficult. A child like Muzi, when he grows up, will obviously need the same type of support and attention.

My other Christmas story is also about children. This time the girls at Bethany Home. I was invited to attend the 40th anniversary of this home which is only a few years younger than me. I have known this Home for as long as I have lived in Soweto. There has always been something sinister, something negative, something almost secretely unhealthy about of this home for *stout* children.

Weeping

I saw the girls at the anniversary. They made me feel like weeping. They are like your daughter or mine. But there seems to be something missing, a spark, an ambience of joy and freedom that is so beautifully seen in children with their own home. I am not for one moment suggesting the Bethany Home staff are not doing excellent work. In fact they have worked hard under and in a hostile situation. What bothers me is the lack of *ubuntu* from the people of Soweto about such places.

These girls should not be made to feel like outcasts or delinquents. These children should become part of our lives. We should not be taking a charitable view in helping them with money etc, we should have them in our homes. In fact one of my resolutions for the New Year would be to start a scheme in which we the community can "adopt" children, have them in our homes for weekends and holidays.

I could weep to think that some of them are going to spend Chrsitmas locked up behind the forbidding walls of the Home. If nothing can be done about them this year, this paper, under my command, will see to it that we do something about brightening these wilting flowers before they grow into womanhood. We owe it to them and ourselves.

Widow

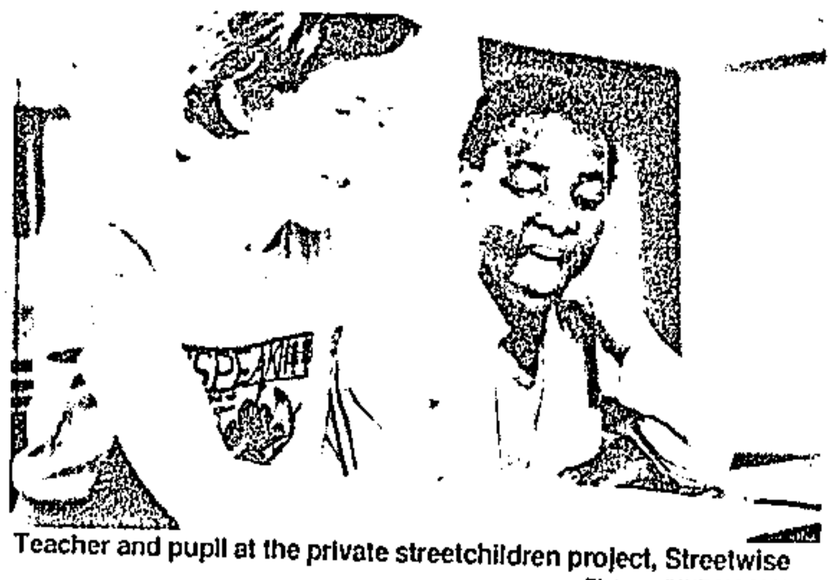
Incidentally, the lady, who is running the home, is Mrs Sithole, widow of the late Major Sithole, who was a close and dear friend of mine. She almost brought a lump to my throat when she said in her speech that she was unused to making public speeches, but because her husband was no more, he was standing behind her and helping her to make these talks, and perhaps also keep Bethany Girls Home going.

I will wish you a merry Christmas now, but one cannot be too sure what will happen in the next few weeks before we reach that date.

298

The state's gloomy 'solution' for homeless kids

About 9 000 children are believed to live on the streets of cities, sniffing glue, begging and stealing to stay alive. The State is spending more money on the problem than before, but social workers question whether the official solution is at all appropriate, reports PHILIPPA GARSON



Teacher and pupil at the private streetchildren project, Streetwise
Picture: JUNE MOOLMAN

THE government has finally responded to the growing numbers of street children, an estimated 9 000 countrywide, who live on the pavements and scrounge a living by begging and prostitution.

But the state's solution of housing these children in reformatory-like institutions, or places of safety, is being questioned.

Vast sums of money have been spent in the last three years on establishingeight provincially-run places of safety, some of which are converted prisons, around the country. These institutions — such as Van Rhyn Deep on the East Rand, Tsosoloso in Soshanguve and Bayhead in Durban — have become temporary sanctuaries for street children while their families or foster homes are found for them. But those having no home to go to may languish indefinitely in a place of safety.

And many street children, who are usually picked up by police, may stay in police cells for weeks while waiting to be processed by the juvenile or children's courts, before being transferred to an institution.

Many escape from the reformatories or industrial boarding schools and make their way back on to the streets.

Children, who attend the privately run Streetwise education programme by day and sleep at the Hillbrow Twilight Children shelter by night, reluctantly spoke about their experiences in police cells and places of safety.

One child told of his time in Van Rhyn, "the place with no love.

"One day on the streets the police caught us and took us to Van Rhyn. It was horrible there. Sometimes we did nothing, other times we worked all day in the garden. They never gave us enough food there and they would talk badly to us — sometimes they hit us. I can't say I learnt something in that place. They didn't teach us anything. One day we ran away — six of us. We jumped the fence — through a hole."

Some boys talk of their experiences in jail, where they were allegedly bullied or sodomised by older boys, beaten by warders and not given enough food.

