SOCIAL SECURITY — MEDICARE

1990

JANUARY — MAY

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Medical aid inquiry nears completion

LINDA ENSOR

THE Competition Board's investigation into possible restrictive practices in the medical aid sector is at an advanced stage and should be completed in about a month's time.

Board chairman Pierre Brooks says it will then be submitted to Trade and Industry Minister Kent Durr.

The board is also investigating alleged restrictive practices in the pharmaceutical and video industries.

Brooks says the aim of the investigation into medical aid schemes — which commenced early in 1989 — is to look at the role they play with regard to the costs of health services and to examine whether there is sufficient competition. BLDan 23/11/90

An aspect of the probe is the role of the Representative Association of Medical Aid Schemes.

The investigation has also examined whether insurance companies could become more involved in providing cost-effective medical aid cover.

Regarding the pharmaceutical industry Brooks says there have been allegations that pharmacists have been instructed to boycott Mediscor, an intermediary acting between medical aid schemes and pharmacists in competition with the Pharmaceutical Society's counterpart, Medikredit.

Brooks says pharmacists have allegedly been threatened with a withholding of supplies by wholesalers should they contract with Mediscor which offers a discount to members of medical aid schemes contracted with it who purchase medicines from contracted pharmacies.

The investigation into the video industry which is under way concerns allegations that video distribution firms are involved in restrictive practices vis à vis video outlets in that outlets are required in terms of distribution contracts to purchase a package of videos for the first month of their launch and are not allowed to select individual videos.

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Foreign medical costs 'call for insurance cover'

LALA CAMERER

EXORBITANT foreign medical costs are forcing South Africans travelling abroad to take out heavy medical insurance packages.

Diner Club International (Diners) MD Hugh Peatling said medical costs incurred by overseas travellers who required treatment or had to be hospitalised were in excess of the local equivalent.

Diners had just increased its medical insurance cover to R1m.

Travel insurance consultant Gus Munroe said the weak rand and the high cost of medical services abroad contributed to expensive medical costs.

North America and the Far East in particular had high charges.

"A hospital bed in the US costs between R2 300 and R3 000 a day. A bed in an intensive care unit overseas can cost up to R7 500 a day," Munroe said.

Association of SA Travel Agents (Asata) president Rupert Lawlor said all travellers should take out medical insurance.

"The few hundred rands it costs are a cheap form of guarantee, and it is worrying how many South Africans ... do not feel it necessary to cover themselves.

"An accident within SA can easily be covered by one's Medical Aid Scheme, but overseas hospitals and medical treatment are very expensive and have to be paid for immediately in cash or dealt with by an insurance contract," said Lawlor.

Munroe said Rennies Travel offered up to R1,5m on medical insurance which covered living expenses should one have to remain overseas for an extended period.

TFC Travel and Miller Weedon Travel also offered insurance packages.

Health costs are at 'disturbing level'

BID cm 24/11/90

GERALD REILLY

PRETORIA — The cost of health services had increased to a disturbing level in the past few years, Health Services, Welfare and Housing Minister Sam de Beer said yesterday.

Opening a new wing at the Far East Rand Hospital, he said in 1986 health services appropriated 9,1% of the Budget.

Current indications were that this had risen to 10,2%.

One reason for the escalating expenditure was patient demand for the most modern equipment and treatments.

Simple arithmatic, he said, precluded the possibility of increasing health expenditure per capita in SA.

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Own affairs

Economic imperatives obliged government to look for alternatives and more imaginative health care solutions.

Defending the own affairs principle De Beer said it had been repeatedly stated that other races could receive treatement in own affairs hospitals.

The granting of maximum authority to each population group over issues which affected their interests could scarcely be seen as prejudical to other population groups.

Meanwhile, government sources said yesterday, it was virtually certain substantial increases in the pay of nurses and police would be announced in the March Budget, if not before.

The sources said the crisis in the nursing profession and the consequent threatened breakdown, or restriction, of hospital services, and the rising crime rate in urban townships, as well as the Natal violence, had conditioned public opinion to pay rises.

□ SA Nursing Association president Odelia Muller said yesterday negotiations on nurses salaries were well advanced.

However, the association had been told there would be no interim increases.

Star 25/1/90

'Clean-break' divorce must be an option

Court Reporter

The clean-break principle in divorces is increasingly becoming part of the South African legal system and should be considered during every divorce.

This is the view of Mr Casper le Roux in an article in the January edition of *De Rebus*, the Association of Law Societies' journal. Star 25/1/90

Mr le Roux says the clean-break principle applies only to divorces in which it must be determined whether periodic payments should be made to the ex-husband or wife.

The clean-break principle acknowledges that it is advantageous to spouses, as well as the broader community, that after a divorce former spouses have as little contact with each other as possible.

"The former spouses should be encouraged to get the bitterness of a family break-up out of their system and start a new life which is not overshadowed by the broken relationship," says Mr le Roux.

Traditionally, a former spouse, usually the husband, was left with a obligatory maintenance after the divorce.

Where minor children are involved, the court should carefully consider the interests of those children and determine whether a clean break will have a significant influence on them.

Learn CPR and save a life – doctor

By Toni Younghusband, Medical Reporter

Hundreds of South African lives could be saved each year if more people knew how to apply cardiopulmonary resuscitation, believes Dr Walter Kloeck, head of the SA Resuscitation Council.

In Seattle in the United States, the number of accidental deaths dropped dramatically when it was decided to train a large portion of the population in CPR.

"We can do the same in South Africa and I believe we could save many lives if we just knew how," said Dr Kloeck.

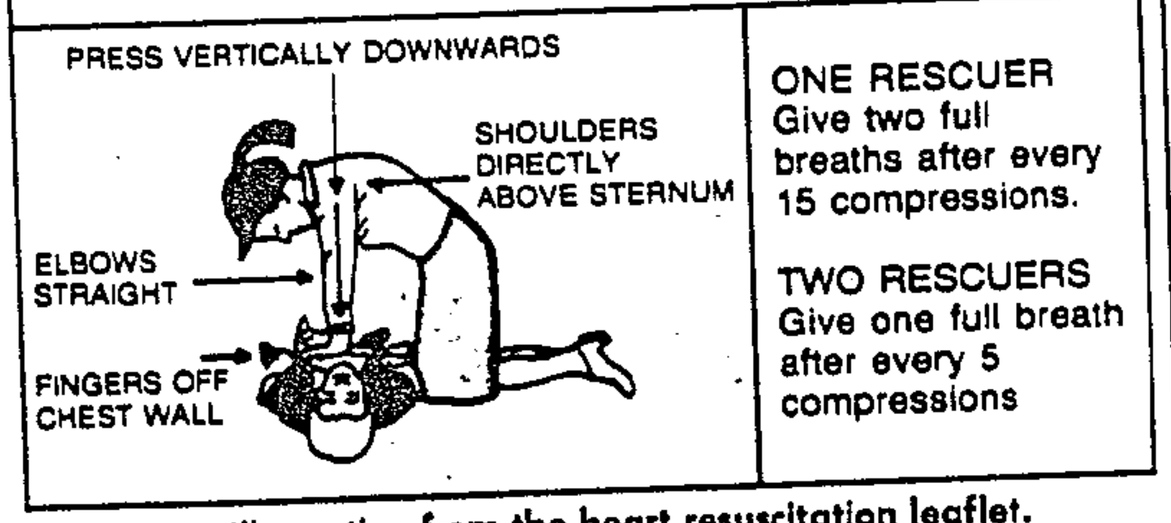
He pointed out that in recent months there had been two reports of people drowning because bystanders did not know how to apply CPR.

In Munich, Germany, 20 people watched as three small boys struggled for their lives after falling through ice covering a lake. They all died. Shortly before Christmas a man drowned in a lake in Kensington, Johannesburg, while a crowd of onlookers stood by helplessly.

The SA Resuscitation Council, founded in 1987, is launching a public awareness campaign this year during which it hopes to get as many laymen as possible trained in simple principles.

"CPR is a simple technique which could save many lives every day. We urge the public to learn these basic principles."

The leaflets will be available from St John Ambulance, the Heart Foundation, SA Lifesaving, the SA Noodhulpliga and the SA Red Cross Society.



An illustration from the heart resuscitation leaflet.

Star 25/1/90

'Bad blood' needle causes Aids fear

MBABANE – Leaders of a Swazi church who draw "bad blood" from people they consider sick are causing alarm because they use the same needle to treat many people. There are fears that this could spread Aids.

The practice is reported to be common in the Zion Christian Church.

A woman member of the church told a local newspaper that a hypodermic needle was used by church leaders who treated as many as 20 people with the instrument. A government official condemned the practice and said there would be an inquiry. – The Star's Africa News Service.

Council loans 3 motorcycles to Canaries

Municipal Reporter

Johannesburg City Council has loaned three motorcycles to the Canary Islands to be used during the Pope's visit from today until Saturday and the Democratic Party has claimed that a senior traffic departmemt official has accompanied the bikes.

DP council leader Mr Ian Davidson claimed the management committee's decision to agree to a request by the Foreign Affairs Department was clear proof that the council was subsidising Mr Pik Botha's department.

But Mrs Marietta Marx, deputy chairman of the management committee, dismissed the criticism, saying the loan would not cost the city a cent and would improve relations between South Africa and the Canaries.

She said the report to the committee had not mentioned that any staff would accompany the motorcycles but she would investigate Mr Davidson's claim.

Mr Davidson said if the committee was unaware of the fact that a certain Mr John Nicol had gone to the Canaries, it was proof that there was no control over the situation."

It was clear the council had lost sight of the need to operate on a business basis.

"The latest move follows other instances where Johannesburg's traffic officials had escorted Ministers and guests of the department on trips around the country," he said.

New approach to health services

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By SOPHIE TEMA

CP News 25/1/90

A TOTALLY new approach to health services throughout the country is being considered for immediate as well as long-term implementation.

This was revealed in a statement by National Health and Population Development Minister Dr Rina Venter and Fanie Ferreira, MEC responsible for health services, after a visit to the HF Verwoerd Hospital, Johannesburg, to study problems in the cardiac unit.

The function of academic hospitals would have to be reviewed and they should be developed into "centres of excellence", said the statement.

A sifting process would be applied to patients and less serious cases should be treated at community health centres and at community and regional hospitals.

Hospitals would be relieved of the pressure of less serious cases because academic hospitals should concentrate primarily on training and research.

Venter also visited the King Edward Hospital in Durban and intends visiting Baragwanath Hospital in Soweto soon.

In order to find solutions for the problems of hospitals in the Transvaal and to try to determine how they should function a meeting will be held in Pretoria on February 8 between Ferreira and all rectors of academic hospitals in the province, or their representatives.

Greatest killers are on the ground

Own Correspondent

CAPE TOWN — Motor accidents, circulatory disorders and malignant growths are the major cause of death in South Africa, according to an article in the latest issue of the *Continuing Medical Education Monthly.*

"Road accidents account for 42 percent of all non-natural causes of death. Yet the public alarm caused by an aircraft accident overshadows concern about road deaths," writes Sanlam's chief medical adviser, Dr Altus van der Merwe.

SMOKERS

In fact, motor cars cause 19 times more deaths per kilometre than air travel and motor-cycles 480 times more.

But a smoker is 20 times more likely to die from smoking than in a traffic accident.

One in 400 smokers who smokes less than 20 cigarettes a day is likely to die for every year of exposure compared to one in 8 000 people in a traffic accident.

Circulatory disorders are responsible for 41,9 percent of male deaths and 40,3 percent of female deaths and growths cause 17,5 percent of deaths among men and 18,2 percent among women.

In a study conducted between 1973 and 1982, it was found that motor-cycle accidents caused paralysis in 24,8 percent of the cases.

PREVENTABLE

Relative risks of paralysis from popular sporting activities were listed as: riding 18 percent, diving 16 percent, mountaineering 14 percent, gymnastics 12 percent, trampolining 8 percent, motor-cross 7,7 percent, and hang-gliding four percent.

"It gives one food for thought to see that 65 percent of all premature deaths and 83 percent of potential years of life lost are due to preventable conditions. Can society afford not to take up this challenge?" Dr van der Merwe concludes.

Medical schemes wary of AIDS claims

MEDICAL aid schemes with unlimited liability will be crippled if more than 10% of their members get AIDS.

Medscheme deputy MD Les Hollis said that initially there had been a "rash of conservatism" among medical schemes, with many introducing specific retraints on payouts to AIDS patients, including the R100 legal minimum.

Medscheme administers 34 schemes with one million members.

Now, said Hollis, most of its schemes had introduced category sub-limits and overall annual limits of between R10 000 and R15 000 for all members, including those with the AIDS virus.

He said many schemes were trying to be as liberal as they could towards AIDS sufferers but at the same time

TANIA LEVY

had to be careful not to cripple the entire scheme. Very few had left their liability open-ended.

A number of medical schemes have limited their annual payout for AIDS treatment to less than R500.

Medical Schemes assistant registrar Danie Kolver said a number of schemes had reduced liability to AIDS sufferers to the legal minimum.

In terms of the Medical Schemes Act any member of a registered scheme — including someone with AIDS — is entitled to a minimum R100 a year for each of five medical service categories including medicines, hospitalisation, physiotherapy, doctors and dentists bills.

He said it was difficult to say how many of SA's 250 registered schemes had applied this or other limits to benefits for AIDS treatment.

Kolver said no scheme had introduced a clause specifically limiting the payout for AZT, the only drug used to treat AIDS at present.

Affiliated Medical Administrators (AMA) chairman Tony Leveton said most societies placed an annual limit — ranging from R2 000 to R5 000 — on medicines. This amount would be used up quickly by someone being treated with AZT, which costs between R500 and R800 a month.

The drug costs R537 for 100 capsules, and dosages vary from three to five capsules a day.

Leveton said none of AMA's 10 medical societies, representing 185 000 families, had adopted specific restrictions on benefits to members with AIDS.

Doctors lose 'caring touch'

ACHMED KARIEM

IT WAS "partly true" that doctors were losing the caring touch in treating patients, Medical Association of SA chairman Bernard Mandell said last week.

He was responding to an SA Medical Journal article in which physician Dr Clive Evian said the medical profession was "out of touch" with caring for patients and their families in the face of severe and debilitating illness. The article was based on Evian's experience when his father was dying.

Mandell said the SA Medical and Dental Council had approved the introduction of vocational training in family practice in addition to basic medical training to help improve doctor-patient relations.

Health care a 'privilege not a right'

Cape Times 30/11/70 249

By CLAUDIA KING

HEALTH care is a privilege and not a right and the individual must accept the responsibility for his own health, Dr Hugo Snyckers, president of the Pharmaceutical Manufacturers' Association of South Africa, said yesterday.

Speaking at a symposium on future health challenges in South Africa, Dr Snyckers said the government could no longer accept sole responsibility for a health-care delivery system and employers were no longer able to accept uncontrollable increases in health-care costs as part of the remuneration package.

"This shifts greater responsibility to the individual for his own health care and places a new priority on preventive medicine. For this reason the PMA believes a major programme should be launched to promote responsible self-medication among the general population." he said.

New principles bringing free-market forces into operation should be the underlying strategy of a new health-care system.

During a subsequent discussion period the MP for Langlaagte, Dr Johann Vilonel, said the benefits of a free-market system must be brought to all the people of the country or the majority would not buy it.

"It's a pity Mr (Nelson) Mandela was not released in time to attend this conference as the vast majority of people in this country are not represented here. The system must be sold to a much broader spectrum of the population," he said.

Health is no special case when it comes to privatisation

B Dan 31/11/90.

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W DUNCAN REEKIE

AS WE move in fits and starts toward a racially liberalised society, vested interests motivated by factors other than racial grouping will become ever more evident. In particular producer power (as opposed to consumer sovereignty) will become, as elsewhere in the world, an issue of consequence.

The reasons why producer groupings, as opposed to consumer groupings, are effective political lobbyists are well known. Producers are relatively few in number, they have focused and well defined goals. They consequently find it easy, cheap and worthwhile to organise and lobby for the attainment of their objectives.

This is true whether we are talking about a handful of mining houses lobbying for a tax break, several thousand retail pharmacists arguing that chemist shops should only be owned by "professionals" and not bodies corporate, or several tens of thousands of trade unionists striking for a pay rise.

By comparison, millions of consumers are costly to organise. As each individual in turn has a vast array of differing goals, the attainment of any one of which is to consumers only of relatively trivial value, they tend not to coalesce readily into pressure groups. The consumer must generally look to the market or the state to ensure his interests are optimally served.

Since the state is under pressure from producer vested interests, there is a presumption, at least, that the market, if unregulated and not subservient to producer pressure via the state, will be the better safeguard.

The deregulation and privatisation trends worldwide consequently have significant economic and social arguments in their favour. At a recent conference held on the issues at the University of the Witwatersrand, one speaker from the floor agreed in general but argued that privatisation should not be extended to health care — after all it is surely different and the cold calculus of the market should hardly be applied to the allocation of resources in the area of human suffering.

Recently several health-care producers (in particular medical academics) have also begun to argue along similar lines. Health care is different and the conditions necessary for the market to operate effectively are absent. Informed and responsible consumers are not present on the demand side (we need physicians, surgeons, pharmacists and so on to take decisions for us as patients).

On the supply side these same producers do not compete for custom because professional and ethical codes of practice, often given *de facto* legal status by government-approved occupational licensure boards, prohibit inter-producer rivalry such as price competition, product-quality variation or the promotion and advertising of such differences. (This lack of suppplier competition is generallly argued by the professions to be in "the public interest" and so a protection for the ignorant against exploitation by "quacks").

Finally, the "health care is different" school argues that supply and demand do not meet in a cash nexus. There is third-party payment by the state or medical aid schemes. This often results in little incentive for suppliers to act efficiently as they are paid for the service they provide and consumers bear little direct expense.

The incentive system thus encourages both production and consumption, not conservation or efficiency. To aggravate the situation, existing regulation not only hampers competition between suppliers of care, it also inhibits competition and innovation between forms of third-party reimbursement.

There are really two issues here. First is health care really different? Second, should its privatisation or deregulation have a government health warning attached? (The warning, of course, would be designed by the producers and bureacrats who often claim to know what is best for others).

Is health different? How much do you really understand about the recent compact disc player you bought? Or the automatic 35mm camera? The questions are not trivial. Most of our purchases are made with a degree of ignorance. Health care is not a special case. We use agents, retailers, dealers, specialists, doctors, advertising, friends' advice and so on to gain information before we buy.

Economist Dennis Robertson suggested there was "great spiritual comfort in buying a known and trusted brand of cocoa, rather than a shovelful of brown powder of uncertain origin". My own well loved physician gives me a not dissimilar feeling of contentment.

On the supply side, of course, competition is minimal but this is an argument for, not against, deregulation of the professions. It is the physicians' and pharmacists' guilds protected by law or custom against rivalry, or even investigation by the Competition Board, which are special, not the provision of health care.

Finally, third-party payment or insurance is ubiquitous. It is not confined to health care. Who pays if your house is burgled or your car is smashed? Probably not you. Again it is regulation of health care and the prohibition or discouragement in SA of alternatives which make health care special, not the lack of a cash nexus as such.

Consider some US experience with innovative and competitive third-party payment schemes.

Health Maintenance Organisations (HMOs) such as the Kaiser Permanente are a burgeoning and successful phenomenon. Patients pay annually in advance for care irrespective of the quantity consumed. Physicians receive either a salary or share of the profits after hospital and other costs have been paid.

The incentives are not to overprovide (or profits fall), not to skimp on treatment (or semi-cured patients will return) and to do so efficiently (or patients or their employers will seek out an HMO with cheaper rates next year).

Hospital utilisation is lower with HMOs than with conventional insurance plans or the type permitted in SA.

Even in the government sector in the US, market-related pricing has reduced hospital utilisation. The state scheme for the elderly, Medicare, experienced a 12% fall in average length of stay per diagnostic grouping when it switched from a retrospective payment scheme to a prospective one. Providers had an incentive to minimise costs to maximise their residual surplus.

SA has two main health care systems: a state-provided scheme and a heavily regulated private one. There is no free market in health care of any meaningful consequence.

How then can we find a better way of curing and caring for ourselves? Markets, as Nobel Laureate Hayek reminds us, are "discovery processes". Only deregulation can permit us to find the best system or (more likely) the optimal plurality of systems.

The alternative, letting those with vested interests decide, namely the bureaucrats or the medical care producers, is akin to asking an admiral if he believes his navy should have another aircraft carrier.

☐ **Prof Reekie is Dean of Commerce at the University of the Witwatersrand.**

School needs cash

By SELLO SERIPE

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THE principal of Soweto's JC Merkins School for the physically disabled has appealed to the community for help in funding expansion.

Principal Dennie Schoeman said R200 000 was needed to finish building a hostel, a therapy room and a hydropool. Plan 4490

A piece of land opposite the school would be developed into a sports field and park when funds were available, he said.

When these had been completed a walk-in refrigerator, stoves and bedding, costing about R200 000, would also be needed.

"Although the school receives a 95-percent government subsidy, it is not enough," he said.

"Most of the funds are derived from fund-raising activities and sponsorship from the Association for the Physically Disabled (Transvaal)."

School fees – R50 for day scholars and R500 for boarders a year – was used to supplement the school's budget.

At present the 10-year-old school in White City, Jabavu, has 50 boarding pupils.

Schoeman said that when the extension was completed, 140 more day pupils would be accommodated.

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Bleak days for the sick and injured

Medical charges reach for the sky

By Karen Stander

Medical aid contributions are set to soar by nearly 25 percent in another blow to hard-pressed consumers.

Medical costs have already risen by almost 300 percent since 1980 — double the all-price inflation index for the period — according to figures provided by the Government's Central Statistical Services.

In a hard-hitting statement in reaction to the latest increases, a spokesman for the Consumer Council yesterday called on medical schemes to take a strong stand against the continuous increase in medical services charges and medicines.

The spokesman said the cost of medicines and medical aid contributions had risen by 112 percent since 1985.

In addition, doctors' and dentists' fees had increased by 60 percent and hospital services by 79 percent. This totalled a general increase in health care costs of 92 percent in five years.

Inflation trends

Contribution increases in the 89 schemes run by the four biggest administrators of medical aids — Davidson & Ewing, Medscheme, Affiliated Medical Administrators and Medicaid — varied between 12 and 25 percent, with most about 20 percent higher than last year.

Administrators said the increases were the result of general inflationary trends, including the cost of technology imported from overseas; medicines, which were expected to increase in price by about 25 percent during the year; the rising cost of hospital care; an escalation in building costs for new hospitals; greater usage of services, particularly by black and coloured patients; and adjustments to the scale of benefits.

Mr Rob Speedie, executive director of the Representative Association of Medical Schemes (Rams), said he was not surprised by the level of contribution increases.

"Contribution increases of 20 percent will just about cover increased expenditure this year."

In recent years, patients have been forced to pay out over and above their medical aid contributions because of an increasing trend for medical practitioners to charge more than the scale of benefits.

Dr H A Hanekom, acting secretary-general of the Medical Association of South Africa, said Masa shared public concern at the rising cost of health care and was involved in discussions to consider methods of curtailment, and to ensure that good medical care was available, affordable and accessible to all.

Masa believed the inflexibility of the present system was a major stumbling block in cost containment. Patients should be allowed to select insurance according to their individual needs, and not according to a set package.

Dr Hanekom said a doctor who changed the Rams scale of benefits was in fact giving a discount of up to 56 percent less than what Masa recommended as reasonable.

Masa and Rams have been at loggerheads for several years over the rates paid by medical schemes. The scale, which Masa says is too low, is set by Rams after consultation with Masa.

Doctors, also feeling the pinch of inflation, are opting to charge according to the guidelines recommended by Masa, which are more than double the scale of benefits.

This leads to an additional burden on the patient, who must pay the difference between what the doctor or dentist charges and what the medical aid will pay.

Medical crisis conference

Medical Reporter

A CONFERENCE has been called in May to resolve the crisis in academic medicine and to design future strategy.

According to Dr Hendrik Hanekom of the Medical Association, Masa has warned for years that a crisis was developing at teaching hospitals and that patients would suffer.

The conference, called by Masa and backed by Gencor, will be attended by decision-makers in both the private and public health sectors.

Medical aid contributions set to soar by up to 25pc

299 ARGUS 7/2/90

The Argus Correspondent

JOHANNESBURG. — Medical aid contributions are set to soar by up to 25 percent in another blow to hard-pressed consumers.

Medical costs have already risen by almost 300 percent since 1980, double the all-price inflation index for the period of about 150 percent, according to figures provided by the government's Department of Central Statistical Services.

And, in a hard-hitting statement in reaction to the latest increases, a spokesman for the Consumer Council called on medical schemes to take a "very strong stand" against the continuous increase in tariffs for medical services and the price of medicines.

The spokesman pointed out that the cost of medicines and medical aid contributions had risen by 112 percent since 1985.

In addition, doctors' and dentists' fees had increased by 60 percent and hospital services by 79 percent.

This meant a general increase in the cost of health care of 92 percent for the five-year period.

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Mr Rob Speedie, executive director of the Representative Association of Medical Schemes (Rams), said he was not surprised by the level of contribution increases.

"Contribution increases of 20 percent will just about cover increased expenditure this year," he said.

Health care costs will soar

Sowetan 7/2/90

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SOWETAN Reporter

THIRTY million Americans cannot afford hospital care within their largely privatised health care system.

If this can happen in the richest country in the world, the privatisation of health care services in South Africa can be expected to be a little short of disastrous, argues the Centre for the Study of Health Policy at the University of Witwatersrand.

The privatisation of hospitals will lead to a rapid escalation in the cost of hospital care and health may be a commodity afforded only by the very wealthy.

The centre argues that private health care is definitely not cheaper than public health care and rejects the Government's contention that the operation of the free market means that the private sector is more cost effective than the bureaucratic Government health service.

Market

"A free market assumes well informed consumers making rational decisions, in health care the so-called "information gap" means that almost all the decisions are made by the suppliers - the doctors and private hospitals," says a report by the centre.

Since the same suppliers decide what drugs should be prescribed, how long should the patient stay in hospital, and since they are also paid for each service they provide, the economic incentive tends to encourage the provision of more services than are strictly necessary, the prescription of more expensive brand name drugs than the cheaper but equally effective ones.

Private hospitals would also have to make profit for the shareholders which would mean an additional cost over and above expenses related directly to the delivery of care.

Funds

The Government's argument for privatisation of health services, that it was short of funds and that those who could afford private health care should do so, was "the most irrational and voodoo economics at its most macabre."

In 1987 alone, consumers spent R4-billion on health care in the private centre, which made a tidy profit for itself, reports the Centre.

Had the provincial hospitals, which can provide quality care more cheaply, buy drugs more cheaply and pay their doctors less, provided those services, the income generated could be used for both capital improvements and to increase staffing. It would also free government tax money to pay for the care of the poor people.

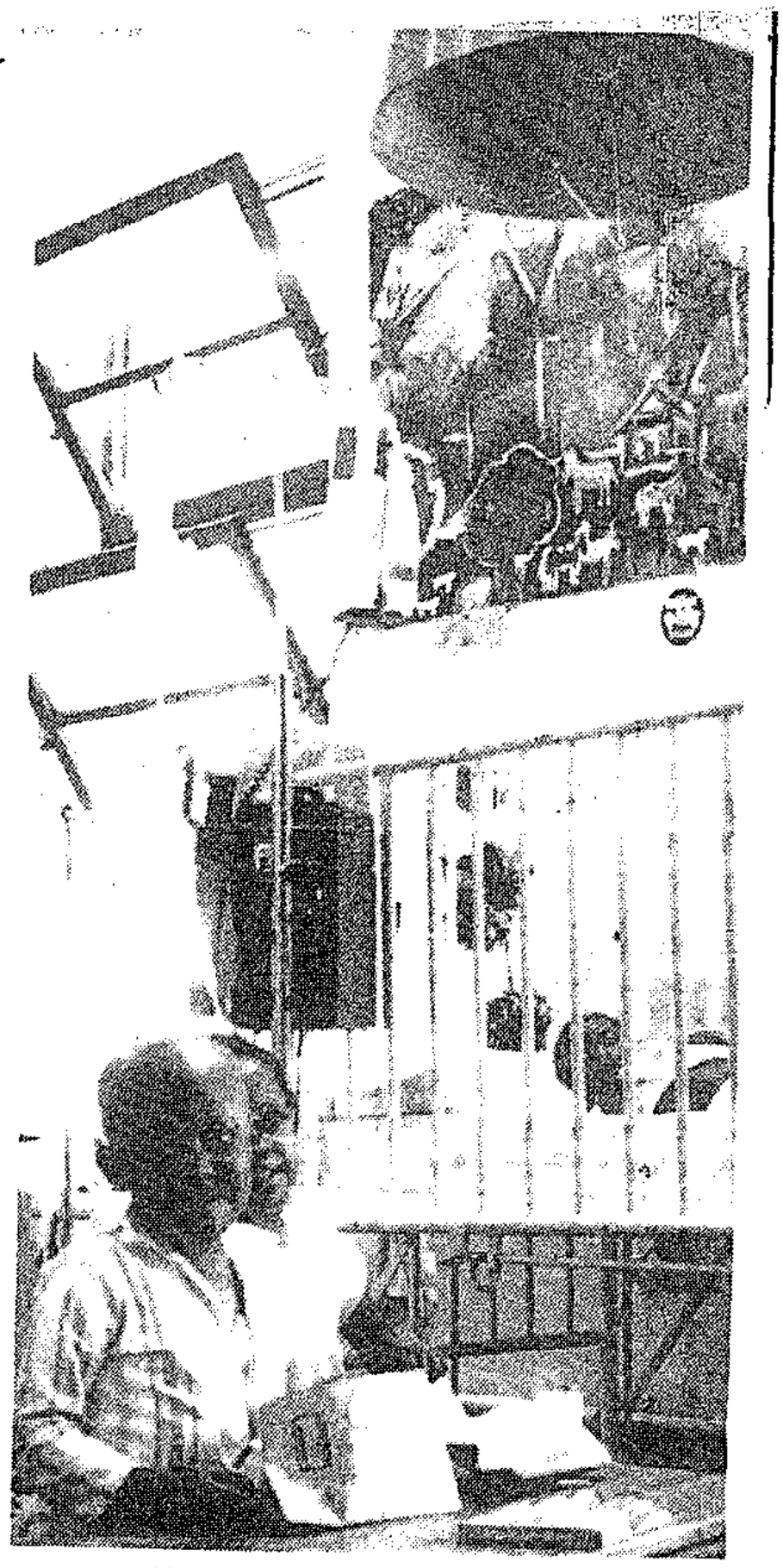
While the organisation was not against the state's objective to use private funds to pay for health care, it stated that it was opposed to the "illogical" conclusion that that meant the transfer of public hospitals to the private sector.

The Centre also attacked the racial segregation of health services, the removal of which was a necessary condition.

Letter

"There are economic costs to duplicating super-specialist facilities in order to preserve racial purity, quite apart from the injustice and indignity involved."

A letter in the South African Medical Journal this year suggested that the Orange Free State alone wastes R37-million a year to maintain apartheid in the academic hospitals in Bloemfontein.



Health care will rise steeply once it is privatised.

Powerful reasons to treat health care as a human right

B/Day 9/2/90

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JONATHAN BROOMBERG

IN A thoughtful article in Business Day last week, W Duncan Reekie contended that health should not be regarded as different from other commodities when it comes to debates about privatisation.

Prof Reekie in fact made two separate, but connected arguments. The first is that the failure of the market to function properly is not unique to the health sector. This, he implies, undermines the usual case against deregulation and privatisation of health care. He then argues positively for the merits of these measures, as a crucial means of improving efficiency in health services.

Let us take these arguments one at a time. I would agree fully that the market does operate to some extent in the health sector (and that other sectors exhibit varying degree of market failure). But this does not constitute sufficient grounds for regarding health as similar to other commodities.

I say this for two reasons. Firstly, there is a deeply held social consensus that there exists a fundamental human right of access to adequate health care. This is not to say we all share a belief in the right to free health care, but no one would argue that we regard access to a compact disc player, or to a motorcar in the same way as we do access to health care.

This belief in some form of a right to health must impact on our assessment of the functioning of the market in health care. In a private health sector, access to health depends entirely on ability to pay. In SA today, less than 20% of the population can currently afford private health care. The proportion is unlikely to increase in the near future.

An extension of market forces in the health sector will bring us increasingly close to the American health care nightmare in which, despite expenditure of 12% of GNP in the richest country in the world, fully 30-million Americans cannot afford access to health care at all.

The problems of the market in health care extend beyond financial barriers to access. Market forces in the private health sector also ensure extreme maldistribution of all health resources. Private hospital owners and practitioners set up shop only in areas where the population can afford to patronise them. The result is a heavy concentration of facilities and practitioners in wealthy urban areas, and a corresponding dearth in rural and less wealthy urban areas. To the extent that the market does operate in health care, there are powerful reasons for avoiding the unrestrained operation of market forces when people's health is at stake.

But what of the argument that market failures occur in all sectors, and that health care is therefore no different? Reekie rightly points out that there is a degree of consumer ignorance in most economic sectors. He is wrong when he suggests that the substantial differences in the extent of such ignorance are unimportant.

The average consumer may not know all that much about a compact disc player. She does, however, know what sound quality she wants, what she can afford, and will make her decisions accordingly. In the case of a sudden onset of chest pain, however, almost the only decision a patient makes initially is the one to visit a doctor. Thereafter, virtually every decision as to investigation, medication and hospitalisation lies firmly in the hands of the doctor.

No doctor is likely to offer a choice of possible medicines, or operations, with their respective prices, and ask the patient to make the choice. Since the choices made by doctors constitute by far the bulk of total health expenditure, demand in this sector is very substantially "supplier induced".

Reekie's arguments also ignore the effect of the method of reimbursement of health care suppliers. In our private health sector, the bulk of suppliers are paid a fee for each service they provide. Given their ability to induce demand, the fee-for-service system generates powerful incentives to suppliers to overtreat. This leads to significant over-utilisation of services. It should come as no surprise, therefore, that the private health sector spends close to 47% of total health expenditure in the country while providing care for less than 20% of the population.

In short, to the extent that the market does function in health, it creates serious barriers to access to what most of us regard as a fundamental human right; and when the market fails, as it clearly does, these failures produce extremes of inefficiency not encountered in other sectors.

What does all this say about deregulation and privatisation of health care? For a start, we need to make a clear distinction between the two concepts. The health sector may well benefit from some degree of deregulation, but the dangers of an unregulated market can be severe.

The example of the Health Maintenance Organisation (HMO) delivery system in the US is a case in point. The extremely tight competition between profit-making HMOs has led to the now pervasive practice of "skimming" in which HMOs cream off the better-risk members, leaving the ill and elderly without coverage. Precisely this problem of "risk rating" by the medical aid schemes now confronts us in SA.

Recent changes to legislation, long clamoured for by the schemes themselves, now permit the schemes to discriminate between members on grounds of risk. We too can thus look forward to a situation in which the fit and the young will be offered cheap cover while the higher-risk elderly and the ill will be unable to afford to adequate health insurance packages.

Privatisation per se is a different issue. Strictly speaking, privatisation refers only to the transfer of ownership and control from the public to the private sector. Deregulation may or may not accompany this process. In theory, a well regulated and managed private health sector could be highly efficient. Such a sector may have an important role where there is a well-endowed public sector, with excess capacity.

However, in SA, with its increasingly underfunded and overburdened public health sector that has to care for the vast majority of the population, privatisation portends disaster. It in fact means the progressive unburdening by the state of its responsibility for the health care of the population.

It thus means that an increasing fraction of the population will have to rely on the expensive, inefficient and maldistributed private sector, while those who will never afford private care will be forced to use progressively deteriorating public facilities.

What we need in health care is not deregulation and privatisation. In fact, in the short term we need a better-regulated private sector, and we also need some way of co-ordinating private and public sector care, and of redistributing resources between the two. If we fail, we face the prospect of excellent health care for a privileged minority, and unacceptable levels of care for the majority. This is no way to distribute a basic human right.

☐ **Dr Broomberg is a research officer at the Centre for the Study of Health Policy, Community Health Department, Wits Medical School.**

B/Day 16/2/90

Masa, LOA issue separate tariffs

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LINDA ENSOR

THE tariff agreement between the Medical Association of SA (Masa) and the Life Offices Association (LOA) has collapsed because of disagreements over fee increases and the bodies have issued separate tariffs.

Doctors are caught in the middle.

Meetings held in Cape Town this week failed to reach agreement on the 1990 increase in fees paid for life assurance medical examinations.

Assurance companies, which are members of LOA, have agreed not to pay more than the LOA-recommended fee, effective from January 1.

Some life assurers have asked doctors to fill in a form indicating whether the LOA fee was acceptable or not and according to LOA chairman Dorian Wharton-Hood, a number had said they were happy with the tariff.

He said the LOA consulted the Registrar of the SA Medical and Dental Council (SAMDC) and received the assurance that doctors who accepted the LOA tariff would not be contravening Rule 19 of the SAMDC's ethical rules.

But Masa Federal Council chairman Dr Bernard Mandell said this was not the issue as, while doctors might decide to accept the LOA tariff, the SAMDC did not permit doctors to enter into contracts with lay bodies.

Should doctors commit themselves in writing to the LOA tariff "they may be contravening Ethical Rule 12, which prohibits tendering for appointments as 'preferred doctors', and Ethical Rule 26, which prohibits exploitation of doctors by lay bodies in that the doctor would not be able to charge fees regarded by Masa as reasonable".

The LOA offered an across-the-board increase of 20% with a 22,5% increase for standard medical examinations (R55,10 each), which make up about 75% of all work done for life assurers by doctors.

Masa rejected this, proposing, according to Wharton-Hood, a 77% increase (R80 each compared with the R48 recommended by Masa for private patients) for the basic medical investigation and offering in return to reduce the fees of certain specialist investigations.

Mandell disputed the 77% figure but did not wish to disclose the increases recommended by Masa.

The last increase came into effect in October 1988.

DRUG INDUSTRY FIM 16/2/90 299

Philosophical split

Outwardly, Pharmaceutical Manufacturers' Association recommendations, unveiled recently in Cape Town, are in line with the

FIM 16/2/90 299

views of the healthcare sector as a whole.

Most of the text is concerned with such popular themes as individual responsibility in healthcare and the promotion of privatisation and deregulation. Buried in the text, however, the grinding of axes is still audible. Though the association is an affiliate of the Pharmaceutical Society of SA, there are differences of opinion on some key issues.

When it comes to prices, the manufacturers feel immune to criticism. There have been six major investigations into the cost of medicines, starting with the Snyman Commission in 1961, and all found manufacturers' prices were not excessive.

The upshot is that the association feels it can take the high ground against the rest of the industry.

For instance, it favours allowing retail pharmacists to advertise the price of prescription medicines. However, the society is sticking to its long opposition to the suggestion. "The society, at least at this stage, believes that advertising the prices of prescriptions will have little effect upon the price of medicines, bearing in mind that doctors select the products prescribed for patients," says society executive director Boet van der Merwe.

A more serious rift is over generic substitution. The association has opposed in court the right of pharmacists to substitute a branded medicine for a cheaper equivalent and will do so again unless unambiguous legislation is passed soon. Generic manufacturers are hoping the De Villiers Report, expected to be made public this year, will support them.

Association president Hugo Snyckers is uncertain of the benefits of measures that encourage the use of cheaper drugs, such as the Maximum Medical Aid Price, which reimburses members for no more than the price of a generic.

"There are short-term cost savings in these ad hoc measures but only a proportion of medicines can be substituted by therapeutic equivalents."

Snyckers is supported by Wits Commerce Dean Duncan Reekie who argues that "the thrust towards generic substitution is possibly misplaced in that the potential savings in hospitalisation costs from the discovery of new drugs are so large that they justify the encouragement of the innovative drugs companies."

However, Van der Merwe points out that generic substitution and code lists "are found to assist in containing costs" in provincial hospitals, so by implication they should contain costs in the private sector.

The medical aid movement stands somewhere in the middle. Representative Association of Medical Schemes executive director Rob Speedie says the movement encourages generic prescribing when appropriate but wants a balance between cheap medicine and encouraging innovative research-based companies.

"SA must continue to have access to new medicines but, in order to do this, multinational companies need to enjoy sufficient returns from their branded products." ■

Care group appeals for funds

By SAMKELO KUMALO

Sunday Times 18/2/90

AN organisation that cares for the disabled is appealing for funds to enable them to continue their work. 18/2/90

The Itsoseng People's Organisation urgently needs funds to send 19 disabled children to school and R3 million to build a school, workshop and recreational centre on land donated by the local town council.

IPO chairman Peter Mabusa said many children would not be able to attend school this year if help was not forthcoming.

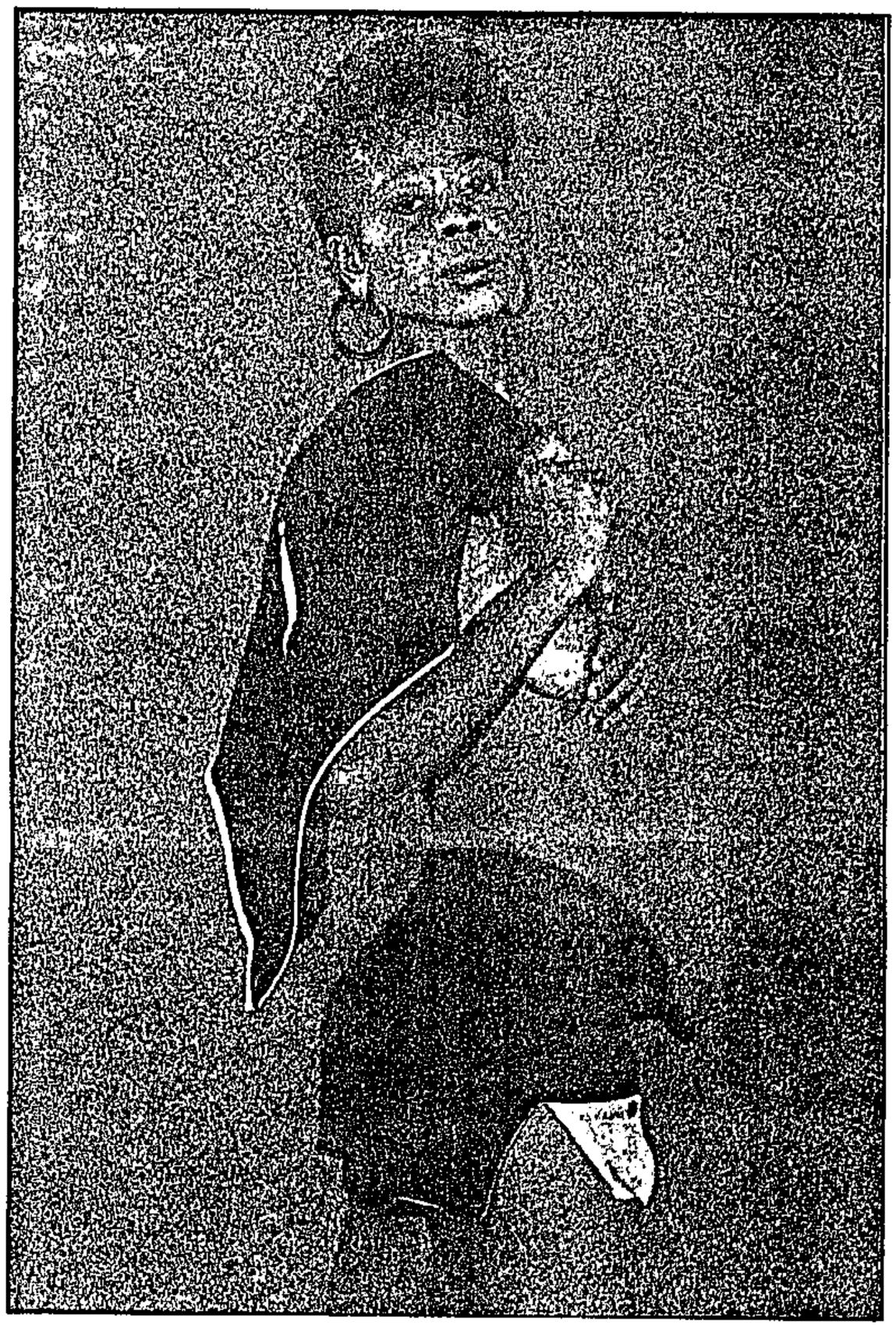
"Our problem is that we do not have money to pay the children's transport. Last year we were assisted by a white businessman. (297)

"At the beginning of the year he said he had problems and would not be able to assist us for some time.

"The previous year we were also subsidised by a local black businessman, but since his death we have run into trouble.

"We have since approached a number of businessmen, but there has been no response."

Mabusa said many of the parents and relatives did not seem keen to provide for their children.



Gertie's a girl who's always on the go

Sultry Gertrude Mnguni, 23, from Thokoza is a busy girl. She's a full-time model and when she's not doing that can be found doing aerobics or dancing. If she can't be found at all she's probably travelling. Gertrude's ambition is to be a fashion designer and open her own modelling school.

Pic: BONGANI MNGUNI

Club to pick top woman

By LULAMA LUTI

BUSINESSWOMEN have been oppressed by both society and government for years but are becoming a force to be reckoned with in the economic system.

In a bid to correct shortcomings, the Executive Women's Club of Southern Africa founded the Businesswomen of the Year competition in 1982.

EWC president Jennifer Kinghorn said there were many South African women who were making a significant contribution to their profession and to industry that deserve recognition.

Kinghorn said: "There are no cash prizes for the winner. As a reward for her achievement, she gets invitations to address public and business forums and this exposure is an incentive to her business." Sunday Times 18/2/90

Women can submit personal nominations and do not need to be nominated. The closing date is April 27 and the awards ceremony will be held at Carlton Hotel on August 29. 18/2/90

More information and application forms can be obtained from EWC at (011) 887-0809 and (021) 438-9831.

Breidbach by members of

Health insurance could save plenty

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B/Day 16/2/90

INFLATION has to be accounted for in travel insurance as in any other field of risk cover.

It is costing more to break and mend a leg anywhere in the world — and more to secure the funds to pay for it.

But a number of competing policies provide options.

The attractive medical cover and other travel cover benefits such as in-flight insurance available at either no cost or a low charge when purchasing air tickets through Diners Club is believed to be a major motivating factor in the organisation's high share (59%) of air tickets purchased on cards.

All airline tickets purchased on a Diners Club card carry free and automatic cover of R500 000 for accidental death and permanent disbility while in transit or R100 000 while not in transit and R250 000 medical cover while the insured person is outside the SA Common Monetary Area.

At a cost of R20 a ticket, R350 000 extra cover on accidental death or permanent disability "in-flight" is offered; R1 500 luggage replacement cover; R400 for expenses related to flight delay of longer than four hours and up to R200 for baggage delay; plus R2m personal liability cover.

Diners Club's Phase Three for R100 a ticket is for R500 000 additional in-flight cover and R750 000 medical cover with GESA assistance which includes:

Emergency

- ☐ Medical assistance with emergency medical referrals;
- ☐ Transfer to and from medical facilities and payment of medical expenses outside SA;
- ☐ Emergency visits to the person's bedside;
- ☐ Legal assistance;
- ☐ Administration assistance with lost or stolen passports.

An equivalent package to Diners Club's Phase Three rises in price according to the length of time for which cover is required.

It is quoted at R235 for under 10 days, up to R350 for 17 to 24 days and R405 for 25 to 32 days.

Travel Assistance, which is linked to parent company Europ Assistance, is the largest travel insurance organisation in the world, with 300 agents in 210 countries, extending even to the USSR and China.

Travel Assistance general manager Munro Deysel says recent cases from files indicate some of the problems and costs business travellers can encounter:

- ☐ Heart attack in Los Angeles, five days in intensive care — hospitalisation bill: R80 000;
- ☐ Motor accident in Italy, treatment and repatriation accompanied by a nurse — R110 000;
- ☐ Employee on contract in the Comores taken seriously ill. Repatriation by jet with doctor and ICU nurse required — R40 000.

Insurers in bid to ease health costs

ST Mon 18/2/90.

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By Robyn Chalmers

THREE big players in insurance have banded together to produce a health-care specifically for employees.

Soaring costs have widened the gap between expenses and medical-aid scheme payouts.

First Bowring, Crusader Life and General Accident have launched the First Bowring Group Major Medical Expenses Plan to supplement medaid benefits of employees.

Payout

Crusader Life joint managing director Bob Rowand says the plan will not compete with medaid schemes, but will fill the gap between recommended fees and benefits.

"In the event of an accident, the policyholder will receive a tax-free lump sum, calculated on a unit system. Included in this is a recuperation benefit, which no other plan to my knowledge provides for, and a 50% increase in payment for those who are treated in foreign hospitals."

Crusader Life medical director Marius Barnard says a patient undergoing a hip replacement operation is charged R1 664, but receives a payout from a medical scheme of only R732,20.

Dr Barnard predicts that medical costs will continue to climb rapidly. In 1980, coronary artery surgery cost R4 000. Today's cost is R30 000 and by the year 2000 it will be between R250 000 and R300 000.

"In addition, the pattern of disease is changing. In the early 1900s, infectious diseases caused the most deaths in SA. Pneumonia and influenza accounted for 11,8% of deaths a year. Heart disease caused 8% of deaths, strokes 6,2% and cancer 3,7%.

"Today, the picture has changed dramatically. A total of 49,6% of deaths in SA were caused by heart disease in 1980, 20,9% by cancer and 8,6% by strokes, pneumonia and influenza accounting for only 2,6%."

Combination

Dr Barnard says it is imperative that the private sector heed the Government and become involved in financing medical services.

Insurers have slowly become more involved in the provision of health-care protection plans. Towards the middle of last year, Crusader Life launched its Total Health Care package.

BOB ROWAND . . . bridging the health gap

It combines three Crusader products — Hospitalplan, Major Medical Expenses Plan and Dread Diseases — with an endowment policy. Under the policy the insured will have an amount invested at the end of 10 years.

First Bowring Group Major Medical Expenses Plan is intended for companies which are concerned about their employees' well-being and security.

For R15 a month an employee aged 40 can cover himself and his family for medical expenses up to a maximum of R200 000 a year.

According to the unit system on which benefits are calculated, an employee can, for example, receive about R17 226 for a coronary bypass operation — which includes two days in intensive care, eight days in hospital and recuperation expenses.

Doctors and assurers clash over medical fees

A TARIFF agreement between the Medical Association of South Africa (Masa) and the Life Offices Association (LOA) has collapsed after Masa's recent demands for a "large" increase in the fees for life-assurance medical examinations.

In the past, the LOA and Masa have agreed on fees which doctors could charge life assurers for various investigations for life-assurance purposes.

According to a statement issued by the LOA yesterday, standard medical examinations, for which Masa demanded an increase of 77%, comprise about 75% of all work done for life assurers by the medical profession.

In return, Masa offered to reduce the fees for certain specialist investigations.

As a result of the failure of negotiations, the LOA has issued its own tariff of fees effective from January 1 this year and member companies have agreed not to pay more than the recommended fee.

Masa has in turn published its own set of fees, recommending that life assurers be charged R80 for a basic medical examination while private patients are charged R48 and medical-aid schemes pay R21,15 for similar examinations.

Compared to these fees, the LOA has offered to pay R55,10 for a basic medical examination.

"Despite repeated requests to Masa for justification of the large increase in medical fees and for an explanation why life assurers should pay so much more than everybody else, this has not been forthcoming," said the chairman of LOA, Mr Dorian Wharton-Hood, in the statement. "We therefore have no choice but to make our position clear."

Chairman of the Cape Western Branch of Masa, Dr John Steer, said in an interview yesterday that doctors were entitled to charge less than the Masa rate if they wanted to. — Staff Reporter and Sapa

Children in need

NINETEEN Kagiso children, who have been attending schools for the disabled in Soweto, are unable to continue their schooling due to transport problems.

Mr Peter Mabusa, chairman of the Itsoseng People's Organisation, explained that their minibus would only be available in March, and has appealed to the community for help.

Mabusa can be contacted at 410-1501.

Home medicine could cut down medical costs

Sowetan 23/2/90

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Sowetan Correspondent

SELF-MEDICATION can contribute greatly towards containing spiralling medical costs and lessening the burden on overworked doctors.

The director-general of National Health and Population Development, Dr Coen Slabber, said at a responsible self-medication seminar at the CSIR self-medication could be encouraged by providing selected drugs with standardised labels and informative inserts.

The inserts should include indications for use, recommended dosages, and warnings regarding possible drug interactions.

However, he stressed that while self-medication should be encouraged every attempt should be made to protect the public against any unacceptable risks it might entail.

Self-medication preparations should provide quick and effective relief from symptoms that did not require a medical consultation, reduce increasing pressure on medical services for the relief of minor symptoms and increase the availability of health care to the rural population.

Slabber said guidelines should be developed and adapted to ensure careful selection of self-medication drugs to be sold without prescriptions. The criteria for selection of these drugs should include effectiveness, a cost factor and the evidence of a wide safety margin.

Health education was central to the safe and effective use of drugs and should be developed as an integral part of drug policy in South Africa. It should include education in the basic concept of drug usage and information on specific treatments, said Slabber.

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tee that

SA health-care policy 'stresses' self-medication

GERALD REILLY

PRETORIA — SA's national health policy stressed the importance of self-care and self-medication, Health and Population Development director-general C F Slabber said here yesterday.

Speaking at a Proprietary Association of SA (Pasa) symposium at the CSIR, he said self-medication could play an important role in containinmg spiralling medical costs.

According to a study by the University of the Witwatersrand economic research group, 60% of the population studied suffered from some non-chronic complaint or combination of complaints.

The study endorsed that self-medication was widely practised.

Slabber said for more than a decade there had been intense concern over rapidly rising expenditure for medical care and health services. Main reasons for the escalating costs were a dramatic rise in the number of people living beyond 65, and the rapid proliferation of new diagnostic and therapeutic measures.

He stressed the need for resources to be used optimally and the need for accessibility to primary health services for all South Africans. BIDM 23/2/90

TANIA LEVY reports that medical scheme members will spend at least R3bn on medicines this year — the largest single expense item on claims.

Affiliated Medical Associations chairman Tony Leveton, speaking at the same conference, said spending on medicines accounted for about 36% of all claims made by members.

Despite identical benefits, the actual cost and use of medicines through dispensing doctors and pharmacists differed among the various population groups.

Black members obtained nearly 74% of medicines claimed from dispensing doctors, while pharmacists supplied 66% of medicines claimed by white and Asian members.

Leveton said responsible self-medication could play a significant role in reducing health costs in SA.

Advertising

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Deregulation had to take place at the professional level to encourage cost awareness at consumer level, he said.

The sale of medicines needed to take place in a more competitive environment. Advertsing had to be permitted and pharmacists had to be free to decide their own mark-up.

The Medical Scheme's Act would have to be relaxed to allow incentives for self-medication.

He said reward structures had to be devised not only to provide health professionals with an income but also to make sure they earned it by practising cost-effective medicine.

Strategy for health service being created

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CAPE TOWN — The National Health Policy Council was at present developing a total strategy for health services in SA through which it was hoped to eliminate problems and arrive at a more cost effective system, National Health Minister Rina Venter said yesterday.

She was replying in Second Reading debate on the Associated Health Service Professions Bill to a question from Peter Mopp (LP Border).

He asked whether she had considered recommending to the Cabinet that the "wasteful" own affairs system be abolished in health services and if she had not considered doing so, would she?

Dr Venter said more would be heard on the Council's investigation later.

She also said not enough attention had been given and recognition accorded to the role which the traditional midwife and healer played. Sapa

Regulated 23/2/90

"These health workers certainly need more attention because they enjoy wide recognition and support among a substantial part of our population, particularly those who lack access to conventional health services and facilities."

The professions which were regulated by the Associated Health Service Professions Act thus had an important role to play.

Negotiations in which the nature and extent of their involvement would be discussed had already been arranged.

In written reply to questions by Mike Ellis (DP Durban North) she said provincial hospitals had lost 3 528 registered nurses in 1989 due to resignations.

Health authorities had received 41 875 applications by trainee nurses for 2 511 vacancies in 1988, with 2 729 being accepted and 1 579 completing their training, she said. — Sapa.

Medical aid fiasco gets sorted out for workers

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City Press 25/2/90

MORE than three dozen employees of KwaQuqa Town Council near Witbank complained to *City Press* about the Bonitas medical aid scheme.

"We were forced to join this scheme, but we get no benefits," they said.

"We have never received membership cards. We pay membership fees every month but if we are sick we have to pay out of our own pockets.

"When we complained to the council, we were told the council was not eating our money and that Bonitas were crooks. We don't know how to get our membership cards or our money back."

City Press referred their complaint to Bonitas, who took it up with the KwaQuqa Council. A spokesman for Bonitas explained that it was standard procedure for the employer to contact Bonitas if any employees had problems.

Bonitas has promised to honour all claims the men should have been able to make.

Guard your heart

Doctors suspect that city living promotes cardiac failure

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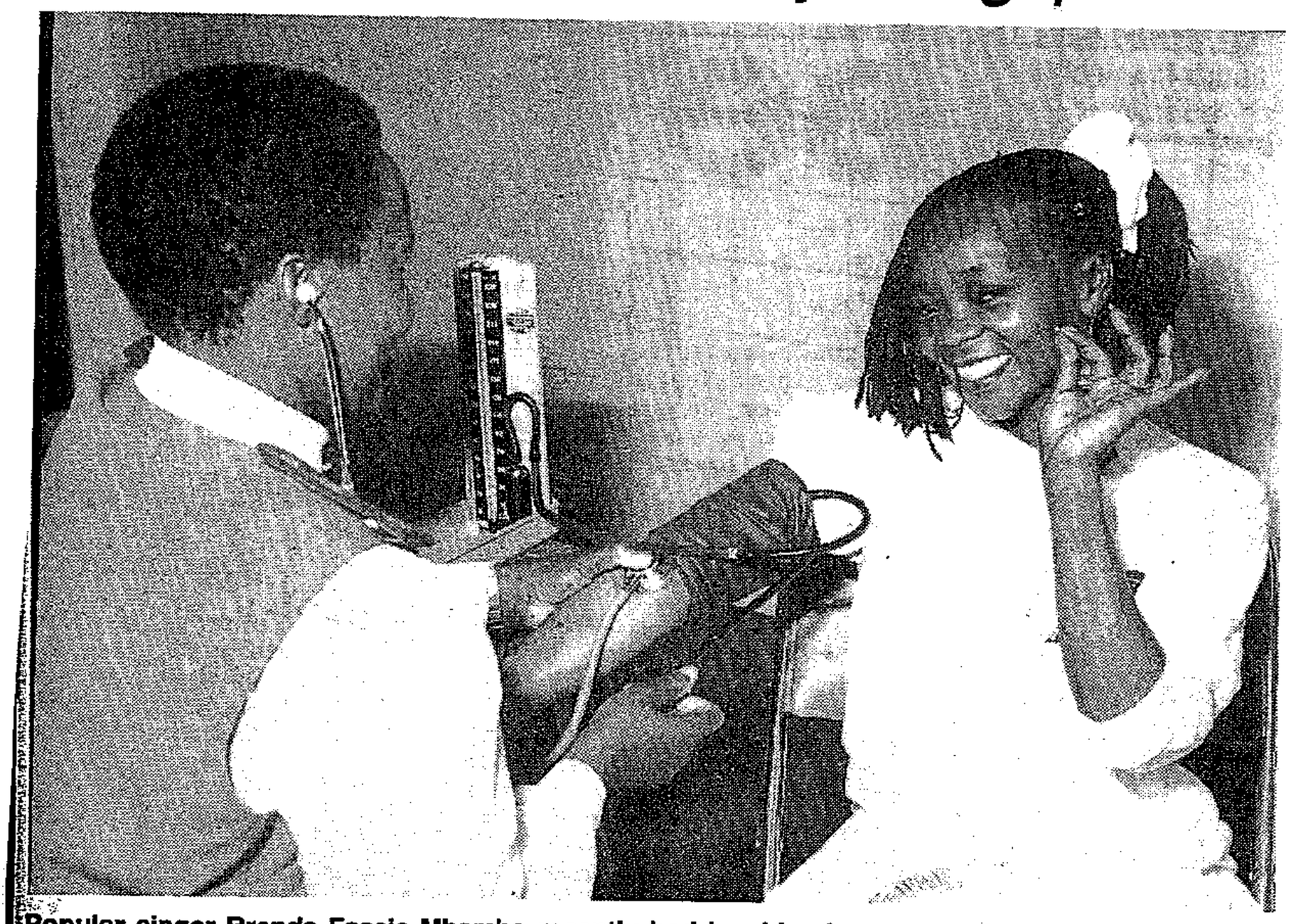

Popular singer Brenda Fassie Mbambo recently had her blood pressure checked as part of the MRC's heart attack risk study, to be conducted in the Western Cape.

THE Medical Research Council and the University of Cape Town are to initiate a study to determine the potential for heart disease among the urban black population of the Western Cape.

This study, at first on a home-to-home basis, will test a trend noticed by doctors in big city hospitals that migration to the cities has exposed people to a lifestyle conducive to heart attacks.

Diets may change, resulting in an increase of fats in the bloodstream, and elevated blood pressure levels. Smoking rates are also rising, and all these factors could lead to early heart attacks.

South Africa's high rate

South Africa has one of the highest rates of heart attacks with about 12 000 people dying from cardiac failure annually.

A senior researcher at the MRC, Dr Krisela Steyn, said it was important to examine the risk factors preceding heart attacks. She said the study would involve about 1 600 people, selected on a scientific basis. Steyn said fieldworkers had been trained at the MRC to assist with the project.

"Blood pressure will be measured and a blood sample taken. Participants will be required to complete a questionnaire, which will determine the presence of risk factors, for example, smoking," she said..

Steyn has appealed to the community to support the project.

(3) (a) Yes.

(b) J S Slabber—Services temporarily utilized at Area Office.
L Redelinghuys—Transferred to Good Hope College.
G M W Visser—Services utilized at the Umzingisi Special School.
P H de Wet—Transferred to Head Office.
C S Kelly—On sick leave pending application for early retirement due to ill health.
J J Schutte—Transferred to Head Office.
H S J Coetzee—Services temporarily utilized at Area Office.
W Slabbert—Services temporarily utilized at Area Office.
C W van der Vyver—Services temporarily utilized at Area Office.

Harms Commission: investigators

*13. Mr D J DALLING asked the Minister of Justice:

Whether, with reference to his statement on 7 February 1990, a team of investigators to be put at the disposal of the Harms Commission has been appointed; if so, (a) what are the names of the persons involved, (b) what are their qualifications and (c) by whom are they employed at present? B338E

The MINISTER OF JUSTICE:

Yes.

(a) (i) Advocate T P McNally, SC.

(ii) Advocate L J Roberts, SC.

(iii) Major-General R N van der Westhuizen.

(iv) Lieutenant-Colonel J P Wright.

(b) (i) Advocate McNally is the Attorney-General of the Orange Free State and has been eonrolled as an advocate of the Supreme Court of South Africa.

(ii) Advocate Roberts is a Deputy Attorney-General of Natal and has been enrolled as an advocate of the Supreme Court of South Africa.

(iii) Major-General Van der Westhuizen is a member of the Detective Branch at the Head Office of the South African Police.

(iv) Lieutenant-Colonel Wright is a member of the Detective Branch at the Head Office of the South African Police.

(c) Advocates McNally and Roberts are employed by the Department of Justice while Major-General Van der Westhuizen and Lieutenant-Colonel Wright are employed by the South African Police.

Lead concentration exceeded

*14. Mr R F HASWELL asked the Minister of National Health and Population Development:

Whether the maximum allowable concentration of lead in the atmosphere, as specified in the reply to Question No 506 on 26 May 1989, was exceeded in Cape Town on any day in 1989; if so, on how many days? B339E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

No, the concentration was never exceeded during 1989.

Hout Bay: development of harbour area

*15. Mr C W EGLIN asked the Minister of Planning and Provincial Affairs:

(1) Whether any progress has been made with the plans for the development of the harbour area at Hout Bay; if not, why not; if so, when will the plans be finalized;

(2) whether, in considering these plans, his Department or the Cape Provincial Administration has commissioned an environmental impact study relating to such development; if so who undertook the study;

(3) whether this environmental impact study will be made public; if not, why not; if so, when;

(4) whether his Department or the Administration has discussed the plans for the proposed development with representatives of the local community; if not, why not; if so, (a) with what representatives and (b) when? B340E

The MINISTER OF PLANNING AND PROVINCIAL AFFAIRS:

(1) Major developers were asked to submit sketch plans for the development of part of the harbour at Hout Bay for purposes of tourism. Two groups of developers came to the fore, and the preliminary plans of these two groups are at present with the Provincial Executive Committee for a decision and the appointment of one of them. Subsequently the successful developer will be asked to submit full architectural plans, which, if necessary, will be subjected to an environmental impact study.

(2) Falls away.

(3) Falls away.

(4) No, because there are as yet no final plans which can be discussed with the local community. The final plans will be open to inspection by interested parties.

Mr C W EGLIN: Mr Speaker, arising out of the hon the Minister's reply, may I take it that although they are called "final", the plans will not actually be finally formalised until an impact study has been done and approved and until the local residents have been consulted and have made their input?

The MINISTER: Mr Speaker, what is happening at the moment is that two different plans are being evaluated. One of these developers will then be asked to present architectural plans, as they are rather expensive items. Once they have been received, those plans will be submitted to the local community for their input and comment.

Brown's Farm: housing

*16. Mr J VAN ECK asked the Minister of Planning and Provincial Affairs:

(1) How many persons will Brown's Farm be able to accommodate after it has been developed;

(2) whether any other land has been allocated for those persons who were forced to leave the Crossroads area in 1986 and cannot be accommodated on Brown's Farm; if not, why not; if so, what land? B341E

The MINISTER OF PLANNING AND PROVINCIAL AFFAIRS:

(1) The assumption is made that the 218 ha development area at Philippi is at question. A total of 5 036 erven is to be developed, and at a family size of 6 the estimated number of people is in the order of 30 000.

(2) No. Current indications are that the development area will be sufficient for *inter alia* the particular category of people.

Business interrupted in accordance with Rule 180C (3) of the Standing Rules of Parliament.

Cape Town railway station: certain police officer present

*17. Mr J VAN ECK asked the Minister of Law and Order:

(1) Whether a certain police officer, whose name has been furnished to the South African Police for the purpose of the Minister's reply, was present on the third-class concourse of the Cape Town railway station on the afternoon of 31 January 1990; if so, why;

(2) whether this officer or any policemen under his control took any action there; if so, what action;

(3) whether he will make a statement on the matter? B342E

The MINISTER OF LAW AND ORDER:

(1) Yes. The officer was in charge of a group of policemen who were performing duty on the station.

(2) No.

(3) No.

Tartrazine (299)

*18. Mr M J ELLIS asked the Minister of National Health and Population Development:

Whether her Department has received any representations regarding the use of tartrazine in foodstuffs during the past five years; if so, (a) from whom, (b) when, and (c) what was the (i) purport of and (ii) response to these representations, in each case? B343E

(3) (a) Yes.

(b) J S Slabber—Services temporarily utilized at Area Office.
L Redelinghuys—Transferred to Good Hope College.
G M W Visser—Services utilized at the Umzingisi Special School.
P H de Wet—Transferred to Head Office.
C S Kelly—On sick leave pending application for early retirement due to ill health.
J J Schutte—Transferred to Head Office.
H S J Coetzee—Services temporarily utilized at Area Office.
W Slabbert—Services temporarily utilized at Area Office.
C W van der Vyver—Services temporarily utilized at Area Office.

Harms Commission: investigators

*13. Mr D J DALLING asked the Minister of Justice:

Whether, with reference to his statement on 7 February 1990, a team of investigators to be put at the disposal of the Harms Commission has been appointed; if so, (a) what are the names of the persons involved, (b) what are their qualifications and (c) by whom are they employed at present? B338E

The MINISTER OF JUSTICE:

Yes.

(a) (i) Advocate T P McNally, SC.

(ii) Advocate L J Roberts, SC.

(iii) Major-General R N van der Westhuizen.

(iv) Lieutenant-Colonel J P Wright.

(b) (i) Advocate McNally is the Attorney-General of the Orange Free State and has been eonrolled as an advocate of the Supreme Court of South Africa.

(ii) Advocate Roberts is a Deputy Attorney-General of Natal and has been enrolled as an advocate of the Supreme Court of South Africa.

(iii) Major-General Van der Westhuizen is a member of the Detective Branch at the Head Office of the South African Police.

(iv) Lieutenant-Colonel Wright is a member of the Detective Branch at the Head Office of the South African Police.

(c) Advocates McNally and Roberts are employed by the Department of Justice while Major-General Van der Westhuizen and Lieutenant-Colonel Wright are employed by the South African Police.

Lead concentration exceeded

*14. Mr R F HASWELL asked the Minister of National Health and Population Development:

Whether the maximum allowable concentration of lead in the atmosphere, as specified in the reply to Question No 506 on 26 May 1989, was exceeded in Cape Town on any day in 1989; if so, on how many days? B339E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

No, the concentration was never exceeded during 1989.

Hout Bay: development of harbour area

*15. Mr C W EGLIN asked the Minister of Planning and Provincial Affairs:

(1) Whether any progress has been made with the plans for the development of the harbour area at Hout Bay; if not, why not; if so, when will the plans be finalized;

(2) whether, in considering these plans, his Department or the Cape Provincial Administration has commissioned an environmental impact study relating to such development; if so who undertook the study;

(3) whether this environmental impact study will be made public; if not, why not; if so, when;

(4) whether his Department or the Administration has discussed the plans for the proposed development with representatives of the local community; if not, why not; if so, (a) with what representatives and (b) when? B340E

The MINISTER OF PLANNING AND PROVINCIAL AFFAIRS:

(1) Major developers were asked to submit sketch plans for the development of part of the harbour at Hout Bay for purposes of tourism. Two groups of developers came to the fore, and the preliminary plans of these two groups are at present with the Provincial Executive Committee for a decision and the appointment of one of them. Subsequently the successful developer will be asked to submit full architectural plans, which, if necessary, will be subjected to an environmental impact study.

(2) Falls away.

(3) Falls away.

(4) No, because there are as yet no final plans which can be discussed with the local community. The final plans will be open to inspection by interested parties.

Mr C W EGLIN: Mr Speaker, arising out of the hon the Minister's reply, may I take it that although they are called "final", the plans will not actually be finally formalised until an impact study has been done and approved and until the local residents have been consulted and have made their input?

The MINISTER: Mr Speaker, what is happening at the moment is that two different plans are being evaluated. One of these developers will then be asked to present architectural plans, as they are rather expensive items. Once they have been received, those plans will be submitted to the local community for their input and comment.

Brown's Farm: housing

*16. Mr J VAN ECK asked the Minister of Planning and Provincial Affairs:

(1) How many persons will Brown's Farm be able to accommodate after it has been developed;

(2) whether any other land has been allocated for those persons who were forced to leave the Crossroads area in 1986 and cannot be accommodated on Brown's Farm; if not, why not; if so, what land? B341E

The MINISTER OF PLANNING AND PROVINCIAL AFFAIRS:

(1) The assumption is made that the 218 ha development area at Philippi is at question. A total of 5 036 erven is to be developed, and at a family size of 6 the estimated number of people is in the order of 30 000.

(2) No. Current indications are that the development area will be sufficient for *inter alia* the particular category of people.

Business interrupted in accordance with Rule 180C (3) of the Standing Rules of Parliament.

Cape Town railway station: certain police officer present

*17. Mr J VAN ECK asked the Minister of Law and Order:

(1) Whether a certain police officer, whose name has been furnished to the South African Police for the purpose of the Minister's reply, was present on the third-class concourse of the Cape Town railway station on the afternoon of 31 January 1990; if so, why;

(2) whether this officer or any policemen under his control took any action there; if so, what action;

(3) whether he will make a statement on the matter? B342E

The MINISTER OF LAW AND ORDER:

(1) Yes. The officer was in charge of a group of policemen who were performing duty on the station.

(2) No.

(3) No.

Tartrazine

*18. Mr M J ELLIS asked the Minister of National Health and Population Development:

Whether her Department has received any representations regarding the use of tartrazine in foodstuffs during the past five years; if so, (a) from whom, (b) when, and (c) what was the (i) purport of and (ii) response to these representations, in each case? B343E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

Yes, Hansard 6/3/90

(a) seven members of public and one member of Parliament,

(b) from 11 June 1987 to 5 July 1989. Unfortunately information is only available as to the past three years,

(c) (i) in general, representations were based on people's fear of tartrazine. Requests were made for either the banning of this colourant or stricter control over the use thereof in foods,

299

(ii) as tartrazine is a substance which is harmful, to certain individuals only, a regulation has been published in terms of section 15(1) of the Foodstuffs, Cosmetics and Disinfectants Act, 1972 in Government Notice no. R908 of 1977 as revised by Government Notice no. R2298 dated 26 October 1984. This regulation prohibits the sale of any foodstuff containing the colourant TARTRAZINE C.I. no. 19140 unless the word "tartrazine" appears in the list of ingredients in letters not less than 2 mm in height.

Hydroquinone

*19. Mr M J ELLIS asked the Minister of National Health and Population Development:

What steps have been taken with a view to implementing the banning of the manufacture and importation of products containing hydroquinone, as announced in the reply to Question No 8 on 21 February 1989?

Hansard 6/3/90 B344E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

Government Notice R1227, published in the Government Gazette dated 24 June 1988, prohibits the use of hydroquinone in cosmetics as from 1 January 1991.

However, I am considering advancing the date of this prohibition.

Seaweed: permit for certain company

*20. Mr E K MOORCROFT asked the Minister of Environment Affairs:

Hansard 6/3/90

HOUSE OF ASSEMBLY

(1) Whether a certain company, the name of which has been furnished to the Minister's Department for the purpose of his reply, has been granted a permit to gather seaweed off the east coast of South Africa; if so, (a) who granted this permit and (b)(i) when and (ii) subject to what conditions or specifications was it granted; Hansard 6/3/90

(2) whether his Department monitors the gathering of seaweed by this company; if not, why not; if so,

(3) whether the gathering of seaweed by this company has in any way affected the local environment; if so, in what ways?

B345E

The MINISTER OF ENVIRONMENT AFFAIRS:

(1) Yes

(a) Minister of Environment Affairs, Mr G J Kotzé, MP

(b) (i) 1 November 1988

(ii) The Permit Conditions are:

1. The Permitholder shall be a member of the South African Concessionaires' Association (SASCA).

2. This permit shall be subject to the following fees, payable to the Department of Environment Affairs, Private Bag X2, Rogge Bay, 8012 (the 'Department'):

(a) Annual permit fee of R1 500,00 per concession area payable in advance; and

(b) A levy of R4,00 per ton (dry mass) of all seaweed collected/harvested, shall be *payable before or on the 15th day of May each year*, and thereafter at *six-monthly intervals*. The levy shall be submitted together with an appropriately completed levy form V1/13/5/1L. Should payment not reach the Department of Environment Affairs before or on due date, interest at the standard rates for Government loans and advances shall be payable from the due date to the date of receipt.

3. Should the Permitholder fail to pay the annual permit fee and/or levies as prescribed in clause B3 above by due dates and still fail to pay such fees within 30 days after payment has been demanded in writing by the Department of Environment Affairs, the Minister of Environment Affairs and of Water Affairs (the 'Minister') may cancel this permit without further notice, and the Permitholder shall be liable for all fees plus interest due in terms of this permit.

4. The Permitholder shall, on the prescribed form V1/13/5/1E, furnish monthly to the Chief Directorate: Sea Fisheries, Private Bag X2, Rogge Bay, 8012, the details specified.

5. Notwithstanding anything to the contrary contained herein, the Minister may at any stage during the period of validity of this permit amend or supplement the conditions contained therein, or withdraw and cancel the permit in its entirety, by giving notice of his intention to do so and his reasons therefor, in a prepaid registered letter addressed to the *domicilium citandi et executandi* of the Permitholder, in which case, the Permitholder shall be entitled to a *pro rata* refund of the permit fee.

6. Subject to review, this permit may be extended:

(a) for two further periods of five (5) years each, or

(b) indefinitely, should the Minister be satisfied that the Permitholder processes locally. *To qualify as a local secondary processor a Permitholder shall within the Republic of South Africa convert to final consumer-use a substantial proportion of raw material it handles.*

7. The Permitholder may surrender the permit by giving six (6) months' written notice to the Department of Environment Affairs, in which case the Permitholder shall be entitled to a *pro rata* refund of the permit fee.

8. This permit is not transferable.

9. The Permitholder indemnifies the State against all expenses, losses, actions and claims, including claims for damages, injuries to persons or damage to property and all costs between attorney and client which the State may be adjudged or obliged to pay, arising directly or indirectly from any action which may be taken by any person(s) as a result of the granting of this permit, or as a result of any act performed by the Permitholder, its employees, contractors or customers, on the said land pursuant to the permit. The Permitholder shall be held responsible for any contravention its contractor(s) may commit while in its employ.

10. The Permitholder may at any time apply in writing to the Department for permission to collect/harest seaweeds excluded from this permit.

11. Nothing contained in this permit shall detract from the powers conferred on the Minister and the State President by Sections 4, 5 and 10 of the Seashore Act, 1935 (Act 21 of 1935), in relation to third parties.

12. Seaweeds shall be collected/harvested only by collectors in the employment of the Permitholder or of its accredited representative(s) or contractor(s).

13. Seaweeds shall be harvested by hand-plucking or such other method(s) as is/are prescribed by the Department.

14. The Permitholder shall ensure that its employees, while engaged in collecing/harvesting operations:

(a) shall, as soon as possible, remove and return to the sea all limpets accidentally included with the collected/harvested seaweed;

(b) do not collect any shellfish;

(c) do not create a public nuisance whether by reason of unacceptable noise, smell, or anything likely to endanger public health;

(d) shall comply with all regulations relating to public health;

(e) shall make use of authorised and satisfactory sanitary facilities that shall, if necessary, be provided by the Permitholder where appropriate;

(f) are distinctively dressed so as to be readily identifiable;

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

Yes, Hansard 6/3/90

(a) seven members of public and one member of Parliament,

(b) from 11 June 1987 to 5 July 1989. Unfortunately information is only available as to the past three years,

(c) (i) in general, representations were based on people's fear of tartrazine. Requests were made for either the banning of this colourant or stricter control over the use thereof in foods,

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Hansard 6/3/90 B344E

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(f) are distinctively dressed so as to be readily identifiable;

(299)

Angel of the handicapped

Woman of the Week

AUDREY MABOYA

AUDREY Maboya (34) is supposedly still very young to have immersed herself in community work, but she believes one is never too young to help one's fellow beings.

She left her teaching post at a local high school in 1988 to head Phelang, a school for the mentally handicapped in Kwa Thema. Puzzled friends wondered if she understood what the implications of the decision meant. She ignored them because she had already set her heart on it.

"To a certain extent, I did not understand the implications. But I was so determined to work with the children that when problems cropped up, I took them in my stride," Maboya said.

She said her greatest challenge was to break the ostracism of handicapped people by going into the community and creating awareness on what the school was about.

"It is very difficult to explain to people that schools for mentally handicapped children are not asylums. I addressed organisations, councillors and other sectors in the community.

"It is important that people know about these schools because the schools rely, on the community for their livelihood. They are not fully funded by the State as they are said to be community-based, whereas normal schools are.

"The State only gives us a certain percentage of our total running costs as a subsidy and we have to go to the very community that knows little about us to ask for the outstanding amount," she said.

Through her talks this Wattvillle Benoni, mother of one child, has gained immense support from business people, clubs and organisations in kwaThema, Springs, where the school is based.

They donate money and clothes to the school and volunteer their services when needed.

Educating people on, among other things, why her school should ask donations from them, Maboya was also faced with the task of getting used to the family instead of the child-orientated concept of the school system.

When children suffer neglect or have problems at home, it is her duty to investigate the cause and help find solutions.

Phelang, whose buildings are coming up next to the prefabricated structures that house the school now, has a roll of 101 pupils aged between 6 and 29.

The children are grouped according to their mental age into four categories: senior, middle, junior and infant - which Maboya occasionally tutors.

They are taught basics in education and socialisation. They also do handcrafts and have produced wall-hangings, mats and candles.

Maboya's relationship with her pupils is very fulfilling. At first , she said, they kept away from her as they do with all strangers.

"But now we have struck a very rewarding relationship. They are a very loving lot. They are also honest and truthful. They have no inhibitions. I often laugh at their forthrightness. They say what they feel, raw, without any censorship. I find their truthfulness very fascinating. I often tell people that these children are not abnormal, that they are more normal than the normal," she said.

The school does not discharge any of its pupils even though the State says that they should leave when they are 18. Children who are over age, Maboya said, would be employed in the protective workshops that the new school would have.

Pupils will be trained by some of the graduands of the skills training scheme that the school is going to start soon for unemployed people.

Sowetan Woman appeals to readers to write to Box 6663, Johannesburg 2000 with the names of women who have made major contributions to the wellbeing of their communities but have not received any recognition.

would geographically speaking be part of Lesotho should the normal contour of the mountain be followed as the international border as proposed by Lesotho. In terms of the above-mentioned agreement the triangle has always been RSA territory.

(b) The difference of opinion will again receive attention as soon as talks can be held with the new Minister of Foreign Affairs of Lesotho to discuss the matter.

(c) The following steps have already been taken or are now envisaged:

(i) On 30 June 1989 a Joint Commission of Enquiry visited the area. After completion of the enquiry the officials involved in the Commission came to the conclusion that the matter would have to be resolved at Government level. Lesotho consequently requested that the matter be referred to me and Colonel Thaabe Letsie of the Military Council of Lesotho for consideration.

(ii) The Department of Foreign Affairs has on various occasions since then tried to further the discussions.

(iii) At the beginning of 1990 it was once again suggested that a meeting be arranged in Lesotho as soon as possible after the opening of the RSA parliament. In February it was proposed to Lesotho that the Deputy Minister of Foreign Affairs visit Lesotho for this purpose on 26 or 28 March 1990. Because of the changes in the Military and Ministers' Councils of Lesotho soon afterwards and specifically the retirement of Colonel Thaabe Letsie as Minister of Foreign Affairs, Lesotho's reaction is at present being awaited as to when a meeting with the

new Minister of Foreign Affairs can take place.

(2) Falls away.

Compulsory transferable pension scheme

*11. Mrs C H CHARLEWOOD asked the Minister of National Health and Population Development:

Whether any consideration has been given to the establishment of a compulsory transferable pension scheme; if so, (a) what consideration, (b) when and (c) with what result; if not, why not? B422E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

Yes,

(a) the matter was investigated by various committees over a number of years,

(b) over the period as from December 1964 to February 1987,

(c) no positive results could be achieved because of opposition to such a scheme from various bodies and/or organisations.

Distribution of free condoms

*12. Mrs C H CHARLEWOOD asked the Minister of National Health and Population Development:

(1) Whether funds are allocated by the State for the distribution of free condoms; if not, why not; if so, what funds;

(2) whether there are any (a) surcharges and/or (b) duties on imported condoms; if so, what surcharges and/or duties;

(3) whether, in view of the increasing number of cases of Aids, she will take steps to have such surcharges and/or duties withdrawn; if so, (a) what steps and (b) when; if not, why not? B423E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) Yes, for the purchase of 21 000 000 condoms.

(2) (a) and (b) yes,
— surcharge: 20%
— import duties: 25%

— general sales tax: 13%
— provincial handling fee: 8%

(3) (a) and (b) yes, the matter has already been discussed with the State Tender Board and with Customs and Excise of the Department of Finance, but is to be placed on the agenda for discussion again.

Robben Island: prisoners on hunger strike

*13. Mr A J LEON asked the Minister of Justice:

Whether any prisoners held on Robben Island have been on a hunger strike since 1 January 1990; if so, (a) how many prisoners are involved, (b) when did they (i) start and (ii) end their hunger strike, (c) what were the stated reasons for the hunger strike and (d) what action was taken by the authorities to end it? B424E

The MINISTER OF JUSTICE:

Yes.

(a) The numbers varied from 303 to 344.

(b) (i) 26 February 1990.

(ii) 8 March 1990.

(c) The prisoners offered a large number of complaints and demands as reasons for the hunger strike. These varied from complaints about privileges and classification to demands for release.

(d) The authorities acted consistently in terms of internationally accepted practices. These varied from the application of the Declaration of Tokyo to discussions and my request to the acting Judge-President of the Supreme Court of the Cape of Good Hope. The Honourable Judge M R de Kock, to deal with the complaints of the concerned prisoners. Judge De Kock's report has now been received and is presently being studied. I also refer the honourable member to a press statement issued by my office last night.

Black pupils: technical education

*14. Mr K M ANDREW asked the Minister of Education:

Whether his Department provides technical education for Black pupils at secondary school level; if not, why not; if so, (a) what technical education, (b) where, (c) how many pupils can be catered for and (d) how many pupils are enrolled for technical education at secondary school level? B425E

The MINISTER OF EDUCATION:

(a) Education for the technical field of study. Pupils who follow the technical field of study have to take Technical Drawing as well as at least one technical subject (Woodworking, Welding and Metalwork, Electrician work, Electronics, Fitting and Turning, Motor Mechanics, Motor Body Repairing, Plumbing and Sheeting Metalworking, Bricklaying and Plastering).

(b) At comprehensive schools countrywide located in the different regions as follows:

Diamond Fields	2
Highveld	15
Johannesburg	12
Cape	7
Natal	2
Northern Transvaal	3
Orange-Vaal	4
Orange Free State	4

(c) Workshops are designed to accommodate 100 pupils per field of study. With the existing facilities technical education can be provided to approximately 22 500 pupils at 49 schools.

(d) 9 313 pupils in Std 6–10.

Registrar of Reporting Organizations

*15. Mr D J DALLING asked the Minister of Justice:

(1) Whether he has appointed a Registrar of Reporting Organizations and Persons in terms of section 2 of the Disclosure of Foreign Funding Act, No 26 of 1989; if so, what (a) is his name and (b) are his qualifications;

(2) whether the Registrar of Reporting Organizations and Persons has submitted a report in terms of section 7(1) of the said Act; if not, (a) why not and (b) when is it anticipated that the report will be completed? B426E

would geographically speaking be part of Lesotho should the normal contour of the mountain be followed as the international border as proposed by Lesotho. In terms of the abovementioned agreement the triangle has always been RSA territory.

(b) The difference of opinion will again receive attention as soon as talks can be held with the new Minister of Foreign Affairs of Lesotho to discuss the matter.

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— general sales tax: 13%
— provincial handling fee: 8%

(3) (a) and (b) yes, the matter has already been discussed with the State Tender Board and with Customs and Excise of the Department of Finance, but is to be placed on the agenda for discussion again.

Robben Island: prisoners on hunger strike

*13. Mr A J LEON asked the Minister of Justice:

Whether any prisoners held on Robben Island have been on a hunger strike since 1 January 1990; if so, (a) how many prisoners are involved, (b) when did they (i) start and (ii) end their hunger strike, (c) what were the stated reasons for the hunger strike and (d) what action was taken by the authorities to end it? B424E

The MINISTER OF JUSTICE:

Yes.

(a) The numbers varied from 303 to 344.

(b) (i) 26 February 1990.

(ii) 8 March 1990.

(c) The prisoners offered a large number of complaints and demands as reasons for the hunger strike. These varied from complaints about privileges and classification to demands for release.

(d) The authorities acted consistently in terms of internationally accepted practices. These varied from the application of the Declaration of Tokyo to discussions and my request to the acting Judge-President of the Supreme Court of the Cape of Good Hope, The Honourable Judge M R de Kock, to deal with the complaints of the concerned prisoners. Judge De Kock's report has now been received and is presently being studied. I also refer the honourable member to a press statement issued by my office last night.

Black pupils: technical education

*14. Mr K M ANDREW asked the Minister of Education:

Whether his Department provides technical education for Black pupils at secondary school level; if not, why not; if so, (a) what technical education, (b) where, (c) how many pupils can be catered for and (d) how many pupils are enrolled for technical education at secondary school level? B425E

The MINISTER OF EDUCATION:

(a) Education for the technical field of study. Pupils who follow the technical field of study have to take Technical Drawing as well as at least one technical subject (Woodworking, Welding and Metalwork, Electrician work, Welding, Electronics, Fitting and Turning, Motor Mechanics, Motor Body Repairing, Plumbing and Sheeting Metalworking, Bricklaying and Plastering).

(b) At comprehensive schools countrywide located in the different regions as follows:

Diamond Fields	2
Highveld	15
Johannesburg	12
Cape	7
Natal	2
Northern Transvaal	3
Orange-Vaal	4
Orange Free State	4

(c) Workshops are designed to accommodate 100 pupils per field of study. With the existing facilities technical education can be provided to approximately 22 500 pupils at 49 schools.

(d) 9 313 pupils in Std 6–10.

Registrar of Reporting Organizations

*15. Mr D J DALLING asked the Minister of Justice:

(1) Whether he has appointed a Registrar of Reporting Organizations and Persons in terms of section 2 of the Disclosure of Foreign Funding Act, No 26 of 1989; if so, what (a) is his name and (b) are his qualifications;

(2) whether the Registrar of Reporting Organizations and Persons has submitted a report in terms of section 7(1) of the said Act; if not, (a) why not and (b) when is it anticipated that the report will be completed? B426E

Laws must shield the disabled, says Rowland

WOMAN

299

By SIZAKELE KOOMA

LAWS preventing discrimination against disabled people would alleviate their serious unemployment problem, a seminar on the disabled was told last week.

Chairman of Disabled People of South Africa, Dr William Rowland, said at a Johannesburg seminar organised by the Women's Bureau of South Africa that the unemployment rate of disabled people was double that of 'normal' people and the disparity was mainly prejudicial.

He said most companies did not employ disabled people because of the general impression that the disabled were always asking for something and had nothing to offer.

Trade unions, except for the National Union of Mineworkers, were also uninterested in disabled people or had not adopted policies that accommodate them, he said.

"The employment of disabled people is a matter of human rights to be secured by law," Rowland told the seminar.

Avoided

"Disabled persons have the right to economic and social security and to a decent standard of living. They have the right, according to their capabilities, to secure and retain employment or to engage in a useful, productive and remunerative occupation and to join trade unions."

South African employers, he said, avoided hiring anyone who lowered productivity and organised labour resisted the employment of anyone who reduced bargaining power.

Consequently, disabled people, perceived to be unproductive and difficult to integrate into the workforce, found themselves thrown upon the goodwill of employers and fellow workers. Goodwill was not sufficient to guarantee a fair proportion of jobs for disabled people, he said.

A research project carried out on 3 000 companies by the University of Potchefstroom, he said, revealed that 55 percent of the companies which responded employed no disabled people. In general there was one disabled person for every 386 workers.

Rowland said that legislation on its own would not reverse the negative siatuation.

"Positive discrimination such as diversified training, professional employment services, intensive placement techniques, appropropriate technology, public education, rights advocacy, trade union agreements and labour codes are necessary to achieve the essential breakthrough," he said.

Chairman of Disabled People of South Africa Dr William Rowland, who is blind.

Health spending goes up to R7bn

299 MIKE ROBERTSON

CAPE TOWN — Total government spending on health has been raised by 8% to R7bn in this year's Budget.

Finance Minister Barend du Plessis announced yesterday that health expenditure amounted to 9,8% of total expenditure for 1990/91.

He said that by international standrads the level of government expenditure on health services in relation to the level of development in SA was already significant, in spite of the fact that large backlogs still existed. BIDA 15/3/90

Du Plessis said that from the point of view of affordability attention should be given not only to the level at which health services were to be rendered in future, but also the structural nature of the services. In future greater emphasis would be placed on preventative rather than curative health services.

Progress had been made in the urgent investigation into the improvement of health services which formed part of the broader process of structural adjustment in the socio-economic sphere, he said.

Soweten 9/4/90

FRIDAY MAVUSO

Disabled say 'no' to killings

THE Disabled People of South Africa will hold a demonstration opposite the Baragwanath Hospital, Soweto, tomorrow, in protest against the wave of political violence sweeping the country.

Mr Friday Mavuso, chairman of the association, said the DPSA had noted the Natal carnage in particular with alarm.

He invited all disabled people in Soweto and other townships to join in the demonstration.

The protest action starts at 1pm on the old Potchefstroom Road outside the hospital.

☐ Increases were:
☐ Transfer of resorts — R9,4m;

(R250 668).
Spending
was up by R

Pension rises to be paid out from April, says De Beer

MIKE ROBERTSON

CAPE TOWN — The R25 a month increases in social pensions announced in the Budget are to be paid from April 1, Health Minister Sam de Beer said in a statement yesterday.

De Beer said R58,4m was made available to the own affairs administrations to supplement social pensions.

From April 1, he said, social pensioners and needy parents who received allowances would be paid R276 a month.

Foster parent grants would be increased by R18 to R194 a month and child allowances would be increased by R8 to R84 a month.