Most children seem to have little knowledge of the legal procedure which smooths their way to a reform school. Attorney Fiona Mclachlin, a committee member of a private street children's home in Johannesburg, Prosces, says children may remain for months in places of safety while their cases are pending, because of the backlog created by inadequate child care facilities for blacks and the difficulty of tracing parents.

But what is worse, she says, is the majority of street children are regarded as criminals and juvenile delinquents and are usually dealt with in terms of the Criminal Procedures Act as opposed to the Child Care Act. If not sent to a reform school they are sentenced to a whipping and sooner or later are back on the streets again.

"But these kids are not criminals," she says. "They are picked up for petty theft or begging" — activities without which they would not survive. "They're on the streets not because they think it's fun, but because they have nowhere else to turn."

The government has come up with the industrial school solution to cope with homeless "delinquents". The Department of Education and Training is to build nine such schools.

Despite frequent requests the *Weekly Mail* was denied access to the places of safety, or the existing industrial boarding school, Ethokomala. This reformatory-type school on the East Rand — known as Kinross — rehabilitates street children with a measure of success according to some, though says one childcare worker, many children escape the converted prison and are back on the streets again. Kinross will house 360 children by 1990.

"Peter", 13, has run way from both Kinross and Prosces and currently slums it in Yeoville with a number of other boys. He talks about his experiences at Kinross: "I ran away from that *stow* school (reformatory) place after two months. The big boss there fights with us, and the *boeties* (child care workers) too. They make us work. They make us take out the grass with our hands."

He attended school there but hated to study in the prison-like environment. Older boys were able to visit parents or go to the shops but "Peter" says he was never allowed out.

Of the food, he says: "We get stones, some plastic and some hair in our food." He describes a "small jail" inside the premises for boys who misbehave or attempt to run away: "If you try to run away they put you in this place."

He was caught this year trying to jump the fence: "They put me in there for nine days. There is only one boy in each room, which has wire on the windows, and if its full they put two boys inside. I had to sleep on the floor with one blanket. The *boctie* hit us every day, and I felt scared."

"Peter" went to Kinross after police picked him up and took him to social workers at the Transvaal Provincial Administration. "The police did not hit us. They were nice," he says.

But social workers at private institutions express dissatisfaction about the way children are randomly scooped up and whisked off to police cells and institutions. Many of them had been under private care at the time of being taken to a government institution, without private child care workers being told of their whereabouts. But many children run away and return to places like Streetwise, or the streets.

Children of the streets, who live by begging and prostitution. Thousands of rands are being spent on their welfare, yet more and more of them can be seen on the streets every day
Picture: ANNA ZIEMINSKI, Afrapix

Says Jill Swart, academic and founder of Streetwise: "Many of our children have disappeared. Usually they have been progressing in our care — they certainly did not need to be institutionalised."

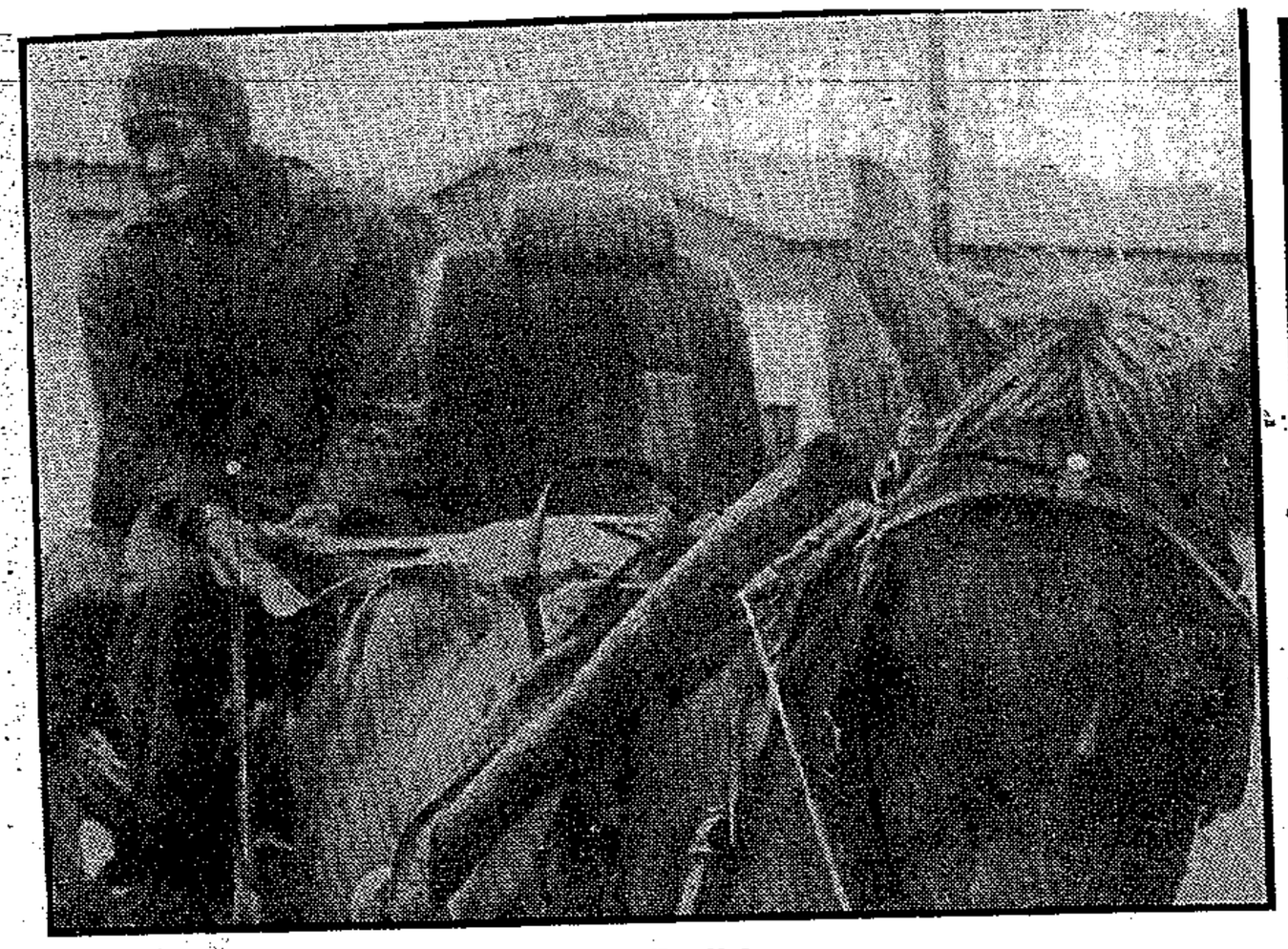
Street children, says Swart, have grown used to their freedom and do not respond well to being cooped up and removed from society.