De Beer said financial provision had also been made to adjust the means test to accommodate these concessions.

Single care allowances and allowances payable in terms of the Mental Health Act would also be increased by R25 to R276 a month.

De Beer said this was the first time in 19 years that the increases were to be granted from April rather than recipients having to wait until October.

However due to administrative problems it would only be possible to implement the increase in May.

But pensioners would receive the arrears increase for April with their payment for May, he said.

give us an indication whether or not this specific type of aircraft, which was used on this flight, is one of the new acquisitions of SATS?

†The DEPUTY MINISTER: Mr Speaker, I do not have the information at my disposal. I do not know whether it is a new one or not.

†Mr J H VAN DER MERWE: Oooooooo! Oooooooo!

†Mr SPEAKER: Order! The hon member for Overvaal does not have to agree or disagree with everything that happens in the House!

Botswana: two persons held captive

*13. Mr H J COETZEE asked the Minister of Foreign Affairs:†

(1) Whether two persons whose names have been furnished to the Minister's Department for the purpose of his reply, are bein gheld capitve in Botswana at present; if so,

(2) whether they are South African citizens; if so, (a)(i) on what grounds and (ii) since what date have they been detained and (b) what are their names;

(3) whether the Government is taking any steps to have them released and/or tried; if not, why not; if so, what steps?

B507E

The DEPUTY MINISTER OF FOREIGN AFFAIRS:

(1) Yes.

(2) Yes.

(a) (i) and (ii)

They were detained on 21 June 1988 on various counts in terms of the National Security Act and the Penal Code of Botswana and were found guilty by the High Court of Law of Botswana on 8 December 1988 of assault with the intention to cause grevious bodily harm and sentenced to 10 years imprisonment and 8 strokes each. The sentence was confirmed by the Court of Appeal of Botswana on 4 July 1989 with the 8 strokes being set aside.

(b) Mr Theodorus Hermansen and Mr Johannes Basson.

(3) No, in the interest of the two persons not at the present time.

Pietermaritzburg: alternative highway by-pass route

*14. Mr M A TARR asked the Minister of Transport:

(1) Whether steps have been taken to study an alternative highway by-pass route for Pietermaritzburg; if so, (a) who is undertaking the study and (b) when is the report on the study expected; if not,

(2) whether he or his Department has been approached to undertaken such a study; if so, (a) when, (b) by whom and (c) what was the response thereto?

B509E

†The MINISTER OF TRANSPORT:

Yes.

(1) (a) The consulting engineers Bruinette Kruger Stoffberg Incorporated, in conjunction with a team of environmental specialists from the University of Natal under leadership of Professor Breen, is undertaking the study on an alternative highway by-pass route for Pietermaritzburg, on behalf of the South African Roads Board;

(b) The report is expected during April 1991.

(2) (a); (b) and (c) Fall away.

*15. Mr R J Lorimer—Public Works and Land Affairs. [Question standing over.]

Atmospheric Pollution Prevention Act: amendments

*16. Mr R F HASWELL asked the Minister of National Health and Population Development:

(1) Whether her Department intends motivating amendments to the Atmospheric Pollution Prevention Act, No 45 of 1965, during the current session; if not, why not; if so,

(2) whether she will consider introducing amendments providing for (a) stricter

national and regional regulations and (b) economic schemes; if not, why not?

B511E

†The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) No, the Department of National Health and Population Development is still awaiting recommendations from the National Air Pollution Advisory Committee regarding amendments to the Atmospheric Pollution Prevention Act, 1965,

(2) (a) yes,

(b) yes.

SADF: contact with publication/person

*17. Mr S S VAN DER MERWE asked the Minister of Defence:

Whether there has been any contact between him and/or the South African Defence Force and a certain (a) publication and/or (b) person, whose names have been furnished to the Defence Force for the purpose of the Minister's reply; if so, (i)(aa) what was the nature of such contact and (bb) when did it take place and (ii) what are the names of the publication and person concerned?

B512E

The DEPUTY MINISTER OF DEFENCE:

The Minister of Defence has no knowledge of the publication "Adage News" and has had no contact with the said person, Dr A. Guenon.

There was contact between Dr Guenon and the SA Defence Force regarding the making of a feature film on the security situation in the RSA in which SA Defence Force scenes would have appeared.

The contact took place during December 1987 and early in 1988.

One department of health

*18. Mr M J ELLIS asked the Minister of National Health and Population Development:

(1) Whether her Department has taken any steps to consider the administrative, financial and national health implications of one department of health for South Africa; if so, what steps; if not, why not;

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

B513E

†The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) No, the Department of National Health and Population Development have fully evaluated the relevant implications under the present constitution. Extensive measures to co-ordinate and eliminate duplication of health services already exist. At present the Department of National Health and Population Development is busy creating measures to ensure the optimal utilisation of resources.

(2) no.

*19. Mr M J Ellis—Administration and Privatisation. [Withdrawn.]

Heidelberg, Transvaal: autopsy

*20. Mr L FUCHS asked the Minister of Justice:

(1) Whether, with reference to information furnished to the Minister's Department for the purpose of his reply, an autopsy was held into the death of a certain person on 13 February 1990 near Heidelberg, Transvaal; if so, (a) when, (b) by whom and (c) on whose orders;

(2) whether any evidence suggesting a connection between an assault and the death of this person was found; if so, by whom;

(3) what were the other findings of the autopsy?

B515E

†The DEPUTY MINISTER OF JUSTICE:

(1), (2) and (3)

The Magistrate of Heidelberg (Tvl) authorised on 21 February 1990 the performance of a *post mortem* examination on the body of an adult Blackman who as far as could be ascertained was the body of the late Thomas Mavimbela Thikitha.

The South African Police is at the moment busy to investigate the matter and since a docket has as yet not been submitted to the Attorney-General or Public Prosecutor concerned I am not in a position to furnish any further information.

The MINISTER: Mr Chairman, I would like to tell the hon member who raised the issue—who knows that it is in my constituency and is so particular about this—that this Question Paper was printed some time ago. If there was a typographical error and if the hon member did the honourable thing and read the Question Paper, then he would have made that correction a long time ago. If he thought this question was going to embarrass me, then he is wrong.

Mr M RAJAB: He is still a fool!

The MINISTER: He got it all wrong and as I said earlier I suggest that the hon member put it in writing. Hansard 20/3/90

If he wants to persist in calling me a fool, I believe that that is a reflection on his own qualities.

The CHAIRMAN OF THE HOUSE: Order! Did the hon member for Springfield refer to the hon the Minister as a fool?

Mr M RAJAB: Mr Chairman, I certainly called the hon the Minister a fool.

The CHAIRMAN OF THE HOUSE: Order! The hon member must withdraw it unconditionally.

Mr M RAJAB: Mr Chairman, the hon the Minister is not a fool.

The CHAIRMAN OF THE HOUSE: Order! The hon member must withdraw it unconditionally.

Mr M RAJAB: Mr Chairman, I withdraw it.

Asiatic Bazaar: construction work

*3. Mr D K PADIACHEY asked the Minister of Housing:

(1) Whether any persons constructed or are constructing buildings on property belonging to the Administration: House of Delegates in the Asiatic Bazaar in Pretoria; if so, what are their names;

(2) whether any action is being taken against the persons concerned; if not, why not; if so, what action; Hansard 20/3/90

(3) whether his Department has received any representations for the actions of these persons to be condoned; if so, what are the relevant details?

D50E

The MINISTER OF HOUSING:

(1) No.

HOUSE OF DELEGATES

(2) No. Hansard 20/3/90

(3) Falls away.

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, arising out of the hon the Minister's reply, may I know who owns the properties in the Asiatic Bazaar?

The MINISTER: Mr Chairman, only property within a proclaimed Indian group area falls under this Administration. That area is not controlled by this Administration, and therefore it is not the property of this Administration.

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, further arising from the hon the Minister's reply, does the Administration or the Housing Development Board administer this particular area referred to by the hon the Minister?

The MINISTER: Mr Chairman, I could furnish the hon the Leader of the Official Opposition with an answer after making the necessary enquiries, but at this point in time I cannot give him the overall picture as far as that area is concerned.

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, further arising out of the hon the Minister's reply, is he aware of any representations made by the Indian MEC in the Transvaal to any officer of the regional office in Pretoria about this?

The MINISTER: Mr Chairman, before I answer that question, I just want to jolt the memories of everybody, including the hon the Leader of the Official Opposition: There is no need to descend to this gutter level. [Interjections.] I make a plea, Mr Chairman.

The LEADER OF THE OFFICIAL OPPOSITION: Preach to your own side!

The MINISTER: Mr Chairman, I make a plea to everybody: Let us conduct ourselves here in a manner which will bring respect to this institution. This is my sincere plea. [Interjections.]

The CHAIRMAN OF THE HOUSE: Order! I appeal to hon members to try and keep the level of debate and discussion here as high as possible.

For written reply:

General Affairs:

Ministers' Council of House of Delegates: monthly allowance

8. Mr K PANDAY asked the Minister of Public Works and Land Affairs: Hansard 20/3/90

(1) Whether his Department pays a monthly allowance to any members of the Ministers' Council of the House of Delegates for residing in their own homes; if so,

(2) whether he will furnish details in this regard; if not, why not; if so, (a) who are the members concerned and (b) what amount is paid to each per month;

(3) whether these amounts are paid during sessions of Parliament only; if not, on what basis are they paid;

(4) whether any other payments are made by his Department to these members; if so, what are the relevant details?

D59E

The MINISTER OF PUBLIC WORKS AND LAND AFFAIRS:

(1) Yes.

(2) Yes.

(a) and (b)

Dr J N Reddy MP, Chairman of the Ministers' Council and Minister of Housing	— R1 925,00 p.m. plus actual expenditure on municipal services and rates and taxes
Mr B Dookie MP, Minister of Health Services and Welfare	— R1 708,50 p.m. plus actual expenditure on municipal services and rates and taxes
Mr Y Moolla MP, Minister of Local Government and Agriculture	— R1 925,00 p.m. plus actual expenditure on municipal services and rates and taxes

The above-mentioned amounts include compensation for use of own furniture, general maintenance and cleaning and gardening services as other Ministers are provided with furnished official residences. The Department is also responsible for the maintenance of official residences and the furniture therein as well as the rendering of cleaning and gardening services.

(3) No. Members of the Ministers' Council are entitled to furnished official residences in both Cape Town and Durban and if the Department of Public Works and Land Affairs cannot provide such accommodation, the private residences of the relevant Ministers are used as official residences. As official residences provided by the Department are at the disposal of the relevant Ministers at any time compensation is paid throughout the year to those Ministers whose private residences are used as official residences.

(4) No.

Own Affairs:

Disability grants: cancelled

16. Mr K CHETTY asked the Minister of Health Services and Welfare: (299)

(1) Whether any disability grants administered by his Department in respect of any physically disabled and mentally retarded persons were cancelled in 1989; if so, (a) how many, and (b) 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;

(3) what criteria are applied in determining whether an applicant is eligible for a disability grant?

Hansard 20/3/90 D58E

The MINISTER OF HEALTH SERVICES AND WELFARE:

(1) Yes.

(a) 468 who no longer qualified.

(b) They were found not unfit in terms of the criteria set out in reply to question (3) hereunder.

(2) Yes.

(a) 257.

(b) On review, additional medical evidence has been submitted.

(3) An applicant will qualify for a disability pension if, in the opinion of the Pensions Medical Officer, with the information at his disposal, his physical or mental condition is such as to render him unfit to earn an income from employment; provided also that he is not precluded by the application of the Means Test laid down in the regulations promulgated under the Social Pensions Act No. 37 of 1973.

HOUSE OF DELEGATES

damage to property, (i) housebreaking with intent to steal and theft and (j) possession of drugs were reported at each specified police station in the Cape Town police district in 1989?

B197E

The MINISTER OF LAW AND ORDER:

	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Cape Town	20	21	243	346	39	503	701	352	1215	12
Camps Bay	—	—	12	26	7	5	45	27	152	0
Maitland	14	14	97	83	17	79	123	75	318	3
Milnerton	6	9	59	108	19	28	92	97	336	—
Pinelands	7	0	8	40	2	29	101	44	328	—
Sea Point	2	6	45	155	8	34	208	97	734	4
Kensington	12	2	166	148	26	42	49	136	129	2
Woodstock	17	7	118	216	18	111	294	243	824	48
Tableview	3	10	34	26	12	2	67	64	237	—
Melkbosstrand	—	9	6	7	0	0	0	0	35	0
Atlantis	61	14	452	531	89	147	74	744	436	14
Table Bay	11	0	72	23	2	8	9	35	70	4

Note: Because the South African Police is not satisfied with the crime situation in the RSA, crime tendencies are continously monitored. I wish to assure the honourable member that everything possible is being done to prevent crime. When it is apparent that there is an increase in crime, active steps are taken to counteract this tendency.

Wynberg police district: offences

78. Mr C W EGLIN asked the Minister of Law and Order:

How many cases of (a) murder, (b) culpable homicide, (c) assault with intent to do grievous bodily harm, (d) common assault, (e) rape, (f) robbery, (g) theft of vehicles and cycles, (h) damage to property, (i) housebreaking with intent to steal and theft and (j) possession of drugs were reported at each specified police station in the Wynberg police district in 1989?

B198E

The MINISTER OF LAW AND ORDER:

	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Wynberg	10	8	48	141	14	81	170	120	378	2
Fish Hoek	20	8	144	146	12	23	65	154	392	—
Simonstown	—	5	22	34	2	7	9	16	53	—
Rondebosch	—	2	26	40	3	27	260	44	424	—
Muizenberg	2	7	147	111	22	49	116	78	372	6
Mowbray	—	14	12	51	2	34	137	32	290	2
Hout Bay	14	4	125	96	20	23	31	72	234	—
Diepriver	2	10	38	102	9	41	182	60	539	—
Claremont	3	9	58	137	5	33	511	135	767	2
Steenberg	30	2	424	394	63	184	165	418	414	—
Kirstenhof	2	12	137	75	9	30	133	104	410	2

Note: Because the South African Police is not satisfied with the crime situation in the RSA, crime tendencies are continously monitored. I wish to assure the honourable member that everything possible is being done to prevent crime. When it is apparent that there is an increase in crime, active steps are taken to counteract this tendency.

Vaal Triangle/Eastern Transvaal Highveld: pollutants

148. Mr C B SCHOEMAN asked the Minister of National Health and Population Development:†

(1) (a) What pollutants occur in the air of the Vaal Triangle and the Eastern Transvaal Highveld and (b) in what concentrations do these pollutants occur;

(2) whether, with a view to the protection of human health and plant life; scientifically based levels of pollutants that may not be exceeded have been determined; if not, why not; if so, what levels;

(3) whether the present levels of these pollutants in the atmosphere in the Vaal Triangle and Eastern Transvaal are lower than the maximum permissible concentrations that have been so determined;

(4) whether her Department has inspectors that monitor industries in order to ensure that the conditions in respect of the release of pollutants are complied with; if not, why not; if so, what mechanisms are there in this regard?

B362E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) (a) Mainly oxides of sulphur and nitrogen, hydrocarbons, smoke, metal-oxide dust and many lesser pollutants;

(b) not all concentrations are measured at all stations. It is impossible to supply all concentrations for all measuring sites, due to the large amount of data available.

As an example sulphur dioxide concentrations are quoted as ranging between 3,4 and 15,9 parts per billion as annual mean,

(2) yes, a list of maximum allowable concentrations are available. Some more important ones are listed below.

Annual mean:

— Sulphur dioxide: 30 parts per billion
— Nitrogen oxides: 200 parts per billion
— Ozone: 10 parts per billion
— Suspended particulates: 150 microgram per cubic metre
— Smoke: 100 microgram per cubic metre.

Monthly mean:

— Lead: 2,5 microgram per cubic metre

(3) yes, for about 99% of the time;

(4) yes, regular inspections and measuring of emission and ambient concentration levels.

Persons: HIV positive

156. Mr M J ELLIS asked the Minister of National Health and Population Development:

How many (a) White, (b) Black, (c) Coloured and (d) Indian persons tested HIV positive in 1987, 1988 and 1989, respectively?

B375E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

The latest available information as at 30 October 1989. Information is not available regarding the respective years.

(a) Whites	956
(b) Blacks	907
(c) Coloureds	91
(d) Indians	10

Unknown population group 432.

Tuberculosis

157. Mr M J ELLIS asked the Minister of National Health and Population Development:

(a) How many cases of tuberculosis were reported in each province in 1989 and (b) how many (i) cases of tuberculosis were hospitalized, and (ii) tuberculosis patients died, in each province in that year?

B376E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(a) Notifications for the reporting period during January to December 1989. It should be noted that "cases" of tuberculosis refer to notified instances of contact, not patients or people. Repeat notification of individuals per annum is thus possible. The following information is furnished as at 5 March 1990,

HOUSE OF REPRESENTATIVES

QUESTIONS

†Indicates translated version.

For oral reply:

General Affairs:

Hillbrow area: health conditions

*1. Mr T R GEORGE asked the Minister of National Health and Population Development:

(1) Whether her Department recently investigated health conditions in the Hillbrow area; if not, why not; if so, (a) when and (b) with what result:

(2) whether she will make a statement on the matter? C22E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) No, in terms of section 20 of the Health Act, 1977 (Act 63 of 1977) it is the duty of the City Council of Johannesburg to take all lawful, necessary and reasonably practicable measures to maintain its district at all times in a hygienic and clean condition and to prevent the occurrence of any nuisance within its district. Where any condition which will or could be harmful or dangerous to the health of any person occurs within the district of a local authority, it is the responsibility of the local authority to remedy such condition.

Whenever I receive a complaint that the health of any person within the district of a local authority is endangered by any harmful condition however, the Department of National Health and Population Development may take certain steps in terms of Act 63 of 1977. No such complaint has recently been received as far as the Hillbrow area is concerned and therefore no recent investigation was conducted by the Department. I am however aware of the fact that the City Council of Johannesburg is at present intensively investigating health conditions in the specific area.

(2) no.

Toekomsrus: police station

*2. Mr T ABRAHAMS asked the Minister of Law and Order:

(1) Whether it is the intention to build a police station in Toekomsrus, Randfontein; if not, why not; if so, (a) where in Toekomsrus and (b) when is it anticipated that building operations will be (i) commenced and (ii) completed;

(2) whether he will make a statement on the matter? C23E

The MINISTER OF LAW AND ORDER:

(1) No, because the need for a police station has up until now, not yet been identified.

(a) and (b) Fall away.

(2) If the honourable member is of the opinion that there is a need for a police station in the area, on request I am prepared to have a feasibility study carried out for that purpose.

Riverlea: post office

*3. Mr T R GEORGE asked the Minister of Mineral and Energy Affairs and Public Enterprises:

(1) Whether any progress has been made in regard to the building of a post office in Riverlea, Johannesburg; if so, (a) what progress and (b) when is it anticipated that building operations will be (i) commenced and (ii) completed;

(2) whether any problems have arisen in regard to this post office; if so, what problems;

(3) whether he will make a statement on the matter? C24E

The MINISTER OF LAW AND ORDER (for the Minister of Mineral and Energy Affairs and Public Enterprises):

(1) Yes;

(a) A suitable site has been acquired and planning of the building has commenced

(b) (i) May 1991

(ii) November 1991;

(2) no;

(3) no.

UWC: payment of certain staff members

*4. Mr P A S MOPP asked the Minister of National Health and Population Development:

(1) Whether an amount of R759 000 is to be paid over to her Department for payment of certain staff members of the University of the Western Cape upon retirement; if so,

(2) whether she will furnish particulars of the staff members concerned; if not, why not; if so, what are their (a) names and (b) ages;

(3) whether part of this amount is to be paid out as a result of legal action that was instituted; if so, what are the relevant details;

(4) whether she will make a statement on the matter? C28E

†The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) Yes.

(2) yes.

(a) *Names*	(b) *Ages at retirement*
Mr P P Kirstein	58
Mr J H C Stassen	48
Mr H J Pienaar	53
Prof P J Smith	53
Mr N K Prins	40
Mr A D P J v Rensburg	52
Mr A P S de Kock	59
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Mrs C E du Plessis	49
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Mrs C J Strutt	34
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Mr F H Boot	52

(3) no,

(4) no.

Fire-arm licences: different requirements

*5. Mr A ESSOP asked the Minister of Law and Order:†

Whether different requirements are set for the issue of fire-arm licences to Whites and non-Whites; if not, what requirements are set; if so, what requirements are set for (a) Whites; (b) Coloureds, (c) Indians and (d) Blacks? C29E

†The MINISTER OF LAW AND ORDER:

No.

Irrespective of race and sex, each application is considered on the basis of the personal circumstances of the applicant concerned and certain general and specific guidelines.

Personal circumstance include inter alia the applicant's age, educational qualifications, status in the community, marital status and the nature of the profession or occupation.

General guidelines include inter alia the following:

Whether the fire-arm is suitable for the purpose for which it is required;

Whether it is required for the protection of life and/or property;

Whether it is required for practising sport.

Specific guidelines include inter alia the following:

The applicant's knowledge of the handling of the fire-arm concerned;

The applicant's knowledge of the legal provisions regarding the safekeeping and use of fire-arms;

The applicant's previous convictions;

Does the applicant have a safe place for storage of the weapon;

Has the applicant previously been declared unfit to possess a fire-arm;

Has the applicant previously lost a weapon or were any of his fire-arms confiscated;

Does the applicant live in an urban or rural area;

Does the applicant possess any other fire-arm;

Exceptional circumstances which may influence the applicant's application.

B | Day 23|3|90

299

Health care: crisis 'looming'

GERALD REILLY

PRETORIA — SA is running headlong into a health care funding crisis.

National Health and Population Development director Coen Slabber indicated this in Potchefstroom last night when he stressed that the demand for services was increasing and the ability to fund them was becoming more difficult.

Speaking at a Potchefstroom University pharmacy faculty graduation ceremony, he outlined reasons for the demand for services against a background of a population increase of 11-million by the year 2000.

Life expectation was rising. In 1988 there were 1,3-million people over the age of 65. By 2000 this would have increased to 4-million.

He said expenditure on health services was four times greater in the over-65 age group.

Urbanisation, too, would increase the demand. In 1985, 40% of the black population was urbanised. At the century's end it would rise to 70%, which meant an increase of 13-million in urban dwellers.

In the past five years the CPI had risen by an average of 14,8% a year. However the index for medical care had risen in the same period by 17,5% a year.

The only solution appeared to be an adjustment in the way services were rendered, he said.

tion Union of SA (Neusa) and the NECC in Johannesburg to discuss grievances of 6 000 striking Soweto and Alexandra teachers. B|Dan 26/3/90.

New hospital cover scheme

B|Dan 26/3/90 TANIA LEVY (299)

A NEW type of medical scheme which provides 100% cover on unlimited hospitalisation at particularly low member subscription costs will be introduced today.

Medscheme chairman Keith Hollis says the HiCare scheme is a low cost alternative for individuals and families with good health who are nevertheless prudent enough to fully cover themselves against serious illness or emergencies requiring hospitalisation.

By holding down annual non-hospital benefits to a minimum — within the requirements of the Medical Schemes Act — member subscription rates will be kept substantially lower than average medical scheme rates.

A member earning R1 141 a month, will contribute less than R200 a month.

There is no overall hospitalisation limit and benefits include general ward, intensive care and theatre charges as well as 100% cover on doctor and specialist fees, blood transfusions and theatre and ward drug costs.

NATAL UNREST DEATHS

September 1987 — January 1989:	668
February 1989 — March 22 1990:	738
Past 72 hours' official toll:	2
TOTAL:	1 408

10 MINUTE X-WORD 7558

Sowetan 21/3/90

Pretoria 'chalk-down' spreads

By MONK NKOMO

More than 300 pupils at the Philadelphia Secondary School for the disabled in Soshanguve, boycotted classes yesterday in protest against the school's decision to erect barriers on campus segregating male pupils from female.

Acting principal LR Davel, confirmed the boycott of classes and said every effort was being made to resolve the matter.

Davel said he had met members of the Student Representative Council yesterday morning and they had presented him with a list of their grievances.

Boycott

Meanwhile, scores of teachers from other schools in Mamelodi boycotted classes yesterday, apparently disillusioned by the Department of Education and Training's response to their grievances.

Few high schools in the Pretoria area were experiencing effective teaching, DET regional director Job Schoeman said yesterday.

The decision to boycott - popularly dubbed "chalk down"- was taken by teachers at a meeting held in the township last week.

Schoeman also announced yesterday that the Flavius Mareka Secondary School in Atteridgeville had been indefinitely closed due to continuing violence at the school.

Schoeman said teachers had been held hostage inside the staffroom last week and threatened with death by a group of pupils who demanded that their school fees be refunded.

Threats

Pupils also threatened to set alight vehicles belonging to teachers at the Flavius Mareka and Solridge Secondary schools.

Schoeman said he had submitted a reply to grievances expressed by Mamelodi teachers last week - 90 percent of which were related to conditions of service.

However, DET had "no power to unilaterally change conditions of service," he said.

Some of the demands were unreasonable, he added, and included a 500 percent salary increase and a 15-hour working week, instead of 40 hours.

But some of the grievances were genuine, Schoeman said, and these DET would attempt to address.

New hope of cure for hospital bill agony

JOHANNESBURG. — A new type of medical scheme which provides 100% cover on unlimited hospitalisation at particularly low subscription costs will be introduced today.

Medscheme chairman Mr Keith Hollis says the HiCare scheme is a low-cost alternative for individuals and families with good health who are nevertheless prudent enough to fully cover themselves against serious illness or emergencies requiring hospitalisation.

By holding down annual non-hospitalisation benefits to an absolute minimum, subscription rates will be kept substantially lower than average.

There is no overall hospitalisation limit and benefits include general ward, intensive care and theatre charges as well as 100% cover on doctor and specialist fees, blood transfusions and theatre and ward drug costs.

SA may rethink abortion laws

By NICCI YOUNG

THE Government is taking a new look at the controversial abortion issue, and this week invited comment on the 15-year-old Abortion and Sterilisation Act. ST Times 25/3/90

"Our statement was a pre-emptive step," said Health and Population Development Department liaison director Dr Johan van Niekerk.

"It was drawn up in response to speculation in Parliament that people might approach the department on this matter."

Under the current legislation, legal abortions are only available if a woman can prove she was a victim of rape or incest or a carrier of the AIDS virus or that she or her baby would suffer irreparable physical or psychological harm if it was born.

299 **Moral**

"I find it very interesting that the Government has actively invited comment on the Act," said DP MP for Umbilo and spokesman on women's affairs Carole Charlewood.

"It demonstrates an open-mindedness despite the Government's traditionally conservative moral stance and its fear of the Roman Catholic and Afrikaner sections."

Abortion Reform Action Group spokesman Chris Diamond said an estimated 200 000 women a year risked their lives by having illegal abortions.

And a gynaecologist at Soweto's Baragwanath Hospital, Professor C van Gelderen, estimated that between 10 and 20 women attended the hospital each day as a result of back-street abortions.

New medical aid packages planned

BD Day
28/3/90 LINDA ENSOR (299)

ROCKETING health care costs are causing companies to rethink the need for traditional medical aid, says specialist consultancy Mibsa Healthcare Services MD Malcolm Wilson.

The newly formed company aims to assist firms in finding a more cost effective solution to escalating health care costs.

Wilson believes the future of managed health care lies in a combination of medical aid, insurance and investment options to enhance risk control and this is the type of package which his company will be devising.

"Companies and their employees are resisting the ever-increasing demand for higher contributions, and there is a growing need for packages tailored to the specific needs of individuals or groups of employees."

Contributions to medical aid schemes have risen by up to a compounded 20% a year, with the result that "healthy and responsible members" are subsidising those who make big claims.

Wilson believes members of medical aid schemes will increasingly be forced to pay higher portions of their medical costs.

"The cost of hospitalisation is where members stand to lose the most financially, and this is an area demanding creative protection."

Wilson says Mibsa Healthcare Services will negotiate terms with medical aid administrators and insurers, particularly where medical aid schemes fall short of covering the costs of expensive medical services.

Medical aid scheme formed

Cape Times 29/3/90

299

Own Correspondent

JOHANNESBURG. — Three medical aid societies within the Medicaid Administrators group merged yesterday to form one of the biggest medical aid schemes in the country.

Known as Meddent Medical Scheme (MMS), it was formed by the mergers of Meddent, KWB and Economed and will offer more than 35 000 members and their dependants countrywide a choice of three benefit arrangements.

In a statement released yesterday, Medicaid Administrators managing director Mr Jeff Slome said: "This merger was structured to streamline administration, claims handling and service to members."

MMS will be fully operational as a single scheme from May 1 and will start next year with reserves of about R22 million.

SOWETAN Thursday March 29 1990

We may be expelled, say disabled pupils

By MONK NKOMO

OFFICIALS at Filadelfia Secondary School for the Disabled in Soshanguve yesterday allegedly threatened 300 striking pupils with expulsion unless they returned to classes.

The pupils, who include cripples, deaf, dumb and blind children, started boycotting classes on Monday in protest against several issues, including "bad and sometimes rotten food".

They also complained about a decision by the school's authorities to erect barriers that prevent them from leaving the premises. The steel barriers also prevent male pupils from visiting females.

The school's governing council met a delegation of eight pupils on Tuesday afternoon to resolve the matter.

The delegation later told the pupils that the council had threatened to suspend or expel certain pupils. It also threatened to close down the school indefinitely if pupils did not return to classes.

A spokesman for the Department of Education and Training in Pretoria yesterday confirmed the class boycott but said he did not know about the governing council's decision to expel pupils or to close down the school.

Pupils interviewed said they had submitted a list of their grievances to the acting principal, Mr LR Davel, on Monday.

They demanded the introduction of an SRC; and improved standard of entertainment and the introduction of pupil cards allowing them to leave the campus to buy food and other necessities.

Pupils said the council had agreed to consider the grievances except the one over barriers in the corridors, gates and on certain sections on campus.

"The council told our delegation that these barriers were erected for security reasons and will not be removed. We believe they were ereoted to inconvenience us", a pupil said.

A meeting between council and pupils is to be held today.

"The delegation is also expected to submit our constitution to pave the way for the official introduction of an SRC", pupils said.

B/Day 29/3/90

Mass merger creates a medical aid giant

DANIEL FELDMAN

THREE medical aid societies within the Medicaid Administrators group merged yesterday to form one of the biggest medical aid schemes in SA.

Known as Meddent Medical Scheme (MMS), it will offer more than 35 000 members and their dependants countrywide three benefit arrangements to choose from.

It was formed by the merger of Meddent, KWB, and Economed.

In a statement released yesterday by Medicaid Administrators, MD Jeff Slome said: "This merger was structured to streamline administration, claims handling, and service to members."

MMS would be fully operational as a single scheme from May 1, and would start next year with reserves of about R22m, he said.

The three benefit packages MMS would offer are Meddent, which would offer 100% benefits funded through differentiated contributions; Unimed, which would offer 100% benefits on the basis of integrated contributions; and Economed, which as a flexible scheme would offer 70% benefits to an agreed limit and thereafter 100%.

Meddent deputy chairman Don Plough said the merger "holds many benefits, such as stability and strength for the respective memberships".

EDUCATION

Centre brings light and love to township life

Story-telling is brought to life through shadow theatre (below). Women make "TV" sets from cardboard boxes and use paper dolls to illustrate their stories. A hobby horse is made by stuffing an old sock and placing it over a stick (right). Toy-making is an important part of the educational course.
● Pictures by Sean Woods.

A whisper of optimism is lifting the spirits of township children whose educational future is uncertain in the wake of recent teacher strikes.

In schools that have been set up in garages and township squats the emphasis lies on love and the spiritual essence of the child rather than formal intellectual pursuits.

"Children under seven need mothers and fathers, not teachers," says Ms Carol Liknaitsky, a former Waldorf teacher. She is one of the founder-members of the Baobab Centre for Teaching Enrichment started in 1985.

The aim of the group is to teach women in townships how to educate and nurture children.

"We started 'enrichment' workshops in townships when teachers started being attacked by the DET and students," says Ms Liknaitsky.

Upgrading childcare

"Few of the women are qualified teachers. We're not interested in qualifications. We take anybody interested in upgrading childcare. The only criterion is that they must love children.

"The emphasis is on the spiritual being of the child. We believe the children are our future and we have to provide the soil for them to grow."

The three-week course, based on the Waldorf method of education, teaches women toy making, "shadow" theatre, arts and crafts as well as the rudiments of remedial therapy, music and movement.

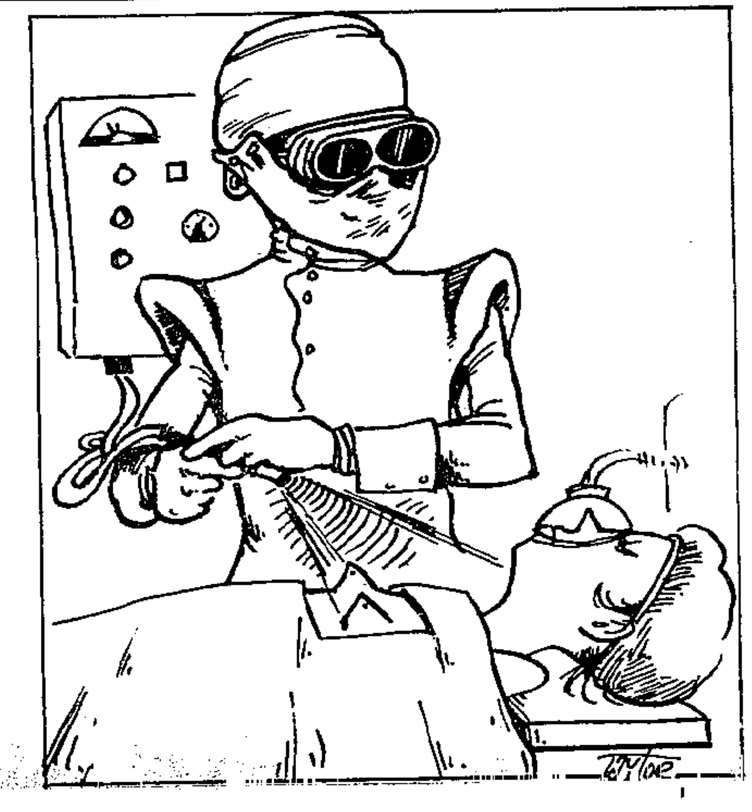
"At the end of the course, mothers set up informal situations for children to get a few hours of quality care and enrichment," says Ms Lipnaitsky.

The Waldorf educational system, founded by Rudolf Steiner, is based on insight into the spiritual development of the human being. The next course will be held at the Alexandra Clinic in July.

CAROLINE HURRY

Mothers are becoming teachers in the townships to alleviate the education crisis in some small way, thanks to the work of the Baobab Centre for Teaching Enrichment. "All you need is love," says one of the founder-members of the group.

MEDICINE



Delving deep but using surgery without scars

Britain's first medical centre to offer patients surgery without scars is to open in May, paving the way for a revolution in the way many major operations are performed.

And if the revolution follows the path predicted, in many major operations the surgeon's knife could soon be a thing of the past.

Doctors behind the venture claim patients will feel less pain, recover more quickly and have less chance of developing serious complications than with traditional techniques.

The Minimal Invasive Therapy Unit at the London Clinic will concentrate initially on the removal of gallstones, gall bladders and, ultimately appendixes.

Rather than cutting open the body, surgeons at the unit will use instruments that can be passed through the skin, leaving patients with no stitches and no scars.

The pioneering techniques have been tested by doctors in America and Europe, where they have been used to treat a variety of conditions including hernias, kidney stones, heart disease and certain cancers.

In most minimal invasive therapy procedures, surgeons use a straw-like telescope called an endoscope, which is inserted through the skin and guided by X-ray or ultrasound to the problem area. A tiny light at the endoscope's tip gives the surgeon, who looks through an eye-piece, a clear view.

Various tools, including lasers, can be fed through the endoscope to tie, cut, burn or extract. A benefit of laser surgery of this kind is that swelling can be avoided.

Mr John Wickham, a urologist who is director of the unit, says that minimal invasive therapy can take up more of the surgeon's time than traditional surgery because of the delicacy of the operations.

"However, you have to weigh up other factors. There are few complications with endoscopic surgery."

Mr Wickham says that while the new unit will have access to the London Clinic's 120 beds, few people will need to be treated as in-patients.

A major advantage of endoscopic techniques is that unnecessary surgery (and pain, stitches and scars) can be avoided as doctors are able to see the exact nature of the internal problem before they operate on it, Mr Wickham says.

He says that while the minimal invasive therapy unit will initially be open only to private patients, its services could soon be available on the national health service.

There are few training opportunities in minimal invasive therapy, largely because the techniques have been pioneered by individual surgeons around the world. This could be changed by the International Society for Minimal Invasive Therapy, which was set up last December for surgeons to pool information and swap experience, he says.

"Surgeons are all too quick to open you up when something is wrong; with minimal invasive therapy none of that is necessary."

THE INDEPENDENT

MEDICAL SCHEMES (299)

Gaining flexibility

As a result of reduced regulation, medical aid packages are now offering more flexibility. FIM 30/3/90

Medical aid schemes formerly had to charge a set amount, depending solely on a member's income and number of dependants. But since last October schemes have been able to base charges on claims experience — so that members making low claims can pay lower subscriptions than members making high claims — and on age and length of membership.

The first scheme to take advantage of full experience rating on a group basis has been the Chartered Accountants' Medical Aid Fund.

Fund manager Malcolm Button says each firm using the fund will be rated according to its own risk profile, determined mainly by the age and claims experience of the members in the preceding year. Button says the size of the firm is an important criterion for the way in which the rating formula is applied.

FIM 30/3/90 (299)

The fund won't be offering a no-claim bonus as such, but firms that make low claims will be rewarded in future rates.

The much larger, Durban-based National Medical Plan, with more than 100 000 dependants, was the first major scheme to register a full-fledged no-claim bonus. It will offer a R600 cash rebate for all members with more than one dependant who make no claims in the next year. Single members will receive a R200 bonus and those with one dependant, R500.

"These incentives are for 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," says the plan's CE, Robbie Basson.

None of the better-known administrators, which include Medscheme, Affiliated, Medicaid and Stability, have yet to use the new rating system, but they are starting to launch more adventurous packages. Medicaid's Hospital Plan and Medscheme's HiCare offer full cover on hospitalisation, but only R100 a year for general practitioners and they have low limits for prescriptions. They are able to hold down subscriptions to under R200 for a member with dependants, compared with about twice that for full-service schemes.

However, even though schemes offer "full" cover, they aren't allowed to pay more than the official medical aid tariff. Sandton's Morningside Clinic, for example, is charging R32 a day more than the tariff covers and even a super deluxe medical aid isn't allowed to pay the full fee by law.

"We are considering a tie-up with a short-term insurer so that we can offer extra cover as well as, perhaps, international cover and recuperative benefits," Button says.

FIM 3013/90 (299)

Affiliated chairman Tony Leveton, however, says he hopes the legislation will soon be changed to enable medical schemes to offer these services in-house. "We are in a good position to offer this service because we have the data base and the facilities to process paper."

A criticism of the new flexibility that medical schemes now have is the fear that people will be declared uninsurable. Jonathan Broomberg, of the Wits Centre for Health Policy, says medical aid traditionally has been based on cross-subsidisation. With "flexibility," schemes could become unaffordable to the people who really need them.

Stability chairman John Ernstzen, however, says schemes have acted responsibly and haven't introduced wild variations in contributions. ■

Kids get 30 min to quit

Sowetan 2/4/90

MORE than 300 crippled, deaf-and-dumb pupils at the trouble-racked Filadelfia Secondary School in Soshanguve were given 30 minutes to leave the premises before the school was closed down late on Thursday.

Scores of the striking pupils, some from as far away as Durban, were left stranded after the school's governing council closed the institution at about 4pm. Pupils from afar were allowed to remain on campus only for the night.

Those interviewed said their parents were not notified about the decision to shut the school. Parents are usually informed a week or two before the school closes for normal holidays so they can make arrangements to fetch their children or meet them at bus or railway stations.

The pupils, who also include blind children, started boycotting classes last Monday in protest against several issues that included "rotten food" and the authorities' decision to erect steel barriers that prevented male students from socialising with females. The barriers, according to pupils, also prevented them from leaving the campus to buy food and toiletries.

Parents interviewed yesterday condemned the governing council's decision to close the school without consulting them. Parents also accused the authorities of being "heartless and irresponsible".

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Racism

A father, who did not want his name published, said: "This is blatant racism. How can disabled children be expected to pack and leave the premises within 30 minutes and without any parent or guardian to help them? The governing council showed no sympathy to our children. I wonder if the same decision would have been taken if these children were white."

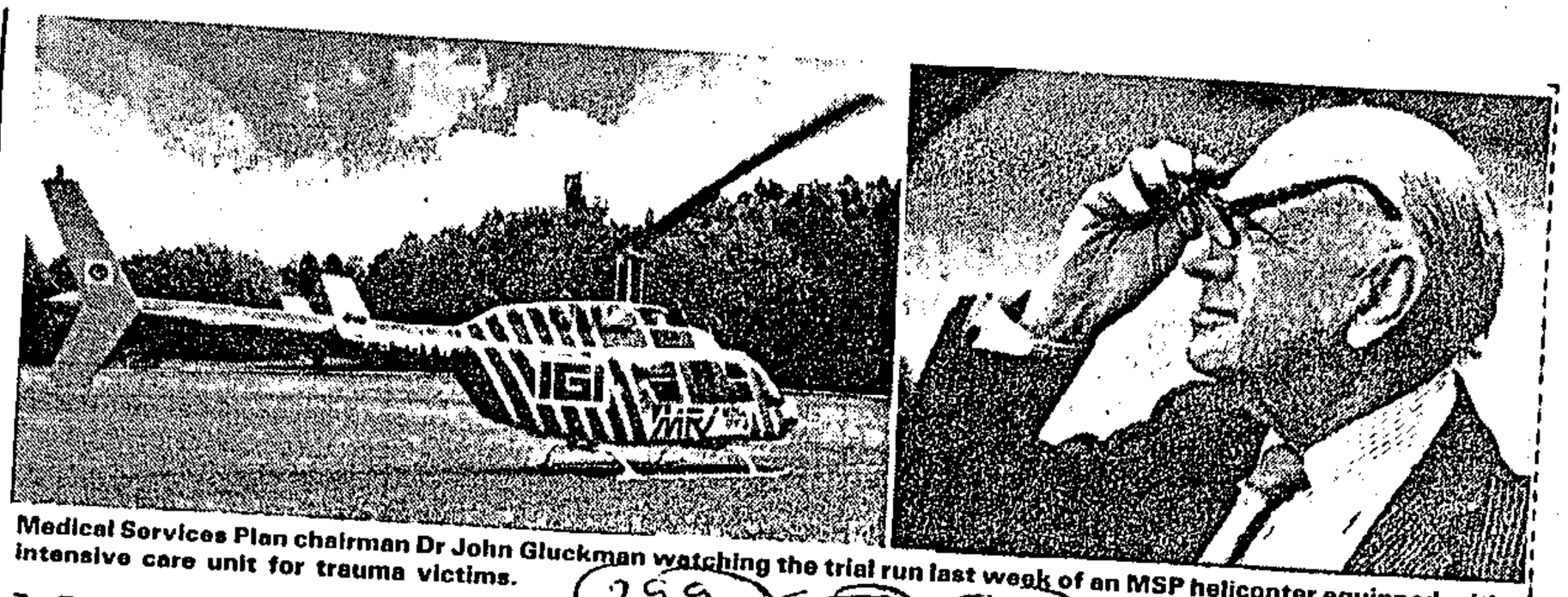
Mr L R Davel, acting principal of the school, refused to discuss the matter with *Sowetan*. "No comments for you," he said.

The school falls under the control of the Department of Education and Training. A spokesman for DET said he did not know about the closure of the school and said the college was run from Head Office.

Scheme for SADF wounded

A new project to care for South African Defence Force wounded, injured and handicapped was announced by the Deputy Minister of Defence, Mr Wynand Breytenbach, in Pretoria yesterday.

Speaking at a South African Medical Service medal parade, Mr Breytenbach said the project would involve four aspects: updating of records; prevention of injuries; treatment, stabilisation and rehabilitation; and re-training. — Own Correspondent.



Medical Services Plan chairman Dr John Gluckman watching the trial run last week of an MSP helicopter equipped with an intensive care unit for trauma victims.

Pictures: ROBERT BOTHA

Medical scheme starts its own airborne rescue service

DANIEL FELDMAN

MEDICAL Services Plan (MSP) became the first medical scheme in SA at the weekend to introduce a comprehensive medical rescue service for its 19 000 members.

The service includes helicopters equipped with intensive care units, as well as a fleet of ICU-equipped ambulances. Medical services will be provided by an associated company, Medical Rescue International (MRI), whose medical rescue centre is manned 24 hours a day by trauma-trained nursing sisters, paramedics and doctors, according to MSP chairman and MRI director Dr John Gluckman.

When a patient's condition cannot be handled by nearby medical facilities and requires evacuation to one of the five trauma centres in SA, a trauma team will be flown or driven to the patient to provide on-the-spot stabilisation for transfer to the trauma centre.

There is currently one ICU-equipped helicopter in the Johannesburg region and another in the Durban region. Within a year, MSP hopes to launch similar flying ICUs in Bethlehem and Port Elizabeth, according to MRI GM Martin Marburger.

He said each helicopter cost R2,6m initially and was fitted with more than R500 000 of medical equipment and navigational supplies. The helicopters will operate within a 250km radius of their base.

Gluckman said about 11 000 people of the 110 000 injured in SA annually died as a result of trauma. "Of these deaths, 10% could be prevented through the provision of rapid and appropriate medical response. Our new service will help to offer it."

MSP will not increase its subscription rates as a result of the new service.

Poignant demo outside Bara

Stop collecting guns plea from cripples

299

Sowetan 11/4/90

A demonstration by disabled people outside Baragwanath hospital took a poignant turn yesterday when Mr Friday Mandla Mavuso broke down and cried while making a speech.

By SOWETAN REPORTER

Mavuso, co-chairperson of Disabled People South Africa, appealed to people to throw their weapons away. "For those who are collecting one million rifles, I appeal to you to think twice before you buy them. "Those one million guns will cause suffering and misery. Those guns are going to maim black people," he said.

"How long must people kill each other? The hospitals are full of disabled people. That is why we are having our demonstration here."

Dr William Rowland, co-chairperson of DPSA, said for every one person killed violently, three and a half people were blinded or permanently disabled.

"This means about 10 000 people have died through violence in Natal over the past three years; and between 12 and 14 000 people in South Africa."

He said DPSA called the demonstration to oppose violence in all forms and from all sides.

"Disabled people faced a future of poverty, unemployment and discrimination. Services and structures are hopelessly overloaded."

A statement issued by the organisation said "Apartheid has taken its toll on disabled people in South Africa. Many of our people became disabled as a direct result of state repression.

"Others sustained injuries in violence as a result of socio-economic conditions in apartheid's townships. Disabling diseases related to health conditions have claimed still more victims.

"It is with a sense of great urgency that DPSA joins in the call by political leaders for an immediate end to the violence by all parties.

"We especially condemn the excessive use of force by the police in situations of conflict."

People in wheelchairs carried boards reading 'Shot 76' and 'Stabbed'.

One man walking with crutches carried a placard reading 'See what violence does'. Others said 'No more violent actions', 'We don't believe Vlok or Buthelezi - Stop the killing' and 'Stop police violence'.

DPSA represents 10 000 disabled people. The majority of its membership were disabled through violence. It is open to disabled people, regardless of creed, colour or political affiliation.

Please stop the killings!

By SELLO SERIPE

DISABLED people on the Reef this week made a heartfelt plea to factions in the Natal "war" to end the fighting which has turned the province into a bloodbath.

At least 200 paraplegics staged a placard protest outside Baragwanath hospital on Tuesday, calling for an immediate ceasefire.

The protest, which was preceded by a kilometre "march" on wheelchairs, was organised by the 10 000-strong Disabled People of South Africa (DPSA).

Addressing the media at the scene, manager of the Self Help Association of Paraplegics (Shap) and co-chairman of DPSA Friday Mavuso called on parties involved in the fighting to iron out their differences at a negotiating table.

Since the beginning of the year, 300 people have died and about 12 000 have been left homeless as a result of running battles in Natal.

Mavuso, who was paralysed from the waist down by a stray police bullet in 1974, said for each person killed in the violence, three were permanently disabled.

"For how long should we suffer?" asked an emotional Mavuso.

Disabled stage protest against Natal carnage

"The hospitals are full of paralysed and disabled people as a result of this senseless fighting.

"To be disabled in South Africa is a terrible fate. It means a life of poverty, isolation and discrimination on all fronts."

DPSA development officer Jerry Nkeli said that while other victims of police action were regarded as heroes by the community, the disabled were forgotten – despite the circumstances which led to their disability.

■ Soweto businesswoman and director of the Eyethu cinema in Mofolo, Dombolo Tshabalala, told *City Press* the film *Cry Freedom* will be screened for a week starting April 27 at the cinema.

Proceeds of R5 000, to be raised from the sale of 500 tickets selling at R10, will be donated to Shap.

There will be a cocktail party for these ticketholders after the movie, which starts at 7.45pm.

200 paraplegics demonstrated outside Baragwanath Hospital in a bid to end the Natal violence.

(2) whether he or his Department has investigated the (a) economic and (b) juridical implications of these steps; if not, why not; if so, what are these implications, in each case? B718E

The MINISTER OF MINERAL AND ENERGY AFFAIRS AND PUBLIC ENTERPRISES:

(1) No. A final decision regarding the granting of mining rights will be taken after the completion and evaluation of the environmental impact assessment which is presently being undertaken.

(a) and (b) Fall away.

(2) Falls away.

*20. Mr R M BURROWS — Administration and Economic Co-ordination. [Question standing over.]

GST on prescribed medicines: revenue

*21. Mr M J ELLIS asked the Minister of Finance:

What was the total amount of revenue received by the Government from general sales tax on prescribed medicines for the 1988-89 financial year? B738E

The MINISTER OF FINANCE:

Inland Revenue does not require registered vendors to furnish the particulars of sales tax collected on each type of commodity as this would place an unreasonable administrative burden on the business sector. For this reason separate statistics of collections on prescribed medicines are not available. The Pharmaceutical Society of South Africa has estimated that the sales of prescribed medicines for the 1989 calendar year amounted to R1 040 million. If one assumes that sales tax was payable on the whole of this amount the revenue collected would amount to R120 million. These figures exclude prescribed medicines supplied by medical practitioners and hospitals.

GST on prescribed medicines: abolition

*22. Mr M J ELLIS asked the Minister of Finance:

Whether consideration is being given to abolishing general sales tax on prescribed medicines; if not, why not? B739E

The MINISTER OF FINANCE:

No. Representations have on numerous occasions been made for prescribed medicines to be exempted from general sales tax and careful consideration has been given to the matter. It is, however, essential, particularly in the case of an indirect tax such as sales tax, for the base to be as wide as possible. If an exemption was granted in respect of prescribed medicines it would not only open the door for exemptions in respect of other equally meritorious cases, but would mean that the loss of tax would have to be recovered by an increase in the rate of tax.

Colonel Bob Denard: residence permit

*23. Mr L FUCHS asked the Minister of Home Affairs:

(1) Whether a temporary or permanent residence permit has been issued to Colonel Bob Denard; if so, (a) for how long and (b) why;

(2) what is the total anticipated cost to the State of providing refuge to Colonel Denard;

(3) whether he will furnish details on the present whereabouts of this person; if not, why not; if so, (a) where is he residing at present and (b) at whose expense is he residing there? B740E

The MINISTER OF HOME AFFAIRS:

(1) A temporary residence permit has been issued to him. An extention will be required from 1 May 1990. Colonel Denard's residence in South Africa must be seen against the background of the turbulances which occurred in the Comores in December 1989. On occasion my colleague, the Minister of Foreign Affairs, has made public statements on the events. It boils down to the fact that both the former government of the Comores and the French Government have requested South Africa to accommodate Colonel Denard. The South African Government was initially not in favour thereof, but after repeated appeals by the two aforementioned governments, the government, for the promotion of peace and quiet in the Comores, agreed to be of assistance. In the meantime discussions

with the French Government regarding Colonel Denard's position and future are being conducted.

(2) None.

(3) No. He is being housed privately and it is not deemed expedient to furnish details.

Mr Lennox Sebe in SA

*24. Mr L FUCHS asked the Minister of Foreign Affairs:

(1) Whether Mr Lennox Sebe is currently residing in South Africa; if so, (a) under what conditions has he been granted permission to do so and (b) at what total anticipated cost to the State;

(2) whether he is to be granted political asylum; if not, why not; if so, for what reasons? B741E

The MINISTER OF FOREIGN AFFAIRS:

(1) Yes.

(a) Under circumstances where he left his country as Head of State and where a coup d'état was carried out in his country during his absence. He was not unwilling to return to the Ciskei. After consultation with the South African Embassy in the Ciskei and the National Council of the Ciskei, he was advised not to return to the Ciskei for the time being in the interest of the promotion of peace and quiet in the Ciskei, which is at the same time in the interest of South Africa. Further, Mr Sebe is receiving medical treatment in South Africa.

(b) He and his spouse are being accommodated in a house which was available. He pays for their upkeep himself.

(2) No request for political asylum has been received.

Retirement annuity funds: extension of retirement age

*25. Mr H H SCHWARZ asked the Minister of Finance:

Whether any consideration has been given to extending the age of retirement in respect of retirement annuity funds beyond 70; if so, what conclusion has been arrived at; if not, why not? B743E

The MINISTER OF FINANCE:

Yes. It was concluded that the age limit should not be extended as the purpose of allowing a deduction in respect of contributions to retirement annuity funds is to permit a person to defer tax on a portion of his income during his productive years until after his retirement. Very few people remain productive after attaining the age of 70 years, and it appears that any raising of the age limit would mainly benefit those senior citizens fortunate enough to have more than sufficient income to meet their needs, and who merely wish to further defer the payment of tax.

Durban prison at Westville: emergency detainees

*26. Mr R M BURROWS asked the Minister of Law and Order:

(1) Whether any persons are being detained in terms of the state of emergency at the Durban Prison in Westville; if so, how many;

(2) whether he will make a statement on the matter? B744E

The MINISTER OF LAW AND ORDER:

(1) Yes, 18 persons on 17 April 1990.

(2) The detention of these persons is as a result of the conflict situation in Natal and is in the interests of the maintenance of law and order, the public safety and the termination of the statement of emergency.

Minister/Mandela: meetings outside prison

*27. Adv S C JACOBS asked the Minister of Justice:†

(1) (a) On how many occasions did he meet Mr Nelson Mandela outside prison premises and (b) (i) where and (ii) when did each such meeting take place;

(2) whether he was accompanied by any other Cabinet Ministers at these meetings; if so, by what Ministers;

(3) whether the constitutional future of South Africa was under discussion at any of these meetings; if so, at which meetings? B752E

Medical aids raise fees 22%

(299)

GERALD REILLY

PRETORIA — Medical aid schemes have increased members' subscriptions by an average of 20% to 22%.

Association of Medical Schemes chief executive Rob Speedie said yesterday mounting costs of illness had intensified pressure on the schemes and benefit payouts could exceed R5,25bn this year.

The question of whether contributions will have to be raised again this year would depend largely on the extent of mooted salary increases for nurses. Private hospitals had already expressed serious concern about the impact of the increases. BIDay 18/4/90.

National Health and Population Development Minister Dr Rina Venter recently indicated substantial salary increases for nursing personnel would be announced soon. They are expected to be backdated to April 1.

Speedie said another major factor loading costs was the sharp rise in medicine and drug prices in the past few months. Manufacturers had raised prices by between 22% and 35%, which was much higher than expected.

He said doctors' fees were raised in terms of the scale of benefits in January and it was extremeley unlikely there would be another increase this year.

Beneficiaries of all schemes, including unregistered schemes such as those of the police and prisons department, had increased to about 6,5-million.

On scheme payouts, Speedie said the latest available statistics (for 1988) showed that general practitioners received 16,1% of total payouts, medical specialists 18%, dentists 11,3%, provincial hospitals 5,8%, private hospitals 15,8%, and medicines and drugs 26,1%.

The percentages were likely to change this year with hospital, medicine and drugs payouts rising sharply.

State and markets both have role to play in health care

BDay 18/4/90.

MIKE MULLER

299

A MAJOR meeting on post-apartheid health policy has just been held in Maputo. That it was held there rather than in SA is symbolic of the distance that separates the domestic parties in this critical policy area, as well as a reflection of the speed of change.

The delegates from the Frontline health ministries, the ANC health department, internal organisations and professional groups debated, among other things, lessons from the experience of the Frontline states — experience based on the principle of "health for all" which South Africans would be rash to dismiss.

Meanwhile, our health industry appears determined to follow its current path of "health for some", with medical aid schemes clamouring to offer preferential rates for low-risk members and to hell with the rest. But it follows this path at its peril, given the existing problems of free market medicine.

These begin at birth, as illustrated by the decision of the SA Society of Obstetricians and Gynaecologists to revise its fee system. This revision attempts to deal with suggestions that caesarean deliveries might be performed for financial rather than clinical reasons. "A global fee for confinements was decided upon in an attempt to lower the extremely high number of caesarean sections done in private practice," it explains in its recent Guide to Fees review.

The would-be free market midwives of the new SA economic order should take heed. If they thought through the implications of this symptomatic piece of voluntary regulation, they might reconsider the more extreme of their policy prescriptions lest the baby they deliver is a mutant monster.

The debate about how to provide health care in a new SA, including articles in Business Day over the past few months, has important implications for many other areas of life. In particular, it highlights the caution needed in addressing the vexed and central question of the role (if any) of the state. Essentially, the debate is between those who believe in the cure-all of the market and those who prefer their prescriptions to be rather more specific.

Prof W Duncan Reekie of the Wits Business School set the ball rolling (Business Day, January 31) with a fervent plea for deregulation of medicine. "Health care is not a special case," he argued, adding that you don't understand much about how a CD player works when you buy it, either.

Prof Reekie has a long track record of defending the existing system of private health care and promoting the further extensions of privatisation and deregulation. He believes that "only deregulation can permit us to find the best system or (more likely) the optimal plurality of systems".

What Reekie ignores, however, is the evidence which we already have. Last year he argued in the SA Medical Journal that over-the-counter medicine from chemists provided good, cost-effective treatment. The economics looked compelling; the facts are not.

Take the survey published in the SA Medical Journal in November 1989, which showed that more than 60% of Johannesburg chemists recommended the wrong medicine for children with diarrhoea. The products some of them offered are not only ineffective; they are well known worldwide to be potentially dangerous, in the extreme, fatal; more efficacious remedies are widely known but not very profitable to sell.

"These findings are perturbing, because acute diarrhoeal disease is the biggest cause of mortality of children aged one to four years in SA," comment Dr Peter Barron and his students from the Wits Department of Community Health, who conducted the survey.

A senior pharmaceutical professional commented, anonymously, that the situation revealed by the survey was "unforgivable". The problem was that those in the chemists' business were schizophrenic, professionals who had to give sound advice but also businessmen who had to sell medicines to make a living. His only consolation was that doctors' prescribing for the same condition was just as bad.

There are many more examples. But for the purposes of the present debate, what matters is whether the end results are acceptable — and they are not. SA was recently relegated by the World Bank from upper-income to the medium-income developing country league; but we don't even look good when we compare lemons with lemons.

Although SA is near the top of the 35-country medium-income league, with Brazil and Malaysia, our life expectancy and infant mortality figures fall in the bottom quarter with those of the Philippines, Zimbabwe and the Dominican Republic. This is despite the fact that we spent about the same proportion of GNP on health as do the other countries — that is, we spent more per head than poorer countries but got less for our money.

Extreme, untested prescriptions in the vein of "let the market take the strain" are not the answer. Suggestions that medical aid schemes should be deregulated so that they can offer reduced premiums to low-risk groups are dangerous nonsense which would leave more people dependent on the state.

Health is a basic social goal and international experience is that some form of co-operation is necessary if basic health care is to be made available to all. This does not mean that all health care must be provided by the state. The state need only give the private sector a framework in which to operate — by obliging medical aids to opt into, rather than out of, high-risk care and thus enlarging the community which can pay its own way.

A compulsory national health insurance system to which all wage earners would have to contribute has been mooted. This would firstly ensure that those with means covered themselves for health risks. Secondly, it would ensure competition.

Present medical aids are too small and too many to match the might of the providers. So a national scheme would not just pay health bills. It would use its strong central bargaining position to ensure that the health consumer got value for money in a market in which the role of consumer (usually a doctor) and provider (also a doctor) are today hopelessly mixed up.

Services could continue to be provided by private enterprises working in a market environment. The existing medical aids could act as agents for the national system.

It has authoritatively been suggested that savings from such a compulsory insurance system could pay for a parallel health-care system for the indigent. Intelligent state intervention would thus use the market to achieve its social goal. It would bring more people into self-financed health care and minimise the residual burden for the state which will always have to provide for the rest — for Ken Owen's "poor lunatic, always last in line" (Business Day, March 6).

The market mechanism can undoubtedly promote economic growth; this in turn may well improve the welfare of the community. But health, in its broadest sense, is a welfare objective which can and should also be addressed directly, by efficient health services. Why go the long way round?

☐ **Mike Muller, development specialist and author of The Health of Nations, has written extensively on international health policy.**

Call for equal services

Sowetan 18/6/90 299

Sowetan Africa News Service

MAPUTO - An international conference on health in Southern Africa has called for the transformation of South Africa's health and social services into "a non racial, accessible, equitable, cost-effective and democratic national health and welfare system."

The conference drew together a large numbers of health workers and anti-apartheid activitists, members of the ANC and representatives of the Frontline states.

In its final declaration the conference said priority in South Africa should be given to "the development of a progressive primary health care strategy as the basis for the provision of health and welfare services."

It stressed "the importance of making realistic assessments of the resources required for meeting national health and welfare needs equitably, and researching means for mobilising such resources."

Medical aid scheme subs jump 20-22%

CNA Times 18/4/90 (299)

Own Correspondent

PRETORIA. — Medical aid schemes have increased members' subscriptions by an average of 20% to 22%.

Association of Medical Schemes chief executive Mr Rob Speedie said yesterday that mounting costs of illness had intensified pressure on the aid schemes.

He said benefit payouts could exceed R5,25 billion this year.

The question of whether contributions would have to be raised again this year would depend largely on the extent of the coming increase in salaries of nursing personnel.

Mr Speedie said private hospitals had already expressed serious concern at the likely impact of the pay increases on total costs.

Another major factor loading costs, he said, was the sharp rise in medicine and drug prices in the past few months.

Manufacturers had raised prices by between 22% and 35% — far in excess of what had been expected, Mr Speedie said.

Doctors' fees were raised in the scale of benefits in January and it was extremely unlikely there would be another increase this year.

Beneficiaries of all schemes, including unregistered schemes — like the police and prisons department schemes, had increased to around 6,5 million.

On scheme payouts Mr Speedie said that in 1988 — the latest available statistics — general practitioners got 16,1% of total payouts, medical specialists 18%, dentists 11,3%, provincial hospitals 5,8%, private hospitals 15,8% and medicines and drugs 26,1%.

The percentages were likely to change this year, with hospital and medicine drug payouts rising sharply.

However, Mr Speedie stressed that the vital and unknown factor which would determine whether schemes' subscriptions would have to be raised again this year was nurses' salaries.

Other sources pointed out that National Health and Population Development Minister Dr Rina Venter had indicated that substantial salary increases for nursing personnel would be announced soon.

They are expected to be backdated to April 1.

"Stop the killings" ... disabled demonstrators, themselves victims of violence such as the 1976 riots, mustered in Soweto yesterday to protest against the violence in Natal and elsewhere in the country. Picture by Ken Oosterbroek.

'Disabled people in protest

By Montshiwa Moroke

Members of Disabled People South Africa (DPSA) staged a demonstration outside Soweto's Baragwanath Hospital yesterday to register their protest against the current wave of violence in Natal and other parts of the country.

An emotional Mr Friday Mandla Mavuso, co-chairman of the organisation, pleaded: "For God's sake, for how long must people kill each other?"

The protesters, some from as far as Tembisa, then took to the old Potchefstroom Road and brought traffic to a standstill.

Blew hooters

Diepmeadow traffic officers controlled the flow of traffic as some motorists blew their hooters in support.

Some protesters were carrying placards, one of which read: "We don't believe Vlok and Buthelezi can end the violence".

Others said: "I was shot in 1976" and "I was stabbed".

Uniformed police in a minibus monitored the demonstration.

The DPSA said it was with "a sense of great urgency" that the organisation had joined in the call by political leaders for an immediate end to violence by all parties.

"We especially condemn the use of excessive force by the police in situations of conflict.

"In the past month, 300 people have been killed in political violence in Natal alone.

"Already we have heard of too many people who have been blinded, paralysed and otherwise disabled in the current violence."

The DPSA said it was a terrible fate to be disabled in South Africa. For the vast majority, it meant a life of poverty and isolation, facing discrimination on all fronts.

The few support services which existed for disabled people were hopelessly over-burdened and had little to offer to the majority of such people.

"Apartheid has taken its toll on disabled people in South Africa. Many of our people became disabled as a direct result of State repression. Others sustained injuries in violence as a result of socio-economic conditions in apartheid's townships," the DPSA said.

R1 000 monthly medaid by 2000

ST Times 22/4/90 · (299)

THE 20% to 22% increase in medical-aid subscription rates announced this week presages members' payments of up to R1 000 a month by the year 2000.

Soaring costs of medicine, overuse of benefits, overservicing by medical practitioners, an ageing population and alleged inefficiencies on the part of medaid schemes have hurt members where it hurts most — in the pocket.

The increase announced by the Representative Association of Medical Aid Schemes (Rams) translates into a R200 to R300 annual rise in rates.

The 1988 report by the Registrar of Medical Schemes shows that the 20% of the population who are members of medaid schemes face average premiums of up to R1 000 in 10 years' time.

The forecast is based on subscription increases, which average 20,1% since 1978 on a compound annual growth rate.

Rams chief executive Rob Speedie says mounting health-care costs mean payouts could rise to R5,20-billion this year. Last year's payouts were an estimated R4-billion.

The lion's share of payments goes to medicines and drugs — more than 26%. But increased medicine and drug prices of between 22% and 35% by manufacturers in the past few months could lift the percentage sharply.

By Robyn Chalmers

Medical specialists receive 18%, general practitioners 16%, private hospitals 15,8%, dentists 11,3% and provincial hospitals 5,8%. The rest is spent on administration.

Central Statistical Services says medical costs have risen by almost 300% since 1980 — double the all-price inflation index for the same time.

Double

Since 1985, it estimates the increase to have been about 112%, doctors' and dentists' fees rising 60%, and hospital services by 79%.

The Registrar's 1988 report shows that the payout for medicines and drugs in 1987 was 26,9% of total medaid income, so the percentage has remained steady in the past few years.

In 1987, income for schemes was R2,8-billion, of which R2,4-billion was paid in benefits. But as each year passes, the gap between medical expenses and medaid payouts is getting bigger.

The result has been a swing to schemes offered by insurance companies. They claim they fill the gap left by medaid schemes, not compete with them.

The reason for the growing gap between recommended fees and benefits is that an increasingly number of doctors and most private hospitals have opted out of the scale of benefits.

In 1989, more than 70% of private hospitals raised their fees above those laid down by Rams. They said costs had risen way above the annual increases in the scale of benefits.

Rams announced increases last year in the scale of benefits ranging from 10% to 15%.

Private hospitals and graded day clinics received an 18% increase, dentists got 15% and physiotherapists 16,7%. Its payout for doctors' services rose to 15%, as well as for consultative and other services rendered by general practitioners, gynaecologists and pathologists.

Disabled pensioners forced to wait up to two years for grants

By S'BU MNGADI

DISABLED pensioners in KwaZulu have to wait up to two years to get their grants because of an elaborate system of renewing eligibility for the next grant.

Community workers have also blamed widespread corruption and embezzlement of funds for the pensioners' woes.

Seventy-five year old partially blind Mrs Mageba (no first name given) expressed her agony in a letter to the KwaZulu Minister of Health and Welfare after her pension was suspended in November 1988.

She has filled the necessary renewal papers and has taken up the case with Ulundi but she is still waiting.

Mr Majoka (no first name given), cited in a recent Black Sash report on the state of black pensioners in South Africa, has waited more than 18 months for his grant.

Majoka is a disabled pensioner from a remote rural area in Umbumbulu. He went to the Black Sash office in Durban in October 1988 for help after not having received his disability grant since January 1988.

Black Sash wrote to Ulundi and sent a copy to the magistrate at Umbumbulu asking him to investigate. Two months later, Majoka came back to check on progress.

He had grown tired of living off the charity of his neighbours.

The following year he contacted Ulundi and he was advised to go for a review. After he was sent from pillar to post the Umbumbulu office said review forms had been forwarded and Majoka should wait "a couple of months".

By the end of May 1989 the original forms had not reached Ulundi and Majoka was asked to fill in a form for a second review.

In the middle of June the Black Sash phoned Ulundi who said they had backdated payment to March 1989.

After several similar promises from officials in Ulundi, Majoka is still waiting.

KwaZulu's senior citizens shuttled from pillar to post

Similar stories come from an advice office in Maritzburg.

Most of the pensioners seeking advice in Maritzburg have not received payment since January 1989.

The Black Sash has identified a number of problems in the issuing of grants. Among the problems are:

- Rules for the granting of disability grants are becoming stiffer; and
- Grantees are required to get updated medical certificates. If not completed in detail they are sent back to the relevant magistrate's office with instructions for the grantee to go back to the district surgeon for a more detailed report. These instructions are seldom, if ever, passed on to the applicant.

The report said it was lamentable that disability grants were being cut at a time when the number of the disabled in KwaZulu was on the increase because of the political violence in the area.

KwaZulu Minister of Welfare and Pensions MM September has admitted that some of the claims made to *City Press* were true.

He undertook to investigate personally the allegations made by Mageba and Majoka.

September said breakdown in communication between his department and its agents had contributed to the pensions crisis.

"Clearly, efficiency on our part is lacking, and I have been hammering people about it," he said.

The hearing will [illegible] embassy, and this could cause some embarrassment for ANC members expected to accompany Coetzee. arrived in Lon[illegible] Thursday for the hearing, which could last two weeks.

Primary health care 'falling by the wayside'

TANIA LEVY

CLINIC hours have been changed to protect health workers whose lives have been threatened in the unrest-racked Maritzburg region.

And attendance at clinics has dropped by about 25% in the past two months as violence in the area intensified.

Maritzburg Medical Officer of Health Iain Walters said people had become so concerned with sheer survival that primary health care such as immunisation and family planning had fallen by the wayside.

He said attendance had also dropped at the only clinic in the area that treated sexually transmitted diseases.

Walters said some of his staff had lost their homes in the unrest and several had received death threats, as had black health inspectors.

At refugee centres in the region volunteer health workers have provided primary health care to people who have fled their homes.

Walters said Maritzburg's usually whites-only Grey's Hospital had had to admit many injured UDF supporters who refused to be treated at KwaZulu-administered Edendale Hospital, which they see as an Inkatha stronghold. Northland Hospital's trauma unit has also been flooded with victims of the violence.

Natal Provincial Administration comment was unavailable at time of going to press.

□ Sapa reports from Pretoria that Canada will provide $200 000 in emergency assistance to victims of Natal violence according to an announcement last week by Secretary of State for External Affairs Joe Clark and External Relations and International Development Minister Monique Landry.

A statement from the Canadian embassy in Pretoria said the contribution is to be halved between the International Committee of the Red Cross (ICRC) and the SA Council of Churches (SACC).

The ICRC and the Maritzburg Council of Churches, on behalf of the SACC, will manage the distribution of the money, which will be in the form of food, blankets and other emergency provisions to those forced to flee their homes.

Training the disabled

Sowetan 23/4/90

WOMAN

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Woman of the week

Bertha Mkhwebane

BERTHA Mkhwebane is the brains and energy behind the Vosloorus Mental Health Project.

The idea for the project struck Mkhwebane, a senior community development officer of the Vosloorus Town Council, in 1985, after she had discovered from the department's casework that mentally handicapped children in Vosloorus suffered neglect and in some cases sexual and physical abuse.

Research into the problem revealed a great need for the project, according to Mkhwebane.

"In meetings with parents of mentally handicapped children, I found that they desperately needed help," she said.

And so, in 1988, Mkhwebane established a day care centre, which is run from the township's community hall.

"Initially the project was aimed at caring for the children during the day but we decided to start an informal school where they were divided into learning groups, according to their mental capabilities," she said.

Socialising

The centre has 32 children aged between five and 26. They are taught socialising, physical training and household chores. They are also taught reading and writing, and two of the centre's graduates were recently admitted to a technical college.

Mhwebane is a University of the North BA social work graduate. Born in Benoni 34 years ago, her interest in social work was not accidental. It was influenced largely by those in the profession who used to visit her home when she was young.

"My father had a heart condition that kept him in hospital most of the time," she said.

"Social workers would visit to check on his progress outside the hospital and how the family was coping. It was then that I became interested in the profession.

"The mental health project was one way of ploughing back the goodwill that the social workers had shown to my family," she said.

Grants

A mother of one, Mkhwebane, said her goal was to acquire a site and have a proper school built for the children. She has already made it possible for most of the children to get State grants. Children under 15 receive R70 a month and 16-year-olds and above get R150.

She has resolved to dedicate herself to the project until the Department of Education and Training takes it over.

Old Mutual launches new venture to cover health care

LESLEY LAMBERT

CAPE TOWN — Old Mutual has launched a new short-term insurance company that will provide a comprehensive range of new health-care products and cost-effective administration of medical aid schemes.

The company, Old Mutual Health Insurance, represents an extension of the concept of health insurance introduced by Crusader Life and is expected to be copied by other leading life insurers once they have assessed the response to the new company.

Old Mutual's Employee Benefits assistant GM Henk Beets says the company has been established to supplement existing medical aid schemes in an environment where sharply rising costs, restrictive legislation and the growing gap between medical aid tariffs and actual costs has made health care increasingly prohibitive.

The recent loosening up of some restrictive conditions in the Medical Schemes Act has also made it easier for insurance companies to enter this market as they can now apply rates more flexibly and ensure — by charging high-risk members more and low-risk members less — that one group of members does not end up subsidising another.

The range in insurance cover will include hospital and major surgery cover, hospital confinement cover, an income plan to ensure regular income in case an accident or illness interrupts earning ability, convalescence financing, an evacuation scheme to cover emergency professional medical response, funeral expense cover and financing of nursing and home care. Employers and individuals will be able to tailor their own schemes from this range

...become a ... farmers. Audit fees were R3m. — Sapa.

Ban on hydroquinone surprises Twins

TANIA LEVY

MEDICAL professionals and consumer organisations have scored a victory in the skin lightener "war" with National Health and Population Development Minister Rina Venter's decision to ban the use of hydroquinone in cosmetics.

Venter announced in the Government Gazette her intention to remove hydroquinone from the scope of the Foodstuffs, Cosmetics and Disinfectants Act. This means products containing hydroquinone will have to be registered as a medicine and be subject to more stringent control.

Dermatological Society of SA president Mary Ann Sher yesterday welcomed the announcement as it was something organisations such as the Medical Association of SA and the Black Consumer Union had been trying to achieve for two years.

She said research had shown about 30% of black women in the PWV area had irrevocable skin damage from using products containing hydroquinone.

Twins Pharmaceuticals — which has about 75% of the R80m a year skin lightener industry — has been taken by surprise by the announcement as the ban on skin lighteners had originally been postponed to January 1 1991.

Twins marketing GM Maurits Rood said government could lose R28m a year in taxes from the skin lightener industry if the ban succeeded in stopping sales.

He said Twins would apply for some of their strong brand name skin lighteners to be registered as a medicine. Others would be marketed — without hydroquinone — as complexion creams.

He said the key question was the date when Venter's intention would be formalised.

Noristan acquires Crest

Star 24/4/90 By Jabulani Sikhakhane 85 299

Noristan Holdings has reached an agreement in principle for its subsidiary, Aurochs Investment, to acquire 100 percent of Crest Holdings for R7,2 million, which is the equivalent of 105c per share. Crest's share price closed at 85c yesterday.

The acquisition is in line with the policy to change the nature of Aurochs' business from that of a property company to one operating in the health care industry.

The finalisation of the transaction is subject to the major licensor, which is represented by Crest, agreeing to the transaction and transferring its licensing and distribution agreements.

In terms of the transaction, effective from October 1 last year (the beginning of Crest's current financial year), Crest shareholders will receive R46,50 in cash and nine Aurochs shares for every 100 Crest shares held. Aurochs shares will be issued and allotted at 650c each and the listing of Crest will be terminated on completion of the transaction.

Aurochs, which will own 100 percent of Crest, will have cash or near cash of R12,5 million from the sale of its property subsidiaries by no later than June 30 1990 to Hunts (an FSI company) for R15,7 million.

Citizens (a 55 percent subsidiary of W&A), which owns 20,1 percent of Crest, will hold 124,270 shares in Aurochs and cash resources of R4,8 million. If no suitable investment opportunity for Citizens is identified before the completion of the sale of its holding in Crest, Citizens will become a cash shell and its listing will be suspended.

(2) whether there are currently any vacancies at (a) primary and (b) high schools as a result of such resignations; if so, how many in each subject area in each case? B674E

The MINISTER OF EDUCATION AND CULTURE:

(1) (a) (i) 461
(ii) 1 044
(b) (i) 7,72
(ii) 11,73
(c) loss of 667,
(d) acceptance of non-teaching posts
better salaries and working conditions
personal reasons
further study;

(2) (a) no,
*(b) yes,

Afrikaans First Language	2
Business Economy	1
Biology	3
Electrician	3
English First Language	3
Home Economics	1
Instrumental Music	4
Physical Education	2
Physical Science	6
Accountancy	1
Technical Drawing	5
Typing	1
Guidance	1
Mathematics	6

* in the normal course of events these posts are filled by qualified teachers who are not appropriately trained in these subjects. They are, however, assisted by means of in-service training, distance training, etc. in order to provide adequate tuition in the subject.

State Revenue account: capital expenditure on universities

104. Mr J H MOMBERG asked the Minister of Education and Culture:

What was the total capital expenditure from the State Revenue Account on universities under the control of his Department in the 1989-90 financial year? B678E

The MINISTER OF EDUCATION AND CULTURE:

The total capital expenditure was R12 429 901,21 consisting of an amount of R9 859 901,21 in respect of the University of Pretoria for the extensions at the Faculty of Veterinary Science and an amount of R2 580 000 in respect of the University of Cape Town for its Medical School at the Groote Schuur Hospital. These figures do not include the subsidies in respect of interest and capital redemption on State and private loans.

HOUSE OF REPRESENTATIVES

QUESTIONS

† Indicates translated version.

For oral reply:

General Affairs:

Eersterus: health services

*1. Mr P R E DA GAMA asked the Minister of National Health and Population Development:

(1) Whether her Department (a) renders and (b) intends to take over any health services at Eersterus; if not, why not; if so, what health services in each case;

(2) whether her Department intends to hand over any health services to the Administration: House of Representatives; if not, why not; if so, what health services;

(3) whether her Department will contribute financially to the building of a new community health centre at Eersterus; if not why not;

(4) whether she will make a statement on the matter? C80E

†The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) (a) No;
(b) no, the City Council of Pretoria supplies preventative health services which include child health for the age group 0–5 years, immunisation, treatment of contagious and communicable diseases, pre- and post natal services, family planning, treatment of malnutrition diseases as well as an environmental health control service. The Administration: House of Representatives is responsible for curative services and the treatment of the elderly;

(2) falls away;

(3) yes, if such a request is received from the health authority concerned;

(4) no.

Call to extend medical aid cover to more people

BTday 25/4/90 299

TANIA LEVY

WITH only 21% of SA's total population protected by a medical scheme, extending medical coverage to a greater percentage of the population was the major challenge facing the industry, Representative Association of Medical Schemes (RAMS) executive director Rob Speedie said last night.

A system would have to be devised which balanced health care affordability with acceptable quality, Speedie said at the opening of a new branch of Medicaid Administrators in Port Elizabeth.

SA would have to move toward a system of managed health care such as the US health maintenance organisations which had proved successful.

Local medical benefit societies were a similar type of system but still comprised a very small proportion of medical schemes and should be extended in future.

There was a mistaken impression that administration costs were inflating contribution, he said. These costs had grown only 16,6% a year over the past ten years.

Schemes were non-profit organisations which allocated more than 90% of members' contributions to claims settlement. The remainder went to administration costs.

SA could not afford to follow the example set by the US and had to somehow contain health care costs.

However this was easier said than done as SA's health care system did not promote cost-consciousness on the part of either suppliers or consumers of services.

Total claims costs against medical schemes had risen at an annually compounded rate of 23,6% between 1978 and 1988. Hospitals and medicines claims had been the major contributors to the increases.

Old Mutual launches new firm

OLD Mutual has launched a new short-term insurance company which will provide a comprehensive range of health care insurance options to supplement South Africa's ailing and costly medical system.

The company, Old Mutual Health Insurance Ltd, enables Old Mutual to offer wide-ranging health care insurance cover to individuals through their employers.

Leon Bekker, said from Cape Town said the new company set the stage for Old Mutual's expansion into the health care field at a time when sharply rising costs were making health care prohibitively expensive.

"It has become clear that there is a need for a

By MOKGADI PELA

major assurer with the necessary underwriting muscle and medical aid experience to take up the challenge," Bekker said.

Old Mutual's new range of health care insurance, known as Medmaster, comprises eight separate packages.

Range

Medmaster is designed to supplement existing medical aid schemes and as a range of free-standing health insurance products.

The range includes hospital and major surgery cover, hospital confinement cover and funeral expenses cover.

Bekker said the system would offer employers more flexibility in their medical aid arrangements.

Old Mutual's Employee Benefit assistant general manager, Mr Henk Beets, said the establishment of the company was a significant event in the South African assurance industry.

Medicine costs in SA near top

Results of a study released yesterday show that the price of medicine in South Africa is higher than in most Western European countries, SABC radio reports.

A researcher at the Pretoria College of Pharmacy, Mr David Boyce, said the first phase of the study undertaken in 1988 showed that local medicine prices, in rand terms, were 20 percent higher than in Britain, 70 percent higher than in Australia, but 41 percent lower than in the United States.

Mr Boyce said that in a comparison with 11 Western European countries and the US, only three countries had higher prices than South Africa.

Mr Boyce, who was speaking at a pharmaceutical congress in Johannesburg, said it was evident that a way would have to be found to keep prices of medicines in South Africa manageable if no price control system was going to be introduced. — Sapa.

Unofficial HIV figures top 55 000 — Minister

Political Staff

CAPE TOWN — A total of 3 431 South Africans had been reported HIV-positive by March 9, Health Mininster Dr Rina Venter said yesterday.

However, this figure was based only on voluntary anonymous reports received from diagnostic centres.

Venter said the best available estimates based on varibus data sources suggested that the number of people infected with HIV in SA at the end of last year was about 55 000.

The World Health Organisation has estimated that almost 500 000 people in SA could be infected with HIV by the end of next year.

Venter said in reply to a question from Francois Pauw (CP, nominated) that more than 90% of transmissions of HIV infection took place by sexual contact or were transmitted from the mother to the unborn child.

Less than 10% of HIV infection was preventable through medical technology. "This is already taken care of by rendering a blood transfusion service as safe as possible."

Venter said various disciplines of the health services were already involved in awareness and knowledge dissemination campaigns.

"Motivation towards safer sexual practices is mainly done in small groups or on an individual basis."

To this end the department had established AIDS training and information centres in Cape Town, Port Elizabeth, Durban, Bloemfontein and Johannesburg.

"These centres are to act as sources of information to assist trainers and counsellors to motivate local communities and attain community involvement and participation in anti-AIDS campaigns," she said.

Call on business to plan for AIDS

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LINDA ENSOR

OLD MUTUAL's projection of the spread and consequences of AIDS sees a drastic decline in business confidence by as early as 1995 as a result of the spread of the disease.

In a speech to the Tygerberg Chamber of Commerce and Industry yesterday, Old Mutual chief operating officer Gerhard van Niekerk said businesses should make possible consequences central to their 10-year plans.

There would be a massive diversion of resources to medical care and other welfare spending because of AIDS, which would also have a big effect on tourism. The population could decline sharply, spelling bad news for the rand and inflation.

BTday
27/4/90

HEALTH CARE

What hospitals think

Hospital superintendents and managers hold sharply divided views on privatisation and a national health system. Some diehards remain as racist as ever.

These were the findings of a survey by Pim Goldby Management Consultants on the challenges facing SA hospitals. The survey was conducted late last year and the results were released last week. The questionnaire was sent to the top people in more than 700 hospitals in the private and public sectors. About 30% replied. Some respondents defied the ban on taking part in surveys that some provincial administrations maintain.

The survey pointed out wide discrepancies in hospital occupancy. No less than 13% reported an occupancy rate of more than 100%, which meant that some patients were sleeping on the floor. In Natal, 28% reported an overflow of patients. Moreover, the survey was compiled before the height of the current violence. On the other hand, 10% of the hospitals surveyed reported occupancy rates of less than 50%, well under the 60% break-even point in the private sector.

"Don't sell Bara"

The survey results included a series of comments and privatisation proved to be a most divisive issue. Predictably, 75% of private sector hospital chiefs felt that privatisation would lead to a cheaper and more efficient health care system, though a surprisingly high 23% disagreed.

In the provincial sector, the strongest opposition came from superintendents of hospitals with more than 700 beds — those chaotic public institutions such as Baragwanath in Soweto and King Edward in Durban that could benefit the most from private sector discipline. Of these, 53% felt privatisation would not lead to a less expensive and more efficient system.

"Frankly, it's difficult to imagine anyone wanting to buy Baragwanath," says Pim Goldby's Greg Candy. "But it could certainly be commercialised and certain services could be contracted to the private sector."

Comments reflect the public/private polarisation: "A system of national health is the only fair system," says the head of a state hospital in a large city. A manager from the private sector states: "Privatisation would give better management in terms of control, innovations, asset utilisation, cost savings and high standards." But another private administrator says "privatisation of health care should be preceded by the establishment of national health insurance for the whole country."

Racism is still firmly rooted at many hospitals; a diehard proportion of administrators oppose nonracialism, though desegregating hospitals is the most obvious way to rationalise. Fully 17% believe that it would have a detrimental affect on their services and 21% felt that it would actually hurt finances, even though it would obviously increase occupancy rates in white hospitals.

The good news is that a majority of the public sector chiefs, 51%, agree that desegregation would have a positive effect on their finances. One head of a hospital in a medium-size city says: "Duplication of services — separate black, white and Asian/coloured hospitals — costs three times as much. Furthermore, nurses have become stereotyped and do not learn cross-cultural nursing." ■

4,8%.

HEALTH INSURANCE (299)

Topping up FIM 27/4/90

Old Mutual's move into employee health insurance taps an under-exploited market. At present, employees are locked into medical aid schemes whose functions are limited by the Medical Schemes Act. The system is based on cross subsidisation, with healthy members carrying the costs of the less healthy. To stay viable, funds pay out according to a defined scale of benefits and cannot go beyond a prescribed maximum.

Health insurance, on the other hand, looks at group insurance for a company as a separate risk. Premiums are based on employee profile (including age) and type of work and are paid by the company or shared by employer and employees.

Though medical aids may offer bereavement plans and travel insurance and, in future, may be allowed to provide the more comprehensive cover of health insurance, current legislation precludes this. Old Mutual's Health Insurance is designed to supplement existing schemes. This "top-up" approach will provide additional income to employees whose expenses cannot be met by an existing medical aid system.

FINANCIAL MAIL APRIL 27 1990

Old Mutual Health Insurance functions as a short-term insurance company and, therefore, falls under the Insurance Act. ■

Old Mutual to the patient's rescue

ST Times 29/4/90

By Robyn Chalmers

COMFORT FOR AILING MEDAID MEMBERS

PROSPECTS for the troubled medical-aid business are looking up with Old Mutual's entry to health insurance.

Old Mutual launched a company this week to provide a wide range of health-insurance products.

Its announcement follows estimates that medaid members could face subscription rates of up to R1 000 a month by the year 2000. Medical costs have risen by almost 300% since 1980, putting a heavy strain on medaid schemes.

Old Mutual employee benefits assistant general manager Henk Beets says there is huge potential for change in health care.

"The most important assets needed to make health insurance work are major capital resources and actuarial and other systems.

"Old Mutual has them — as well as the experience and credibility which the health insurance needs. We have injected R15-million working capital into the Old Mutual Health Insurance."

Soaring medical costs and an inability of medaid companies to cover the full costs of treatment have long caused concern for both employees and employers.

A study commissioned by the Hollandia Reinsurance Group in 1989 found that short-term and life insurers would have to move into medical aid if the movement was to remain alive.

[redacted]

The report expressed serious reservations about the future solvency of some medaid schemes, and said insurers should move in as complementary agents to the schemes.

It advanced four arguments in favour of private health insurance — lowering the taxpayer's burden, increasing productivity, alleviating patient anxiety and enhanced competition in mediaid.

Crusader Life had a head start in insurance by offering health cover. But Old Mutual is the first to register a company with the specific purpose of providing health-care insurance.

Mr Beets says one reason why insurers should succeed where medaid companies are struggling is that they are not bound by the Medical Schemes Act.

The Act compels medaid schemes to offer a set amount of cover and pay costs according to a scale of benefits. This means there is cross-subsidisation among schemes, healthy members funding the more sickly.

Insurance companies, however, are governed by a different law. They base health-insurance premiums on the individual's age, medical history and type of work undertaken, for example.

This means they can offer a tailor-made product instead of an all-encompassing scheme. They can thus cut costs and increase the cover offered.

Old Mutual stresses that its products are meant to supplement the ailing medaid system. The reason is that under the Medical Schemes Act, insurers cannot offer general medical cover.

Plans such as Old Mutual's provide additional money to those whose expenses cannot be met by medaid schemes. But they cannot take over the role of medaid schemes.

[redacted]

But under the Insurance Act, they can make products and cover more flexible. The Old Mutual range, for example, includes hospital and major surgery cover and a plan to ensure regular income in case an accident or illness.

It also offers convalescence financing, a scheme to cover emergency professional medical response, funeral expenses and financing of nursing and home care.

Bickering hindering rural health, conference told

Star 30/4/93 (299)

Own Correspondent

Bickering between pharmacists and doctors is affecting the implementation of community health services in South Africa.

Stamping grounds were being defended, said Dr Stephen Louw from the University of Cape Town during a panel discussion on the impact of utilised research findings on community health, held at the Human Sciences Research Council (HSRC) in Pretoria last week.

In response to a question from the floor on whether the bickering was ethical he replied "one should use the resources on hand to help as many people as possible in a community".

'Egotistical' cancer

One delegate said he believed the implementation of medical research was strongly restrained by the egos involved.

"This is an inherent cancer which has crept into health care.

"It is a global phenomenon," replied Dr Derek Yach from the Medical Research Council.

Another said one of the gravest problems of implementing community health in rural areas was that the contribution which could be made by qualified community health nurses was often overlooked.

Dr Yach replied that the implementation of these services hinged on a multidisciplinary team approach.

He said a paradox existed in community health research.

The Department of National Health and Population Development was gradually shifting the health care em phasis to the poorer communities.

Much of the research was handled by universities, which had a lot to lose in terms of labratory facilities and equipment through budget cuts.

Dr Louw said universities were already suffering from financial cutbacks imposed during the past two years and many posts were now vacant.

Another delegate said a balance be tween the training of "top people" and the rendering of community health services was essential.

During another panel discussion on research and environmental conservation strategies Professor John Butler-Adam from the University of Durban-Westville said the Government had no fixed conservation policy. Neither did most conservation groups, which meant implementing research findings was extremely difficult.

He said conflicts of interests occurred between conservationists, Government officials and developers using South African beaches. These differences were being investigated.

Jomo Sono lines up for the disabled in fund-raising drive

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Sowetan 3/5/90

By MATSHUBE MFOLOE

MORE than 100 disabled people from various centres on the Reef will take part in a wheelchair marathon race in Alexandra Township on Saturday.

The event has been organised by the Self Help Association for Paraplegics and the Self Help Association of Disabled of Alexandra to raise funds for workshop equipment for the Alexandra centre.

Paraplegics from Soweto, Tembisa, Daveyton and Natalspruit will take part.

Managing director of Jomo Midas Cosmos Jomo Sono has offered to sponsor the event.

Yesterday he presented a cheque for R2 000 to the chairman of Shadax, Mr John Gwebu, in addition to his earlier offer to provide full kits to participants and refreshments during the run.

Sono estimated that about R20 000 would be needed to finance the entire event and for buying the needed machinery. He appealed to interested businessmen to help.

The 2,5km race will start from Bramley View at noon to the Alexandra stadium. The Bramley traffic department will assist in controlling the traffic flow on selected routes.

A series of activities have been lined up for the afternoon. They include a raffle at the stadium and a charity soccer match at 3pm.

Cosmos soccer stars Thomas Madigage, Lawrence Siyangaphi and Sono will be in the team to play an Alexandra select team.

Proceeds from the game will go to Shadax.

Promotion of dental health

Sowetan 4/5/90

As part of its promotion of dental health, Beecham South Africa has donated a Mitsubishi minibus to the Medunsa Department of Community Dentistry.

Beecham has also donated tubes of toothpaste and toothbrushes for the project, Jane Bunce of Transworld Promotions said.

A spokesman for Beecham said part of their social responsibility commitment entailed the promotion of dental hygiene. He said if dental hygiene habits were instilled at an early age, they set the foundation for lifetime healthy teeth and gums.

MEDICAL INSURANCE (299)

Finding fault FIM 4/5/90

Just as Old Mutual launches its new package of flexible medical cover (*Economy* April 27), medical schemes are claiming such insurance packages have serious flaws.

Under the Medical Schemes Act, medical schemes may not pay more than the scale of benefits. Largely because most private hospitals charge more than the scale for hospitalisation, there has been a surge of interest in insurance cover to top up hospital costs — though these policies still don't provide for the extra cost of medical consultations or medicines.

Traditionally, insurers have treated hospitalisation cover as an additional benefit of a life policy. The oldest of these policies is the Crusader Life dread disease cover, which provides a lump sum on the diagnosis of a dread disease, such as cancer. More recently, hospital cover policies have been provided on a short-term basis. But now, for the first time, an insurer has openly said it's in competition with medical schemes.

"Medmaster can be used as additional cover for people already on medical aid but it can also be purchased by people who want some security for major medical expenses and are prepared to self-insure on smaller items," says Old Mutual's Hank Beets. "We are also looking to insure lower-income people who rely on the State now but don't have access to proper State facilities."

The problem is that such schemes usually operate from the third day for smaller bills or have a heavy excess.— R7 000 in the case of Medmaster. Since the average stay in a private hospital is 3,8 days, benefits are applicable for only less than half the average stay.

Nevertheless, hospitals encourage these policies. The head of the Zandfontein Clinic John Cowlin says these packages make sense at the top end of the market as insurance against big ticket surgery, such as heart surgery. "Top business people will want a cash payout to make their lives easier, which does allow them a chance to recuperate in comfort after a major illness."

But Affiliated Medical Aid chairman Tony Leveton says insurers can choose who they'll insure and contracts are annually renewable. Medical schemes, on the other hand, can't expel members and are obliged to offer continuing cover to pensioners.

"We're offering a social security product and insurers are offering an additonal product for the well off. But I'm not sure if it's always marketed that way.

"Moreover these policies don't cover all serious illness. Two people might be diagnosed for cancer. The first would get his benefit because the illness is operable. The second case might be inoperable and so the patient would be ineligible for payment under the policy. But the cost of treatment might be just as great, because he would have an enormous bill from life-sustaining drugs."

According to the report of the Registrar of Medical Schemes, just 16% of medical aid benefits are paid to private hospitals, compared with 34% to doctors and 26% for medicines.

Another major concern is the value insurance policies provide. According to the Registrar, administration charges take up 6% of costs. This means 94c in every rand is allocated for claims and reserves. On the other hand, says Jeff Slome, MD of Medicaid, which is part of the Priceforbes insurance group, insurers take off 20c for commission and 20c for administration and profit, leaving just 60c in the rand for benefits. "I'm not hostile to health insurance. I'm just not sure that it's in the public interest."

The conclusions of the Competition Board report on medical schemes should be made public by mid-year. There is strong speculation that the system of maximum benefits will be scrapped, which would enable medical schemes to offer additional cover in areas, such as the northern suburbs of Johannesburg and the southern suburbs of Cape Town, where almost all doctors and hospitals have contracted out. ■

Hospice to the rescue

HEALTH NEWS

By MOKGADI PELA

"WE aim to make the death of a person as meaningful as his life has been," says the Hospice Association of the Witwatersrand.

Initiated 11 years ago, HAW is now among 18 hospice organisations countrywide, all belonging to the Hospice Association of Southern Africa. The association's objective is taking care of terminally ill patients.

"The hospice philosophy is based on the quality of life. Its services are directed by medical professionals and are offered on the basis of need only, not ability to pay and without regard to race or religion," said Hospice's Wits chief executive officer, Mr Stan Henen.

The association is also to host a workshop in Soweto on Saturday May 12 which will cater for those needing the service in the complex. Henen said hospice had acquired a site in Soweto and would start building soon. He said the growing number of terminally ill patients in Soweto necessitated the construction of such a facility. The workshop would be held at the Orlando East Methodist Church, near Orlando Stadium, from 11am to 5pm.

Henen said invitations had been extended to officials of the Azanian Peoples Organisation and the African National Congress. After the official opening the programme will include talks by the mother of a terminally ill child, a social worker, a nursing sister on her role in the specialised care of these patients and a minister of religion.

Nursing

He said hospice provided nursing care, symptom management, nutritional planning and psycho-social and spiritual cousselling. The Hospice-At-Home nursing sister is on call 24 hours a day at (011) 974-8787. Hospice also provided an inpatient unit with about 150 families at any one time.

Henen said one in four deaths in the country were due to terminal illnesses. He said Soweto alone experienced between 3 000 and 4 000 deaths each year due to such diseases. The diseases include cancer and Aids.

Most patients currently receiving such care cannot afford the medical fees and are being cared for free of charge. Hospice is subsidised by the private sector. If it was not so, patients would have been required to fork out R150 a day.

Stan Henen ... explaining the role of Hospice.

Cape residents petition for health bond scheme

Sowetan 11/5/90

SOWETAN Correspondent

ENTHUSIASM for a state "Health Bond" scheme to inject capital in to the country's ailing health services is mounting as thousands around the Peninsula sign petitions.

A Fish Hoek woman, Mrs Sandra Burman, telephoned *The Argus* to say she and a team of others had collected thousands of signatures in the Simon's Town constituency during the past three weeks.

Chronic

"We even have 90-year-olds collecting signatures at the home for the aged!"

Burman's concern for the chronic state of South Africa's health services, in particular the major teaching hospitals, prompted her to start a petition in Fish Hoek, Simon's Town and Kommetjie calling on the State President, Mr F W de Klerk, to authorise a Health Bonus Bond scheme in the same way as funds were raised for Defence in the late 1970s.

Hospice group plans aid for Soweto, West Rand patients

Sowetan 15/5/90

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SOWETAN Correspondent

THE Hospice Association of the Witwatersrand hopes to double the size of its existing in-patient unit this year and to establish programmes to meet the needs of the West Rand and Soweto.

At the official opening of national Hospice Week at the Witwatersrand association's Johannesburg headquarters yesterday, Barbara Bauer, HAW projects co-ordinator, said a mandate to provide services in Soweto had been obtained at a function in the township at the weekend.

Hospice provides care for the terminally ill and their families as well as bereavement counselling.

Speaking at yesterday's opening ceremony, Stan Henen, HAW's chief executive, said: "The Government has all-too-often abrogated its responsibility and made no meaningful contribution to programmes such as hospice.

The time has now come for it to stand up and be counted.

"I believe that government should either match the private sector contribution or recognise companies' efforts by permitting corporate donations to fall within the gambit of Section 18 (a) of the Income tax Act."

Guests at the function included the chairman of Johannesburg Consolidated Investments (JCI), Murray Hofmeyr, whose organisation has over the past few years given financial support to HAW, and the mayors of Johannesburg, Randburg, Dobsonville and Alexandra.

Making inroads in health care

PHARMACEUTICAL company Warner Lambert has made inroads in the vital area of primary health care in places where such services do not reach.

Public affairs manager Russell Ruiters says his Cape Town-based concern has moved closer to its community to determine what is needed.

Once the needs are established, regular interaction with progressive community leaders and organisations and an in-house CSR committee consisting of a cross-section of the company's employees follows.

Warner Lambert's CSR programme encompasses a wide spectrum of activities, including education, healthcare, community development, small business development, training and advancement of employees.

Ruiters says support for education is the empowerment of people to shape their own destinies, ensuring the availability of well-educated people able to take their rightful place in society.

The company's primary health-care efforts include encouraging the formation of a unitary health-care delivery structure to ensure adequate service for all.

Ruiters says the company's attitude to and belief in CSR has its roots in a progressive business philosphy — the sometime mooted objective of business to make a return on investment is short-sighted.

"No organisation operates in a closed system. Any attempt to behave as if the system is closed will eventually result in a collapse of the business."

He says it is the lack of appropriate action by business to the despair of the community that has led to the belief by some that the free market system and apartheid are synonymous.

"Vanguards of the free market should never allow such a distorted perception to exist when it is the pursuance of a particular political ideology that has led to the inequalities in the community."

CSR should be a vehicle through which business can redeem itself in the eyes of the dispossessed, he says.

Business cannot assume the role of a dispassionate bystander in the process of reform and transition, he says.

Medi-Clinic profits soar

Medi-Clinic had an excellent year to end-March with profits jumping by over 200 percent.

Net income attributable to shareholders rose to R11,29 million compared with last year's R3,63 million. Earnings per share showed a similar jump, moving from 4c to 12,4c.

Trading income was R16,17 million (R10,37 million), while interest received doubled to R3,55 million (R1,59 million).

The group states that as a result of accumulated tax losses it is not at present liable for taxation. On a fully taxed basis earnings per share this year would have been 6c (2c).

A dividend of 3c a share has been declared.

The directors are confident that growth will continue but add the changing hospital salary structures made it difficult to forecast the extent of the growth. — Sapa.

Disabled pair need aid on jobs

SO weten 17/5/90

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By NKOPANE MAKOBANE

TWO disabled people from Tembisa, who have just completed a one-year business studies course with a Randburg college, are appealing to employers to give them jobs.

They are Mr Lucas Madutlela (31) and Ms Juliet Mapaya (21). Their course at the college was made possible by Mrs Agnes Makgato, a social worker with the Tembisa branch of the Association For the Physically Disabled.

Fees

She also found them sponsorships from Beecham South Africa, who provided transport, lunch and tuition fees.

Madutlela, whose right leg is slightly disabled and uses a walking stick, obtained distinctions in eight subjects of his course.

Mapaya is cerebral palsied, which has resulted in her having an uneven gait. She also has a defect in her eye but has good vision.

She did nine subjects and obtained a 60 percent passing mark, three percent more than the required 57 percent.

Both have matric certificates.

Subjects

Their subjects at the college included functional English, Bookkeeping, understanding computers, business methods, business English applied, employment skills, framework 11, Lotus 1-2-3 and Dbase 111.

Mrs PA Rigby, the director of the college, said the two would be an asset to any company that would offer them jobs.

Both were pleasant people to work with and showed respect.

Any organisations interested in the services of the two could contact Mrs Agnes Makgato at (011) 920-3309 or (011) 646-8331.

Woman with heart of gold

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Woman of the Week

Ruth Machobane

RUTH Machobane is a diligent member of the Transvaal Association for Black Blind Adults (Tabba), which she helped found in 1973.

This gutsy woman does her duties for the association as if she is not blind. She straddles through barriers that have kept many people like her holed up in oblivion, and as if they did not exist.

She was the first black blind woman to work as switchboard operator and was last year conferred with a BA degree from Vista University.

"The degree was a test for both myslef and my lecturers," Machobane said.

"They had never had a blind student before, except one who was partially blind. They did not know how to handle my case."

While studying, Machobane was still working for Tabba. As a part-time student she would be in the office during the day and at times at school or the other way round.

At her office, her phone rings constantly and she is only too happy to listen and give advice.

"I would not abandon my job at the association. Tabba plays an important role in improving the quality of life of blind people. I am committed to its cause," she said.

The association offers services such as counselling, placement in employment, generating projects and self-improvement workshops to the blind in all its three regions in the Transvaal. It helps blind children through school by paying for their tuition and books. Its brick-making project, which was started in 1988, employs 14 blind men.

Tabba is non-profit organisation, solely depended on donations for survival. They have got several projects in the pipeline which cannot take off becuase of lack of funds. These include a project for wives of blind men, a plant nursery, a fibre glass project and a rent-a-toilet business scheme.

Machobane, a mother of four children aged between 27 and 19, is devoted to the betterment of the blind. Her achievements are dedicated to them and are meant to prove to them that "they too can do it."

"A lot of blind children look at the future with awe. Most of them feel there is no reason to study because they would only be going back to sit in the sun. I do it for them so as to follow me,"she said.

Ciskei government: recognition by SA

*13. Mr A E DE WET asked the Minister of Foreign Affairs:

(1) Whether the South African Government has officially recognised the present Ciskei Government; if so, when; if not,

(2) whether the South African Government is considering doing so; if so, when will it do so; if not, why not?

Hansard 22/5/90 B1058E

The MINISTER OF FOREIGN AFFAIRS:

(1) No.

(2) Consideration will be given to the matter in due course.

Former inhabitants of Nqonkqweni: resettlement

*14. Mr A E DE WET asked the Minister of Foreign Affairs:

(1) Whether he has discussed with the current Ciskei Government the resettlement of the former inhabitants of Nqonkqweni on the land originally occupied by them; if so, (a) when and (b) with what results; if not,

(2) whether he will intercede with that government on their behalf; if not, why not; if so, when?

Hansard 22/5/90 B1059E

The MINISTER OF FOREIGN AFFAIRS:

(1) The Deputy Minister of Foreign Affairs discussed the matter with the Council of State of Ciskei.

(a) 7 May 1990.

(b) The Council of State reacted positively to the resettlement of the former inhabitants at Nqonkqweni.

(2) Deliberations are held on a regular basis with the Council of State in this regard.

Citizen Force members: arms/ammunition bought

*15. Mr K M ANDREW asked the Minister of Defence: Hansard 22/5/90

Whether any arms or ammunition were sold and/or are being sold to individual members of Citizen Force units in the Cape Peninsula or anywhere else in the Republic; if so, (a) where, (b) why, (c) what arms and ammunition, (d) on what conditions and (e) on what basis are the prices of these items calculated?

Hansard 22/5/90 B1060E

The MINISTER OF DEFENCE:

Yes.

(a) At all Citizen Force Units.

(b) The weapons were phased out and the selling thereof to members of the Permanent Force, Citizen force and Commandos has been part of the South African Defence Force's disposal procedures since 1961.

(c) .303 rifles, .38 revolvers and small arms ammunition.

(d) Members

— must be serving members with at least 5 years service;

— must be in possession of a valid firearm licence;

— may only buy one of a specific type of weapon; and

— may not dispose of such weapons within 5 years of purchase, except in the case of finalisation of the members' estates.

(e) Weapons are sold at book value plus General Sales Tax. Phased out ammunition is sold at purchase price plus General Sales Tax. Other small arms ammunition is sold at contract price plus General Sales Tax and a levy of 15%.

Medical aid societies: funds for employees of local authorities (299)

*16. Mr J VAN ECK asked the Minister of Planning and Provincial Affairs:

(1) What are the names of the medical aid societies or funds which are available to employees of the local authorities for the various race groups in the Cape Province;

(2) whether employes of such local authorities are free to join any of these societies or funds; if not, Hansard 22/5/90

(3) whether any employees are compelled to join medical aid societies or funds whose membership is restricted to one particular race group; if so, which (a) medical aid societies or funds and (b) local authorities are involved;

(4) whether any consideration is being given to changing rules compelling employees to join such societies or funds; if not, why not; if so, what steps have been taken in this regard? (299) B1061E

The MINISTER OF PLANNING AND PROVINCIAL AFFAIRS:

(1) Local Authorities Medical Aid Fund (Cape) (LAMAF)
Whites

Pro Sano Medical Aid Scheme
All race groups

Bonitas Medical Fund
All race groups

(2) No, in respect of LAMAF

(3) Yes.

(a) Local Authorities Medical Aid Fund (Cape) (LAMAF)

(b) All local authorities established in terms of the Municipal Ordinance, 1974 (Ordinance 20 of 1974) and the Regional Services Councils Act, 1985 (Act 109 of 1985)

(4) No. In terms of its rules, eligibility for membership is determined by LAMAF itself.

Eastern Transvaal: atmospheric pollution

*17. Mr B B GOODALL asked the Minister of National Health and Population Development:
Hansard 22/5/90

(1) Whether her Department has ceased financing the monitoring of atmospheric pollution in the Eastern Transvaal by the Council for Scientific and Industrial Research; if so, why;

(2) whether this project is to be resumed in the future; if so, when; if not, why not;

(3) whether she or her Department has received any representations regarding such monitoring; if so, (a) from whom and (b) what was the (i) purport of and (ii) response to each such representation?

B1063E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) Yes, temporarily, in order to switch to a system where tenders are allocated for this task by the State Tender Board. Previously, this task was executed as a part of a CSIR research project;

(2) yes, as soon as tenders has been allocated;

(3) no. Hansard 22/5/90

SADF: IEM

*18. Mr R J LORIMER asked the Minister of Defence: Hansard 22/5/90

(1) Whether the Council for the Environment's procedures on Integrated Environmental Management (IEM) have been brought to his notice and/or that of the South African Defence Force; if so,

(2) whether the Defence Force is developing IEM procedures as a part of its internal physical development and planning procedures; if not, why not; if so, what progress has been made in this regard;

(3) whether the Defence Force is utilising IEM philosophies and procedures in the management of the land under its control; if not, why not; if so, with what results;

(4) whether the Defence Force will feed back its experiences and opinions on IEM to the Council for the Environment to assist the latter in improving and refining IEM procedures and guide-lines; if not, why not; if so, when?

B1064E

The MINISTER OF DEFENCE:

(1) Yes.

(2) and (3) As a result of the guide-lines for Integrated Environmental Management issued by the Council for the Environment work is now being done on the policy and procedures for the application thereof in the South African Defence Force. The impact of the utilisation of Integrated Environmental Management philosophies and procedures will thus only be available in due course.

(4) Towards the end of 1990.

Jagoe: for disability rights

KATHY Jagoe speaks with a quiet, determined voice that refuses to let social or political barriers stand in her way.

Although too modest to admit it, Jagoe has been and still is regarded as a champion for those in society with restricted mobility, impaired hearing and sight.

She is director of the Disability Unit at the University of Cape Town — a unit which she was largely responsible for establishing.

Her activities involve working towards removing barriers that handicap the normal participation of disabled people on campus and lecturing on Disability Studies in psychology, building science, paramedics and medics departments.

Involvement

Jagoe's involvement stretches back a long time. In many ways, she and her colleagues have been responsible for spearheading more radical approaches to dealing with the plight of disabled people than the more conventional welfare approach.

"Welfare is a hierarchical, top-down organisation, doing something for you on behalf of you. Traditional welfare is an equivalent to while domination," says Jagoe.

Influenced by the political ideas of Black Consciousness leader, Steve Biko, and the ways in which disabled people drew on the experiences of the Civil Rights movements

Jagoe found her perspective shifting.

Her move to Johannesburg from the Eastern Cape, where she had completed degrees in Fine Arts and Education at Rhodes University, coincided with her growing practical involvement.

Participation

She became increasingly aware of the power of promoting social change for people with disabilities through active participation.

Jagoe says: "1981 was marked as the International Year Of Disabled People by the United Nations; the South African government chose to ignore this.

"Groups of disabled people took this up as an issue. We were no longer prepared to allow the government to divide us into blind, deaf, quadraplegics ..."

Jagoe and a colleague, Mike du Toit, set up a group in Johannesburg.

"We found we had more in common: we were barred from societies and experienced the same forms of general discrimination," she says.

In 1984, the group launched a national umbrella body, Disabled People South Africa (DPSA), the first movement to be run by disabled people.

Discrepancy

Although originally apolitical, it heralded a major transformation for the politics of the disabled rights. For the first time, people with different disabilities and political attitudes, and from different racial groups sat together and communicated as equals.

Jagoe, however, recognises the discrepancy that exists between white and black disabled people in this country. In papers delivered throughout the country, she cited apartheid as one of the main causes in creating black disabled people.

She argued that unhygienic townships, poor sanitation, unproductive rural areas and overcrowded hospitals resulted in long-term disabilities such as polio, tuberculosis and leprosy.

Jagoe also recognised that, while most whites sustained spinal injuries through car accidents and sport, most black spinal injuries were caused through domestic and political violence.

WhenBaragwanath Hospital closed down its Spinal Unit, people with spinal injuries in Soweto had nowhere to go. Jagoe and Thulani Tsabalala aslo a spinal injured colleague set up a health group in the out-patients department where they did part-time counselling.

According to Jagoe, the two main killers of the spinally-injured are pressure sores and urinary tract infection. The only chance of survival depends on education and proper sanitation.

"In 1981, we could hardly find a quadraplegic, black, spinally-injured person in Soweto; they simply died." says Jagoe.

Speaking to a journalist a few years ago, she said that, some patients opened their pressure sores with blades so they could return to hospital.

For Jagoe, the reasons for this were clear: the hospital was seen as preferable — compared to the conditions in the townships. Returning to a community where houses have toilets not accessible to wheelchairs, where there may be no bathrooms or electricity, or the only source of water may be a tap shared by hundreds, meant a certain death.

Besides the socio-political features of disability, one of the major problems facing disabled people is a lack of access to society. Jagoe has worked on this for several years.

Changes

In 1981, while lecturing in various departments at the University of Witwatersrand in Johannesburg, she started a battle to persuade the government to recognise the disabled in building regulations.

She also pressured the university into making structural changes to the campus buildings to enable disabled people to have greater access to the campus.

While working as a consultant to Anglo American Property Services (Ampros) on barrier-free design, Jagoe developed a toilet for people on wheelchairs.

For Jagoe, though, the barriers are not just architectural.

There are also barriers created by people's attitudes towards the disabled.

"Sexual stereotypes about disabled people being asexual are deep-seated. Although people can get over some stereotypes — they accept you as a colleague — they still find it difficult to accept a disabled person as a lover," says Jagoe.

Media advertisements of glamorous bodies are partially responsible for creating perceptions which narrowly relate sex to intercourse, she says.

The spiralling political violence in South Africa since 1984 made her aware that, while there was wide publicity about deaths and detentions, people disabled by political violence were simply forgotten.

"Organisations do not see disability as an issue. This is not totally the fault of the political movements. Disability has not been presented to them as an issue," says Jagoe.

She points out that miners with spinal injuries are sent to special clinics. The National Union of Mineworkers (NUM) never sees them.

Statistics

"There are readily available statistics of those who die, but we don 't have statistics of those disabled, because they never return.

"Unions fighting for health and safety should not be concerned only with death; they have to look at disability," she says.

While Jagoe feels it is important to see the ANC putting issues such as the environment on its agenda, she would like to see the same being done with disability.
— *Krisen Pather*

 # Kathy Jagoe, a champion for those in society who have restricted mobility, hearing problems and blindness

KATHY Jagoe broke her neck when she dived into a sandbank while playing in the surf off Eastern Cape when she was 15 years old. All four limbs were paralysed.

Since then, she has had to contend with many battles — both physically and psychologically. Initially, she wanted to have nothing to do with disabled people, refusing to go to a special school.

When her application to enrol at Rhodes University was turned down and the government refused to give her a teaching bursary, she fought their decisions until they were rescinded.

At the age of 32, disaster struck for the second time. While she was driving down to Cape Town, a tyre on her specially-constructed van exploded. The accident cost Jagoe her left leg, a specially -constructed van and her motorised wheelchair.

But she has risen above her problems. Her personal battles have been translated into broader battles for both black and white disabled people. SOUTH interviewed her in her home, decorated with her paintings:

Row over medical discounts

29/6/90

Sowetan

A CONTROVERSY is raging between doctors and a major medical aid society over discounts on medicines.

The row stems from a demand by Medscheme for a 15 percent discount on all medicines dispensed by doctors to its members.

This week, a group of doctors resolved at a meeting to stop honouring medical cards belonging to Medscheme until they dropped their demand for discounts.

One of the doctors, who cannot be named for ethical reasons, said the society was demanding the discount for what it termed prompt processing of medical aid statements and for services like postage.

Mr Les Hollis, mananging director of Medscheme, said the Medical Schemes Act compelled them to pay a doctor for his services if he charged the scale of benefits which was the gazetted price list.

ties and technikons.

The corporation's Central Training Unit — which employs about 50 professional Unit, which aims to increase Anglo's and its associate companies' business transactions with the small-business sector.

Changing health threats will need new services — report

B'day 29/6/90 299

CAPE TOWN — AIDS, assaults, smoking and alcohol-related diseases will replace diarrhoea and measles as major health threats in poorer communities during the next decade and dealing with them will require fundamental changes in health services.

This is the conclusion of a group of academic doctors in a recently published paper entitled Critical Issues for Community Health in the 1990s.

The authors argue that socio-political and demographic changes, particularly associated with high fertility rates and rapid urbanisation, will have a profound influence on the state of community health and

LESLEY LAMBERT

the provision of health care.

Another major influence will be the residual effects of apartheid which will remain for some time once the current race-based system has ended, they say.

To address the new health threats, fundamental changes will be required in the way community health professionals are trained, in the direction of medical research and the relationship between state health authorities at all levels and non-governmental organisations.

In addition, non-governmental organisations will be required to play an increasing role in extending and complementing the changing function of government health services.

The authors emphasise the need to address the private sector's tendency to treat conditions that produce maximum profit, while neglecting preventive, promotive and rehabilitative activities.

They accept that involvement in the less profitable activities will need to be compensated and that this may require a revision of medical aid benefits.

They welcome government and ANC announcements on the restructuring of health services with more emphasis on primary health care.

Bill aims to crack down on maintenance dodgers

(299) 23/6/90

By JOCELYN MAKER
Weekend Argus Reporter

A TOUGH new Bill aimed at cracking down on men who do not pay their maintenance commitments has been welcomed by welfare authorities.

Maintenance dodgers could have their assets attached, their particulars passed on to credit bureaus and interest added to their arrears, according to a Bill before parliament.

A memorandum on the Maintenance Amendment Bill proposes photographing offenders to enable authorities to keep track of them.

It has also been proposed that the powers of the court be extended to enable payments to be made directly to a financial institution or to the mother and children.

In addition to maintenance orders the courts would also be empowered to make orders on lying-in costs, arrear maintenance and medical expenses.

Blood tests would be used more often to determine paternity.

The tests were expensive and people who could not afford them should be assisted, the memorandum said.

Legal experts who deal with maintenance cases, welfare organisations and other bodies involved have welcomed the recommendations.

A prominent Cape Town advocate said maintenance courts were inadequate. He would like to see the Supreme Court become more accessible to all levels of society.

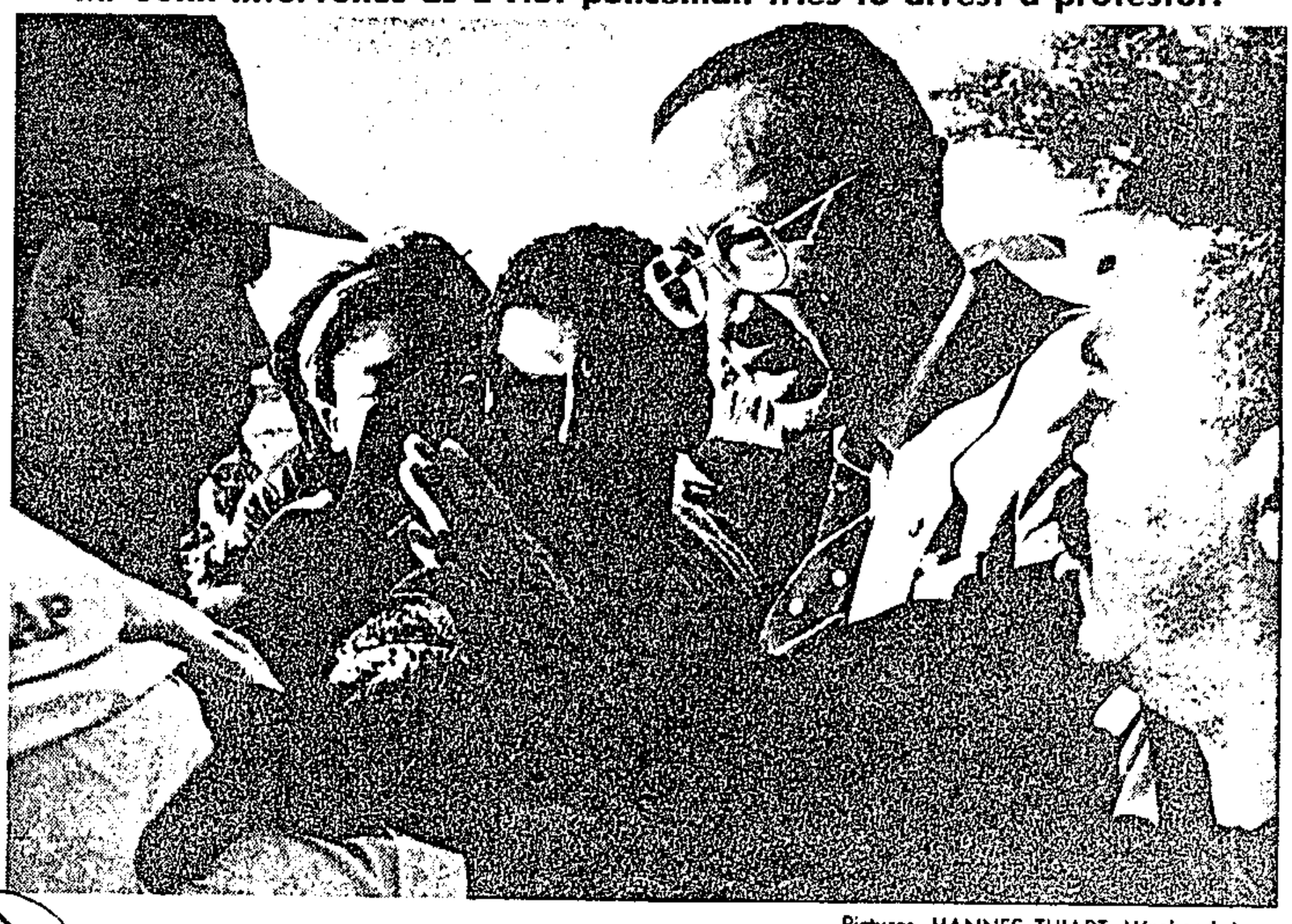
The director of the Cape Town Child Welfare Society, Ms Helen Starke, said the burden on single mothers would now be lifted.

"We have been asking for amendments for a long time and we support this bill if it changes the situation."

Another legal expert said many children not only had the trauma of divorce but a much lower standard of living once their parents had parted.

The stringent measures against defaulters have resulted from recommendations by a committee in the Department of Justice.

Peninsula Technikon rector Mr Franklin Sonn and about 25 others who took part in an illegal "March for Peace" were arrested at Athlone today. Above, before the march Mr Sonn, second from left, Imam Hassan Solomon and Mr Huxley Joshua set out in behind an ANC banner. Below, Mr Sonn intervenes as a riot policeman tries to arrest a protestor.



Pictures: HANNES THIART, Weekend Argus

MEDICAL AID SCHEMES (299)

On the carpet FM 22/6/90

The Competition Board's investigation into Medical Aid Schemes won't end until it has studied the medical, dental and pharmaceutical professions and private hospitals.

It has, however, issued a working document in which it declares many provisions of the Medical Schemes Act (which controls the medical aid movement) to be restrictive practices not in the public interest.

As widely predicted, the document finds the system of maximum benefits (which puts a tariff ceiling on amounts medical aid schemes are permitted to pay) restrictive. Minimum benefits are also seen as restrictive. Similar judgments also apply to guaranteed payments to doctors, who charge at the scale of benefits, and even the scale of benefits itself.

Medical schemes argue that the scale of benefits keeps down costs because 85% of doctors keep to this rate — now R21,10 a consultation — rather than the Medical Association's recommended R45.

One bemused source in the sector says: "The whole medical aid movement would be thrown open if these recommendations were implemented. Doctors and hospitals could start demanding what they liked and expect to be reimbursed. I can't see government, for instance, allowing minimum benefits to go.

Under-insured people would become the responsibility of the State."

The document points to Transmed, the in-house scheme run by Transnet, as a good model for schemes. It runs many of its own facilities, including dispensaries, but the report stops short of explicitly recommending that private medical aids should be allowed to emulate this.

To the annoyance of the predominantly English-speaking medical aid administrators, the 57-page document was issued only in Afrikaans — so the main administrators were unwilling to talk to the *FM* until translations had been done. Afrikaans colleagues say they need time to digest the report before commenting. Rob Speedie, bilingual executive director of the Representative Association of Medical Schemes, says it would be inappropriate to comment publicly on an interim report.

The document expresses views of the investigating team though not necessarily those of the full board. The fact that board chairman Pierre Brooks allowed it to be issued indicates that he is in broad agreement with it. ■

Bargain with your GP - Masa

Sowetan 22/6/90 (299)

Medical fees are set to rise

MANY general practitioners in Durban and the rest of the country are in the throes of raising their consultation fees - from an average of R30 per consultation to R35 with some charging up to R48, the maximum laid down by the Medical Association of South Africa.

Because medical aid organisations only pay R21.10 per consultation, medical aid patients will have to find R14.90 extra for each R35 consultation and R26.90 for a consultation charged at the maximum R48.

The Medical Association of South Africa has meanwhile urged patients "not to despair, but to bargain and talk money with their general practitioner" and have also advised doctors to "charge according to each individual case and financial situation."

General practitioners were recently advised by the Association that they should put up "signboards" in their rooms giving patients the green light to "openly talk" about what they can and cannot afford to pay the doctor.

This was said by the president of the Masa, Dr Henk Kayser.

Survey

Kayser, who is also the Minister of Health for the Ciskei, was attending the Seventh Annual General Practitioner's congress at the Wild Coast Sun last week along with 300 other general practitioners from all over South Africa.

In a snap survey done among the GPs at the Congress, it was determined that they charge about R40 per consultation in Pietersburg, about R35 in the East London area, somewhere between R30

OWN CORRESPONDENT

and R40 in the Cape, as much as R45 in parts of Johannesburg, while the average consultation in Durban costs about R30.

In an interview, Kayser said that a "total restructuring of the doctor/patient financial relationship was needed so that both patients and doctors learnt how to discuss money in an open and honest fashion.

"We are finding that more and more patients are unable to pay their medical bills or the difference between what medical aid will pay and what the doctor charges. This results in a situation where nearly all general practitioners (unless they are lucky) are finding that at least 45 percent of the money owed to them is outstanding by more than 120 days," said Kayser.

'Tailoring'

Kayser and other general practitioners, who cannot be named for professional reasons, said that it was almost impossible for a doctor to survive if he charged only Scale of Benefit fees (the amount set by the Representative Association of Medical Aid Schemes which is paid in full by medical aid schemes) as it now is lagging at more than 50 percent behind the Masa tariffs.

Some examples given by doctors of "tailoring" their fees would be to charge less for a quick consultation - for example a cold.

One general practitioner said that if a family of four came in to see him he would charge the first person something in the region of the Masa tariff while the rest would be charged at medical aid rates.

Combat a killer disease

299
Sowetan 20/6/90

Conference makes urgent call

Dr Harry Seftel of the Wits Medical School ... says advertisers promote bad habits.

By MOKGADI PELA

THE medical world should urgently take steps to prevent Coronary Heart Disease (CHD), South Africa's number one killer, according to Prof Harry Seftel of the Wits Medical School.

In his concluding remarks at the CHD seminar in Durban, Seftel said most people in South Africa, either through ignorance or sheer laziness, chose to do nothing to help themselves to avoid "this dreaded disease".

"To compound the matter, we are being fought on every side by the advertisers who promote bad habits like smoking and drinking. These merchandisers of death aim their advertisements at a very vulnerable audience," Seftel said.

'South Africa experiences a heart attack every 12 minutes'

"But we must not let this put us off. Rather let us learn from the American example where healthy living is rewarded, not fought at all levels. In the USA many medical insurance schemes now reimburse their members for Quit Smoking classes and health fitness programmes," he said.

Responsibility

Ms Rika de Ruiter of the Heart Foundation said importance should be placed on the individual responsibility for heart health. She said the community should seek to establish and maintain a desire for healthy living, cultivate a sense of responsibility for personal and community health, develop a capacity for effective social interaction, promote a sense of positive self-esteem as well as an ability to cope with change in themselves and their environment. She said South Africa experienced a heart attack every 12 minutes.

Other causes of heart disease mentioned were: hypertension, high consumption of cholesterol, smoking, obesity, diabetes and sloth or allergy to movement (lack of exercise).

Dr Altus van der Merwe, chief medical advisor of Sanlam Assurance, said CHD was the biggest cause of death claims in South Africa. "On average, more than 10 death claims per day are due to cardiovascular disease. This means the industry is providing more than R200 million per annum in benefits for CHD victims," Van der Merwe said.

The CHD profile stands as follows:

* 25 to 44 years - 22,5 percent.
* 45 to 64 years - 46,5 percent.
* 65 years and over - 47,1 percent.

Cardiologists

An analysis of life assurance claims shows the following: 32 percent are due to cardiovascular disease, 15 percent to cancer, five percent to respiratory causes, 30 to accidents and violence, and 18 percent resulted from other causes.

Van der Merwe said there was also a shortage of cardiologists in South Africa. He said the Netherlands' cardiologist-patient ratio was one for every 1 250 people, in the USA it was one cardiologist for 1 000 people, while in South Africa there was one cardiologist for 450 000 patients.

He said the insurance industry offered people who led healthy life-styles lower premiums as an incentive. "By adhering to proper lifestyles, you can add an average of 20 years to your normal lifespan," he said.

'The merchandisers of death aim their advertisements at a very vulnerable audience'

A visiting American scientist, Dr Jacques Rossouw, said the influence of cholesterol has been fractioned into that of low-density (LDL) and high density (HDL).

Risk factors

"Clinical trials offer the most powerful evidence that a risk causes the disease. Attempt to show that the three primary reversible risk factors (serum cholesterol, blood pressure and smoking) were causal for CHD were successful," Rossouw said.

"The decline of CHD in the USA coincided with a decrease in smoking, better treatment of blood pressure, a decrease in cholesterol levels and animal fat intake, and an increase in vegetable intake. These programmes coincided with national programmes aimed at highlighting the dangers of the CHD risk factors," Rossouw added.

Lending an air of realism to the symposium were three members of the Transvaal branch of the Mended Hearts Club Support Group: Eta Smith, Denise Isenberg and Leikie Rod.

Recounting their own experiences, they talked about the constant worry of living with CHD, and the overwhelming fear that occurs in the first few months. All three have taken steps to ensure a healthier lifestyle for their families. Each has modified her family's diet and exercise programme.

Heart disease costs SA's insurers 'R200m a year'

B 10,4m - 18/6/90 (299) 6887

TANIA LEVY

THE life assurance industry paid out more than R200m a year in benefits for victims of heart disease, the single biggest cause of death claims, Sanlam Life Assurance chief medical adviser J Altus van der Merwe said in Durban at the weekend.

Speaking at the Pfizer Media Tutorial: Fighting Coronary Heart Disease in SA in the 90's, Van der Merwe said on average more than 10 death claims a day were due to cardiovascular disease.

The disease accounted for about a third of total life assurance claims. Cancer was responsible for 15%, while accidents and violence were the cause of about 30% of claims.

Van der Merwe said about 47% of deaths of people over 45 were caused by coronary heart disease. Cancer caused about 19% of deaths in this age group. Cardiovascular disease victims claimed about 50% of total dread disease claims.

Dread disease insurance covers all traumatic diseases such as cancer, strokes, coronary bypass and kidney failure.

An essential insurance product in SA, dread disease cover could only be underwritten where the medical investigation and data existed to support it, Van der Merwe said.

Factors

Smoking was the most important risk factor taken into account by insurers, Van der Merwe said. Statistics showed there were 15 smokers to every non-smoker among people who died of lung cancer. Non-smokers who died of hypertension were outnumbered eight to one by smokers.

Hypertension, obesity and high cholestrol were other risk factors considered for insurance purposes.

Visiting scientist at the National Health Institute in Maryland Jacques Rossouw said the SA population needed to be continually reminded that smoking, saturated fat and dietary cholestrol, untreated blood pressure, obesity and inactivity were bad for their health.

However, health information was not enough, he said. Messages needed to be endorsed by people and organisations with high credibility — a powerful strategy used in the US.

Regulatory action to modify the environment was essential and included smoke-free areas and health warnings on cigarette packs.

Specific strategies were needed to meet the needs of different groups in SA. The familial type of high blood cholestrol in Afrikaans families should receive attention and, in Indians, diabetes.

Reasons for the alarming increase in high blood pressure among urban blacks needed to be clarified and effective programmes to treat and prevent hypertension had to be implemented.

Aid scheme to hit widows

JOHANNESBURG. — Pensioners and widows linked to the Statutory Organisations Medical Scheme (Soms) are set to pay medical contributions for the first time from July 1.

Soms administration manager Mr A M le Grange said the overwhelming majority of the scheme's more than 110 member organisations had already agreed to the proposal.

All except one of the employer organisations linked to Soms had also agreed to subsidise the contributions of pensioners and widows, Mr Le Grange said.

"I think most of our members will pay above 50% of the new contributions," he said.

Mr Le Grange was unable to give any details of which organisations had agreed to subsidise the medical contributions of pensioners and widows or how much they were prepared to pay.

If the changes were not introduced Soms would go bankrupt, he said. — Sapa

Building a healthy nation is main focus

Sowetan 14/6/90

AS PART of the Nation Building campaign, Kelloggs will have a campaign for healthy living on each Saturday in October.

The campaign will be conducted in major parts of the Transvaal and the Free State and will highlight the need for all-round good health in the family.

A qualified dietician from Baragwanath Hospital and a clinical psychologist from Medunsa will host a series of talks that will include the family's eating patterns and their psychological needs.

"Get the Taste of a Healthy Life" will include the role nutrition plays in preventing disease, infant and preschool feeding, pregnancy, the role of fibre in the the diet and the granny's dietary needs.

Parenting in the 90s includes talks on the understanding of a child's basic needs, the various development stages and appropriate behaviour in children.

Sowetan and Kelloggs have invited readers to ensure that the programme is a success.

299

Young males most common head injury victims

Sowetan 14/6/90 (299)

By MOKGADI PELA

AN 18-month study of head injuries in Johannesburg in 1983 revealed that 729 different types were treated, according to the chairman of the National Head Injuries Association (NHIA), Dr Nadine Abelson.

Of those injured, 45 percent sustained minor head injuries while 56 percent received serious wounds like bleeding on the brain, fracture of the skull and gunshot wounds.

Trend

The sources of the injuries ranged from traffic accidents and sports wounds.

The trend has been consistent ever since prompting the NHIA to establish the first Day Care Rehabilitation Centre in Rosettenville. The centre hopes to spread its tentacles to other areas to cope with about 2 000 severe head injuries occurring each year in South Africa.

The sex ratio was four males to one female who normally suffered such injuries.

The commonest age group was between 18 and 29 and those were the money earners in whom the country invested.

Abelson said another worrying factor was that even major hospitals in the country did not provide comprehensive rehabilitation facilities for head injured patients.

Abelson and NHIA's co-director, Mrs Jo Campion, said their objectives were to:

* assist the head injured person to function at maximum capacity;

* encourage the establishment of rehabilitation units and day-care centres for head-injured patients;

* be a support group to the patient and the family;

* bring people with similar problems together for mutual benefit;

* provide social and other activities for the long-term handicapped;

* create closer co-operation between parents, patients and the medical staff with regard to the understanding and management of head-injured patients;

* encourage and promote self-help groups to start anywhere in areas where they do not exist; and.

* promote public awareness through education;

Abelson explained that the roots for NHIA were traceable to 1982 when a support group for head injured patients was started. "We realised then that there were no rehabilitation centres and families were looking after the patients at home. In 1985 we applied for a fund-raising number and the following year we were accorded welfare organisation status," Abelson said.

Workshop

In offering rehabilitation to injured patients, NHIA has opened a "protected workshop", which aimed to engage patients for a day in contract work. The work will include simple jobs like sticking labels on bottles.

She said such jobs raise the patient's self-esteem and discipline. Patients would also receive some remuneration as an incentive.

At the Day Care centre, patients would be offered comprehensive treatment in physiotherapy, occupational therapy and speech therapy.

There would also be psychologists, neurologists and social workers to deal with their various needs.

Patients who qualified for such treatment were those who would not be able to get on to the open market as a result of their injuries.

NHIA also offered a life-line service at: PO Box 64310, Highlands North, 2037.

Abelson called on the private sector to help them in making their project a success by donating funds.

New branches have been earmarked for Soweto, Port Elizabeth, Durban, Pretoria and Cape Town.

New health care scheme

BPam 1/6/90 EDWARD WEST (299)

HEALTH care and life assurer Crusader Life Assurance Corporation was introducing a Crucare range of policies on a universal life basis, the assurance group said in its 1990 annual report.

Crulife's fourth element of its health care portfolio was the development of a "universal health care" product embracing a medical scheme, catastrophe stated benefits and a longterm insurance fund, the annual report said.

The policy holder would be issued with a credit card which "paid" all medical expenses on an indemnity basis, and a monthly statement indicating the cardholder's "financial status".

A computerised life system was acquired from the UK to handle increased volumes of business emanating from Crucare universal life policies. This system was in its final stages of implementation, the report said.

Crulife's dividends grew 25% while new business written increased by 49%, the report for the year to December showed. Net premium income grew by 51% to R60,73m while total assets exceeded R120m.

The report said Crulife's budget for 1990 was promising and substantial growth coupled with a further decline in expense ratios was anticipated.

Group executive chairman Alexander Rowand expressed disappointment at Crulife's share price which was about half that of August 1987, in spite of dividends increasing from 8c to 14,4c and without any contribution from its UK investment as yet.

The group did not believe the current price fairly reflected the group's performance, Rowand said in the annual report.

Pegasus Life, Crulife's 24,2% held associate in the UK, sold its first policy late in May 1989.

Crulife envisaged a first trading profit by 1992. Earnings would be over and above profits generated in SA and it might be possible to allow shareholders a direct stake in Pegasus when it sought a London Stock Exchange listing in due course, Rowand said.

†Mr H A SMIT: He has no respect for the Chair!

[The hon member for Overvaal thereupon withdrew from the Chamber.]

†The CHAIRMAN OF THE HOUSE: Order! I now once again call on the hon the State President.

†The STATE PRESIDENT: Mr Chairman, the hon the Minister of Justice said in public that he had informed me after I became leader of the NP and that I was aware of the fact that Mr Mandela would meet Mr P W Botha. On account of my line function prior to this, I was not involved with this matter. [Interjections.]

Ministers:

Question standing over from Tuesday, 22 May 1990:

Nuclear Non-Proliferation Treaty: signing

*20. Mr C W EGLIN asked the Minister of Foreign Affairs:

Whether, subsequent to his reply to Question No 9 on 20 February 1990, the Government has taken a decision to sign the Nuclear Non-Proliferation Treaty; if not, why not; if so, when does it intend to sign the treaty? B1066E

The MINISTER OF FINANCE (for the Minister of Foreign Affairs):

The position of the Government has not changed in essence since I replied to Question No 9 on 20 February this year.

New questions:

Adoptions: different race groups

*1. Mr L FUCHS asked the Minister of National Health and Population Development:

Whether the race group of prospective adoptive parents is a factor in determining their suitability; if so, why? B1048E

†The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

Yes.

The Child Care Act, 1983 (Act 74 of 1983) provides that the court shall not place a child in the custody of any person whose classification in terms of the Population Registration Act, 1950 (Act No 30 of 1950) is not the same as that of the child except where such person is the parent or guardian of the child.

Mr L FUCHS: Mr Chairman, arising out of the hon the Minister's reply, can she inform us as to whether any steps are being taken to do away with this discrimination?

†The MINISTER: Mr Chairman, the Government is committed to removing all discriminatory legislation, and this matter will receive attention when the Child Care Act is revised next session. [Interjections.]

†Mr H D K VAN DER MERWE: Mr Chairman, further arising out of the hon the Minister's reply, in the case of a White being married to a non-White, may a married couple adopt a child of any race group at present?

†The MINISTER: Mr Chairman, I think that is a hypothetical case. Each adoption is evaluated according to specific circumstances, and I do not want to speculate now, solely on the grounds of superficial remarks, on how a child may be placed.

Crossroads Town Committee: licences to carry fire-arms

*2. Mr J VAN ECK asked the Minister of Law and Order:

Whether licences to carry firearms have been issued to certain members of the Crossroads Town Committee, Cape Town, whose names have been furnished to the South African Police for the purpose of the Minister's reply; if so, (a) for (i) how many fire-arms, and (ii) what types of firearms, in each case, (b) why and (c) what are the names of the members in question? B1055E

The MINISTER OF LAW AND ORDER:

(a) to (c)

It can only be ascertained beyond doubt, whether a person is the holder of a fire-arm licence on the basis of the person's identity number and name. I can unfortunately not furnish the required information, owing to insufficient particulars furnished by the hon member.

Cape Town: deaths due to unrest-related incidents

*3. Mr P G SOAL asked the Minister of Law and Order:

Whether any persons died in Cape Town as a result of unrest on or about 6 September 1989 if so, how many? B1056E

†The MINISTER OF LAW AND ORDER:

No. As far as could be ascertained not in the area of jurisdiction of the Cape Town police station.

Durban academic hospital: earthworks programme delayed

*4. Mr R M BURROWS asked the Minister of National Health and Population Development:

(1) Whether the Cabinet injunction not to proceed with major hospital construction has meant that the commencement of the earthworks programme for the new Durban academic hospital has been delayed; if so, (a) for how long has it been delayed and (b) what additonal costs are likely to be incurred as a result;

(2) whether the University of Natal has been informed of the delay; if not, why not; if so, when;

(3) whether she will furnish the date on which the said earthworks programme will commence; if not, why not; if so, what is that date? B1068E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) No;

(2) falls away;

(3) the existing planning provides for the calling of tenders during July 1990.

Mr R M BURROWS: Mr Chairman, arising from the reply of the hon the Minister, I wish to say that her reply now is in total contradiction to a reply to a similar question asked in respect of the Natal Provincial Administration's Hospital Services Section, which indicated that there had been a delay of six months in the earthworks commencement.

The CHARMAN OF THE HOUSE: Order! What is the hon member's question?

Mr R M BURROWS: Mr Chairman, is the hon the Minister aware of the position of the Natal Provincial Administration?

The MINISTER: Mr Chairman, the answer is yes. I stated during the discussion of my Vote that the situation at King Edward VIII Hospital is being considered as a priority

*5. Mr R R Hulley — Law and Order. [Question standing over.]

Irradiated food: health problems

*6. Mr M J ELLIS asked the Minister of National Health and Population Development:

Whether she or her Department has received any reports of instances or alleged instances of individuals experiencing health problems as a result of the consumption of irradiated food; if so, (a) when, (b) from whom and (c) what was the (i) purport of and (ii) response to each such report? B1071E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

No.

Harms Commission: evidence by Minister

*7. Mr C W EGLIN asked the Minister of Defence:

(1) Whether he, in his capacity as the Minister of Defence, is willing to give evidence in person before the Harms Commission; if not, why not; if so,

(2) whether he has indicated this willingness to the chairman of the Commission; if not, why not; if so, when? B1075E

†The DEPUTY MINISTER OF DEFENCE:

(1) Yes.

(2) Yes. By means of my legal representative during February 1990 and personally on 2 March 1990. The hon member is also referred to column 1631 of the Hansard of 26 February 1990.

Cycads illegally removed

*8. Mr R J LORIMER asked the Minister of Justice:

(1) Whether certain persons, particulars of whom have been furnished to the Minis-

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Govt health role 'the biggest'

GERALD REILLY

PRETORIA — Only 21% of SA's population could pay for medical services and even then the state was often responsible for the provision of high-tech services, National Health and Population Development Minister Rina Venter said yesterday.

Speaking at a conference in Magaliesburg on the future of academic hospitals, Venter said goverment would remain the biggest role player in the field of health in the foreseeable future.

Because ordinary market forces could not function in health services, the participation of the private sector could never be the complete answer to the financing of services, she said.

There would have to be a definite method and order on which the reconstruction of SA's health services could take place.

It was clear to all, particularly in the squatter settlements and in the deep platteland, that health services were often not available, she said.

● VENTER

She denounced the argument that fragmentation of health services was the greatest cause of the country's health care problems as an over-simplication of a complex problem.

She said about 10% of the current Budget was allocated to health services.

To eliminate the under-utilisation of available facilities, the Cabinet had decided on a moratorium on all state hospitals still in the planning stage from December 1989. Before the development of any new hospital was authorised, a re-evaluation in all regions of SA would have to be made.

Venter said it was a waste of money to treat a patient with a cold in an academic or any other hospital. Yet this happened because there were insufficient community services.

The 13 academic hospitals with 32% of the country's total beds handled 29% of all in-patients and 40% of all out-patients. To provide this service they received 43% of the total health budget and still there were pleas that the allocation for academic hospitals be raised further, Venter said.

Income

Besides the development of a management model, there were two additional solutions already approved.

The first was increasing the income of academic hospitals which meant private patients in future would have to pay for professional services at academic hospitals. An analysis had been commissioned.

While many hospitals were over full, there were other hospitals which were totally under-utilised. The surplus of beds in white hospitals was estimated at 11 700 against a shortage of 7 000 in black hospitals.

Venter said it was not possible to first solve the problems at academic hospitals and then attend to the other gaps in health services.

As long as families had to live in poor socio-economic conditions where there was no clean water or sanitation, there would be shortage of beds for babies with gastro enteritis. SA remained one of the countries with the highest road accident figures and therefore there was a shortage of beds in intensive care units.

And as long as the violence associated with poor living conditions persisted, casualty stations would be over-burdened with the victims.

Answers therefore did not lie in the hospitals but in the communities.

Venter prescribes health care remedy

299
Sowetan
29/5/90

THE South African Government would for many years to come not be able to afford dramatic changes in its health care budget, Health Minister Dr Rina Venter, said in Magaliesberg yesterday.

Venter was delivering the opening address at a conference on the future of academic medicine organised by the Medical Association of South Africa.

She said the challenge for all responsible actors on the health scene was co-operation in utilising available funds to their maximum and most efficient manner.

South Africa was spending 5,4 percent of its Gross National Product on health care. Only 21 percent of the South African population could afford its own medical costs, which meant almost 80 percent of the population relied on the State for health care, Venter pointed out.

"The reconstruction of health care services must accordingly take place within the financial abilities of the State."

With reference to poor existing socio-economic conditions, Venter said the answer to health care for all lay not only with the hospitals, but also "outside in the community".

She said:"According to a United Nations report, a one percent rise in female literacy is three times more effective in reducing child mortality than a one percent rise in the number of doctors. This clearly demonstrates the linkage of the population development programme and health care."

She said there was "near universal consensus" that there was substantial inequality and inefficiency in terms of allocation of health care, leading to an undercurrent of consumer discontent about the way in which health care services were provided.

Venter said all governments accepted that good health care affected the health of the whole community. Good health care was, therefore, the goal of this Government, she said.

She outlined guiding principles which would serve to address health care:

* The rights of all people to have access to health care, which must incorporate a high priority role to primary health care.

* Efficient health care programmes which take into account health care requirements of the whole population.

* Affordability. About 10 percent of the present Budget was allocated to health services, but R21m was presently needed to put into operation 26 health centres not in use, while another R200m was needed to upgrade existing equipment in hospitals.

Few can afford own treatment — Venter

Carl Trotts 29/5/90 (2) (2) (299)

Own Correspondent

PRETORIA. — Only 21% of South Africa's population could pay for its own medical services and the state was often responsible for the provision of high-tech services, National Health and Population Development Minister Dr Rina Venter said yesterday.

Speaking at a conference on the future of academic hospitals, she said the goverment would for the foreseeable future remain the biggest role player in the field of health.

It was clear to all, particularly in the squatter settlements and in the deep platteland, that health services were often not available, she said.

She denounced the argument that fragmentation of health services was the greatest cause of the country's health care problems as an over-simplication of a complex problem.

One solution was to increase the incomes of academic hospitals, which meant private patients would have to pay for professional services at academic hospitals.

While many hospitals were overfull, other hospitals were totally under-utilised, she said. The surplus of beds in white hospitals was estimated at 11 700 against a shortage of 7 000 in black hospitals.

As long as families had to live in poor socio-economic conditions where there was no clean water or sanitation, there would be a shortage of beds for babies with gastro-enteritis. SA had one of the highest road-accident figures and therefore there was a shortage of beds in intensive-care units.

And as long a the violence associated with poor living conditions persisted, casualty stations would be overburdened with the victims.

Answers therefore did not lie in the hospitals but in the communities.

New alcohol, drug centre opened

A NEW alcohol and drug dependents centre was recently opened 40km north-west of Johannesburg.

Owned by the Lifecare group, Riverfield Lodge is staffed by a highly trained multi-disciplinary team consisting of medical doctors, nursing sisters, social workers, psychologists and occupational therapist.

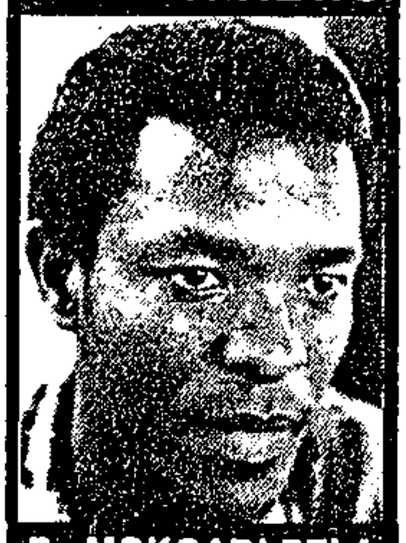
Admission to the centre is preceded by an intensive assessment involving the patient and his family.

In 1985 the Human Sciences Research Council and the South African National Council on Alcoholism and Drug Dependence estimated that more than 750 000 people were potentially alcohol dependents needing urgent intervention.

Added to this, in 1987, South African courts dealt with more than 40 000 drug-related cases.

Presently there is one bed for every 100 white patients needing institutional treatment as opposed to a single bed for 5 000 black patients.

HEALTH NEWS



By MOKGADI PELA

Surveys of general practitioners indicate that at least 10 percent of patients suffer from alcohol or drug-related problems.

For instance, more than 80 percent of cirrhosis of the liver and pancreatic cases can be directly linked to alcohol dependency.

According to surveys reported in the British Medical Journal in 1987, many alcohol dependents remain undetected because doctors fail to take accurate histories of alcohol consumption.

The estimated cost to South Africa of alcohol and drug dependency-manhours lost, medical and hospital fees-is well over R550 million per year.

Added to this are the psychological damage to immediate families, the number of suicides and alcohol-related accidents, the number of mentally retarded children born to alcoholic mothers, the link between alcohol and cancer of the breast, liver, lung, colon and rectum.

A company faced with a drug-related problem can do one of the two things:

* Tolerate the employee and shift him to where no damage can be done;

* Look for ways of treating the disease or as a last resort fire the person.

Many companies have found that an Employee Assistance Programme (EAP) is an invaluable aid in identifying the twin dependencies and setting some form of treatment in motion.

In South Africa a large number of the top 100 companies have EAP's.

NO DICE

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FIN 25/5/90

Nationalist MP Hennie Bekker's strong plea for a State lottery, to help finance health services, has been unconditionally rejected by Health Minister Rina Venter.

Speaking in parliament last week, Bekker, MP for Jeppe, said the time had come to give serious attention to a lottery. He pointed out that New York, Ireland and many African states used lotteries to boost funds for social services. While acknowledging the sensitivity of the issue, he argued that if it were legal to gamble on horse races and at casinos in homelands it was surely possible to deal effectively with the question of a lottery.

Venter wasn't interested. She gave parliament a categorical assurance that no changes to the Gambling Act were being considered to allow for a lottery. "This has been thoroughly investigated and is not an option in our current society."

SOCIAL SECURITY

MEDICARE - 1990

Investors and not the heirs enjoy the fruits of frugality

ST Times 11/7/90

LIVING benefits — those paid to the policyholder while he or she is still alive and not to a deceased estate — have increased dramtically.

Last year 80% of all the benefits paid by Old Mutual were to the living. This is a measure of the move to living benefits and savings.

The investing public is seeking a means to increase a financial base while alive and to enjoy the fruits of investment.

The concept of major medical expenses insurance (MME) is a new and urgent area for insurers. Although it is essentially a short-term form of insurance, it is offered by life companies together with employee benefits.

The Medmaster plan was set up by Old Mutual because of high medical costs for dread diseases and disability arising from accidents.

299 **Dread**

A heart bypass operation costs about R32 000 and a hip replacement R16 000, neither being fully covered by all medical aids.

In effect, Medmaster tops up medical aid which often does not pay for all sophisticated services or long-term care.

Crusader Life initiated this type of insurance a couple of years ago. It was the first company in the world to introduce dread disease cover, and is considered a leader in living benefits.

By taking out MME cover, many people are able to reduce their medical aid subscriptions. By self-insuring or carrying their own day-to-day medical costs, they are insuring for the catastrophes when they will have to rely on specialists, surgeons, hospitals and even helicopters in the event of an accident or becoming ill far from home.

B109 21790 (299)

Old Mutual follows the trend in insurance

OLD Mutual has waded into the growing trend for short-term health insurance with is new Medmaster plan offered by a new short-term company called Old Mutual Health Insurance.

The company enables Old Mutual to offer health insurance cover to individuals through their employers.

The new range of insurance, known as Medmaster, covers a wide range of health-related areas such as income loss, dread disease, convalescence, hospitalisation and major expenses.

Old Mutual says the plan allows employers to tailor health care cover around their existing medical aid scheme.

For instance, in the event of any dread diseases specified by the firm being diagnosed, the Medmaster Convalesence Plan provides cover with a tax-free lumpsum benefit.

The health problems falling under this are heart attack, stroke, coronary artery surgery, cancer, renal failure, major organ transplant and paraplegia/quadriplegia.

The plan also allows for different levels of cover for different groups.

All standard short-term insurance exclusions apply to the benefits payable.

It also offers a Hospital Plan and Major Expense Plan.

Sanlam has also entered the direct health-care field with its Trauma Benefit, which covers dread diseases.

The maximum initial cover is R150 000. There is an extra proviso in that the amount can be protected against inflation through Cover Growth, in which the sum assured will increase automatically by 60% of the premium growth rate every year.

Banding together for better service

SDay 2 17790

299

THE number of medical aids in SA is so large, due primarily to the rigidity of the Medical Schemes Act, that a successful and well-organised network of medical aid brokers has emerged.

They have formed an association to organise the industry and police members.

The National Council of Medical Aid Consultants has 15 members, with about 10 companies still outside it.

Spokesman Sidney Bernic, who is also Mapp Medical Aids MD, says the council was formed to prevent a few "unscrupulous" companies giving the industry a bad name.

It is busy establishing a fidelity guarantee of a minimum of R50 000.

He says while having such an intermediary may add to the general cost of the industry, the merits far outweigh this.

Brokers will improve the level of service and security for clients seeking the best cover for their needs.

Healthsure MD Jonathan Vardi says one of the benefits is that the broker will follow up an unpaid claim or any problem a client has with it and ensure it is settled.

Financial crisis is a boon to the insurance men

AS MEDICAL costs spiral, insurers eager to make up the shortfall of medical aid societies have had to pay out millions every year.

The parlous state of many medical aids and the financial crisis the industry is facing have been a major boon to the medical insurance industry.

Many in the insurance industry feel medical aids are duping the public by telling them they pay 100% of claims when it is only 100% of tariff.

There are serious discrepancies between tariff and actual cost.

The latest Medical Association of SA fee schedule preface says Rams' scale of benefits is 56% less than Masa's recommended fees.

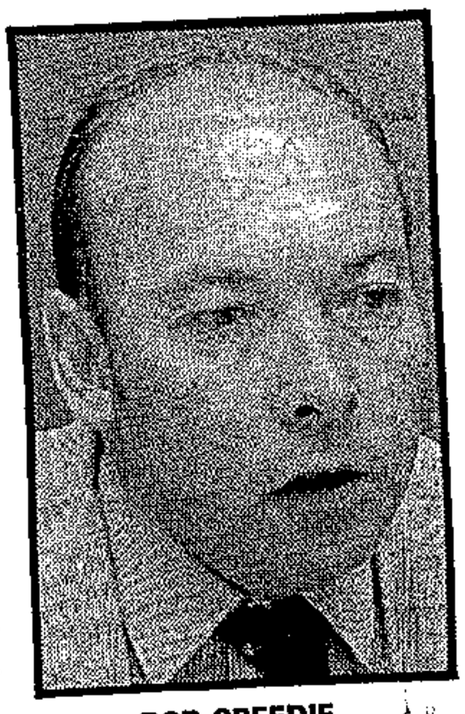
Proviso

Medical aid spokesmen say while insurance premiums may be low, most hospital plans do not provide cover until at least the third day of hospitalisation and many include a proviso that a payout will only be made once the first R5 000-odd has been paid, which rules out small operations.

Insurers offering health cover say they are constrained by the Medical Schemes Act — as are the medical aids in different ways.

Anyone defraying medical expenses on an ongoing basis falls under the Act and insurance companies have to ensure all their cover falls outside the regulations or they will be subject to the inflexible constraints of the Act.

As a result, insurance firms may not pay out the cost of an operation according to a scale of benefits or expense. They have to offer guaranteed payouts regardless of actual charges, and the money does not have to be used for health costs.



ROB SPEEDIE

A study on health care commissioned by Hollandia Reinsurance Group last year says short-term and life insurers will have to move into medical aid if the movement is to remain alive.

Representative Association of Medical Schemes (Rams) spokesman Rob Speedie says the medical aid industry feels the freedom and licence enjoyed by insurance companies in the health field is unfair and representation has been made to the Competition Board on the issue of restraints on medical schemes.

Not fair

"It's not fair that insurance companies have the opportunity of providing cover where the cause of the loss is a health condition," he says.

One of the advantages insurance companies have is selection, and they will not have to carry bad risks.

Professor of management economics at Unisa's School for Business Leadership Jan Hupkes, who conducted the study, says insurance should only supplement medical aids, not replace them.

Luxury tag is looming as costs escalate

(299)

B Day 2/7/90

MEDICAL aid is generally seen as a standard employee benefit, but this decade could see it becoming a luxury, with costs already escalating ahead of inflation.

Medical aid schemes have got some concessions out of government to make the Medical Schemes Act more flexible and allow them to make their packages more competitive.

Schemes welcome the right of choice, although the new legislation has not made much difference to the industry as yet.

The essence of the changes is that:

☐ Contribution levels may be based on factors other than simply income and family size. Age, area of residence and the claims history may be taken into account;

☐ It is possible for a medical aid scheme to introduce a no-claim bonus;

☐ Multiple benefit packages within one scheme are permissible. However, each benefit package must still include benefits in respect of all six medical disciplines.

Representative Association of Medical Schemes (Rams) spokesman Rob Speedie says the new legislation "loosened things quite considerably" but will have to be handled carefully not to push up premiums.

The ongoing battle over medical aid tariffs has led to 70% of SA's private hospital beds being contracted out of the tariffs.

Medscheme deputy MD Les Hollis says it will be "very tricky" to implement the new legislation as schemes will lose the benefit of cross-subsidisation, making it an expensive exercise.

Flexible

He says Medscheme has put in place a system for immediate implementation of a more flexible payment scheme but will not use it unless a member requests it.

Most schemes have not rushed to change their packages and are not likely to do so.

Medscheme is probably SA's largest medical administrator, with 375 000 members and 34 schemes under its wing. It pays out between R65m and R70m a month in claims.

Affiliated Medical Aids executive chairman Tony Leveton says if the new legislation is implemented, premiums in general and especially worst-risk premiums will rocket.

"But we will be exploring these options.".

He says the new regulations have not gone far enough and calls for further deregulation.

Although there are many complaints about medical aid shortfalls, if medical aids push their payout to, for instance, 120%, it will automatically push up premiums, as will a rise in medical aid tariffs.

He says one should be able to choose the level of benefit wanted, as is done to an extent with insurance schemes.

Insurance will be unnecessary with the right medical aid cover.

Sanlam subsidiary Sanmed GM Koos van der Merwe says people are keen to look at different packages, but they invariably have doubts when it comes to signing.

Old Mutual Employee Benefits assistant GM Henk Beets says changes to the Act are significant and will go some way towards making the medical aid system more efficient.

But there are further steps to be taken to align medical aid legislation more closely with social needs.

Business Day SURVEY

National Minister of Health Rina Venter may have announced the scrapping of hospital apartheid but little appears to have been done. Meetings have been held but nothing agreed on. ***DIANNA GAMES*** *reports on the health industry and the burgeoning health insurance industry.*

RINA VENTER

Sub-committee review for industry

THE Actuarial Society of SA has established a medical aid sub-committee to review the medical aid movement in SA and overseas.

It will examine the long-term financial implications of medical aid practice for members, pensioners, employers and the schemes themselves.

It will also analyse the financial burden of continuing existing health care provisions, especially the affect of AIDS.

The role of actuaries in the medical aid movement will be assessed as well as the extent to which the profession can influence the development of health care in SA.

The sub-committee has been involved in discussions with the Representative Association of Medical Aid Societies (Rams) and the Registrar of Medical Aid Societies.

Changes have not been followed up

B|Day 47190 299

MOST medical schemes, although welcoming the move, have not implemented changes to their benefits after the October change in the Medical Schemes Act.

The general feeling seems to be that if not handled carefully, it could make premiums far more expensive but cut off a major source of funds — cross subsidisation.

This means schemes could become unaffordable to the people who need them.

However, there are some schemes which have taken the step.

Durban-based National Medical Plan has announced an annual cash bonus for members and their dependants for "simply remaining in good health" and not claiming unnecessary expenses.

It implemented the bonus for its 60 000 members from January and CE Rob Basson says the first payments will be made in March 1991.

He says the cost of this subsidy in the first year will be about R1m and will be taken from reserves.

The new system has the benefit of removing "unjustified" cross-subsidies, with the cost burden being placed at source.

The large medical aids say these two factors are the problem with the new regulations.

Returned

He says members stand to have up to 30% of their premiums returned to them.

The no-claim bonus repayment for a member with more than one dependant will be R600 tax free, R500 for one dependant and R200 for single members.

Chartered Accountants Medical Aid Fund (Camaf) has also taken advantage of the changes.

Fund manager Malcolm Button says each firm using the fund will be rated according to its risk profile determined mainly by the age and claims experience of the members in the preceding year.

The fund will not offer a no-claim bonus as such, but firms that make low claims will be rewarded in future rates.

Keeping an eye on the problem of fraud

299
Bldam 21790

MEDICAL aid fraud has been exposed several times over the past few years and the extent of it has been staggering.

The latest report on the subject, in Personality magazine, claims schemes are being defrauded by up to R150m a year — nearly R70 for each of the more than two million members throughout the country.

The allegations are attributed to medical investigator Colin Wilson, who says schemes have preferred not to take action.

However, Medscheme deputy director Les Hollis says they have investigations into several cases still pending and are looking at the problem all the time.

Medscheme spends about R1m a year on claims audits and the Association of Medical Schemes is also investigating.

Medscheme is one of SA's largest medical aid administrators.

Hollis says in the US it has been estimated an average of 5% of claims are fraudulent.

With SA's total payout, this could amount to over R20m a year, he says.

Specially for the smaller business

299
Bl Day 2/7/90

THE Southern Medical Aid Society was designed especially for individuals, professionals and smaller companies.

Affiliated Medical Administrators marketing director Shaun Leveton says it allows members a choice of any medical practitioner and hospital and operates countrywide.

AMA, a Southern Life company, administers the society, which has had a very good response, says Leveton.

An advantage is that members are not required to pay an entrance fee, which in some cases may equal the first month's contribution, nor is a service or administration fee added to the normal monthly contribution.

However, the society has the right to impose exclusions or even reject an application, and normal underwriting procedures apply.

Premiums

A month's notice is required either way.

Premiums are based on the member's income and number of dependents.

It pays out 100% of the scale of benefits with various ceilings, for instance, the ceiling on hospitalisation is R35 000 a member and/or dependant.

Medical Aids Advisory Services also specialises in smaller business.

Spokesman Hugh Millar says they have had a very positive response.

AMA administers 10 medical aid societies with 186 000 members. Its daily payout is R2,1m and it deals with over 30 000 claims a day.

PEOPLE WILL PAY FOR PROPER CARE

Bloay 21 7 98

PEOPLE want First World medical care and are prepared to pay for it, says Crusader Life MD Bob Rowand.

His company pioneered SA's health insurance industry in 1982.

It now has four major schemes with more on the drawing board.

One of the four is the dread disease cover.

Rowand says the company began looking at the concept of dread disease in 1982 and developed the world's first life policy for dread disease, which was launched with Standard Bank brokers in 1983 and First Bowring in 1984.

Dread disease cover is now fairly widespread in SA and overseas.

Crusader's life policy pays the full benefit on policies up to R200 000 on diagnosis of cancer, paraplegia, heart attack, stroke, blindness, renal failure and on surgery for coronary artery disease, a disease of the aorta, heart valve replacement and organ transplants.

People may not take out this policy if they have already suffered, for instance, a heart attack

BOB ROWAND

and once they have claimed on the policy they have the option of building it up again.

There are about 60 000 holders of this package.

Crusader also offers a hospital benefit plan marketed directly through institutions such as banks and major companies. This provides hospital cover from day three of a hospital stay.

Major medical expenses cover is also offered based on a formula according to the Medical Association of SA fee guide. (299) (98)

Union to discuss strike at Edgars

Star 7/7/90

ABBEY MAKOE

A legal strike is looming at Edgars after two unions, Fedcraw and Saccawu, clashed head-on with the group over wages this week.

The unions demanded a R180 across-the-board increase, and a minimum salary of R900. Edgars group offered a R155 increase across-the-board, and a minimum salary of "not less R700" for new staff members and R800 for current employees.

Unions also demanded recognition of June 16 and March 21 as paid holidays, but Edgars offered to add an extra day to annual leave, which employees could choose to use as they liked.

However, Edgars agreed to pay its employees by the 30th of every month. Workers had before been paid on the "sixth of every new month".

Among the the unions' grievances is the existence of two medical aid schemes. One is said to cater for whites, coloureds and Indians and the other for blacks.

Fedcraw's general secretary, Nat Ketlele, said his union members would be meeting over the weekend to determine whether to develop the "without prejudice" talks or to "embark on a legal strike".

Saccawu could not be reached for comment at the time of going to press.

Health care in focus

299
South 5/7-11/7/90

OPPORTUNITIES for improving health care in a changing South Africa is the theme of a national conference to be held at UWC this weekend.

African National Congress national executive committee member Steve Tshwete will open the conference on Friday.

The conference is being organised by a group of health and development projects, health worker organisations and individuals committed to the idea of progressive primary health care (PPHC).

FM 13/7/90 - (299)

Managing health care

John Cowlin, MD of Zandfontein Clinic and director of Medicaid Health Clinics, is a leading authority on health care and medical aid services.

Privatisation of certain sectors of the economy has been government policy for several years. We have all heard a great deal about the privatisation of health care but saw little action until February, when government announced the privatisation of five hospitals: the Andre McColm, Evander, Cullinan, Kempton Park and Ontdekkers Memorial.

The terms and conditions of this privatisation are not available from the Department of Health. A group of private-sector management consultants is apparently busy with the second phase of investigations, after which privatisation tenders will be sought. In the words of one health official: "It's unlikely that anything will happen for the next three years."

Superficially, it would seem that government is prevaricating over the issue of privatisation of health care. But in fairness, most people in the industry concede that privatisation is an emotional, subjective and potentially explosive subject.

People don't elect to get sick and there is the pervasive view that it can't happen to me. This is compounded by the views held by most people that health care is a right and not a privilege; that paying for health care is the problem of the medical aid schemes; as well as the attitude that the doctor is the last to be paid.

The looming privatisation of local and even regional hospitals raises further unsolved problems: Who is going to care for pensioners and the unemployed, previously provided with health care services by State hospitals? Who will provide and pay for emergency services after hours, also provided now by State hospitals?

Who will provide and finance a secondary referral centre for patients who can no longer afford special investigations in the private sector? Who will determine the price for the sale of the State hospitals to the private sector? What guarantee will the community have that State hospital services will continue to be provided by the private operator of such a hospital?

Should the State agree to fund the health care requirements of the pensioners and indigent in these circumstances and who will guarantee the quality of service they receive from the private sector?

What will happen to the pensioner who received medication from the State for chronic illnesses, such as diabetes, hypertension, heart disease and so on — medicines that have been supplied through the State tender system at prices very much lower than those of the private sector?

In the light of these problems, one can have some sympathy for government dragging its heels over this issue. Unfortunately, the dilemma facing it remains — the State can't afford health care for most people.

Thus, in order for privatisation to proceed, cost-effective, innovative and flexible health care delivery systems must be developed by the medical aid sector.

Suppliers of services cannot exist without suppliers of finance. In the years ahead, the provision of health care financing will switch from the medical aid-type, fee-for-service structure to what is known as managed health care.

Managed health care is exactly what it implies: medical schemes involving themselves in the control and effective utilisation of health care resources. These could be hospitals, pharmacies, medical personnel, operating theatres and so on.

The concept of managed health care is not new — medical benefit schemes have been operating in this country since the Forties. Additional examples of managed health care are:

- ☐ In-house medical services, for example, where a company employs nursing sisters and doctors and runs clinics on the premises, as at mining houses;
- ☐ Health maintenance organisations; and
- ☐ Preferred provider options.

It has been shown in the US that managed health care is considerably less costly than fees-for-service systems. Certainly the experience of medical benefit schemes has been that they are more economical than medical aid systems.

There will always be a place for fee-paying health care but the future for most people is managed health care.

F|M 13|7|90

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time in memory, subscriptions could be increased in mid-year by another 5% to cover the impending increases in hospital fees.

Private hospitals have been compelled to match the increases in nurses' pay granted by the State to avoid losing staff. Nurses in provincial hospitals received increases of be-

tween 23% and 48% in June.

Afrox Healthcare GM Dick Williamson says nurses' pay accounts for 46% of a private hospital's costs. So, with increases averaging just over 30%, hospital costs will rise by about 15%. He indicates that private hospitals would like to see increases of at least this amount in medical scheme tariffs.

"We can't absorb this kind of cost," he says. "In 1986 we requested an interim increase in our tariff, but it wasn't granted, and our industry's return on capital has never recovered to the levels it enjoyed before then. We are negotiating with the Representative Association of Medical Schemes and will hold off any (hospital fee) increases until the talks have been concluded."

Clinic Holdings chairman Barney Hurwitz says hospital costs will rise. "We are confident the medical schemes will increase their tariff to us. If not, we'll have to recoup directly from the patient." Most private hospitals now charge more than the schemes pay them.

Day clinics, which charge no more than the medical schemes reimburse, are also requesting an interim tariff hike. "We've had to increase salaries in order to keep staff," says Day Clinic Association president Carl Grillenberger. "Nurses aren't as high a proportion of our own costs as they are of private hospitals — more like 30% — but the increases are still significant enough for us to seek an adjustment."

Medical Schemes Association executive director Rob Speedie says the schemes are taking the hospitals' request for tariff increases seriously. He adds that a final decision won't be reached until August 2.

It seems likely that interim tariff increases approaching 15% will be granted but, in return, private hospitals can expect a smaller increase in tariffs in January. Last January private hospital tariffs increased by 18%.

Either way, the public is going to pay, whether through higher fees to hospitals or higher medical aid subscriptions. Private hospitals account for 16% of medical aid payments so subscriptions would rise by 2,5% to cover the increases, though the increase in the number of claims that schemes have had this year could increase this to 5%.

An interim increase would represent a change in approach from the traditional confrontational stance between private hospitals and the association. The association has previously dismissed hospitals' requests for higher tariffs and pointed to the healthy bottom lines in the sector. Clinic Holdings, leader in the sector, increased its dividend this year and rival Medi-Clinic posted a dividend for the first time since its listing in 1987.

"Private hospitals should absorb some of these increases rather than passing them on to the consumer," says the Consumer Council's Jan Cronje.

Unfortunately, sick people are the ultimate captive market. There is no real consumer choice between hospitals. Patients are sent to the hospitals that their doctors choose for them, so there is little competition between groups.

If medical schemes refuse to grant an interim increase, they know that public pressure against the schemes' limit on reimbursements will grow.

The Competition Board has already said, in an interim report (*Business* June 22), that the system, which prohibits medical schemes from paying more than the limits, is a restrictive practice.

Cronje says: "It seems unfair to the man in the street that he pays ever increasing subscriptions to medical schemes and yet he still has to top up his hospital bills."

Stephen Cranston

HOSPITAL FEES F|M 13|7|90

Coughing up (299)

There's no letting up for medical aid members. Subscriptions have been rising at a compounded rate of more than 20% a year over the past five years. Now, for the first

Sandton and Midrand said.

'Shabby treatment' by taxi drivers

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HANDICAPPED people in Pretoria have threatened to stage public demonstrations in protest against the shabby treatment allegedly received from taxi drivers. Sowetan 17/7/90

This threat was made yesterday by Mr Harry Mogale, vice-president of the Associated Blind of South Africa.

Mr Enos Makena, chairman of the Pretoria United Taxi Association, said such behaviour would not be tolerated by his organisation.

Health care problems highlighted

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Sowetan 14/8/90

WITH the possibility of a democratic South Africa emerging, a critical redress of the present health service will be necessary.

A National Health Service (NHS) based on the principles of primary health care and aimed at providing a comprehensive approach to health, including welfare and mental health, will be the best way to provide a non-discriminatory health care in a future South Africa.

This, in brief, is the summary of a workshop on a National Health Service for South Africa held earlier this year under the auspices of the Health Study Commission of the Transvaal region of the Centre for Development Studies.

Twenty health organisations were invited and most were represented. Among the delegates were Drs John Kalk, Joe Veriawa (convenors) Eric Buch, Melvyn Freeman, Nicky Padayachee and Tom Wilson (the working committee).

There are two major problems arising from the present health system the first of which is its historical record, shaped by segregation, fragmention and apartheid.

By ISMAIL LAGARDIEN

The consequences of the existing system is well known and resulted in "substantial wast of resources," Mr Cedric de Beer of the Centre for the Study of Health Policy at Wits Medical School said, outlining the problems with the present system.

"This occurs not only because of the duplication, indeed the multiple duplication, of administrative structures for the provision of health care, but also because there are substantial under-utilised resources which could be far more cost effectively used within a single planned health care service," De Beer said.

Curative

The private health care sector, he said, possibly consumes half of all the resources spent on health care while providing services for only a privileged few.

"This promotes and an extravagant form of curative care which leads to the expenditure of unneccessary resources which could be better used in providing care for those who need them.

"It undermines the public sector by attracting away doctors and nurses.

"Thus we have come to argue the case for a national health service with strong central control as the only way of undoing fragmentation, dismantling the effects of apartheid on our health care system, creating greater equality of access to health care and allowing for an effective process of planning and policy coordinating which is needed to achieve these goals," De Beer said.

But what exactly is a National Health Service?

The envisaged NHS should be controlled by the state with a view to ensuring that resources are allocated equitably and in such a way as to provide the best possible health care for all.

It can be assumed appropriate for the state to own the vast majority of health care facilities - meaning both hospitals clinics and community health centres - and that health care should be free at the point of service and paid for by the state.

Health workers, because of the aforementioned control, will be state employees paid on a salary basis.

This is currently the case with with doctors and nurses witin the public service.

Contributions to medical aid schemes set tax posers

21/7/10 FINANCE STAFF 299

EVER since the 1989 assessment year, taxpayers under the age of 65 have, in many instances, been unable to obtain tax relief for either medical expenses or contributions to medical aid societies.

This is the opinion of KPMG Aiken & Peat partner, Alister MacKenzie.

Mr MacKenzie says: "Under the present rules, taxpayers under the age of 65 can only deduct medical costs for tax purposes when medical expenses or contributions exceed the greater of R1 000 or five percent of their taxable income.

"On this basis the five percent limit will apply whenever taxable income exceeds R20 000.

"To ensure that at least contributions to medical aid societies are deductible, many schemes have changed their rules and now operate on a non-contributory basis.

"The payment of the full contribution, like any other employment cost such as salaries, is fully tax deductible.

"In this regard," said Mr Mackenzie, "certain companies may wish to take account of this additional cost when setting the level of other employee benefits, including actual renumeration paid.

"Section 7(1) of the Income Tax Act includes in an individual's taxable income any income which is 'dealt with on his behalf ...'," said Alister MacKenzie.

"To avoid the application of this section, where medical aid rules previously stated that contributions were payable on, say, a 50:50 basis, these need to be changed so that instead all contributions are payable by the employer company who then can be given a discretion on how and when it may recover such amount.

Sowetan 23/7/90 (297)

Teachers and pupils of the Iphumelela School for the Mentally Handicapped in Senaoane, Soweto, display some of their artwork which they will exhibit at Pretoria Museum later this month as part of a fund-raising project for the school. They are (from left) Lerato Nkwe, Mrs Mami Mathivha, a teacher at the school, Mduduzi Khoza, Jacob Digashu, Mrs Julia Leoka, the school's principal, Bruce Moiloa, Johannes Maseko and Mrs Elsie Mwali, an art teacher.

'Blind doesn't mean second rate'

'NO' TO BIAS! Blind workers protest in Salt River against "second-rate treatment". PIC: YUNUS MOHAMED

Soull 2677-11/8/90

A MOVE by blind workers in the Cape to join a union has highlighted the problems the handicapped face in the workplace.

The Paper, Print, Wood and Allied Workers' Union (Ppwawu) has signed up about 65 workers at the Civilian Blind Society's workshop in Salt River, Cape Town.

The workers, who do cane and basket work, say they joined the union because they are tired of accepting "second-rate treatment" just because they are blind.

"We do a full day's work like sighted people but are paid a fraction of what other workers earn," said Mr Frank Sam who has worked for the Civilian Blind for 26 years.

Sam earns R320 which he says is not enough to support his family.

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The workers said the minimum wage at the institute is R120 and trainees earn R95 a month.

Sam pointed out that he and other blind workers do not get benefits which other workers take for granted like a sick fund and maternity leave.

There are also certain expenses unique to the blind such as double transport costs — for themselves and a guide.

Although most of the workers attended special schools for the blind where they received training in trades, they don't have a wide choice of jobs because society is biased against employing handicapped people.

A Ppwawu spokesperson said the union would fight for the workers to get a better deal.

The Society for the Civilian Blind refused to comment.

because of increasing JSE charges and the expense of developing infra-

Graphic: FIONA KRISCH Source: JSE

hold.

Norimed's float looks like a healthy winner

NORIMED, which will be floated on the JSE via a reverse listing of Crest Holdings on August 6, is forecasting earnings of 87,8c a share in the year to end-June 1991.

The only operational business at the time of the listing will be that of Crest Healthcare, involving the manufacture, marketing

MARIETTE DU PLESSIS

and nationwide distribution of medical equipment to state and private hospitals, the company said in a statement released today.

Norimed, a health care company controlled by Noristan Holdings which is 21%-held by W & A Investment Corporation, has the backing of both.

This, together with R12,6m in cash and no borrowings, will enable it to finance further development of the Crest businesses and to expand Norimed's presence in the health care industry.

Three-million ordinary shares in Norimed, formerly known as Aurochs Investment company, will be listed in the pharmaceutical and medical sector of the JSE.

The company expects dividends of 29c a share for the current year and an attributable profit of R2,658m, before implementing any expansion moves.

Jump in TPA hospital fees

EDYTH BULBRING

PRETORIA — Hospital fees at the Transvaal Provincial Administration's 81 hospitals went up substantially yesterday, doubling in some cases.

TPA MEC for hospital services Fanie Ferreira said in a statement yesterday the increase in hospital fees was due to considerable escalations in the costs of consumer goods and hospital running costs.

The increases for category H2 patients, who earn under R6 000 a year and have one child, up to a salary of less than R16 200 a year with five children, doubled to R10 for in-patients. B10am 21/8/90

Confinement at community hospitals for H2 maternity cases doubled to R40.

Category H3 patients, who fall between those earning up to R9 000 with one child and those earning not more than R19 000 with five children, will pay R10 a day instead of the old R10 admission fee for in-patients. They will pay R15 as an out-patient at a community hospital, up from R8.

The H3 patient will pay R10 a day with a minimum of R75 for maternity confinement, up from R40. (299)

The category H4 patients, who earn from not more than R12 000 with one child to not more than R22 000 with five children, will pay double in out-patient (R25) and in-patient (R40 a day) fees at community hospitals.

They will also pay R40 a day for maternity confinement at a minimum expenditure of R140.

The fees for private patients who earn more than R12 000 with one child to more than R22 000 with five children, or have medical aid, will pay slightly more.Instead of paying R101 a day as an in-patient at a community hospital, the cost will be R134 a day.

Ferreira said tariffs for private patients were adjusted to bring them in line with the benefit scales of medical aid funds.

Medical aid dilemma for thousands

THOUSANDS of members of a major medical aid society could next week find themselves caught in the middle of a long-simmering feud when angry doctors refuse to recognise their membership cards.

From next week about 60 Cape Town doctors will refuse to recognise the membership cards of the medical aid society which represents about 50 000 public servants in the Western Cape.

Full story — Page 3

Thousands hit by medical aid split

By HENRY LUDSKI

DOCTORS embroiled in a long-simmering row with a major medical aid society over poor payment are threatening to refuse to recognise membership cards.

The move by 60 doctors in Cape Town affects hundreds of patients who are all members of the ProSano medical aid society which has about 50 000 members in the Western Cape.

In a letter to patients, the doctors said they had been forced to take this action after several unsuccessful attempts to liaise with ProSano.

As from August 6 they would be prepared to treat members of the society as private patients only.

Threat

They are to hold talks with medical aid management committee representatives over the next week in an attempt to resolve their problems before they carry out their threat.

The doctors claim that the medical aid fee paid to doctors by ProSano is less than 50 percent of the recommended professional rate.

They also accuse the medical aid administrators of demanding a discount on medicine.

"All these factors place a tremendous strain on the efficient management of a medical practice and threaten to undermine the standard of health care," said the doctors, who urged members to bring pressure to bear "to force" the medical aid to "act swiftly".

Unfair

Many doctors have for a long time been unhappy with the deals offered to them by medical aid societies.

ProSano management committee chairperson, Mr Cyril Beukes, described the action by the doctors as "grossly unfair" on patients.

He said the issue of a 15 percent discount for medicines had been under discussion since September last year but its implementation had, at the request of doctors, been repeatedly delayed.

He said the threat by doctors was "an attempt to apply unreasonable pressure on medical aid schemes".

Beukes said doctors were being "grossly unreasonable".

Some Tvl hospital fees are doubled

NEW Transvaal provincial hospital tariffs in effect from yesterday are in some cases double the fee charged last year.

According to MEC for Health Services in the Transvaal Fanie Ferreira "patients in Government hospitals should make a bigger contribution to the costs of health services".

The new tariffs are:

For H2 patients - with a family income of up to R16 200 and depending on the size of the family - R10 an admission in community hospitals and R15 an admission in regional or academic hospitals.

For H3 patients - with a family income of up to R19 200 and depending on the size of the family - R10 a day in community hospitals and R15 a day in regional or academic hospitals.

Sowetan Correspondent

The charge for H3 patients was R15 an admission in regional and academic hospitals until yesterday.

For H4 patients - earning as a family from R9 000 to R22 000, depending on the size of the family - R40 a day for community and R60 a day for regional or academic hospitals.

Private

The H4 fees in regional and academic hospitals are double those of last year.

Private patients - people with medical aid schemes or those earning more than R12 000 for a one-person family up to more than R22 000 for a five-person family - will pay R134 a day in com-

To Page 2

Hospital fees up

From Page 1

munity and R170 in academic or regional hospitals.

This is an increase of R42 a day in regional and academic hospitals and R33 a day in community hospitals.

The increases do not affect people who are already in-patients or whose admission was approved before yesterday.

Ferreira said more patients who previously qualified as private patients will now be classified as hospital patients, to be treated in provincial hospitals at the all-inclusive tariff provided they are not members of medical aid schemes.

Doctors threaten action over 'low' fees

Big city medical aid crisis looms

Cape Times 4/8/90 299

A MAJOR row appears to be looming between the administrators of the Cape-based Pro Sano Medical Aid Scheme and numerous Greater Cape Town doctors — who have threatened to implement a policy of cash-before-treatment to scheme members from Monday.

The row is sure to affect Pro Sano's 75 000 membership — 50 000 in the Western Cape alone — who will be caught in the middle of the rumpus, as the Association of Medical Scheme Administrators (Amsa), the Society for Dispensing Family Practitioners (SDFP) and the National General Practitioners' Group (NGPG) sort out differences between the "high" medical aid subscriptions received as opposed to the "low" medical aid fees received by dispensing doctors.