"This is out of step with worldwide approaches to the problem, where the move is not to institutionalise children who are deprived rather than delinquent. For any child the most valuable right is his freedom — within limits of course."

Chief social worker for the TPA, Naomi Koutoulogeni, says 351 street children were "handled" by the administration within a year. She admits that the places of safety are not suitable for street children who have "unique problems": "They have become anti-social, broken ties with their families and formed gangs. They are rebellious against any form of discipline."

Though respecting the informal initiatives set up to cope with the street children problem, Koutoulogeni says: "They (the children) should not be treated in Hillbrow. It is not their place of origin, and it is unnatural to have these kids in a white area." She adds that in Hillbrow the children have access to the corruption — prostitution, begging, stealing — to buy drugs like dagga and glue.

As to why more and more black children were taking to the streets Koutoulogeni gave "family breakdown" rather than poverty as the reason: "People have always been poor yet 10 years ago we didn't have this problem."



Dira Potjiri.

Child labour is still a crying shame

SOWETAN 29/8/88

By SIZA KOOMA

CHILD labour is rife in South Africa despite denials by Minister of Manpower Mr Eli Louw.

A 16-year-old boy behind a horse-driven cart heavily loaded with bags of coal is a common sight in township streets.

These children, who range in age between eight and 16, are oveworked, underpaid and usually housed under appalling conditions. They cannot stand up to their bosses for better deals since most of them are desperate for a job.

Sowetan visited the Kliptown Market and eight coalyards in White City, Orlando East, Mofolo, Central Western Jabavu and Zola. Some of the market traders and about four of the yards employ children who are either local or from outside areas. Most of the children live on the premises. Their wages range from R30 to R50 a week.

Low pay

Dira Potjiri comes from Butha-Buthe in Lesotho. He works in a coalyard in White City. He was brought to Johannesburg by a friend, who also works at the same coalyard. He earns R40 a week selling coal in the township.

"The money is very little considering I have to send some to my family back home, buy food and pay rent for the room I share with three other boys on the coalyard premises," Dira said.

"I am aware that there is no future for a family man in this job but I cannot hope to find a better job because I did not go to school

I plan to buy a horse when I have saved enough money and set up my own business," he said.

There are about 20 other boys Dira's age and younger, employed by the five coal merchants who operate from the vast yard just outside White City. The boys come from Lesotho, Natal and the Northen Transvaal.

Their day starts at 7am when, after loading the carts, they set out for surrounding townships to sell. They come back for lunch

To Page 19

P.T.O.

298 8/12/89 Sowetan

Child labour

From Page 18

at 11 and go back to the streets at 2pm where they stay until dusk.

While Dira was brought by desperation and poverty to the city some of the boys left their homes for the fun of it.

Alex Mabaso and his friends left Swaziland two years ago to seek adventure. They landed in Kliptown, outside Soweto, where they were employed by an Indian vegetable market owner. He has used them as cheap labour for his business. For a six-day week he pays them R30. They live on his premises.

"I do not really mind the money. It is better than working as a shepherd for no pay. The job might be strenuous but we get paid," Alex said.

The indifference and in some cases the desperation of most of these children, makes them vulnerable to exploitation.

Nyawuza, a Transkeian who has been a coal merchant in Orlando East since 1960, agreed that most of the children, especially those under 10, do not mind being paid peanuts for their services.