In a pamphlet circulated in the Greater Cape Town area this week, nearly 200 doctors pledged to support the non-recognition of Pro Sano membership cards from Monday, following several "unsuccessful attempts" by their respective bodies to liaise with Pro Sano or its administrators.

In the notice, the doctors warn all Pro Sano members that although they will not recognise any Pro Sano membership card from Monday, they will, however, continue to care for members and their families — but only as private patients.

The pamphlet further states:

● "You are no doubt aware that your subscriptions have increased substantially over the past few years. However, you are probably not aware that the medical aid fee paid to doctors is now less than 50% of the recommended professional rate.

● "Pro Sano expects you to pay a levy on medicines. This is impractical and inconvenient.

● In addition your medical aid administrators now also demand a (15%) discount on medicine. Many other administrators do not demand a discount."

The action yesterday received the backing of the Cape Western branch of the Medical Association of South Africa (Masa), which said the policy would affect only "non-emergency patients" who produced Pro Sano membership cards.

In a statement dated July 30, Pro Sano said that during 1989 Amsa had, on behalf of Pro Sano, negotiated a 15% discount on medicine with the SDFP and the NGPG, with effect from January 1 this year.

Pro Sano said the 15% discount was based on the Ethical Price List, which was the highest price for medicine and if applied, this would guarantee direct payment to the doctor for medicine dispensed.

"The unilateral decision by the doctors was taken without prior attempt to discuss their actions with all parties concerned, and this decision has caused financial hardship to members," Pro Sano said.

PresMed presents a picture of health

Star 7/8/90

Diagonal Street
(299)
LYNNE PEACH

Health services group PresMed is relatively unaffected by economic recession and this, together with its on-going expansion programme, should ensure continued profit growth, brokers say:

In the annual report, chairman PHN Bremer discloses that existing facilities will be improved in the coming year and that a hospital development in Rustenburg will come on stream before year-end.

The Bedfordview Hospital is expected to open in mid-1991. After starting business five years ago as the operator of three day clinics, PresMed now owns seven day clinics and three private hospitals. There are 28 theatres and 500 beds.

Mr Bremer says PresMed remains one of the few hospital and day clinic groups contracted into the Gazetted Medical Aid Tariffs of the Medical Aid Movement.

He believes this policy has contributed to increased occupancy levels at each of the hospitals and day clinics.

In the year to February, turnover shot up 75 percent from R22,1 million to R38,8 million.

Mr Bremer says the turnover of all operational companies improved substantially.

He adds that a significant contribution to turnover was made by the Jan S Marais Clinic, whose turnover was only included in the PresMed group for six months of the previous financial year.

Attention to operational effeciency has paid off, with operating profit doubling from R2,4 million to R5,8 million.

After the interest bill increased 34 percent from R0,9 million to R1,2 million, pre-tax profit tripled from R1,5 million to R4,6 million.

A decline in the effective tax rate from 50,2 percent to 49,7 percent pushed taxed profit to R2,3 million and more than tripled the previous year's R0,7 million.

A relatively greater portion of profits to outside shareholders and the preference dividend of R0,6 million resulted in attributable profit increasing 89 percent from R0,7 million to R1,3 million.

Earnings per share rose from 8,1c to 15,4c.

The dividend for the year amounted to 4c, compared with a payout of 2,7c in financial 1989.

In March this year the 2,82 million preference shares were converted to ordinary shares on a one-for-one basis.

This meant the number of ordinary shares in issue rose 32 percent from eigth million to 11,52 million.

Net asset value, including intangible assets, stands at 63,3c a share, which is nine percent higher than 58,2c a year ago.

PresMed, priced at 85c, is trading on a P/E ratio of 5,5 andprovides a dividend yield of 4,7 percent.

The rating is attractive, brokers say, but the shares are hard to come by because the directors directly and indirectly own more than half of the shares in issue.

The long-term outlook will turn unfavourable should the price fall below 80c.

Doctors break with two aid schemes

CAPT Times 7/8/90

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By DANIEL SIMON

ABOUT 350 doctors in Cape Town and Johannesburg stopped recognising the validity of membership cards from two medical aid schemes yesterday, in protest against levies imposed for medicines and demands that doctors allow a 15% discount to the schemes on medicines dispensed.

The decision not to recognise both Pro Sano Medical Aid Scheme and Bonitas Medical Aid Scheme membership cards was adopted unilaterally by the doctors, despite a meeting between them and the management committees of both schemes on Saturday.

Yesterday's move was supported by the Cape Western branch of the Medical Association of South Africa, which said that under these circumstances both schemes would be shown as "redundant" organisations.

"In effect, the hold they had on doctors has now been broken. This action will now allow the doctors to set their rates while the patients must now claim from their medical aids."

Pro Sano and Bonitas — which are part of the Medscheme stable — represent about 850 000 medical fund beneficiaries countrywide.

Pro Sano represents about 75 000 coloured state employees and Bonitas represents about 140 000 black state employees. About 50 000 Pro Sano members live in the Western Cape.

Pro Sano and Bonitas said: "The 350 dispensing doctors demand direct and prompt payment for medicines and refuse to reduce their mark-up on the cost of medicine — the profit margin — as is already provided by pharmacists, private hospitals and by more than 80% of about 3 000 doctors."

CITY NATIONAL

Doctors' moves backed in medical aid battle

By SHARKEY ISAACS and ANDREA WEISS
Staff Reporters

THE Medical Association of South Africa has come out in support of dispensing doctors waging a campaign for a better deal with two major medical aid schemes of the Medscheme group in the Cape and the Transvaal.

The move follows the refusal by doctors to recognise the medical aid cards of more than 600 0000 beneficiaries of the Cape-based ProSano and the Transvaal Bonitas medical aid funds.

Masa said in statement the decision of doctors not to accept certain medical aid cards was the result of "continuous interference by certain medical aid schemes in doctors' professional practices".

The chairman of Masa's federal council, Dr Bernard Mandell, urged patients having difficulties settling their accounts before claiming from medical aids, to discuss the problem with their doctors.

He stressed the action was aimed against medical aid schemes and not against patients.

In the Cape deadlock has been reached in the latest round of talks between dispensing doctors and a ProSano on the refusal by general practitioners to recognise members' cards.

The move has left nearly 50 000 members of the ProSano Medical Aid Scheme facing the prospect of being treated as private patients and paying cash up front.

The doctors, members of the Dispensing Family Practitioners' Association of the Western Cape, operating mainly in sub-economic areas, said their representatives had been treated discourteously by the presiding chairman at the talks.

"We shall not be returning for further talks until an apology is forthcoming."

He denied ProSano's claim that the doctors had taken a "unilateral decision".

Claims for medicine paid by ProSano exceeded R45-million a year, one of the major drains of members' funds. To contain costs in this area, ProSano had obtained discounts on medicines dispensed by pharmacists and private hospitals in exchange for direct and prompt payment.

The doctors, representing about 350 dispensing general practitioners, demanded direct and prompt payment for medicines and refused to reduce their mark-up on the cost of medicine.

of the violence. the Government, the chur- Mr FW de Klerk." - *Sapa.*

Lawyers' group agrees to extend aid to rural areas

THE National Association of Democratic Lawyers resolved in Durban at the weekend to extend their advice and legal aid activities to rural areas and have created a post for paralegal services to meet that need.

Nadel president Mr Pius Langa said the association was concerned that they had not been able to reach rural areas in the past.

SOWETAN Correspondent

"We were very concerned that during the countrywide State of Emergency many people who were on the receiving end of the security forces in rural areas needed legal advice and we were not in the field to give it to them," said Langa.

He said paralegals were people who had basic legal training, usually through law firms and legal resource centres, who travelled in rural areas advising people on legal matters.

Sowetan 7/8/90

The conference also created the posts of a projects officer for constitutional options and a women's desk.

Private hospitals fees up

FEES at private hospitals will go up by an average of eight percent from August 15, the Representative Association of Medical Schemes announced at the weekend.

The increase, applicable to all wards, high cost care and intensive care, will range from R7,50 more a day in approved day clinics to R38 more a day for specialised intensive care in major hospitals, according to Rams executive director Rob Speedie.

Sowetan 7/8/90

He said the increase was agreed to in order to enable private clinics to raise the salaries of their nursing staff following recent increases at provincial hospitals which had left private nursing staff at a "salary disadvantage".

Speedie said normally Rams adjusted all scales of benefit once a year but since the pay hike at provincial hospitals had forced private hospitals to increase salaries to retain staff, the interim increase was agreed on.

Medical aid schemes in 'cash' row with doctors

LESLEY LAMBERT

CAPE TOWN — Two medical aid schemes are urgently negotiating with a large group of dispensing doctors who have refused to recognise their membership cards and who are demanding cash payment for treating their members.

Both medical aid schemes — Bonnitas and Pro Sano, with almost 700 000 beneficiaries — are administered by the Medscheme group.

The bulk of their members are black and coloured public sector employees in the Transvaal and Western Cape.

The schemes have been targeted by 350 Western Cape dispensing doctors, who are demanding that they reduce the discrepancy between the "high" medical aid subscriptions received from their members and "low" medical aid fees paid to doctors.

The doctors, who belong to the Society for Dispensing Family Practitioners, allege that the schemes are making their members pay for levies imposed on medicine and that their demands for discounts on medicines are uneconomical.

A Pro Sano spokesman said yesterday that the measures had become necessary as a result of increasing medical costs.

Without the increased income from subscription fees and the discounts on medicine, the schemes would have to fund the growing costs from dangerously low reserves imposed by statute.

Spokesmen from both schemes issued separate but similar statements yesterday after urgent discussions with the doctors at the weekend.

They said they had obtained discounts on medicines dispensed by pharmacists and private hospitals in exchange for direct and prompt payment in an attempt to contain the rising cost of claims.

But dissenting doctors were demanding direct and prompt payment without being prepared to reduce their markup on the cost of medicines in line with pharmacists, private hospitals and the majority of about 3 000 dispensing doctors.

Hardship

The medical aid spokesmen also claimed the doctors were threatening to lift their consultation fees above the approved scale of benefits charges — a move which would result in further increases in members' subscriptions.

They said the demand for cash payment would cause unwarranted financial hardship and could mean that sick members who could not afford cash payment would not receive proper health care.

A spokesman for the doctors said the group was due to meet yesterday and today to decide on their response.

Private hospital bed tariffs rise

TANIA LEVY

PRIVATE hospital beds will cost about R13 a day more from August 15 when accommodation charges will be raised about 8%.

Accommodation fees make up 40% of private hospital tariffs and the other components — such as theatre charges and pharmaceuticals — remain unchanged.

National Association of Private Hospitals (NAPH) chairman Edwin Hertzog said yesterday the association had requested the adjustment to offset the cost of nurses' salaries which increased by between 23% and 48%. Salaries accounted for about 50% of private hospitals' operating costs.

The NAPH, which represents 80% of the country's 110 private hospitals, initially asked for an 11% increase in accommodation charges but the Representative Association of Medical Schemes (RAMS) granted an average 8% increase.

Hertzog said it was the first time in five years that RAMS had granted an interim increase to private hospitals.

Mrs Sylvia Ndimande of the Diepmeadow health department

Diepmeadow celebrates health day

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By PEARL MAJOLA

FREE health services were brought to hundreds of people in Diepmeadow on August 4, Family Health Day, by the Diepmeadow health department and the Transvaal Provincial Administration.

Teams of medical officers from the TPA and the Diepmeadow health department made rounds in Diepmeadow, offering family planning, dental care, preventive health, youth and environmental and primary health services.

There was also a Baby Best promotion where samples of maize meal for children's cereal were given out.

Awareness

"We saw the need for the campaign to raise awareness of the community towards available health resources. Our main aim was to offer special health services for mothers, children and families," said Mrs Sylvia Ndimande of the Diepmeadow health department.

"We had a very good turnout and we would like to do this more often. There was good team spirit on our side and people took full advantage of the services.

"The objectives of the day were carried out well and on August 14 we will be doing home visits at the Mzimhlophe hostel for the whole day," she said.

Boycott of medical schemes may spread

CAPE TOWN — Boycott action by a group of dispensing doctors against two major medical aid schemes could spread to other schemes if it is found they are also setting "unacceptable conditions" for settlement of their accounts.

The action in which a group of 350 western Cape doctors are refusing to recognise the membership cards of the two medical aid schemes with more than 600 000 members, began after the parties failed to resolve their differences during an urgent meeting at the weekend.

The schemes submitted proposals for the doctors' consideration yesterday but the doctors — members of the Dispensing Family Practitioners Association (DFPA) — have not yet responded. They have demanded cash payment from members who have received treatment since their boycott began on Monday.

A spokesman for the DFPA said yesterday the group was trying to determine whether the "unacceptable conditions" were applied more widely in the medical aid industry. The two schemes which are currently under attack are Pro Sano in the western Cape and Bonitas in the Transvaal. Both fall under the umbrella of the Medscheme group which administers a number of other major schemes throughout the country.

In another development yesterday, the Medical Association of SA (Masa), which represents 13 000 SA doctors, issued a statement in which it sympathised with the dissenting doctors but said it was prepared to try to resolve the dispute in the best interests of all parties concerned.

A separate statement issued by the DFPA, the Society of Dispensing Family Practitioners and Masa listed resolutions

LESLEY LAMBERT

— similar to the dissenting doctors' claims — which had been adopted at the weekend meeting with the medical aid schemes.

The basis of the doctors' dispute is that the schemes are offering preferential terms of settlement to doctors who are prepared to enter into agreements which are uneconomic and place patients at a disadvantage.

They object to the discrepancy between the "high" medical aid subscriptions received from the schemes' members and the "low" medical aid fees paid to doctors. They claim the schemes are demanding uneconomic discounts on medicine.

Interference

The schemes argue that these measures became necessary as a result of increasing medical costs. Without the increased income from subscription fees and the discounts on medicine, they would have had to fund the growing costs from dangerously low statutorily imposed reserves.

In a statement issued yesterday Masa's Federal Council chairman Dr Bernard Mandell said the doctors' boycott action was the result of "continuous interference by certain medical schemes in their professional practice".

An example of this interference was the setting of conditions for settlement of the schemes' accounts. Doctors who were not prepared to enter into contracts with these schemes were being discriminated against, he said.

Masa said the medical profession would ensure that "the health of patients would not be compromised".

Doctors begin to boycott medaids

Medical Reporter

About 2 000 dispensing doctors in South Africa today started a boycott of several major medical aid schemes belonging to the Association of Medical Scheme Administrators (Amsa).

The official decision to refuse to recognise membership cards of these medical schemes, which include Bonitas and Prosano with a combined membership of more than 700 000, was taken by the Society of Dispensing Family Practitioners.

The move follows Amsa's decision to deduct 15 percent discount from all dispensing doctors' medicine charges from the beginning of the year. The doctors demand that the discount be scrapped immediately.

The result is that hundreds of thousands of members, mostly industrial employees, have to pay cash for medical attention.

The doctors' society chairman Joe Maelane said initial action started two weeks ago had already resulted in several medical schemes deciding to abandon the discount principle.

The doctors' decision is backed by the Medical Association of South Africa (Masa).

Medical scheme boycott starts

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MATTHEW CURTIN

A DISPENSING doctors' nationwide boycott of medical aids belonging to the Association of Medical Scheme Administrators (Amsa) started yesterday.

Society of Dispensing Family Practitioners (SDFP) chairman Dr Joe Maelane said the SDFP's general meeting at the weekend resolved to refuse to honour the medical aids' membership cards. The schemes in question were administered by Medscheme Ltd and included Barlow Rand, Premier Milling, Murray and Roberts and Tongaat-Hulett schemes.

The protest was sparked by Amsa's January decision to deduct a 15% fee from dispensing doctors' medicine charges.

Maelane said 53 of Amsa's 80 funds had agreed not to deduct the fee.

Doctors remained committed to their patients, and were accepting payment in cash or on account from people belonging to the boycotted schemes.

Amsa chairman and Medscheme director Keith Hollis yesterday said the dispute centred on schemes taking action on behalf of their members, and doctors acting to guarantee that they received the full retail price for medicine they dispensed.

Amsa and Medscheme acted solely on the instruction of the scheme companies, of which half insisted on the 15% discount.

He said these firms faced "phenomenal" cost increases. Medscheme worked on behalf of 1,3-million beneficiaries. There was room for manoeuvre in the dispute.

Maelane said that only when the fee had been scrapped would doctors agree to negotiate with Amsa.

The deduction, termed a "discount" by Amsa, amounted to an attempt to force doctors to dispense at a loss.

Medical Association of SA Federal Council chairman Dr Bernard Mandell said the boycott was the result of "continuous interference by certain medical schemes in the professional practice".

The schemes say measures like the discount on medicine have become necessary because of increasing medical costs.

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Oral hygiene lessons for Pretoria children

By ALINAH DUBE

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MEDUNSA'S Department of Community Dentistry is hosting a five-day conference to highlight National Dental Week and make people aware of the importance of oral hygiene. Sowetan 14/8/90

Yesterday's opening function was attended by dental workers, teachers and children from Soshanguve and Garankuwa primary schools and nurseries. The children rendered items based on basic programmes aimed at teaching them to look after their teeth and mouths.

Professor JB Du Plessis, head of the Community Dentistry Department, said the National Dental Week was declared seven years ago "to make people aware of their oral health status and of the fact that they were the only ones who could prevent major oral diseases by practising good oral hygiene."

He said nurseries were the best places for children to be encouraged to learn oral hygiene.

leave the country to preserve the organisation outside.

"We reached the Soviet Union only at [illegible]

"In 1976 I became involved in trai[illegible]ering these youth."

Continued commitment to progressive health care

South 1217 - 18/7/90

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"HEALTH is not only something that happens in a hospital or clinic with a doctor and nurses".

With these words, a delegate sums up the feeling at the conference of the Progressive Primary Care Health Network held at the University of the Western Cape last weekend.

The network consists of health and development projects, health worker organisations and individuals in community organisations who are committed to the idea of progressive primary health care (PPHC).

They provide care outside of hospitals, in clinics or the community. Members of the organisation believe it is important to examine and change conditions in which communities live, the type of health care offered and the attitudes of health workers and to define to whom these health workers are accountable.

The PPHC network was formed after the National Medical and Dental Association (Namda) brought together participants in health and community projects in 1987 to discuss the need for a national PPHC strategy.

The first national conference, at which the PPHC Network was established, was held in September 1987.

At its third national conference last weekend, the most contentious debate centered around links with state bodies.

Should progressive health workers have links with state health bodies? What can be done to step up the fight against Aids? These were some of the issues debated at the Progressive Primary Health Care Network conference last weekend. REHANA ROSSOUW reports:

After a health conference held in Maputo in Mozambique recently, the ANC said it was important that progressive health organisations debate whether to form links with state health structures.

The network had not discussed its response to the issue. When its Southern Transvaal region was invited by the state health department to attend a discussion on health issues, it declined the invitation.

Delegates to the conference asked whether it was possible to influence state institutions. They felt it was not their role to concentrate on developing links with state bodies and argued that they continue their involvement at a local level and leave national issues to national health organisations.

They believed that, if they were drawn into links with state institutions with token representation, they would be "co-opted" by those institutions.

"We must be involved from planning to implementation and not just in the latter," the conference resolved.

"We should support the ANC in their negotiations and await national resolutions on links with the state.

"Our efforts should remain directed at preventive and educative health matters."

The conference decided it was important to set preconditions to cooperation with state health bodies. Delegates agreed that their cooperation could be misused and the state could "bask in the glory of our efforts".

They said they would cooperate only if the Natal violence was ended, if the state made an effort towards eliminating privatisation in health and committed itself to socio-economic change, and if the decision was approved by their communities.

The conference called on the ANC to produce an Aids video and manual which could be distributed throughout the country.

Aids was a primary health care problem, the conference heard, because common diseases like TB and diarrhoea became more widespread among people once the HIV virus took hold.

They also resolved to improve inter-regional relationships between organisations involved in fighting Aids and to share knowledge and resources.

Delegates also examined the problems of disabled people in South Africa, where one in 13 people is physically or mentally disabled.

Problems highlighted included a lack of resources and services for disabled people, a lack of consultation with them, discrimination in employment and lack of acceptance in society.

The PPHC resolved to train community rehabilitation workers, cooperate with existing rehabilitation organisations, produce information packages on available resources and finance projects for disabled people.

They also resolved to increase their efforts to get communities involved in controlling existing health care facilities where they lived.

Women want return of tests

Sowetan 15/8/90

WOMAN

AMONG the many meetings and marches to mark National Women's Day, one stood out in that it was not a cry for the freeing of women from male bondage but concern for their survival.

About 100 women in Soweto, Dobsonville, Johannesburg and Mamelodi marched to their local clinics and provincial hospitals in protest against the stopping of pap-smear tests in most township clinics and hospitals.

Pap-smear tests help in the early diagnosis of cervical cancer, the most common cancer among black women.

The march was organised by the Advice Centres' Association which, according to women's desk coordinator Yvonne Ngakane, has been campaigning for the reinstatement of the service since it was stopped several years ago.

Ngakane said the issue, along with abortion and sex education, had been dealt with as a priority by the community-based organisation.

They sent a petition to the Department of Population and Health expressing their grievances about the stoppage. The only reply they received was that their complaints were being looked into.

"Stopping pap-smear tests puts a lot of women's lives in danger, especially those who do not have money to pay for them in institutions that offer them for a fee," Ngakane said.

"We hope that with this action the Government will realise our concern for our health and be prompted to take immediate action.

"We feel it is taking them too long to decide on this matter and to come up with constructive solutions."

Funding

Chairman of the southern Transvaal region of the National Cancer Association Dr M Gordon-Grant said the reason the State had terminated the service was lack of funds.

He said some hospitals were now offering the service for about R10. The NCA was also offering it in factories but could not afford to do the tests on everybody.

The South African Association of Obstetrics and Gynaecology had written to the Department of Health on several occasions for the reintroduction of the service but had not received a reply. They wrote two months ago to Minister of Health Dr Rina Venter.

"One out of every four black women die from cervical cancer every year. There are tests that could stop these deaths but they are not available to people who need them," Gordon-Grant said.

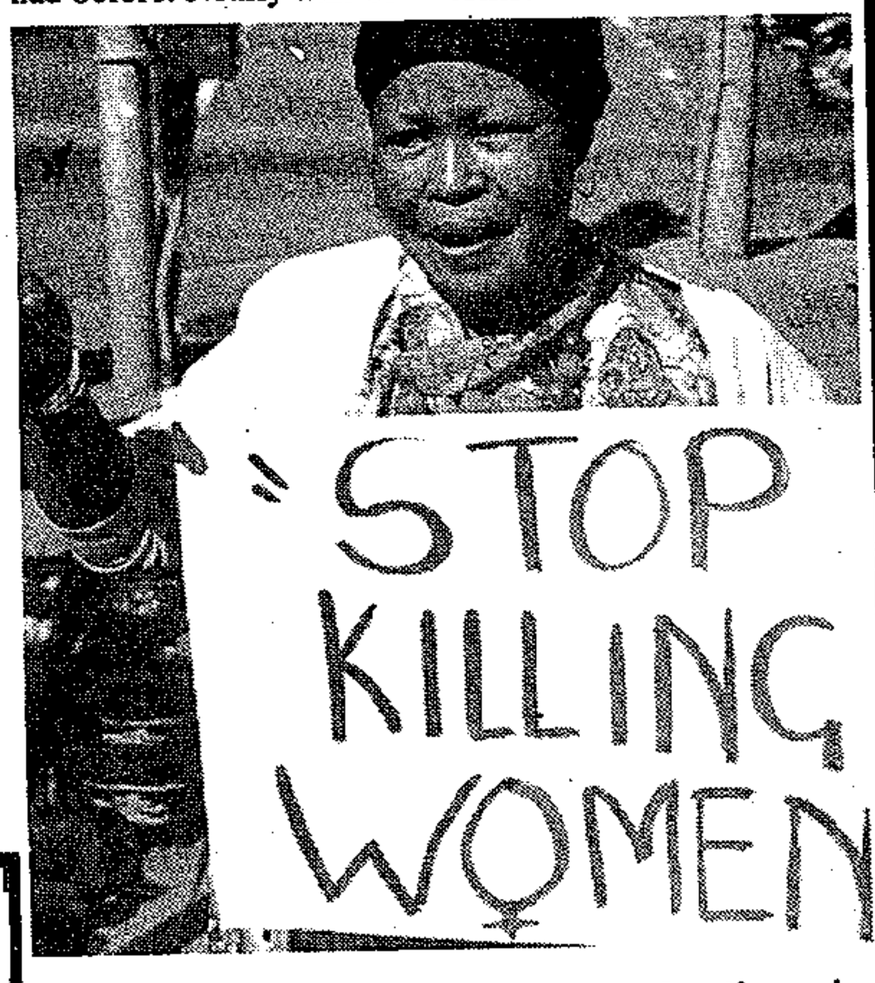
He said the cancer, also prevalent among coloured and other women in the lower socio-economic group, could be detected and eradicated if early diagnosis was made of the abnormal cells that caused it.

"Any woman who is sexually involved is at risk. The disease is transmitted sexually and infects the cervix. It spreads into the bladder, the bowel and to the bones and kills the sufferer once it reaches this stage.

"Last year our hospital detected 553 new cases of the cancer, which was more than we have had before. Nearly half of the cases were advanced," he said.

The cancer is symptomless at an early stage when the cure rate is 100 percent.

Intramenstrual bleeding, contact bleeding, foul smelling watery discharge, dysuria and pain are some of the symptoms.



Yvonne Ngakane is campaigning for the reintroduction of pap-smear tests for women.

Medical aid, medics now in race row

Sowt 16/8 - 22/8/90

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By LANCE NAWA

THE medical aid wrangle involving doctors and a major medical aid society took a new turn this week when patients were allegedly advised to seek treatment from white doctors.

A spokesperson for the Pro Sano Medical Aid Society, however, strongly denied the allegation.

A patient of an Athlone doctor contacted by SOUTH claimed the advice was given to about 400 workers at the Philippi Telecommunications Centre "as an attempt to help patients who are being refused treatment by black doctors on Pro Sano medical aid cards".

"We are shocked to hear that Pro Sano can stoop to such a level," was the response of the chairperson of the Dispensing Family Practitioners Association.

Mr Ismail Schroeder of Pro Sano said the allegation was a "desperate attempt by some people to spread malicious untruths about Pro Sano, and further their cause.

Discounts

"I never told people at the meeting to consult white doctors. I told patients to see doctors of their own choice, should their regular ones refuse to treat them."

The dispute between Pro Sano — which has about 50 000 members in the Western Cape — and about 60 Cape Town doctors erupted about two weeks ago over tariffs and discounts.

A Grassy Park doctor accused Pro Sano of avoiding a resolution of the issue.

He warned that "rather than trying to address the issue, it seems Pro Sano is entering a terrain of racial conflict among doctors — with patients being the ones on the receiving end".

Medical aid body suspends drug discount

MARIETTE DU PLESSIS

MEDICAL aid schemes represented by the Association of Medical Scheme Administrators (Amsa), including Pro Sano and Bonitas, have suspended the 15% discount on medicines that they had previously insisted dispensing doctors grant.

The suspension, effective from yesterday, followed Monday's nationwide dispensing doctor's boycott of medical aids represented by Amsa. B 10 Aug 1718 190

Announcing the move yesterday, Amsa chairman Keith Hollis said the decision would negatively affect contributions paid by medical aid members.

Pro Sano chairman Cyril Beukes and Bonitas chairman Paul Luthuli said the suspension opened the way for both medical aids "to negotiate their own cost-containment measures with doctors".

The 15% discount was devised to reduce the drain on both Bonitas's and Pro Sano's funds and to keep medical aid subscriptions at acceptable levels. Unless alternative cost-containment measures were negotiated with dispensing doctors, the cost of medical aid subscriptions would rise.

Scheme to drop discount

The chairman of Pro Sano Medical Aid Scheme, Cyril Beukes, announced yesterday that Pro Sano would suspend the 15 percent discount on medicines previously required of dispensing doctors.

The decision to suspend the discount opens the way for Pro Sano to negotiate its own cost-containment measures with doctors.

Mr Beukes said that the original 15 percent discount was introduced as a uniform cost-containing measure.

Such discounts were devised to reduce the drain on Pro Sano medical scheme funds and keep medical-aid member subscriptions to acceptable levels. — Sapa.

Focus is on teeth hygiene

WOMAN

Soweten 17/8/90

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By PEARL MAJOLA

TODAY is the last day of National Dental Health Week and the public have the last chance to exchange old toothbrushes for new ones and view the oral health products exhibited at the Highgate shopping complex.

This year's theme has been "Smile to a brighter future".

Emphasis

Exhibitors and oral health services personnel from different dental clinics in Soweto have spent the whole week educating the public about the different oral health products and the importance of brushing teeth twice a day.

"Dental Health Week is an emphasis of the campaign we have throughout the year where we try and make people aware that dental diseases are preventable if we brush our teeth and care for them properly.

"In fact, 97 percent of dental diseases are preventable," executive director of the Dental Association of South Africa Dr Helmut Heydt said.

"We have always emphasised our campaign on children and we hope that those who were five years old when we started 17 years ago do not have decay problems and in turn their children will not have them.

Extractions

"Extraction is no longer a problem and more people understand now that they have other options. So our campaign has been very successful indeed," he concluded.

Health doesn't have to mean wealth

By KATHY STRACHAN

THERE is no simple quick-fix to the problems of primary health care in South Africa, an international expert has said.

However, South Africa could learn much from countries in Africa as well as Central America and Asia, says Dr Gill Walt of the London School of Hygiene and Tropical Medicine.

"In lots of ways South Africa is unique because of the monster of apartheid," said South African-born Walt, who is visiting the country for the second time in 30 years. But she added that it does share a changing pattern of disease with other better-off Third World countries she has worked in.

"They share a transitional stage where there is a shift: where diseases such as malnutrition, infectious diseases and diarrhoea are the main causes of death — especially in children — to the chronic degenerative diseases of industrialised countries, such as heart diseases, cancer ... accidents," she said.

"South Africa will have to move towards a unified national health system. Looking after a particular racial group is not good for health."

She was encouraged by the way primary health care has taken off in South Africa in the last 10 years and attributed it to the awareness of alternative health groups to local health problems.

"The idea of the community health worker has been greatly influenced by the Chinese 'barefoot doctor'. People were excited that the community could choose someone among themselves to be trained and to return to the community to give health care."

An important lesson can be learnt from Cuba, which "took seriously the effects of other sectors on health. They built up water supplies, guaranteed a minimum amount of food for each person and reallocated resources from the capital, Havana, to the provinces in order to improve health."

Zimbabwe, she added, has also built up a successful primary health care network and found strategies to keep health workers in rural areas — a problem which South Africa also faces.

will be achieved in the interest of the people of Greater Soweto."

It said bridging finance to council would be curtailed by the end of this month.

Soweto to get its own hospice

TANIA LEVY

A SOWETO hospice is to be started in October to care for about 3 000 people who die in the area every year as a result of terminal diseases.

Witwatersrand Hospice Association CE Stan Henen said the need for hospice care in Soweto was obvious — at any time there were about 60 terminally ill people being treated at Baragwanath Hospital. The rest were being cared for at home or had been sent to the rural areas where health systems were inadequate or non-existent, or relatives poorly equipped to cope.

The association, which is funded entirely by private donations, was developing a network of people to support and care for Soweto's terminally ill at home.

Henen said it was probably the first time an autonomous organisation had gone into Soweto and gained equal acceptance from groups as diverse as the government, the ANC and PAC.

Undoubtedly an in-patient centre would be needed, but the first priority would be on home care, he said.

The Witwatersrand Hospice Association managed to care for about 12% of the estimated 6 000 people who died in the central Witwatersrand region each year. The majority of these were cancer sufferers.

Henen said the hospice's reach was limited by a shortage of finances. The need for funding grew 70% a year as the need for hospice services by the terminally ill increased 30%. Government provided no subsidies although it acknowledged the work being done by the association.

Henen said government would need R40m a year if it were to cover costs of a hospice model of care for about 20 000 terminally people in SA each year. About R160m would be needed to fund curative care in hospitals for these people, he said.

The need for services would be even greater as the number of AIDS patients increased.

Sowetan 29/8/90

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SA Breweries' Frank Johnson hands over the keys of a mini-bus to Shadax's John Gwebu, in the company of Shadax staff. Shadax has always had to rely a lot on wheels - and its newest set are especially welcome. Most of the 58 Alexandra residents for whom the self Help Association for the Disabled provides jobs are confined to wheelchairs and transport to the Shadax workshop is often a problem

Sowetan 30/8/90 (299)

The Harvey Cohen Centre for the mentally handicapped in Eldorado Park received a R50 000 cheque to buy a mini-bus for the centre. The presentation was made by the SAB's Southern Transvaal public affairs manager, Mr Frank Johnson (left) to Ms Dorothy Cornelius (in the bus). In the foreground are some of the children of the centre.

Govt urged to act on medicine costs

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MARIETTE DU PLESSIS

GOVERNMENT should intervene to help reduce the cost of medicine and improve health care in SA by addressing problems in the pharmaceutical industry, Gresham Industries chairman Gordon Utian said yesterday.

Rising costs could severely hamper pharmaceutical wholesale and retail businesses if

● UTIAN

government did not alleviate the present situation.

At Gresham's AGM yesterday Utian stressed the need to address inequities in the pharmaceutical industry, where vested interests had created a situation in which wholesalers were caught up between manufacturers, retailers and doctors.

Manufacturers demanded exeptionally high prices for their products, and doctors, influenced by advertising and sampling campaigns, prescribed their products.

Consequently, consumers remained oblivious to the fact that in many cases there were equally effective medicines available at a fraction of the price.

Utian also questioned the credibility of the medical aid system, in terms of which pharmacists were being pushed by medical aid societies to assume the role of a discounter.

This and other urgent issues were brought to the attention of the Department of Health and Development three years ago, when the De Villiers Committee of Inquiry was appointed to look into pharmaceutical matters. Utian said no feedback has been received from the department since.

A department spokesman said yesterday the De Villiers committee should be able to report back during late September.

Pensioners face medical aid increase

Sitel 3/9/90 (299)

Pensioners struggling to survive the spiralling cost of living are about to suffer another blow in the form of higher medical aid fees, reports **HELEN GRANGE.**

Pain in the neck . . . An increase in medical aid fees will be a blow to pensioner Susanne Coetzee's small budget. ● Picture by Ken Oosterbroek.

A monthly contribution of R11,58 to a medical aid scheme may be a drop in the ocean to most people. But if your income is only R215,93, it represents a substantial amount.

For Susanne Coetzee (67), a pensioner who is living on this tight budget, an increase in her medical aid membership fees would be a heavy blow — but one she would have to accept.

She suffers from a worsening eye condition, so it is essential for her to see a doctor every month for a new prescription of tablets.

"If the tariff went up, I would have to pay. I would just have to go without a thing or two."

Millions of pensioners who are in the same predicament as Ms Coetzee may soon have to face an increase in medical aid fees.

According to National Health Minister Rina Venter, this tariff adjustment could be expected because of the increasing number of pensioners drawing from medical aid schemes.

Dr Venter reasoned that the claims pattern of pensioners as a group generally caused the cost structures of medical schemes to increase at a higher rate than that of other members.

It is not disputed that pensioners draw from medical aid schemes more than other subscriber groups. What is a point of contention is whether the medical aid schemes are dealing with the problem correctly.

According to Medicaid Administrators director Gideon van Zyl, the problem was that the payout to pensioners in proportion to the membership fees paid was substantially higher.

"Traditionally in South Africa, people's medical aid contributions drop significantly once they go on pension. This means that the average pensioner claims up to three times as much as his contribution," he said.

And with an increasing number of workers retiring early or being retrenched, the number of pensioners on medical aid was escalating.

"As it is, pensioners are being subsidised by other medical aid contributors. This is a serious problem," Mr van Zyl said.

However, according to National Council for the Aged chairman Sid Eckley, medical aid schemes should expect this imbalance and accommodate it.

"The whole medical aid system needs to be revised. Why, if a person in the long term has not drawn on his medical aid, should he be penalised just because of his age?

"I have no objection to a system that increases the tariffs for people drawing excessively on the scheme for some or other reason — but to penalise the aged is discriminatory," he said.

Mr Eckley said an increase in the already exorbitant medical service fees could be unbearable for the elderly.

"One solution would be to manage medical aid schemes like short-term insurance policies. When a person does not claim against the scheme, he could get a discount on premiums. The elderly would therefore not draw excessively because they would not want to lose their benefits."

Mr Eckley added that there were also too many medical aid schemes and that fewer schemes, which were run more cost-effectively, would benefit pensioners.

Another problem was that medical aid schemes did not pay out unless the pensioner had visited a doctor or had been in hospital.

"Pensioners, realising they can't claim for medicines purchased at a pharmacy, go to a doctor for medication. They deliberately go for the more expensive medical service because they will be covered by medical aid," he said.

The medical aid schemes, currently geared to the younger, working subscriber, needed to focus far more on services for the elderly, Mr Eckley said.

There was also a need to "educate" pensioners about using their medical aid schemes carefully. "They should be taught that it is not necessary to run to the doctor for every ache and pain," Mr Eckley said.

Cheshire Home brings hope to the disabled

Sowetan 31/8/90 (299)

WOMAN

THERE is a growing awareness for the need to support physically disabled people in this country. Many shopping complexes and public areas now provide an alternative to stairs and other facilities for them.

By PEARL MAJOLA

Until now the only place for treating physically disabled people in Soweto has been Baragwanath Hospital. Once patients reach a point where they no longer require hospital services, they are left on their own.

A few lucky ones have somebody to care for them at home, but many have to face the dilemma of fending for themselves, usually relying on meagre pensions.

However, the Cheshire Homes movement has brought hope for these people with the opening of the first Cheshire Home for blacks in Soweto and plans are under way for the building of more homes in the townships countrywide.

The Soweto Home presently accommodates only four people, but will eventually accommodates nine.

For the time being only residents who can cope without major nursing are admitted until sufficient funds have been raised to employ more staff to care for more seriously disabled people.

Founder

The occasion to officially open the Home was graced by the presence of Group Captain Leonard Cheshire, the founder of the organisation.

"I longed for many years to see a Cheshire Home for blacks in South Africa and now it has happened," he said.

"This function is the most moving function I have taken part in. The first Home in China will be opened in November and the first one in Moscow will be opened soon, but somehow this overshadows those.

"Also, this is our big day in South Africa because this year is our 25th anniversary."

Cheshire started the organisation after World War 2 when he realised that disabled people were simply left to their own devices and were never able to feel secure or be given support.

"Having fought throughout the war and survived, I felt that whoever survived had a duty to those who did not, so I had an urge to take that responsibility."

The building and running of Homes depends on donations and once they have been built funds have to be raised to provide food and other facilities.

The estimated cost of running the Soweto Home with nine residents is R5 000 a month. Donations to this Home have been made, among others, by First National Bank, Ithuba Trust, Edgars, Liberty Life and the Premier Group.

The Soweto Cheshire Home now has room for only four people, but will eventually take nine.

Pensioners are warned of hike in medical aid fees

DURBAN — The number of pensioners was increasing and it could be expected that their medical aid membership fees could escalate further, National Health Minister Dr Rina Venter said at the Natal NP congress.

Venter was replying to a motion relating to the increases in medical aid tariffs, particularly with regard to pensioners' contributions. (299)

"Persons with a high claims pattern, like pensioners, are often dissatisfied if their membership fees are increased to a rate higher than that of other members.

"However, the claims pattern of pensioners as a group generally causes the cost structures of medical schemes to increase at a higher rate than that of other members.

"Pensioners, as a category of members, are increasing in numbers and it can therefore be expected that their membership fees may escalate further in future;" she said. — Sapa. BIDay 31/8/90

Noristan lifts earnings 43pc

By Jabulani Sikhakhane

Health care group, Noristan Holdings, has reported attributable earnings 42,8 percent up on a 54,9 percent hike in turnover to R97,095 million for the year to June.

But earnings per share rose only 12 percent to 19,6c because of an enlarged share base.

The number of shares in issue increased 27,2 percent after Noristan issued 10,5 million "A" ordinary shares to acquire Aurochs Investments (an FSI company).

After the payment of dividends for the year under review, the "A" ordinary shares automatically become ordinary shares and Noristan will then revert to its policy of paying dividends covered three times by earnings (2,6 times in financial 1990).

A dividend of 6c will be paid to ordinary shareholders and 6,8c for holders of "A" ordinary shares, to make a total for the year of 13,2c.

Noristan acquired a controlling interest in Aurochs with effect from July 1989 and refocused it from property development and ownership to a healthcare operation.

Aurochs, renamed Norimed, acquired a 100 percent interest in Crest Healthcare Technology.

A major benefit from the Aurochs deal was the R2,379 million realised by the sale of Norimed property assets to Hunts.

This helped off-set a 60,74 percent hike in interest charges to R1,032 million (R642 000), leaving Noristan with interest income of R1,347 million.

MD Dr Hugo Snyckers is confident about long-term benefits expected to flow from the link forged with FSI through the acquisition by W&A (an FSI company) of an initial 21 percent stake in Noristan. The acquisition of Crest has also helped the group enter the manufacturing and distribution of medical equipment.

The pharmaceutical division, which accounted for 60 percent of turnover, had good results, despite difficult trading conditions and pressure on margins.

Subject to stable trading conditions and before allowing for deployment of the liquid funds on deposit, Noristan directors expect earnings to show satisfactory growth in the year to June 1991.

The group has created a sound management and financial structure which, Dr Snyckers says, should enable it to investigate and take advantage of opportunities in the broad healthcare market.

SPECIAL FOCUS ON:
THE LEAGUE OF FRIENDS OF THE BLIND

Taking the sting out of blindness

IIMAGINE that you wake up one morning and can't see anything — not even the sunlight streaming through your window!

This is what actually happened to Katie (not her real name) three years ago.

An active single lady in her mid-20s, Katie had a good job as a bookkeeper, drove her own car to work and enjoyed nothing more than dancing the night away at her favourite night club.

When she lost her sight so suddenly, she felt as if her world had ended.

"Even the doctors did not know what to do," Katie says now. "They finally decided a virus I had at the time had put pressure on the optic nerve.

"They operated and after that my sight improved, but not totally. Then after a few weeks, [illegible]

agreed to visit the centre."

Katie met the full rehabilitation team of occupational therapist, rehabilitation assistants and orientation and mobility instructors and was so motivated by their plans for her that she agreed to attend regularly.

Although she could see a little, by this time she was determined to learn braille and touch-typing as well as all the skills of daily living that no longer came easily to her. She also needed counselling to come to terms with her failed sight and later joined an Adaptation to Blindness group.

"Just meeting other visually-impaired people was therapeutic and helped me stop feeling like a freak," she admits. "I also met two blind staff members at Lofob — which made me start thinking that I could get another job if I wanted to."

At the same time, she was receiving regular home-visits from an occupational therapist and learning how to use a cane and travel inde-

blind."

Once she'd passed the denial stage of insisting it was all a bad dream from which she would soon wake up, Katie was persuaded by her mother to stop feeling sorry for herself.

"Mom phoned the League of Friends of the Blind (Lofob) in Grassy Park and told them about my problem. The next week a social worker came to visit us and said: 'We've a Rehabilitation Centre; why don't you come in once a week for a while?' I was furious. Who did she think I was to accept charity."

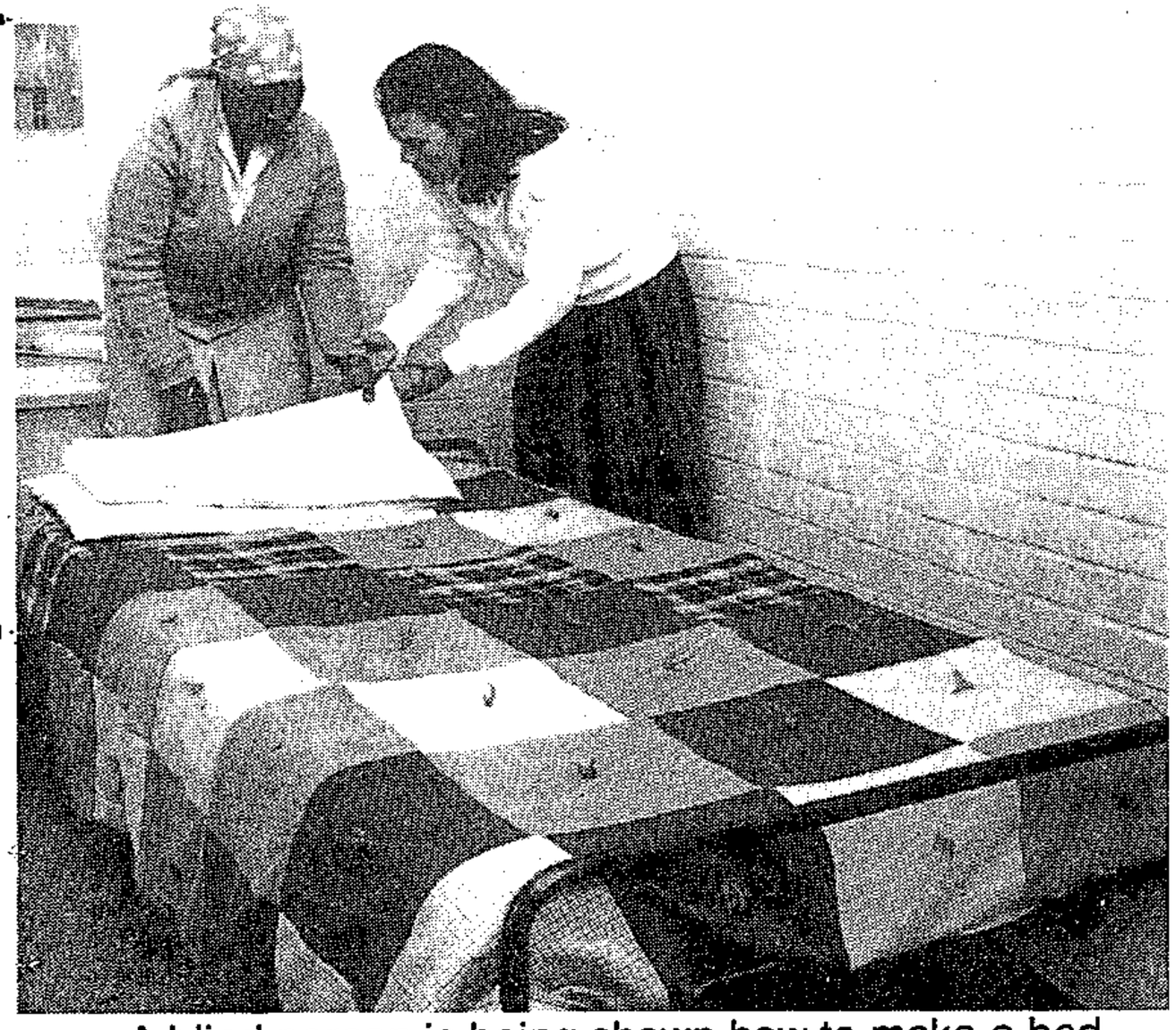
It took three weekly visits by the social worker before Katie changed her tune.

"She was just so good, the way she kept coming and showing me things like how to identify money or use the phone again. I finally

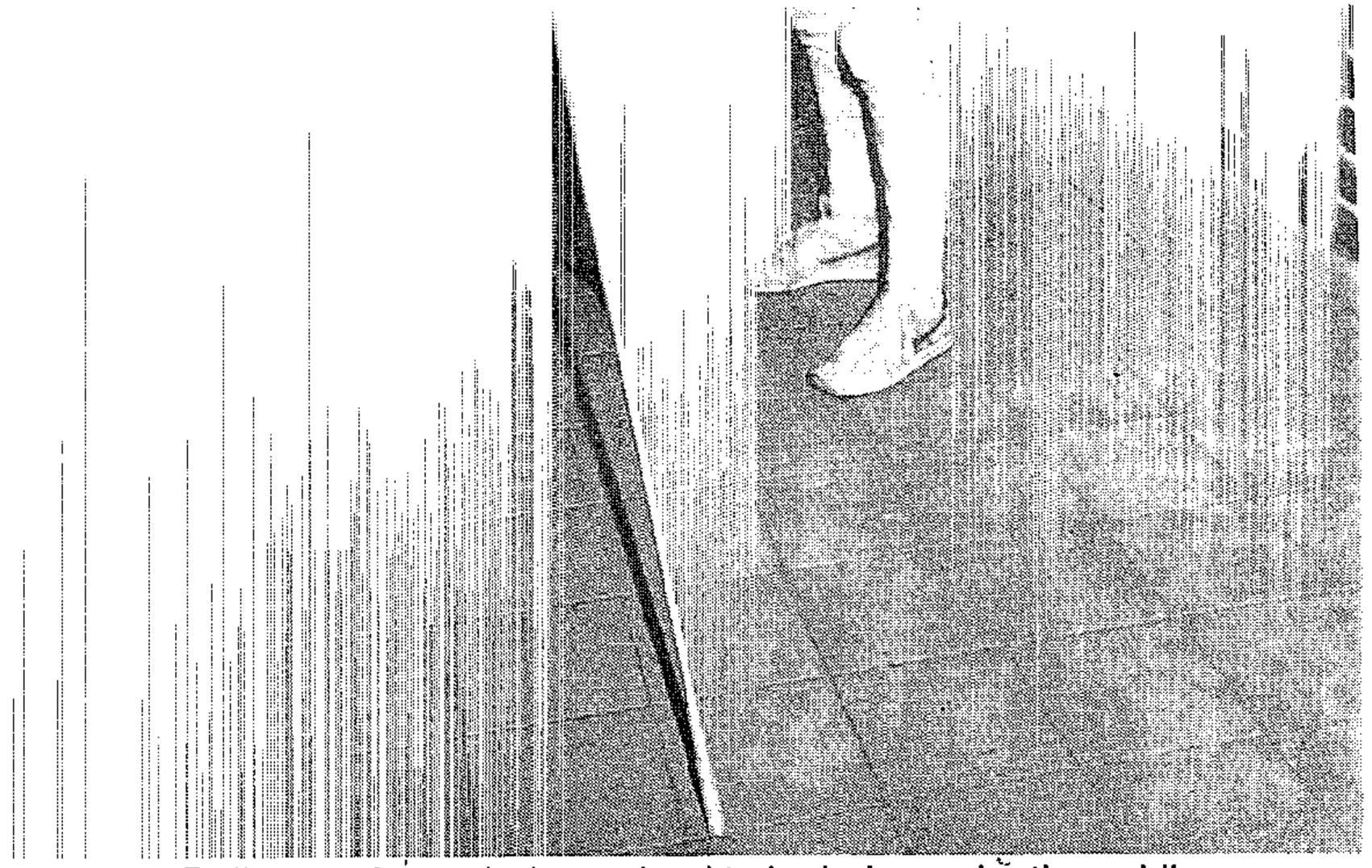
As her confidence improved, Katie was also allowed to work on first a simulation and later the real switchboard at the rehabilitation centre twice a week. Before long, she was encouraged by her social worker to consider applying for a job and, to her amazement, actually found a position as a doctor's receptionist.

"It did involve compromises," Katie's mother says. "She was back home a long time before she finally found her own flat and, of course, the car had to go. But she travels very competently by herself on the bus or train.

"She enjoys her job but it doesn't pay as well as bookkeeping, so Katie is studying by correspondence — and doing well, too. Rehabilitation at Lofob certainly took the sting out of blindness for Katie."



A blind person is being shown how to make a bed



Daily people are being trained to be independently mobile

Lofob's will & determination

THE opening of the new centre of the League of Friends of the Blind (Lofob) in Klip Rd, Grassy Park on February 3 this year marked a milestone on the road towards achieving equality of opportunity, self-awareness and self-respect for blind people of the disadvantaged sections of the South African population.

This centre is confirmation of the will and determination of Lofob to provide blind people with the facilities that will assist them to develop to become fully independent and participate in ordinary daily life.

A week after the official opening, Lofob held a conference with the blind to gauge their feelings about the services it offered. The visually-impaired of all ages and from different socio-economic backgrounds participated with enthusiasm and spoke about their personal experiences, their hopes, their fears and their dreams.

It was clear that they wanted opportunities to educate the sighted, to earn a fair wage, to have the facilities to use the innovative equipment available and to show society their capabilities. 299

Lofob is committed to ensure that this vision of equality and human dignity is turned into reality. Sc-CC 1319-17/11/90

This new centre provides:

- Accommodation for Lofob's infant stimulation and development programme;
- A resource centre where blind people can have hands-on experience of devices available;
- Facilities for developing communication skills;
- Facilities for developing home management skills;
- A work centre providing meaningful employment to 100 blind people;
- Office accommodation for Lofob's professional and administrative staff.

with billings topping R150m. Along with the merger came a top-heavy manage-

important accounts, including the multi-million rand BMW account which it had held for 16 years.

Study says govt should pay private doctors to aid poor

CAPE TOWN — A national health system in which the state pays a fixed fee to private sector doctors for the treatment of people who cannot afford to pay, will solve many of the problems of the existing system.

This is the view of Andersen Consulting's Health Care Practice manager, Maurice Goodman, who has done an extensive study on developing a system which co-ordinates SA's First- and Third World health-care needs.

Such a system will encourage vital co-operation between the public and private sector health-care providers, allowing the state access to private health-care facilities and management expertise, he says.

This has proved to be more economical.

The system, referred to as a capitation-based system of funding health care, will also encourage private doctors to become more involved in primary health care — an area they currently regard as financially unviable.

Reimbursement schemes like the fee-for-service system of payment, where doctors and hospitals are paid for specific

LESLEY LAMBERT

services, provides no incentive for private doctors to become involved in health promotion and disease prevention services.

"Operating under these systems, the private sector health-care providers are directly dependent on the level of ill-health in their communities to make their money.

"But, with the capitation-based system, the providers get a fixed revenue stream from the state and it is in their interests to contain costs to maximise profits."

"The USA system, called the Health Maintenance Organisation (HMO), provides health-care services to more than one third of the population and their experience has shown that it is the most cost-effective system for providing quality and comprehensive health care," he says.

Although HMOs are not allowed in SA because of laws which restrict group practices and the employment of doctors by the private sector, Goodman says it will still be possible to implement a health-care service based on capitation principles.

SPECIAL FOCUS ON: THE LEAGUE OF FRIENDS OF THE BLIND

A blind person being taught by a braille and typing instructress

Authorities need to change their attitude

(299) Sowetan 13/9 - 19/9/90

THE League of Friends of the Blind (Lofob) have expressed concern that teachers who were blinded as a result of an accident or eye condition are not allowed to continue their teaching activity.

Commenting on the practice, Lofob director Mr Philip Bam said: "Throughout the years we have come into contact with teachers who became blind and, as a result, were forced to leave the profession.

"We at Lofob believe these people could still be gainfully employed by the education department. We also believe a blind teacher can teach in a so-called normal school for sighted pupils.

"Discipline is one of the many excuses being offered by the education authorities why blind people could not be allowed to teach."

However, it had been said many times that a good teacher did not have to see to maintain discipline in a classroom. With the availability of technology, Lofob believed it was quite easy to retain the services of blind teachers.

Recently, a survey was completed and the results were made available to education authorities and agencies serving blind people. Lofob was awaiting the response of the education department.

Teachers

"We believe teachers who are qualified should be employed as such, and that the support services should be made available — if required — so that they could remain within the profession," Bam said.

"We appeal publicly to the authorities to reconsider their attitude towards blind teachers.

"Lofob will continue to strive for the integration of blind people into the so-called normal society. We believe people should not be denied the opportunity to practise their profession because of their visual impairment.

"We believe society needs a change of heart and that the authorities need a change of attitude," Bam said.

Challenge for children

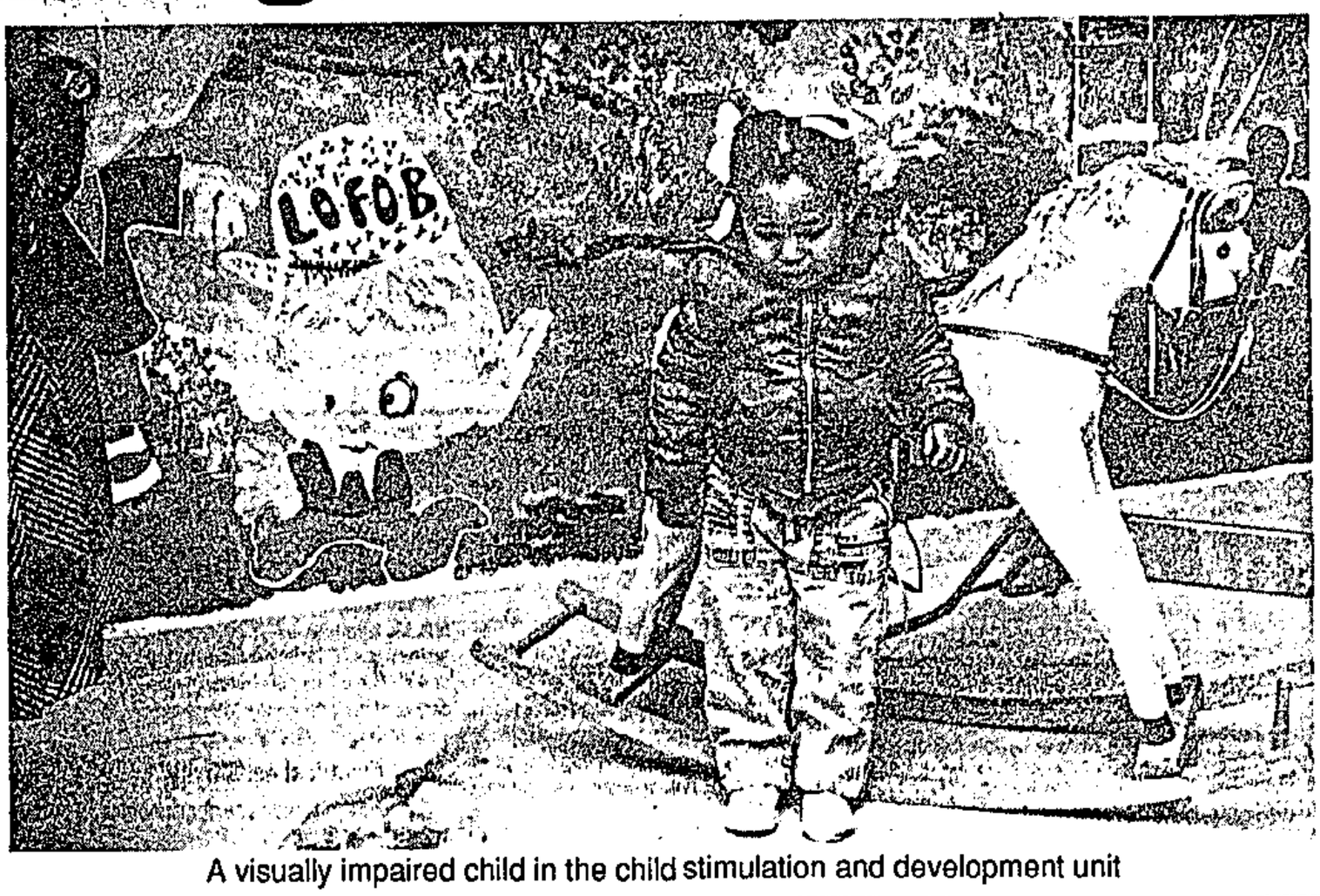
CHATOW is a bright, active three-year-old whose mother sometimes despairs because he is so lively and energetic.

He loves cars, trucks and going to the park to play on the swings. And, once a week, he waits anxiously for the kombi that will take him to the children's units at Lofob, where he takes part in the infant stimulation programme offered there.

When Chatow was four months old, he was discovered to be totally blind as a result of having been born several weeks prematurely.

"I suspected from very early on that he couldn't see," his mother, Sharon, says. "So it was really quite a relief when this was confirmed at the hospital. After that, the doctors were able to operate on his optic nerve. Now, with the help of glasses, he can see a bit and his sight may improve even further.

"He's going to attend a crèche for so-called normal children where they regard his sight problem as a challenge. Later, he'll either go to a local junior school or attend Athlone School for the Blind in Bellville South — depending on what'll be best for him by then."



A visually impaired child in the child stimulation and development unit

His mother does not intend to over-protect him because of his problems — Chatow also suffers from eczema — and says: "It's important for him to learn to look after himself as he gets older and mix easily with others, including sighted children.

"I've done karate and I'd really like him to learn this too one day as I was told it would improve his coordination and give him self-confidence."

After Chatow was accepted for the Lofob playground, his parents were invited to join the related parent support group established by a social worker.

Sharon feels attending these meetings helped her to be a better mother.

She met mothers who had come to terms with their children's blindness or other disabilities and was able to contribute to group discussions on various aspects of parenting the visually-impaired child.

"It was just so nice to get out and meet others in the same position. We went on a super picnic with almost 50 of Lofob's clients at Christmas time and Chatow even took part in the Lofob nativity service.

"He learnt a lot, I must say, and so did I" said Chatow's mother.

Helping blind independence

MARIA (not her real name) is registered as a blind person but can actually see a bit.

She has always been hard-working, so when she found her three children grown and no longer needing her, she began to look for a job. However, due to minor ill health, her doctor advised her not to accept the work as a cleaner she had been offered.

She had recently completed rehabilitation at the centre of the League of Friends of the Blind (Lofob) in Klip Road, Grassy Park, and mentioned her problem to staff there.

Within a week, Maria was working in Lofob's work centre created to give visually-impaired people the opportunity to be gainfully employed doing contract and other work.

Lofob helps blind people become independent and improve their quality of life, offering various practical training and development programmes. These include braille and typing lessons, handwork, cooking, recreation, mobility instruction, counselling and employment.

If you know of any blind person who would like to make use of Lofob's services, telephone (021) 795-3754 or write to PO Box 10, Grassy Park, 7888.

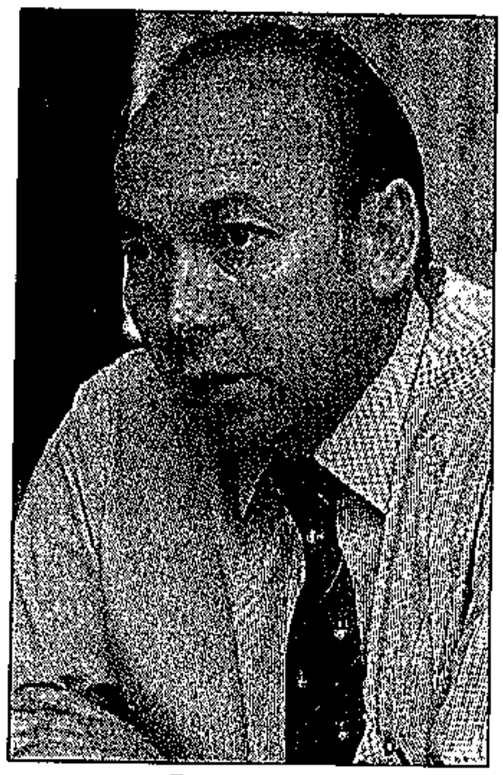
PAYING FOR HEALTH CARE

ADAPTING TO THE STRAIN

FM 14/9/90 (299)

LIMITED RESOURCES AND GROWING DEMAND NEED IMAGINATIVE ANSWERS

Financing of health care is one of the most contentious issues SA will face. The *FM* brought together four experts: Duncan Reekie, Dean of Commerce at Wits; Rob Speedie, executive director of the Representative Association of Medical Schemes (Rams); Dick Williamson, GM of Afrox's health care division; and Jonathan Broomberg of the Centre for the Study of Health Policy at Wits Medical School. *FM* deputy editor Michael Coulson asks the questions.



Speedie

Broomberg

Reekie

Coulson: What is the biggest problem facing the health care system, particularly regarding its financing?

Broomberg: SA has a limited total resource for health care and we are probably more or less at that limit, close to 6% of GNP. But there's massive maldistribution of resources between the public and private sectors. The private sector consumes close to 50% of total health care expenditure and delivers services to 20% of the population.

Coulson: What are equivalent figures for other Third-World and First-World countries?

Broomberg: They range from around 5% for low-middle income countries like us up to 11%-12% in the US. They can be as low as 2%-3% in very low-income countries.

Reekie: Pouring more money into the system will not increase actual real resources available, which are largely manpower — doctors, nurses and the like. Allocation of existing resources is the problem. Even in countries such as the US, with possibly double the percentage of GNP spent on health care, allocation is a problem.

Coulson: There is a belief that the way medicare is structured in the US actually increases the cost structure. Isn't there a problem here, that a cost structure can feed on itself?

Reekie: It is a problem not just for the public sector or private sector in SA, but globally. The structure of the market often offers little incentive for patients or providers to minimise consumption. Very often at the point of consumption, the price is zero to the immediate provider and to the patient — there is a third party reimburser. The patient may have paid a portion of the cost through some sort of insurance premium or tax contribution, whether it is private or public, but at the time of consumption, there is no cost to him other than attendance at the practitioner's office or hospital.

Speedie: Medical scheme expenditures have risen over the past 10 years by around 20% compound a year, a good five percentage points ahead of CPI. One simply cannot carry on along this path. I agree that the prime cause is lack of cost-consciousness and a system that in fact encourages waste and does not encourage — I won't say frugality — but a sense of cost-consciousness.

Coulson: How do we change that?

Speedie: It will mean changing certain laws — the Medical Schemes Act — among other things. It also means a major attitude change for both doctors and patients. It is no easy task. The public and professionals have been spoilt for years and it is deeply rooted.

Broomberg: The reimbursement structure for providers that we call the fee-for-service system is another cause of waste. It creates an incentive to deliver more service, by both hospitals and individual practitioners. The evidence is abundant that when the price of each service is held back against inflation, providers respond by increasing the number of services delivered.

Coulson: Should we move towards something like the British National Health system, where the doctor gets virtually a standard fee per patient, more or less irrespective of the number of calls the patient makes? There are people who think that this encourages patients to make even more calls.

Broomberg: We need to move in the direction of new payment methods, and the capitation system is one. It may be useful to look at a mixture of systems to encourage providers to do things that they normally do and discourage them from doing too much of the things they normally don't do.

Williamson: There are a number of models. There is a place for fee-for-service, and alongside that comes free choice. People who have the money and want to pay for free choice are entitled to. A movement that has merit in our circumstances is the Health Maintenance Organisation or HMO, which is well established in the US. It's a joint venture between patients and their financiers, be they medical aids or whatever, on the one side and suppliers of service on the other side. Built into that joint venture is an incentive to save money.

Under our system, once you've paid your medical aid fee you are entitled to demand Rolls-Royces all the time, because most medical aids provide 100% cover. A few provide 80%, and that means that the patient does share the financial considerations. In the HMO model, the patient has an incentive to know what prices are and to get involved. So do doctors and hospitals and suppliers of other services. The anomaly of our system is that I make more profit out of providing a R10 catheter than I do providing a R5 catheter — the incentive is upside-down.

Reekie: Medical aid scheme regulations preclude the HMO model. This is the type of regulation that stops our markets from operating freely. We do not have a free-market system, we have a highly regulated private market system. One regulation is the prohibition on medical aids from specifying what type of providers their clients should use.

Speedie: The system is fundamentally flawed inasmuch as it does not permit free and competitive negotiation. Doctors' hands are to some extent tied by the scale of benefits. The same applies to private hospitals and medical schemes, which are not able to bring their full negotiating power to bear on the supplier of services to change things. Until we achieve that, we'll be left with distortions in the market.

Williamson: Another distortion is that at least 90% of my bills are paid by members of medical aid schemes under the Representative Association of Medical Schemes (Rams) umbrella. Rams, from our point of view, is a legal national buying cartel because it publishes prices and all its members stick to that. As Duncan was saying, it's very far from a free market. I don't believe it is right that someone outside my industry should decide

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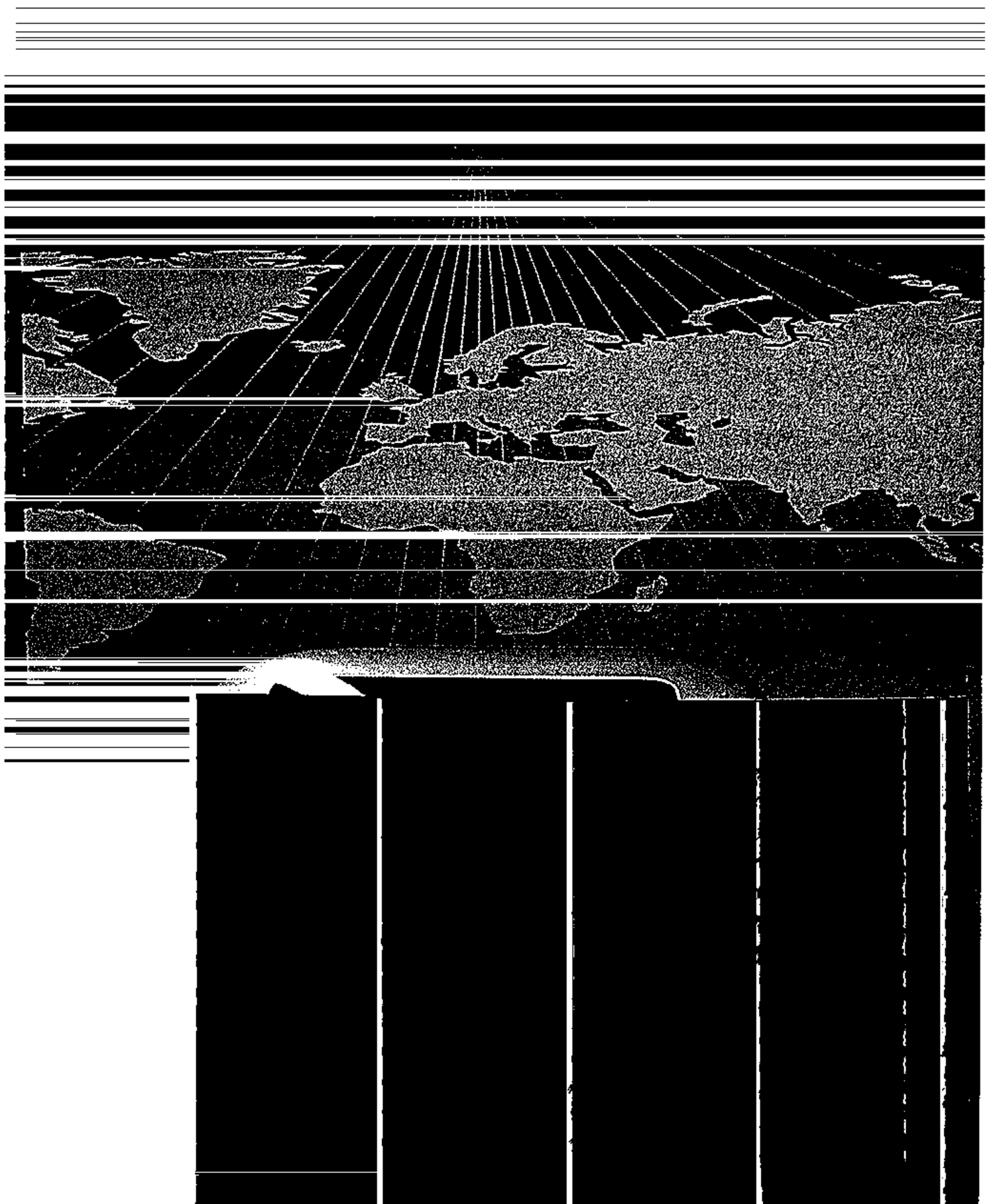

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06

●IN South Africa 12,7 percent of the population are disabled, equalling 3 810 000 people. Of these 900 000 are mentally handicapped, 120 000 of them severely. (299)

w/mail 14/9 - 20/9/90

Pollution study on Vaal kids

RESEARCH which will determine how air pollution affects a child's immune system is underway in the Vaal Triangle. Soweten 27/9/90

The Medical Research Council investigation will include drawing blood samples and assessing lung function efficacy and will be conducted on about 600 pupils between 15 and 18 who live in Vanderbijlpark.

Questionnaires will also be distributed further afield.

A MRC statement said that by conducting tests on the body's immunity system, researchers hoped to establish whether the air pollution in the Vaal Triangle had the same effects on the body as smoking.

The first phase of investigation should be completed by March next year. - *Sapa.*

Special Mary Harding Games

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South 27/9 – 3/10/90

By WAGHIED MISBACH

MONDAY was a special day for 260 mentally disabled athletes.

They came from all over the country to participate in the Mary Harding Games in Athlone, Cape Town.

Held in conjunction with the 10th annual celebrations of the Mary Harding institute for the mentally disabled, the games brought together for the first time 11 institutions from Natal, Transvaal, Eastern Cape, Boland and Southern Cape.

According to George Africa, the principal of Mary Harding, this event is the first non-racial event for the mentally-disabled and sufferers of cerebal palsy.

Don't pity us, say disabled

(299)
South
27/9 - 3/10/90

By YUNUS MOHAMED

DON'T pity us, treat us like normal human beings.

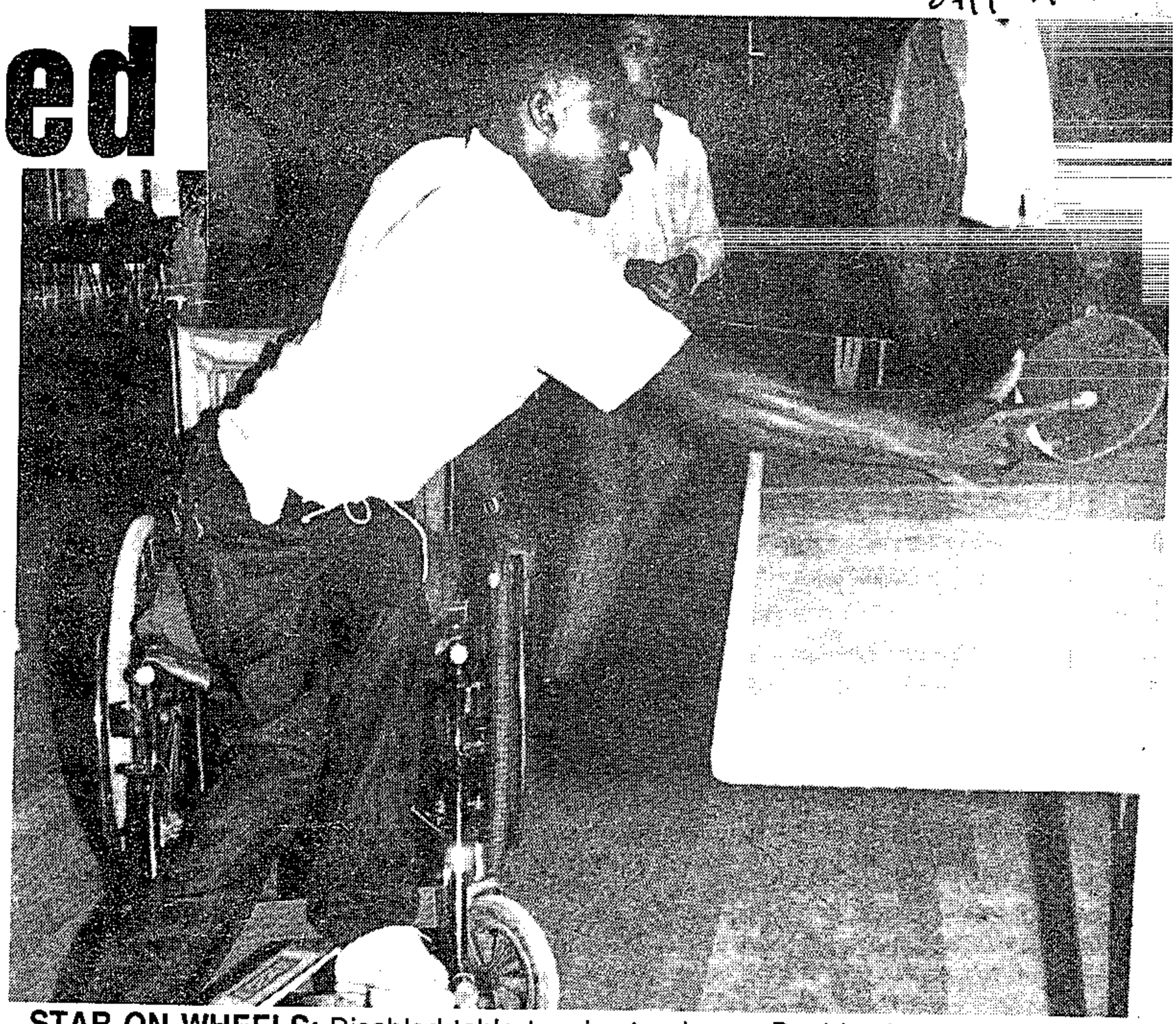
This was the sentiment expressed by most of the participants at the third Association of the Physically Disabled Games on Saturday.

Held at the Lentegeur Psychiatric Hospital grounds in Mitchells Plain, Cape Town, codes included table-tennis, bowls, darts, rings, kerrim, dominoes and soccer.

Seventy-four year old Mr Benjamin Williams, of Ocean View, saw little difference between the Games and sport played on an organised basis by "normal" people.

When he had his legs amputated a few years ago, he was confined to a wheelchair and lost complete interest in life.

"The Games have brought a new dimension to my life. I was miserable and lonely until I joined the club in Ocean View last year," said Williams, who enjoys dominoes and klawerjas.



STAR ON WHEELS: Disabled table tennis star James Davids shows his versatality and mobility in a wheelchair

Table-tennis whizz James Davids, 31, of Worcester, said he had made more friends at the Games than in his entire life.

Davids was struck down by polio when he was 18-months-old and has been in a wheelchair ever since.

This has, however, not stopped him from gaining provincial colours for almost 14 years at the sport he loves.

He glides almost effortlessly around the table-tennis board, moving the wheelchair with one hand while playing with the other.

A noisy disco in another section of the large hall provided further evidence of normality".

Everyone, from the severely mentally handicapped, to those in wheelchairs and on crutches were doing their "own thing".

"Noone giggles or stares at us as if we were aliens," Davids remarked.

Davids was also the founder of a table-tennis club the in Boland which presently consists of 25 members from Ashton, Worcester and surrounding areas.

The day-long events also inlcuded "normal" rules soccer and "five-pace" soccer, designed specially for the physically disabled.

The players included those on crutches and those who had special shoes for disparity in leg-length.

Five pace soccer rules allows players to move five paces before they have to pass the ball.

The day ended with a talent contest and a prize-giving ceremony for the winners of each of the sport and talent categories.

Some of the winners were: Darts: 1 Orion, 2 Cape Mental Health. Table Tennis: 1 Paarl A (Jacobus Arendse and Willy Roodtman), 2 Social A. Best Organised Worshop: Cape Mental Health. Carpet Bowls: Cape Mental Health. Talent Show: Andries Diergaardt.

CRITICAL CONSUMER

Are Caesareans planned for doctors' convenience?

W/E Mail 28/9 – 4/10/90 299

PREGNANT consumers will be amazed at just how skewed nature is.

Women in private hospitals are 50 percent more likely to have a Caesarean section than are those being treated by salaried doctors and midwives at state hospitals. Furthermore, twice as many CS births take place during the week than over a weekend, and only a quarter of those will be accounted for by plans made before labour begins.

Among non-Caesarean deliveries in the private sector 56 percent more babies will be delivered during the week than on the weekend, suggesting that more births are induced in private hospitals than in public hospitals.

All these facts, and others, emerge from a study done by two University of the Witwatersrand doctors. Max Price and John Broomberg, which was published in the *South African Medical Journal* last month.

The two have received hate mail from gynaecologists in private practice who resent the inference that their practice is sometimes determined by money and convenience and not always by medical need.

PAT SIDLEY

Price and Broomberg took a sample of women aged between 20 and 35 years old who were having their first babies.

The data was collected from the records of 637 women who had their babies at the Johannesburg Hospital under the care of salaried midwives. Another 620 women were selected from three medical aid schemes; most had their babies delivered by "fee-for-service practitioners".

Of the 637 babies delivered at the Johannesburg Hospital, 124 (19,5 percent) of them were by CS — as opposed to 178 (28,7 percent) out of the 620 deliveries by fee-for-service practitioners.

This result shows that the private patients were 50 percent more likely to have their babies delivered by CS than those in the Johannesburg Hospital.

The doctors say they expected to find roughly "the same number of Caesarean sections done on each day of the week". But this was not so.

Caesarean sections and induced births (which often resulted in Caesareans) were planned for weekdays "so there would always be a slight excess of deliveries and Caesarean sections during the week.

"The number of deliveries and the number of Caesarean sections on each weekday were 67 percent and 97 percent higher than the number per weekend day in the medical aid sector."

At the Johannesburg Hospital, however, deliveries and Caesarean sections are seven percent and 25 percent higher on weekdays than over weekends.

The doctors state that while the figures in the private hospitals are statistically significant, the figures at the Johannesburg Hospital needed a larger sample.

Price and Broomberg analysed health and other details of the two groups of women.

They note that the women at the Johannesburg Hospital had on average lower incomes than those in the private hospitals. This they remark on because women in the lower socio-economic groups are apparently more likely to have problems delivering babies. One would therefore expect there to have been more Caesarean sections at the Johannesburg Hospital.

"If the difference in the socio-economic profile of the two groups of patients does have any effect, it is therefore likely to lead to an underestimate of the difference between the CS rates," the doctors state.

Price and Broomberg anticipate the argument that too few Caesareans are carried out for the good of the patients in public hospitals. But they cite several studies which show no simple relationship between Caesarean sections and the quality of care.

In many countries Caesarean sections are rare. Figures cited in the study show rates from 9,4 percent (in Norway) to 24,1 percent (in the US).

The study also deals with induced labour, stating that a failed induction is one medical indication for CS — once the doctor has tried to induce labour and this has not worked, he or she will be forced to give a CS.

But figures from the study show that many more doctors in private practice than in the public hospitals induce labour. This was supported by the fact that there were 56 percent more non-Caesarean births during the week than over weekends in private hospitals.

The figures lead the doctors to say that "26 percent of white women delivering their first baby in the private sector were induced who would not have been induced had they delivered at the Johannesburg Hospital".

The doctors said their figures provide evidence that "doctors have the ability to induce the demand for their services". When patients are paying for their service in private hospitals doctors respond "by increasing the rate of obstetric interventions".

They state that the "rates of Caesarean sections and inductions are higher in the private medical aid sector than in a central academic hospital, with no apparent medical explanation".

The doctors state this raises two concerns regarding staffing and resources and whether the mother is getting the best care.

"A Caesarean delivery consumes far more resources than a vaginal delivery, in terms of skilled personnel time, theatre time, drugs, days in hospital, nursing care and finances."

They suggest that the place to start rectifying this is to regulate, if not eliminate, "fee-for-service" care. –

C/Press 30/9/90

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Nightmare ride

This one is just for you Dad, says Thobela

By PULE MOKHINE

NEWLY-crowned World Boxing Organisation junior-lightweight champion Dingaan Thobela says he has dedicated his title to his number one fan – his father.

Thobela, nicknamed the "Rose of Soweto", became the first local to win the WBO title when he beat Mauricio Aceves of Mexico on points in Texas, USA, last Saturday.

Thobela told *City Press* at his 24th birthday celebration at a Soweto nightclub this week that his father, Godfrey, had always encouraged him in his boxing career.

"Since I started boxing, my father has been giving me moral support and I feel I owe I him a lot," said Thobela.

When he was still an amateur, his father – a Soweto panelbeater – bought him boxing magazines to help him improve his boxing knowledge.

He is the second son in a family of eight children – four sisters and four brothers.

His mother died last year and he is presently staying in an outside room at his grandparents' house in Chiawelo.

"I'm planning to buy a house for my family and to unveil a tombstone for my mother because I believe I'm what I am because of these people," he said.

Thobela said if all went according to plan, he would pursue his studies next year.

He was among the unlucky students expelled last year from the Soweto Teachers' Training College after failing their first-year courses.

"I would like to see myself educated before I decide to hang up my gloves and while I'm still the champion," he said.

Asked about his marriage plans, he said he would consider getting married within the next two years.

Dingaan Thobela celebrates his 24th birthday and his WBO victory with his biggest fan, his father Godfrey

Thugs hijack bus, abandon paraplegics at graveyard

By CHARLES MOGALE

A TRIP by a group of disabled Sowetans turned into a nightmare this week when their minibus was hijacked by gun-toting thugs who left them stranded at a graveyard.

"They drove us to the graveyard, threw us out with our wheelchairs, and told us to find our own way home," paraplegic Boniswa Mkhumbeni, 30, said this week.

Still visibly shaken after their ordeal, the group – all employees of Soweto's Self Help Association of Paraplegics (Shap) – related how the gang pounced on them just before sunset on Monday evening.

Driver Fanie Gambu, 29, who has an artificial leg, had just stopped the minibus to offload colleague Mkhumbeni when three youths shoved a gun through the window of the minibus, and demanded the keys.

"I protested and tried to explain that the vehicle was used by disabled people, but they were aggressive and would not listen. They threw me out and drove off with the three women and one child in the car," Gambu said.

He hobbled to the nearest house and asked to use the telephone to call the police.

"They told me to go to the police station," Gambu said.

Meanwhile, the disabled passengers in the minibus were ordered to close their eyes as the vehicle drove off. It stopped at the Doornkop Cemetery and the passengers were thrown out with their wheelchairs. They were told to find their own way home, and had to travel up to 5km in the dark to get home.

"I was scared, I feared more for the safety of my child who was sleeping innocently through it all," said Mkhumbeni, clutching her 18-month-old baby Sifiso.

Tiro Fako, 34, and Sophie Molomo, 22, both wheelchair-bound, said they also believed their last moments had come.

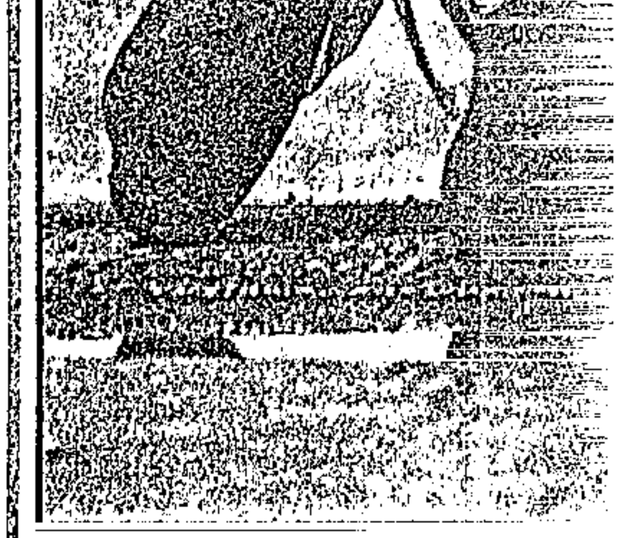
"The men said we were lucky to have escaped in the morning. It was clear they had been tailing us for some time," Fako said.

Shap director Friday Mavuso lashed out at the police for showing lack of enthusiasm in apprehending the hijackers. Shortly after the hold-up, he said, children who witnessed the incident gave the name and address of the leader.

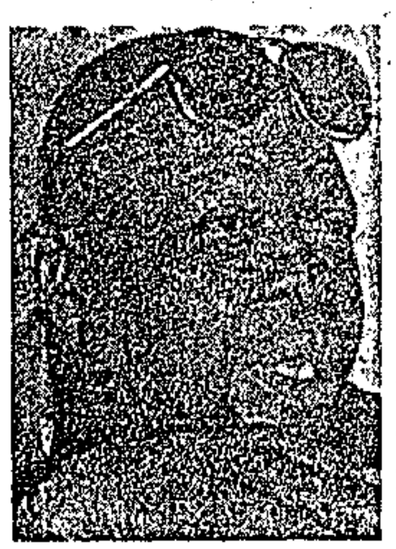
"I personally gave the name and address to a policeman at the Dobsonville police station, and suggested his home be raided. I was given the assurance that he would be raided that night, but the following morning when I went to the police station, I was given excuses about lack of staff," Mavuso said.

"For the whole day I tried to communicate with the policeman who took a statement from us, but he was not there. Twenty four hours later, nothing had been done, making it more difficult for the car to be recovered. I am bitterly disappointed. This is the second vehicle we have lost in a few months, and our insurance company has warned that we could soon be classified high risk. As disabled people we just have to close shop if we can't get a vehicle," he said.

The following night, while driver Gambu was delivering staff home, he

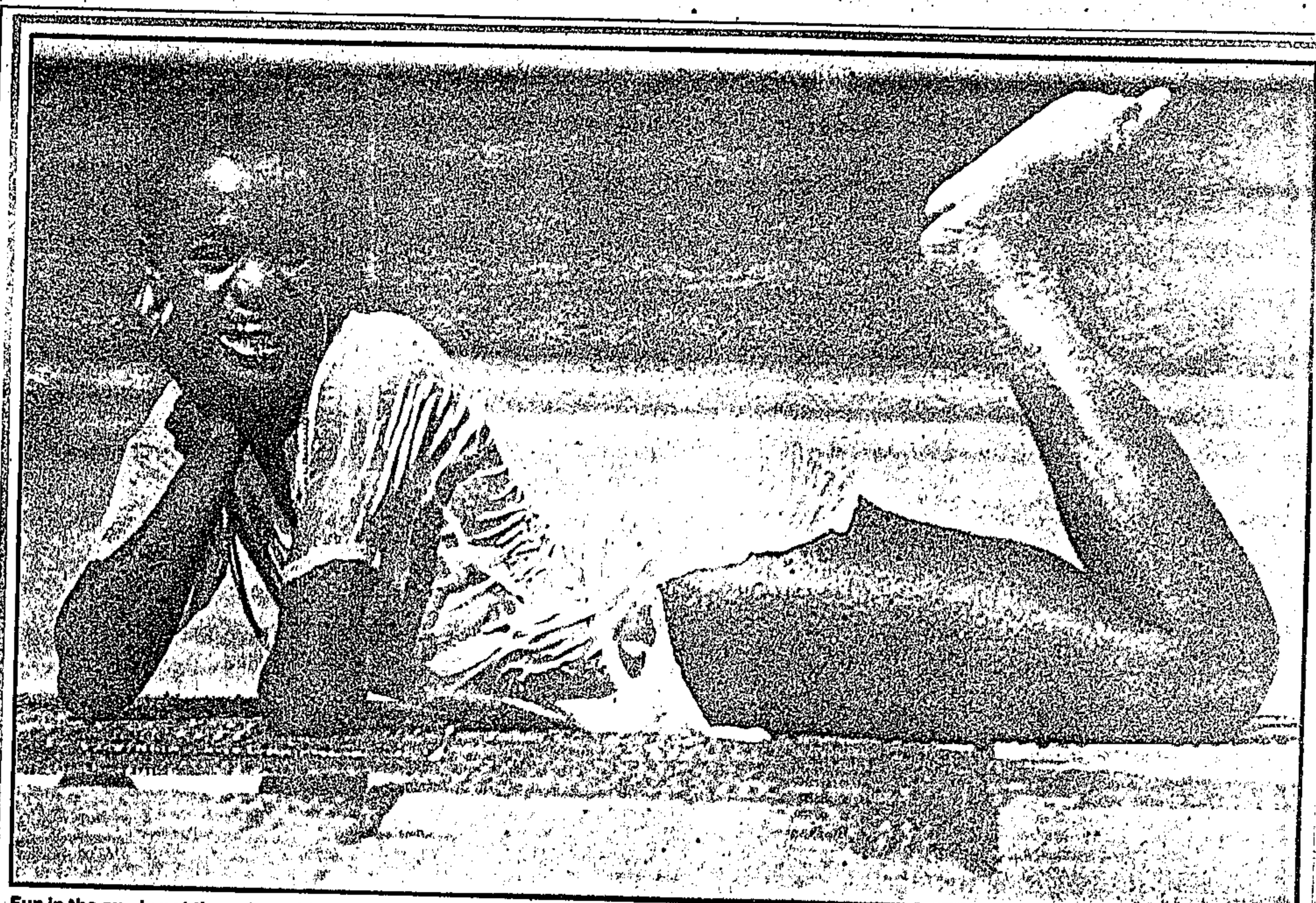


Fun in the sun is not the only ambition



Friday Mavuso: police did very little to help.

ride for disabled



Fun in the sun is not the only ambition of lovely Mmabatho Letwaba, 21, of Meadowlands. In addition to looking good, she wants to be a lawyer.

ance that he would be raided that night, but the following morning when I went to the police station, I was given excuses about lack of staff," Mavuso said.

"For the whole day I tried to communicate with the policeman who took a statement from us, but he was not there. Twenty four hours later, nothing had been done, making it more difficult for the car to be recovered. I am bitterly disappointed. This is the second vehicle we have lost in a few months, and our insurance company has warned that we could soon be classified high risk. As disabled people we just have to close shop if we can't get a vehicle," he said.

The following night, while driver Gambu was delivering staff home, he was stopped by the flying squad, and related the incident to them.

"They immediately accompanied me to the home of the suspect. There we were told he had died three weeks ago, but they persisted with the investigations until they established from his friends that he was alive.

"He had been seen driving the vehicle. At least those white chaps showed commitment to their duty," Gambu said.

Soweto police liaison officer Lieut G Marimuthu confirmed the incident and said an early arrest was expected. The police were on the track of a suspect, and his home had been raided, without success.

Friday Mavuso: police did very little to help.

Boniswe Mkum benli feared for her child.

Cop acquitted of theft

By DAN DHLAMINI

A KLERKSDORP cop who was alleged to have broken into an abattoir and stolen three sheep carcasses was this week given the benefit of the doubt and discharged.

The State alleged that Det Const Paul Noppe 26, committed the crime on January 28.

In his defence, Noppe, who appeared before Klerksdorp magistrate LP Virtue, told the court he had seen people carrying carcasses and when they saw him they dropped them along the railway line and fled. That was how they came into his possession.

In acquitting him, magistrate Virtue said Noppe acted suspiciously on that day but he could not convict him on suspicion and gave him the benefit of the doubt.

Noppe, who had been carrying his service revolver in the dock, smiled after his acquittal and left the court in the company of his lawyer.

Kids bank on Aquanaut

IF Aquanaut wins the R750 000 OK Gold Bowl at Turffontein on Saturday – and he is the new favourite at odds of 4-1 – Othandweni Children's Home in Soweto will get R20 000. And if it doesn't, the home still cannot lose.

When 20 members of the media were invited to draw a horse for the big race, and name a charity to collect the winnings, *City Press* drew Aquanaut and nominated Othandweni to pick up the prize money.

R20 000 goes to the winner, R15 000 to the second, R6 000 third, R4 000 fourth and R2 500 fifth.

The rest of the 20 runners each qualify for R1 000.

Cape Town's Aquanaut, trained by Mark Watters and ridden by Mark Khan, was previously quoted at 7-1.

The seven-year-old has won the big race at Turffontein twice – in 1987 and 1988 – and looks sure to again see out the tough 3 200m race. The main obstacle is that Aquanaut carries topweight of 58kg.

Out of 41 runs, Aquanaut has had 13 wins and 12 places for R1 171 577 in stakes.

The commission also gave a break-down of detentions in SA, Transkei and Bophuthatswana.

constitutional alternative.

"In these circumstances, who is going to maintain stability while the parties negotiate?" he asked.

tions since February 2, are a matter of public record and hardly need to be described again".

☐ The first protest against the Iron

seven days, "failing which other forms of struggle will be resorted to".

ANC local official Baba Schalk declined to spell out the nature of these "other" actions. — Sapa.

Profuse praise for Rina Venter

Bday 24/9/90

THE words "approachable" and "commended" cropped up repeatedly when health and welfare professionals were asked to comment on Health and Population Minister Rina Venter's first year in office last week.

Besides her obvious achievements such as opening hospitals to all races, Venter was seen to be an involved health minister with a clear desire to get primary health care to the whole population.

The medical profession lauded Venter's desegregation of hospitals and hoped sufficient funds would be made available to fully implement the decision, said Medical Association of SA (Masa) chairman Bernard Mandell.

The National Policy for Health Act introduced by Venter earlier this year to ensure a more effective, comprehensive health service was a positive step towards combating uneconomic fragmentation, said Mandell.

The five-point plan announced by Venter during the Budget debate in May intended to reconstruct the national health service, making it more accessible, affordable and effective.

Mandell said doctors had found Venter approachable and commended her ability to grasp the complexity of her portfolio.

TANIA LEVY

Venter was given credit for playing a mediating role in the continuing battle between dispensing doctors and pharmacists.

She had not taken sides but had been firm about wanting the two sides to solve their differences in the interests of health care.

Pharmaceutical Society of SA (PSSA) president Tom Carse said that during the past six months Venter had facilitated meetings in which PSSA and Masa could thrash out their conflicting interests. He believed the two societies were coming to a solution which would be recommended to the Minister.

(299) Prompt

It was good to know that Venter's final decision would be impartial, he said. "She deserves applause for being enthusiatic and concerned about total health care for the whole population."

The PSSA welcomed her prompt action in speeding up the ban on skin lighteners last month, said Carse. Venter's predecessor, Willie van Niekerk, had been widely criticised for postponing the original June 1988 deadline to January 1991.

Pharmacists welcomed the control they would be able to exercise on skin lightening creams, which would no longer be sold as cosmetics but as medicines. Creams with less than 2% hydroquinone would be supplied at the pharmacist's discretion; those with more than 2% hydroquinone would require a doctor's prescription.

Johannesburg Child Welfare director Adele Thomas said Venter had to be commended for personally visiting unrest victims in hospitals and townships during past weeks.

Venter was easy to talk to and, as a social worker, understood welfare issues, Thomas said.

Her moves in terms of primary health care were very important. It was hoped that a similar approach to social welfare would be adopted. More grassroots community social work was needed in SA, rather than sophisticated First World services.

Thomas said Venter had to address the funding needs of welfare organisations, which were generally in dire financial straits.

Existing welfare policy, which entrenched inequalities, was a further area requiring critical attention. Venter had to push for a single state welfare system for all with parity in grants, subsidies and spocial pensions, said Thomas.

Bigger SAP 'wouldn't need tough laws'

Bday 24/9/90

GERALD REILLY

PRETORIA — A bigger, more professional and sophisticated police force would be less dependent on drastic legislation, Police Commissioner Johan van der Merwe said at the weekend.

Speaking at a human rights conference at Unisa, Van der Merwe emphasised public order — an absence of riots, insurrection and violence — could be maintained effectively only if police had adequate equipment and manpower.

He said a charter of human rights would force the police to adjust their approach in certain aspects of policing. With "terrorists" ordinary methods of detention and apprehension had to apply as far as possible.

Human rights, whether guaranteed by a charter or not, could not be absolute or unlimited. A charter had to be balanced between the rights of individuals, the community and the state.

was facing a ... would affect the economy disease would decimate the create power vacuums. ...

Masa submits a model for unitary health care system

B 10 am 11/10/90

PRETORIA — A unitary health care system with one Health Ministry supported by a health advisory council is one of two major proposals in a model for academic medicine submitted to the National Health and Population Development Department.

The submission, by the Medical Association of SA (Masa), also provides for greater managerial autonomy at hospitals.

The submission follows a recent summit on the future of academic medicine.

Masa secretary-general Hendrik Hanekom said real changes had to be made in the current health delivery service.

The model anticipates major restructuring, particularly at central government and provincial administration levels.

It was drawn up by a firm of management consultants.

An ideal system would allocate health services to each level of the health system.

Important too would be involvement in and encouragement of other socio-economic measures aimed at improved health status for all.

The model provides for the country to be

GERALD REILLY

divided into "academic complexes", each centred around a university and including facilities for meeting the training needs of universities.

This would ensure teaching took place at tertiary, secondary and primary health care levels. (299)

Seven complexes are suggested in the model — surrounding the Universities of Cape Town, Stellenbosch, Free State, Natal, Witwatersrand, Pretoria and Medunsa.

Other areas would be served by regional health boards.

Neither the boards nor the complexes would follow provincial boundaries.

Chief executive officers — not necessarily doctors — would be appointed to each academic complex, board and hospital.

The model also provides for access by patients to the level of treatment needed and academic hospital admissions would be on a referral basis only.

d of its business to Bidvest Limited ("Bidvest") and its

CRITICAL CONSUMER

W/E Mail 5/10 – 11/10/90. 299

Pregnant women have rights — and should demand them

WOMEN who have their babies in private hospitals are 50 percent more likely to have them delivered by Caesarean section, according to a study reported last week in this column. Those who think their doctors have not been entirely open with them are not alone.

Nor are those alone who believe they do not have enough control over their own bodies and the birth experience.

A lack of control is by far the most common complaint of women having babies in situations where they have some perception of choice: patients in private hosptials. This is particularly so since the rise of the women's movement and the increase in the average age of women having babies for the first time — 26 years old, in Britain.

The authoritative consumer organisation in the United Kingdom, the Consumers' Association, has conducted a survey among women who had given birth in the two years preceding the survey. They were asked what they thought about their birth experience.

About 26 percent said they would do things differently next time — and many of those wanted the next birth at home. The majority of the women gave birth in National Health hospitals — very few women in Britain use private health facilities.

Over half the women saw the general practitioner or midwife as the main provider of antenatal care. But this relationship seldom continued into labour — where hospital staff took over.

Eight percent of women had had changes made to their birth plans without their consent; 45 percent agreed to some changes. Just under half, about 47 percent, had the birth of their choice.

In this country, birth plans are not used very often and many doctors disregard them as being a function of a cranky "women's lib" type. Making further problems, the consent form a mother signs on entering a private hospital makes a mockery of the notion that she should have any choice at all in a private clinic.

Women about to give birth should ask their doctors for statistics, explanations and information to help them make decisions regarding the delivery. **By PAT SIDLEY**

The survey also asked women about the technology and tests they had been subjected to, like ultrasound tests, amniocentesis (for defects in the foetus) or electronic fetal monitoring. About 90 percent of women had ultrasound tests at about 16 weeks, but many of them did not know whether the test posed a risk (the risk is minimal, according to *Which? Way to Health* in which the Consumer Association's survey was published).

About 25 percent had labour induced, 20 percent had an epidural (anaesthetic delivered through the spinal cord). About 14 percent of the women believed many of these procedures were unnecessary. Many women said they would have liked more information about the tests and procedures.

The Consumers' Association believes there ought to be radical changes in training for junior doctors and future GPs. They recommend improved communication skills and "an open attitude to discussion which revolves around the woman as an individual".

A third recommendation would appal the doctors who compiled the study which suggests that doctors do caesareans and induce births for more money. The association suggests that GPs need more incentives to involve themselves in the birth process.

For black women using public hospitals in South Africa, most of this won't apply. Their experience would cause malpractice suits in many other countries.

Olga is a local char who had her baby on the East Rand. When the baby began to arrive in the world nobody but Olga was in the delivery room. And nobody arrived, despite her screams.

The baby was in distress and blue and became stuck in the birth canal. Help arrived just in the nick of time.

But then the exhausted mother was placed under general anaesthetic and sterilised. She did not ask for it, did not know it was happening and was informed only afterwards she would never again be able to have a baby.

Julie, a domestic worker, said the experience of giving birth at Baragwanath Hospital near Johannesburg was "fine" only if the student doctors were around. Her perception was that the students tended to the needs of the women they needed it for higher marks. However, she had nothing but condemnation to offer about other hospital staff.

Doctors hearing about women's views on their birth experience usually raise the Great Safety Debate. Births need to be in hospital with high-tech facilities and not at home with a midwife because it is safer. They cite statistics from this century of live healthy births to back them up.

The Consumers' Association quotes some of these arguments and statistics. In the UK for every 1 000 births, fewer than nine babies die at birth or within the first week of life. It says maternal deaths are now rare — under nine for every 100 000 deliveries.

But the association also says that some "statisticians are less certain about the link between obstetric technology and improved safety records. They think the improvements may have more to do with better living standards, better maternal nutrition, the availability of birth control, legal (in the UK) abortion, improved care for the newborn and the fact that individual women are having fewer babies".

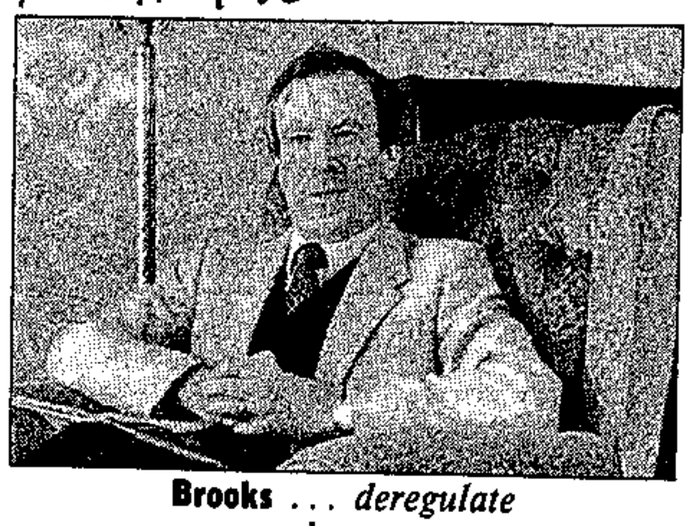
Supporters of home births and independent analysts claim that mortality rates for home births have been consistently lower than those for hospital deliveries, the Consumer Association says. It notes that in the Netherlands, where around 35 percent of all births are at home, the mortality rates are among the lowest in the world.

National Medical & Dental Association. Most important, the Medical Association, the doctors' trade union, softened its stance on HMOs.

Officially, the council says the matter will be referred only to its executive committee but the pressure on that body to reform the rules is immense. Conventional medical aid costs are increasing by more than 20% a year. There is little incentive to control costs because a high percentage of patients covered by medical aid pay little or nothing for a visit to the doctor or a stay in hospital.

On the other hand, an HMO would run or subcontract its facilties. HMOs would be funded entirely from subscriptions and profits would come from the funds that weren't spent on medical bills. Members would be required to visit only those doctors and hospitals under contract to the HMO. Experience in the US has shown that savings of up to 40% can result from HMOs.

Medical aid schemes are leading the charge. Municipal Medical Aid Scheme GM Fanie Roodt says: "There is a pressing need for a cheaper model than the present fee-for-service. Medical aid covers just 20% of the population and a more cost-effective model is needed for the rest of the working popula-



Brooks ... *deregulate doctors*

tion. If the council refuses to allow it, it could come under pressure from trade unions who are looking for affordable health care for their members."

Private hospitals have until recently opposed HMOs. They've been afraid that the buying power of HMOs could be used to slice their profit margins. But two of the three major hospital groups, Rembrandt-controlled Medi-Clinic and Afrox Healthcare, are now expressing interest in HMOs.

Afrox's Brian Davidson says: "In a contract between an HMO and a private hospital, the hospital might get guaranteed occupancy."

For a hospital with high fixed costs and low variable costs, high occupancy is the key to success. Private hospitals now average just over 60% occupancy.

"We're not expecting fee-for-service to disappear," he adds. "There will always be a section of the population that wants complete free choice. Our concern is to bring an entirely new group of people — mainly blue-collar workers — into the private sector."

Barney Hurwitz, the chairman of the biggest private hospital group, Clinic Holdings, is still an implacable opponent of HMOs. "They lead to a restriction on free choice and inevitably doctors are told what they can do and what they can prescribe. Besides, I think the cost control in health has been effective. Increases have averaged just two percentage points above the rate of inflation and that compares favourably with any industry that's both labour-intensive and capital-intensive. Just look at the motor industry."

In the meeting, supporters of HMOs stressed that doctors would remain in personal control and the HMO would not interfere with their judgment.

This is a major anxiety expressed by the Medical Association. "The association could support the establishment of HMOs provided they are run on a non-profit basis to avoid exploitation," says Bernard Mandell, chairman of the association's federal council.

Since medical aid is already run on a non-profit basis, this shouldn't prove an insurmountable obstacle. Medical aid schemes also accept that a doctor's right to refer patients should not be impeded, and that if a limited drug list is part of the HMO, it should be drawn up with the full participation of doctors.

It was also agreed that advertising, canvassing and touting for business should not take place. Medical schemes are willing to accept this, though the restriction on advertising may soon be overturned by the Competition Board. The board is steering its efforts away from anti-monopoly cases towards deregulating the professions (*Business* September 28).

Chairman Pierre Brooks says: "We aren't afraid to confront a body that acts in breach of competition law, whether it's a profession, a trade or a business. It should be a matter of individual choice for doctors whether they wish to be employed by the private sector. They should not be dictated to by a higher body."

He adds: "It wouldn't seem to be in the public interest to prevent a doctor forming a group practice with pharmacists and nurses, especially in rural areas, where there aren't enough doctors to serve the population."

Stephen Cranston

MEDICAL COSTS

REFORM IN THE WINGS?

The biggest obstacle to the creation of a more rational and less expensive healthcare system could soon be overcome.

The SA Medical & Dental Council does not allow doctors to be employed by private hospitals nor medical schemes, or to form interdisciplinary partnerships with other professionals. The argument has been that unless doctors are independent and self-employed their integrity could be compromised — though apparently this doesn't happen when they work for the State.

But a meeting convened by the council in Pretoria on Friday showed very considerable support for allowing group practice and health maintenance organisations (HMOs). The support came from medical aid schemes, private hospital groups, the Department of National Health and even the left-leaning

Health services will not be unified yet — Venter

B Day 9/10/90

(285) (299)

TANIA LEVY

SA's fragmented health services would remain in place until a unitary health system was negotiated as part of a new constitution, Health and Population Development Minister Rina Venter said in an interview yesterday.

Although fragmentation complicated the development of an efficient health care system, she did not believe money was being wasted by running 14 different authorities.

Venter said it was difficult to say exactly how much was being spent administering the different health departments.

Government would stick with own affairs health authorities, which used only 6% of the R7bn-a-year national health budget.

Provincial health services accounted for 72% of the budget.

Restructuring the health system would form part of the negotiation process. Meanwhile, the existing system would have to be addressed in its present form, said Venter.

Despite the opening of hospitals, government would be able to afford fully utilising hospital capacities only in five to eight years' time.

With the opening of hospitals to all races earlier this year, an extra R700m would be needed to staff and operate 11 700 unused beds at the former white hospitals, she said.

Clinics

Venter said she would report by the year-end on the effects the desegregation moves had had on redressing the imbalance of underutilised white and overcrowded black hospitals.

She hoped to open about 50 primary health care clinics, which had been built but never commissioned, by the end of 1991.

The extra R12m allocated for primary health care earlier this year would also be allocated shortly.

Strengthened primary health care facilities would reduce by 40% the pressure on academic hospitals, especially casualty sections.

Venter said the first step towards improving the existing system was the development of a more effective and autonomous management system for the country's 13 academic hospitals, which used 43% of the national health budget.

About 10% of this cost could be saved through better management, she said.

A proposed model being considered by relevant university professors would hopefuly be implemented in the new year, she said.

Venter will visit Natal on Thursday to discuss how the R50m allocated by President F W de Klerk last week, should best be used.

Not only immediate backlogs, but the range of primary to tertiary health care needs in the area would have to be looked at, she said.

Sabta's Tebello Radebe addressing a group of people during a seminar for the disabled held at the Takalani Centre in Soweto.

Clamp on drivers who abuse the disabled

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Sowetan 11/10/90

IN future if the South African Black Taxi Association receives a complaint from a disabled person who has been abused by a driver, Sabta has arranged with the Department of Transport that the offending driver's permit be withdrawn.

By PEARL MAJOLA

This was revealed by Mr Tebello Radebe of Sabta at a seminar at Takalani centre in Soweto which was organised by the Greater Soweto Liaison Committee for Disabled People.

The objective of the seminar was to launch the establishment of a working relationship between Sabta and the committee regarding the transport needs of disabled people. Its theme was *Transportation as the key need for the rehabilitation of the disabled people.*

"We realise that our drivers need to be trained on how to deal with the public, especially the disabled, and we would like to train them but we do not have the money to do it and the Government won't give it to us.

"However, we are addressing the problem and at the moment we have Project Spear which is a training programme we have started with the hope that it will help limit complaints against our drivers," Radebe said.

"It is time people realised that laws are not going to change the abuse and lack of understanding towards the disabled people - it is the attitudes of taxi drivers and passengers that have to change.

"Sometimes it is the passengers who, when drivers stop for slow, disabled people, complain that they are in a hurry and their time is being wasted. In this regard attitudes have to change and there has to be co-operation between the passengers and the drivers."

Also at the seminar was Sandy Heyman of the People for Awareness on Disability Issues who said that the public should be responsible and responsive to people with disabilities and they should rather empathise than sympathise with them.

Heyman emphasised that organisations with projects aimed at helping people with disabilities should consult them about projects.

Big increase in medical costs ahead

Star 11/10/90

By Carina le Grange,
Medical Reporter

Private patients face staggering increases in medical costs from January 1 with the announcement yesterday by the Representative Association of Medical Schemes (RAMS) that general practioners' scale-of-benefit consultation fees are to be increased from R21,10 to R24,80.

However, since not all doctors charge scale-of-benefit rates, and the Medical Association of SA guideline fee (from January 1) for a consultation is R55,20, a large number of private patients will pay much more for visits to general practitioners.

Medical aid schemes could raise their subscription fees by between 20 and 25 percent and total health care costs are predicted to soar by R1,5 billion to about R7,5 billion.

RAMS announced that the benefits to doctors would increase by 18 percent. However, executive director Rob Speedie warned that the continuing increase in the use of private health-care services was likely to boost the overall figure to 25 percent.

Medical schemes want law changed

TANIA LEVY

MEDICAL schemes have called for legislative changes which would enable them to exercise financial discipline over members and medical professionals.

Affordable health care would slip out of the reach of large sectors of SA's population unless urgent steps were taken to overhaul the country's present system, which encouraged wasteful and unnecessary expenditure, said Representative Association of Medical Schemes (RAMS) executive director Rob Speedie yesterday.

RAMS — representing more than 200 medical schemes in SA — announced that its 1991 scales of benefits would increase by 15% for private hospitals and day clinics, 13,5% for dentists and physiotherapists and 18% for doctors.

RAMS had asked Health and Population Development Minister Rina Venter to amend the Medical Schemes Act which compelled a 100% guaranteed payout by medical schemes.

Management

Because a third party was footing the bill, medical professionals and members were not price conscious, he said.

Statistics showed doctors contracted to medical schemes saw patients about 25% more often than private doctors.

Changes to the ethical rules of the Pharmacy Council and the SA Medical and Dental Council (SAMDC) were needed to allow medical schemes to run their own multi-disciplinary practices similar to benefit schemes or health management organisations (HMOs) in the US, said Speedie.

Member contributions could be lowered by a quarter through the introduction of schemes' own medical practices, hospitals and pharmacies.

Medical schemes would be able to cut medicine costs to members by between one-third and a half if they could run their own pharmacies as non-profit-making organisations, he said.

This was particularly important as medicine costs were expected to escalate at about 30% a year.

Speedie said the proliferation of private hospital beds, which increased 20% over the past year, further contributed to unnecessary economic inefficiencies and cost pressures in the health care system. In addition, a licensing authority was needed to oversee the importing of expensive high-tech equipment, which could be shared rather than duplicated unnecessarily.

In a statement yesterday Medical Association of SA (Masa) chairman Bernard Mandell said Masa would support establishment of HMO's provided they complied with criteria such as that they be run on a non-profit basis to prevent exploitation.

Masa had presented proposals on HMO's to the SA Medical and Dental Council, which would have to amend its ethical rules to ensure fair competition between doctors employed by group practices, such as HMOs, and fee-for-service doctors.

Mandell said Masa had for some time maintained that medical schemes were too inflexible and not fulfilling their role in providing for the health care needs of a growing divergent population.

If managed health care provided a quality health system at affordable cost to the whole population, and if this was superior to the existing fee-for-service system, Masa would support it.

□ LINDA ENSOR reports that the Life Offices' Association (LOA) and Masa have settled their dispute over doctors' fees — until the next round of negotiations begin on the 1991 tariff increase.

LOA director Jurie Wessels said yesterday a compromise R64 fee had been agreed upon for a curtailed standard medical examination.

For the full standard medical examination, R80 would be charged.

Medical fees are set to go up next year

299

Sowetan 12/10/90

MEDICAL aid schemes benefits would be raised by at least 18 percent next year increasing current consultation fees from R21,10 to R24,80, says Representative Association of Medical Schemes executive director Mr Rob Speedie.

By PHANGISILE MTSHALI

However, the continued increase in the use of medical facilities may boost the rise to 25 percent as private sector health-care costs were set to rise by a staggering R1,5 billion, from R6 billion to R7,5 billion.

"Rams is alarmed by this runaway increase in the costs of medical care which has been caused, in no small measure, by a persistent increase in the utilisation of medical services," Speedie said.

He said the Medical Association of South Africa's rate for consultations by doctors was R55,20, but many practitioners were charging less.

Masa chairman Dr Bernard Mandell scorned the proposed 18 percent increase by Rams, saying it still left a significant gap between the benefits for members and Masa's fees recommmended as a reasonable payment for doctors' services.

"Masa had repeatedly urged their members to take financial interests of their patients into consideration," Mandell said.

"This was one of the reasons why 85 percent of doctors continued to render their services in accordance with the scale of benefits."

The predicted increase, which is far higher than the inflation level, was the benefit which a medical aid member would receive but it was not a fee that doctors were compelled to charge, said Speedie.

"This makes it necessary for Rams to stress, once again, that medical schemes are highly concerned about the prospect of health-care becoming less and less affordable to the man in the street.

"We have made representations to the Government for changes to be made to the system to help medical schemes combat this cost spiral," Speedie said.

Star 12/10/90 299

Call for medaid law change

By Carina le Grange, Medical Reporter

South Africa needs changes in legislation in the Medical Aid Schemes Act to prevent affordable health-care slipping out of the reach of its population, Representative Association of Medical Aid Schemes (Rams) executive director Rob Speedie said in Johannesburg yesterday.

Mr Speedie was speaking at a press conference at which it was announced that scale of benefit tariffs for dentists would be increased by 13,5 percent from January 1 1991.

On Wednesday, Rams announced increases to general practitioners of 18 percent.

Together with the increase in dental tariffs, private patients can expect increases in medical aid contributions of up to 25 percent.

Mr Speedie said SA needed changes to ethical rules which at present prevented, among other things, multi-disciplinary practices.

He said if medical schemes were allowed by the system to run their own pharmacies as non-profit organisations, they would be in a position to cut the cost of medicines by between 33 and 50 percent.

The chairman of the federal council of the Medical Association of South Africa (Masa), Bernard Mandell, said last night in response to Mr Speedie that Masa would support the establishment of managed health-care organisations.

This was provided that they complied with certain criteria, one of which would be that they be run on a non-profit basis.

David Pincus

HEALTH CARE

DOCTORS AND DRUGS

Until recently dispensing doctors had a good press because of their contribution to price competition in drugs.

They now dispense more than 30% of prescription medicines and, in reaction to competition from doctors, pharmacists have been forced to give medical aid schemes a 15% discount on approved prices. With the approved medical price usually cost plus 50%, the discount still leaves them with a comfortable margin of 27,5%.

Medical aids now feel it is time for doctors to contribute more to cutting rising medical costs which, on the face of it, they are reluctant to do.

The credibility of GPs was strained by their decision to boycott medical schemes belonging to the Association of Medical Schemes. Their decision came just a few days after the association won a 15% dis-

count from the National General Practitioners' Group that was supposed to begin on July 1.

In particular, the bulk of dispensing doctors who operate in black and coloured areas refused to honour the discount. Medicines account for no fewer than 40% of the claims of the largest black medical aid in the country, Bonitas, and 26% of these claims are from dispensing doctors.

Doctors were accused by organisations such as the Housewives' League of reneging on their agreement and contributing to higher medicine costs and medical aid subscriptions. The Centre for the Study of Health Policy wrote: "The doctors, in refusing to

honour their patients' medical aid cards, were at best making life difficult for their patients. At worst, it might be argued that they were prejudicing their patients' best interests."

Ray Kobrin, a spokesman for the practitioners' group, says this argument is one-sided. "The so-called negotiations weren't negotiations, but demands. We were told that if we refused to give a discount, then the medicine cost would be paid directly to the members.

"The vast majority of dispensing by doctors is done in lower-income areas so low-paid patients who are given money (by medical aids) may be tempted not to reimburse the doctor (for medicine received on credit). Medical aids demand levies, of say 10% of the drug cost, to be paid for medicines, but many patients can't afford this so it's common to waive the levy. We suggested the levy should be abandoned as a form of discount, but the medical schemes wouldn't listen to that."

Kobrin adds that many doctors don't charge GST on medicines to keep down the cost to patients.

Bonitas chairman Paul Luthuli hopes individual schemes will be able to negotiate with doctors but he isn't optimistic.

Because the question of doctors dispensing is under ministerial investigation, neither the Pharmaceutical Society of SA nor the Medical Association can comment officially on this latest dispute, but it is good news for the embattled retail pharmacy.

The society's policy is to preserve the patient-doctor-pharmacist triangle. It argues that if doctors can gain financially from prescribing more expensive drugs, then that temptation should be avoided by the intervention of the pharmacist to be in charge of dispensing, unless it's an emergency.

But the society is still opposed to allowing medical aids to direct patients to get medicines only from a limited list of dispensaries that offer medicines at a discount.

One such organisation, Mediscor, is planning to take business away from dispensing doctors through competitive pricing. Mediscor MD Kosie van Zyl says: "The pharmacist now has an opportunity to restore his image and beat the doctor on both price and service."

Mediscor offers a 22% discount on the recommended price, which makes it competitive even with doctors, who are supplied with medicines at lower prices than those available to pharmacies.

Unfortunately, legislation doesn't allow medical schemes to tell members where to send their scripts, with a few exceptions, such as Transnet's scheme, Transmed, which runs its own dispensaries. The pressure to amend this, though, is increasing.

John Cowlin, MD of Zandfontein Clinic, who was a dispensing doctor while in practice, says: "There's a real danger to the medical profession that the fee-for-service system will become so expensive that fewer people will be able to afford private practice. It is adding to the pressures for managed health care programmes."

Cowlin adds that dispensing should always be allowed as an ancillary service but, if it accounted for much of a doctor's income, there would be public suspicion over whether a doctor was primarily concerned with consultation or just saw consultation as a way of drawing in customers for medicine sales.

Wits' Cedric de Beer says in the long term another remuneration method must be considered. "Under the present system of third-party payment, there is no incentive for cost-containment. In any case, there are good arguments for questioning whether it's ethical for a doctor to profit from dispensing."

Kobrin denies this: "Any man who is involved in work is doing so for a profit. Why in the case of doctors should this suddenly be treated as dishonesty? If doctors are improving their income and patients are receiving a better price for medicine, I do not see that there is anything wrong." *Stephen Cranston*

day, October 18 1990

Nationalising 'will ruin health care'

Bldsun 18/10/90

MARIETTE DU PLESSIS

THE country's health-care system would be crippled if nationalisation and redistribution were to form part of SA's economic policy, pharmaceutical manufacturer Noristan chairman Niko Stutterheim said in a statement yesterday.

He warned against economic policy changes which would cut SA off from health-care technology abroad.

"Nationalisation and an imposed redistribution of wealth, as advocated by some quarters as part of their desired scenario for SA, would lead to further disinvestment and could eventually cut us off from the sources of technology on which health care greatly depends."

Stutterheim stressed the importance of an overall policy based on consultation, co-operation and a sound information base, because government resources alone would not provide adequate care for all.

Therefore an efficient and affordable policy which drew on the resources of the state, the pharmaceutical industry, private clinics and hospitals, the pharmacists, dispensing doctors, medical aids and nursing services was of utmost importance.

He said the benefits of technology transfer and developments in pharmaceuticals and medical equipment had provided tremendous productivity benefits in recent decades, such as short recovery times after operations and illnesses.

Imbalance

It was clear from expenditure on health care as a percentage of GNP, birth rates, life expectancy and mortality rates, that SA's health services compared reasonably well with those of African and developing countries' standards, Stutterheim said.

However, there was an imbalance between the level of expenditure on curative medicine compared with spending on preventative care.

Only through early diagnosis and disease prevention, could expensive and sophisticated health services be applied where they were most needed, improving the general health level of the population in an effective manner, he said.

Clinics demand dead babies' bills be paid

CLINICS have demanded that parents whose babies died in intensive care pay bills of up to R30 000.

The babies' recent deaths in neonatal intensive care units have been linked to contaminated drip solutions, withdrawn by Sabax earlier this month.

Eleven sets of parents resolved yesterday to refuse to pay outstanding bills and asked government to appoint an urgent judicial commission of inquiry into the deaths, their attorney Peter Soller said.

Nine babies had died at the Park Lane Clinic and two at Morningside Clinic, he said. However, Morningside this week said at least four babies had died as a result of klebsiella bacterial infection, possibly

TANIA LEVY

picked up from contaminated drips.

Most parents felt it was abhorrent to have to pay bills for a child that had died, mother Diane Webb said. Bills of between R10 000 and R30 000 were for babies' treatment only and did not include mothers' confinement, which cost R2 800 at Park Lane Clinic.

Clinic Holdings MD Jeffrey Hurwitz said yesterday parents would definitely be charged full accounts as Park Lane had done everything it could, and more, in rendering services to the babies. He said he was convinced the clinic could be absolved of any blame.

Like any business, it would send out payment demands.

Soller said the parents' first priority was to find out the truth about the deaths of their prematurely born babies. Many felt they had not been told the truth about the infection that had killed their babies. In some cases, death certificates had been withheld until after burial or cremation.

Spokesmen for National Health Minister Dr Rina Venter and House of Assembly Health Services and Welfare Minister Sam de Beer yesterday confirmed Soller's request for an inquiry had been received. They said the request would be considered once all relevant information had been collected, hopefully early next week.

◊ arts ◊ advice ◊ living ◊ music ◊ **environment** ◊

Your health is at stake

South 18/10 – 24/10/90 299

DEMAND THE BANNING OF CHEMICAL PESTICIDES AND HERBICIDES
DEMAND ORGANICALLY GROWN, CHEAP ALTERNATIVES

WHAT ALL THAT JUNK FOOD IS DOING

WALK into any supermarket and the chances are you'll be greeted by long aisles of neatly-packaged ready-to-go food — each product the result of many hours of research and advertising by food companies.

The brand names often bear little resemblance to the nature of the product — like "Mutant Ninja Turtle Chips" and "Rambo Pizza", obscure names chosen for their mass appeal.

If food manufacturers were not obliged by law to label some of the main ingredients used, they probably would not. Besides, the listings found in small type on most packaged food give no indication of the presence of trace chemical elements, many of which enter the food cycle at its source, the factory farm.

Since World War II, farmers have increasingly been using chemical pesticides and hormone herbicides.

The toxic chemical DDT was once seen as a "miracle" chemical which would solve all farming problems. Almost 30 years ago, Rachel Carson exposed the disastrous effects of DDT in her book, "Silent Spring".

Breast milk

DDT travels up the food chain until it eventually concentrates in the fatty tissues in the human body. A recent survey of the breast milk of American mothers found traces of DDT in almost every sample taken.

DDT is known to cause cancer in humans. The Department of Health still uses DDT in Zululand to spray huts for malaria control.

Pesticides are used to control unwanted insects, yet increasingly more insects develop natural resistance to the chemicals, making it necessary to create even more toxic replacements.

High pesticide residues find their way into our food in various ways. Carelessness or ignorance on the part of the grower is often a factor. Too much chemical is applied or the wrong kind of chemical, or crops are sprayed too near to harvest.

Some pesticides are extremely persistent in the soil, and can be picked up by crops planted in succeeding years. A few persistent chemicals, such as DDT, have been banned in many countries, but others remain on the market.

We expect our food to have a perfect appearance, the right size, shape, colouring and the absence of blemishes. This forces the farmer to use pesticides to prevent those unsightly holes in lettuce or the odd worm in our apple.

Supermarkets also demand that products have a long shelf life, causing the farmer to use fungicides to prevent the spread of fungus — although this is a natural process in the life of any vegetable or fruit. All these chemicals concentrate in our food which we then eat, blissfully unaware as to the risk we are taking.

Cause cancer

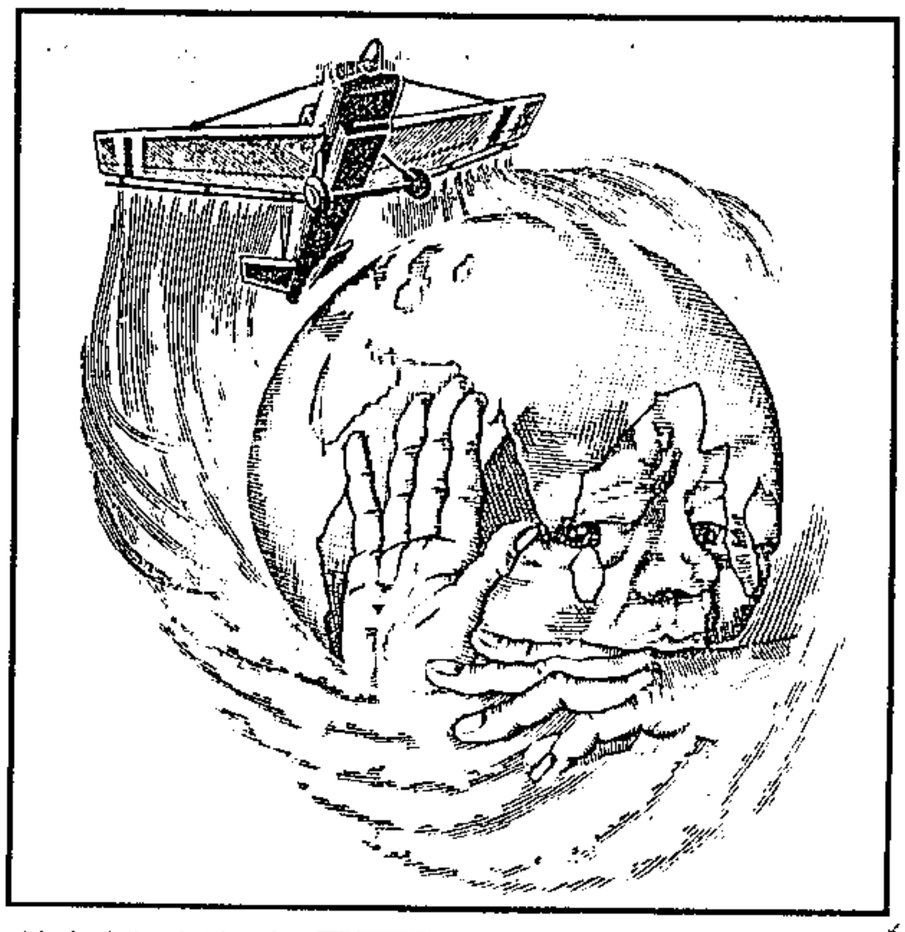
Other pesticides found in mothers' milk are Dieldrin and PCBs. Both are still used extensively in South Africa. Although Dieldrin has been banned, the CSIR continues to find relatively high levels in the environment. Both chemicals, as can be expected, cause cancer.

A group of Natal vegetable farmers failed to win a supreme court application earlier this year to prohibit the manufacture and sale of hormone herbicides. They alleged that the herbicides — the same chemicals used during the Vietnam War as defoliants — were causing extensive damage to the environment.

The chemicals are used by the sugar industry to kill weeds but also affect nearby agricultural land where they enter our food chain. Hormone Herbicides have been linked to spontaneous abortion in pregnant mothers and foetal abnormalities.

It is not only those who consume chemically contaminated products who are at risk. It is quite normal for workers in the fields to be exposed to vapour drift from aerial crop spraying.

Doctors in Groote Schuur Hospital have described the death of vineyard workers from skin absorption of Paraquat, a herbicide used by many Western Cape wine farmers as a weedkiller.



It is clearly time that the public demands food free from chemicals and other toxic residues. Our health and the health of those on the "frontline" in the fields and orchards is at stake.

We need to lower our expectations of "fresh forever" fruit and "photogenic" cauliflowers. Organically-grown produce is an alternative that has remained the exclusive choice of the wealthy. But there is no reason why this should be the case.

The manufacture of pesticides consumes an enormous amount of time and energy and ultimately compromises the health of our children.

— Dave Lewis

WHAT YOU CAN DO

- demand adequate testing of food products for chemical residues
- campaign for the banning of chemical pesticides and herbicides
- demand organically-grown, cheap alternatives
- demand adequate health protection for farm workers
- read up about the effects of pesticides on our health and educate your friends

and services boycott.

● See Page 6

Medical crisis plan on offer

TANIA LEVY

A MEDICAL package for SA businessmen travelling to African countries with sparse medical facilities has been developed by a local medical crisis intervention company.

Medical Rescue International (MRI), the company involved in airlifting refugees from Sao Tome, Gabon, earlier this year, has developed a service which guarantees rapid medical treatment in case of serious accident or illness.

At a cost of between R2,40 and R4 a day, depending on the length of the trip, businessmen could be assured of immediate and expert medical assistance, usually including evacuation back to SA, MRI MD Paul Davis said.

The first two hours after a serious accident were crucial, he said, but often telecommunication in African countries was problematic.

MRI had a massive communications network comprising not only telephone and telex facilities but also sophisticated satellite, VHF and high-frequency radios. A control centre, with a doctor on duty 24 hours a day, had a database of all available medical services worldwide, hes said.

CRITICAL CONSUMER

Don't blemish your beauty with bugs and bacteria

W/E Mail 19/10-25/10/90

299

HAVE you ever wondered exactly what you have smeared on your face in the name of beauty?

Well, there is a good chance it has bacteria in it — and a better chance that the claims of the manufacturer won't stand up to a rigorous test. It was also probably tested on animals.

Cosmetics can collect bugs, depending on how long you have kept the product, what the ingredients are, how it was packaged and who else has used it. You could pass on herpes simply from your lipstick, for instance.

PAT SIDLEY

Most creams and lotions are based on an emulsion of water and oil. Cold Cream, says a health and beauty book called *Which? Way to Health*, dates back to the second century and was traditionally an emulsion of water, beeswax and olive oil. As it is applied to the skin the water in it evaporates and this cools the skin — hence the name.

You may want to know how your skin is cared for by cosmetics when they are not harming it. Moisturisers work by covering the skin with an oily film, stopping the evaporation of water. Although this may help you look younger by keeping water in and smoothing lines caused by dryness, the effects are unlikely to be long term.

It's impossible to name all the ingredients contained in cosmetics — there are 6 000 to 8 000 of them. And often a manufacturer will regard a product's contents as a closely guarded trade secret. This does not help if you are allergic to an ingredient not listed on the package.

Worse still, some ingredients are toxic. Lead and mercury, now banned in many parts of the Western world, were used in cosmetics from the 16th century. And good old hydroquinone, the now-banned ingredient used in skin-lighteners, can still end up illegally on shop shelves.

Besides allergies, some ingredients in cosmetics cause a skin reaction. When cosmetics are contaminated with bacteria (or the herpes virus) they can cause skin or eye infections. Says *Which? Way to Health:* "Each time a cosmetic product is opened it may collect bacteria from the air."

Most cosmetics have preservatives — but these are not always adequate. The type of packaging can also influence what manages to "live" in your cosmetics. Bacteria are likely to be found in pots of cosmetics with openings into which you put your fingers. Mascara sticks can also carry infections.

In order to prevent nasty reactions — or to prove some claim about the product — many cosmetics are tested on animals. Public opinion is now forcing cosmetologists not to do this. If you are opposed to animal testing, stick to products which state that they advocate beauty without cruelty. Even so, many products — or certain components — will have been tested on animals at some point.

Unfortunately, manufacturers are not about to label their products any more fully than at present. In the meantime, in order to minimise problems with your cosmetics:

- Don't share or swap cosmetics
- Don't leave them to gather bacteria
- Don't keep them for a long time
- Ask for more information from manufacturers.

MEDICAL SCHEMES F/M 19/10/90

SLICING THE CAKE (299)

The annual round of complaints about the increase in payments that medical schemes have decided to grant to doctors, dentists and hospitals is in full swing once again. This time, after a year of falling inflation, the increases seem generous.

From January 1, the medical schemes will pay doctors 18% more, well above the 13,6% increase in the consumer price index over the last year. Private hospitals will get a 15% increase and that's on top of the interim 8% increase they received in August. Dentists will get a smaller but still reasonable 13,5%.

In order to pay for these increases, the public will have to fork out 25% more to their medical schemes next year. The reason is that every year there are more consultations, hospital stays and drug bills per member.

For instance, medical schemes increased the amount they pay for services by general practitioners by 18% last January. But overall, medical schemes are paying GPs a total of 29% more this year because of the greater number of consultations. Total payouts to private hospitals are increasing by 34,7% this year, even though medical schemes are paying only 19,3% more for each service.

Medical schemes have no control over the biggest single item of expenditure, medicine. In the first seven months of this year alone, payouts on medicine increased by 23,3%.

The Representative Association of Medical Schemes estimates that its members will pay out R1bn more next year, for a total of R6,4bn, and that this money will have to come from subscribers.

Reaction to the increases has been cautious. Afrox Healthcare GM Dick Williamson, who runs the country's second largest private hospital group, says medical schemes will not be paying more for the use of equipment such as laser machines for opthalmic surgery and so, in reality, the increase paid to hospitals has risen by just 14%.

"This compares with an inflation rate of 18% in our sector — even if you exclude the extra cost of nurses' salaries, which accounted for the interim increase in August."

Williamson says Afrox will have to consider whether hospitals in the group, such as the Eugene Marais in Pretoria, will still be able to charge what the medical schemes reimburse them, or whether they should opt out of the medical scheme system and charge patients fees that are higher.

Though doctors have been awarded higher increases than other suppliers of health services, the R25 consultancy fee will still be half the R50 fee recommended by the Medical Association.

Says Medical Association chairman Bernard Mandell: "Payouts by medical schemes to doctors have decreased from 38,6% (of all medical scheme payouts) in 1978 to 34,1% in 1988. In contrast, payouts to hospitals by the schemes have increased from 17,3% to 21,6% in the same period."

The increased share by hospitals, though, can be accounted for by the growth of the private sector and a policy that has evolved of discouraging medical scheme patients from using provincial facilities if an alternative private service is available.

Rob Speedie, executive director of the medical schemes association, says there was a 20% increase in the number of private hospital beds in the year to June alone. "This has contributed to a decline in occupancy rates, which, in turn, works against efficient and economical use of resources."

He adds that if occupancy was increased from the present 60% to more than 70%, then there would be less need to increase ward and theatre fees, but this is unlikely because hospitals of competing groups are often in the same catchment areas. ■

SGI offers cover for ill health

Business Times Reporter

LIFE assurers can now provide cover for surgery and hospital costs.

Short-term insurers have previously provided this cover, but without official approval and without the backing of life assurers.

Standard General Insurance has introduced a new policy known as Cash Plan, which covers hospitalisation, surgery and confinement in intensive care.

The daily basic benefit can be between R200 and R400. The annual maximum net claimable amount is R60 000 for an individual and R360 000 for a family.

Premiums start at R40 a month and the guaranteed renewable policy can be attached to any permanent life policy, including a pure endowment.

Fewer suffer from bone deformities

THE number of people with vitamim D deficiency rickets, a disease that causes severe bone deformities in infants and children, and the severity of deformities caused by it, have diminished in the last 20 years in South Africa.

According to Professor John Morley Pettifor of Wits University this is largely because of an increasing public awareness of the need for vitamin D supplementation and the greater use of fortified infant milk formulae for feeding infants.

Apart from vitamin D from diet, another source for this vitamin is the conversion of 7-dehydrocholesterol in the skin under the influence of UV-radiation to vitamin D.

During their first year of life, infants depend mainly on the dietary intake of vitamin D to maintain a normal vitamin D status as they cannot be exposed to too much sunshine.

Breastmilk not enough

Although it is common belief that breastmilk contains lots of vitamin D, infants cannot rely entirely on breastmilk for vitamin D. It is therefore prudent to supplement all breastfed infants with vitamin D.

On the other hand if an adequate intake of milk can be assured for formula-fed infants, vitamin D supplementation in unnecessary. However, as a number of infants are partially breastfed and particially formula-fed, it is recommended that all infants under one year should receive vitamin D supplementation.

Other people who suffer vitamin D deficiency are elderly people because they are less likely to be exposed to enough sunshine causing reduction in their production of vitamin D in the skin.

Deficiency for this group can manifest itself with an increase in muscle weakness and a greater risk of pathological fractures.

Information supplied by the Nutrition Society of Southern Africa.

city council's planned new R550m treatment plant at Faure.

Australia had the world's most expensive water.

Medical Schemes Act is due for a facelift (299) Venter

PRETORIA — The Medical Schemes Act was due for review against a background of clamour for greater legislative flexibility, National Health and Population Development Minister Rina Venter said yesterday.

Speaking to the Central Council for Medical Schemes, she said accusations that insurance companies were precluded from underwriting health cover in a free market "are most prominent".

"Retrictive measures of this kind are not well received in the market place and it seems there is a growing demand for the type of cover offered."

Before the Act was reviewed, however, a report on the issue from Administration and Economic Coordination Minister Wim de Villiers and the Competition Board would have to be studied.

GERALD REILLY

Scheme administration costs, Venter said, were bones of contention. Some said administrators of medical schemes made fortunes. But she said she was not advocating poor and cheap administration.

"Unscrupulous administrators have to be taken to task and the Registrar of Medical Schemes has to have power to see that expenses are realistic."

Scavenging

On the large number of medical schemes, Venter said it seemed there was a proliferation of schemes by groups hiving off from existing schemes.

Some professional administrators and brokers had resorted to scavenging for the "shells" of schemes that were in the process of dissolution or amalgamation and had lost many members in the process.

On the issue of too many schemes, Venter said there were advantages in economies of scale if the number of schemes could be drastically reduced.

The huge membership fee increases envisaged for the coming year were disturbing, "especially since membership fees have already exceeded the level where there is considerable resistence from employers and from the public".

□ Also yesterday, Venter visited Valmed in Vanderbiljpark and said there would be more AIDS patients in SA than there were private and public sector hospital beds if just 0,5% of the population contracted the disease. The costs associated with the treatment of such numbers could be compared with the total health budget.

Minister slams increase

299

Sowetan 26/10/90

THE Minister of National Health and Population Development, Dr Rina Venter, has described the "huge" increases in membership fees planned by medical schemes for next year as "disturbing".

To remain competitive, medical schemes would have to find ways to provide affordable health care cover for their members, Venter said at the annual meeting of the Central Council for Medical Schemes in Pretoria yesterday.

One of the factors pushing up membership fees was administration costs, she said, and added that she had heard some were making a "fortune" from administration. - Sapa.

CRITICAL CONSUMER

Don't rely on primrose oil to relieve your eczema

W/E Mail 26/10-1/11/90 299

A HELPFUL friend suggested that the only cure for eczema was evening primrose oil — an extract from the seed of the evening primrose plant.

It is a commonly held belief and has some truth in it.

But, says the *Drugs and Therapeutics Bulletin* published by the British Consumers' Association, the claims are probably exaggerated.

Eczema, which goes under the guise of many other names, causes redness, itchiness and scaling of the skin.

It is not clear whether it can be cured, and certainly treatment is difficult.

In this country, it seems doctors will use the most drastic form of treatment first — corticosteriods (cortisone).

So it is worth looking at any other claim, and this is a view endorsed by the *Bulletin*.

But before their results, it's worth a look at what exactly eczema is.

As well as the itchiness and scaliness, small blisters may form and if they burst they can become infected.

The skin may become thick with layers flaking off.

There are several different types of dermatitis, as some doctors like to call it.

Some are caused by skin irritants, perhaps detergents or acids or alkalis, and some are caused by allergies triggered perhaps by nickel, preservatives, lanolin or even plants (and countless other substances).

But the type of dermatitis or eczema that drives people nuts, can't be easily cured and upsets mothers whose young children are scratching themselves into insensibility, is from "internal" causes and mostly has a genetic component. In other words, it is hereditary.

PAT SIDLEY

Some treatments can keep it under control, and often it simply clears up.

It is often related to hay fever and asthma and may also be linked with allergies to milk, eggs, fish or other foods.

The *Drugs and Therapeutics Bulletin* decided to look at the therapeutic claims of one particular manufacturer of evening primrose oil. The company marketed the substance to doctors for prescription and it was consequently licensed by the relevant British authorities. It is licensed to relieve symptoms and claims to act at a "fundamental metabolic level in this disease". More specifically, they claimed the drug produced a "substantial and highly significant clinical improvement".

Other evening primrose oil products in Britain are not marketed to doctors and, accordingly, not licensed either.

But all of them are rather expensive — as they are here.

The *Bulletin* analysed several tests conducted on evening primrose oil. Some compared their results with liquid paraffin or olive oil as placebos (a replacement that the patient believes is the drug).

The skin became smoother after a month of treatment, which was maintained for three months. In another study, the itch improved but the overall severity did not.

In other studies, criticism was levelled at aspects of the testing.

But in the largest and most thorough study the itch was helped significantly. Eventually, and in some highly scientific language — as the publication is aimed at doctors although produced by an independent consumer group — the *Bulletin* concludes that evening primrose oil may "have a modest therapeutic effect, but only the effect on the roughness of the skin has been reliably demonstrated".

The *Bulletin* says the manufacturers' claim that it produces a substantial and highly significant clinical improvement "seems exaggerated" and they suggest that it is best "regarded as an optional addition to existing treatment and as a dietary supplement rather than a medication for eczema".

And, they warn, it is expensive.

So, back to the drawing board, and the following may be of use to those having to live with the skin disease:

- Use soap substitutes such as emulsifying ointment
- Wear cotton rather than wool (in winter)
- Avoid extremes of temperature or humidity
- Minimise dust and dust mites by airing bedding regularly and washing bedclothes at high temperatures
- Tar preparations return thickened skin to normal, and have an antiseptic and soothing effect
- Emollients can reduce the need for corticosteroids.

Why, if it helps, you may ask, should you avoid steroids?

Well, although they help give relief quickly, they can cause a recurrance or increased severity when you stop them, and if the dose is too high it can cause some pretty awful side effects.

These can include thin, fragile or transparent skin, stretch marks, thread veins, easy bruising and greater susceptibility to infection.

And, *Which? Way to Health* warns that overuse of strong steroids can slow a child's growth. It also warns that they should not be used on broken or infected skin — something that appears to elude many local doctors.

It is also very dangerous, once they have been prescribed, to use them for anything other than the condition for which they were prescribed.

So, before you hit the steroids, question your doctor thoroughly about the need for them and try some of the other remedies, including evening primrose oil — it may just help.

5. **KLOUSULE 15:** JAARLIKSE VERLOF EN OPENBARE VAKANSIEDAE MET BESOLDIGING

(1) In subklousule (2) (a) voeg die uitdrukking 'Werkersdag,' in na die uitdrukking 'Gesinsdag,'.

(2) In subklousule (2) (c) voeg die uitdrukking 'Werkersdag,' in na die uitdrukking 'Gesinsdag,'.".

(2) In the English text of the Schedule insert the following after clause 3 and re-number the existing clauses "4" to "6" to "6" to "8".

"4. **CLAUSE 11:** PAYMENT FOR OVERTIME AND WORK ON SATURDAYS, SUNDAYS AND PUBLIC HOLIDAYS

In subclause (4) insert the expression "Workers' Day,' after the expression 'Family Day,'.

5. **CLAUSE 15:** ANNUAL LEAVE AND PAID PUBLIC HOLIDAYS

(1) In subclause (2) (a) insert the expression 'Workers' Day,' after the expression 'Family Day,'.

(2) In subclause (2) (c) insert the expression 'Workers' Day,' after the expression 'Family Day,'.".

No. R. 2505 **26 October 1990**

LABOUR RELATIONS ACT, 1956

CANVAS GOODS INDUSTRY, WITWATERSRAND AND PRETORIA.—EXTENSION OF AGREEMENT

I, Dennis van der Walt, Director: Labour Relations, duly authorised thereto by the Minister of Manpower, hereby, in terms of section 48 (4) (a) (i) of the Labour Relations Act, 1956, extend the periods fixed in Government Notices Nos. R. 203 of 12 February 1988 and R. 727 and R. 728 of 14 April 1989, by a further period ending 31 October 1991.

D. VAN DER WALT,
Director: Labour Relations.

No. R. 2506 **26 October 1990**

LABOUR RELATIONS ACT, 1956

BUILDING INDUSTRY, WESTERN PROVINCE.—AMENDMENT OF MEDICAL AID FUND AGREEMENT

I, Eli van der Merwe Louw, Minister of Manpower, hereby—

(a) in terms of section 48 (1) (a) of the Labour Relations Act, 1956, declare that the provisions of the Agreement (hereinafter referred to as the Amending Agreement) which appears in the Schedule hereto and which relates to the Undertaking, Industry, Trade or Occupation referred to in the heading to this notice, shall be binding, with effect from the first payweek commencing on or after 1 November 1990 and for the period ending 31 March 1993, upon the employers' organisations and the trade unions which entered into the Amending Agreement and upon the employers and employees who are members of the said organisations or unions; and

5. **KLOUSULE 15:** JAARLIKSE VERLOF EN OPENBARE VAKANSIEDAE MET BESOLDIGING

(1) In subklousule (2) (a) voeg die uitdrukking 'Werkersdag,' in na die uitdrukking 'Gesinsdag,'.

(2) In subklousule (2) (c) voeg die uitdrukking 'Werkersdag,', in na die uitdrukking 'Gesinsdag,'.".

(2) In die Engelse teks van die Bylae, voeg die volgende in na klousule 3 en hernommer die bestaande klousules "4" tot "6" tot "6" tot "8".

"4. **CLAUSE 11:** PAYMENT FOR OVERTIME AND WORK ON SATURDAYS, SUNDAYS AND PUBLIC HOLIDAYS

In subclause (4) insert the expression 'Workers' Day,' after the expression 'Family Day,'.

5. **CLAUSE 15:** ANNUAL LEAVE AND PAID PUBLIC HOLIDAYS

(1) In subclause (2) (a) insert the expression 'Workers' Day,' after the expression 'Family Day,'.

(2) In subclause (2) (c) insert the expression 'Workers' Day,' after the expression 'Family Day,'.".

No. R. 2505 **26 Oktober 1990**

WET OP ARBEIDSVERHOUDINGE, 1956

SEILWARENYWERHEID, WITWATERSRAND EN PRETORIA.—VERLENGING VAN OOREENKOMS

Ek, Dennis van der Walt, Direkteur: Arbeidsverhoudinge, behoorlik daartoe gemagtig deur die Minister van Mannekrag, verleng hierby, kragtens artikel 48 (4) (a) (i) van die Wet op Arbeidsverhoudinge, 1956, die tydperke vasgestel in Goewermentskennisgewings Nos. R. 203 van 12 Februarie 1988 en R. 727 en R. 728 van 14 April 1989, met 'n verdere tydperk wat op 31 Oktober 1991 eindig.

D. VAN DER WALT,
Direkteur: Arbeidsverhoudinge.

No. R. 2506 **26 Oktober 1990**

WET OP ARBEIDSVERHOUDINGE, 1956

BOUNYWERHEID, WESTELIKE PROVINSIE.—WYSIGING VAN MEDIESE HULPFONDSOOREENKOMS

Ek, Eli van der Merwe Louw, Minister van Mannekrag, verklaar hierby—

(a) kragtens artikel 48 (1) (a) van die Wet op Arbeidsverhoudinge, 1956, dat die bepalings van die Ooreenkoms (hierna die Wysigingsooreenkoms genoem) wat in die Bylae hiervan verskyn en betrekking het op die Onderneming, Nywerheid, Bedryf of Beroep in die opskrif by hierdie kennisgewing vermeld, met ingang van die eerste loonweek wat op of na 1 November 1990 begin en vir die tydperk wat op 31 Maart 1993 eindig, bindend is vir die werkgewersorganisasies en die vakverenigings wat die Wysigingsooreenkoms aangegaan het en vir die werkgewers en werknemers wat lede van genoemde organisasies of verenigings is; en

(b) in terms of section 48 (1) (b) of the said Act, declare that the provisions of the Amending Agreement, excluding those contained in clause 1 (1) (a), shall be binding, with effect from the first payweek commencing on or after 1 November 1990 and for the period ending 31 March 1993, upon all employers and employees, other than those referred to in paragraph (a) of this notice, who are engaged or employed in the said Undertaking, Industry, Trade or Occupation in the areas specified in clause 1 of the Amending Agreement.

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E. VAN DER M. LOUW,
Minister of Manpower.

SCHEDULE

INDUSTRIAL COUNCIL FOR THE BUILDING INDUSTRY (WESTERN PROVINCE)

AGREEMENT

in accordance with the provisions of the Labour Relations Act, 1956, made and entered into by and between the

Master Builders' and Allied Trades Association

Master Masons' and Quarry Owners' Association (South Africa) representing its members in the Monumental Masonry Industry

(hereinafter referred to as the "employers" or the "employers' organisations"), of the one part, and the

Amalgamated Society of Woodworkers of South Africa

Amalgamated Union of Building Trade Workers of South Africa

South African Operative Masons' Society

South African Woodworkers' Union

Building Workers' Union

(hereinafter referred to as the "employees" or the "trade unions"), of the other part,

being the parties to the Industrial Council for the Building Industry (Western Province),

to amend the Medical Aid Fund Agreement published under Government Notice No. R. 1280 of 27 June 1980, as amended and extended by Government Notices Nos. R. 2283 of 28 October 1981, R. 2351 of 29 October 1982, R. 2158 of 30 September 1983, R. 962 of 11 May 1984, R. 2123 of 21 September 1984, R. 728 of 4 April 1985, R. 336 of 28 February 1986, R. 503 of 23 March 1989 and R. 2323 of 27 October 1989.

1. SCOPE OF APPLICATION

(1) The terms of this Agreement shall be observed in the Building and Monumental Masonry Industries—

(a) by all employers who are members of the employers' organisations and by all employees who are members of the trade unions;

(b) in the Boland and in the Cape Peninsula.

(2) Notwithstanding the provisions of subclause (1) (a), the terms of this Agreement shall—

(a) in respect of the Cape Peninsula only apply to employees for whom wages are prescribed in clause 16 (1) (h) of the Agreement published under Government Notice No. R. 504 of 23 March 1989, including any amendment or extension thereof, or any succeeding Agreement (hereinafter referred to as the "Peninsula Agreement");

(b) kragtens artikel 48 (1) (b) van genoemde Wet, dat die bepalings van die Wysigingsooreenkoms, uitgesonderd dié vervat in klousule 1 (1) (a), met ingang van die eerste loonweek wat op of na 1 November 1990 begin en vir die tydperk wat op 31 Maart 1993 eindig, bindend is vir alle ander werkgewers en werknemers as dié genoem in paragraaf (a) van hierdie kennisgewing wat betrokke is by of in diens is in genoemde Onderneming, Nywerheid, Bedryf of Beroep in die gebiede in klousule 1 van die Wysigingsooreenkoms gespesifiseer.

E. VAN DER M. LOUW,
Minister van Mannekrag.

BYLAE

NYWERHEIDSRAAD VIR DIE BOUNYWERHEID (WESTELIKE PROVINSIE)

OOREENKOMS

ooreenkomstig die Wet op Arbeidsverhoudinge, 1956, gesluit deur en aangegaan tussen die

Master Builders' and Allied Trades Association

Master Masons' and Quarry Owners' Association (South Africa) wat sy lede in die Monumentklipmesselnywerheid verteenwoordig

(hierna die "werkgewers" of die "werkgewersorganisasies" genoem), aan die een kant, en die

Amalgamated Society of Woodworkers of South Africa

Amalgamated Union of Building Trade Workers of South Africa

South African Operative Masons' Society

South African Woodworkers' Union

Building Workers' Union

(hierna die "werknemers" of die "vakverenigings" genoem), aan die ander kant,

wat die partye is by die Nywerheidsraad vir die Bounywerheid (Westelike Provinsie),

om die Mediese Hulpfondsooreenkoms, gepubliseer by Goewermentskennisgewing No. R. 1280 van 27 Junie 1980, soos gewysig en verleng deur Goewermentskennisgewings Nos. R. 2283 van 28 Oktober 1981, R. 2351 van 29 Oktober 1982, R. 2158 van 30 September 1983, R. 962 van 11 Mei 1984, R. 2123 van 21 September 1984, R. 728 van 4 April 1985, R. 336 van 28 Februarie 1986, R. 503 van 23 Maart 1989 en R. 2323 van 27 Oktober 1989, te wysig.

1. TOEPASSINGSBESTEK

(1) Hierdie Ooreenkoms moet in die Bou- en Monumentklipmesselnywerhede nagekom word—

(a) deur alle werkgewers wat lede van die werkgewersorganisasies is en deur alle werknemers wat lede van die vakverenigings is;

(b) in die Boland en in die Kaapse Skiereiland.

(2) Ondanks subklousule (1) (a) is hierdie Ooreenkoms—

(a) ten opsigte van die Kaapse Skiereiland slegs van toepassing op werknemers vir wie lone voorgeskryf word in klousule 16 (1) (h) van die Ooreenkoms gepubliseer by Goewermentskennisgewing No. R. 504 van 23 Maart 1989, insluitende enige wysiging of verlenging daarvan, of enige daaropvolgende Ooreenkoms (hierna die "Skiereiland-ooreenkoms" genoem);

(b) in respect of the Boland only apply to employees (excluding learners) for whom wages are prescribed in clause 16 (1) (f), (g), (h) and (m) of the Agreement published under Government Notice No. R. 460 of 18 March 1988, including any amendment or extension thereof, or any succeeding Agreement (hereinafter referred to as the "Boland Agreement").

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2. CLAUSE 9.—CONTRIBUTIONS

(1) In subclause (1), substitute the figure "R23,20" for the figure "R17,60".

(2) In subclause (2), substitute the figure "R11,60" for the figure "R8,80".

(3) In subclause (10), substitute the figure "R23,20" for the figure "R17,60".

Signed at Cape Town this 3rd day of September 1990.

H. McCARTHY,
Chairman.

L. P. DAGNIN,
Vice-Chairman.

J. J. KITSHOFF,
Secretary.

No. R. 2507 **26 October 1990**

LABOUR RELATIONS ACT, 1956

BUILDING INDUSTRY, WESTERN PROVINCE.—AMENDMENT OF AGREEMENT FOR THE CAPE PENINSULA

I, Eli van der Merwe Louw, Minister of Manpower, hereby—

(a) in terms of section 48 (1) (a) of the Labour Relations Act, 1956, declare that the provisions of the Agreement (hereinafter referred to as the Amending Agreement) which appears in the Schedule hereto and which relates to the Undertaking, Industry, Trade or Occupation referred to in the heading to this notice, shall be binding, with effect from 1 November 1990 in the case of clauses 1 and 5 and with effect from the first payweek commencing on or after the said date in the case of clauses 2 to 4 and 6 to 9, and for the period ending 31 March 1993, upon the employers' organisations and the trade unions which entered into the Amending Agreement and upon the employers and employees who are members of the said organisations or unions; and

(b) in terms of section 48 (1) (b) of the said Act, declare that the provisions of the Amending Agreement, excluding those contained in clause 1 (1) (a), shall be binding, with effect from 1 November 1990 in the case of clauses 1 and 5 and with effect from the first payweek commencing on or after the said date in the case of clauses 2 to 4 and 6 to 9, and for the period ending 31 March 1993, upon all employers and employees, other than those referred to in paragraph (a) of this notice, who are engaged or employed in the said Undertaking, Industry, Trade or Occupation in the areas specified in clause 1 of the Amending Agreement.

E. VAN DER M. LOUW,
Minister of Manpower.

(b) ten opsigte van die Boland slegs van toepassing op werknemers (uitgesonderd leerlinge) vir wie lone voorgeskryf word in klousule 16 (1) (f), (g), (h) en (m) van die Ooreenkoms gepubliseer by Goewermentskennisgewing No. R. 460 van 18 Maart 1988, insluitende enige wysiging of verlenging daarvan, of enige daaropvolgende Ooreenkoms (hierna die "Boland-ooreenkoms" genoem).

2. KLOUSULE 9.—BYDRAES

(1) In subklousule (1), vervang deur die syfer "R17,60" deur die syfer R23,20".

(2) In subklousule (2), vervang die syfer "R8,80" deur die syfer "R11,60".

(3) In subklousule (10), vervang die syfer "R17,60" deur die syfer "R23,20".

Geteken te Kaapstad op hede die 3de dag van September 1990.

H. McCARTHY,
Voorsitter.

L. P. DAGNIN,
Ondervoorsitter.

J. J. KITSHOFF,
Sekretaris.

No. R. 2507 **26 Oktober 1990**

WET OP ARBEIDSVERHOUDINGE, 1956

BOUNYWERHEID, WESTELIKE PROVINSIE.—WYSIGING VAN OOREENKOMS VIR DIE KAAPSE SKIEREILAND

Ek, Eli van der Merwe Louw, Minister van Mannekrag, verklaar hierby—

(a) kragtens artikel 48 (1) (a) van die Wet op Arbeidsverhoudinge, 1956, dat die bepalings van die Ooreenkoms (hierna die Wysigingsooreenkoms genoem) wat in die Bylae hiervan verskyn en betrekking het op die Onderneming, Nywerheid, Bedryf of Beroep in die opskrif by hierdie kennisgewing vermeld, met ingang van 1 November 1990 in die geval van klousules 1 en 5 en met ingang van die eerste loonweek wat begin op of na genoemde datum in die geval van klousules 2 tot 4 en 6 tot 9, en vir die tydperk wat op 31 Maart 1993 eindig, bindend is vir die werkgewersorganisasies en die vakverenigings wat die Wysigingsooreenkoms aangegaan het en vir die werkgewers en werknemers wat lede van genoemde organisasies of verenigings is; en

(b) kragtens artikel 48 (1) (b) van genoemde Wet, dat die bepalings van die Wysigingsooreenkoms, uitgesonderd dié vervat in klousule 1 (1) (a), met ingang van 1 November 1990 in die geval van klousules 1 en 5, en met ingang van die eerste loonweek wat begin op of na genoemde datum in die geval van klousules 2 tot 4 en 6 tot 9, en vir die tydperk wat op 31 Maart 1993 eindig, bindend is vir alle ander werkgewers en werknemers as dié genoem in paragraaf (a) van hierdie kennisgewing wat betrokke is by of in diens is in genoemde Onderneming, Nywerheid, Bedryf of Beroep in die gebiede in klousule 1 van die Wysigingsooreenkoms gespesifiseer.

E. VAN DER M. LOUW,
Minister van Mannekrag.

Hard-hearted? Not us, says clinic boss

By MARK STANSFIELD

CLINIC Holdings chairman Barney Hurwitz this week rejected accusations that private clinics charge excessive fees for their services.

He was questioned after disclosures that some parents had received bills of up to R30 000 following the deaths of their babies through Klebsiella infection and that "threatening" demand letters had been sent out.

"We charge approved medical aid scale of benefit rates, even though we are contracted out of the medical aid scheme," he said.

"Because medical aid schemes do not pay for certain items, we add R35 a day extra to cover these losses. Our clinics cannot absorb this loss and it would be detrimental to patients if we stopped using the medicines not covered by medical aid.

"We have not yet sent out threatening letters demanding payment from the parents of those babies.

Risks

"We submit bills and 10 days later send out reminders. Two weeks after this, we request payment and ask patients to come in and see us to discuss difficulties they may be having. If this is ignored, we sue them."

Admission forms signed by all patients entering clinics under the Clinic Holdings banner stipulate:

"... should I default in payment of any amount due to the clinic, the clinic shall be entitled to recover in addition to such amount due, all costs disbursed by itself to its attorneys in securing my compliance, which costs may be taxed and recovered on the scale as between attorney and own client and shall include the costs of all necessary attendances, tracing fees and opinions given, whether action has been instituted or not."

But, said Mr Hurwitz, the clinic's owners were not as hard-hearted as it would seem. He disclosed that his group sometimes treated "deserving charity cases" free.

However, he also admitted that clinics under his control had turned patients away before admission because they were found to be credit risks.

"This is a business like any other. Our overheads are high. Our salaries alone make up 64 percent of total expenditure," he said.

Bad debts

Mr Hurwitz criticised para-statal medical aid schemes, accusing them of contributing to his company's bad debts because they refused to pay clinics directly.

"The para-statal medical aid schemes insist on paying their clients, who are meant to hand the money over to us. Instead, many blow the money and we end up having to sue. We could reduce hospital costs if medical aid schemes were to pay us.

"Patients belonging to non-recognised medical aid schemes pay a deposit before admission. Recognised medical aid scheme members pay no deposit.

"There have been cases where we have turned patients away because they are a credit risk."

Asked to comment on the ethics of charging for medical treatment needed because of secondary infection — due to faulty medicine or equipment — Mr Hurwitz said: "If something goes wrong, the patient has a claim if he goes through the right channels. He should first pay the medical bills and then arbitrate."

Clinic Holdings' Barney Hurwitz who says that, far from overcharging, his group sometimes treats genuine charity cases free Pictures: TOM EDLEY

Saflife's interim dividend up 150%

B Day 6/11/90

SAFRICAN Life Investment Holdings (Saflife), the life assurance group in the IGI fold, has declared a 150% increase in its interim dividend for the six months to end-September on a 90,7% rise in earnings a share.

A dividend of 12,5c (5c) was declared on a reduced dividend cover of 1,8 (2,4) times.

Chairman Mike Lewis said the life assurer had managed to perform extremely well despite deteriorating economic conditions.

During the period the group had focused on consolidating its position within the market place. Cost increases were also curtailed.

Lewis said Saflife had increased its market share during the period.

The board had decided to reward shareholders with a significant dividend increase as it was confident the growth in premiums would continue in the second half. A further increase in the final dividend was likely.

LINDA ENSOR

Attributable profit for the six months to end-September rose 90,3% from R3,5m to R6,7m, generating earnings a share of 22,5c (11,8c).

Gross recurring premium income rose to R96,5m (R47,4m) and net recurring premium income to R93,8m (R44,6m). Gross and net premium income from single premium business fell from R23,3m to R200 000, giving total gross premium income of R96,7m (R70,6m) and total net premium income of R94m (R67,9m).

Lewis said Hosken Consolidated Investments' (HCI's) bid to take over Crendall Investments — formerly the R42m Arwa cash shell — was at an advanced stage, but approval still had to be obtained from the Registrar of Insurance. The deal would increase HCI's stake in Saflife from 11% to 75%. The deal would be ex Saflife's interim dividend.

B Day 6/11/90

Presmed income leaps by 96%

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MARIETTE DU PLESSIS

IMPROVED occupancy levels at most of the hospitals and day clinics helped to boost President Medical Investments' attributable income by a whopping 96% to R1,15m (R587 000) in the six months to end August 1990.

Results released today show a 120% increase in operating income to R3,8m (R1,7m) while earnings rose 49% to 10c a share compared to 6,7c for the same period last year.

This followed Presmed's acquisitions of an 80% stake in the Cape-based Jan S Marais Clinic. The subsequent conversion of 2,82-million compulsorily convertible preference shares to ordinary shares on March 1 1990 increased Presmed's total issued share capital to 11,52 million shares.

MD Carl Grillenberger said improved occupancy levels, special attention to collection of debtors and strict cost control helped Presmed's performance. He was optimistic present margins would be maintained.

He said Presmed hospitals and day clinics would remain contracted in to medical aid schemes despite tariff increases.

New proposals to extend health care

(299) B/Day 29/10/90

PROPOSALS for a new health care system which would meet both First and Third World needs in SA are made in a comprehensive study by Andersen Consulting's health care specialist Maurice Goodman.

The proposals recommend co-operation between the public and private health sectors in a system aimed at broadening the scope of private hospitals and relieving state hospitals of worsening space and financial constraints.

Goodman argues that if private hospitals receive state subsidies on behalf of people who cannot afford health care, they will be able to broaden their scope from the essentially curative, First World niche they occupy and lift some of the pressure off limited state resources.

Contracts

He says the study has attracted the interest of both ANC medical experts and government because it recommends a compromise between a fully socialised health care system and the existing one. Although the present system incorporates both the public and private sector, it is neither cost effective nor comprehensive enough.

The proposed system is based on a "capitation principle" — widely applied in the US — where the state contracts with a hospital, clinic or even a major corporation to provide health care to a certain section of the population. The provider receives a fixed fee based on the number of patients it serves.

LESLEY LAMBERT

Goodman argues that this would inevitably lead to greater involvement by the private sector in primary health care — an area which the Health Department is committed to assisting — and it would encourage greater efficiency as hospitals would have to develop strategies to contain costs.

He says existing financing systems such as the fee-for-service and Diagnosis Related Group schemes, both of which are based on reimbursement, discourage the private sector hospitals from providing primary and preventive services because they are unprofitable.

Reimbursement systems are also not cost effective because they provide an incentive to do "as much as possible" to increase the number of services rendered.

The best known capitation-based system is the Health Maintenance Organisation (HMO) which provides health care services to more than a third of the American population.

HMOs are not allowed in SA because of legislation restricting group practices and the private sector employment of doctors.

The recommendation of deregulation is likely to be resisted by many doctors who are concerned that in an HMO-type system, health care ethics could be compromised by business decisions.

Ultimately, says Goodman, "the chosen system will only be implementable if it is both attractive to the private sector and cost effective for the state".

R1m fund bonus possible

B Loan 7/11/90 (299)

GILLIAN HAYNE

MEDICAL aid company National Medical Plan (NMP) could pay out nearly R1m in bonuses in December if its members continue to refrain from claiming "run of the mill" medical expenses.

So says NMP CE Rob Basson, who confirmed that more than 6 000 members had qualified for the no-claim and low-claim bonuses offered by NMP to encourage members to cut down on small claims.

The incentive scheme, introduced in January, set out to create an awareness of medical costs. By not claiming for small expenses the members could receive a cash bonus of either R600 or 25%-30% of their premiums.

Basson said although the company would never know the full extent of the saving, the scheme was working extremely well because not only were 6 000 members — 11% of total membership — eligible for the bonuses, but unit costs for the membership as a whole had dropped.

Basson stressed the scheme did not involve serious claims such as for operations, heart attacks and the like, which would not affect the members' no-claim bonuses.

lying close to the body

Soweto is earning results in battle against diseases

WILSON ZWANE

SOWETO health authorities say they are winning the battle against communicable diseases.

Local Medical Officer of Health Dr Ngokoana Khomo said yesterday a recent survey found 97% of Soweto children under the age of seven had been immunised against diseases such as measles.

Primary health care awareness among residents was definitely on the increase, Khomo said.

Survey

However, the incidence of children who had recently moved into Soweto and who were not immunised was causing some concern.

Speaking at a media conference, Khomo said the Soweto City Health Department conducted a survey in August this year which showed an increasing number of children had been immunised.

"This year we found that 97% of the children below seven years had been immunised — a 5% increase from 92% in 1989," Khomo said adding that the figure indicated a growing primary health care awareness among Soweto residents.

According to Khomo this awareness had been created by the Soweto City Health Department's concerted campaign to make health services more accessible, affordable and acceptable.

"We do not stand at corners. We do not wait for the people to come to us. We go into their houses and shacks and educate them about primary health care," Khomo said.

The growing numbers of shacks posed a problem, as most of the children of shack dwellers had never been immunised, Khomo said, adding that a recent survey showed that 349 Soweto-born-and-bred child respondents had never been immunised while 912 "imported" children had never been immunised.

However, community nurses were making a special effort to create primary health care among the shack dwellers.

Court hears opposition to pools' closure

SUSAN RUSSELL

AN APPLICATION by a local resident challenging the validity of a decision by the Springs Town Council to close two swimming pools in July this year, following the scrapping of the Seperate Amenities Act, began in the Rand Supreme Court yesterday.

Michael Hart is asking the court for an order setting aside the council's decision to close the Casseldale and Selection Park swimming baths.

The council, which is opposing the application, contends the pools were closed for economic reasons.

However, Hart claims that despite the pools being maintained at a loss for years, the council resolved as a matter of urgency to close them after the scrapping of the Act on July 11.

He has asked the court to draw the inescapable inference that the council decided to close the pools rather than see black people using them.

The matter was postponed until tomorrow.

PEANUTS By Charles Schulz

Holidays have come a bit early for these two JC Merkin pupils, Mahloadi Mokoena (left) and Monwabisi Tsipa.

Rumours over school denied

By PHANGISILE MTSHALI

THE JC Merkin School for the Physically Handicapped has closed early for the holidays "to safeguard the lives of staff and pupils", director of the Association for the Physically Disabled Mr Guy Houtton said yesterday.

Houtton was reacting to rumours that the school had been closed permanently by the governing body which was against the formation of a Parent - Teacher - Student Association.

"The governing body regrets that due to interference from outside sources it found it necessary in the interests of the safety of the pupils and staff to close the school on November 15 for the December holidays," he said.

"Examinations had been completed and reports will be sent to parents after November 30. The school will reopen on January 16."

The principal, Mr Dennis Schoeman, said problems started when the meeting he had called was hijacked by outsiders.

"They took over, appointed someone to chair the meeting and informed us there was a revolution," he said.

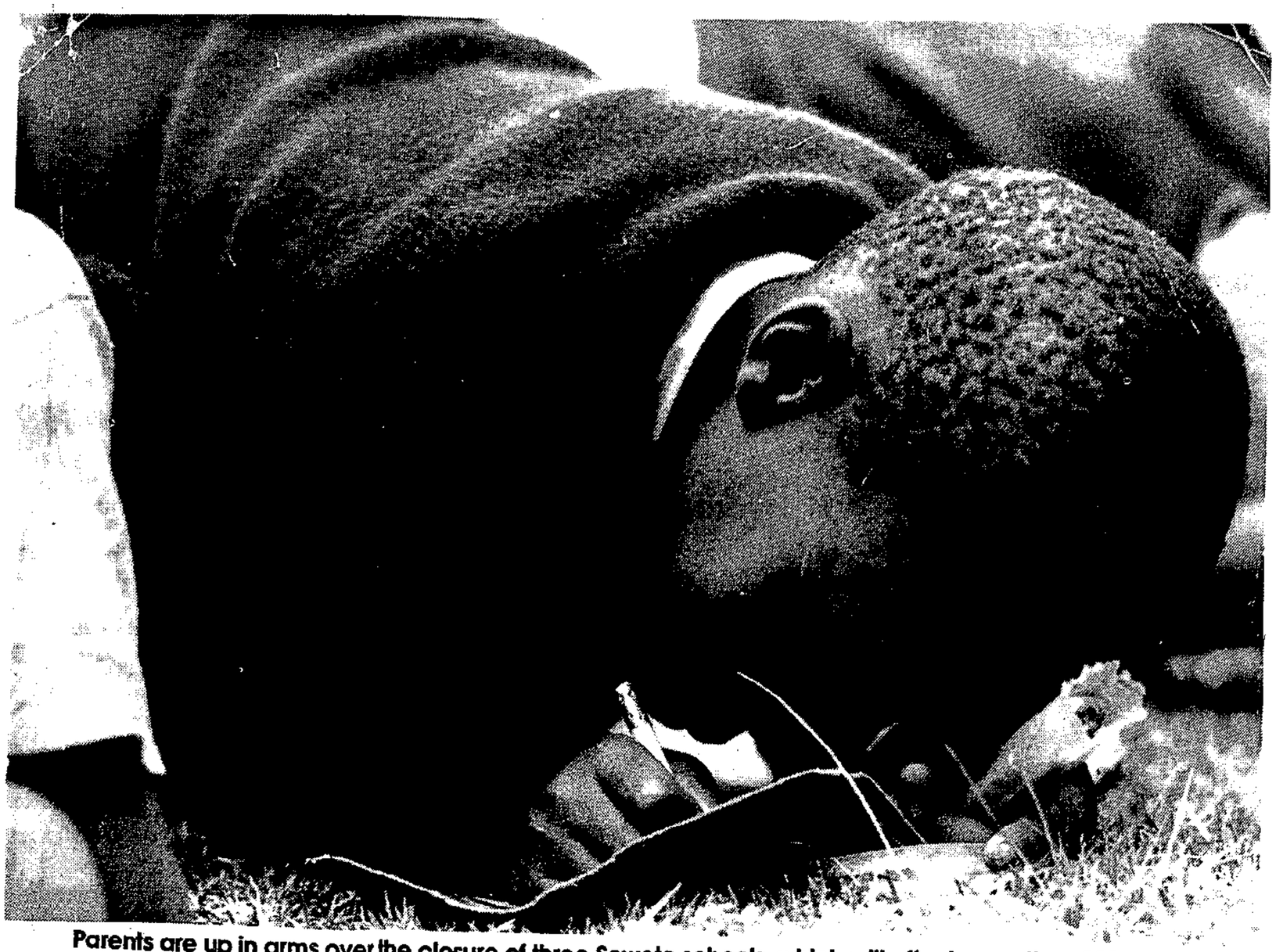
Merkin was the second special school to be disrupted over the formation of PTSA.

Pumlo, which caters for severely mentally handicapped pupils, was temporary closed two weeks ago.

Sowetan 22/11/90 (299)

Shock closure of schools for the disabled

New Nation (Pupils Forum) 23/11/-29/11/90 (299)



Parents are up in arms over the closure of three Soweto schools, which will affect more than 500 pupils.

HUNDREDS of mentally and physically disabled children in Soweto face a bleak future after the Department of Education and Training (DET) closed down their schools last week.

The closure, according to teachers who did not wish to be named, was prompted by the formation of Parents' and Teachers' Associations (PTA) in at least three of the township's five schools for disabled children.

But Soweto Education Co-ordinating Committee (SECC) spokesperson David Maepa said the DET had denied that the closure had come because of the formation of PTAs.

The schools to be closed are Pumla and Pumelela for the mentally handicapped in Orlando West and Senoane respectively and JC Merkins for the physically disabled in White City.

The three schools cater for more than 500 children between the ages of six and 18.

Fears are mounting that the remaining two schools in the township could be closed since the formation of PTAs is also on their agenda.

PUPILS FORUM has learnt that the schools are sponsored by the Witwatersrand Mental Health Society. Both the DET and the society were not available for comment at the time of going to press.

A parents' meeting was held on Sunday under the auspices of the SECC and a resolution was taken to discuss the matter with the owners of the schools.

Maepa warned that the schools belonged to the community and said that both the DET and the Mental Health Society should consider this when taking their decisions.

He said that, if negotiations failed, the community would be left with no alternative but to resort to legal action.

According to the teachers, who were not told about the fate of their jobs, it has transpired that the closure of the schools was requested by the principals and executed by the DET after a request by the chairpersons of the management councils.

It is alleged that the principals told the authorities that they were not on "good terms" with the teachers because they were members of teachers' unions.

The headmasters are also reported to have accused the teachers of having spearheaded the formation of the PTAs to usurp their powers.

The closure of the schools, according to the teachers, was not discussed with the parents.

Medi-Clinic profits begin to feel tax bite

MARCI KLEIN

REMBRANDT-controlled hospital group Medi-Clinic posted a 36% increase in earnings per permanent unit of capital to 3,8c (2,8c) a share in the six months to end September.

The increase is based on a calculation of the 1989 earnings on a fully-taxed (50%) basis so comes off a low base. No tax was paid last year due to accumulated tax losses while the tax rate at interim stage was 24,5%.

Profit available for distribution increased by 2% to R9,8m while the distribution on permanent capital increased by 31% to R5,7m.

The company maintained the return to profitability which began late last year after reporting large losses in the two years previously.

Pre-tax profit grew by 34,5% to R12,9m (R9,6m) on a 57,2% increase in turnover (42,9% last year). However the move into a tax paying position saw income after tax only 1,6% higher at R9,75m (R9,6m).

An interim dividend of 1,5c a share was declared. No interim dividend was declared last year but a full year maiden dividend of 3c at the March 1990 year-end was declared.

Medi-Clinic has a contracted capital commitment of R4,4m (R3,4m) and R2,8m (R2,3m) authorised but not accounted for.

Directors said occupancy rates of hospitals in the group were satisfactory.

Although tariffs of medical schemes were adjusted in August, this was insufficient to compensate for the sharp increase in nurses' salaries due to such increases in government hospitals.

The group had applied to the Representative Association of Medical Schemes for increased tariff structures to fund proposed salary increases for its nursing staff.

Cape Argus

hospital wages war on price of medicine

By MAGGIE ROWLEY
Business Staff

THE administrating body of South Africa's only medical aid hospital is spearheading a campaign to reduce medical costs and control the price of "life-sustaining" medications.

The Libertas Hospital Trust, formed by a group of medical aid societies, recently bought the 13-storey Libertas Centre in Goodwood and is turning the building into the country's first reduced-fee hospital, community health and medical centre.

Mr Mike Boyd, general manager of the Trust, said this week the mark-up on medication was 50 percent and pharmacies could drop the price of "life-sustaining" medicines by at least 20 percent and still make a reasonable profit.

Discounting medicines

"By discounting medicines needed by patients with serious health conditions on a long-term basis, they would not only attract customers, but, on a long-term basis, could also contribute to saving their lives.

"Some patients, most elderly, have to spend up to R800 a month on medication, which means after six or so months they have exhausted their medical aid limits.

"Many are not in a position to pay the full cost of this medication and are therefore forced to stop taking it at the risk of their lives.

"By reducing the price of these medicines pharmacists would allow patients at least a month or two extra medication.

Mr Boyd said the Libertas Hospital charged within medical aid tarriffs and had been offering "life-sustaining" medicines at 25 percent less than the recommended listed price to members of those schemes that had equity in the trust, or are managed by major medical aid administrator D and E Holdings or associated with it at managerial level.

"Once they have exhausted their medical aid limits they can buy the drugs from the hospital for cash at the discount price."

The Trust's pharmacy in Johannesburg provided the same discount facility.

The Trust was also investigating discounts on hospital services to medical aid societies that paid within a stipulated period.

"We will begin with the member societies in the trust, but will no doubt extend this to any other medical aid that supports us."

He said the South African Pharmacy Council "had problems" with undercutting medication to medical schemes managed by D and E Holdings.

"But we are only doing this with life sustaining medication and would urge all pharmacists to do likewise.

"We are not trying to take business away from the pharmacies; we are just attempting to assist those people who require on-going life-sustaining medication.

"It is essential more people in the industry do something to control medical cost.

"We have also written to the Competition Board explaining the service."

The Trust, which operates on a non-profit basis, took over the Libertas Centre in October and has embarked on a major revamp of the building, which, he said, had been neglected.

Work on converting the former premises of the OK Bazaars — a total of 2500 m² — into a large community health centre housing health-related service organisations and limited emergency facilities is to begin shortly.

Negotiations were well advanced with the Cancer Association, the Heart Foundation, a breast feeding clinic, the Community Chest, a gym for stroke victims, blood transfusion services, alcohol and narcotic advisory services and others.

A joint reception area and two conference/lecture rooms available to organisations on an hourly basis would be provided.

Better organising

While the Libertas, as a private hospital, was not permitted to treat people off the street, an after-hours emergency service would be introduced for patients whose general practitioners used the centre. This would be staffed by GPs or their locums and would operate on a similar basis to all night pharmacies.

Mr Boyd said once the revamp of the centre had been completed about 20 000 m² of the 24 000 m² lettable space would be occupied by the hospital and other medical and related services.

While there were no plans at this stage to increase the number of beds from the present 171, application for additional beds would be made if demanded.

"It is just a matter of better organising and restructuring what we already have," he said.

The Trust planned to open a second hospital in Johannesburg and possibly a third in Durban.

Wider gap between medical costs and benefits

Bipcy 30/11/90 (297)

PRETORIA — The gap between escalating costs of illness, drugs and medicines, and the benefits offered by medical aid schemes is widening alarmingly, say medical sources.

Price Waterhouse affiliate Winchester Financial Services MD Dave Bauer said the need for additional medical insurance to cover serious accidents and illnesses had become increasingly obvious.

It was in the interests of staff and employers in the market for supplementary major medical cover.

He confirmed the gap between costs incurred and the amount medical aid schemes could pay was rising.

Supplementary insurance that covered major medical procedures such as heart and spinal operations should be looked at closely.

He cited a patient on medical aid with a shortfall of nearly R8 000 after a back operation and another with a shortfall of R20 280 after a coronary by-pass.

Representative Association of Medical Schemes

GERALD REILLY

(RAMS) executive director Rob Speedie said RAMS acknowleged the gap but the question was "what to do about it".

The Competition Board was looking into the issue of schemes being able to provide top up cover.

If certain limitations on schemes were lifted it would be possible to close the gap.

Other sources said to provide comprehensive medical aid through medical schemes against a background of escalating costs would mean a huge increase in subscriptions.

This year the average increase in subscriptions was between 20% and 25%.

Medical Association of SA secretary-general Hendrik Hanekom said doctors were finding it increasingly difficult to maintain viable practices if they aligned their charges with medical schemes' scale of benefits.

Health care should be for all, says human rights activist

South 6/12 - 12/12/90

By CHIARA CARTER

PRIMARY health care should be made available to a much greater range of people in South Africa.

This view was expressed by Ms Mary Burton, the newly-appointed commissioner for Human Rights in the Western Cape, at a graduation ceremony for the Medical and Music schools at the UCT campus this week.

Burton said it gave her "special satisfaction" to be part of the ceremony at which UCT's first black women doctors graduated and at which the first Master of Science Nursing degree was conferred.

Disadvantaged

"I hope the time will come when there will be no reason for special comment on the achievements of people who are female or black," Burton said.

"For the present, however, their success offers encouragement to the many others, also disadvantaged by gender or racial classification, who will follow them."

Burton said the provision of health care was becoming prohibitively expensive and this was aggravated by the trend towards privatisation.