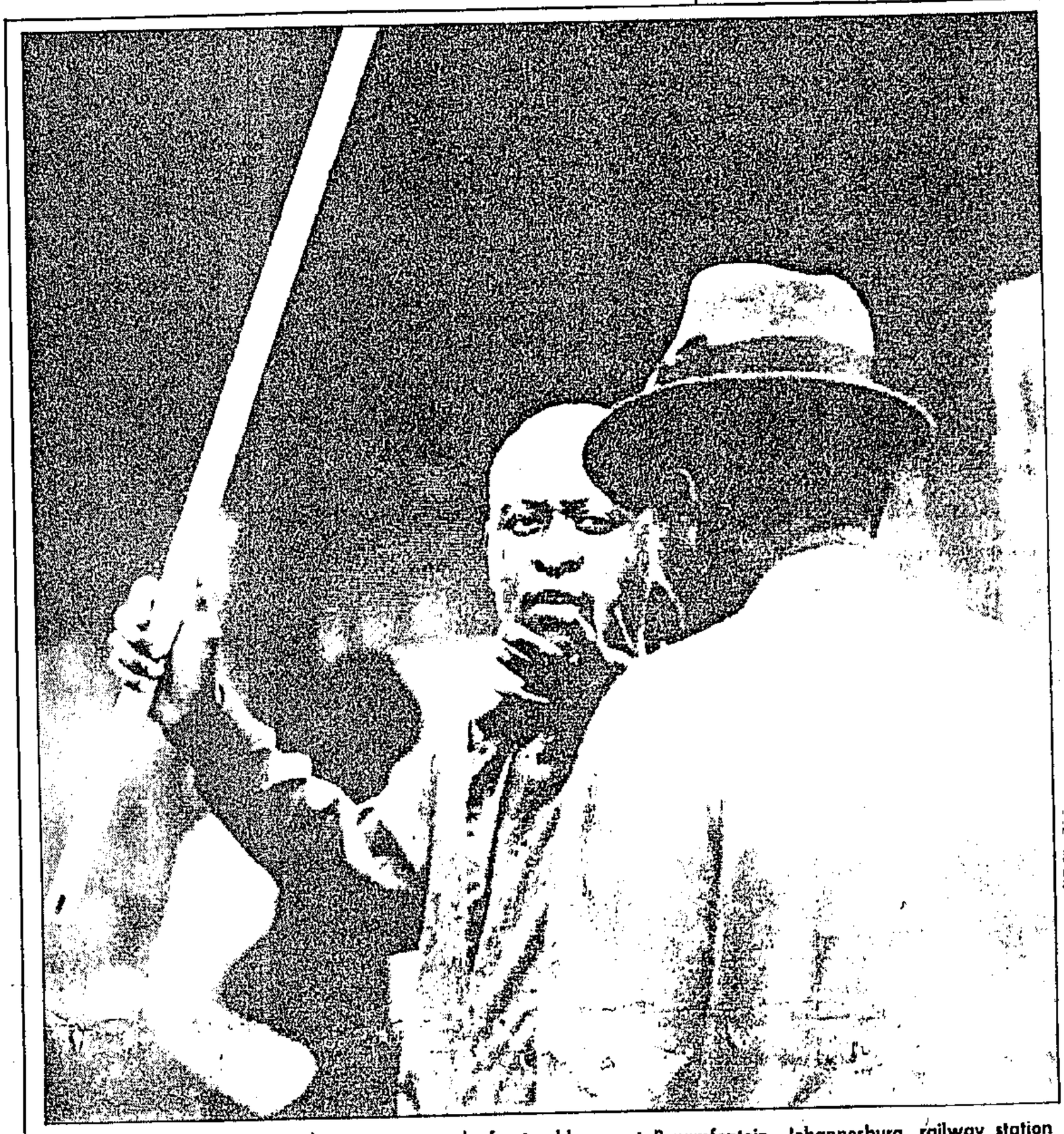
"A child of 10 cannot do much in this kind of job. He is satisfied when you give him a rand for clearing the yard and doing odd jobs," Nyawuza said.

"Some of these children are runaways who would do anything just to stay in the yard. We get a lot of delinquents coming here to look for jobs. I chase them away and I am sure some of the merchants do the same.

"People think we go into the township to recruit these children but we don't. They come here on their own," he said.

Nyawuza said he did not employ children because they were very unruly when they had been sniffing glue.

again.



Menacing ... Two Sats workers — one ready for trouble — at Braamfontein, Johannesburg, railway station yesterday. More than 15 000 workers have been fired during the violence-hit strike.

Cleaning up ... Schoolchildren pick up rubbish on the Braamfontein railway line.
● Picture by Stephen Davimes.

Children fill in for absent rail workers

Star 14/12/89

By Louise Burgers

Schoolchildren and clerical workers in the South African Transport Services (Sats) are being used to fill the positions vacated by striking workers.

Sats spokesman Mr Frikkie Stevenson said 82 children were presently being employed as casual workers with their parents' approval in safe places where there were security personnel.

"Many parents approached Sats and asked if we had jobs for their children during the school holidays. Most have just finished school and are waiting to go into the army or start work.

"I must stress that their safety is a priority. We are using them to deliver parcels and in cleaning jobs."

The Star came across several youngsters picking up litter on the railway lines at Braamfontein Station. They were pleased to be earning money during the holidays.

There are also 600 other temporary personnel being employed to fill the gaps.