Fund may provide loan relief for needy students

South 13/12 - 17/12/90

CASH-STRAPPED black students may receive relief from the high cost of tertiary education if plans to implement a national loan scheme are successful next year.

The Independent Development Trust (IDT), administered by Mr Jan Steyn to allocate R2bn set aside for urban development, has approved several innovative projects in education, health and housing that will cost more than R160m.

The IDT is examining the possibility of a national loan scheme for funding tertiary education, specially for the most disadvantaged students who are unable to find support for their studies.

Leading educators from all over South Africa assisted in determining the IDT's priorities during September and October this year.

Specific areas in which the trust could perform a catalytic function and develop role models for broader replications were then canvassed and investigated in the field, throughout South Africa.

They want to give greater access through investment to educational opportunities for disadvantaged students.

Technikons

The IDT has allocated R495 000 to the Medical University of South Africa (Medunsa) for an academic development programme in natural sciences and R500 000 to UWC to support their academic development programme.

Technikons admitting black students, like the Mangosuthu Technikon and Wits Technikon, have received R2m.

The IDT has allocated R600 000 to the Education Foundation for the establishment of a national clearing house for educational data in the country.

JAN STEYN
Fund administrator

ANC provides homes for backyard

South 6/12 - 12/12/90

THE Mossel Bay branch of the African National Congress and the local civic organisation have decided to provide shelter for the thousands of homeless in the South Cape town.

Since November 28, more than 300 shacks have been erected in the Kwanonqaba township under the supervision of the two organisations.

"We drew up a list of all the homeless people, which totalled 3 800," said Mossel Bay Advice Office worker Mr Johannes Yantolo.

"Some of the people were sleeping in the bushes or in the backyards of people's homes in the township."

The organisations met with the Cape Provincial Administration on November 26 to tell them of their plans.

They were told the land belonged to Eskom and that permission could not be granted for the construction of dwellings.

A second meeting will take place on January 30 next year.

"The police have visited the shack area to ask who was responsible for building them," said Yantolo.

"The residents told them they had decided they could no longer wait for the CPA to implement its promise to provide land.

"Since then, police have been tried a few times to find out who is responsible, but no

VAT will be test of farmers' bookwork

B1 Day 6/12/90

FARMERS would have to get their paperwork and accounting systems in order or lose out on credit refunds when the value added tax (VAT) system was introduced next year, accountants said yesterday.

They would not be able to leave their paperwork until year-end as was the case with GST. The VAT system was invoice-driven and invoices had to be supplied whenever a taxable service was received or supplied, the accountants said.

While efficient farmers had nothing to fear from the introduction of VAT — provided they already had good accounting systems — those without proper accounts would have difficulty in reclaiming the tax component included in their bills for purchased inputs.

When all tax paid on purchases or services (input tax) was deducted from the total tax farmers charged their customers (output tax), farmers could claim credit only if input was greater than output.

To a certain extent VAT would provide a built-in checking mechanism and although tax collected would have to be paid over to the tax authorities, VAT paid and shown on invoices could be claimed as a tax credit paid on goods and services obtained for farming purposes (inputs).

"The ideal VAT system should have as few exceptions and zero-ratings as possible to ensure that it will be a broad-based consumption tax," said Mark Badenhorst of Price Waterhouse.

MARIETTE DU PLESSIS

He added that all primary producers such as farmers, fishermen and timber growers would have to be included to safeguard the integrity of the system.

There were large numbers of farmers on medium-sized farms who would be caught in the middle between the large primary producers and small producers.

They would be faced with the problem of ensuring that their accounting systems and records complied with requirements such as VAT registration, which was necessary to claim input tax credit, and correct invoicing, giving the registration number and amount of tax charged, Badenhorst said.

Refunds

An insignificant percentage of small farmers falling below the threshold turnover limit of R50 000 would be exempted and, therefore, not liable to comply with the VAT requirements, while large producers already had accounting systems and records to ensure adequate compliance.

Because farming was seasonal, farmers would tend to claim refunds at the beginning of the agricultural year, when purchasing inputs, before making heavy payments to the Receiver after harvest, economists said. This made government revenue more seasonal.

Appeal over health budget

B1 Day 6/12/90

PRETORIA — The Medical Association of SA yesterday appealed to President F W de Klerk to give urgent priority to the health care budget for next year.

In a letter to De Klerk, Masa said it was seriously concerned about the deterioration of health services in the public sector.

This was caused by the loss of public sector health personnel to the private sector and to jobs in other countries because of inadequate pay, stressful work, outdated equipment and lack of career incentives at state hospitals.

Wits University's Specialists Association, using information from medical personnel at medical schools, estimated 76% of the doctors planned to move to the private sector; 41% were considering emigrating; and 9% planned a career change.

It was feared if the trend of losing state doctors continued, public sector health care services would be unable to provide care for a growing population.

Masa secretary-general Hendrik Hanekom stressed the vast majority of South Africans were totally dependent on state health care services. A preliminary report by management consultants commissioned by Masa warned that losses of senior practitioners and administrators to the private health care sector were a major threat to the public health sector.

GERALD REILLY

Hanekom stressed that in the past 10 years there had been increasing concern over the deteriorating standards of academic medicine.

The standard of health care was determined by academic medicine standards and Masa had warned for years that urgent steps were needed to head off the crisis now developing.

Masa, Hanekom said, was waiting for feedback from a leadership conference on academic medicine held earlier this year but in the meantime it had started its own investigations into the funding aspect.

DAY, Friday, December 7 1990

Public health faces crisis over specialists' grievances

B1 Day 7/12/90.

299 85

B1 Day 7/12/90

AT LEAST 80% of full-time medical specialists intend leaving the public health service within two years if conditions do not improve, says a survey by specialist associations.

A spokesman for the Association of Specialists of the University of the Witwatersrand (ASUW) said yesterday the survey, based on the anonymous responses collected from 25% of SA's full-time specialists to two questionnaires, found nearly one in 10 specialists were considering leaving the medical profession.

When doctors with 15 years training were prepared to abandon their profession because of poor working conditions, it showed the critical condition in which academic medicine in SA found itself, he said.

By the end of 1990 Johannesburg Hospital would be without any neurosurgical specialists, sistopathologists, and half the necessary complement of anaesthetists, while there were reports half of Baragwanath's senior surgeons were about to resign.

The spokesman said of the specialists interviewed, 96% felt "very strongly" that salaries were inadequate and 80% said provincial administrations did not sufficiently appreciate academic medicine. There was also inadequate time for medical research.

MATTHEW CURTIN

But 93% of the doctors said if they were allowed to generate private income while still fulfilling stringent medical audits for the public service they provided, it would recompense them for their poor salaries.

Reconstruction

The Medical Association of SA (Masa) presented the survey's finding to National Health Minister Rina Venter at a meeting in Pretoria on Wednesday.

Venter said yesterday the government was "fully aware" of the problems raised by the survey.

It was for these reasons that government had embarked on a health services "reconstruction programme", but she warned "adjustments cannot be made immediately".

In the statement Venter said some steps had been taken already. There had been "much progress" in drafting a "management model for academic hospitals" and the Ministry was reviewing the salaries and career opportunities of all hospital staff.

The SAUW spokesman shared the minister's concern and hoped action would be swift to avert a deepening of the crisis.

Sapa reports Medical Association of SA secretary-general Hendrik Hanekom said yesterday the association had made an urgent appeal to President F W de Klerk to give priority to the health care budget for 1991.

He said the fact personnel were being lost to the private sector and to foreign posts was due to inadequate remuneration, stressful working conditions, outdated equipment and lack of career incentives at hospitals.

There was serious cause for concern over the "the deterioration of health services in the public sector".

A further decline in the standard of medicine practised at state hospitals would have a serious negative impact on the health care of the vast majority of people who were totally dependent on state health care services.

Health care costs smother patients. And medical aids aren't helping

299
W/Mail 7/12 - 13/12/90.

The cost of belonging to a medical scheme — which covers only 18,9 percent of the population — is slipping out of the reach of many. Perhaps the solution lies in a public health service.

By PORTIA MAURICE

WHEN Susan Damons and her husband decided to have a child, they were ill-prepared for the R12 000, 20-page bill that would come with the package.

Yes, the baby was premature and had to stay in the incubator at the private clinic for two and a half weeks — setting them back a fine R4 572. But added to that were a host of other exorbitant costs: R894 for the gynaecologist; R591 for the paediatrician; R1 666 for the pathologist; R390 for the anaesthetist; and R2 613 for Susan's four days in the general ward.

Each little drug and medical tool was meticulously listed on the bill: R2,33 for a cotton bud; R5,20 for each 2ml syringe and 32c for each needle; R4 for 50ml of olive oil and R1,95 per feeding tube.

Susan and hubby were lucky to be covered by medical aid for most of these costs but, although the baby was born in February, they paid their last R100 this month.

"The clinic wanted us to pay cash up front and then claim. We couldn't afford this and sent our bills in to the medical aid — but they took so long to pay that the clinic began sending us snotty, threatening final notices," said Susan.

Common influenza, which won't go away without a dose of antibiotics on prescription, could cost you up to R80 to put to bed these dats if you aren't on medical aid — up to R30 for a consultation, a good R30 for antibiotics, and about R20 for a reasonable cough mixture.

With the 18 percent increase in medical aid scale of benefits announced by the Representative Association of Medical Aids (Rams) for next year, and another rise looming — the Medical Association of South Africa has set R55,20 as the maximum recommended fee for general practitioners — health care is moving further out of the reach of most people.

The pressure, says Rob Speedie, executive director of Rams, comes from increased running costs of doctors and hospitals.

"We have a standing disagreement with Masa about the reasonableness of its guidelines," he says, "but it is their prerogative to determine what they should charge, and it is ours to determine what members can afford.

"Medical aid schemes are strictly non-profit organisations," says Speedie, "and the gap between these two rates is now so large that to close it would result in a huge hike in contributions."

As it is, medical aids — through which employees make a monthly contribution to a scheme which pays for members' health services — cover only 18,9 percent of South Africans. The rest, most of whom are unable to afford these benefits, use provincial hospitals and clinics. In fact, of the 5,8 percent of its gross national product South Africa spent on health in 1987, 44 percent was sent in the private sector, which cares for about 20 percent of the population; and 56 percent on the care of that 80 percent dependent on the public sector. At least half of the medical profession is now in private practice.

For those privileged enough to receive private health care, medical aid schemes eat away relatively large portions of their salaries. In one case for example, an individual who works in a computer company pays a staggering R350 a month for himself and his wife. The company matches his contribution rand for rand. Another scheme charges an individual member with no dependants and who earns under R600, R176 a month for services. If he has one dependant, he pays R264.

"Health care is becoming more and more unaffordable each year, even for those in employ and with access to medical aids," says Max Price, spokesman for the National Medical and Dental Association (Namda). "For many workers, these schemes now comprise up to 10 percent of their salaries."

In a recent study of medical aids, Price and Jonathan Broomberg of the Centre for the Study of Health Policy at Wits University point out that members' contributions to the schemes have escalated on an annual average of 23 percent since 1978 in relation to a 13,4 percent inflation rate. So, whereas in 1977 the average monthly contribution was R17,72, by 1987 this had escalated to R112,43. Today it is much higher.

"The costs of medical aids are rising faster than those of the economy in general and clearly much faster than wages," says the report.

Price and Broomberg argue that this cost spiral is inherent in the medical aid system because of the "fee for service" method of payment. Because doctors charge

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patients for "each item of service, each drug, each day in the hospital ..." separately, the doctor's income is determined by the quantity of service he/she provides. There is no incentive to use cheaper drugs or tests.

Also, they argue, because it is the medical aids who pay for health care, and not the patients or providers, there are not financial constraints on what doctors should charge and people tend to overuse private medical services to get the full benefit of their contributions.

Speedie agrees: "Escalating utilisation is a big problem. With the crisis in the public sector, most people are using expensive treatment, the cost of which must be borne by medical aids.

"High-tech medicine is becoming much more common in South Africa and generally more medicine is consumed per patient. Whereas in the old days, people used ordinary X-rays, today magic scanning techniques provide better quality of definition, but are also costly."

The administration costs of the over 250 medical aid schemes in South Africa are also passed on to contributors. According to the report of the Registrar of Medical Aids for 1989, administration costs increased in 1988 by 28,5 percent. Of a total income of R3 087 518 651, R167 565 588 went towards administration.

Many schemes sub-contract the processing of their claims and, sources say, it is these which require members to pay cash up front for services and prescriptions.

Because of escalating expenses, some administration companies have begun to pressure for changes in the law to offer more limited coverage through flexible benefit packages. At present, medical aid schemes are obliged by law to pay at least 70 percent of the recommended tariff for any service the package covers, as well as a certain minimum range of benefits.

Were this to succeed, it would mean good benefit packages could become more expensive and others could provide completely inadequate care.

For most people who join, the prime concern is for more access to routine care without needing ready cash on hand. But, in general, medical aid only really becomes useful in the event of an expensive operation or accident damage. It is based on the principle of spreading the risk of a rare, unpredictable event over a large number of contributors.

Said one prospective user: "It's a real dilemma. I would probably save money just paying for the odd dental or medical check-up; but if anything untoward should happen to me, I'd have problems."

Despite these disadvantages, membership of medical aids is growing — especially among unionised black workers. Although employers are not legally obliged to match their employees' contributions, unions have been able to include this benefit in most negotiation packages.

In fact, whereas medical scheme cover for the white population appears saturated at 70 to 75 percent, the number of African beneficiaries increased six-fold between 1977 and 1986. However, only 5,5 percent of Africans belonged to medical aids at the end of 1988, according to the Registrar.

Inadvertently encouraging this trend, many medical aids have cheaper rates for African clients — the rationale being that because of historical disadvantages they are not fully aware of the benefits. Until recently, general practitioners were scarce in the townships, and specialists even more so.

Price and Broomberg say the present system of medical aids is inadequate and that increased membership will only boost the private health sector, relieving the state of its responsibility to plan and co-ordinate adequate health services for all.

"This," say the two academics, "will increase the obstacles to equal access to adequate health care for all by exacerbating the maldistribution and misallocation of resources, increasing financial barriers, and undermining the public health sector."

Because the private health sector is determined largely by market forces, its expansion will reinforce the concentration of services in affluent urban areas, to the detriment of poverty-stricken townships and rural areas.

All parties agree that the problem is a structural one which, says Speedie, "needs to be attacked on many fronts".

An alternative posed by Broomberg and Cedric de Beer — also of the policy unit — at the April 1990 Maputo conference on "Health and Welfare in Transition" is a mechanism of centralised control of health financing through which privately-owned facilities and practitioners can be integrated into a national health service.

The finance for central funding should come either from general tax revenue available to the government, or from an additional contributory scheme such as a national health insurance. In this case, the money people currently pay directly to the private health sector should rather be paid into a central state fund which will administer the provision of health care services for all.

"That's not in keeping with a free market economy," said Speedie, responding to the concept.

"Although the results of centralised control of health care are positive in a country like Canada, in Britain, the picture is different: because of long queues for public health care and a shortage of hospital beds, the country is reverting to private health insurance and provision of health care."

The real question in deciding whether to prioritise private or public health care, as he points out, is what the nature of a future South African economy will be.

EXAMINING A LOW-COST MODEL

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FIM 7/12/90

As medical costs rise, the search for options to the medical schemes system goes on. Everything from a National Health Service to tailor-made medical insurance packages is punted as the solution.

A good model may be a medical benefit fund that's operated for more than 40 years in Vanderbijlpark. Medical aid administrators, the SA Medical & Dental Council and other health groups are studying the fund — Vaalmed — to see if it could be a prototype for other low-cost, high-quality health care schemes.

Unlike conventional medical aids, which simply pay the claims filed by members and don't employ medical professionals, Vaalmed works like a health maintenance organisation (HMO). Members pay a monthly fee and can see any of the fund's medical staff free of charge. The choice is

Vaalmed . . . *pharmacists are free to do what they're trained to do*

wide — Vaalmed employs 24 salaried GPs, nine dentists and a range of specialists. It also owns a pharmacy set up before the Pharmacy Act of 1976, which prohibits medical schemes from owning pharmacies.

Vanderbijlpark, site of Iscor's largest steel mill, was built by Iscor as a company town in the Forties. Iscor started the Vanderbijlpark Benefit Fund as a normal fund but, determined to keep down costs, conducted an international search for a more effective model. It chose California's Henry Kaiser HMO, which now operates throughout the US.

Vaalmed has 17 000 members and 45 000 beneficiaries. All but 330 work for the 30 member companies, including firms with local operations such as Dorbyl, Metal Box and Consolidated Wire. Iscor still provides 60% of the members.

Vaalmed GM Rolie Buys says: "We have a broad spectrum of members who are prepared to sacrifice absolute free choice for lower contributions. But they still have 24 GPs to choose from."

There's no denying that Vaalmed has been effective in keeping down contributions. The maximum subscription is R260 a month, less than two-thirds the cost of a full-cover medical aid scheme. Subscriptions will increase by 16% next year compared with a sector average of 25%.

Savings are possible, Buys says, because additional consultancy work doesn't mean additional revenue, so unnecessary medicines and tests are cut back. The average script from Vaalmed doctors is valued at R40 rather than the R70 for private doctors.

"In medical school, doctors seem to be taught to handle illness at all costs. No effort is made to teach them cost consciousness. But here they are part of the organisation and are therefore partially responsible for the financial planning — as opposed to receiving payments from an anonymous medical aid."

Predictably, the Medical Association of SA, which represents doctors, is opposed to extending Vaalmed-type schemes to other towns and claims it would "adversely affect private practice initiative."

"Individuals who would normally go to private doctors can be invited to join Vaalmed, whereas private doctors cannot directly recruit patients or advertise their services," says Bernard Mandell, the association's chairman. But the association has always opposed ending the prohibition on doctors' advertising.

Vaalmed also has the advantage of being a one-stop service. Instead of a doctor sending a patient across town to a specialist, he or she can be sent to someone in the same building.

The dispensary is another significant source of savings. It employs nine full-time pharmacists, who dispense 20 000 prescriptions a month. "The pharmacists are free to do what they are trained to do and they don't have to embark on commercial activities to keep up their income," Buys says.

The dispensary's considerable buying power allows for large savings on most drugs. Tablets that would cost a retail pharmacist R75 for 100 are bought by Vaalmed for R30.

Vaalmed farms out services it cannot provide at a lower cost on the premises. "It would never make sense to perform heart surgery here, as there are only five cases a year, nor to have neurosurgeons," Buys says. "Nor could we invest in a magnetic resonance image scanner. We have to keep reviewing our services. If we are spending more on a service than we would have by paying medical scheme tariffs outside, then we would consider abandoning that service."

Some specialists are paid a fee to consult at Vaalmed part-time, including an orthodontist, two urologists and an ear, nose and throat specialist who consult at certain times. Vaalmed also covers preventive services, which are not covered by medical aids. It runs allergy clinics, obesity clinics and ante-natal clinics. It was recently granted a licence to build a 78-bed hospital, which will also be open to non-members.

The Medical Association argues that reduced costs must mean reduced standards. Buys flatly denies this. "Are standards really kept up when a doctor is chasing fees? No one would argue that an accountant who works for a salary and is not in private practice is necessarily a worse accountant. We provide our doctors with fully-equipped facilities and they can apply annually for new technology and equipment to ensure that adequate standards are maintained."

Paul Kruger, the director of GPs, says there are many attractions for doctors in working for a salary with a package that includes a car and housing allowance. The pressure is less intense than in private practice because the doctors deputise for each other after hours. Two doctors are on call every evening. This means that each doctor is on call only once every 12 evenings.

The Vaalmed formula may not necessarily be transferrable to all communities. A more affluent community, such as Sandton, would probably prefer to continue with the fee-for-service system. At the same time, the Vaalmed subscription rates would be out of reach of the bulk of Soweto residents.

But, Buys says: "The HMO model can be applied to poorer communities, and the range of benefits tailored to their requirements."

Cancer Association forced to cut budget

By Carina le Grange

Speculation that the Southern Transvaal Branch of the National Cancer Association (NCA) is to close down have proved to be false.

However, the NCA is planning to rationalise its services and some staff members are expected to be retrenched, according to president Professor Douglas Anderson.

These moves are a result of rising costs and an increase in demand from patients while public donations have dropped concurrent with the economic climate, the NCA said yesterday.

On reports that members of staff at the Southern Transvaal branch received notice of their retrenchment, Professor Anderson said the NCA was looking at retrenchments as only one of the measures of meeting the budget.

He said these letters did not "finalise their retrenchments", but could not say how many people would be affected countrywide. He denied the NCA was going bankrupt and would close down, but added there would be no expansion of services as in past years.

The NCA offers services free to cancer patients and their families, ranging from counselling to prostheses, from pain control to support during bereavement.

It is totally reliant on public donations, with less than one percent of its operating costs subsidised by the State.

Donate blood before you go away (299) appeal

The National Blood Transfusion Council has urgently appealed to all donors to give blood before they go on holiday.

In a statement, it cites the example of former star Springbok rugby flank, Rob Louw, whose life was saved by 20 blood donations after a serious boat race accident at Langebaan a week ago.

"What happened to Rob Louw is a good example of how much blood one can suddenly need when one least expects it," said Gordon Buckle, spokesman for the national campaign currently being run by Blood Transfusion Services.

A full blood supply could not be stored in readiness for the festive season as blood had a maximum transfusable life of only 35 days.

"Unfortunately neither can we put off accidents and sickness until people return from their holidays. To cope with the demands for blood over the festive season, donors are therefore requested to come in and donate before they go off on holiday," Mr Buckle said.

Transfusion services generally had a problem in retaining their blood stocks during this time as there was a massive exodus of donors.

Factories and educational institutions, which were vital sources of blood supply, usually closed over this period and blood transfusion services had to rely on individual donors. — Sapa.

'Disabled rights neglected'

Star 10/12/90. (299)

By Shehnaaz Bulbulia

Disabled people's rights were neglected issues because Apartheid human rights campaigners have tended to be more concerned with civil and political rights than socio-economic rights, Lawyers for Human Rights (LHR) said.

LHR's socio-economic unit researcher, Wendy Landau, has found that poor families were often thrust deeper into poverty because disability placed heavy demands on resources of individuals and families.

The World Health Organisation had estimated there were more than 500 million disabled people in the world — one in every 10.

In South Africa, while accidents, domestic violence, crime and disease caused disability, many people had also been disabled during police action and their fate was often forgotten, said Ms Landau.

Disabled people were discriminated against in the workplace and were often denied full educational opportunities, as well as discriminated against by the absence of public facilities, she said.

The Universal Declaration of Human Rights on disabled people — the right to security, adequate health care and standard of living, should be applied.

MediKredit gets board all-clear

The Competition Board has given the Pharmaceutical Society of South Africa a clean bill of health after four years of investigation unto the society's MediKredit scheme. (299)

The board found the scheme had not practised "horizontal price collusion" with affiliated medical schemes.

The board started the investigation after complaints that a monopoly of medicine prices had been created by MediKredit. Star 19/12/90

The board's favourable decision comes shortly before the exemption granted by it for the scheme to continue during the investigation was due to lapse at the end of December. — Medical Reporter.

Medic Alert hopes (299)
Star 19/12/90
SA will aid expansion

By Carina le Grange
Medical Reporter

Medic Alert International hopes that South Africa will be instrumental in expanding the work of the foundation through the rest of Africa, the chairman, Dr Richard Wilbur, said in Johannesburg yesterday.

"We have not been able to establish affiliates in the rest of Africa before, but now hope to do so and have already received inquiries from Zaire and Kenya," Dr Wilbur said.

More than 300 000 South Africans wear the distinctive Medic Alert bracelets which carries neccessary medical information to assist doctors in case of accident or illness.

Dr Wilbur himself wears a bracelet — because he wears contact lenses.

"Any person who has any condition a doctor ought to know about within 10 minutes of emergency treatment should wear a bracelet. Such conditions include diabetes and other chronic or hidden diseases and allergies," Dr Wilbur said.

Clean bill of health for chemists' body

w1Mail 20/12/90 - 10/1/91

By PORTIA MAURICE

AFTER four years of investigation, the Competition Board has given the Pharmaceutical Society of South Africa and its contracting subsidiary, Medikredit, a clean bill of health.

Medikredit is an accounting service used by many pharmacists to process the prescriptions of medical aid clients, send them to medical scheme administrators and arrange payments. In this way, patients are given credit for their pharmaceutical requirements, and avoid having to pay cash up front.

Medical aids contract in to Medikredit and in return receive discounts on pharmaceutical goods.

Allegations had been made to the Competitions Board that the Medikredit accounting system constituted "horizontal price collusion" because it set "notional prices" for medicines to facilitate computerisation. Complainants said Medikredit was price fixing and dominating the market in this way.

On announcing the Board's decision this week Boet van der Merwe, executive director of the PSSA, explained that the Medikredit system "did not preclude pharmacists from granting patients whatever discounts on medicines their business could bear".

He said millions of rand had been invested in mainframe computer installations and programming, for the benefit of pharmacies and medical scheme members they served.

"It would have been catastrophic if the machinery for settling medical scheme claims were not allowed to continue by a negative Competition Board ruling," he said.

"Millions of medical scheme members would have found that they could no longer obtain medical scheme credit for prescribed medicines at pharmacies throughout the Republic," he said.

Health care apartheid is still intact — researcher

TANIA LEVY

APARTHEID in health care remained largely intact despite government's statements that it had been abolished, the Wits Centre for the Study of Health Policy found.

In practice little had changed since National Health Minister Rina Venter's announcement that hospitals were open to all races and beds were to be used according to need, said research officer Johnathan Broomberg.

Venter's statements had left too many loopholes to ensure real integration, he said.

Many public hospitals in the country were not exclusively black or white but had separate wards, different entrances, segregated outpatient and casualty wards and sometimes even separate X-ray and theatre facilities for black and white patients.

Sowetan 20/12/90

Segregated

The new policy did not require that segregation within hospitals be abolished, he said. And Venter's announcement did not extend to local authority services.

Broomberg said most previously segregated hospitals continued to serve only one population group because they were the most conveniently situated for the local communities.

He said the administration of health services by racially separate own affairs departments and 10 homeland health departments was "administratively irrational and economically inefficient". He said it perpetuated racial inequality.

For example R23,04 per person was spent in Lebowa compared with R149,51 per person in the Transvaal.

Dismantling hospital apartheid required a clear unambiguous public policy from Venter.

A haven for society's young rejects

(299 Staw 24/12/90)

By Dawn Barkhuizen

In a dusty township on the edge of the Winterveld, there is a shining testimony to love and personal sacrifice — the Gift of Love Children's Home.

Established by four sisters of Mother Teresa's Missionaries of Charity order, the home is for society's smallest rejects — mentally handicapped and deformed children.

There are 52 children, mostly under the age of five, and the degree of deformity is overwhelming.

Some have bodies so deformed they cannot even slide from their cots on to the floor. One small boy can do little more than roll his head backwards on his pillow and view the world from upside-down.

Not all the children are mongoloid or retarded. Some must bear the anguish of having alert minds trapped inside tortuously twisted bodies.

Until the home was opened in May, the handicapped children of the Winterveld had largely to fend for themselves.

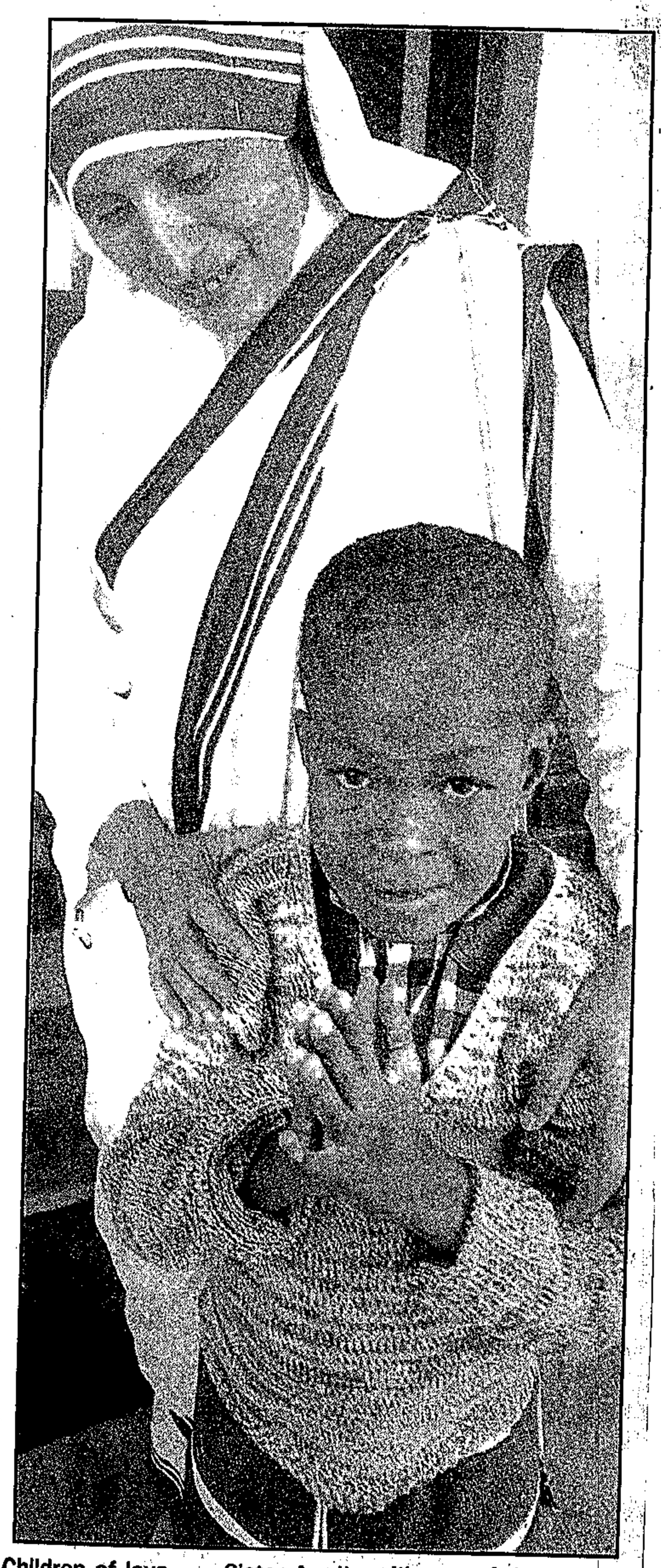
Impoverished parents were often forced to go out and work, leaving children alone or with relatives, according to Sister Amrita.

Now the children have constant care. Twelve women assist the sisters, and a doctor visits regularly — and they have the love and attention of four warm, selfless women.

The sisters — three from India and one from Poland — arrived in South Africa 18 months ago and based themselves at the Klipgat Catholic Church.

After becoming aware of the scores of handicapped children in the area, they established the home, which operates entirely on charity.

Anybody wishing to contact the sisters can do so by writing to Mother Teresa Missionaries of Charity, care of the Catholic Church, PO De Wildt 0251.



Children of love . . . Sister Amrita with one of the youngsters who has found love. Pictures: Wayne Fisher

An opportunity to be happy . . . This youngster is one of many at the Gift of Love Children's Home who has found love and care from Mother Teresa's missionaries.

Call for changes to medical schemes

MARIETTE DU PLESSIS

PHARMACEUTICAL companies and doctors are clamouring for changes to SA's health-care legislation, especially with regard to medical aid schemes.

In Adcock Ingram's annual report, chairman Robbie Williams called for the deregulation of medical aid schemes to offer members a more broadly based series of options, ranging from all-inclusive cover to disaster cover, in line with other forms of insurance.

At Gresham Industries' AGM chairman Gordon Utian also questioned the credibility of the medical aid system, in terms of which pharmacists were being pushed by medical aid societies to assume the role of a discounter.

Dispensing Family Practitioners (DPF) chairman Robert Rapiti issued a statement saying: "Medical schemes are failing to deliver the goods and have abused the archaic state of present legislation governing health care in the private sector."

He also questioned the manner in which the 5% to 10% was used for administration since "medical aid contributions were public funds".

Department of Health director-general Coenie Slabber said requests were made to all interested parties to submit their suggestions regarding the present health-care situation and the matter was receiving attention.

He said it was out of step with the government's policy of deregulation to legislate for the control of either the remuneration or the income levels of health-care providers in the private sector.

Slabber emphasised that government's health-care policies were not only formulated to be in the interest of all its citizens, but administration costs of medical schemes were under constant scrutiny.

Costs were audited annually and reported to members and the Registrar of Medical Schemes, he said.

SOCIAL SECURITY – MEDICARE

1991

JULY – DEC.

Taxing route to health

Own Correspondent

DURBAN — A national health service funded by taxes from "those who can afford them" is called for in an ANC discussion document.

The document, which will be debated at the organisation's annual conference at the University of Durban-Westville this week, says present health services reflect "all the injustices and irrationality of apartheid".

"No one should be excluded from public health services because they do not have money to pay," it says.

Only when this is achieved, would it be possible to reduce the different standards in health care.

The Government would therefore have to pay for health care and would have to tax those who could afford it to fund the national health service.

The document notes that there are major differences in access to good health care between black and white, rich and poor and urban and rural communities.

"The most advanced hospital care is inaccessible to the majority of people because of the costs and the time involved in travelling to the major urban centres where these hospitals are located."

A national health service would be:

- Unified and non-racial, and all communities should be provided with local clinics, community health centres and hospitals.
- Accessible and affordable — no one should be denied access to essential health care because the service is too far away or costs to much.
- Geared to giving priority to those most in need — children, mothers, the elderly, the mentally ill, unemployed, workers in hazardous situations and the disabled.
- Focused on eradicating or controlling major diseases such as Aids, tuberculosis, measles and polio.

VAT: Health to be exempted?

299
CT 4/7/91

From GILLIAN HAYNE

JOHANNESBURG. — Health services might be exempted from VAT before the tax is introduced on September 30.

Inland Revenue chief director Mr Trevor van Heerden said VAT on health services was still under consideration. No decision had been taken.

He said a meeting had been held with the Dental Association of SA (Dasa), Minister of Finance Mr Barend du Plessis and Minister of National Health and Population Development Dr Rina Venter. A further meeting was scheduled for August 2.

Dasa president Dr Wynand Dreyer said in a statement yesterday the association was not fighting for a zero rating.

This was because "it seems unprofessional for the suppliers of health care to reap the benefits of the system without accepting its responsibility".

Zero rating would allow the profession to charge no VAT on services while still claiming a refund from revenue for VAT paid on inputs.

He said the dental profession was fighting for an exemption from VAT and would be prepared to absorb the additional costs of VAT on inputs.

Calculations indicate the burden to dental practices would be about 1,4% of turnover.

Dr Dreyer said the major reason health care should be exempt from VAT was that the cost of it would be unnecessarily increased. It would have a significant effect on "an already overburdened public health sector".

It would further strain the relationship between the health services industry and medical aid societies.

VAT would also place an unnecessary administrative burden on the suppliers of health services.

In an open letter to the profession, Dr Dreyer said members should attend seminars on VAT in case the tax was introduced on health services.

VAT on health undecided

B1Dasa 4/7/91

299

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VAT

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☐ From Page 1

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In an open letter to the profession, Dreyer said Dasa members should attend seminars on VAT in case the tax was introduced on health services.

He said: "This arrangement should, however, not be interpreted as subliminal support for VAT on health services; nothing could be further from the truth and your association will continue to fight the system as best it can."

No cash for care centre

THE former Nontsapho Cripple Care Centre is struggling to gain popular support after years of being associated with the regime of ousted president Lennox Sebe.

It was named after Virginia Nontsapho Sebe, the homeland's former First Lady, and relied heavily on "donations" extracted from unwilling Ciskeians.

The centre has been renamed Enoch Sontonga Rehabilitation Centre after the celebrated composer of Nkosi Sikelel' iAfrika, and is trying to shed its past associations with the Sebe regime.

But now that Sebe has gone, people who felt obliged to pay R2 a month towards the centre are no longer willing to do so.

This has meant a dramatic decrease in revenue for the project. Last year's donation to the centre was R2 000 – as opposed to the R50 000 to R80 000 previously obtained through donations.

Involuntary donations were a R2 "fee" collected in each government department and in residential areas.

During Sebe's time, the centre also attracted enormous donations from businessmen inside and outside the homeland. It also enjoyed an annual government grant.

The present government has increased this grant, but the project is still struggling to survive financially.

Centre director Nomandla Molefe said the project was established in 1985.

Since then, it had trained 208 people. Of these, 97 were working in factories at Dimbaza and Fort Jackson.

Currently there are 45 students, who are taught weaving, knitting, carpentry and joinery, said Molefe. There was no shop to sell its products, but the centre planned to set up a bazaar.

At Sontonga, there is a space problem, but two four-room timber houses are at present being built to ease congestion.

The sewing class is so overcrowded that only a few students can be taught at a time, while others have to sit idly by. The same situation exists in the carpentry class. Storage, woodcutting and display are in one congested building.

Plumbing instructor Hamilton Jobo said: "Our problem is that we have no workshops. For woodwork we need a powershop, sprayshop for finishing, a workshop and a stall."

Besides the association with the Sebe regime, there is also general apathy toward the problems of the disabled.

"I do not know whether it is our upbringing, but it is mostly whites who are concerned about disabled people," said Molefe.

"Initially we were helped by social workers to identify disabled people and prospective students for the centre. This year, our instructors had to go up and down looking for disabled people. Social workers no longer help. They see this as extra work.

"We cannot do anything without the support of the community," said Molefe. – Elnews

PSYCHOLOGY

Now, a tax on mental health

299
Star
8/7/91

Psychologists will not be able to play their role in treating the consequences of violence in South Africa once Value Added Tax is imposed on psychological services, says the president of the Psychological Association of South Africa (Pasa).

Dr Theo Veldman says psychological services do not qualify for compulsory benefits in terms of the Medical Schemes Act, but only for benefits which represented between 30 to 40 percent of Pasa's recommended tariffs.

"In practice this means the Representative Association of Medical Schemes (Rams) only pays about R10 of Pasa's recommended tariff of R25 per counselling session," he says.

This has created the situation where psychological services could only be afforded by, predominantly, the white middle class.

"There is an urgent need for across the board group-based services — particularly for black youths who have been severely traumatised by the violence in the townships," he says.

SAPA

No payout, shot hold-up victim told

(299)
Star 8/7/91

By Jacqueline Myburgh

The medical aid society which refused to pay a man's medical bills after he was shot during a bank hold-up last year was acting within its rights, according to RAMS, the Representative Association of Medical Schemes.

Executive Director Rob Speedie said Beland Medical Aid, which refused to pay R10 000 in medical bills, was probably acting in accordance with a provision included in the Medical Schemes Act.

This provision states that in cases where costs of treatment can be recovered from a third party, the medical aid scheme is not required to pay out.

Manfred Siebenhaar, of Edenvale, complained to The Star after he was shot in the shoulder and knee by a robber with an AK-47 during a hold-up at the First National Cleveland branch last year.

According to his wife Ursula, Beland Medical Aid would not pay for her husband's medical treatment because they said shot wounds were not regarded as an illness.

Mr Speedie said Mr Siebenhaar's situation could be compared to a motor vehicle accident, in which costs could be recovered from a third party.

Investigation into the matter revealed that most medical aid schemes opted to pay the member's medical costs and claimed the money back once the third party had paid its share.

"It is up to each medical scheme to determine its own policy. Rams cannot prescribe what they should do," Mr Speedie said.

The registrar of Medical Aid Schemes, Ellis Langeveld, said Mr Siebenhaar had probably not read the exclusion clauses in his medical aid contract properly.

Mr Langeveld said that not reading these clauses was a common problem with irregular claims.

VAT on health care slated

Star 8/7/91 (299)

By Jacqueline Myburgh

If enough people make representations to the Department of Finance on the subject of VAT on medical services, they may be forced to reconsider, the Consumer Council has said.

"It happened with municipal rates: there was such an outcry that, though it formed part of the draft Bill, it was scrapped," the council's Daan Kruger said.

The council was shocked when it was revealed that medical costs would be subject to VAT, as the Margo Commission report and the White Paper had suggested they should be excluded. Health care is currently not subject to GST, and the impression had been created that it would be exempt from VAT.

"If they impose VAT on health care it will become a hazard to fall ill, and people will be afraid to use medical services," Mr Kruger said.

Consumer Council director Jan Cronje said the possible advantages of VAT could be compared with the disadvantages

In its submission to the VAT Committee, the council supported its introduction on condition that the rate be set at 7 percent.

In the current economic situation and with continually rising costs on a broad front, VAT would take health care beyond the reach of most consumers, Mr Cronje said.

Search under way for new health plan

Pretoria Bureau

A model for a new health dispensation for South Africa, focused on decentralising health services, has been proposed at a conference of Ministers of health and welfare from South Africa and the self-governing territories.

It was proposed that it was time that attempts were made to arrange health services in such a way that they were more accessible and affordable.

A document said there were signs that the health status of inhabitants was deteriorating and that the present system was no longer affordable.

Local authorities, including regional services councils, should form the base of any future health dispensation — and all other services built on this base.

It was also established at the conference that the distribution of medical practitioners in the self-governing territories (Lebowa, QwaQwa, KwaZulu, Gazankulu, KwaNdebele and KaNgwane) was unsatisfactory compared with the rest of the country.

There was one doctor for 15 625 people in the six territories, against one doctor for every 1 099 in South Africa.

Costs may halt rise in medical index

BDay 11/7/91

X183

299

WILLIAM GILFILLAN

ANALYSTS have warned that the cost crisis facing the medical industry could halt the climb of the JSE's pharmaceutical and medical index, which has risen 71% to 1 070 points since the beginning of February.

The rise in the index has outstripped that of the industrial index, which has risen 33% over the same period.

Analysts say its sharp rise reflects the accumulation of blue chip and recession-proof stocks by institutions.

But they now fear that problems facing medical aid societies will eventually hurt pharmaceutical manufacturers.

The pharmaceutical index is heavily weighted towards drug manufacturers. Adcock Ingram, a Tiger Oats subsidiary, comprises 75% of the index and Fedvolk's SA Druggists makes up 14%. The remaining 11% is made up by the private hospital group Clinic Holdings.

Representative Association of Medical Schemes (RAMS) executive Rob Speedie said the increasing squeeze on medical aid funds had been caused by claims rising faster than contributions.

Analysts believe this will force manufacturers to concentrate on the lower margin products such as generic drugs.

Until recently pharmaceutical groups have tended to produce higher margin patented and branded generic drugs rather than the cheaper generics.

Adcock's MD Don Bodley said there was a place for generic products in the low income market. However, new patented products were "often superior and more innovative" which resulted in improved cost effectiveness, Bodley said.

Adcock Ingram Pharmaceuticals, a division of Adcock, manufactured patented and branded medicines, and generics. It contributed 17% to total group turnover.

Analysts believe demand for branded drugs could drop because an increase of the primary health care infrastructure will be closely alligned with a switch from branded to generic drugs.

Study

SA Druggists executive chairman Johan van der Walt said: "In trying to achieve an affordable health care system we will have to move more to generic substitution in order to make the rand stretch further."

Van der Walt said any drop in margins would be made up by increased volumes.

The ANC said at its conference last week it had conducted a feasibility study into creating a state controlled pharmaceutical utility. This would sell basic generic drugs, 160 of which have been identified by the World Health Organisation.

Sweet music to the ears of the deaf

Sowetan 12/7/91

299

WOMAN

By PEARL MAJOLA

AUDIO Dealers Association has launched a competition with hi-fi prizes to the tune of R60 000 in aid of the South African National Council for the Deaf.

ADA, a network of specialist hi-fi dealers, will be holding the second Real Hi-Fi Show at the Braamfontein Hotel from August 2 to August 5. Tickets to the show, which cost R2,50 each, will automatically qualify visitors for the competition.

Donation

ADA Chairman Mr Jan Sime said: "We felt that deaf people are possibly the only people who do not experience the joy of listening to music and do not benefit from it in any way. So our members wanted to do something for the deaf to make their lives better."

The national director of SANCD, Mrs Henna Opperman, said the donation would be a very important and appreciated contribution to the education of deaf people in this country.

"There are four million deaf people in South Africa and their biggest problem is low language abilities. This means some of them can read words but cannot understand their meaning.

Research

"So three years ago we began to research sign language in order to publish a sign-language dictionary here. The dictionary will finally be published in September in six volumes and it will cost us about R500 000. This sponsorship from ADA will then help us in that regard," she explained.

The main prize is a sophisticated state-of-the-art high fidelity system worth R50 000. It features a CD player, a 3B preamplifier, a P180 power amplifier, a digital signal processor, a tuner, Apogee Centaur hybrid loudspeakers and a stand.

There will be four other consolation prizes including a Rotel hi-fi system worth R5 500, two CD players and a PM30 integrated amplifier.

Tickets for the hi-fi show can be obtained by phoning Charmaine Pauls at (011) 482-1610.

AIDS insurance claims rise 25% to 216

CAPE TOWN — The total number of AIDS claims lodged with insurance companies increased by 25% to 216 between January and 9 July this year, research by re-assurer Mercantile & General shows.

The payout in respect of permanent health insurance monthly benefits has more than trebled.

Mercantile & General, which keeps statistics on AIDS claims, found that 64% of claims had been made within the first five years of a policy's life. However, it cautioned that notifications were sometimes delayed and statistics could change later.

6/pay 17/7/91

LINDA ENSOR

However, the re-assurer said "there does not appear to be any evidence of anti-selection in so far as large sums assured are concerned". Anti-selection is the process of taking out insurance when one knows one is at risk.

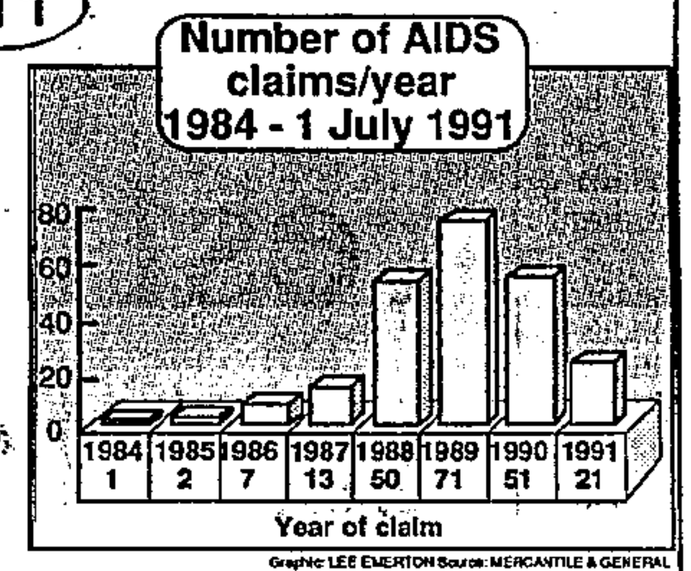
Men are predominant among the claimants. Of the total number of 127 claimants as at July 9, 119 were men, 72 of whom were single, 29 married and 10 divorced.

Including women, 76 of the total claimants were single, 32 were married and 11 divorced. Two were widowed and the status of six was unknown.

The average age of the claimants was 38 years. One claimant was under 20 years old, 22 were aged between 21 and 30 years, 61 between 31 and 40 years, 33 between 41 and 50 years and 10 over 50 years.

Of the 216 policies claimed against (a claimant might have had more than one policy) 137 were individual life policies with sums assured totalling R6,55m, 28 were group life policies with sums assured totalling R1,9m, 19 were individual disability policies and six were group disability polices. There were nine individual and 17 group permanent health insurance policies.

299



Medical aid shock looms for patients

299

Staff Reporter Star 19/7/91

Medical aid patients will have to pay medical bills up front if draft legislation proposed by the Government is approved.

In some cases, where a patient undergoes expensive procedures such as x-rays or scans, patients will have to pay out hundreds of rands, which they will then have to claim back from their medical aid schemes.

The draft legislation proposes that medical aids no longer pay doctors or medical service suppliers directly, but deal only with patients, who will be reimbursed according to the set medical aid scale of benefits.

The Dental Association of SA (Dasa) and the Medical Association of SA (Masa)) yesterday confirmed that the Government had asked them for their opinion on the matter before the draft Bill is passed.

The director of Masa professional services Dr Martin de Villiers yesterday said it had been argued in the past that guaranteed payment by medical aid schemes had resulted in over-servicing by doctors and over-use by patients.

Dr de Villiers said a system whereby monies were paid directly to a patient could lead to their spending their benefits on things other than medical bills.

He said retaining guaranteed payment and offering patients no-claim bonuses would prove a more effective means of addressing the problem of abuse of benefits.

A representative of Dasa said members of medical schemes received benefits according to a scale determined by the Representative Association of Medical Schemes (Rams).

He said the scale had not kept pace with the increasing costs of dental practice and therefore members of Dasa used the National Schedule of Fees, determined by Dasa, as a guide.

According to a Johannesburg dentist, who is a member of the southern Transvaal branch of Dasa, the guarantee of direct payment to practitioners had given a large section of the population access to dental treatment.

He said the abolition of the guarantee would result in lower-income groups being deprived of private-sector oral health services.

It would also have a negative effect on practitioners, he said.

However, he said, the guarantee was "a curse" in his profession as it had led to many cases of malpractice such as over-servicing — something that was openly admitted by certain members, he said.

He said his branch would meet on Tuesday to decide on proposals which, if accepted, would be made to Rams.

The proposals are that:

- Rams determine from time to time, but at least on January 1 every year, the minimum proportion of members' dental fees that medical schemes will pay.
- Rams shall not have the right to alter the recommended tariff without informing Dasa at least 60 days in advance.
- Any benefit due to a member be paid to the dentist and not the member.

The national president of the Housewives League, Lyn Morris, strongly condemned the proposed amendment. She said health was one of the basic things in life and everyone should be able to afford it.

HRCT 19/7/91

Pay on the spot plan for patients

(299)

The Argus Correspondent

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The national president of the Housewives League, Mrs Lyn Morris, strongly condemned the proposed amendment. She said health was one of the basic things in life and everyone should be able to afford it.

She had a degree of sympathy with doctors who often had to wait months for the medical aid to settle the accounts but said to punish the member was unfair.

"People pay medical aid as a form of insurance. They pay it knowing treatment would be paid for if an operation or other treatment was needed. But they will not be able to afford medical services any more if payment is demanded immediately after treatment."

MEDI-CLINIC 299 FM 19/7/91.

CLEAN BILL

Activities: *Provides hospital services in private medical clinics.*
Control: *Rembrandt Group 93,4%.*
Chairman: *J N de Villiers; MD: L J Alberts.*
Capital structure: *90,98m ords. Market capitalisation: R120m.*
Share market: *Price: 132c. Yields: 3% on dividend; 11% on earnings; p:e ratio, 9,1; cover, 3,6. 12-month high, 135c; low, 70c. Trading volume last quarter, 284 000 shares.*

Year to March	'88	'89	'90	'91
ST debt (Rm)	—	9,2	—	—
LT debt (Rm)	9,2	—	—	7,5
Debt:equity ratio	n/a	n/a	n/a	n/a
Shareholders' interest	0,85	0,85	0,87	0,79
Int & leasing cover	n/a	n/a	n/a	n/a
Return on cap (%)	3,8	8,2	9,3	12,0
Turnover (index)	143	201	311	435
Pre-int profit (Rm)	6,3	13,8	16,2	24,7
Pre-int margin (%)	n/a	n/a	n/a	n/a
Earnings (c)	(2,7)	4,0	12,4	14,5
Dividends (c)	—	—	3,0	4,0
Net worth (c)	66,7	70,6	77,5	92,4

Rembrandt Group, holder of 93% of Medi-Clinic, is an old hand at identifying growth industries. It does not take much to perceive that demand for hospital beds will continue to expand along with the country's population.

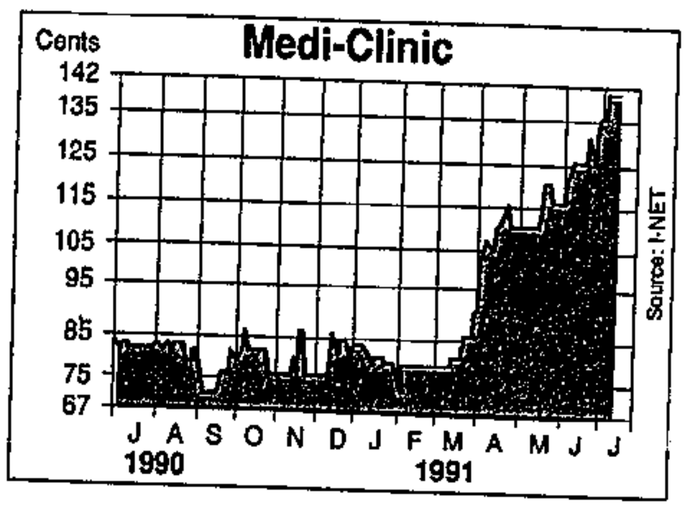
A 53% rise in operating income was boosted last year by an increase in interest received, with the result that pre-tax income of the Medi-Clinic group of private hospitals leapt by 86%. As tax was paid for the first time since the listing in 1986, attributable earnings were up by only 17%.

Higher occupancies and more efficient use of resources contributed to these results. Panorama Medi-Clinic, the first hospital to be commissioned by the group, has met all expectations within the first five years. Unlike the previous year, occupancy of the Mitchell's Plain Medical Centre attained an acceptable level of utilisation.

There were maiden profit contributions from wholly owned Medical Innovations, whose name describes its activities, and from United Hospitals Supplies Corp, formed during the year in partnership with the hospital division of the Afrox group; this is to be a joint purchasing organisation for the pharmaceutical requirements of both companies. Operating income should gain a further boost when the new complex in Stellenbosch comes on stream soon.

FM 19/7/91 299

According to chairman Jannie de Villiers, there is a surplus of hospital beds in SA and licences to build new facilities will be restricted. This inhibits competition but also restrains Medi-Clinic's expansion prospects. De Villiers adds that neither large-scale privatisation of State hospitals nor nationalisation of private hospitals is envisaged. But there is some apprehension that State hospitals, especially training hospitals, may start competing with private ones to provide services to members of medical aid schemes.



A large slice of Medi-Clinic's capital consists of convertible debentures which can be converted in any year, but conversion becomes compulsory when the dividend on the ordinary shares is 11c. After conversion, Rembrandt's stake will be reduced to 50%.

Judging by the rapid rise in the share price from 85c in March, investors have high expectations. It now stands on a similar p:e ratio to that of its only other listed competitor, Clinic Holdings. But the dividend yield is 3%, compared with more than 5% for Clinic. With major capital projects coming on stream, the share could prove a good growth stock.

Gerald Hirshon

FM 19/7/91 299

Alex mayor enraged by Hurd's health centre donation

Star 20/7/91

299

WHEN Douglas Hurd, British Foreign Secretary, made a R460 000 pledge to the Alexandra Health Centre during his South African visit, little did he realise that he was bruising the ego of Prince Mokoena, the township's mayor.

Mr Mokoena is not only unhappy because the British parliamentarian did not inform him of his visit to the township, he has also criticised Mr Hurd's pledge to the health centre as a political gesture.

JOVIAL RANTAO

"Mr Hurd did not have the courtesy to inform me, as head of the Alexandra community, that he would be in my township on that day. He simply ignored me and pretended I did not exist," the mayor said.

During his visit, Mr Hurd met members of the Alexandra Civic Organisation (ACO) and was taken on a tour of the health centre and other places in Alexandra.

Mr Mokoena said the centre was well-equipped and already received financial backing from the University of the Witwatersrand.

"We have another clinic in Eighth Avenue, which is ill-equipped, accommodated in makeshift structures and has only one doctor.

"Alexandra does not have an ambulance to serve its 350 000 residents. We use a minibus, which is not equipped to serve as an emergency vehicle.

"I believe the money from the British government should have gone towards the upgrading of all medical facilities in Alex," Mr Mokoena said.

Reacting, Moses Mayekiso, ACO's chairman, said he was surprised that Mr Mokoena was suddenly interested in the welfare of the community.

"The man has never lifted a finger to upgrade medical facilities and the living standard in Alex," Mr Mayekiso said.

Medical Act haste deplored

299

Star 23/7/91

By Carina le Grange
Medical Reporter

The Society of Dispensing Family Practitioners (SDFP) accused the Government yesterday of attempting to "push through" amendments to the Medical Schemes Act with a dictatorial approach.

SDFP treasurer Dr M E Sarlie said that if the amendments to the Act were promulgated, there would be serious negative consequences for the ordinary medical aid member as well as the providers of the service.

Among the proposed changes was one that patients would have to pay medical bills upfront, after which they would be able to claim the money from the medical scheme, and another allowing individual medical schemes to determine their own scales of benefit.

The society said it was disconcerting that so little time had been allowed for representations and comment to the proposed changes.

"Such important legislation involving the health care needs of a large percentage of the population ought to be considered more in-depth and with more circumspection, and not to be seen to be virtually pushed through.

"Has the opinion of the public been canvassed or even considered in this instance?" the society asked.

The SDFP said it agreed there were serious problems with the present medical aid system, but these could not be solved by replacing the system with a worse one.

"The solution lies in negotiations and consultations with all parties concerned and not the dictatorial approach that appears to have been adopted."

● The SDFP has begun a nationwide publicity campaign to oppose VAT on medicines and medical services.

Calling for a zero rating on medical services and accusing the Government of "imposing a tax on illness", the SDFP has embarked on an advertising campaign to raise awareness of the issue and to collect a million signatures from people opposed to VAT on medical services.

Dr Sarlie said yesterday that it was becoming more difficult for the public to afford basic health care and that the imposition of VAT would aggravate the situation.

Medi-Clinic diversifies to offset clamp on expansion

B|DM 26|7|91

LINDA ENSOR

CAPE TOWN — Medi-Clinic, the JSE-listed private hospital group, has embarked on a programme of diversification to counter the clamp placed by government on the provision of additional hospital beds, a move which has limited its expansion possibilities.

The group has seven hospitals — two in Johannesburg and five in Cape Town — and is currently spending R14m on a 58-bed two-theatre facility in Stellenbosch with a capacity to expand to 92 beds and three theatres at a later stage. The group's hospitals include the Sandton and Morningside clinics in Johannesburg.

MD Louis Alberts says there are no plans for additional hospitals as government has indicated that in the light of the oversupply of hospital beds, new hospital licences would be rare.

"We anticipate that it will be difficult to get licences in future," Alberts said in an interview, adding that the clamp had placed an unexpected damper on development.

The privatisation or contracting out of government hospitals and the granting of greater autonomy to training hospitals also poses a threat to the private hospital sector, although it could open up new opportunites.

Alberts said Medi-Clinic is keen to take up opportunities for the management of hospitals should these arise.

● ALBERTS

He does not think private hospitals will be nationalised by a new government, saying that they do not cost the authorities anything, reduce pressures on the government and allow it to direct its efforts at primary health care.

Despite the recession the 1 550 hospital beds in the group have been reasonably occupied this year. One effect of the downturn has been the delaying of elective operations, but Alberts believes there will still be a growth in profits in the year to end-March.

In the previous year fully taxed earnings of 8,7c (5,9c) a share were generated on an operating profit of R24,7m (R16,2m).

Alberts sees future growth coming from Medi-Clinic's diversified activities.

A small company, Medical Innovations, was formed about two-and-a-half years ago to manufacture hospital equipment such as theatre tables and table attachments. The market is dominated by imported equipment and Alberts says it will take some time to penetrate the market, although he adds that Medi-Clinic can offer a price and local content advantage.

In conjunction with Afrox's hospital subsidiary Home and Hospital Dispensaries, United Hospital Supplies Corporation was formed to buy pharmaceutical items jointly. Alberts says the company is the second biggest buyer of pharmaceutical products after the state and is able to secure better prices.

The third leg of the diversification programme was the establishment a few months ago of a medical maintenance company Medimo, an extension of the Medi-Clinic Occupational Health Service company. Medicaid Administrators and Afrox's hospital division came in later as partners. Medimo offers a form of medical aid to employees and secures contracts with specific practitioners to provide free medical services to its members.

Alberts says Medimo addresses the needs of the middle segment of the medical care market, offering a less expensive form of medical cover.

Protectionism is at the root of rising health care costs

GREG CANDY

SOUTH Africans in the private sector pay three-and-a-half times more for health care today than they did only eight years ago. A person earning R2 000 a month, for example, today could spend almost 20% of this before-tax income on family health care.

The recent draft Bill on amendments to the Medical Schemes Act proposes changes which will have far-reaching effects on the financing of private health care in SA. Some of these changes may facilitate the establishment of alternative systems such as health maintenance organisations (HMOs).

HMOs are health care entities which, in return for a fixed pre-paid fee, contract to provide members with a wide, pre-determined range of health services. They can dramatically reduce the cost of health care by reforming the existing system in which health care is provided to long-suffering consumers who can no longer afford the cost of medical aid.

One local HMO, Vaalmed, disclosed recently its average annual increase in contributions over the past seven years had been 16%, compared to 22% for medical aid societies. If this is correct, the compounded saving is 40% over the period. In the US, during the 1980s, HMOs demonstrated similar types of savings. The largest and best known there is Kaiser Permanente.

The common factor which has contributed to the problem of soaring costs is the protectionist manner and structure in which private health care is financed in this country.

Existing legislation ensures that the so-called financiers of health care (the medical aids) have little control over the suppliers of service (doctors, pharmacists and so on) and furthermore, because suppliers are rewarded only when patients are ill, it encourages over-servicing.

Moreover, because patients do not normally pay at the point of service, there is no incentive for either suppliers or receivers of service to be cost-conscious. Not surprisingly, costs rise unrelentingly.

HMOs often employ their own doctors and nurses, and have their own pharmacies which are required to provide cost-effective services without compromising quality. The emphasis is on preventive care and keeping patients healthy because there is no financial incentive to over-service.

HMO staff are offered competitive salaries. While they may not be able to earn quite as much as in private practice, HMO employment offers shorter, more predictable working hours, fewer after-hours calls, lower business risk and work in a "health team" environment.

HMOs generally provide medical practitioners (and other suppliers of services) and patients with incentives for the latter to remain healthy. This therefore helps control health care costs. It helps break the upward spiral of costs which the present arrangement encourages.

Professional staff are encouraged to optimise services such as prescriptions, X-rays, laboratory tests, surgery and hospitalisation. Because an HMO has the ability to monitor its work it can feed this information back to the doctor, to help him optimise the use of resources and be cost-effective.

Both overseas and locally, HMOs have shown that cost savings of 40% can be achieved without necessarily compromising quality. This is because consumers and the suppliers of health services are encouraged to use preventive health care (and minimum intervention) to ensure that people remain healthy, in contrast to the current system where the emphasis is on expensive, high-tech, curative services.

This combination of cost-effectiveness and high quality of service, has resulted in the rapid development of HMOs in the US, and has helped to break down determined resistance from vested interests who supply health services. Today HMOs are one of the fastest growing organisations in the American health care market and in 1990 supplied health services to more than 32-million members.

The main obstacle preventing the establishment of HMOs in SA is legislation. However, the draft Bill on amendments to the Medical Schemes Act — if passed — will permit medical aid and medical insurance companies to own hospitals and clinics and to employ medical professionals, which will facilitate the establishment of HMOs.

However, additional legislation is required to reduce health care costs, and to make HMOs fully viable. This should include:

- ☐ Permitting the establishment of group practices between different medical and para-medical professions; and
- ☐ Generic substitution of branded pharmaceutical products which are no longer on patent.

Factors which have resisted the establishment of such systems will have to be overcome. These are not limited to one group of health care suppliers, such as doctors. There are individuals (including patients), groups of people, and companies that are abusing the system and, therefore, driving up costs.

They have traditionally blamed each other for rising costs where, in fact, the system offered by medical aid is the root cause of the problem.

Among the many reasons behind rising costs are:

- ☐ The cost of medicines in SA which, in the past eight years, has consistently outstripped inflation by as much as 10% a year;
- ☐ The cost of a particular drug to the state is often only a small fraction of the cost to the private individual; and
- ☐ SA has invested heavily in expensive hi-tech equipment to the extent that we have the same amount of certain types of sophisticated equipment (such as magnetic resonance imaging scanners) as Britain. One treatment with an MRI scan costs R1 350.

Changing legislation and allowing more market-oriented competition in the entire area of health care will ensure a wider range of choices for the consumer. Cost-effective providers of health care, across the spectrum, will survive and flourish. Those which are not competitive and do not provide cost-effective health care will clearly not survive.

This scenario applies to all providers of health care including doctors, dentists, pharmacists, private hospitals, pharmaceutical manufacturers and the like.

As a developing, Third World nation, SA simply cannot afford — even in the private sector — an excessively costly health care system. With so many demands on public and private resources, we must ensure that the same levels of efficiency are achieved in health care as we have rightly come to expect of other industries and sectors of the economy.

This is one area at least in which we can, and should, try to immunise SA from the debilitating ailment of poverty.

☐ **Candy is a health care specialist at Deloitte Pim Goldby.**

Employers await changes to medical aid

THE Durban Chamber of Commerce has advised its members not to make any new commitments regarding medical schemes because of "dramatic" changes proposed to the Medical Schemes Act.

According to the chamber's weekly newsletter it was impossible to say whether health insurance policies flooding the market would be appropriate under the new legislation.

Government's recently published draft legislation would deregulate medical schemes if the bill was

TANIA LEVY

passed in parliament next year, the chamber said.

Representative Association of Medical Schemes (Rams) executive director Rob Speedie declined to comment until Wednesday, the deadline for comment submitted to government.

The newsletter said the proposed amendments would allow medical schemes to pay more realistic benefits and to tailor benefit packages to affordable levels of contribution.

Medical schemes have been shackled to a government scale of benefits which has become unrealistic compared with fees being charged in many cases, the newsletter said.

The proposed amendments would allow medical schemes to deal more effectively with abuse of benefits.

Serious malpractices had arisen from the the fact that the current Act forced direct minimum payment on doctors and pharmacies for certain services.

● See Page 8

Up in arms . . . disabled Bernice Dobson.
Picture: Alf Kumalo.

Disabled bus users feel the pinch

By Louise Burgers
Municipal Reporter

Disabled bus commuters and students have petitioned the Johannesburg City Council to reintroduce season bus tickets or face protest action.

Students and disabled people have been hard hit by the withdrawal, on July 1, of season tickets which cost a person on a disability grant R31 a month and students R59 for three months unlimited travel.

Now both groups have to buy bus tickets at between R11,70 and R20 for 10 bus trips — and bus fares are set to increase on August 1.

Several welfare organisations have petitioned the council to introduce special concessions for disabled bus commuters and Wits students have decided to campaign for some relief against the high fares.

The city council maintains it was losing in excess of R1 million a year with season tickets and contends that this facility was being abused.

Bernice Dobson will now have to pay a massive R140 a month on bus tickets — half her R304 monthly disability grant.

She uses three R11,70 tickets a week, having to change buses to get to the Belgravia centre where she is on a rehabilitation programme.

"I can't afford it. I only have R10 to R15 left a month to buy my toiletries and I have to rely on relatives to buy my clothing.

"I don't know how I'm going to manage, and there are many of us like this."

For other welfare and self-help organisations which employ the mentally and physically handicapped and pay their transport costs, the price of bus tickets has tripled.

In June, Goodwill Industries paid R2 500 in bus tickets for 130 employees. In July the cost rose to R7 000. Their R40 000 grant-in-aid from the city council will only cover the cost for five months.

Secretary Janithee van Rensburg said they might be forced to ask some of the mostly mentally disabled people to pay their own fares, which most could not afford.

Med scheme changes will hit patients

(299)

Sowetan 31/7/91

A SECOND blow is to be dealt to those requiring medical treatment with proposed changes to the Medical Schemes Act of 1967.

A notice appearing in the June 14 issue of the Government Gazette proposes the repealing of statutory direct payment

SA PRESS ASSOCIATION

by medical schemes to doctors and allowing insurance companies to enter the medical schemes market.

In a statement on Monday Dr David Green, Director of the National Medical and Dental Association, said many patients would no longer be able able to afford private medical care, forcing them to seek some, if not all of their health care from the public sector.

But he added that the public sector was ill-equipped to cope with an increased patient load.

Insurance

Green said the proposal to allow insurance companies to enter the medical schemes market would result in "risk rating" where younger healthy people would have access to cheap health insurance while those who needed health insurance most would face escalating costs.

"The reduction of risk sharing, a concept fundamental to health insurance, will result in rising costs putting health insurance out of reach of many people presently insured", Green said in the statement.

Costs

Green said this would be a second blow to the consumer after the introduction of the controversial VAT tax, due to be implemented at the end of September.

He said that Namda had called for a zero rating on medical services and medication - in an attempt to curb the rising costs of medical care.

While the proposal was still to be tabled in Parliament at the next sitting, Green was of the opinion the changes would be "pushed" through and could be implemented by the end of next year. - *Sapa*

The blind reveal their dark world

Sowetan 31/7/91 (299)

James Mthoba will be featured on TV3's *Ntome Tsebe* at 8 tonight. Mthoba is a nominee in the *Sowetan*/TV2&3 Community Builder of the Year competition. Readers will be asked to choose the winner after all six finalists have been featured in the *Sowetan* and on TV2&3. PHANGISILE MTSHALI reports.

"LET the blind people speak for themselves, let them tell us how it's like in their dark world."

That was the thought that was ringing in actor and director James Mthoba's mind when he scouted for talent among the blind to form a theatre association.

He found six talented people who are today members of his Khomanani Theatre Association. This was just the beginning in Mthoba's ambition to form an umbrella cultural body for the blind.

Objective

It was only through cultural activities, drama, music and dance that the disabled and the able bodied could find a common ground, said Mthoba.

"My main objective is to give the blind a mouthpiece to voice their feelings and fears and at the same time, stimulate their creativity while they make a living," said Mthoba.

Khomanani was launched in 1987 after it had already performed its debut play *Mehlondini* (Bloody Eyes) at the Market Theatre and at the University of Cape Town.

Cassettes

Mthoba, a married father of three, stays up until the early hours recording the script for his actors on cassettes.

"I could not afford to have it typed in braille so I decided to tape the cassettes myself," he explained.

"Sometimes it can be very frustrating. When I, for instance, coughed because I had flu, the actor would also cough at that particular instance at the next rehearsal."

Currently, Khomanani is rehearsing their second play, a love story titled *Lavisa*.

"This will be a deciding play for us," said Mthoba. "If it takes off well, we will be half way through our main objective to start a cultural club for the blind."

Mthoba has to divide his time between his full-time job as a drama teacher at Fuba, his other community work as a co-ordinator of field workers at the Market Theatre Laboratory, Khomanani and his family.

Farms

But his involvement with the blind is not his first voluntary attempt to popularise theatre.

In 1975 he worked with six other people to take theatre to the *bundus*. Isingqi, as the group was known, staged a number of successful plays in remote farms and in the ghettos.

"My plan was to train this group to be able to perform for the blind and then to train them in sign language so that they would play for the mute," he said.

"But I soon abandoned that idea and decided to let the blind and the mute 'speak' for themselves. I am currently taking sign language lessons preparing to workshop a sign language drama."

Mthoba, however, admits that his working with the blind is to a certain extent a self-indulgence and helps him to ease his shame at the way sighted people treat the blind.

"On a number of occasions I have been shamed by friends who would address a blind person through another person," he explained.

"Sighted people treat the disabled as stupid and that is not always the case."

James Mthoba - uplifting the blind.

Hospital bills 'doctored'

299

City Press 1/9/91

By SOPHIE TEMA

PATIENTS are being swindled out of thousands of rands every year by unscrupulous hospital clerks, some of whom have been pocketing about R3 000 in a fortnight.

This was revealed during investigations by hospital officials following reports of swindles in some hospitals on the Reef and in the Vaal Triangle.

Recently some patients have been taken to court for not paying hospital bills they know nothing about.

City Press sources said the swindling was most rife at Sebokeng Hospital and has been going on for about four years. This has been brought to the attention of the hospital authorities.

Superintendent Anne van der Spuy this week confirmed that allegations were being investigated and that so far only two hospital employees had been taken to court.

Admission clerks are known to have falsified records and receipts and changed the amounts paid or owed. Other methods are also used.

Most victims are the aged, people who cannot read or write and migratory workers.

Medical taxation slammed

THE introduction of VAT on health services means that black people are being taxed for suffering from diseases that are caused by the political deprivations, a doctor has said.

Dr Aaron Motsoaledi, vice-chairman of the Northern Transvaal region of the ANC, was addressing a fundraising dinner of the organisation on Saturday night and told the gathering that 80 percent of black people were not on medical aid, while 80 percent of whites were.

Unfair

"This means that 80 percent of the entire nation is not on medical aid and are therefore going to be taxed each time they go to a doctor or to hospital.

By MATHATHA TSEDU

"When we look at the diseases that black people suffer from, you find that they are tuberculosis, cholera and kwashiokor.

"All these are related to the lack of clean water and food.

Hospital

"The responsibility to provide purified water is with the Government but many areas in the rural areas have no water at all, let alone clean water.

"These are the people who get sick and are going to be taxed for being ill due to the deprivation by Government," Motsoaledi said.

"It is all so unfair," he said, adding: "We are fighting against this but who will help us?"

Masa: VAT not breaking rules

299

Star 6/9/91

By Carina le Grange
Medical Reporter

The collection of VAT from patients would not be in contravention of rules of the South African Medical and Dental Council (SAMDC) which state that a doctor may not share his fee with any person who had not taken part in the services, the Medical Association of South Africa (Masa) said yesterday.

In a letter published in The Star yesterday, Dr S Flax of Malvern said he believed that any medical practitioner charging VAT for services, and then sharing the fee with the Minister of Finance, would be contravening SAMDC rules.

Sharing fees

He referred to a Government notice referring to rules specifying "acts or omissions in respect of which the council may take disciplinary steps" which included "sharing fees".

Dr Flax said that from this it was clear to him that Minister Barend du Plessis was ordering him to act unethically.

Masa secretary-general Dr Hendrik Hanekom said it fully supported the principle that VAT should not be collected on medical services, and that it identified and had empathy with doctors who had difficulty with the principle of collecting VAT from patients.

Masa could not, however, not "support the argument that this would amount to unethical behaviour".

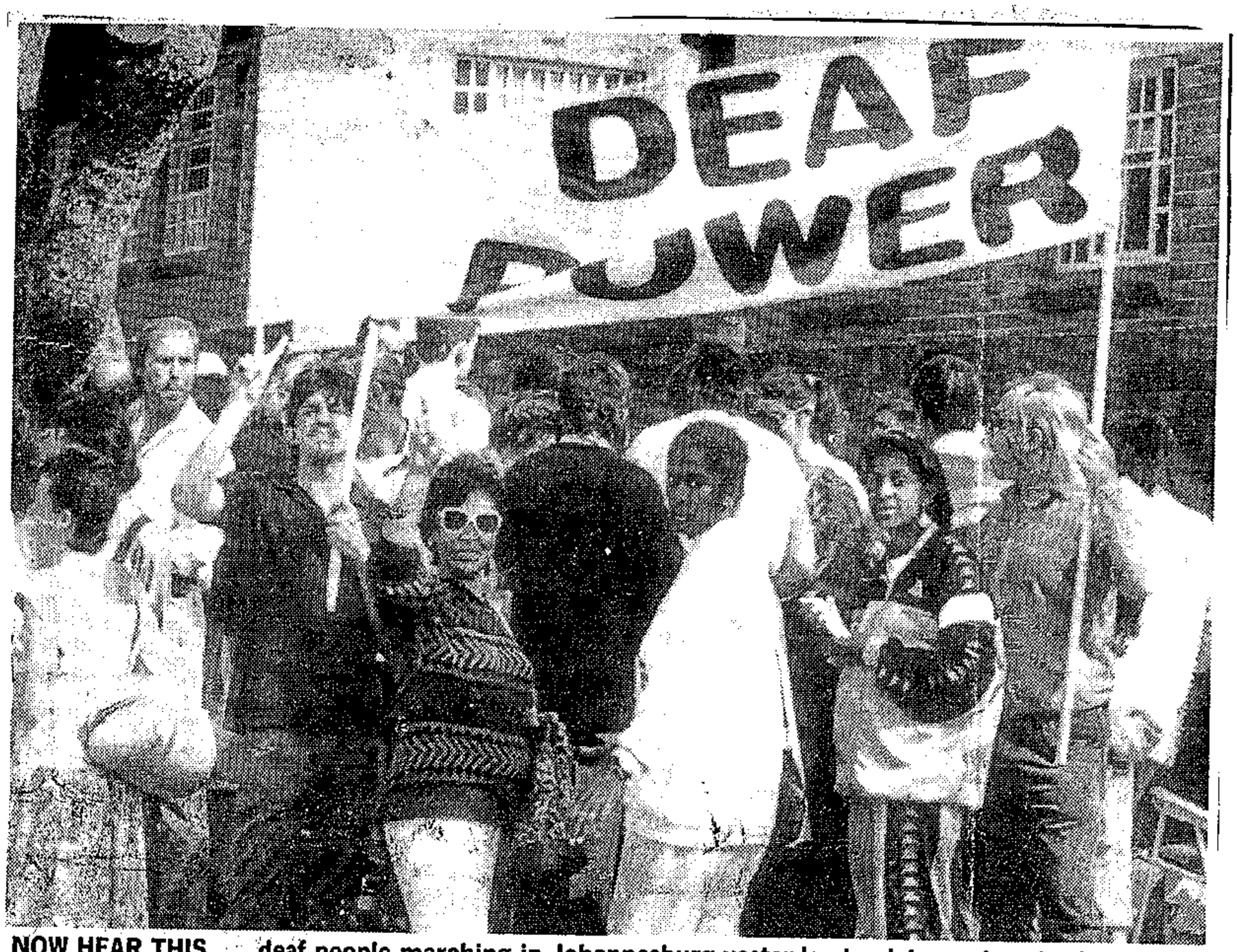
"Doctors are not sharing fees; they are adding value on to their fees in terms of the provisions of the Value Added Tax Act, and collecting this on behalf of the Receiver of Revenue ... VAT is viewed in terms of the Act as an amount over and above the fee charged for services rendered," Dr Hanekom said.

It would not be illegal or unethical, the body said.

National Medical and Dental Association national director Dr David Green said Namda agreed with the sentiments regarding the ethics of taxing medical services and that it believed there were strong moral arguments against it.

"However, the legal situation ... is complex and relatively contentious. Can VAT on a doctor's bill be construed as part of the fee?" Dr Green asked.

The Department of National Health, the SAMDC and Namda are expected to respond to the issue today.



NOW HEAR THIS . . . deaf people marching in Johannesburg yesterday to claim a place in the new SA

200 deaf on march for rights

By LAURIE DAVIDS

THE silent minority made themselves heard at an enthusiastic and cheerful march yesterday.

About 200 deaf people staked their claim to a place in the new South Africa in Johannesburg, saying they were being denied basic rights that hearing people take for granted.

"In the past we were like a dog. We had a wagging tail, but no hands to help ourselves," said Deaf Equality Awareness Foundation committee member Stephen Venter.

"We held the march to build a bridge between hearing people and the deaf."

DEAF committee member Kirsty Fraser complained: "In this new SA they tell us we will be fully multiracial, recognising the ethnic and cultural rights of all people. We will be multilingual, accommodating the needs of all majority and minority languages.

"Deaf people are still denied the right to their own language, signing," she said.

Apartheid 'still rules health care'

By Michael Chester Star 10/9/91

Big business warned the Government yesterday that health care problems had reached crisis levels and urged sweeping action to abolish stubborn remnants of apartheid in medical services.

The South African Chamber of Business (Sacob) disclosed it was seeking urgent talks with National Health Minister Dr Rina Venter over the crisis.

Studies by a special social affairs committee showed that racial segregation was still encountered in the hospitals, despite Government assurances that apartheid had been abolished by public sector health services.

A special report released at a news conference in Johannesburg said Government statements had left too many loopholes to ensure real integration.

It claimed most superintendents at provincial hospitals still refused to desegregate wards, using the excuse that they still awaited written instructions.

It urged the creation of a single central department of health that guaranteed equal treatment for all.

"Much of the blame for the health care crisis in South Africa must be placed squarely at the door of the Government and the Department of Health," said the report.

Dr Mike Baker, one of the authors, issued a warning that medical aid costs were set to increase by at least 25 percent this year.

"Vested interests are fighting to maintain a status quo," he said. "It will take courage to press ahead with changes."

and entrenched.

'Merge health ministries'

TANIA LEVY

SA CANNOT afford to double its health spending to give all races the kind of private health care enjoyed by whites, Sacob says in a new position paper.

Sacob's personnel practices and social policy committee lays blame for much of the health crisis "squarely" at government's door.

It calls for the merging of health ministries.

It adds that the response of the public and private sectors to the health crisis has been disappointing.

The National Health Department seems intent on privatisation, while the private sector has looked after its own economic interests, it says.

The paper says government is interested in health privatisation for the wrong reasons: unburdening itself of rising costs and transferring them to the private sector and individuals.

Privatisation of provincial hospitals would further increase the cost of hospital care and lead to a decline in its quality and availability.

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Call for single body on health

Own Correspondent

JOHANNESBURG. — South Africa cannot afford to double its health spending to give all races the kind of private health care enjoyed by whites, the SA Chamber of Business says in a new position paper.

Sacob's personnel practices and social policy committee lays blame for much of the health crisis "squarely at the door of the government and the National Health Department".

The paper, which has been forwarded to Minister of National Health Dr Rina Venter, says the different health ministries should urgently be disbanded and merged into a single health department.

It adds that the response of the public and private sectors to the health crisis has been disappointing.

Wrong reasons

The National Health Department seems intent on privatisation, while the private sector has looked after its own economic interests, it says.

The government, the paper says, is interested in health privatisation for the wrong reasons — to unburden itself of escalating costs and transfer them to the private sector and individuals.

But privatisation on a wide scale would further increase the cost of hospital care and lead to a decline in its quality and availability.

About 80% of the population depends on public-sector health provision, the paper says.

Only about 6% of the black population belongs to a private medical aid, compared to about 70% of whites.

VAT and doctors

PATIENTS can expect to pay 8% more for doctors' services, and not 10% when VAT comes into effect, the Medical Association of SA said yesterday.

Masa said in a statement the 8% adjustment was arrived at by taking into account that portion of medical practice already subject to GST and other in-put costs which would be reclaimable from the Receiver of Revenue.

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PRIEST IN
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Doctors' fees up 8 percent next month

Doctors' fees are expected to go up by 8 percent with the introduction of VAT on October 1, the Medical Association of South Africa said yesterday.

Federal council chairman Dr Bernard Mandell said Masa had carefully weighed the real impact of VAT on medical practice with a view to minimising actual cost increases.

"The adjustment of 8 percent was arrived at by taking into account that portion of medical practice that was already subject to GST and other input costs which would be reclaimable from the Receiver of Revenue," he said.

Masa was perturbed that all medical services had not been zero-rated and was disappointed and concerned that the relief passed on to patients of the public health service had not also been passed on to patients in the private sector.

"We have warned the Government that many poorer patients who are at present being treated in the private sector will not be able to cope with the additional cost. This will inevitably increase the burden on State health services," he said.

Star 12/9/91
THE STAR
VAT
WATCH

Medical aid schemes now losing members

JOHANNESBURG. — The South African medical aid system had become over-priced and increasingly unaffordable, the managing director of Medaid Administrators, Mr Jeff Slome, said yesterday.

He told the Institute of Marketing Management that during the period 1989-1991, medical aid contributions of whites, coloured people and Asians increased by over 36% while salaries had risen just under 15%.

299 CT 12/9/91

"For blacks the situation was even worse: Their medical aid fees shot up by over 43% compared to a salary hike of only 15,6%," said Mr Slome.

For the first time in South Africa, lower-income group members were withdrawing from schemes.

● Patients can expect to pay eight percent more for doctors' services, and not 10%, when VAT comes into effect on September 30, the Medical Association of South Africa said yesterday.

Medaid pharmacies could slash muti cost

299

51 Times Bus

By IAN ROBINSON 15/9/91

MEDICINE prices could drop by as much as 36% if medical aid schemes had the right to run pharmacies.

This emerges from figures supplied to Business Times by Transmed, Transnet's medaid scheme. Transmed is one of the few allowed to run pharmacies.

It found that this year the average cost of an ethical medicine dispensed to its members by retail pharmacies came to R43,80 compared with R27,80 for the identical one provided by its pharmacies.

A Transmed spokesman stresses that the R27,80 covers all overheads and the two figures are directly comparable.

John Cowlin, director of medaid administrator Medicaid, calls for changes in the Pharmacy Act to allow all schemes to operate pharmacies.

The retail-protective legislation is reinforced by ethical rules of the Pharmacy Council that forbid pharmacists from being employed by anyone other than pharmacists. This prevents non-pharmacist managers of medaid schemes from employing them.

Dr Cowlin says: "Enormous savings could be achieved if medical-aid schemes were permitted to employ pharmacists.

"Medical-aid schemes are struggling to keep costs down. The highly regulated pharmaceutical industry contributes to achieving the opposite."

A total of R1,6-billion is spent annually by medaid schemes on medicines. Pharmaceuticals are the largest single cost for medaid, accounting for about 28% of bills. 15/9/91

Dr Cowlin says the collusive and restrictive pharmaceutical practices contribute to the crisis in health care.

His view is shared by a Competition Board report on pharmaceuticals in July. It criticises the industry and says that "this investigation is the latest in a series of investigations that have been conducted over the years involving participants in an industry, certain sectors of which, with a few notable exceptions, have at best been lukewarm in their adherence to the basic tenets of a free-market economy".

Pharmaceutical Society of South Africa (PSSA) executive director Boet van der Merwe says he would welcome an independent investi-

☐ To Page 3

Medicines

From Page 1

gation.

The PSSA opposes granting the right to medaid schemes to dispense medicines because it would close many retail pharmacies and severely restrict the availability of their services.

Mr Van der Merwe says pharmacies are already being put out of business because more doctors are being allowed to dispense medicines.

One reason for the rising share of medicine as a proportion of total medical costs is that medication is being used increasingly as a substitute for hospital care and surgery.

Medical aids to change rules to curb increases

(299) CT 20/9/91

Staff Reporter

A NUMBER of medical aid schemes are changing their rules, reducing prescribed medicines benefits and limiting visits to doctors, in a bid to reduce imminent increases in contributions.

This emerged yesterday when the principal officer of Medscheme, a company which administers 38 medical aid schemes, confirmed that Premier Medical Plan is to reduce medicines benefits from 100% to 80% and limit the amount of consultations per annum to between 20 and 60, depending on family size.

Mr Keith Hollis said many schemes would have to raise their fees by between 20 and 30% before the end of the year.

Reasons for the increases include rising costs, an "abnormally high" number of claims this year and the introduction of VAT on October 1.

The intention of curbs such as those accepted by Premier would be to limit the proposed increases to about 10%.

Although he said could not comment fully on the introduction of such limits, "many" schemes were implementing them.

"This is not out of the ordinary as far as I'm concerned," he said.

The executive director of the Representative Association of Medical Schemes (RAMS), Mr Rob Speedie, said last night that it was up to individual medical aid schemes to change their rules to allow such measures.

It was not the responsibility of RAMS to prescribe rules to schemes, Mr Speedie said.

Medical aid: Higher subs or fewer benefits?

(299)
CT 21/9/91

Staff Reporter

MANY medical aid schemes were faced with a stark choice between raising members' subscriptions or cutting back on their benefits, the Registrar of Medical Aid Schemes, Mr Ellis Langeveld, said yesterday.

Speaking from Pretoria, Mr Langeveld said he had noticed a tendency on the part of scheme administrators to resist subscription increases in consideration for their members. In many cases, members would prefer to have their benefits cut.

"I cannot say how many of the 198 schemes registered in terms of the Act are in this situation."

Those medical aids which fell under the Medical Schemes Act were entitled to change their rules as long as they did not contravene the minimum levels of service set out in the Act.

He said there were six prescribed services: Medical, surgical, dental, physiotherapy, hospitalisation, and prescribed medicines. For each of these, a medical scheme must provide its members with benefits to the value of at least R100.

Beyond that, benefits offered depended on the subscriptions members were prepared to pay.

Doctors reject VAT on health

Star 23/9/91

299

De Klerk urged to debate issue on TV

By Paula Fray
Consumer Reporter

On the eve of a massive anti-VAT summit today, more than 300 angry doctors yesterday resolved to resist VAT on medical services and prescription medicines if the Government refused to zero-rate them.

One of the possible strategies the doctors put forward was to refuse to collect VAT on their services or pay the tax for those services to the Government — a proposal they will put to the Cosatu-led Co-ordinating Committee on VAT summit in Johannesburg today.

The summit, comprising representatives from 93 organisations, is meeting to formulate a plan of action against VAT, which comes into effect at midnight on Sunday.

The Dispensing Family Practitioners' Association (DFPA) meeting at the Jan Smuts Holiday Inn also called on State President de Klerk to debate openly on prime time television the morality of introducing VAT on medical services and prescription medicines.

He appealed to Finance Minister Barend du Plessis to rescind his decision. "The Minister has erred and he must change," he said.

Western Cape chairman of the (DFPA), Dr R Rapiti, said New Zealand was the only other country to apply VAT on health.

"Tax on health care is an act of sheer financial desperation," said Dr Rapiti.

He predicted that VAT on medical services would lead to mass resignations from medical aid societies, the filling of overcrowded State hospitals and the demise of more medical aid societies.

"We are not opposed to VAT, we are just saying the way it is being implemented is not good," Dr Rapiti said.

He said VAT could mean an extra R5 to the average patient for a consultation and up to R6 000 extra for a major operation.

The association also called on the Medical Association of SA, the National Medical and Dental Association and other medical bodies to support their stand.

In his opening address, Dr Joe Maelane said doctors rejected "the serious blunder made by so-called VAT experts" who included health in the VAT net.

● Most people still puzzled, angry — Page 2.

Health care was there to sustain, prolong and increase the quality of life, he said, adding that medicines such as insulin were a matter of "life and death".

The Minister, he said, refused to debate on the morality of taxing health care as he had no argument.

Speaking on behalf of the Cosatu-led Co-ordinating Committee on Vat, National Medical and Dental Assocation representative Dr David Green was applauded when he proposed that doctors boycott VAT.

Later it was unanimously resolved to call on Mr du Plessis to zero-rate medical services and prescription medicines or face a VAT revolt by doctors.

The doctors also decided to call on the public not to pay VAT on medicines and medical treatment, and to ask medical aid schemes not to pay the extra 8 percent as a result of VAT. Should medical aid schemes pay the VAT, it should be put into a trust fund.

The doctor's meeting followed a final plea from the Housewives League of South Africa for the zero-rating of medical services.

League President Lyn Morris said the league welcomed the exemption of State hospitals from VAT, but felt "those forced to use private hospitals and clinics will see little benefit".

The league also appealed for prescription drugs to be zero-rated — or at least, for life-supporting drugs such as insulin to be zero-rated.

The league pointed out that consumers should see a slight reduction in the cost of medicines from October when the tax dropped by 3 percent.

Visitors to check on apartheid

TWO physicians have arrived in South Africa to examine the extent to which apartheid still exists in healthcare in South Africa.

The two, Dr Tony Waterston of Britain and Dr Gilles de Wildt of Holland, were sent here by the British-based Physicians for Human Rights and the Dutch Foundation for Health and Human Rights.

Their visit follows an announcement in May 1990 by Health Minister Dr Rina Venter that people of all races would have access to health services.

Sowetan 24/9/91

Discussions

The two doctors will go to various hospitals, clinics and private doctors around the country as well as have discussions with the National Medical and Dental Association, Government officials and other medical associations, said a Namda statement.

They will then compile a report and hand these to their respective organisations and government bodies in their countries.

The two doctors are scheduled to leave South Africa at the beginning of October. — *Sapa.*

HEALTH

'Discrimination against the deaf still abundant'

Argus 25/9/91 ARG (299)

VIVIEN HORLER, Medical Reporter

THE Minister of Health, Dr Rina Venter, has called for a campaign of action to change people's attitudes to the deaf.

"Through the ages deafness was equated with muteness and mental retardation. Today we know better. Yet discrimination against the deaf is still abundant," said the minister at the biennial council meeting of the National Council for the Deaf in Worcester yesterday.

Deafness is the most common disability in South Africa, affecting 10 percent of the population and in 30 percent of cases the cause is not known. Forty percent of cases are caused by illnesses and infections, mainly during pregnancy, infancy or early childhood. The other 30 percent of cases are genetic in origin.

Dr Rina Venter

The single biggest problem faced by the deaf, said Dr Venter, was their limited ability to communicate with the hearing world.

"Their primary hearing problem therefore leads to a language problem which in turn can lead to emotional, social, cognitive, speech and educational problems."

It was during the first five years that a hearing child learned the basics of its mother tongue and began to grasp concepts. "The success of this has enormous implications for the child's future development in all spheres.

"But what happens to the deaf child? Do we give the deaf child enough attention?"

Dr Venter said the second major problem facing the deaf was the attitude of hearing people towards them. Discrimination was common.

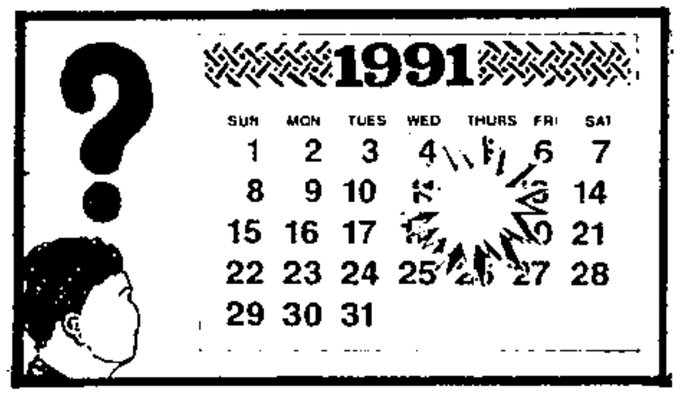
"For instance, there is an absence of qualified sign-language interpreters, an avoidance of discussions, a turning away while talking, an absence of visual alarms in public places, discrimination in the provision of jobs, salary limits, limited promotion and lack of facilities for higher education.

"Why is this? Is this not entirely due to our own ignorance?

"A massive and concentrated public education action is needed to change the attitudes in society."

Dr Venter said she believed hearing people could not speak for the deaf and praised the council for acting as a channel of communication between the deaf and the government.

CURRENT ISSUES



Disability Rights

(299)
11/10 – 17/10/91
New Nation (Learning Nation)

International statistics confirm that over 500 million people in the world are disabled. This means one out of every ten people are disabled.

The World Programme of Action Concerning Disabled People was adopted by the United Nations General Assembly on 3 December 1982, marking the start of the Decade of Disabled People, 1983-1992.

World Programme of Action

The objectives of the World Programme of Action are: 'To promote effective measures for prevention of disability, rehabilitation and the realisation of the goals of "full participation" of disabled persons in social life and development and of "equality". This means opportunities equal to those of the whole population and an equal share in the improvement in living conditions resulting from social and economic development.'

The Disabled People's International

The driving force behind the World Programme of Action is the Disabled

In South Africa, just as in many other countries, disabled people have for a long time occupied an inferior position in society. Their interests, needs and concerns were never considered as a serious matter. They have generally been categorised as "welfare people", who deserve to be confined to institutions for the poor, who cannot occupy any significant position in society and whose survival essentially depends on charity. But disabled people have the birthright to exist in the societies in which they find themselves. They also have as much of a contribution to make as anyone else. A truly democratic society should respect and take seriously the needs of all of its people. Attitudes towards the rights of the disabled are just one marker of a civilized society.

Since its inception in 1986, this committee has achieved very little, if anything at all, for the disabled people of this country, in spite of the claim that its membership was carefully selected from the available experts. Maybe, then, it is time to recognise that disabled people themselves are the only real experts on matters affecting their own needs and concerns. This would involve recognising that disabled people, just like other people, should be given the opportunity of participating in decision-making that will affect them.

Bill of Rights and a Charter for the Disabled

Liaison between the DPSA and the ANC leadership has led to the inclusion of an Article on Disability Rights in the proposed Bill of Rights by the ANC. To give more effect to this development, the DPSA decided in 1990 to draft a charter of Demands of Disabled People.

This year, a massive programme of developing this charter has taken root. This will involve the process of wide consultation with disabled people and the holding of workshops and seminars aimed at educatin them about their ri hts and

headquarters in Stockholm, Sweden. This organisation was formed in June 1980 by delegates from 40 different countries attending the World Congress of Rehabilitation International in Winnipeg, Canada.

The DPI membership is constituted by the national assemblies of disabled people in the various countries. These national assemblies in turn are constituted by organisations of disabled people. In South Africa, for instance, the national assembly is called the DPSA (Disabled People South Africa).

There are regional structures as well, for instance in the southern African region, there is SAFOD (Southern Africa Federation of the Disabled), which has its secretariat in Bulawayo, Zimbabwe.

It is clear from the above outline how united disabled people are and how universal the disability rights movement is. This is because disabled people throughout the world take their rights very seriously and have embarked upon a struggle for equality and freedom.

Many people in S.A. become disbabled in acts of political violence

Efforts made by the SA government

In South Africa, several efforts have been made by the Nationalist government, although largely unsuccessful, to uphold and promote disability rights.

In 1982, the South African Cabinet Committee for Social Affairs instructed a working committee to establish guidelines for the implementation of a welfare policy. In December 1985, a draft policy document was issued to welfare organisations, which in effect was aimed at extending racial discrimination into the field of welfare care and removing much of the burden of welfare care from government shoulders onto those of private organisations. These propositions were rejected by welfare organisations. In 1986, which was declared by government to be the Year of Disabled People, an inter-departmental committee, which was mainly constituted by representatives from the 18 departments, welfare organisations and councils and a few representatives of disabled people, was formed "to conduct an enquiry into the circumstances of disabled people in the Republic of South Africa, evaluate existing services, formulate an overhead policy for disabled care and devise suitable strategies."

inviting them to put forward their demands which will constitute the substance of the charter.

The significance of this charter is that it is intended to form the basis of any future government policy and legislation which affects the lives of disabled people. Later in the year a seminar will be held, at which the charter will be drafted and then, possibly by the beginning of next year, a national conference will be held, at which the draft charter will be presented for adoption.

Disability is a national issue

Disability is not just a political issue. It is also a national, and in fact a global, issue. It cuts across political, ideological, religious and gender boundaries. Any person at any time may become disabled. It could be as a result of a road accident, a disease, poverty or, most painfully, what has become common in our country today, violence and war. Shouldn't disability therefore be a concern to everybody?

For more information, write to: The Director,Socio-economics Unit,c/o Lawyers for Human rights,P.O. Box 5156, Johannesburg, 2000.

An example of disability rights legislation

In 1990, the United States Congress passed an act called Americans with Disabilities Act, which prohibits discrimination against individuals with disabilities in private sector employment, all public services, public accommodation, transportation and tele-communications.

According to this statute, an employer may not refuse to hire a disabled person merely because of his/her disability, if that person is qualified to do the work. The employer is also required to make all the necessary and reasonable adjustments in order to accommodate the disabled person, and when a disabled person applies for a job, he may not be questioned about his ability to perform functions which are not strictly job-related. On the issue of public transport, the act requires that new vehicles bought by public authorities be accessible to disabled passengers, for example those who use wheelchairs.

Examples of disability issues

- Public toilets should be made more accessible to wheelchair users.
- Buildings should be made more accessible through the construction of ramps.
- Blind people should be able to use lifts without having to wait for someone else to assist them.

More health care people should be trained in sign language to help the deaf and dumb - imagine a person who can neither speak nor hear, who is critically ill and confronted with a doctor who cannot use or understand the sign language!!

Med aids blamed for doctor row

299
AMG 12/10/91

DI CAELERS
Weekend Argus Reporter

LOW fees paid by medical aid societies have been blamed for the continuing war between pharmacists and dispensing doctors.

The renewed row follows reports that dispensing was becoming a lucrative sideline for doctors whose "rewards" from pharmaceutical distributors included free trips, TV sets and videos.

Pharmacists, who have been labelled the "innocent casualties" in the battle, say medical aids are destroying the medical service.

It is claimed that they do not pay doctors what they deserve — and the manufacturers fuel the fire by offering better price structures to dispensing doctors than to pharmacists.

Mr Gus Ferguson, director of the Cape-Western Province branch of the Pharmaceutical Society of South Africa, has expressed concern over the patient's position in this chain.

He said automatic control over pharmacists existed simply because they did not choose what they dispensed.

"Doctors are in an awkward retail position ethically. Generally speaking they dispense primarily with profit as a motive.

"And certain pharmaceutical companies are using unorthodox promotional methods to get doctors to dispense their medicines."

Financial statistics had revealed that increases in doctors' rates had not kept pace with inflation.

Doctors were therefore dispensing medicines for purely economic reasons and "not because they hate the pharmicists".

"The perks offered are obviously very tempting for these people who enter a career like medicine expecting it to be a lucrative one," Mr Ferguson said.

Mr Billy Bannatyne, national president of the South African Association of Retail Pharmacists, said he believed doctors had reacted to the pressure put on them by medical aids and their established tariffs, and had looked for other sources of income.

"Medical aids are the problem and I think pharmacists and doctors are in fact co-victims in this very bleak picture."

He said medical aids were orchestrating health care and its future in South Africa.

A major overhaul was necessary "looking to a future which sees maximum use being made of the people and resources we already have.

"If we want health care to work, our suppliers of the health care service (such as doctors, nurses, and medical aids) must work in unison."

Fish Hoek pharmacist Mr John Frylinck echoed this position.

"Dispensing doctors are here to stay. The only real alternative I see is that of group practices where doctors, pharmacists and nursing sisters set up a single practice and operate together," he said.

"That way, instead of fighting each other, we provide a better service which sees the consumer benefiting most."

Mr Frylinck said competition between doctors and pharmacists was unhealthy and created a situation in which the consumer was the ultimate loser.

Pharmacists were in a bad position. "We can't be competitive in the market when our major opposition is dispensing doctors, and with the situation as it stands, what we need first and foremost is a single exit price on medicines from the manufacturers," he said.

A Mowbray pharmacist, who did not wish to be named, said although he believed doctors were poorly compensated by medical aids for their responsibilities, he could not condone them dispensing certain medicines in return for economic bonuses.

Doctors within a 5km radius of a pharmaceutical service should not be allowed to sell medicine, he said. "Doctors are creating a monopoly at the expense of the patient and the pharmaceutical service."

Mr Bannatyne explained that America's national association for retail druggists had succeeded in getting doctors to dispense medicines only in emergencies.

"And they achieved that purely on the principle that it is not in the best interests of the public for the person who diagnoses and prescribes, to supply the medicine too. I think that's the only principle that matters," he said.

Said a Hout Bay pharmacist: "Any good doctor shouldn't have time to be dispensing which deviates from his main line of business.

"That's when you get a sausage machine situation where doctors churn out patients and spend less time on diagnosing because they need to leave time at the end of the appointment to do the dispensing."

Cuban health system for SA?

(45) (299) CP News 13/10/91

By THEMBA KHUMALO

SOUTH Africa should follow the Cuban health system as one of the best alternatives to our fast-deteriorating health services, suggests a document handed to Cosatu.

The document on the inequalities in the health services provided for various communities was first circulated two months ago at the Cosatu conference by health service researcher Gopolang Sekobe. However, there was no time to discuss the proposal.

Sekobe is highly critical of the privatisation of health institutions and says this system consumes 50 percent of total health financing while only caring for 20 percent of the population.

In Cuba, ordinary people are involved at every level in the health service, through committees for the defence of the revolution, women's movements and trade unions.

Community organisations work with professionals to meet set health objectives. The system is financed by the State, but administered locally.

This system leaves the practitioners free to treat patients as they see fit, without the drive of a "fee for a service".

This often results in lower rates of surgery with the same outcome for the same conditions compared to other countries.

In the alternative scheme proposed for South Africa, employers would contribute a percentage of annual turnover to a tax for national health.

Industries producing health risk items such as cigarettes and alcohol must pay a double tax.

These levies would be used to fund research on safer material, work activities and machinery.

Medical, hospital costs set to rise

Sowetan 15/10/91. (299)

THE Representative Association of Medical Schemes yesterday announced an average 16 percent increase in its 1992 scales of benefits for doctors and dentists as well as for private hospitals and day clinics.

The increases - which take effect from January 1 1992, - come on the back of an eight percent hike granted by Rams on September 30 to compensate for the effects of VAT.

Other practitioners - such as psychologists and physiotherapists - get a straight 15 percent across the board.

The increases for private hospitals and day clinics average out at about 16 percent. At the top end of the scale in this sector is a 33 percent rise for intensive care units.

SAPA

"The heavy costs of specialist (mainly imported) equipment, combined with the salary levels of highly skilled nursing staff, have placed a great deal of pressure on intensive care units in the past year - and it was clearly necessary for their needs to be addressed," Rams executive director Mr Rob Speedie said in a statement.

Although the average 16 percent increase for 1992 is more or less in line with inflation, Rams says it is gravely concerned that the total payout next year could go up by well over 20 percent because of persistent overutilisation/ overprovision of health care products and services.

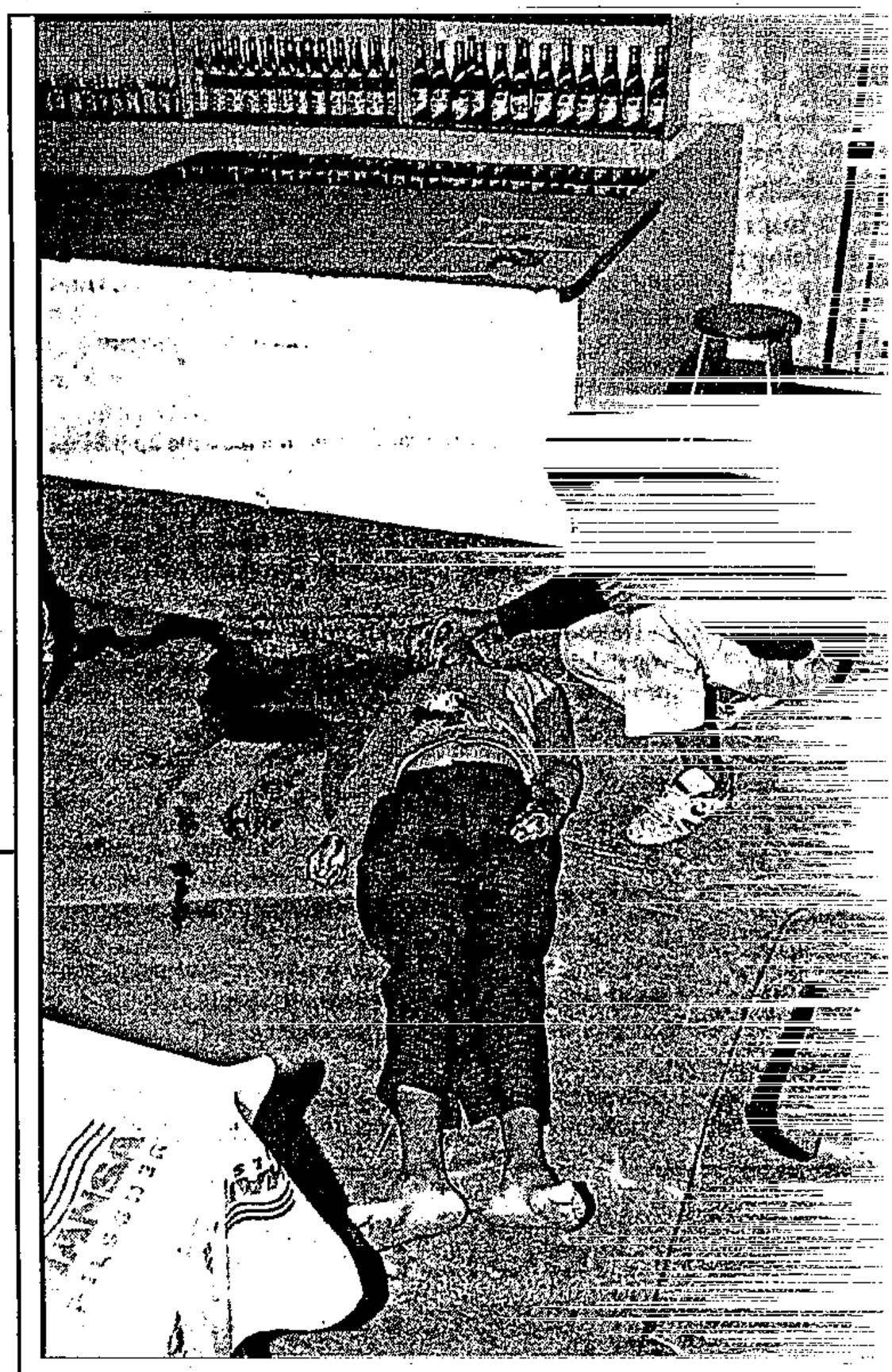
"Rams figures show that this is certainly proving to be the case for the current year - so much so that some medical schemes had to implement interim increases," said Speedie.

"For the man in the street, private health care is becoming increasingly unaffordable with the passing of each year," Speedie added.

To illustrate the point, he said medical schemes will probably pay out an average of R275 a member each month for health care services in 1992, compared with R220 this year and R98 only four years ago in 1987.

"The unfortunate result of spiralling consumption will be an inevitable limitation on, or reduction in, the benefits granted by medical schemes as they strive to contain increases in their subscription rates."

Speedie noted that the cost of health care will rise by more than R1 billion to reach R7,6 billion in 1992.



A man inspects the body of a woman, one of the 10 people killed on night when an armed gang opened fire on people at the Tswe... Lounge in Mapetla, Soweto. PIC: LEN ...

Top union official ambushed, shot

Sowetan 15/10/91. (278)

A TOP official of the National Council of Trade Unions was shot and injured in an ambush near Tokoza on the East Rand at the weekend.

Mr Boaz Mashele (45), national treasurer, was hit in the private parts when two armed men opened fire on him.

He is being treated at Natalspruit Hospital.

A hospital spokesman could; however, not comment on his condition.

East Rand police spokesman Captain Ida van Zwieel said yesterday the incident had not been reported to the police.

A union spokesman said Mashele was attacked when he stopped to inspect damage to his car after another vehicle had hit his from behind.

"The assailants from the car which had hit him from behind opened fire, hitting him in the private parts," union spokesman Mr Cunningham Ngcukana said.

The union has blamed the attack on the "agents of apartheid".

"We believe that the attack was perpetrated by agents of apartheid who are opposed to freedom and democracy," a statement released by the union said.

PROTEA PARK

People 'terrified' of illness as medical costs rocket

Star 15/10/91

299

Staff Reporter

People "are terrified" of getting ill because of soaring medical bills, Housewives' League president Lynne Morris said today.

She was reacting to the Representative Association of Medical Schemes (RAMS) announcement yesterday of an average 16 percent increase in its 1992 scales of benefits for doctors, dentists, private hospitals and day clinics.

Mrs Morris said people "cannot afford to get ill any more".

RAMS has forecast that the cost of private health care will rise by more than R1 billion to at least R7,6 billion in 1992 — chiefly because South Africans over-utilise services.

Total

And if this over-utilisation continues, the total bill could pass R8 billion, says executive director Rob Speedie.

As a result, medical aid subscriptions may go up by, on average, as much as 25 percent in the first quarter.

The scale-of-benefit increases come after an 8 percent rise on September 30 to compensate for VAT.

Some other practitioners will receive 15 percent.

At the top of the scale is a 33 percent rise for intensive care units.

"For the man in the street, private health care is becoming increasingly unaffordable with the passing of each year," Mr Speedie said.

To illustrate the point, he said medical schemes would probably pay out an average of R275 per member a month for services next year, compared with R98 in 1987.

Medical aid costs 'set for 25% hike'

DAVE LOURENS

THE Representative Association of Medical Schemes (Rams) yesterday announced an average 16% increase in its 1992 scales of benefits for doctors, dentists, private hospitals and day clinics, hard on the heels of September's VAT-related 8% increase.

The latest increases come into effect on January 1 1992.

But medical aid subscriptions could rise by 25% or more, said Rams executive director Rob Speedie.

Increases would depend on the individual schemes. Their expenditure was affected by two factors: the cost of providing a service and the frequency with which it was used.

Speedie said while the 16% hike was more or less in line with inflation, a national consumption spree was causing persistent overuse of health care products and services.

"There has been a massive escalation in the consumption of services over the past few years. We need a managed health care system to exercise some form of control on the supply side," said Speedie.

He predicted the cost of private health care in SA would rise by more than R1bn to at least R7,6bn in 1992.

If overuse of health care services continued at the current rate, the total bill for next year could break through the R8bn mark.

As recently as 1987 the total payout by the private sector was well under R4bn.

"For the man in the street, private health care is becoming increasingly unaffordable with the passing of each year," said Speedie. He predicted medical aid schemes would probably pay out an average of R275 a member a month in 1992, compared with R220 this year and R98 in 1987.

"The unfortunate result of spiralling consumption will be an inevitable limitation on or reduction of benefits granted by medical schemes as they strive to contain increases in their subscription rates."

GERALD REILLY reports that the Medical Association of SA (Masa) is alarmed at the fast-rising costs of health care and has called for a concerted effort to slow the spiral.

Masa sources said the increase would intensify financial pressure being felt by most medical aid schemes.

Meanwhile Masa secretary-general Hendrik Hanekom said Masa would continue to fight for the exemption of all medical services from VAT.

The 16% adjustment from January was an annual one intended to compensate for inflation only, he said.

An indiscriminate use of services appeared to be a major factor in the health care costs spiral.

"Unless all providers, users and insurers of health services make a concerted effort to contain costs the future of private health care will be in jeopardy."

Hanekom said Masa saw a need for a structured review of the entire health care system with accessibility and affordability the main criteria.

Masa therefore welcomed the conference soon to be held on amendments to the Medical Schemes Act.

INSURANCE

Disability benefits not simply 'a lucky windfall'

Star 16/10/91. (299)

The very real threat of becoming disabled is the basis of the need for a lump sum disability benefit.

Interestingly enough, as an addition to a basic policy the benefit does not offer extra cover at all but rather extends the scope of the cover.

The cover, usually only payable on death, is extended to cover you if you are totally and permanently disabled.

Thus the benefit is often referred to as an acceleration of the death benefit.

The assumption is that the individual's need for cash in the event of total and permanent disablement is so great that it warrants payment of the full value of the life policy.

Life assurance benefits are then cancelled.

The definition of total and permanent disability varies from policy to policy but is usually related to the inability of the person insured to continue earning a living.

The disability should also be of a permanent nature, not just affecting employment for a few months or a couple of years.

More recently it has become possible to include the disability benefit on only a part of the total sum assured.

The result is that, when disability occurs, only a portion of the death benefit is accelerated and paid out immediately.

The balance of the life cover continues to be in force to ensure a further payout in the event of death.

Peter Atkinson, Fellow of the Institute of Life and Pensions Advisers.

● Man visits doctor 29 times in month ● Fees set to soar

Huge medical aid abuse

Star 16/10/91 (299)

By Paula Fray
Consumer Reporter

A wild spending spree in the private health sector is depleting medical aid reserves and pushing up fees, medical groups said yesterday.

In one case, a patient saw his doctor 29 times in a month, and in another a family of four consulted their doctor 256 times in a year — an average of 64 visits each.

Medical aid schemes have also recorded over-prescribing of medicines.

Urgent solutions are being sought to clamp down on this over-utilisation of private health care as fears mount that more and more patients will flood the already overburdened State hospitals.

"Over-utilisation of services is a widespread and very serious problem," said National Medical and Dental Association (Namda) spokesman Dr David Green.

"Of the R17 billion spent on health services, 55 percent went to the public health sector which provides services for 80 percent of the population. Nearly half, the remaining 45 percent, is spent on the 20 percent in the private sector," he said.

In announcing an average 16 percent increase for scales-of-benefit fees, Representative Association of Medical Schemes (Rams) executive director Rob Speedy predicted that if over-utilisation continued, the schemes' total bill for next year could pass the R8 billion mark.

Medical Association of SA secretary-general Dr Hendrik Hanekom said indiscriminate use of services appeared to be a major factor in the cost-spiral.

Dr Green said Namda has investigated several options, including a national health insurance (NHI) scheme, to make health care more accessible to the public.

Under the NHI system, all employers, employees and the State would contribute to a national fund. "This insurance scheme would ensure a basic package of health care for everyone."

At present, he added, the payment for services was an incentive to oversupply these services. Under the NHI, doctors would be paid a reasonable rate on the number of patients they looked after rather than the number of services they provided.

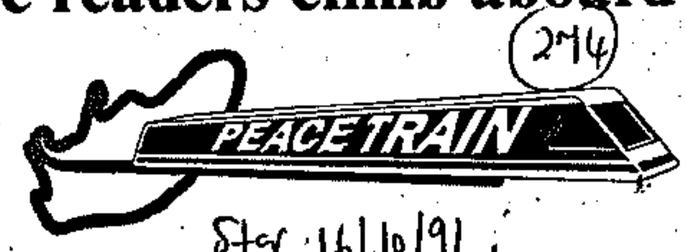
Rams said monthly payouts by the private sector averaged R98 per member a month in 1987. This year, medical aids could pay an average of R220 a month — and R275 a month next year.

● People 'afraid of illness' — Page 11

Fighting pollution . . . members of the Wits Medical Commando, led by Captain Karin Nelson, step in to clean the ailing Mondeor Spruit south of Johannesburg yesterday.
Picture: Ken Oosterbroek

Enthusiastic readers climb aboard

Political Staff



Star 16/10/91 (294)

The Peace Train will not be short of passengers, judging by the immediate response to yesterday's launch of The Star's campaign for peace.

From the AWB man who said he was "going to chuck away his gun and try to do something more positive", to the township organisations which welcomed the opportunity to tell the media that good, as well as bad, things were happening in their areas, callers to The Star put across a common message.

They hoped the Peace Train would be "booked out", and would prompt many similar initiatives involving ordinary people in the quest for peace — instead of just the top-echelon politicians.

"I think you should make the delegates at the Commonwealth conference in Harare — as well as President de Klerk and his Government — read these stories about the positive side of what is happening," said a caller who identified himself as a "ware Afrikaner" from the northern Transvaal.

"Then maybe they'll realise what a wonderful effect it can have on the country if they sound like they have the same dream, instead of swearing at each other. I think we're all ready for a bit of optimism."

A reader from Atteridgeville said she hadn't been "sure what ordinary people could do about the bloodshed" until she heard of the recent "citizen's arrest" of alleged train-killers. "Now I know we can stop all this."

Sylvester Thahane, secretary for finance and projects of the northern Free State branch of the ANC Youth League, said the Peace Train was an initiative that needed the support of the youth throughout the country.

"Although our area has not experienced the same level of violence as the Transvaal and Natal, we suspect that efforts are being made to set hostel residents up against each other in our areas.

"This has to be stopped and we believe The Star's initiative can help us do that," said Mr Thahane.

A caller who identified himself as Mr Dwyer said money needed to be raised to pay people to hand in weapons such as AK-47s. He said he had been told that the police had offered up to R6 000 for people to hand in such weapons.

Jan Lister, a school principal, said The Star's initiative was long overdue and she hoped political leaders from across the spectrum would get together and engage in something positive to create an atmosphere of peace.

"Talking across tables often just results in hot air, but if people work together on something it creates a bonding," she said.

● More reports and Peace Pledge — Pages 2, 5

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People now 'afraid of illness'

Star 16/10/91.

By Paula Fray (299)

The 16 percent adjustment in medical schemes scale of benefits for 1992 was in line with a Medical Association of South Africa (Masa) recommendation of a 15 percent increase in its guideline fees for doctors, secretary-general Dr Hendrik Hanekom said yesterday.

However, the increase in the cost of health care has once again brought the issue of VAT on the private health sector under the spotlight — after an 8 percent VAT-related increase last month.

Dr Hanekom said Masa continued to be extremely concerned about the alarming rate at which health care costs were increasing.

"This has been exacerbated by the introduction of VAT on medical services, to which Masa strongly objects, and against which it will continue to make representations."

The increases announced this week come into effect in January and are intended to provide for inflation.

In announcing the average increase of 16 percent in scale of benefits for doctors, dentists, private hospitals and clinics, the Representative Association of Medical Schemes (Rams) said medical-aid subscriptions could go up by, on average, as much as 25 percent next year.

"For the man in the street, private health care is becoming increasingly unaffordable with the passing of each year," said Rams executive director Rob Speedie.

National Medical and Dental Association (Namda) spokesman Dr David Green said his organisation was "very concerned about the increased cost for the patient".

"Namda is worried about the effect this would have on health services," he said. "A 25 percent increase in subscriptions would be devastating for a significant number of people who rely on private health care."

The organisation — represented on the Co-ordinating Committee on VAT which is fighting for a zero-rating of medicines and medical services — predicted that an increase in medical services as a result of the new tax would drive 5 percent of the population from the private into the already overburdened public sector.

"This will obviously be much higher now," he said.

Housewives League president Lyn Morris said the escalating medical aid costs were getting beyond the average person.

"I think people are frightened of getting ill. Some people are past that point already."

She believed people would begin considering leaving medical aids and joining the public health sector.

Mrs Morris expressed concern that employers — particularly small businessmen — would now find subsidising employees' medical funds a burden.

Over 2-million are almost deaf

Sowetan 17/10/91 (299)

DID you know that in South Africa about two million people have difficulty hearing?

This week I talk about hearing problems in adults.

Q: What are the causes of hearing problems in adults?

A: Loud noise is the biggest cause of hearing loss. Hearing is more likely to be damaged if a person listens to the noise for a long time.

Q: How could that happen?"

A: This could happen when people:

- Work with loud machines, such as in the mines;
- Live in areas where there is a lot of noise, such as in the city;
- Listen to loud music a lot, like in a disco; and
- Who use earphones to listen to music.

Q: How could the damage be prevented?

A: People who work with loud machines must wear ear protection. If the employer does not provide it the worker has a right under the law to demand either a quieter workplace or ear protection.

- There is a law which stops people making a lot of noise in public places. We must make sure this law is used.
- Young people should not listen to very loud music.
- Earphones should not be used to listen to music.

It is important that hearing problems are prevented because no one can give you your hearing back.

Q: Some old people have hearing problems.

A: Yes. As you get older your hearing often gets worse, especially for high sounds. In some old people it is so bad that they can't understand when someone speaks. Old people are more likely to have problems if they have had a lot of loud noise when they were younger.

Q: Is there anything that adults can do to make their hearing better?

A: Hearing problems cannot usually be cured but hearing aids can help the person. You can find out about this from your local hospital or doctor.

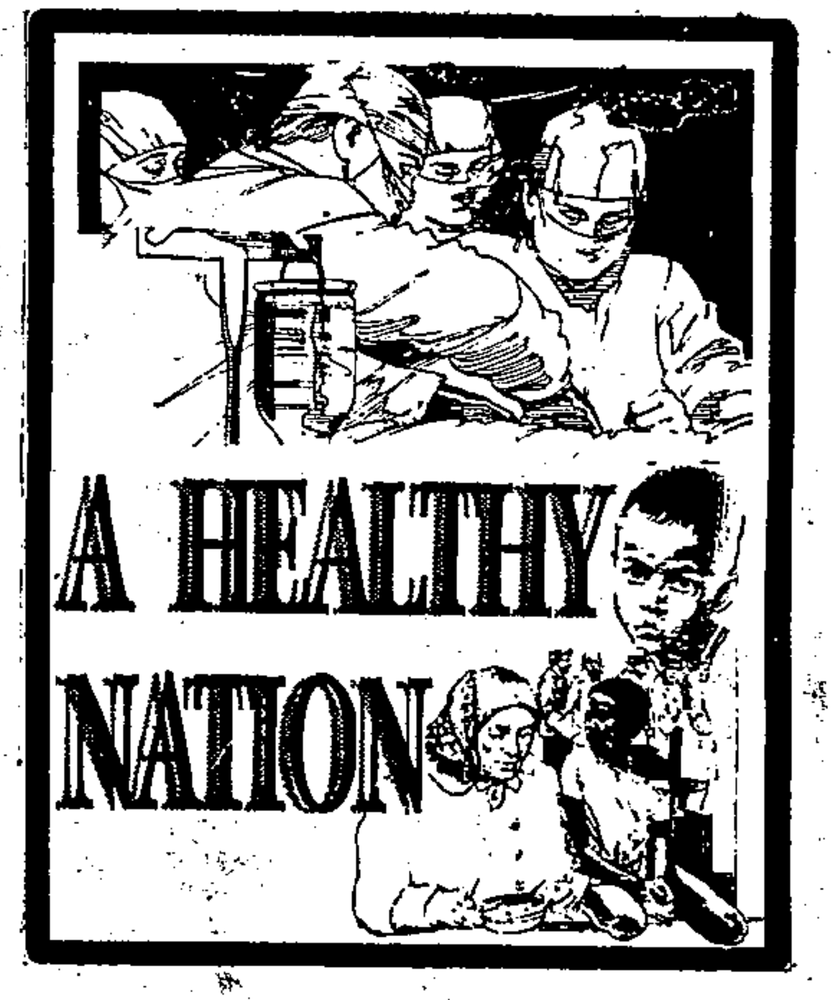
Q: What are the most important things to remember?

A: Try not to listen to loud music.

- There is a law against loud noise at work and in the community. We must make sure this law is used.
- Preventing deafness is easier than treating it.

Here are some other useful things to know about ears.

- Do not use ear buds. They can damage the ear. If you want to clean the ear put a few drops of olive oil from the chemist in before you go to bed at night for about four days. The wax will then come out by itself.
- If a baby is having a bottle of milk it should not lie on its back because the milk can go into the ears and cause problems.



For more information write to: The National Council for the Deaf
Eugenia Mthemba,
P/Bag X04,
Westhoven, 2142
or phone (011) 482-1610.

End of an era as Cowley House changes its role

HOME-COMING: Joseph Mkhuhlwa, Anderson Ncivata and the late Zamuxolo Nojoko celebrate at Cowley House.

PIC: MIKE HUTCHINGS

South (Southside) 17/10-23/10/91 297

With only three political prisoners left in the Western Cape, Cowley House — a haven for prisoners and their families — must find a new role. REHANA ROSSOUW reports:

A CAPE TOWN POLITICAL landmark, Cowley House, has served its time. The building in Chapel Street has ended its role as a haven for political prisoners and their families since 1979.

But the Woodstock house which provided comfort, shelter and a tranquil base for a sensitive reintroduction into society of South Africa's political prisoners will continue to play an important role.

Staff are considering using Cowley House to assist with the rehabilitation of handicapped returning exiles and former political prisoners and victims of state violence.

Rivonia trialist and former Robben Island prisoner Mr Raymond Mhlaba, a member of the ANC's National Executive Committee, said it was with a "tinge of sadness" that the end of the project was marked.

"But this sadness is overshadowed by the joy I feel knowing a new project is being born. Cowley House is addressing the needs of the time."

Speaking at a party held at Cowley House in Chapel Street last Friday, Mhlaba said the way in which Cowley House had cared for prisoners and those fortunate to have relatives visit them was "engraved on the hearts" of many.

Cowley House staff assisted with his marriage — one of the first to take place behind bars.

"After the ceremony at Pollsmoor, my wife, Didika, came to Cowley House."

He said hundreds remembered and thanked the Cowley House staff for their loyal and selfless support for prisoners.

"Those of us who have been imprisoned know how it feels behind bars," he said.

"The general feeling of a prisoner when receiving a letter, a visitor or even having a warder open a door, is comfort.

"That is why people who do something for those behind bars, like the people at Cowley House, have made a tremendous contribution."

Mhlaba said Cowley House had contributed to the political struggle of the people in the region, although few people knew this.

They had also assisted Namibians held on Robben Island — people now running their own country, he said.

Cowley House staff said the three political prisoners in the Western Cape — Phyllis Fante, Johnson Lubisi and Litha Mlahleki — were welcome to use their facilities.

● *These photographs are from an exhibition, launched at Cowley House on Friday, portraying the release of prisoners since February last year.*

DEFIANCE: Women demonstrators cut through the harbour fence and chained themselves to the Susann Kruger ferry.

PIC: SALLY SHORKEND

JUBILATION: Phumlani Ngqungwana sails to freedom on March 21 1991 after serving two years on Robben Island.

PIC: SALLY SHORKEND

SWEET TASTE OF FREEDOM: Released prisoners help each other unload their belongings — packed in apple boxes — from the ferry at the Cape Town docks.

PIC: MIKE HUTCHINGS

Armscor medical benefits cut after R9m loss

KRYGMED, Armscor's medical aid scheme, lost more than R9m between January and July this year, resulting in the amendment of rules and the cutting of some benefits previously covered, according to confidential Krygmed circulars.

Armscor employees — angered at the changes — said yesterday Krygmed management did not adequately consult them; they were simply told of the changes to the scheme at a meeting two weeks ago.

Krygmed manager Johan Janse van Rensburg yesterday refused to comment on the deficit, or to say whether Krygmed had consulted members' representatives

LINDEN BIRNS

on the changes or simply informed members of them.

Andrew Levy & Associates labour relations consultant Johan Scheepers said Krygmed and Armscor "could be on thin ice" in terms of labour relations practice if a unilateral decision to change the rules had been taken. It was "prehistoric" to change contractual conditions without some form of collective bargaining, though there might have been "grounds for the changes based on the deficit".

Circulars — of which Business Day has obtained copies — were sent to Atlas Aircraft Corporation, an Armscor subsidiary, outlining the new Krygmed medical aid scheme rules. The circulars said contributions would be increased from "10% to a maximum 15% of the declared regular income of members".

Some new rules came into effect at the beginning of this month. These included new annual limits on the number of times members may visit general practitioners, excluding hospital visits, and the scrapping of contraceptive benefits.

Krygmed adopted the new measures after realising it could not increase members' contributions by the 133% needed to recoup the deficit.

FACTS FROM THE LATEST HOUSEHOLD SPENDING SURVEY

Consumers spending more on medical care

(299) ARG 19/10/91

DEREK TOMMEY
Weekend Argus Correspondent

JOHANNESBURG. — South Africans are spending almost twice as much as they did five years ago on medical care and less than half of what they did on domestic servants.

These are two of the main facts to emerge from the 1990 survey of consumer spending conducted by the Human Sciences Research Council for the new up-dated consumer price index.

Although full details of the survey have yet to be published, enough preliminary information was available to enable Central Statistical Services to base the September 1991 CPI on the HSRC findings.

The new CPI index (Base: 1990 equals 100) reflects, as far as the statisticians are able to determine, the spending pattern of the average South African.

However, before too much is read into the changes in the spending patterns, it should be pointed that the average South African has also changed.

Today he is a little more white and a little more black than he was five years ago and less coloured and Asian.

According to the new CPI weights, spending by the lower income group (mainly blacks) now accounts for 19,42 percent of total spending, compared with 18,73 percent five years ago.

The higher income group (mainly whites) accounts for 56,5 percent, against 53,93 in 1985, while the middle income group's (mainly coloured and Asians) share has dropped from 27,35 percent to 24,09 percent.

'The average South African has also changed. Today he is a little more white and a little more black than he was five years ago and less coloured and Asian.'

Reasons for these changes will have to await the full HSRC report, but one can surmise that it probably mainly reflects the increase in the number of blacks who now have incomes and also some improvement in real terms in white wages and salaries since 1985.

Perhaps the most spectacular finding of the new survey was that the "average" South African now spends about 5,2 percent of his income on medical and health care, which is more than double the 2,56 percent five years ago.

However, this may not be entirely the result of increased medical costs, but could also reflect the growing number of blacks who belong to medical aid schemes.

A similar consideration also applies to a 33,6 percent increase in expenditure on fuel and power. In 1985 this accounted for 2,44 percent of total spending, today it accounts for 3,26 percent.

It is true that the cost of electricity and coal has risen considerably in the past five years, but at the same time far more blacks now have access to electricity than in 1985.

This also helps to explain the 36,5 percent increase in spending on appliances, as the spread of electrification would also increase demand for these items.

Household spending on eduation also took off, rising 45,5 percent. But at 1,76 percent of the total spending, it is still relatively small.

Another major increase in spending is on what is termed "other" services. These include holidays, insurance and also eating out. In 1985 these services absorbed 6,77 percent of the average South African's income. They now account for some 9,49 percent — an increase of 40 percent.

At the other end of the scale, the proportion of family expenditure going on domestic servants dropped from 1,84 percent to 0,83 percent — a decline of 54,9 percent.

Again, this doesn't mean domestic servants are earning less, rather that more families are coping without them.

Perhaps this is tied up with the fact that expenditure on unprocessed foods dropped 40,9 percent from 11,75 percent to 7,0 percent of total income. Which in turn could help to account for the 44 percent drop in expenditure on "other" foods, which includes spices and condiments, from 2,49 percent to 1,38 percent of income.

However, total expenditure on food also declined, by 18 percent from 22,7 percent to 18,6 percent of total income.

The proportion of the income of people in the lower income group going on food dropped sharply, from 35,3 percent to 25,2 percent of total income — a normal development when income increases.

Middle income spending on food dropped from 26,9 percent to 20,9 percent of income while spending by the higher income group dropped only slightly from 16,26 percent to 15,45 percent of income.

Coca-Cola and other soft-drink manufacturers should be delighted with the news that spending on non-alcoholic beverages has risen 30,2 percent from 0,53 percent to 0,69 percent of total spending.

At the same time temperance societies will welcome the 25,6 percent decline from 1,29 percent to 0,96 percent in the proportion of income going on alcoholic beverages (though researchers warn of a possible "lie" factor here.

Health fundis are likely to be be unhappy with the news that spending on tobacco has risen from 1,02 percent to 1,21 percent of income — an increase of 18,6 percent.

The survey found that the percentage of income spent on vehicles was little changed, probably reflecting the longer time which people keep their cars. Interestingly, car running costs were lower than five years ago. Which raises the question are they making better cars these days, or are people not using their cars for holidays?

Towards a healthy S Africa

A new health policy is on the cards reports HEATHER ROBERTSON.

South (Southside) 9/10-16/10/91 (299)

South Africa's current health care system is infected with two of the most chronic social diseases — apartheid and privatisation. But many in the medical professions argue both are curable and preventable in the long term by a new health policy geared towards primary health care in an equitable national health program.

Progressive doctors and health care workers in organisations like the National Medical and Dental Association (Namda), South African Health Workers Congress (Sahwco), Primary People's Health Care (PPHC) and the ANC's Health Department are rallying together to remedy the situation with health policy alternatives. The establishment next year of a unified non-governmental health body, the National Progressive Primary Health Care Network, will be well placed to shape a new health system.

Various commissions on health policy have been set up by the ANC to investigate policy alternatives headed by some of the country's top doctors and health care professionals.

Krish Valabhjee, President of Sahwco, cautions that, despite these plans, the prospects of attaining the World Health Organisation goal of "health for all" by 2000 are not realistic.

"We should be alert to the fact that such unrealistic slogans raise expectations among the general population which may yet be the undoing of a democratic government."

In a paper presented in Progress journal he argues that the major challenge is economic, specifically the question of how to establish national priorties which balance the limited available resources with the enormous developmental backlog.

'Most people in squatter

ships suffer diseases of deprivation while many wealthy white and black people who have access to private care suffer from diseases of excess like heart diseases and lung cancer.'

There is broad agreement in the progressive health sector that the ultimate objective is a National Health Service that is:

- centrally planned
- decentralised to allow for community control
- built around comprehensive primary health care
- holistic with a developmental approach as opposed to the state's current curative service-oriented approach.

This would mean a single national health department should be established as opposed to the redundant 14 departments of health.

Dr Kamy Chetty, who heads the ANC's commission into a national health policy, argues health care should be seen in relation to housing, employment and education.

She cites the high infant mortality amongst black children as an indication of the extent of the current problem.

"The white infant mortality rate in 1987, according to the Cape Town city council, was five deaths for every 1 000 live births. The Coloured rate was 16 deaths for every 1 000 live births and the African rate was 30 deaths for 1 000 live births. "

"The infant mortality reflects socio-economic conditions where preventable diseases like measles and gastro-enteritis are still the primary cause of deaths," says Dr Chetty.

"Most people in squatter areas and black townships suffer diseases of deprivation while many wealthy white and black people who have access to private care suffer from diseases of excess like heart diseases and lung cancer."

Whereas previously the health care system was fragmented between race groups, at present there is still fragmentation between 14 health departments, curative service provincial hospitals and preventative service clinics.

"We still have an apartheid health system because white people generally have access to hospitals and private doctors while black people still don't have access," says Dr Chetty.

While South Africa has sufficient hospital beds, there is a drastic need for community clinics, she argues. According to the World Health Organisation there should be one clinic for every 10 000 patients.

In the Free State there are 27 000 blacks and 6 000 whites for every clinic. In the Cape there are 11 000 blacks and 6 000 whites for every clinic.

A doctor on the South African Medical and Dental Council concurs with the ANC. "We do not have a shortage of doctors. We have a maldistribution of doctors and all health professionals who invariably work in the metropolitan areas to the exclusion of the rural areas."

"The emphasis is all wrong. It should be on primary health care. However, despite the fact that we are a predominantly third world country, we have seen an ever-increasing trend towards high-tech medicine.

He cites as an example the fact that there are more magnetic resonance image intensifier scanners (MRI scanners), which cost close to R2-million, in Johannesburg than in the whole of Australia. There are also more in South Africa (14) than in the whole of the UK."

"What is more, all except one of these are in private practice and in a single private practice in Johannesburg there are three."

An MRI is a highly sophisticated machine used to pick up cancerous malignancies and lesions at an early stage. A scan costs R2 000.

Because the medical industry is geared towards expensive hi-tech operations and surgery, many small-town general practitioners attempt to make money by dispensing unnecessary medicine.

"Many dispensing doctors abuse their right to dispense simply because the patient does not have to pay himself. For example, one black doctor in the Transvaal dispensed some 11 items, including three duplicates of potentially harmful drugs for no other reason than that the patient was 'covered by Medical Aid'.

"Medical aid societies have intruded into the hitherto sacrosanct doctor patient relationship. The really scary thing is that our very medical priorities for our future medical educational needs are also being decided by these intruders.

"In a system like ours it has always been understood that the brightest students not only remain within academic medicine but in surgery."

As the medical aid tariff was originally decided between Rams (the Representative Association of Medical Aid Schemes) and Masa (Medical Association of South Africa), and as these top doctor officials were then and still are from the surgical disicplines, the tariff is riddled with anomalies. Surgical procedures are remunerated disproportionately to the time and skill involved. For example, if a doctor spends 45 minutes counselling a patient, he is paid R33,10 while if he lances a boil, which takes about six seconds, he is paid R41,40.

According to Dr Chetty the new Medical Schemes Act gives more power to the medical aid societies. The ANC is looking into national health and insurance systems with more checks and balances on how the health budget is spent.

But there is broad consensus, in keeping with the ANC's policy of a mixed economy, that there is scope for private medicine. An ANC government would, however, change the budgetary emphasis from spending on private medicine to focus on the development of a public health system which provides adequate health care facilities in the communities.

At present the government spends 46 percent of the total health budget on the private sector, which caters for 20 percent of the entire population. Fifty percent of South African physicians are in private practice.

Vallabjhee views this as another major obstacle to attaining an equitable health system.

While changing the health system is a major task, the reality is that a new government cannot start with a clean slate, but rather build on what exists.

The executive of the VAT Co-ordinating Committee at a press conference this week where anti-VAT demonstrations were announced. From left are Ian Herrington, Dr David Green, Bernie Fanaroff, Jay Naidoo, Ezrom Matambuye and Tito Mboweni.

VAT 'a nail in our coffins'

Comment by STAN MHLONGO, a diabetic

A SENSE of hopeless desperation came over me as I digested Finance Minister Barend du Plessis' statement that there was no way he would delay the implementation of VAT.

I am not into politics, but the Minister left me with no option but to join the queue of protesters.

You see, I am a type-2 diabetic, which makes me insulin-dependent.

By ignoring the calls to zero-rate medical services, the government seems to have signed the death warrant for me and thousands more all over the country who can barely afford medical costs as it is.

The Government's explanation that VAT has brought down taxation from 13 percent to 10 percent has brought us, the less healthy and the unemployed, further hardship.

To me (a diabetic person) and thousands of other people of poor health, VAT will certainly be the final nail in our coffins.

Health professionals to support VAT protests

Sowetan 30/9/91

299

THE SA Dispensing Practitioners have decided not to charge Vat for medical services and dispensed medicines, and to close all medical practices for one to two days to register protest.

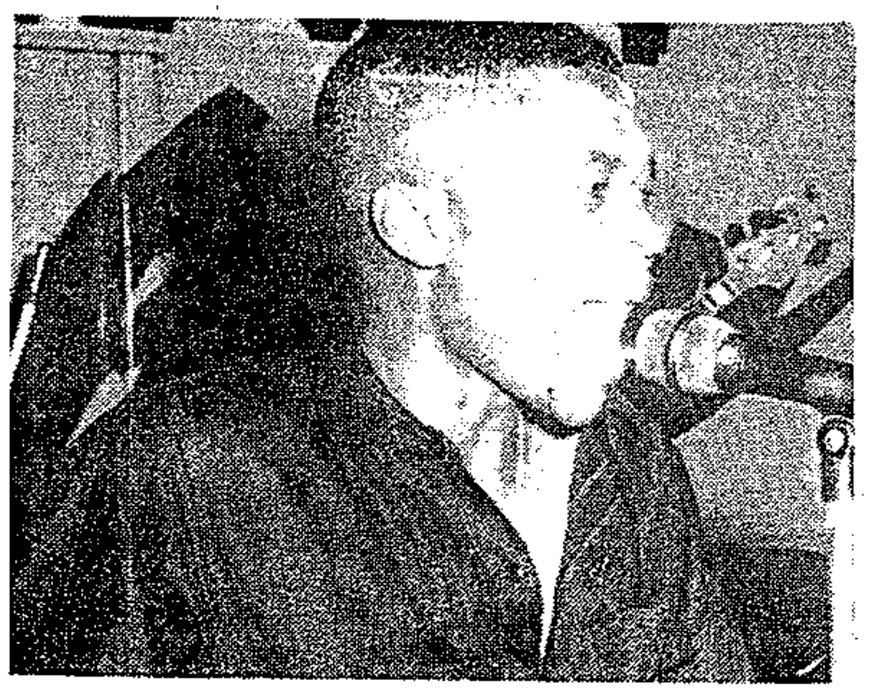
The chairman of the SADP, Dr P J Maelane, said his organisation had appealed at a meeting in Soweto to patients to use public services during the closure, and apologised for the inconvenience. He did not say when the planned closure would take place.

He said the SADP also resolved to ask all health professionals to support the campaign "in the public interest", as well as to appeal to medical aid societies association, Rams, and other independent medical schemes not to increase subscriptions because of Vat.

Campaign

Maelane said practices would display signs informing patients that they would not be collecting Vat.

"We also appeal to the SA Medical and Dental Council to support our campaign on moral and ethical grounds," he said. - *Sapa*



Kamazu. . . for Mamelodi on Saturday.

Sounds will aid deaf people

THE Northern Transvaal Association for the Deaf will benefit from a music festival taking place at Moretele Park in Mamelodi on Saturday.

Sowetan 30/9/91

By ELLIOT MAKHAYA

Mrs Arina de Witt, director of public relations, said the Northern Transvaal Association for the Deaf, as a welfare organisation, was dependent upon funds from the public to fulfil its much-needed functions.

The association is the mouthpiece for thousands of hearing-impaired people of all race groups who do not know where to get help.

"It is also our duty to see to these people's social problems, legal problems and educational facilities, since they do not know how to address these problems," said De Witt.

The music festival, which runs from noon until late, stars Chicco, Blondie, African Youth Band, Kamazu, Spank, Carlos Djedje, Lucky V, Vusi Shange, Captain Rastaman, Sister Jeanet, Peter Maringa and Sarel Hotstone.

Counting the costs

Star 1/10/91 Star (299)

Consumers could be persuaded to use health resources more sparingly, if proposed changes to the Medical Schemes Act lead to medical schemes not having to guarantee payment.

The South African medical aid system has become overpriced and unaffordable, says Jeff Slome, managing director of a firm of medical aid consultants.

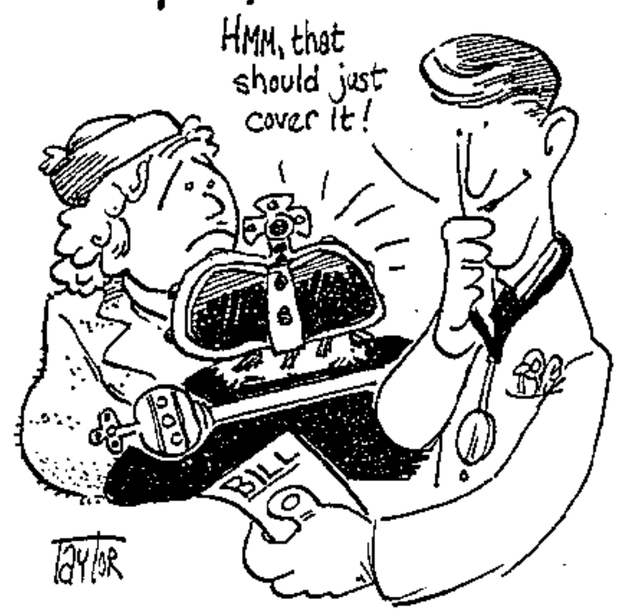
The medical aid contributions of white, Asian and coloured people have increased by more than 36 percent in the past two years while their salaries have risen by just under 15 percent. For blacks, the situation is even worse. Their medical aid fees have shot up by more than 43 percent compared with a salary hike of only 15,6 percent.

"The cost escalation is actually higher than the above figures because it does not allow for providers of medical services who have contracted out of medical aid.

"For the first time South Africa is seeing a withdrawal from medical aid from the lower income groups," says Mr Slome.

Discussing the future of health care in South Africa, Mr Slome said proposed changes to the Medical Schemes Act could lead to medical schemes not having to guarantee payment, which could ensure the consumer used health care resources more sparingly.

"Medical schemes could then reward cost-effective health care providers. The benefit to the patient will be ultimate low contributions.



The available resources could then be channelled into other areas such as major surgery or hospital admissions, where higher and more realistic benefits are needed," he says.

Members of medical aids could, under the proposed new Act, also purchase a level of benefit suited to the cost structure of the area in which they live.

"The big challenge for the future, however, lies with the middle- and lower-income sectors. Here expenditure will have to be funded by means of managed health care systems in the case of the employed and State funding for the poor."

Mr Slome suggests increased involvement by privately managed health care programmes could not only help the employed but also the jobless — "by means of pre-negotiated fees payable by the State for those members registered with the managed health care programmes".

He did not believe any new government in South Africa would enforce a national health service because of major impracticalities. A national health insurance system, administered by present medical aid organisations, seemed a more logical development.

"The advantage of such a system would be that the State would take control of the money in the system and redistribute the funds to those who are currently not provided for.

"The possible reluctance of medical practitioners to move to rural areas could jeopardise such a system. Furthermore, should the practitioners' remuneration prove inadequate, they could well leave the country and aggravate the current skills shortage," he warns.

Mr Slome feels equal health for all is still a pipe dream. He says the realisation of this ideal can be achieved only with full employment and rising income for all.

CAROLINE HURRY

Rich, poor face medical headache

299

Star 4/10/91

Consumer Reporter

The introduction of VAT on private medical services this week will mean between R5 more for minor services and R6 000 more for major operations, according to initial investigations by the medical industry.

Doctors working among poorer communities — particularly where State clinics are not readily available — are concerned about the effect of even a R5 increase on their patients.

SA Dispensing Practitioners chairman Dr Joe Maelane said patients would be hard hit by any rise. "In our areas this is a very serious problem as our patients can hardly raise the bus fare to get here. Even if we talk of only R5 we are making it (health) a very expensive commodity."

"Besides the escalating medical costs, you cannot draw a line in the health sector — health must be zero-rated," Dr Maelane said.

Doctors opposed to VAT are set to announce the date of a two-day mass closure of surgeries to protest against the decision.

National Medical and Dental Association (Namda) spokesman Dr David Green said the slight reduction in the cost of medicines and the introduction of VAT on medical services could mean an average increase of between 7 and 8 percent for costs.

Namda had estimated the VAT-related increases in service costs at R5 extra for stitching up a finger to R6 000 more for a major abdominal operation.

An estimated quarter of those seeking medical care in the private sector would be pushed into the public sector as a result of the increase in costs.

"About 5 percent of South Africans will move into the public health sector," said Dr Green.

VAT briefs

● Lists of new postal tariffs, which have been changed because of VAT, are available at post offices countrywide, despite a delay in their printing due to the drop in the VAT rate.

● Johannesburg Stock Exchange-listed computer services company ABS has announced an average drop of 5 percent in charges because of VAT. ABS Computer Centre director Connie Plokhooy said the VAT inputs, averaging 5 percent, that could be claimed were being passed on. "With heavy users, the savings are considerable."

Judgment opens the way for cheaper medicines

SOUTH AFRICANS can expect to pay less for prescription medicines following two landmark events says Kosie van Zyl, managing director of medicine distribution system broker Mediscor.

The first was a notice in the Government Gazette of August 9 by Minister of Economic Co-ordination Dr Dawie de Villiers which declared unlawful arrangements which seek to prevent pharmacists from giving discounts on the price of medicines, sold on prescription, to the members of any medical scheme.

The second was a judgement by Mr Justice R Hattingh last month which rejected an application to forbid certain pharmacies from advertising their discounts.

"Since the judgement we have been advertising discounts of a minimum of 22% in the press," says Mr Mr Van Zyl.

The Pharmarama group of pharmacies has also been advertising discounts — of 25% — on prescribed medicines since 23 September.

The Pharmacy Act of 1974 conferred the status of custodian of the ethics of the pharmaceutical profession on the Pharmacy Council. The council's advertising code permits pharmacists to make known their prices of prescribed medicines but specifically forbids reference to discounts on prescribed medicines.

In his judgement in Bloemfontein Judge Hattingh declared that the Pharmacy Council's advertising code was not legally binding because it was not approved by the minister nor was it published in the Government Gazette.

However the Pharmacy Council, a statutory body, still regards its ethical rules and advertising code as binding pending a decision by its executive committee.

Daan Naude, registrar of the council, said the council had taken cognisance of the Hattingh judgement. It was studying the precise implications of this judgement and had taken legal advice.

Medical aid schemes have welcomed this judgement. Executive director of the Representative Association of Medical Schemes (RAMS) Rob Speedie described the judgement as "a great step forward towards the application of free market principles which will hopefully lead to increased competition".

By IAN ROBINSON

Health care for all becomes everyone's concern

Journalists were taken on a joyride of a different kind recently. NOEL BRUYNS reports on Project Healthy Nation. South/Southside 9/10 - 16/10/91

IT COULD HAVE been a foolproof CCB abduction operation: 100 journalists who met after sundown at the Sandton Sun Hotel outside Johannesburg last week were whisked away in coaches with the windows totally blacked out.

"We can't tell you where you're being taken to," was all the anxious reporters were told as the coach cruised through the night.

Half an hour later, they disembarked and were herded straight into a nondescript building without being able to look around to establish where they were.

Inside, they entered a cavernous room with black drapes covering the walls entirely; there was not even a window to look through.

But the suspense was lightened when they were presented with champagne and orange juice, smoked salmon, oysters and other snacks, and a string quartet stroking out soothing classical music.

"Ladies and gentlemen, this is not your final destination," said a dapper young man in a tuxedo. "Please remain confused for a while longer, until you are taken to the final venue."

The final venue was reached by leaving the room through a tunnelled passage that, puzzlingly, led to what seemed to be a rural township, with dozens of African people milling about, apparently oblivious to the journalists.

There was a spaza shop, ululating women and dancing children on the stoep of a township shebeen, a man cutting another's hair on the side of a gravel road, and a rural health clinic.

Eventually, everything was explained. We were at a film studio on the Midrand set up as a rural village, with TV2/3 actors playing the "locals".

It was the scene for the launch of "Project Healthy Nation" initiated by the Department of National Health and Population Development, which had invited journalists to experience an example of where primary health care is most needed in South Africa.

The suspense in which the journalists had been kept the whole evening was an effective promotional ploy — all the more so considering that a government department was involved.

The Department's obvious efforts in organising "Project Healthy Nation" may be indicative of the seriousness with which it views the challenge of primary health care.

"Almost all countries in the world are working towards the goal of 'health for all by the year 2000'. The only way in which this goal can be reached is through primary health care," said the Department's director-general, Dr Coen Slabber.

"Project Healthy Nation" aims at increasingly involving the general public, welfare and community organisations, churches, the private sector and the media, in primary health care in order to increase everyone's basic knowledge of health care and skills.

"The Department still accepts full responsibility for the health of the South African population, but on a basic level it cannot cope alone," Slabber said.

Dr Paul Vorster, director of a communications agency commissioned by the Department of Health to promote the launch, explained the Department's approach with this example: If a farmer has a worker who falls ill, he should not have to take him to the nearest town for treatment, but should be able to have him treated with the primary health care facilities he has created on his farm for the workers.

Asked whether community organisations had been approached to endorse and support the project, Vorster said: "For the project to succeed and to ensure those who need primary health care in fact receive it, we need the support of all communities."

Several community leaders, including Dr Nthato Motlana of Soweto, have signed a "Health Pledge" to support the spread of primary health care.

The "Project Healthy Nation" launch was also marked by a new television commercial, drawing a parallel between the suffering and disease many South Africans face daily and the emotional "trauma" of a roller-coaster ride.

The commercial gives an address to which community leaders and leaders in organised commerce, industry and agriculture may write to encourage the spread of health-care knowledge through existing channels. ☐

DR NTHATO MOTLANA: Signing the "Health Pledge".

NP CAPE CONGRESS

Du Plessis defends VAT on medicine

B|Dan 9|10|91

STRAND — VAT on medical services was not a question of morality but one of practicality, Minister of Finance Barend du Plessis told the Cape National Party congress yesterday.

"We do not choose to be sick, but neither do we choose to be hungry. If we are really sick and cannot afford the costs, we can go to a state hospital, but where do we go to find food?

"I have never seen an official statement from a medical association when medical costs have risen by as much as 18%.

"That money goes into the doctor's pocket, but VAT goes to the state, and 40% of it is used for social upliftment.

"I've also never heard doctors, who are shareholders in private medical institutions, objecting when tariffs at those institutions have increased."

He said 80% of people receiving medical attention did so at the cost of the state.

There were two sources of tax — from the production side, and on consumption. GST taxed goods and only a few services, and this created major discrepancies because, as society became more sophisticated, its consumption extended beyond goods and into services.

The poor person paid GST on goods like candles and wood while the wealthier person paid no tax on electricity.

"Tax on services extends the tax base and makes it possible for the rate to come down," said Du Plessis.

Regarding the protest culture in townships of not paying for rentals or services, Du Plessis said it had to come to an end as it would mean the death-knell of investment in the townships.

He said the person who borrowed money to build a house and did not repay the loan, "shoots his neighbour in the foot, if not in the head".

"This business of non-paying in the townships, this protest culture, is the death-knell of investment in the townships. This whole culture must be broken," Du Plessis said. — Sapa.

Home nursing services are introduced

Sowetan 27/9/91

299

A HOME nursing services has finally been introduced into the townships.

Black families with severely disabled loved ones, who have had no one to look after them, will get relief in the service offered by the the Association for the Physically Disabled.

The Care Attendance Scheme, as it is called, has been started in Soweto and Alexandra with 28 disabled people and five attendants.

The attendants, all trained upon employment, visit the disabled at their homes and help them with routine chores they cannot carry out for themselves.

The attendants wash the disabled, offer them companionship when they feel lonely and run basic errands.

The service is offered on a frequency requested by the client and there is a minimal amount paid for the variety of duties.

Mr Kenneth Magane, senior attendant for the scheme, said the service was aimed at discouraging institutionalisation.

It was also meant to remove the secrecy that most black families put around disability, he said.

Magane said APD depended on hospitals and welfare organisations for referrals, but the number of people they were servicing was still not satisfactory.

He appealed for anyone who wanted to know more about the scheme to phone their office at (011) 646-8331.

Health care 'dependent on economy'

Star 27/9/91

Political Correspondent

President de Klerk has warned that South Africa will not be able to afford any dramatic adjustments in health spending for years to come and will have to cope with available resources.

Officially opening the new R166 million wing of the Groote Schuur Hospital, Mr de Klerk said health was a priority and would not be neglected, but the fact was that there were several areas of critical need, such as housing and education.

"Until we have strong growth in the economy based on sound economic policy and principles, we will simply have to cut our cloak according to the cloth," he told the gathering.

Mr de Klerk evaded a phalanx of protesters at the official opening of the new hospital wing, but was unconcerned about what he regarded as a reflection of the "growing pains" of the new South Africa.

As protesters voiced their opposition to the newly built wing at the main entrance, Mr de Klerk slipped in through a side entrance.

PRIMARY CARE AT THE HEART OF HEALTH NEEDS

H·E·A·L·T·H

Sowetan 25/9/91.

Fifty-two projects in the areas of health and rural and comunity development claimed R135,5 million in IDT funds up to July 31, 1991.

Another nearly R30 million was set aside for the welfare sector to encourage community services.

Spending in this IDT portfolio will rise to R514 million over the next two years. All told, the IDT's trustees will be asked to approve about R400 million for health, rural and community development, and about R120 million for welfare.

Making a major impact on people's basic health — especially in rural areas where the poorest live — means dealing with the development issues that affect it, says IDT trustee Dr Mamphela Ramphele, who designed the strategy with Professor Len Karlsson, who is now director of this portfolio.

The IDT has three major focuses. The first is on primary health care. This is aimed at bringing basic affordable health services and facilities to all the people, especially in rural areas where effective care has all but collapsed. Funding will go into:

- Properly coordinated training programmes for voluntary and community workers as well as doctors and nurses;
- Properly staffed and equipped health centres, clinics and visiting points, in which the community is involved from the outset;
- Water and sanitation. Without exception, communities have made drinkable water their highest priority;
- Electrification. Talks are being held with Eskom to push this part of the programme ahead;
- A major AIDS education and care programme that will run alongside the one started by the Department of National Health;
- A big drive to reduce TB in the Western Cape by 50% over the next three to four years.

The IDT's second major focus in this portfolio is on welfare. In a definite move away from old policies, the IDT will fund services that will allow voluntary workers, guided by professionals, to give care to the aged, to cancer patients, and to other people who get welfare, in their homes.

The third focus is on rural and community development. Here the main thrust will be to strengthen organisations throughout the country that are running good programmes, but which need a lot more money. These involve mainly agricultural and forestry projects, for example woodlots that will help slow down the rate at which forests in rural areas are being destroyed.

The IDT would like to see a single national health policy, and is helping bring together the 14 different departments of health and other major players.

Already, different organisations have started to work together in combined programmes.

The approach, says Dr Ramphele, "should enable us to move from a fragmented, inequitable health service, to one which takes care of the needs of everyone".

Prof Karlsson adds: "We're looking for partners from any side, with successful programmes going in these fields, that we can support."

YOU AND YOUR MONEY

FED up with your present medical aid scheme? Then shop around for a better deal.

You'll probably be surprised to find how many medical aid schemes there are on the market. 299

They are advertised in your local newspaper, specialist business publication, or in the bulletin of your local chamber of commerce or industry. Also look in the Yellow Pages, where more than 20 appear under the heading of medical aid consultants, medical aid schemes administrators, and medical aid societies.

As an example, a recently developed medical aid scheme provides incentives to control medical costs as an alternative to conventional 100 percent benefit schemes.

Economed has been attracting an average of 1 000 new members a month and now has more than 10 000 members.

Its swift growth shows it has been able to meet a growing demand from both individuals and companies for a scheme able to provide top benefits for less money.

"The scheme's success is that it provides incentives, not disincentives," says Mr Jeff Slome, managing director of Medicaid Administrators, which designed and developed the scheme. ST Times 20/10/91 (CM-Buss)

"It encourages members to be cost-conscious and to refrain from going to the doctor at the drop of a hat. In this way we have been able to reduce contributions without cutting back on the benefits offered by the scheme."

He explains: "With conventional approaches, contributions can only be lowered if scheme benefits are reduced.

"But Economed, structured as a 70-100% scheme, is able to maintain the level of benefits when members most need them.

"It does this by requiring a 30% co-payment from members for all medical services up to a set threshold value, after which it reverts to paying 100% of the scale of benefits."

Mr Slome adds that, in practice, this system provides an automatic no-claim bonus in that members immediately benefit from lower contributions, and if they don't claim at all or keep claims to a minimum, the money they have saved by paying a lower contribution remains in their pockets.

"The system works on an annual basis with members starting each calendar year with a clean slate.

"Once a member reaches the threshold value — which ranges from R600 for a single member to R2 000 for a married member with three or more dependants — the scheme accepts there is a health problem and it thereafter pays all medical costs at the full scale of benefits for the remainder of the year."

The scheme allows members to exercise some control over their medical costs.

There are other schemes on the market offering the same opportunity. Find them and compare the benefits.

'Elderly must provide for increased medical aid costs'

B(Pay 21/10/91 · LINDA ENSOR 299

CAPE TOWN — Sanlam has predicted that older people, particularly pensioners, will be paying far more for medical aid cover in future and need to take precautionary financial steps now.

Sanlam senior group benefits GM Walter Scheffler said subsidisation of older members of medical aid schemes by younger members would become a thing of the past when medical aid societies began introducing differentiated rates.

Speaking at an Institute of Life and Pension Advisors function at the weekend, Scheffler said: "I think it is very likely that this will happen because of the high cost spiral which will create an unwillingness among employers to continue paying high medical aid rates.

"Economic reality will dictate the introduction of differentiated rates ..."

Medical aid societies offering differentiated and, therefore, lower rates for younger people would tend to attract the cream of the medical aid scheme membership, leaving other societies with the burden of covering the old and sick.

Legislative changes in 1989 made provision for differentiated rates, he said.

'Replace medical aid with national health insurance'

Star 22/10/91. (299)

Pretoria Correspondent

Medical schemes have failed to provide health care to most of the population and should be replaced by a national health insurance scheme, says Dr Max Price.

Dr Price, of the Centre for Health Policy at the University of the Witwatersrand, yesterday said medical aid societies had existed for more than 100 years, but served only 17 percent of South Africa's population of about 38 million.

While more than 70 percent of whites were beneficiaries of medical schemes, less than 5 percent of blacks received these benefits. The ratios for coloureds and Indians were 29,5 percent and 33,3 percent respectively.

Dr Price, addressing the national congress of the National Wholesale Drug Association in Vereeniging, said a national health insurance scheme was an "attractive" alternative.

All salary and wage earners would be required to join the insurance scheme and pay subscription fees according to income, and in the long term, the informal sector would be encouraged to contribute to it.

The balance of the informal sector and the unemployed would be covered by cross-subsidisation and tax revenue, which would give the entire nation access to equitable health care cover.

Dr Price said an insurance system would enable the financing of health care to be cost-effectively centralised under the Department of Health.

It could include "massive medicine purchasing power", in much the same way as the State now bought medicine through the tender system.

The State had been enormously successful in containing drug costs through the tender system and there was no reason why it should not extend this process to benefit all.

Dr Price said an obligatory national health insurance scheme was a sound option, as the private sector, which had failed to contain cost escalation, was facing a crisis.

The threatened deregulation of the insurance and medical aid industries would end existing cross-subsidisation, and large families, the elderly and chronically ill people would no longer receive private care at the expense of small families and young, healthy people.

Old Mutual health-care policy

OLD Mutual has followed a number of life companies in creating a health-care policy in the light of soaring medical aid costs.

Old Mutual yesterday announced the launch of a range of individual health-care products under "flexicare", which will be made available to the public from early next month.

The products are designed to supplement medical aid cover and help meet unexpected losses resulting from disability, extended stays in hospital and expensive operations.

Old Mutual chief medical officer Ivan Lockyer said many South Africans could be limited to basic medical care by the turn of the century because of inflationary pressures.

He added that medical costs were rising faster than the consumer could accomodate them, "with or without medical aid".

Lockyer said the technological explosion

SEAN VAN ZYL

in the medical industry was largely responsible for escalating costs.

He noted, for instance, that a coronary heart bypass, which cost R30 000 today, could rise to about R200 000 by the year 2000, based on present medical cost trends.

He expected SA to follow a medical cost trend similar to that in the US where, as a percentage of GNP, it had climbed from 6% to 12%.

SA's current medical costs accounted for 6% of GNP.

"Someone will have to pay and it won't be the government."

AIDS, Lockyer said, would also have a major impact on the country's future medical costs.

"Against this background, the average man is going to have to consider his options if he is not prepared to compromise on the standard of his medical care."

The route upward is open at Transmed

TRANSMED, the medical aid scheme and pharmacy business unit of Transnet, employs almost 600 people, of which more than half are women.

Of these, more than half are in senior or management positions, says executive manager Retha Ross.

"Transmed is committed to training and development of all races and sexes at all levels," she says.

Personnel are encouraged to further their studies and 36 employees are involved in part-time studies.

About 10% of pharmacists attend a course in small business management each year.

Women enjoy the same opportunities as their male counterparts in terms of development of, for example, leadership skills, interpersonal skills, customer care, in-house and external courses.

Transmed's parent company, Transnet, is concerned with the well-being of all the women employed by it and women whose husbands are employed by the company.

Improve

To this end, a community-orientated women's organisation — Femnet — was established in September last year.

Its objectives are to improve the quality of life of Transnet employees and their families and to become instrumental in promoting the well-being of the Transnet community as well as that of society at large.

HEALTH 488 299

Insurers take over

FM 25/10/91

Old Mutual is the latest financial institution to seek more of the health market. In the past year, over 30 health packages have emerged from the sector. Those from the Mutual and Liberty Life, introduced a month ago, seem the most comprehensive.

There are two reasons for life assurers' surging interest.

Firstly, conventional medical cover schemes will not be able to cope with rising costs — theoretically, as was pointed out at the launch of Old Mutual's Flexicare range of products, it will soon absorb the entire earnings of some workers if traditional levels of medical aid cover are to be maintained.

Clearly, these standards will have to drop.

The other reason is the sheer potential of the health market, in which SA deploys about 6% of GDP. Liberty joint MD Dorian Wharton-Hood has estimated total health-spend at more than R17bn annually; the health insurance segment is growing by more than 25% a year.

Both the Old Mutual scheme and Liberty's "Medical Lifestyle" can be tailored to individual needs. Both are founded in policies which have ultimate investment value.

At the Flexicare launch this week, Old Mutual assistant GM Dave Hudson said some consensus is at last emerging on how medical care could be structured in SA, though several scenarios can be painted. A likely one is a national fund with compulsory membership for those in the formal sector, offering basic benefits, while the State will provide elementary services for the unemployed. People wanting more sophisticated benefits would need to top up, giving life companies their marketing opportunity.

Legislation which would alter the status of medical aid societies could be introduced soon, Hudson hints. ■

No. R. 2562 **25 Oktober 1991**

WET OP MANNEKRAGOPLEIDING, 1981

AKKREDITERING VAN OPLEIDINGSRAAD: OPLEIDINGSRAAD VIR DIE DRUK-, NUUSBLAD- EN VERPAKKINGSNYWERHEID

Hierby word vir algemene kennisname bekendgemaak dat die Registrateur van Mannekragopleiding die Opleidingsraad vir die Druk-, Nuusblad- en Verpakkingsnywerheid, Posbus 6776, Roggebaai, 8012, kragtens artikel 12B van die Wet, op 7 Oktober 1991 geakkrediteer het ten opsigte van die Druk-, Nuusblad- en Verpakkingsnywerheid, soos omskryf in Goewermentskennisgewing No. R. 2339 van 4 Oktober 1991 in die Republiek van Suid-Afrika, en dat al die bepalings van die Wysigingswet op Mannekragopleiding, 1990, geag word op genoemde datum in daardie nywerheid en gebied in werking te getree het.

Vakleerlinge en werkgewers van vakleerlinge in die Druk-, Nuusblad- en Verpakkingsnywerheid se aandag word gevestig op die bepalings van artikel 53 (4) van genoemde Wysigingswet, ingevolge waarvan, ten opsigte van elke vakleering wat in daardie nywerheid en gebied op genoemde datum ingevolge 'n kontrak van vakleerlingskap in diens was, die partye tot sodanige kontrakte binne 90 dae na daardie datum, hul keuse aangaande die leervoorwaardes wat op die betrokke vakleerling se verdere opleiding van toepassing sal wees, aan die genoemde opleidingsraad bekend moet maak.

No. R. 2562 **25 October 1991**

MANPOWER TRAINING ACT, 1981

ACCREDITATION OF TRAINING BOARD: PRINTING, NEWSPAPER AND PACKAGING INDUSTRIES TRAINING BOARD

It is hereby notified for general information that the Registrar of Manpower Training, in terms of section 12B of the Act, accredited the Printing, Newspaper and Packaging Industries Training Board, P.O. Box 6776, Roggebaai, 8012, on 7 October 1991 in respect of the Printing, Newspaper and Packaging Industry, as defined in Government Notice No. R. 2399 of 4 October 1991 in the Republic of South Africa and that all the provisions of the Manpower Training Amendment Act, 1990, are deemed to have come into operation in that industry and area on the said date.

The attention of apprentices and employers of apprentices in the Printing, Newspaper and Packaging Industry is drawn to the provisions of section 53 (4) of the said Amendment Act, in terms of which, in respect of each apprentice who was employed in that industry and area in terms of a contract shall within 90 days after the said date, notify the said training board of their choice regarding the conditions of apprenticeship which shall apply to the further training of the apprentice in question.

No. R. 2567 **25 Oktober 1991**

WET OP ARBEIDSVERHOUDINGE, 1956

MOTORNYWERHEID: WYSIGING VAN MICWU-MEDIESE FONDSOOREENKOMS

Ek, Eli van der Merwe Louw, Minister van Mannekrag, verklaar hierby, kragtens artikel 48 (1) (a) van die Wet op Arbeidsverhoudinge, 1956, dat die bepalings van die Ooreenkoms (hierna die Wysigingsooreenkoms genoem) wat in die Bylae hiervan verskyn en betrekking het op die Onderneming, Nywerheid, Bedryf of Beroep in die opskrif by hierdie kennisgewing vermeld, met ingang van 30 September 1991 en vir die tydperk wat op 30 Junie 1992 eindig, bindend is vir die werkgewersorganisasie en die vakvereniging wat die Wysigingsooreenkoms aangegaan het en vir die werkgewers en werknemers wat lede van genoemde organisasies of vereniging is.

E. VAN DER M. LOUW,
Minister van Mannekrag.

BYLAE

DIE NASIONALE NYWERHEIDSRAAD VIR DIE MOTORNYWERHEID

MICWU- MEDIESE FONDSOOREENKOMS

ooreenkomstig die Wet op Arbeidsverhoudinge, 1956, gesluit deur en aangegaan tussen die

South African Motor Industry Employers' Association

en die

South African Vehicle Builders' and Repairers' Association

No. R. 2567 **25 October 1991**

LABOUR RELATIONS ACT, 1956

MOTOR INDUSTRY: AMENDMENT OF MICWU MEDICAL FUND AGREEMENT

I, Eli van der Merwe Louw, Minister of Manpower, hereby, in terms of section 48 (1) (a) of the Labour Relations Act, 1956, declare that the provisions of the Agreement (hereinafter referred to as the Amending Agreement) which appears in the Schedule hereto and which relates to the Undertaking, Industry, Trade or Occupation referred to in the heading to this notice, shall be binding, with effect from 20 September 1991 and for the period ending 30 June 1992 upon the employers' organisations and the trade union which entered into the Amending Agreement and upon the employers and employees who are members of the said organisations or union.

E. VAN DER M. LOUW,
Minister of Manpower.

SCHEDULE

THE NATIONAL INDUSTRIAL COUNCIL FOR THE MOTOR INDUSTRY

MICWU MEDICAL FUND AGREEMENT

in accordance with the provisions of the Labour Relations Act, 1956, made and entered into by and between the

South African Motor Industry Employers' Association

and the

South African Vehicle Builders' and Repairers' Association

(hierna die "werkgewers" of die "werkgewersorganisasies" genoem), aan die een kant, en die

National Union of Metalworkers of South Africa

(hierna die "werknemers" of the "vakvereniging" genoem), aan die ander kant,

wat die partye is by die Nasionale Nywerheidsraad vir die Motornywerheid,

tot wysiging van MICWU- Mediese Fondsooreenkoms gepubliseer by Goewermentskennisgewing No. R. 1599 van 30 Julie 1982, soos gewysig en verleng by Goewermentskennisgewings Nos. R. 2796 van 31 Desember 1982. R. 1451 van 1 Julie 1983, R. 974 van 30 April 1987, R. 1802 van 21 Augustus 1987, R. 750 van 22 April 1988, R. 252 van 17 Februarie 1989 en R. 1755 van 27 Julie 1990.

1. TOEPASSINGSBESTEK VAN OOREENKOMS

Hierdie Ooreenkoms moet in die Streke omskryf in die Ooreenkoms gepubliseer by Goewermentskennisgewing No. R. 1599 van 30 Julie 1982 nagekom word deur alle werkgewers in die Motornywerheid wat lede is van die werkgewersorganisasies, en deur alle werknemers in genoemde nywerheid wat lede is van die vakvereniging.

2. KLOUSULE 7: BYDRAES

(1) Vervang subklousule (1) deur die volgende:

"(1) (a) Elke graad CA-lid of groep 1-lid van die Fonds wat afhanklikes ooreenkomstig klousule 8 laat registreer, moet soos volg tot die Fonds bydra ten opsigte van elke week diens in die Motornywerheid waarvoor hy geregtig is om vir 23 uur of langer loon te ontvang:

(i) 'n Lid wat een afhanklike laat registreer: R24,50 per week;

(ii) 'n lid wat twee afhanklikes laat registreer: R25,50 per week;

(iii) 'n lid wat drie afhanklikes laat registreer: R26,50 per week;

(iv) 'n lid wat vier of meer afhanklikes laat registreer: R27,50 per week.

(b) Elke graad GA-lid of groep 1-lid van die Fonds wat nie in paragraaf (a) bedoel word nie, moet R21,70 tot die Fonds bydra ten opsigte van elke week diens in the Motornywerheid waarvoor hy geregtig is om vir 23 uur of langer loon te ontvang.

(c) Elke graad B-lid van die Fonds wat afhanklikes ooreenkomstig klousule 8 laat registreer, moet soos volg tot die Fonds bydra ten opsigte van elke week diens in die Motornywerheid waarvoor hy geregtig is om vir 23 uur of langer loon te ontvang:

(i) 'n lid wat een afhanklike laat registreer: R9,20 per week;

(ii) 'n lid wat twee afhanklikes laat registreer: R10,10 per week;

(iii) 'n lid wat drie afhanklikes laat registreer: R11,10 per week;

(iv) 'n lid wat vier of meer afhanklikes laat registreer: R12,10 per week.

(d) Elke graad B-lid van die Fonds wat nie in paragraaf (c) bedoel word nie, moet R8,40 tot die Fonds bydra ten opsigte van elke week diens in die Motornywerheid waarvoor hy geregtig is om vir 23 uur of langer loon te ontvang.".

(2) Vervang subklousule (4) (a) deur die volgende:

"(4) (a) Die bydraes betaalbaar ten opsigte van 'n vrywillige lid wat afhanklikes ooreenkomstig klousule 8 laat registreer, is vir elke week diens in die Motornywerheid soos volg:

(i) 'n Lid wat een afhanklike laat registreer: R18,20 per week;

(hereinafter referred to as the "employers" or the "employers' organisations"), of the one part, and the

National Union of Metalworkers of South Africa

(hereinafter referred to as the "employees" or the "trade union"), of the other part,

being the parties to the National Industrial Council for the Motor Industry,

to amend the MICWU Medical Fund Agreement published under Government Notice No. R. 1599 of 30 July 1982, as amended and extended by Government Notices Nos. R. 2796 of 31 December 1982, R. 1451 of 1 July 1983, R. 974 of 30 April 1987, R. 1802 of 21 August 1987, R. 750 of 22 April 1988, R. 252 of 17 February 1989 and R. 1755 of 27 July 1990.

27 July 1990.

1. SCOPE OF APPLICATION OF AGREEMENT

The terms of this Agreement shall be observed in the Regions defined in the Agreement published under Government Notice No. R. 1599 of 30 July 1982, by all employers in the Motor Industry who are members of the employers' organisations, and by all employees in the said Industry who are members of the trade union.

2. CLAUSE 7: CONTRIBUTIONS

(1) Substitute the following for subclause (1):

"(1) (a) Every Grade CA member or Group 1 member of the Fund who registers dependants in terms of clause 8 shall contribute as follows to the Fund in respect of each week of employment in the Motor Industry for which he is entitled to receive wages for 23 hours or more:

(i) A member who registers one dependant: R24,50 per week;

(ii) a member who registers two dependants: R25,50 per week;

(iii) a member who registers three dependants: R26,50 per week;

(iv) a member who registers four or more dependants: R27,50 per week.

(b) Every Grade CA member or Group 1 member of the Fund not referred to in paragraph (a) shall contribute R21,70 to the Fund in respect of each week of employment in the Motor Industry for which he is entitled to receive wages for 23 hours or more.

(c) Every Grade B member of the Fund who registers dependants in terms of clause 8 shall contribute as follows to the Fund in respect of each week of employment in the Motor Industry for which he is entitled to receive wages for 23 hours or more:

(i) A member who registers one dependant: R9,10 per week;

(ii) a member who registers two dependants: R10,10 per week;

(iii) a member who registers three dependants: R11,10 per week;

(iv) a member who registers four or more dependants: R12,10 per week.

(d) Every Grade B member of the Fund not referred to in paragraph (c) shall contribute R8,40 to the Fund in respect of each week of employment in the Motor Industry for which he is entitled to receive wages for 23 hours or more.".

(2) Substitute the following for subclause (4) (a):

"(4) (a) The contributions payable in respect of a voluntary member who registers dependants in terms of clause 8 shall be as follows for each week of employment in the Motor Industry:

(i) A member who registers one dependant: R18,20 per week;

(ii) 'n lid wat twee afhanklikes laat registreer: R20,20 per week;

(iii) 'n lid wat drie afhanklikes laat registreer: R22,20 per week;

(iv) 'n lid wat vier of meer afhanklikes laat registreer: R24, 20 per week,

en ten opsigte van vrywillige lede wat nie hierbo bedoel word nie, R16,80 vir elke week diens in die Motornywerheid.''.

Namens die partye op hede die 19de dag van Augustus 1991 te Johannesburg onderteken.

T. NIEUWOUDT,
President van die Raad.

C. S. ROBERTS,
Vise-President van die Raad.

H. C. L. LOOCK,
Hoofsekretaris van die Raad.

(ii) a member who registers two dependants: R20,20 per week;

(iii) a member who registers three dependants: R22,20 per week;

(iv) a member who registers four or more dependants: R24,20 per week;

and in respect of voluntary members not referred to above, R16,80 for each week of employment in the Motor Industry.''.

Signed at Johannesburg on behalf of the parties, this 19th day of August 1991.

T. NIEUWOUDT,
President of the Council.

C. S. ROBERTS,
Vice-President of the Council.

H. C. L. LOOCK,
General Secretary of the Council.

DEPARTEMENT VAN NASIONALE GESONDHEID EN BEVOLKINGS-ONTWIKKELING

No. R. 2551 **25 Oktober 1991**

DIE SUID-AFRIKAANSE APTEKERSRAAD

REGULASIES BETREFFENDE DIE GELDE WAT KRAGTENS DIE WET OP APTEKERS, 1974, AAN EN DEUR DIE RAAD BETAALBAAR IS: WYSIGING

Die Minister van Nasionale Gesondheid het kragtens artikel 49 van die Wet op Aptekers, 1974 (Wet No. 53 van 1974), op aanbeveling van die Suid-Afrikaanse Aptekersraad, die regulasies in die Bylae hiervan uiteengesit, uitgevaardig.

BYLAE

1. In hierdie Bylae beteken ''die Regulasies'' die regulasies afgekondig by Goewermentskennisgewing No. R. 2235 van 4 November 1988, soos gewysig by Goewermentskennisgewings Nos. R. 550 van 16 Maart 1990 en R. 2476 van 26 Oktober 1990.

2. Regulasie 2 van die Regulasies word hierby gewysig—

(a) deur in subregulasie (1) (e) (x) (aa) die uitdrukking ''R240'' deur die uitdrukking ''R252'' te vervang;

(b) deur in subregulasie (1) (e) (x) (bb) die uitdrukking ''R120'' deur die uitdrukking ''R126'' te vervang;

(c) deur subparagraaf (cc) van subregulasie (1) (e) (x) deur die volgende subparagraaf te vervang:

''(cc) wat sy verpligte militêre opleiding ondergaan: R63'';

(d) deur in subregulasie (1) (e) (dd) die uitdrukking ''R60'' deur die uitdrukking ''R63'' te vervang;

(e) deur in subregulasie (1) (h) (i) die uitdrukking ''R200'' deur die uitdrukking ''R250'' te vervang;

(f) deur in subregulasie (1) (h) (ii) die uitdrukking ''R750'' deur die uitdrukking ''R1 000'' te vervang.

DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

No. R. 2551 **25 October 1991**

THE SOUTH AFRICAN PHARMACY COUNCIL

REGULATIONS RELATING TO THE FEES PAYABLE BY AND TO THE COUNCIL UNDER THE PHARMACY ACT, 1974: AMENDMENT

The Minister of National Health has, on the recommendation of the South African Pharmacy Council, in terms of section 49 of the Pharmacy Act, 1974 (Act No. 53 of 1974), made the regulations set out in the Schedule hereto.

SCHEDULE

1. In this Schedule ''the Regulations'' shall mean the regulations published under the Government Notice No. R. 2235 of 4 November 1988, as amended by Government Notices Nos. R. 550 of 16 March 1990 and R. 2476 of 26 October 1990.

2. Regulation 2 of the Regulations is hereby amended—

(a) by the substitution in subregulation (1) (e) (x) (aa) for the expression ''R240'' of the expression ''R252'';

(b) by the substitution in subregulation (1) (e) (x) (bb) for the expression ''R120'' of the expression ''R126'';

(c) by the substitution for subparagraph (cc) of subregulation (1) (e) (x) of the following subparagraph:

''(cc) undergoing his compulsory military training: R63'';

(d) by the substitution in subregulation (1) (e) (x) (dd) for the expression ''R60'' of the expression ''R63'';

(e) by the substitution in subregulation (1) (h) (i) for the expression ''R200'' of the expression ''R250'';

(f) by the substitution in subregulation (1) (h) (ii) for the expression ''R750'' of the expression ''R1 000''.

Forced to sell house, car to pay for major surgery?

ST Times (cm) 27/10/91 299

By FRED ROFFEY

WITHOUT adequate health care financing, in a few years' time some people may be forced to sell their house to pay for major surgery.

This was indicated at a conference on health care costs at the Old Mutual head office in Pinelands this week to launch FlexiCare, its new health policy for individuals.

Old Mutual's chief medical officer, Dr Ivan Lockyer, said a routine coronary heart bypass now cost around R30 000. Based on the increase in medical costs over the past five years, this could be about R200 000 by the year 2000.

The "sell your house to pay for major surgery" scenario given by some experts is based on their estimate that by the mid-1990s a three-bedroom house will easily cost well over R250 000 and at the turn of the century over R500 000.

Speakers at the conference warned that medical costs were rising far faster than the average person could accommodate them, with or without medical aid.

Old Mutual's employee benefits manager Mr Lindsay Walker said health benefits were becoming more expensive for employers than retirement funding.

"The graph of the cost to the employer for the funding of retirement benefits has remained fairly constant as a percentage of overall salary over the past 10 years, while that for health benefits funding has rocketed.

"Smaller employers are going to be squeezed out of providing health benefits, while others will be hard pressed to maintain their current level of benefits.

"Pure cost pressures have also pushed up the barriers to becoming a member of a medical aid scheme. For the past two years, membership of medical aid schemes has remained stable, indicating people cannot afford to join."

Mr Walker said that in the US many smaller employers were now not offering health benefits, leaving individuals to pay for them. A similar pattern was emerging here.

Dr Lockyer also referred to the US. He said South Africa's experience of rising medical costs was likely to follow the American pattern where medical costs once comprised six percent of gross national product (GNP). The present level was 12 percent.

"In South Africa, medical costs currently make up six percent of the GNP, but as the demand for exclusive medical care increases, so will the percentage of the GNP taken by the nation for medical care costs. Someone will have to pay and it won't be the government."

Dr Lockyer said a major aggravating factor was Aids.

"Just one projection — possibly optimistic — is that about 27 percent of South Africans will be HIV-positive by the year 2005, when Aids-related deaths could number 700 000 a year."

The impact on medical services would be dramatic. There would be a significant increase in demand, and the treatment of patients with Aids symptoms would have to alter, becoming largely family and home based.

"Aids, the 10 percent increase across the board for VAT and the huge effect rapid urbanisation is having on health services make the high-road scenario — a real increase in GNP — even more imperative," he said.

His warnings are highlighted by a recent estimate by a leading medical aid administrator that it costs between R55 000 and R70 000 a year to treat one Aids patient, and that if one percent of the members of a medical aid scheme develop Aids it will mean a 31 percent increase in premiums for all members.

Really serious Aids cases will have to be hospitalised at a time when many hospitals are full to overflowing — a situation which will not be improved by rapid urbanisation.

The Institute for Futures Research at Stellenbosch University says South Africa's population, including the TBVC States, is expected to increase to almost 45 million by the year 2000 — and the rural-urban drift is expected to assume unprecedented proportions, with the urban population rising from 15,2 million in 1980 to about 29,5 million by 2000, and 38 million by 2010.