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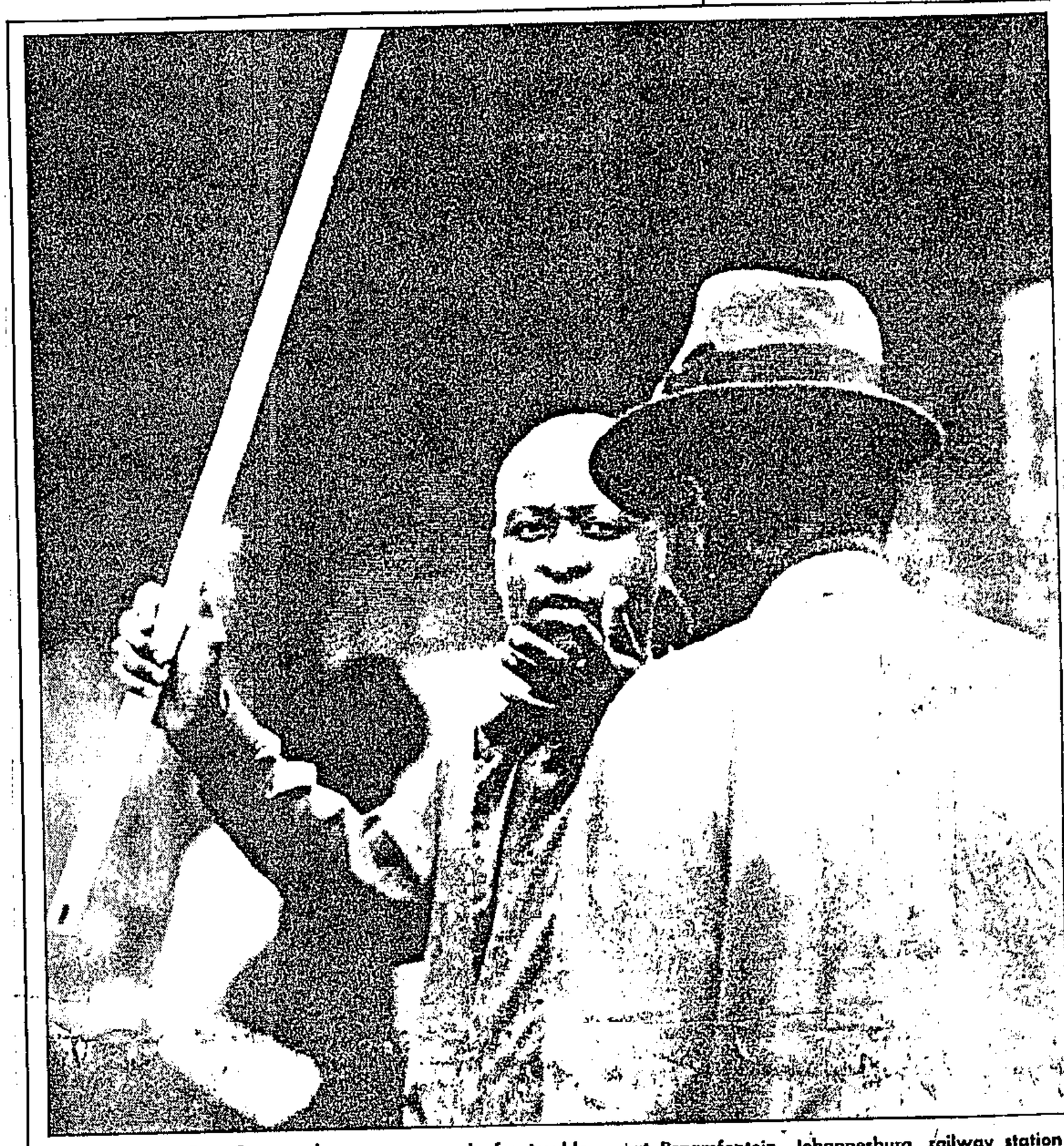

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Fulfilling their possible dreams

A pony ride, a visit to a game lodge, to see the sea for the first time . . . these are some of the simple wishes which Randburg Rotary's "Reach for a Dream" project has fulfilled for scores of seriously ill South African children. The project, which started a year ago, is growing in leaps and bounds. **TONI YOUNGHUSBAND** reports.

To grant a child a simple wish is a special moment for anyone, but when that child suffers a life-threatening illness, the achievement is all the more rewarding.

For the founder of the "Reach for a Dream" project, Mr Owen Parnell, the rewards have been outstanding.

"Being able to make their dreams come true is fantastic. Of course, at times it's a bitter-sweet relationship when you lose a child but it's worth every minute," he says.

Mr Parnell started "Reach for a Dream" a year ago after reading of a similar project in America.

Working with the children's wards at local hospitals, the Rotarians establish contact with the children, learning of their needs and desires.

Counselling

They rely on medical staff to speak to the children and to counsel them if their wishes cannot be met, usually because of financial circumstances or because the child is too ill.

The first child to benefit from this project was six-year-old leukaemia sufferer Johan "J C" Steinmann of Roodepoort. His dearest wishes were to ride a pony and a motorcycle. At his sixth birthday party his dreams came true.

"As parents, it's not always possible to make our children's wishes come true. Because of that it was really so special for us too," J C's mother, Mrs Brigitte Steinmann said. Her brave young son died four months later.

"It is astonishing how simple a child's dreams are. One would imagine they would dream of a trip overseas or would want to go to Disneyland," says Mr Parnell. Should a child request such a trip it would have to be explained that this was financially impossible but that Rotary would do all in in its power to grant another, simplier wish.

"Obviously as the programme develops we hope to get sponsors who will be able to help with these requests. Air carriers or hotel chains which could provide the travel arrangements and accommodation," Mr Parnell says.

Happily, most of the dreams and wishes have become reality. Visits to Sun City and Gold Reef City, rides in helicopters or hot air balloons, a spin in a racing car around Kyalami, meeting a television celebrity, holidays at the coast or at a game reserve. All one child asked for was a fountain pen. Another wished that the hair she lost during chemotherapy would grow again.

The project encourages family participation.

Mrs Rita Badenhorst, whose daughter Debbie is an outpatient at the Johannesburg Hospital's oncology unit, believes family involvement makes all the difference.

"The cost of the medical treatment means we as parents cannot afford to treat our children and we must think not only of our children who are sick but our other children as well. When Debbie was taken on a tour of the SABC her brother Tommy was allowed to go too. That was wonderful," Mrs Badenhorst says.

Debbie (15) told The Star "Reach for a Dream" meant she did not have the time to think about her illness.

"The chemotherapy makes Debbie very sick and she needs something else to think about. She cannot run outside like other children, she needs something to take her mind off being different from the others," Mrs Badenhorst points out.

"Reach for a Dream" is open to children of all ages and races and almost 100 black children from Baragawanath Hospital in Soweto have already benefitted from the project.

"Most of these children don't really have a dream. They haven't experienced anything like this and don't know what to ask for. Some may ask for a bicycle or a watch but offer most of them a holiday at the sea or a new toy and they are absolutely overcome. They get terribly excited," project organiser Mrs Janet Poole says.

Medical staff caring for these children believe the project helps a great deal to boost morale and ease the youngsters' pain and suffering.

Support

To date, some 200 children suffering various life-threatening illnesses have been helped by "Reach for a Dream," which has been adopted by other Rotary clubs throughout the country. Numerous organisations and companies have pledged their support, providing free tickets to the theatre, airfare and flats at the seaside. Fire and traffic departments in the PWV area and entertainment and sports celebrities have given of their time to host the children. One young golf fanatic got to play a round with Gary Player.

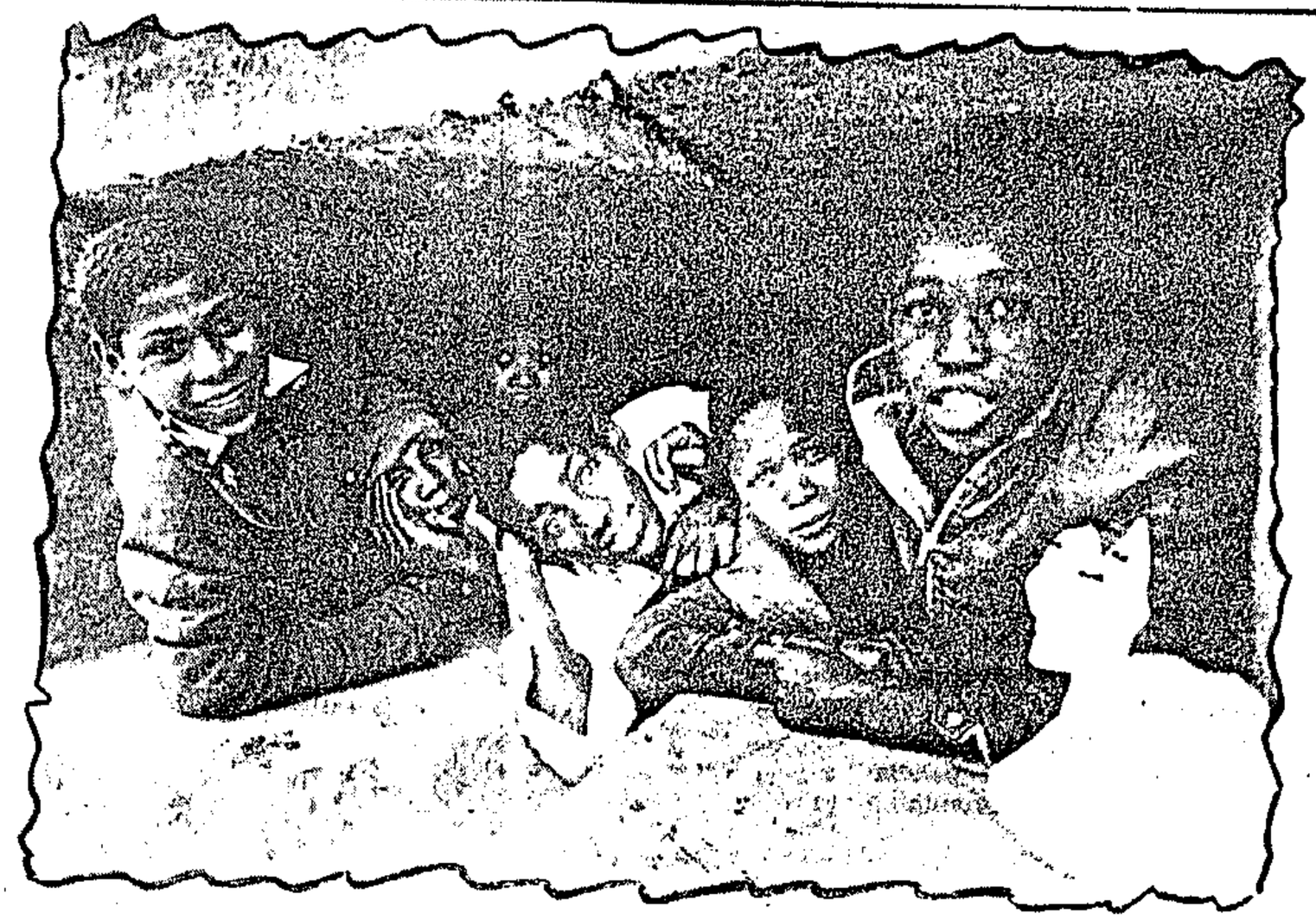
Anyone wishing to know more about the project or sponsor a child should contact the Randburg Rotary Club at Box 50822, Randburg 2125.

20/12/89

Star

298

298 23/12/89



FLASHBACK: The Hole in the Wall Gang. This is the picture, taken in March 1986, that led to the R500 000 home for boys in Langa.

She started it all. Rondebosch housewife Mrs Rose McKenna at the relic of the building which was to become Khayamnandi — Sweet Home.

HOME

By IRVING STEYN
Weekend Argus Reporter

THERE is going to be a party in Langa next year where people from as far afield as Britain and the United States will rise to drink a toast to a dream come true.

The dream is called Khayamnandi and it came true with a recipe including equal parts of tenacity, determination and compassion. It rose from the ashes of an abandoned wreck of a building to become a showpiece, the only home for destitute black boys in the Western Cape. And it was a dream that became reality in the incredibly short period of three years.

It started with the concern of a Rondebosch housewife, Mrs Rose McKenna, who came to Weekend Argus with the story of a gang of glue-sniffing young beggars at The Fountain Centre in Rondebosch whose home was a hole in the wall of the Liesbeeck River.

Name that caught

Weekend Argus immediately named them the Hole in the Wall Gang, a name that caught the imagination of countless numbers of people around the world, people who dug deep into their pockets to establish Khayamnandi — Sweet Home.

No sooner had the editions of Weekend Argus in March 1986 hit the streets when the first steps to the establishment of the home were taken.

An abandoned hostel, once the single quarters of black contract workers, was offered, free of charge. But there were no windows or doors. There was no roof and no floor. There were four blackened, damaged walls. There was no money. It looked hopeles.

Pathetic picture

This pathetic picture was published in Weekend Argus. And then things started to happen. Building giant Besterecta Ltd offered to restore a block for the boys. And they brought all their subcontractors with them.

Slowly Khayamnandi took shape and the boys had a home. As time progressed, more and more people became involved. A prominent force was Peninsula Round Table, who together with the Western Province Baptist Association became an unstoppable driving force.

Pensinsula Round Table had plans drawn for the development of the rest of the hostel complex. Their engineers did

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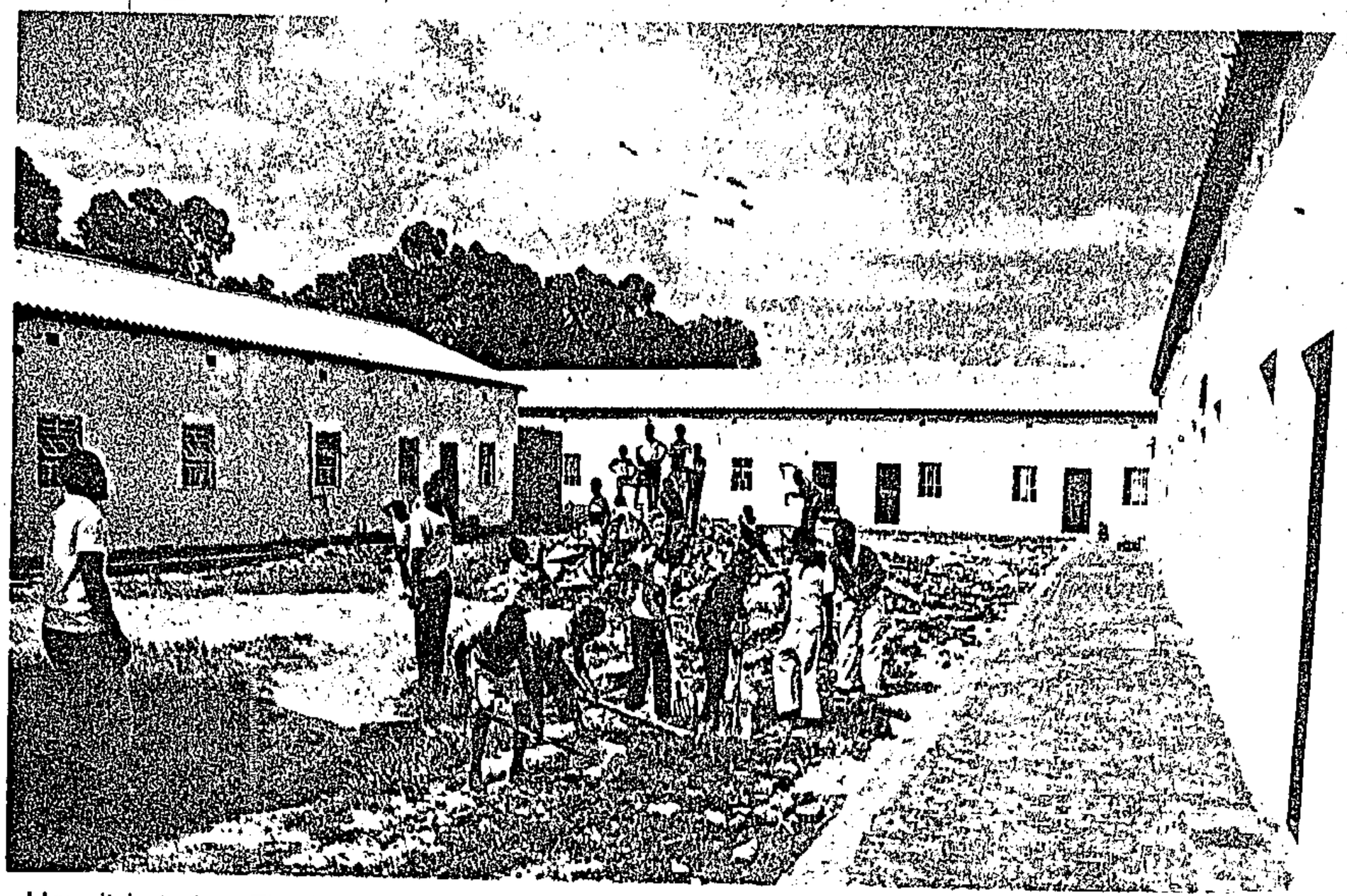

How it is today. The boys of Khayamnandi help clear away rubble from the courtyard of the home which will house 80 youngsters next year.

the planning and they gave the Baptist Association the means to buy the land on a 99-year lease. They were responsible for a high concrete wall which today surrounds the R500 000 complex.

An amazing assortment of people and organisations have become involved. A Dutch television crew flew out from Holland especially to do a documantary on Khayamnandi which, when screened, is expected to contribute a substantial amount in money.

The Dutch Embassy in Cape Town donated a fully eqipped library and a R28 000 bus for the boys.

The plan now is to establish a trust fund of R500 000 to take care of running costs in the future. Already the state is contributing R200 a month for each boy, but this has to also cover salaries and other expenses.

Fanie Ferreira, left, and Dr Trevor Franke

Boom in teen drug abuse

TANIA LEVY 298

ABOUT 25% of all school-going children in SA are experimenting with chemical substances and this year more teenagers than ever before were admitted to clinics for treatment of drug dependence, according to SA National Centre for Alcohol and Drug Dependence (Sanca) Johannesburg deputy director Ronelle Sartor.

SA is an easy market for Colombian drug cartels and it is only a matter of time before SA youngsters discover crack — a cheap cocaine-based drug — she said. BDay 29/12/89

In an editorial in Sanca's latest quarterly publication The Centre, Sartor said very little was being done about the escalating drug problem among SA's youth.

She said the Education Department denied intervention was warranted, although the extent of the problem in SA government schools was said to be under investigation.

"How much more investigation is needed to realise the developments in the anti-drug war in Colombia will also affect SA and its youth?" Sartor asked.

"Do the authorities not believe in the old saying 'prevention is better than cure'?"

She said the annual costs of drug dependency to SA in terms of health costs, productivity and loss of human lives were large.

Prevention of drug abuse could only be achieved through ongoing preventative education at primary school level.

Yet funds to combat drug abuse were always said to be unavailable, Sartor said.

: frees Mkwayi

More than 600 children drowned in SA last year

298

Star 29/12/89

CAPE TOWN — More than 10 children under the age of 15 drown in South Africa each week.

Apart from road accidents, this is the greatest cause of unnatural deaths in the country, according to Ms Jeanie de Wet of the Child Safety Centre at the Red Cross War Memorial Hospital in Rondebosch.

In 1988, more than 600 children drowned in South Africa, most of them in fresh water.

With the summer holidays in full swing, the figure for 1989 could again be alarmingly high.

PRECAUTIONS

Mrs de Wet says 40 percent of all drowning victims in South Africa are children — and they often drown unnecessarily because no precautions are taken.

To try to cut down juvenile drownings, the Child Safety Centre and the Institute for Child Health of the University of Cape Town have compiled a pamphlet with general hints on the prevention of drowning.

Insurance giant Sanlam has sponsored the design and printing costs of the pamphlet.

As far as Cape Town and its surrounding areas are concerned, most drownings occur in dams where there is little protection for the children of farm labourers.

Quite a number of drownings also occur in private swimming pools, baths and fishponds.

On drownings in buckets, Mrs de Wet says no bucket should be without a lid when there are small children around.

Parents or caretakers should get used to never leaving younger children on their own.

"A small child should never be left alone in a bath. Rather ignore the telephone or doorbell and save your child's life," is her advice to parents.

Mrs de Wet strongly recommends children should learn to swim as soon as possible.

"But even if a child can swim, it is no guarantee against drowning. It gives them a second chance, however." — Sapa.