TPA will pay arrears to disabled man

DISABLED father of five Alfred Nkala is owed almost R10 000 by the TPA Pensions Department for a disability pension and maintenance grant which were mysteriously cut off last year.

After City Press intervened the pension and grant were immediately restored and the TPA agreed to pay him what it owes.

New regulations mean the TPA can at its own discretion not pay out arrears, even if payments are cut off because of clerical errors.

Mr Nkala, who was declared 100 percent disabled after his leg and hand were amputated following a train accident, has received a disability pension since 1985. A maintenance grant was given for four of his children in 1986.

Then, all monies were cut off in March last year. The pension pay office at Balfour could not explain it but advised him to fill in forms for reinstatement.

Despite doing so and obtaining medical reports from the district surgeon, the family received nothing for the rest of 1990.

They barely survived on Elizabeth Nkala's earnings as a domestic worker on the farm where Alfred was born and still lives.

In January the pension was paid again, but not the grant. The nine months arrears were not paid.

Without warning, the pension was cut off again in August.

In September and October the R225 his family relied on for survival was still not there. By then the maintenace grant was 18 months in arrears.

Last week Mr Nkala made a difficult and painful train journey to Johannesburg to ask City Press for help.

City Press asked the TPA pensions department to investigate.

TPA spokeswoman Elsabe Ferreira said the pension was apparently cut off because Mr Nkala had not submitted medical reviews and social ~~work~~ assessments.

There was no record of why the pension was cut off in March and the only medical report was from February showing Mr Nkala to be only 60 percent disabled and "able to do light work".

The pensions department had no record of subsequent reports which established that Mr Nkala was in fact 100 percent disabled and unable to work.

Ferreira confirmed that the children's maintenance grant was cut off because Mr Nkala did not supply annual reports from his children's school and from a social worker.

Mr Nkala said he gave the annual school reports to the pensions clerks at Balfour and that in April a social worker from the Heidelberg TPA office visited his family and made a report.

Copies of the school and social work reports are now on record and the TPA will pay what it owes.

Death better than poverty

Cpen 27/10/71

By ERIC NAKI

DISABLED Gladys Khumalo said she would "rather die" than lose her disability grant.

Khumalo, 33, was recently told at the Mofolo pay-out point that it was cancelled.

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She was given a form at the TPA regional offices in Johannesburg to take to a doctor to complete.

She went to the Phomolong Clinic in Phefeni, but to her surprise, a doctor said she did not look disabled.

Khumalo, a hunchback, told him she had been getting the grant for years.

"This doctor asked me a lot of questions and I just could not stand it and walked out," she said.

Khumalo said she would not be able to educate her 18-year-old daughter, Nonhlanhla.

In another incident, semi-blind David Mkhencele, 55, of Bekkersdal in Randfontein, was in tears at the cancellation.

Mkhencele got his disability grant in 1987 after an eye operation.

TPA consultant Nigel Mandy said he would be pleased to investigate any complaints.

Medical aid fraud carries R240m tag

(299)

Bloan 28/10/91.

MEDICAL aid fraud and abuse cost the industry about R240m a year, says Medscheme director Les Hollis.

In a new booklet, The Funding of Healthcare and the Role of Medical Aid, Hollis says fraud and abuse probably contribute about 5% of the industry's total costs.

It takes at least six months to pick up fraudulent claims and medical scheme administrators spend large sums on specialised staff in an effort to monitor members and health care providers, he says.

Fraud usually consists of claiming for procedures not performed, while Hollis defines abuse as over-servicing and over-prescribing.

Registrar of Medical Schemes Ellis Langeveld says in its present form the Medical Schemes Act does not address fraud or abuse. The only way to combat these crimes is through general common or criminal law.

However, the new Medical Schemes Draft Bill includes a section providing for fraud to be punished in terms of medical schemes legislation.

The amended legislation also removes compulsory minimum benefits, guaranteed direct payment and will allow medical schemes to exclude or limit areas open to abuse, and to discipline those guilty of over-use, says National Association of Medical Aid Schemes chairman John Ernstzen.

TANIA LEVY

This would definitely reduce the amount of fraudulent claims paid out by schemes.

Ernstzen says some schemes experience more fraud problems than others. Particularly susceptible are those with less sophisticated members whose culture interferes with their understanding of how medical schemes work.

They allow relatives or friends, who don't have medical cover, to use their medical aid cards.

Ernstzen says he suspects the industry only picks up a fraction of all cases of fraud and abuse.

It is difficult to lay down rules about how many consultations or dosages are needed.

Medical Association of SA (Masa) director of professional services Dr Martin de Villiers says the association formed its cost awareness and peer review committee eight years ago to educate doctors about norms.

The committee, which includes six medical professionals and two representatives of the medical schemes industry, evaluates complaints from patients and medical schemes.

Its possible actions range from consulting the doctor concerned, advising medical schemes to monitor a doctor's claims pattern over a period of time or referring the matter to the SA Medical and Dental Council for possible disciplinary action.

Medical aid loses 'millions'

299 CT 28/10/91

Own Correspondent

JOHANNESBURG. — Medical aid fraud and abuse cost the industry about R240m a year, says Medscheme director Mr Les Hollis.

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New facet to hospital insurance

ST Times (CM) 3/11/99

SANLAM'S Hospital Policy, which provides cover against the high cost of hospitalisation and operations, has been extended free of charge to include angioplasty.

Mr Charl le Roux, Sanlam's assistant general manager, product development, says that nowadays many coronary bypass operations are prevented by using an inflatable balloon to open up narrowed coronary arteries.

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This procedure shortens the time in hospital but still results in major costs.

Sanlam therefore decided to include angioplasty on the list of major operations covered by the Hospital Policy.

The new benefit will not mean an increase in premiums and will be added to all existing policies automatically.

Presmed seeking more money

299
ST Times (Buss)
3/11/91

By IAN ROBINSON

PRESIDENT Medical Investments (Presmed) plans a rights issue to finance the construction of two day clinics and the upgrading of two others.

The money may also be used to buy more day clinics.

Presmed is a pioneer in cost-effective private health care in South Africa. It is one of the few private hospital groups which still charges medical tariffs recommended by the Representative Association of Medical Schemes (RAMS).

It has also promoted the use of day clinics, which managing director Carl Grillenberger believes can play an important role in lowering costs.

Best

Presmed has seven day clinics and five hospitals.

Mr Grillenberger says Presmed aims to provide functional cost-effective health care without compromising on the best care and equipment available.

Presmed's strategy to achieve this objective — and to make a profit — is based on three principles: functional design of clinics, cost control and high use.

Presmed's taxed profits in the six months to August 31 were R1,67-million, an increase of 45% over the same time in 1990. Turnover increased by 41% to R34,88-million.

THE COLUMNIST WHO CARES

Temperatures soar over medical rates

ST Times (CM) 3/11/91

(299)

ELDERLY members of medical aid societies could face huge rises in subscriptions as schemes change the basis of levying monthly fees from income to age.

For retired sales representative Anne Lederman of Sandton, this means an overnight jump in her monthly payment from R218 to R430 — that's 87,5 percent.

If she was under 30 she would be charged just R180 as a member with no dependants. Subscriptions go up R50 as a new decade is reached by members.

"This penalisation of older members is unacceptable and immoral," said Mrs Lederman, who has been a member of the Medicaid medical aid society for more than 40 years.

"Most of these older members are likely to be retired and living on fixed incomes."

Mr Rob Speedie of the Representative Association of Medical Schemes (RAMS) said that, until October 1989, subscriptions could only be levied according to income and the number of a member's dependants.

"After that, other factors — age, claims experience and where members live — can be taken into account," he said.

"But I'm shocked to see a subscription going up to this extent."

Mr Jeff Slome, managing director of Medicaid, admitted the new rates were hard on older people.

"But with the vicious inflation spiral of medical costs there are two options — either cut back on benefits or bring in more money. We're changing from an illogical to a logical basis of working out subscriptions," Mr Slome said.

That's all very well, I suggested, but most medical aid members — who do not make large claims early in life — expect that what they lost on the medical aid claims roundabout in their youth they would gain on the swings later in life.

Mr Slome agreed, but said he did not believe there would be a rethink on the age question.

Medicaid, one of two schemes out of 24 in Mr Slome's stable that have switched to age-related subscriptions, has mainly private and small business people as members and can dictate the method of levying fees.

But people in company schemes could face similar changes.

Mr Lindsay Walker, Old Mutual's marketing manager (employee benefits), admitted that schemes run by his company were considering age-related rates.

Mr Keith Hollis of Medscheme, one of South Africa's biggest medical aid administrators, said: "It's not an option at this stage, but it could become one."

or flowers.

Educating parents on epileptic kids

Sowetan 6/11/91

299

AMBROSE Monyai suffered epileptic fits throughout his schooling and as a result his progress was affected. Today he is a teacher.

Amanda Mogale is also an epilepsy sufferer. At the age of 18 she is only doing Standard 8. Will she be as lucky as Monyai?

Many children with epilepsy have to drop out of school because of the lack of knowledge about the disease by both parents and teachers.

WOMAN

By PEARL MAJOLA

Monyai's wish is for every child with epilepsy to be educated and have a profession and this can be achieved if parents and teachers know more about the disease to help the child.

However, this problem may soon be alleviated in the Krugersdorp area after a seminar about the disease was held at Bonalesedi Nursing College where teachers, parents and medical personnel discussed ways of helping children with epilepsy obtain an education like other children.

A multi-professional team is also to be established to make this possible.

Dr Hettie Bouwer of Leratong Hospital said during the seminar that it would help the child get treatment on time and therefore control the disease if teachers and parents knew the symptoms of epilepsy.

"The teacher or parent should refer the child to a doctor or hospital if the child's performance deteriorates, if he loses concentration (which can be interpreted as daydreaming by the teacher), starts bedwetting or has headaches when he wakes up in the morning," she explained.

"When the child does gets an attack, people should not run away from him. Instead he should be helped by turning him on his side and loosening any tight clothing on him.

"If convulsion persists, he should then be referred to hospital or to a doctor.

Dr Danie Wagener, also of Leratong Hospital, explained how the disease is contracted.

"In most cases, it is difficult to find the reason why one gets epilepsy," he said.

"But in 50 percent of the cases the disease is hereditary. Other causes are injury at birth, drugs and infections, like meningitis."

Wagener said 30 out of 1 000 children under the age of seven had epilepsy and five out of those were in school.

★★★★★★★

ANC prepares for election

THE ANC is busy laying the groundwork for a non-racial election campaign, according to ANC spokesman Carl Niehaus.

He said most of the ANC's 900 branches were looking at potential problems associated with fighting such an election.

Niehaus said voter registration would be an enormous task. A massive effort, including an awareness campaign, would have to be made to get all eligible voters onto the roll. BIDay 6/11/91

Studies had been made of international election procedures and preparations which would ensure the ANC was well prepared when the time came.

A Home Affairs spokesman said there were more than 9-million blacks with ID books — 73% of the projected 12,5-million blacks over the age of 16 in SA.

He said a campaign was needed to get the rest to register.

GERALD REILLY and DARIUS SANAI

Latest statistics show that at end-September this year there were 5,5-million registered white, coloured and Asian voters. White voters totalled 3,3-million.

Central Statistical Service figures show the number of blacks over 18 is more than double, at 11,5-million.

Political analyst Willem Kleynhans said preparing for black participation in SA's first one-man, one-vote election could take until the end of the century.

He said the current register could be used as a base for compiling an electoral roll for a future non-racial general election, but the matter would have to be resolved by political groups when they finally began negotiations.

Venter calls for new social legislation

PRETORIA — A new approach to social legislation should be considered, Health Minister Rina Venter suggested yesterday.

She told a think-tank on care for the handicapped that existing Acts should be made into one umberella Act with subordinate Acts.

This would facilitate the task of players in the field, since they would no longer have to search through various statutes for appropriate legislation.

Umbrella legislation would form an integrated part of the programmes offered by the welfare system. BIDay 6/11/91

Venter said that without neglecting the secondary and tertiary services, more funds should be made available for primary services.

"That means stronger focus should be placed on the development of people, families and communities."

At this stage 1,6% of GNP was spent on welfare services. It should, however, be increased to 3,2% and money should be made available to primary social welfare services, especially in underdeveloped communities, she said.

"In a Third World country which is endeavouring to make primary social services available and accessible to all its inhabitants, it is inevitable that both government and the private sector will bear a heavy financial burden."

She said an aspect that needed attention was that people who could afford social services should be made to pay. — Sapa.

Aegis has special cover to meet additional costs

B/Day 7/11/91 (299)

WITH many medical institutions insisting on up-front payment guarantees from potential patients because some medical aid schemes do not pay all of the costs, special cover has been developed to meet up-front shortfalls.

Aegis has developed and recently launched Medi Assist, which not only caters for the potential shortfall in medical aid reimbursements, but under most emergencies covers a patient's costs from the ground up.

Guarantees

In addition, says Aegis medical division manager Adrian Hofman, Medi Assist guarantees the payment of benefits at all times.

"This means that should a policyholder need emergency treatment any time of night or day, he/she need only contact the number on the reverse side of his/her Medi Assist card.

"That person will be guaranteed treatment without having to either pay a deposit to the medical institution or issue his/her own personal financial guarantee."

What is more, Hofman says Aegis pays for all follow-up treatment for six months after the claim incident and half of such costs after six months up to a limit of R100 000 per event (not per year).

The need for such cover stems from the differential between the medical scale of fees laid down by the Representative Association of Medical Services (Rams) and those laid down by the Medical Association of SA (Masa).

At present, the recommended Rams rate for a consultation is R24,80 and R55,20 for Masa.

Soaring

"This dilemma is causing members of medical aid schemes to pay soaring membership fees for what is perceived as a lesser benefit due to this differential in fees continuing to grow.

"It is due to this difference that many medical institutions are insisting on financial guarantees from potential patients — even if they are members of medical aid schemes," he says.

The product is the first of its kind to launched by the M-Net Business broadcast facility.

Plans revamped to meet changing needs

B/Day 7/11/91 (299)

ONGOING improvements are expected in medical insurance which has been successfully filling the gaps in health benefits.

According to AA Life senior manager Janice Scheckter, trends towards medical products have gathered momentum in SA and developments will continue to provide people with new options.

Through the years, the more innovative life offices have recognised the gaps in the market and developed medical plans to cater for growing needs.

A few years ago, dread disease policies were introduced and most life assurers devised their own plans with small but distinct differences, she says.

Catastrophes

However, dread disease cover policies, designed to supplement medical aid and in some cases replace it, had shortcomings.

While the plans catered adequately for major catastrophes, they did not include the facility to pay claims for everyday medical needs.

They were also sold with inclusive life cover which increased the premiums.

She says not every client needs additional life cover. AA Life this year relaunched a dread disease plan which can be purchased independent of cover. But having found the solution to the life cover issue, the question arose: was the same amount of money needed for each illness? A stroke, for example, may require more medical treatment than major burns.

"At this point another feature was developed — the distinction of payments for various ailments, keeping a policy in force after claims have been made."

Scheckter says there are other medical plans on the market in addition to dread disease cover, providing benefits for hospital stays.

"What has also been developed is benefits for terminal illness, which pays out once diagnosed."

Private sector must give health care top priority

B/Day 7/11/91

299

THE private sector needs to place health care as high on the corporate responsibility list as education and housing, leading medical aid administrator AMA says.

"Unless the private sector assists employees with effective health care and relieves the pressures on state facilities, the entire health industry — already in crisis — will collapse," says AMA executive director Timothy Gelman.

Reassess

"Many companies need to reassess their medical benefits and the options available to employees. The old 'take-it-or-leave-it' concept is no longer acceptable."

He says health care packages need to be innovative and flexible combining, for example, medical aid with allied insurance.

Families need quite different benefits from young bachelors and pre-retirement employees.

Gelman predicts that administrators like AMA, which oversees 10 medical aid schemes, will play a strong "consultancy" role for blue chip companies in particular.

Fedlife deputy GM Stoffel Burger says adequate medical care is essential for maintaining a healthy and productive workforce, particularly for manual workers.

"However, most general workers have no medical assistance and it is difficult to start a conventional medical scheme for those with relatively low salaries.

"Fedlife is thus developing a scheme that provides basic medical benefits on a self-insured (individual account) basis in conjunction with the insurance of higher hospitalisation benefits," says Burger.

Meanwhile, pensioners are still treated unfairly when it comes to adequate medical benefits, says Absa Consultants & Actuaries MD Ben Solomon.

Provision

With contribution rates of medical aid schemes having soared over the past decade, early provision should be made to set aside funds to meet the medical costs of people when they become pensioners.

Solomon says although there are several medical insurance products available, there are too few that address the need of pensioners.

"Much could still happen in this sphere, which will also have to address cross-subsidisation between employees and pensioners," says Solomon.

Shortcoming

Institute of Life & Pension Advisers (Ilpa) council member George Marx says current medical insurance policies do not offer life-long cover.

"Since the brunt of medical costs are incurred in old age, this is a major shortcoming."

Growing concern stems from the fact that pensioners' medical costs are largely subsidised by active members of medical aid schemes and by employers.

He says employers face sharp increases as a result of an ageing population and there is no guarantee that current active members will be subsidised by future generations.

"Hence, there is good argument for money to be set aside in advance to pay for pensioners' medical costs," says Marx.

Norwich aims at top of market

BIDay 7/11/91

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NORWICH Life has carved a niche for itself in what it regards as SA's quality end of the medical insurance market.

While conceding its Hospital Cash Benefit (HCB) and Medical Security Plans (MSP) are "fairly costly" benefits, it says it provides "better and full benefits for the extra reasonable cost".

Products cost more because Norwich does not provide free standing cover as health insurance is linked to a whole life or endowment policy.

"Our philosophy is that cheapness means the client is not getting the full security he/she really needs," says Norwich product development actuary Vernon Boulle.

"Benefits can combine to provide the family with total peace of mind in the event of hospitalisation.

"We provide many valid points for considering them superior to similar products."

Citing the example of HCB, he says while "all companies impose a waiting period" (usually four days), Norwich will backdate the benefit to day one.

Then there is no limit to the number of claims a client may make under HCB, while the benefit is paid two weeks after hospitalisation commences and then every 30 days thereafter until discharge.

Pregnancy is excluded for 12 months before cover commences. Some companies exclude this for 24 months, while others impose an eight-day non-payment period. This reduces a woman's chance of receiving anything since few spend more than a couple of days in hospital after giving birth.

Entry age for both benefits is competitive — between 15 and 65 years next birthday. HCB expires when a client turns 75, while MSP terminates at 70.

Dependent children can be covered from aged one to 18 next birthday or up to age 23 if a student.

"Here the premium is low and is not dependent on the number of children or their ages.

"There is also no limit to the number of children who can be covered."

Low-cost care plan paving the way

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BIDay 7/11/91

WHAT is believed to be SA's first open-ended managed health care plan (MHP), offering cost-effective medical insurance and treatment services for lower paid workers, has been launched in Maritzburg.

MHP service company Medimo, a joint venture between Medi-Clinic Corporation and Medicaid Administrators, has opened its first total health care services (THCS) unit.

Medino MD Pierre de Clerk says the plan paves the way for businesses to become directly involved in solving the problems and inadequacies of SA's health care system.

Prepaid

THCS is a pre-paid system with costs at least 30% below conventional medical aids.

It provides one-stop, quality care managed by private, independent and experienced medical administrators.

Administration is simplified, with no claims to be submitted and hence no waiting for payment.

The service enables the private sector to improve the health of its employees and indirectly uplift the communities from which they come.

"As a managed health care facility, the THCS is an adjunct to Maritzburg's existing medical facilities.

"It is not in competition with them; rather it will bring into the private health care system people who previously could not afford it," says De Clerk.

Old Mutual's new policy designed to avert hardship

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B\Day 7/11/91

WITH medical aid costs expected to rise dramatically, people with medical aid should top up their benefits to counter spiralling costs.

Experts say the rising number of sophisticated procedures to treat serious common ailments and a growing number of AIDS cases mean the average man will need to consider his options if he is not prepared to compromise on his standard of medical care.

"A health care policy such as FlexiCare would become essential if he wishes to avert financial hardship in the event of illness or accident," says Old Mutual's chief medical officer Dr Ivan Lockyer.

IVAN LOCKYER

Benefits

He is referring to Old Mutual's new range of individual health care products made available yesterday.

It provides benefits that cover medical costs and disability.

For years, Old Mutual has provided organisations with health care products on a group basis in the form of medical aid schemes and its group health scheme MedMaster.

Now a new package is available that contains innovations such as:

☐ A no-claim bonus effective after three years and which accumulates after each additional claim-free year, thus ensuring that healthy people reap the benefits of fewer claims;

☐ An individual rating programme for underwriting the risk of each individual according to simple health criteria;

☐ Increasing maturity values after many years of being a policyholder.

FlexiCare's medical needs comprise:

☐ Hospital benefit;

☐ Medical benefit, which is a cash lump sum for protection against the high costs of surgical procedure or treatment of serious disease;

☐ Nursing benefit giving a monthly income for protection against the costs of private nursing;

☐ Living assurance which provides a lump sum on diagnosis of serious diseases.

The are four components to disability needs.

An income replacer provides protection against loss of income in the event of total disability as a result of injury or illness.

Where a self-employed professional is disabled, business overheads can be covered.

The capital provider pays a lump sum upon total disablement for any occupation, with similar cover available for professional occupations by the professional capital provider.

Available as independent plans are the hospital benefit, medical benefit, income replacer and business overheads replacer.

IGI Life 'tops up' existing benefits

B/Daily 7/11/91

SMALL companies and self-employed individuals can get a new medical and health care policy from IGI Life which "tops up" existing medical aid benefits or replaces self-insurance.

IGI Life MD Paul Cushway says the Intensive Care policy provides an ideal alternative route for those faced with having to pay high premiums for medical aid cover.

The shrinking umbrella of medical expenses protection that medical aid schemes have had to make in recent years to offset their ever-rising cost structures has driven many people to seek protection elsewhere.

299 Augment

"They are turning more to medical and health care insurance packages to either augment medical aid cover or to replace it."

Many large company employees with medical aid are among those starting to take out insurance policies against emergencies and high expenditure occurrences such as heart attacks, operations and serious disease.

"Intensive Care is ideally suited for 'topping up' existing medical aid benefits as well as a self-insurance alternative," he says.

IGI Life's sister company Hoskens has also developed a comprehensive package of benefits for employees in medium- to large companies.

A major contributor to the cost spiral is abuse

B Day 9/11/91

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PLAGUED by structural problems and subjected to abuse, conventional medical aid schemes will find it more difficult to meet members' demands — unless major changes are made.

Fincorp Benefits Services director Aubrey Sonnenberg says many people along with small- to medium-sized companies are becoming increasingly dissatisfied with conventional medical aids.

"Not only are individuals looking more to insurance-based products or hybrid products, but so are some companies," he says.

Justified

Fincorp, which provides a medical brokerage service to individuals and companies, suggests cost responsibilities should not fall squarely on employers.

"We believe more companies would seem justified in passing on some of the cost to employees," says Sonnenberg.

Unfortunately, indiscriminate use of medical aid services has been a major contributing factor in the health care cost-spiral, says Medical Association of SA (Masa) secretary-general Hendrik Hanekom.

Fedlife deputy GM industrial pensions Stoffel Burger says costs have been rising at a rate much higher than inflation for many years (see graph).

"The reimbursement of medical expenses on a group cash-flow basis has thus come under considerable pressure".

However, Sonnenberg says medical aid schemes suffer from generic problems, which include:

☐ There is an undue cost subsidy in the present system which creates inefficiencies and encourages people to claim;

☐ Member tariff increases have averaged 23% over the past 10 years;

☐ There is a wide gap between medical charges and the benefit paid out by most medical aid funds.

☐ Elderly members, who are in the minority, are high claimers and they diminish surplus funds; and

☐ There are insufficient incentives for the low (younger) claimers to control their claims and thereby assist in the accumulation of surplus funds in schemes.

Because schemes have been wide open to abuse, many members have taken advantage of this through over-utilisation in order to get their money's worth. Some have also resorted to fraud.

And medical practitioners have not been blameless, as many are believed guilty of over-medication and over-servicing, he says.

In some cases, doctors have issued prescriptions in order to justify charging full consulation fees.

Payouts

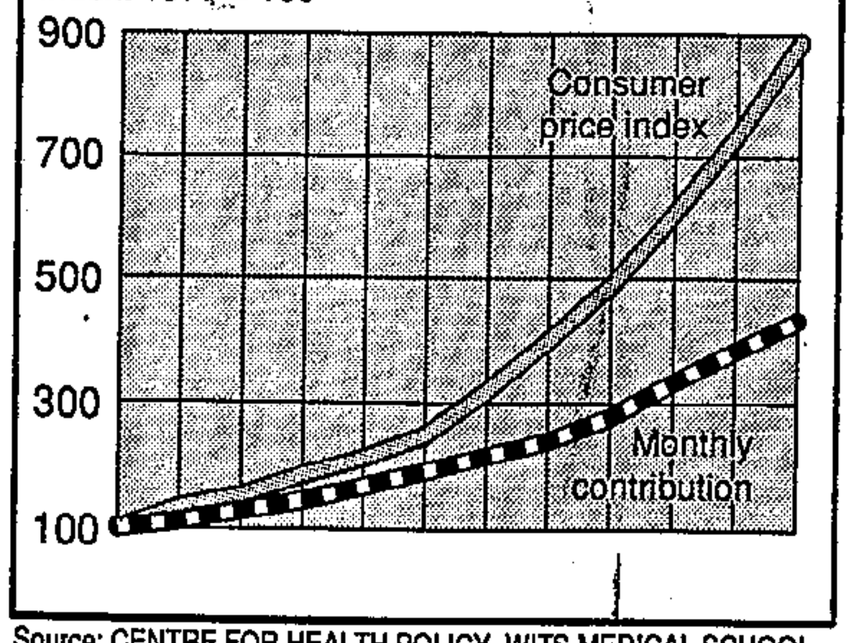
Representative Association of Medical Schemes (Rams) executive director Rob Speedy says payouts by the private sector averaged R98 per member a month in 1987.

"This year medical aids could pay an average of R220 a month. Spiralling consumption will result in an inevitable limitation on or reduction in the benefits granted by medical schemes," he says.

Meanwhile, commercial medical administrators expect to narrow the existing benefits gap once legislation, now at the draft bill stage, is introduced.

Interested parties are expected to attend a conference towards month-end to air their views on proposed draft legislation.

Rising costs of medical scheme cover relative to inflation



Source: CENTRE FOR HEALTH POLICY, WITS MEDICAL SCHOOL
Graphic: FIONA KRISCH

Liberty Life offers money-back product

PEOPLE or companies that do not have or want the benefit of a medical aid scheme could consider what Liberty Life claims is revolutionary new medical insurance product.

What makes its Medical Lifestyle attractive is that Liberty aims to pay all expenses and give the client money back after a period of time.

Whether or not one belongs to a medical aid, it provides an opportunity to supplement existing benefits with good protection against major hospital and surgical costs.

Since entering the market barely two months ago, deputy GM of Liberty Life Herschel Mayers described response to the package as "unbelievable".

B/D wmy 9/11/91

"It is interesting to note from the sale of our product how critical health care is to the man in the street. It is high on his list of priorities," he says.

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Distinguishes

Liberty Life executive director (individual life marketing) Yves D'Halluin says Medical Lifestyle distinguishes itself from other products as it:

☐ Provides a highly comprehensive range of benefits, including those for hospital stays and medical procedures;

☐ Is a universal policy and so provides cash values on death, expiry or surrender;

☐ Offers a whole life term that can be selected; and

☐ May be taken either in place of a medical aid scheme or in conjunction with a medical aid.

"It is applicable to an individual, whether on medical aid or not, or to the corporate market ... where companies intent on maximising profits will seek to provide the best in health care for their employees."

Versatility is a feature of the product which offers two types of plans — high cover and extended cover.

High cover is designed to be taken in place of, or to replace, a medical aid scheme.

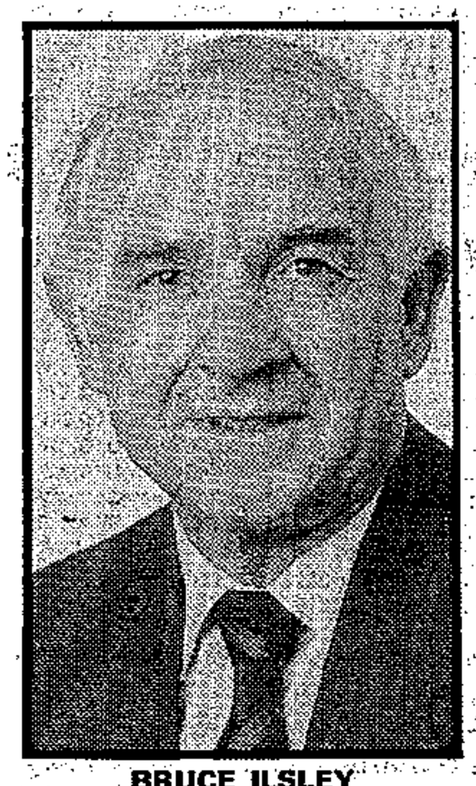
"The benefits paid in respect of serious procedures are commensurate with the actual costs of the procedures rather than with the medical aid tariffs."

D'Halluin says in order to reduce contributions, minor treatment such as visits to the general practitioner are not covered.

Supplement

Extended cover is designed as a supplement to medical aid schemes, with its purpose to fill the large gaps between actual medical costs and medical aid reimbursements.

Liberty estimates the cost of a typical medical aid scheme for a man aged 49 and his dependents — spouse, 44, son, 21, and daughter, 19, would be R540 a month.



BRUCE ILSLEY

No-claim discounts offered on medical insurance

GOOD discounts for medical insurance policyholders who are not hospitalised for three years or more are available.

Sage Life claims to have been the first with a no-claim premium discount of up to 30% for clients and their families through its Hospital PayPlan.

Sage Life marketing director and Ilpa member Bruce Ilsley says clients need no medical examination when taking out the policy which pays hospital bills and can either supplement the medical aid payment of an employee or replace it.

For example, a man of 39 who takes a 30-year policy with R200 a day cover for himself, wife and four children would normally pay R134 a month.

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Reduce

"If none of them has been hospitalised for three years the premium will reduce to R95 a month. If there is no claim the next year a further 10% discount applies," he says.

Another policy, Major Medical, pays out in the event of a major medical problem.

"It is the most comprehensive policy of its kind on the market today, covering almost 1 000 major medical incidents and pays up to R60 000 per incident."

He says such cover today is important as spiralling costs have become a nightmare. Most hospitals can quote instances of lengthy hospitalisation together with surgery where the total account exceeded R100 000.

While most medical aid schemes offer the most comprehensive cover available, it is not cheap and a married man with four children usually pays more than R500 a month.

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Alternative

Insurance companies now offer an alternative to a medical aid, but these policies are not necessarily designed to be as comprehensive as medical aid.

"But you pay much less because they pay out only for major incidents and the insurer is not involved in thousands of small claims."

Ilsley says although it is not always apparent from the marketing literature, wide differences exist among different insurers in the health cover plans, some offering more comprehensive plans than other.

To give one example, the Sage Life Hospital PayPlan and Major Medical are life policies, while many others are short-term insurance.

"The insurer may cancel a short-term policy, but not a life policy," he says.

Non-smokers get a bonus from Hosmed

A BRACE of medical cover schemes has been introduced by two subsidiary companies in the Hoskens Consolidated Investment Group for their group scheme clients.

Claiming to be offering an SA first is Hosmed Medical Aid Scheme's discount on medical aid for company employees who are non-smokers and thus have a lower health risk.

Sister company Hoskens Medical Aid Administrators has also established a new health care service, MediGap, for its group clients.

On the former, Hoskens Medical Aid Administrators MD Rob Davey says statistical evidence in the life assurance industry has made non-smoker rates possible for years.

"The offer of lower contribution rates is the most progressive step to have been taken in the field of health care for many years."

While initial response to the discount was good, it has levelled off as there has been an "avalanche" of medical insurance innovations in recent months.

Medigap, a medical insurance product for companies, but which may be extended to individuals later on, provides a full range of health care associated benefits to enhance the underlying medical aid.

"What makes it different is it combines more health care components than any other scheme," he says.

The service incorporates medical aid, dread disease benefits, hospital benefit plans, medical rescue cover, burial aid, top-up cover, major medical expenses, personal accident, short- and long-term disability and recuperation benefits.

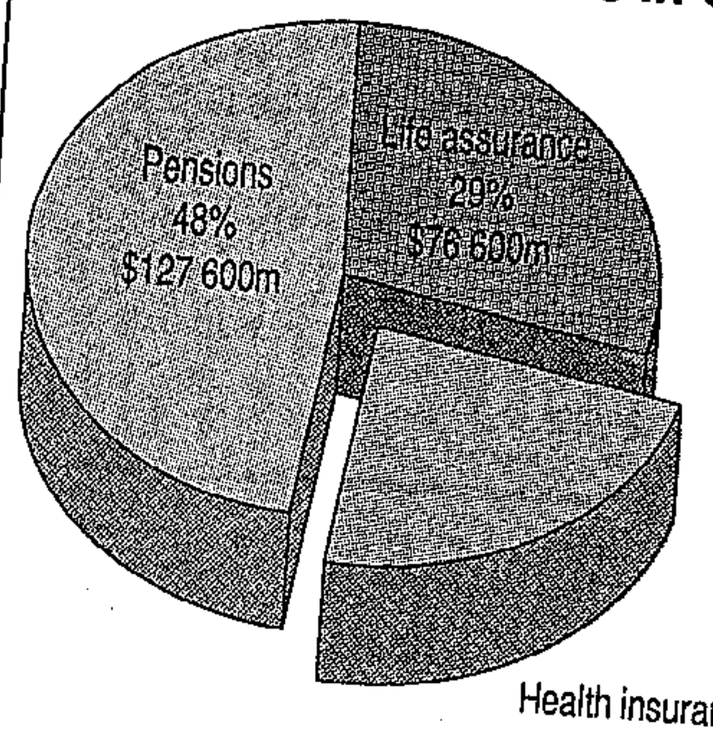
Supplementary to these services is Hosmed's claim that is provides a speedier payment service to group clients with very limited member queries on the fate of their claim payments.

"Members' claims are normally processed within seven days after receipt and a cheque run is undertaken weekly," says Davey.

Business Day SURVEY

Traditional medical cover is no longer adequate and the gap between actual costs and what a medical aid scheme reimburses continues to widen. Analysts believe that with medical inflation outstripping general inflation, medical aid schemes need to be supplemented if they are to solve health care problems. ***LYNN CARLISLE*** *reports.*

Distribution of business in USA



Source: AMERICAN COUNCIL OF LIFE INSURANCE
Graphic: FIONA KRISCH

Health insurance catching on

Bloomday 7/11/91. (299)

MORE South Africans may have to opt for medical insurance in preference to employer medical aid schemes if US trends are anything to go by.

Funding health benefits for employees is becoming more expensive for employers than retirement funding, says Old Mutual employee benefits manager Lindsay Walker.

"The cost to the employer for the funding of retirement benefits has remained fairly constant as a percentage of overall salary over the past 10 years, while that for health benefits funding has rocketed."

He says this is making it increasingly difficult for the small employer. In the US many no longer offer health benefits, but are

DORIAN WHARTON-HOOD

leaving individuals to pay these themselves.

"A similar pattern is already emerging in SA," says Walker.

"Smaller employers are going to be squeezed out of providing health benefits, while others will be hard pressed to maintain their current level of benefits."

Cost pressures have also pushed up barriers to becoming a member of a medical aid scheme — as indicated by membership remaining constant over the past two years.

In the US, the health insurance market is estimated to be as large as the life assurance market, says Liberty Life joint MD Dorian Wharton-Hood.

Its growth rate has been more than 25% a year.

Health insurance forms a large proportion of the long-term insurance industry in the US where that business has grown at a rate steadily above inflation, he says.

In addition, growth has been more stable than that of the US life insurance industry which has at times experienced negative growth.

"We believe that SA is on the same track and is following the same trends."

Wharton-Hood says the potential market runs into billions of rands and includes that currently financed by medical aids (R6bn) and the self-insured market (R3,6bn).

In addition, the state spends R8bn, which is largely aimed at the lower income group.

"The market is enormous and growing fast. Local health care is certainly affordable because the money is being spent already," he says.

Medical cover

Co-operation the way to overcome disarray in services

B Day 7/11/91

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CONCERN is mounting over the growing inadequacy of traditional medical cover to meet market needs, experts say.

"The health care environment is in disarray," says Liberty Life deputy GM technical and admin services Herschel Mayers.

University of Pretoria insurance and actuarial science professor George Marx has called for collaborative interaction and new legislation aimed at improving medical cover.

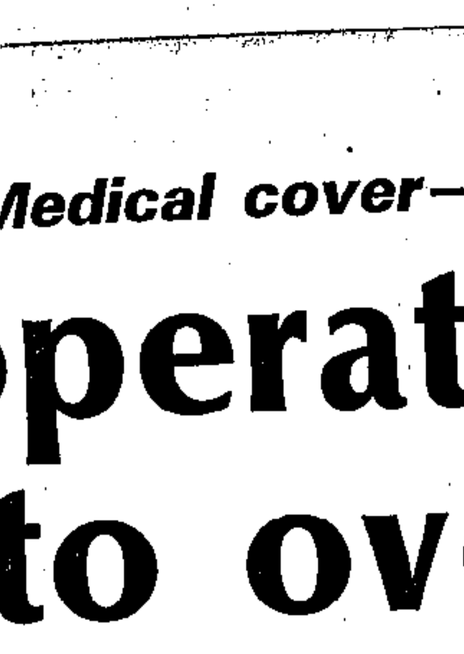
Mayers says the gap between the actual costs incurred by the individual and what the medical aid scheme reimburses is widening all the time.

Inadequate

With the cost of medical inflation outstripping general inflation, he says medical aid schemes have proved to be an inadequate solution to health care problems.

"Medical aid benefits are inadequately structured and cover does not satisfy all the needs of the market.

"Reimbursements are made for the minor medical events, such as medicines and visits to the GP,



HERSCHEL MAYERS

while the individual is left with a very large financial burden in the event of a major medical expense," he says.

Cross-subsidies also have a considerable effect on the cost of medical aid cover. Sick and old members of schemes are subsidised by the young and healthy, says Mayers.

Marx, an actuary and council member of the Institute of Life and Pension Advisers, says schemes and health insurers should review their roles and work closer in order to improve medical cover for the benefit of the public.

"In recent months a growing number of life assurers and short-term insurers have introduced medical insurance products aimed at defraying medical and ancillary costs.

"Many medical insurance policies, although necessary, are somewhat artificial and thus inefficient."

He says shortcomings arise because policies had to be developed around the limitations of the Medical Schemes Act.

"It is clear that some of the changes suggested to the Act — gazetted in June this year — move strongly in the direction of insurance on free market principles.

"This movement is inevitable in SA where the total financial burden for health care cannot be funded out of taxes.

"I seriously advocate that this movement is not done without thorough deliberations with the insurance controllers of the Financial Services Board and the insurance industry as such."

Marx advocates this not as an attempt to protect or benefit the insurance industry, but to prevent the medical schemes industry from overlooking the many valuable lessons which have been learnt by the insurance industry and to ensure that efficient and unambiguous state control is developed.

He says medical schemes and medical insurance should not compete with each other, possibly for the sake of protection of self-interest of the two industries.

Control

"Serious consideration must be given to the possibility of the development of a single Act to control medical schemes and medical insurance, combined with a good measure of industry self-control," he says.

Some medical insurance products are operated by short-term insurers, others by long-term assurers, others by medical schemes, or by Lloyd's of London and some by other international reinsurers.

Yet, all are striving for the same primary aim, namely the private financing of health care.

"This situation is unhealthy," says Marx.

Cash plans can be a useful backup

A HOSPITAL cash plan should be viewed by the potential policyholder as a supplement to a medical aid scheme and not a replacement, says Standard Bank Insurance Brokers MD Doug Tunbridge.

Hospital cash plans do not outlay money for medical practitioner fees or for prescribed medicines, but only pay when the insured is hospitalised.

Shortfall

Because payment is made directly to the patient, it may be used to meet any shortfall between what the medical aid pays and the charges for daily hospitalisation.

Tunbridge advises people not to be cost-sensitive when selecting a hospital cash product. In essence, what you pay is what you get.

"When selecting a plan, balance the premiums payable with the benefit offered."

Also decide if you want a basic, low-benefit product or an all-encompassing, high-benefit one.

A major contribution to lowering the cost of a hospital cash product without affecting the quality of cover offered is the introduction of an "excess" or time period.

Payment after the first three days in hospital means that you are getting "catastrophe" cover at a more competitive rate.

He says look at the small print and assess the benefits offered, relating these to your needs. For example:

- ☐ What is the cut-off age when cover ceases?
- ☐ When are benefit payments halved?
- ☐ Is accidental death and disability cover offered?
- ☐ Are there double benefit payments in the event of hospitalisation arising from heart attack, cancer, stroke, dread disease or intensive care?
- ☐ Does it offer convalescence benefits?
- ☐ Is cover worldwide?
- ☐ Are benefits paid directly to the insured to meet expenses not directly related to hospitalisation, such as transport costs and full-time maid?
- ☐ Is ambulance cover included?
- ☐ What is the waiting period before you receive payments?

Sufficient

- ☐ Are payments sufficient in respect of what your medical aid will pay out and to meet charges by the hospital you would be likely to select?

Tunbridge says one should select a product that has a broker and an underwriter with a solid, secure background.

"Ensure that the company with whom you are insuring has a quick claims turnaround and gives minimum fuss in the event of a claim."

MEDICAL CARE

Fm 8/11/91 299

A national scheme?

Could a national health insurance scheme make medical care more affordable?

Many say a bureaucracy in any form is incapable of generating benefits. But Wits Medical School senior researcher Max Price believes that such a concept offers an attractive alternative to private medical-aid schemes and can in fact deliver the goods.

Addressing the National Wholesale Drug Association last month, Price said the private medical scheme movement had failed to provide health care to the majority of the population.

He pointed out that, although medical aid schemes have been around for more than 100 years, only 17% of SA's 38m people are served by them. He said a breakdown of these statistics was even more alarming.

While over 70% of whites (3,45m) out of a total white population of 4,9m were beneficiaries, only 1 374 500 (4,74%) out of 29m blacks enjoyed similar benefits. The ratios for coloureds and Indians are 29,5% and 33,3% respectively.

Central to his proposals is that such a scheme would be compulsory.

Says Price: "All salary and wage earners should be obliged to join and pay membership subscription fees, graded by income. In the long term, the informal sector would also be encouraged to contribute to the fund. The balance of the informal sector and the unemployed would be covered by cross-subsidisation and tax revenue, providing equitable health-care cover to the entire nation."

But critics say the charges would add a prohibitive amount to the already high tax rates and the small base of income tax payers could not support the massive health-care expenditures envisaged.

Price concedes the inherent problems in such a system. "These problems could be overcome, though, by strengthening patient protection — an ombudsman could be an alternative. The medical profession also needs to be audited. Mechanisms to ensure against malpractice need to be looked at." But he stresses that a capitation fee is only one method of making money available for health care to the poor.

Price believes the scheme is a necessary option because the private sector had failed to contain cost escalation, with medical and contribution ratios escalating at seven to 20 points above the inflation rate.

Predictably, medical aid schemes are not excited about the proposals. Says Medscheme chairman Keith Hollis: "We think it's unworkable because it assumes that a State bureaucracy would be able to deliver the funding and supply of health services in a more cost-effective manner than the private sector. Modern economic thinking suggests this is wishful thinking. You can't say that national health systems have been successful anywhere else in the world."

Hollis, who is also chairman of the SA Association of Medical Aid schemes, fears that the implementation of such a scheme would lead to the complete control of doctors and other health services. ■

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Consumers must count the costs

299
FM 8/11/91

Problems of funding medical care are assuming critical proportions. If costs continue to rise at current rates — an estimated average of 23% annually in the past five years — only the affluent will be able to afford anything more than primary health care.

A subcommittee of the Actuarial Society of SA delivered some interim and tentative conclusions, of a year-long investigation into medical aid schemes, to its annual convention last week.

The subcommittee's brief was to:

☐ Investigate the financial position and wellbeing of medical aid schemes;

☐ Examine the current practice of medical aids in SA and abroad and the role of actuaries in the sector;

☐ Investigate long-term financial implications of current medical aid practice;

☐ Investigate the design of an appropriate system for long-term planning for financial stability for the medical aid movement;

☐ Analyse the influence of Aids, and its emerging costs, on the sector's structure;

☐ Review the financial burden of continuing current methods and standards in the light of social and economic change; and

☐ Analyse the role of the insurance industry in providing medical cover.

Part of the problem lies with consumers.

Rejean Besner and Colin van der Meulen, both consultant actuaries, suggest that the use of medical services must be reduced. They say the State by itself cannot carry more of the health care burden. The total bill for health care is estimated at more than R17bn annually: R8bn coming from the State, R6bn via medical aid schemes and R3,6bn in various forms of self-insurance.

Already 6%-7% of GDP is devoted to health. That's the same as in the UK and about half as much as in the US: in the latter case, health costs are distorted by the astronomical cost of liability insurance carried by practitioners and hospitals.

Among users of private schemes, Van der Meulen says, "there's a perception that if an employee and his employer have paid contributions, there's a medical store from which the member can take anything he wants from the shelves." This has to stop.

"Members must realise they carry the cost of casual visits to the doctor — either in the short term because the member must pay a large proportion of the nontariff costs immediately; or in the longer term through sharply increased contributions."

If users become at least partly self-assured, paying for overconsumption, there will be less pressure on medical tariffs. Eliminating fraud and abuse would also help. According to Medscheme director Les Hollis, abuses probably add 5% to medical scheme costs — about R240m annually.

Overconsumption is just one problem. Another is the way medical schemes are structured and restricted. Besner and Van der Meulen argue that the sector should be freed to become more efficient, seek income from nontraditional sources, become involved in the actual delivery of medical services and to put its investment income to better use.

In all these aspects, they argue, actuarial skills need to be deployed.

Specific changes they recommend affect investment and delivery. Besner notes that medical aid societies, which fund as they go but are supposed to have an average 25% of a current year's projected claims in reserve, have little of the investment expertise built up by life companies. "In many cases, large amounts of money sit in bank accounts, hardly matching inflation and certainly not matching the inflation in medical costs we've seen the past few years."

Lack of investment expertise could become even more significant when an ageing population adds to cost pressures.

The question of distribution may be resolved in proposed revisions to the Medical Schemes Act. Medical aids pay billions of rands to practitioners, clinics and pharmacists but enjoy no fruits from those businesses. If they were able to take equity in the distribution system it would improve their financial position, says Van der Meulen. Besner adds that there is a trend towards this, with some schemes nominating preferred providers.

Aids, they say, will be a serious problem in the medium and longer term, inevitably adding to societies' financial stress. Societies may share a problem with life assurers, which operate group assurance contracts.

Disability, they suggest, will be difficult to define. If an HIV sufferer capable of work is excluded from work because of peer group prejudice the likely outcome, says Besner, is that employers, having a contractual obligation to the employee, will cause the disability payment to be made.

So, as the problem develops, it can be expected there will be steep annual rises in the cost of group life assurance programmes, in addition to the effect on medical aid fees.

But for the medical aid societies, insists Van der Meulen, the biggest challenge remains members' "false perception that medicine is not a consumer product. It is."

He adds: "A system is needed to provide primary care for all. But, like other consumer products, the quality you receive should depend on ability to pay. If you want the most expensive surgeon, or choose elective surgery, there must be a price.

"Most South Africans have not been accustomed to setting economic values on medicine but now they will have to."

As actuaries, they are concerned more with financial stability than planning social structures. But a financial solution could see the State providing minimal health care for all; medical aid schemes restructured to provide sensible benefits for those in the formal sector; and health insurance (coupled with self-insurance) playing an increasing role, particularly for the affluent and younger groups which will perceive (because the message will be advertised) that conventional medical aid schemes require the young and healthy to subsidise the aged and infirm.

Whatever the outcome, medical aid as SA has known it will undergo radical surgery.

Fund open to all miners

B\Day 8\11\91

THE Chamber of Mines' legal victory to open a mining industry pension fund to employees of all races was a tangible demonstration of its commitment to nonracialism, the Chamber said yesterday.

Earlier, the Chief Justice rejected a petition by the Council of Mining Unions to appeal to the Appellate Division against a judgment by the Labour Appeal Court in favour of the Chamber.

The Appellate Court's decision upholds a ruling by the Labour Appeal Court and the Industrial Court that the CMU's objection to the admission of blacks, Asians and coloureds as employee members of the Mine Employees' Pension Fund was an unfair labour practice.

Chamber president T I Steenkamp said the ruling by the Chief Justice was an important and welcome event.

Steenkamp said the practical effect of the Chief Justice's decision was that people of colour who occupied positions at a particular level and who had previously been excluded from joining the MEPF on the basis of race would now qualify for membership. — Sapa.

ANC policy on medicine

B\Day 8\11\91

GERALD REILLY

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PRETORIA — An ANC government would incorporate major sections of the medical private sector into a national health service under government control, ANC health spokesman Dr Aslam Dassoo said yesterday.

Dassoo told a Pharmaceutical Manufacturers' Association of SA conference that in reorganising health services the ANC would aim to provide health care through an improved and strengthened public service accountable to the communities it served.

The public sector health service would attempt to attract staff and to absorb major sections of the private sector. It had to be accepted that the health care system in SA was an obscene perversion which needed replacing, not reforming, he said.

Dassoo, an executive member of the SA Health Workers' Congress, said the right to free health care should be legally entrenched in a future bill of rights and that there had to be a preferential allocation of resources to promote health care within the most vulnerable sectors of the community.

The ANC would strive for a nonracial, single national health system for all. All health services would have to be the responsibility of a single authority.

Viljoen challenges PAC

B\Day 8\11\91

Business Day Reporter

GOVERNMENT yesterday called on the PAC to clarify its position on the armed struggle.

Constitutional Development Minister Gerrit Viljoen said the PAC's armed struggle was "cause for serious concern".

Viljoen was reacting to a claim by PAC Harare spokesman Victor Phama that the PAC's armed wing, the Azanian People's Liberation Army (Apla), was responsible for a weekend attack in Soweto that killed SAP member Martin van Wyk and injured his colleague M M Tuge.

The PAC also claimed responsibility for killing two policeman at Katlehong on the East Rand recently.

Viljoen said in reply to the attacks: "Any organisation acknowledging responsibility for continuing armed action and for assassinations is very seriously imperiling its own involvement in genuine and peaceful negotiations."

ANC foresees control over private health

Star 8/11/91

By Carina le Grange
Medical Reporter

The ANC envisages a future health service in which the private sector would be accountable to the Government and in which funds would be redistributed from the private to the public sector, in a comprehensive national health service, Dr Aslam Dasoo of the ANC's health department has said.

He was speaking in Pretoria yesterday at a seminar organised by the Pharmaceutical Manufacturers' Association.

Incorporated

Other speakers included representatives of the National Party, the Pan Africanist Congress, the Democratic Party and Inkatha Freedom Party.

The private sector would in the long term become incorporated into the national health service "so that it becomes accountable to, and is under the overall control of, the Government", Dr Dasoo said.

"In re-organising the health services, the Government will aim to attract staff and to absorb a major section of the private sector."

He said the ANC did not intend to nationalise the private health sector, and the fact that the ANC believed there should be some control of this sector implied that the organisation accepted its existence.

Dr Dasoo said the private sector thrived at the expense of the public sector in matters such as the training of personnel, on which it drew heavily without giving anything back.

Earlier, he had characterised the present health care system as "an obscene perversion" in which the majority of people had been "subjected to one of the most bizarre, inhuman and unjust sytems ever devised ... which is still perpetrated".

Apart from the redistribution of funds from the private to the public to finance the service, other people would contribute through taxation or contributions to the national health fund.

The ANC also proposed to establish a national medicines policy to deal with availability, distribution and pricing.

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City to give health care

Municipal Reporter

Johannesburg will become one of the first municipalities to take over the provision of primary health care when it signs an agreement today with Health Minister Dr Rina Venter.

The agreement allows the Johannesburg City Council to provide primary medical services to the (coloured) south-western areas of Johannesburg for the House of Representatives.

Up to now, local authorities have only provided preventive health care at clinics and could not treat illness or provide medication.

Health workers can now diagnose and treat illness and injury and provide medication.

More emphasis will also be placed on teaching correct feeding methods, for example, to combat such problems as malnutrition.

Health cuts would be a catastrophe

ST Times 10/11/91 (299)

WE, the Fountain House community, are deeply concerned about your report (October 27) headlined, "Mental hospitals in cash crisis".

Fountain House is a community-based rehabilitation centre for Capetonians affected by prolonged mental illness. We are a community of 140 men and women of all races who are dependent on services rendered by state psychiatric hospitals. We were therefore greatly concerned when we read about the desperate financial plight in which Valkenberg Hospital and other psychiatric hospitals find themselves.

As a community, we resent the neglect we are being subjected to as a result of budget cuts, compromised standards and staff cutbacks and support Professor Robertson's appeal to the Cape provincial administration for funds.

It would be catastrophic for our community should hospital doors close.

It is, however, unfortunate that this article focussed on the most outdated, sensational stereotypes which reinforces the dehumanising stigma attached to mental illness.

Efforts

We object to the impression created by the article that mentally ill people are dangerous. Mentally ill people are more likely to be the victims than the perpetrators of violence.

You are safer visiting Fountain House or Valkenberg hospital than on the streets of Cape Town.

Mentally ill people make a trivial contribution to violence.

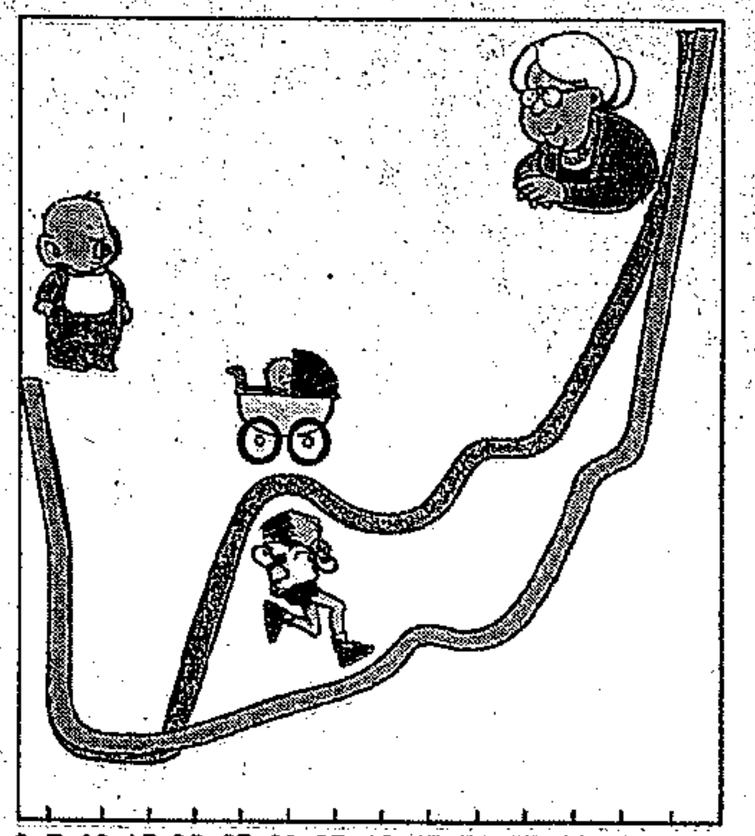
Since Fountain House addresses issues directly related to the community, such as employment, accommodation and rehabilitation, this article, with its reinforcement of stigmatisation, is undoing the efforts we put into the creation of dignified lives for the mentally ill.

Hospital cutbacks and the kind of terminology in your article represent forms of discrimination that we hope will not be part of a changing South Africa. — **Miss E PRINSLOO, project co-ordinator, The Fountain House Community, Cape Town.**

Health insurance 'a life-time affair'

Star 12/11/91 (299)

Health insurance is viable only with a mix of young and old subscribers to a scheme. However, fraud and abuse in the medical aid movement is costing consumers about R240 million a year.



THROUGHOUT his working life, Joe Smith religiously paid his monthly medical aid premiums. Being a healthy lad, he made few claims, and paid in much more than he was ever paid out by the fund.

As he approached retirement, his situation changed dramatically. He became ill and his claims rocketed.

This scenario is not uncommon.

Says Les Hollis, a director at a leading medical scheme administrator, this "cross-subsidisation" is an essential aspect of funding national health, mutual funding and commercial insurance systems.

Health insurance is not short-term insurance, it's a "life-time affair", he says in his book "The Funding of Health Care and the Role of the Medical Aid", published by Medscheme.

The young spend far less on health care than the old, and the bulk of health care expenditure is generally made in the last years of life, he says.

A good mixture of members across the age spectrum is critical to maintaining a viable fund, Mr Hollis says.

But if healthy, younger members migrated from mutual funds to other packages, there is little doubt that within a few years there would be no medical schemes to return to.

Cheap

This would not benefit the consumer of any age who needs help with medical bills.

"You cannot expect to buy down with a cheap package when young, and then hope to buy up for full cover as you go beyond middle age, when heart attacks, strokes, by-pass surgery and cancer wreak their toll.

"Cross-subsidisation, where the healthy, usually young, pay for the ill, usually old, is the cement that keeps the contribution table standing," says Mr Hollis.

Medical aids, their role and application, remain a closed book to most consumers — even those who regularly fork out subscriptions and use the facilities.

But the recent escalation in health costs has highlighted the high incidence of abuse in the industry. Fraud and abuse — by some patients and some doctors — in the medical aid movement is costing consumers about R240 million a year, says Mr Hollis.

This represents between 3 percent and 5 percent of the industry's total expenditure.

While fraud usually consists of claiming for procedures not performed, abuse consist mainly of over-servicing and over-prescribing any given condition.

Although medical administrations spend large sums on specialised staff and observers — to monitor and stop these practices — this is clearly not effective enough.

It's not surprising consumers are constantly searching for better and cheaper.

According to Mr Hollis there has been an upsurge in the interest in commercial health insurance policies. The benefits are based on "events" such as a stay of more than three days in hospital or certain illnesses or diseases.

Incentive

Another alternative — being discussed nationwide — is a national health system such as is presently used in the Britain and Canada.

In South Africa the trend is towards medical aid funds that incorporate an incentive to keep claims as low as possible, with forms of "no-claim bonuses".

PAULA FRAY

First line of defence should be DIY care

SELF-MEDICATION must be allowed to become the first line of health care, backed up by professional care with prescription medicines.

"Governments, however affluent, cannot continue to accept full financial responsibility for good health," Chris Rose, president of the Proprietary Association of SA, told delegates to the Pharmaceutical Manufacturers' Association last week.

"Self-medication forms an integral part of every health care delivery system world-wide.

"In developed countries, it is aimed at reducing the formal health care delivery service costs, and in developing countries it fills the gap created by the non-existence of a formal health care delivery service.

"Both circumstances prevail in SA, making self-medication even more pertinent to any health care delivery strategy."

He said South Africans across the full spectrum had demonstrated their ability to use off-the-shelf medications responsibly.

The Government had allowed this trend to develop by transferring proven prescription drugs to non-prescription status, he says, but the private sector also had a role to play.

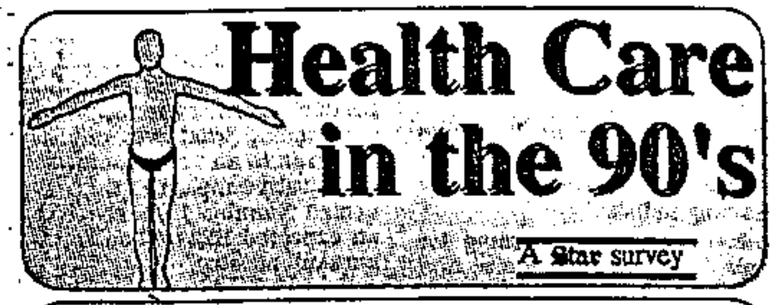
"Doctors, pharmacists and others need to focus more closely on the benefits of self-care."

Mr Rose also called for more readable, user-friendly package and insert design.

"The consumer must be able to recognise the symptoms for which self-medication is appropriate, choose products which will alleviate those symptoms, and administer the correct medicines in the correct dosage for the correct period of time," he said.

At the same time, he said, self-medication products should be available through as many purchase points as possible.

Although the pharmacist should remain the key distributor, he said supermarkets and other outlets should be free to sell proprietary medicines with a proven safety profile.



As medical costs continue to rise, more and more importance is being placed on the question of how people will be able to pay for health care. With the help of experts in the industry, VAL PIENAAR examines the issues.

'How to beat medical costs'

Star 15/11/91 (299)

THE only solution to soaring inflation in medical costs is a complete revamp of current legislation to make effective cost control possible, says Rob Speedie, executive director of Representative Association of Medical Schemes (RAMS).

"Two factors are contributing to increasing expenditure on medical care: price and usage escalation," he adds.

"Existing legislation attempts to control only the first of these, and that throws the system out of balance and leaves it open to abuse."

Observers agree that the statutory medical tariffs are, in many cases, unrealistically low — and give doctors no incentive not to over-service their patients.

Timothy Gelman, executive of AMA, one of the largest medical aid administrators in SA, concurs.

"The system is set up to fail," he says.

"The spectrum of benefits from medical aids is legislated, and payment is guaranteed. Only the amount of the payment is limited by the set tariff.

"In effect, medical practitioners are given an open cheque book — all they have to decide is how many cheques to sign.

"I know of one case of a woman who recently saw her doctor every day of the month but one. Each consultation was after hours — and in every case the diagnosis was migraine."

The solution, Mr Gelman says, is to deregulate the industry.

"We must scrap the statutory guarantee of payments, which is unique to SA," he says.

"Once it is no longer statutory, guaranteed payment can become part of a negotiated arrangement with health care providers.

"Because it will be in the providers' interests to work with us, we will be able to insist on quality, cost-effective care for our patients.

"And in return, we will be able to pay fees that reflect the practitioner's investment in education and responsibility to the community. He will no longer virtually be forced to cheat to make a reasonable living."

The proposed new legislation — contained within a draft bill tabled in July — aims to eliminate the differentiation between medical aids and medical benefit schemes.

If adopted, this legislation will open the door to establishing health maintenance organisations (HMOs) and preferred practitioner operations (PPOs) as a means of controlling costs.

The textbook HMO would consist of a group of health care providers, ranging from GPs, nurses and pharmacists to paramedical practitioners, specialists and laboratories.

Medical aid members would become members of a specific HMO — a system that deprives them of free choice of medical practitioners but drastically cuts prices.

PPOs, by contrast, would allow for limited choice. The medical aid would supply its members with a list of preferred practitioners with which it had negotiated terms.

"What we need is more flexibility in the system," comments Mr Speedie.

"The current legislation is full of anomalies — for instance, in the private sector a pharmacist can be employed only by another pharmacist, and may not enter into any partnership with another health care provider."

He says the overseas experience of HMOs and PPOs has, by and large, been satisfactory.

"The system does subject both doctor and patient to greater control — but for both this is outweighed by the financial advantages.

"The doctor no longer has any financial incentive to be anything other than cost-effective," Mr Speedie explains.

He confirms that a potential problem area could be in giving doctors an apparent incentive to cut corners — but says it would not pay in the long term.

"In the US, a medical ombudsman is appointed to review the activities of the HMO — and if it is found to be giving poor service its members will simply transfer to one of its competitors.

"The free market system can work as well for medicine as for anything else," he comments.

Don't overlook good points of medical aid schemes

Star 15/11/91 (299)

THE gap between what medical aid schemes can offer and what their members need is growing — and the industry is under siege by a wide range of versatile insurance-based products.

John Vardy, spokesman for broker Healthsure, says:

"Medical aids — unlike the many new health insurance products coming onto the market — are non-profit making operations, paying out on average 93 percent of the contributions.

"As such, they represent an outstandingly efficient way of taking care of medical costs, if they are free to respond to market forces."

These restrictions have, in the past, given rise to the proliferation of a wide range of medical insurance products.

Generally these are being marketed as a supplement to medical aids, but more and more people facing financial pressure are tending to regard them as an alternative.

And while hospital insurance is a must for the private individual who is not on an employer's medical aid and cannot afford to buy medical aid cover for himself, it would be unwise to rely too heavily on such a product.

Legally, medical aids could previously pay out only the set tariff for claims — and a major criticism of the system was focused on the growing gap between tariff rates and medical fees.

John Vardy . . . medical aids pay out an average 93 percent of contributions.

Recently, legislation was adapted to allow medical aids to develop "top-up" schemes to enable them to cover the full cost of hospital treatments — a significant benefit, since 25-30 percent of payments are towards hospital costs.

The registrar of medical schemes has enabled schemes to put together a range of cheap, cost-effective products to answer those currently on the market from insurance houses. In the meantime, Mr Vardy says, because medical aid schemes guarantee payment of hospital bills, patients are generally not obliged to pay upfront.

But hospital insurance plans carry no guarantees recognised by hospitals — and patients may find themselves paying cash amounting to tens of thousands of rands out of their own pockets well before they can hope to claim anything back.

A side effect of this system is that the patient has no-one to go to bat for him when excessive medical fees are charged.

A further advantage of medical aids, according to Mr Vardy, is their management structure.

"Medical aid funds are more like mutual insurance 'trust' schemes, administered by management companies that receive a fixed percentage to cover all expenses — including marketing.

"Hospital insurance schemes, on the other hand, can — and do — set aside enormous sums for advertising, and in the end this must be paid by the contributor."

Medical aid contributors can, if they wish, play an active role in ensuring that expenditure directly benefits themselves rather than the scheme.

In addition, he points out, members can transfer fairly freely from one medical aid to another, and membership of a medical aid cannot be terminated without the member's consent.

Even fly-in help is possible . . . thanks to the world's largest travel assistance organisation, which includes medical care among its services.

● See report on opposite page

Medical aid fees up 27 percent a year for past 3 years

Star 15/11/91 (299)

RISING costs of increasingly sophisticated medical apparatus and medication has driven up medical aid membership fees at an average rate of 27 percent a year over the past three years.

At the same time the gap between recommended RAMS rates and those laid down by MASA is widening — to the point where some medical institutions are insisting on financial guarantees even from patients on medical aid schemes.

In response to this need, Aegis Insurance has developed a top-up scheme.

It is called Medi Assist, and covers all medical and surgical procedures at the MASA scale of fees.

In addition, it covers theatre fees, medication costs and R240 a day for normal hospitalisation.

RUTH BEECHAM

New hope for disabled children

Sowetan 15/11/91 (299)

THERE is only one preschool for the thousands of disabled children in Soweto. Those who wish to go further have to travel to far off places or forget about getting an education.

But this, and other problems facing the disabled in the area, may soon be a thing of the past since the formation of a group of concerned paramedics and interested organisations committed to changing the fate of

Sowetan WOMAN

By PEARL MAJOLA

Soweto's disabled.

The group, which is yet to be named, has called on all the disabled, regardless of the type of disability, to a meeting at Takalani Home for the Mentally Handicapped this Saturday.

"The purpose of the meeting is to bring together all the disabled of Soweto, those who assist them, their families and friends and the projects and organisations that provide facilities for them, to plan for their own health services," said the group's spokesperson, Ms Ruth Beecham.

The group was formed out of concern over the rehabilitation and placing back into society of patients with disabilities who were being discharged from institutions like Baragwanath Hospital.

Funds

They also aim to create a network of the groups working with the disabled.

"Disabled people are divided from each other by organisations which only deal with one aspect of a disability.

"Earlier this year we committed ourselves to restructuring health services for the disabled in Soweto," said Beecham.

"The people will have to tell us what they want. We will depend on the private sector to donate funds for those things to be done. We bear in mind that the restructuring of the services is the responsibility of the Government.

"Disabled people and health professionals working together will create a force in Soweto that can change the way South African health services for the disabled are structured," she said.

According to the group, there are about 250 000 disabled people in Soweto but there are few or no facilities for them.

The group says there are 11 000 children under the age of 11, with cerebral palsy and 28 000 individuals with mental illnesses.

It estimates that head injuries are responsible for 3 000 to 5 000 newly disabled people a year, strokes for 2 000 and spinal injuries for between 2 000 to 3 000.

The meeting at Takalani will start at 1.30pm.

Market is growing rapidly

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Star 15/11/91

THE health insurance market is estimated to be as large as the life assurance market, and its growth rate has been more than 25 percent a year, says Liberty Life joint MD Dorian Wharton-Hood.

"Health insurance forms a large proportion of the long-term insurance industry in the US, where that business has grown at a rate steadily above inflation," he says.

"In addition, the growth has been more stable than that of the life insurance industry. We believe that SA is on the same track."

Mr Wharton-Hood says the potential market runs into billions of rands, and includes that currently financed by medical aids (R6 billion) and the self-insured market (R3,6 billion). In addition, the State spends R8 billion, which is largely aimed at the lower income group.

According to Yves D'Malluin, executive director (individual life marketing), the emergence of health insurance will change the face of health care in SA.

"With the health care environment in disarray it was inevitable that life assurers would enter the health insurance market as major competitors to medical aids and other health insurance providers," he says.

"Health care is no longer the preserve of medical aids."

Liberty's Medical Lifestyle package offers two basic plans. Its high cover programme is designed to replace a medical aid scheme.

You can get help all over the world

Star 15/11/91 (299)

AT PRESENT rand values, a brief stay in hospital for a relatively minor ailment could cost more than an arm and a leg.

"This year we have assisted five people who fell ill while travelling overseas without any form of travel insurance. Each of them had to sell their house to pay the bills," says George Novis, key accounts manager of Europ Assistance SA — local division of the world's largest travel assistance organisation.

Europ Assistance offers a wide range of products which, in whole or in part, form part of almost every private and business travel package sold.

They fall into three basic categories: medical care, which is available around the clock in 211 countries including the Soviet Union and China; practical assistance — for instance with replacing lost travel documents; and insurance.

"We help travellers in a wide variety of situations — but the bulk of the requests we handle have to do with medical assistance," he said.

"We get actively involved in arranging the ambulance, ensuring that the patient goes to a good private hospital, paying the bills, advising his family of what has happened and getting him back home again when he is well enough to travel.

"It takes special knowledge to avoid Third World health care — in one case one of our clients was hit by a bus and admitted to a state hospital in Spain with a broken back — and the nurses turned him over every half hour," he says.

Having ensured that the client has the best medical attention available, Europ Assistance also takes care of the expense through its insurance policies.

"The average cost of a consultation with a GP, excluding medicine, comes to R280 in the UK, R220 in the US, R160 in Israel, R85 in Germany and R58 in Australia," he comments.

"Hospital costs can be anything from R1 000 to over R120 000 a day — excluding medicines, doctors' bills and so on. It would not be unusual for a minor operation in Los Angeles to cost R75 000."

In addition to expertise the group offers access to the most sophisticated airborne medical care in the world.

"We can turn any aeroplane into a state-of-the-art intensive care unit," comments Mr Novis.

"Clients who need care while travelling in Europe or America are accommodated on regular flights — we buy enough first-class seats for them to be able to lie down, and to carry a doctor, nurse and equipment.

"In Africa, where scheduled flights are few and far between and health care standards are primitive, we use Learjets to fetch sick or injured clients, who within half an hour of our arrival will be better accommodated than they could hope to be on the ground."

The extra services offered by the group schemes include legal assistance; bringing in a replacement staff member from the country of origin if a businessman is incapacitated.

Laws must change, says Medicaid man

Star 15/4/91 (299)

MEDICAL aid schemes are being hampered by unfair legislation which allows insurance companies to undermine their stability by "skimming the cream" out of their memberships, says Jeff Slome, MD of national medical schemes administrator Medicaid Administrators.

"The only way to solve the crisis created by spiralling medical aid contributions is to change the Insurance Act and the Medical Schemes Act to allow schemes to market medical insurance packages and adopt a completely different approach to rating contributions," he says.

Mr Slome advocates rating contributions on the basis of age as opposed to the present system of rating according to income.

"Our whole approach to medical aid has been wrong. We have allowed a system to evolve in which the law preve us from conducting medical schemes on sound business principles.

"For example, insurers are allowed to offer packages rated according to the risk involved. They may also exclude bad risks or cancel cover.

"Medical schemes, however, are required to accept all risks, and when claims experience is poor they are obliged to keep the risk covered. The playing fields are not level," he says.

The upshot, says Mr Slome, is that insurance companies draw the young, healthy, low-risk members with their tailor-made health insurance packages.

Treatment WILL be more costly

Health Care in the 90's
A Star survey

MEDICAL inflation is rising at a rate of 21 percent a year — rapidly outstripping medical aid members' benefits as well as salaries.

"People will have to contribute a greater proportion of their incomes to medical costs — which makes some form of medical cover indispensable," says Standard Bank Insurance Brokers MD Doug Tunbridge.

Hospital cash products are one supplement to medical aid plans. Designed to meet the shortfall between medical aid pay-outs and hospital charges, these pay out if the client is hospitalised.

Mr Tunbridge suggests guidelines to help buyers select the best option for themselves:

- Don't be purely cost-sensitive — balance the premiums payable against the benefits offered.
- Decide whether you want a basic, low-benefit product or an all-encompassing, high-benefit one — and decide whether the product is for yourself or your family.

UWC's new school a giant step for health

ST Times [CM] 19/11/91 (299)

By GLENDA NEVILL

THE first School of Public Health will open at the University of the Western Cape in 1993, marking a giant step forward in primary health care in South Africa.

Co-ordinating the initiative is Dr Olive Shisana, a social epidemiology graduate of the Johns Hopkins University's School of Hygiene and Public Health in the US.

Pietersburg-born Dr Shisana returned to SA recently after 15 years in exile to take up a post as a specialist scientist at the Medical Research Centre and to develop the School of Public Health.

She was the acting chief and registrar of the Research and Statistics Division in the Department of Human Services for the District of Columbia Government when she decided to end her exile.

"The first step is a colloquium early next year which will include representatives from the Department of National Health, Stellenbosch University, UCT, UWC, Pentech, Cape Technikon, nursing colleges and non-government organisations like the ANC," she said.

OLIVE SHISANA
Course co-ordinator

The aim of the colloquium is to work out the finer details of the course, including funding and the syllabus.

"We are hoping the Department of National Health will help with funding as it is really the government's responsibility. The department has committed itself to attending the colloquium, but not yet to the funding," Dr Shisana said.

South Africa faces major public health problems as large sections of the population have poor access to health services. Ill-conceived health policies have led to a lack of health planning skills and of trained public health personnel.

"Besides the lack of personnel, no research is being done in this field," said Dr Shisana. "In my opinion we need at least three public health schools to make a difference."

In a paper she wrote on the subject, Dr Shisana defined primary health care as "an approach to health services delivery that provides appropriate, accessible and affordable care and promotes equity".

The School of Public Health will offer a Masters degree in public health as well as a diploma course.

UWC will offer short courses during 1992 designed to upgrade the competence of untrained or under-trained workers in the field while the proposal for the School of Public Health is being fine-tuned.

Healthy workers

LACK of primary health care in the work place has led to a crisis in SA, causing unnecessary absenteeism and death.

The new Primary Health Care Project, launched in conjunction with the Department of Health and the Epidemiological Research Council, plans to tackle the problem.

There are about 700 health care projects in SA, all of which need visual material to do their jobs properly. Health Care Project offers a set of eight video modules in English, Xhosa, Zulu and South Sotho.

Businessmen are offered a set for R4 700. For each set they buy, they will be given a second one which they can give to a clinic of their choice with their logo embossed on the cover.

Union and wholesalers sign mum-and-dad pact

299

SHARON SOROUR
Labour Reporter ARG 18/11/91

A PARENTAL rights agreement — the most progressive to date — has been clinched between wholesale giant Makro and the SA Commercial, Catering and Allied Workers' Union.

In a joint statement the parties said the agreement, which affects 2 500 employees, was a long-term investment in the future of South Africa.

In terms of the pact, signed in Sandton at the weekend, all women are entitled to 12 months' maternity leave, subject to the following conditions:

● Pregnant woman can choose when to begin maternity leave provided it starts no later than four weeks before the expected date of birth.

● The mother will be entitled to return to work eight weeks after the birth but no later than 11 months after the birth.

● Makro will grant one month's paid leave after a still birth if a signed medical certificate is produced. Further leave will be granted if recommended by a doctor and if all sick leave has been used.

● If a woman miscarries in the first 28 weeks of pregnancy she will be given two weeks' additional sick leave.

Employees who qualify for maternity leave and who receive the full six months Unemployment Insurance Fund benefits shall be paid for a maximum of nine months.

This will be at a rate of 33 percent of monthly salary for the months they receive UIF benefits and 50 percent of salary for a further three months.

Paternity rights were entrenched, with fathers receiving 14 working days' paid leave.

"A novel provision is that men may use these days to attend ante-natal classes with the pregnant women," said union negotiator Fiona Dove.

If the woman is also a Makro employee, the father may share her maternity leave and will be paid at a rate of a third of normal salary during that time.

Couples do not have to be married to qualify but must have at least nine months' service.

Public health service 'too fragmented'

B Day 18/11/91

299

GERALD REILLY

PRETORIA — Fragmentation of health services had to be eliminated as far as possible because the country could not afford the duplication, National Health and Welfare Minister Rina Venter said in Durban at the weekend.

She said SA was currently spending 6,4% of GNP on health services and that 80% of the population depended on the state for services.

Speaking at a meeting of the Co-ordinating Council of Local Authorities, Venter said SA's present health dispensation was not the answer because services were not affordable. They were also inaccessible to large sections of the community.

She believed services would have to be rendered at the lowest level of government.

Centralisation of executive functions had to be avoided and, within the limitations of the present constitution, fragmentation had to be eliminated.

Cabinet had accepted that all primary health care services would be rendered by local authorities.

Medical aid curbs urged

GERALD REILLY (299

PRETORIA — Consideration would have to be given to limiting or rationing medical aid members' benefits because of the increasing strain on the schemes' resources, Southern African Association of Medical Schemes chairman Keith Hollis said yesterday.

This would make it possible for schemes to operate within budgets and avoid a huge increase in members' subscriptions, he said.

Two factors had placed a tremendous burden on schemes — the escalating costs of treatment and a sharp increase in members using their benefits.

The introduction of VAT had added another 5% to overall costs.

Highlighting the financial difficulties facing many schemes was the expected record benefit payouts of around R6bn this year. BTDay 19/11/91

Hollis said most funds were struggling to maintain reserves.

It had been estimated that costs would rise during the year by about 20%.

Next year the 15% increase in doctors' scale of benefits would come into operation.

Time to sweeten health dilemma

Star 19/11/91 (299)

SOUTH African actor Ron Smerczak is a normal, productive person, who takes special care with his diet and lifestyle. He has to because he is a diabetic.

But he is deeply concerned about the spiralling cost of insulin which, he says, is threatening to become unaffordable for many insulin-dependent diabetics.

It is estimated that at least 5 percent of South Africans are diabetic, and 20 percent of those are insulin dependent. Diabetes is particularly prevalent in the Indian community, where some entire families are diabetics.

Smerczak says it costs him and thousands of other diabetics R10 000 to R12 000 a year to buy phials of insulin to stay alive.

He spoke on a radio station this week about the "morally iniquitous" exploitation of a captive market.

Huge bill

He says that figures in his possession show the wholesale price of a phial to retailers was R61,86. The retail price was R102,07 including VAT.

"If a diabetic is not wealthy, the State does provide insulin. But those who are not impoverished, but not wealthy, end up with a huge bill which is not tax deductible," he says.

"This is discrimination against people with a life-threatening disease. They cannot live without their insulin, although diabetics are normal, productive people. They are often healthier than others because they take great care with their diets and lifestyles."

He adds: "We are facing a brick wall — not the drug companies or pharmacists, but a government which doesn't care about people."

Dot Shuttleworth, SA Diabetes Association Natal branch secretary, says the price of insulin is "ridiculous".

"Some Durban diabetics get treatment at the diabetes clinic at Addington Hospital. But many diabetics' medical aid funds run out by May or June. Some are lucky and get an extension from their medical aid society, but others have to foot the bill.

"Insulin dependent diabetics cannot do without their doses even for a short time. Within four days of not taking insulin, a person can slip into a coma and die. I remember a little boy saying his family could not afford holidays or toys because their first consideration was to buy insulin to keep his mother alive."

Natal University Medical School's Professor Y K Seedat, a recognised world authority on diabetes and hypertension, says the cost of drugs for such chronic conditions as diabetes, hypertension and heart disease is escalating to the extent that medical aid societies are increasingly unable to cover the costs.

"There is little doubt that this is all leading to one important fact: we will have to face a national health insurance scheme."

Doctors must be educated on the correct usage of drugs so that the "more cost effective drugs in a Third World environment" are used.

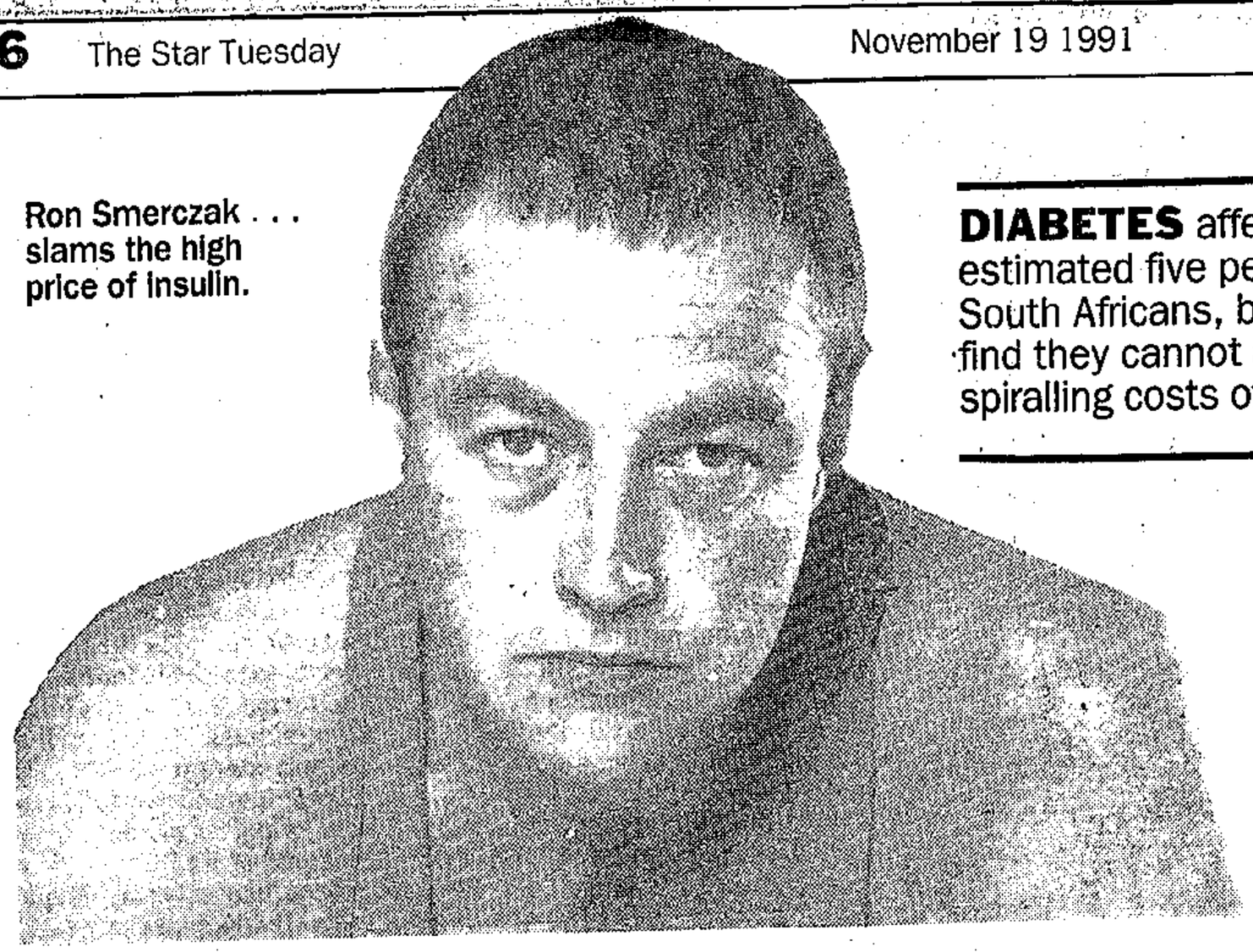
Cheaper drugs

"If one needs insulin, that is what one needs. But when dealing with high blood pressure, for instance, which is often associated with diabetes, cheaper drugs can be used," he says.

Chris Lund, marketing manager of Novo Industries (Pharmaceuticals) which is the country's major insulin manufacturer, agrees that the price is high, but says: "The price we sell insulin at is one of the lowest in the world. But once it goes through the various channels, mark-ups and tax, it becomes higher than the average world price."

He says Novo had increased the cost of insulin by 15 percent in August, below the real inflation rate.

JANETTE BENNETT



Ron Smerczak . . . slams the high price of insulin.

DIABETES affects an estimated five percent of South Africans, but many find they cannot afford the spiralling costs of insulin.

Health care comes on too strong — study

Southside 21/11 - 27/11/91. 299

WHILE HOSPITAL facilities are desperately limited, available medical care resources are not being used in the most effective way. This is the finding of researchers at the Medical Research Council (MRC).

The research found high-level health care facilities are being used by patients who do not need them.

Researchers believe over half the days patients spent in a ward at a large academic hospital in Cape Town could have been spent receiving cheaper and less sophisticated but equally effective care.

The study, in the latest South African Medical Journal, showed nurses spent too much time attending patients who could have been treated at lower levels.

The aim of the study was to determine levels of care necessary as opposed to the amount of professional care provided.

The researchers also tried to estimate how much of the tertiary hospital's resources were being expended on patients who required lower-level care facilities.

Of the total number of patient days (the days every patient spent in the hospital), 54,5 percent could have been spent at a lower level of care, researchers found.

They said 27 percent of patient days could have been spent in a hospital that did not have full-time specialist care, while 20 percent could have been spent in a convalescent hospital with patients seeing a doctor only once every two or three days.

Home care would have been appropriate for 6,8 percent of patient days.

Dr Merrick Zwarenstein, the project's principal investigator, said health care could be provided more economically if more lower-level facilities — primary health care clinics or non-specialist hospitals — were available.

"To lighten the load for our specialist hospitals, primary health care facilities should be expanded and referral patterns improved," said Dr Zwarenstein.

"The plight of South Africa's public sector hospitals has been highlighted in the media over the last year. We must plan for and develop the necessary community health infrastructure if we hope to preserve our sophisticated tertiary health services.

"We must provide appropriate, affordable, quality health care which is accessible to the community."

He said work was necessary to confirm the findings at other hospitals, and a national plan needed to be formulated so that all hospitals and health care resources were used in a cost-effective, coordinated way. □

August, 1991

SA's first private blood bank now open

DAVE LOURENS

SOUTH Africans concerned about the health risks associated with blood transfusions can now build up their own deposits.

The Private Blood Bank of SA was established this month to provide an "autologous" blood service. An autologous transfusion involves the collection and reinfusion of a patient's blood.

Blood Bank MD Malcolm Macdonald said the company had been inundated with calls from the public and surgeons.

"The bulk of our market is elective surgery. Most surgeons say they would prefer to reinfuse their patients' blood. This reduces the chances of incompatibility or rejection."

This would rule out the possibility of contracting AIDS and other diseases, although Macdonald said none of his prospective clients had cited AIDS.

"I do not think AIDS can be contracted from a transfusion in this country. We have the best transfusion service in Africa."

The Private Blood Bank charges R160 per 450ml unit of blood for the first nine months. Thereafter storage is R60 a year.

The bank's advanced technology allows blood to be preserved for up to five years instead of the usual 35 days.

"In 90% of cases a patient would not require more than five units of blood during surgery. A healthy person can donate about three or four units a month," said Macdonald.

The bank, operated by 22 staff members, has sufficient storage capacity for 45 000 units. The service is only available in Johannesburg, but it is planned to expand to Cape Town in January and to Durban in March.

First National Corpora
and/or their renounce
representing 99,55%

The underwriter, Gen
rights.

Johannesburg
22 November 1991

Insurers deal new blow to medical aid schemes

By MONDLI MAKHANYA

LIFE assurers' forays into medical insurance may speed up the establishment of a compulsory national health fund.

Medical insurance schemes — as opposed to medical aid schemes — have proliferated. There are now more than 30 in South Africa.

This is set to deal yet another blow to the medical aid movement, which is already threatened by excessive and fraudulent claims.

Medical aid schemes will not take this lying down. The Medical Schemes Bill — due before parliament soon — will allow medical schemes to venture into assurers' territory and they have indicated they will do so.

Precipitated by rising health care costs — medical inflation is running at 23 percent — the policies are being as marketed as "top ups" to existing medical aid schemes.

Two good examples of comprehensive insurance schemes are those of Old Mutual and Liberty Life.

Old Mutual stresses that a medical aid member who has to undergo a coronary bypass would have to make up the difference between the cost of the operation — about R28 000 — and what the medical aid scheme will pay. This can range from R2 500 to R13 000.

The Old Mutual Flexicare policy and the Liberty scheme provide for the full cost of hospital stays and also cover 100 percent of operation costs. An "income replacer" benefit substitutes for one's income where illness or injury causes temporary or permanent paralysis.

Medical aid schemes concede the insurance houses' innovation is plugging the gap between rising health care costs and inadequate cover, but Representative Association of Medical Schemes director Rob Speedie says the playing fields are not level.

For instance, legislation bars them from providing health care insurance. However, once deregulation as envisaged by the new Bill has been passed, they will be free to provide a much wider cover.

Speedie points out: "At the moment our hands are tied. We cannot be innovative and we cannot bring new products on to the market."

Whereas medical insurance certainly fills a market gap, it also has its flaws. Notes Cedric de Beer, of the University of the Witwatersrand Centre for Health Policy Studies: "In the marketing of their products they have omitted to say that premiums will rise with medical inflation. Although the premiums are relatively low right now they may be hiked by 23 percent next year."

What the assurers' bite into the health care cake might do is to usher in the restructuring of health care funding in South Africa. About R4,5-billion a year is spent on national health by government. Total expenditure of health care represents 6,5 percent of gross national product.

From the ashes of the medical aid system could arise a compulsory national health care fund with the state contributing on behalf of the unemployed.

Another scenario — one favoured by medical aid schemes — is of health maintenance organisations being organised under their auspices.

Medaids want equal terms with insurers

MEDICAL-aid schemes are pinning their hopes on a proposed law to help them counter the invasion of health care by insurance companies.

Insurers began their thrust into health care this year by offering so-called top-up cover of costs not covered by conventional medaids and for those without medical benefits.

The insurers cover major costs only, leaving the policyholder to carry minor expenses.

Many insurance premiums are lower than medaid subscriptions.

Representative Association of Medical Schemes (RAMS) executive director Rob Speedie says medaid schemes cannot compete with insurers under present regulations.

Medaid schemes are obliged by legislation to provide cover that does not fit most members' needs.

If passed, the draft Medical Schemes Amendment Bill will put this right.

Unlike insurance companies, medaids have to provide a full range of cover. This means they have to cough up from the first rand.

Members cannot reduce their subscriptions by buying cover for major expenses only and self-insuring for minor expenses such as visits to a doctor.

By TERRY BETTY

Medaids are not allowed, without permission, to pay a member more than 100% of the scale of benefits. They may not offer cover for expenses incurred while a member is incapacitated. These include loss of income and the cost of recuperation.

Another issue dealt with in the draft amendment is the investment curbs placed on medaids.

Mr Speedie says 40% of medaids' net assets have to be invested in approved securities, such as RSA stock, which have relatively low yields. Their income from reserves is lower because they have limited investment opportunities.

FK Insurance managing director Steve Navra predicts that insurers will take over 95% of the private health-care market.

But Mr Speedie says insurers are looking after a maximum of 25% of the private health-care market. They provide cover mostly for costs arising from hospital treatment and surgery.

Insurers do not generally provide for charges by general practitioners, pharmacists and dentists, for which most claims are made.

An estimated R19-billion a year is spent on health care. Medaids cover most of the private sector and are believed to handle R7-billion a year. The rest is spent by the State.

Skills

The private sector's share is growing because State expenditure on health care is decreasing. By reducing subsidies, the Government aims to make charges at provincial hospitals the same as in private ones by the end of 1992.

Mr Navra says insurers have an advantage in being skilled in marketing their products. Medaid schemes have traditionally waited for business.

But Mr Speedie says medaids have a far lower cost structure than insurers in spite of the fact that the minor claims, which insurance companies do not cover, are the most expensive to administer.

Only 6% of medaids' subscription income is spent on administration. Costs are also lower because medaids do not pay brokers a commission.

Mr Speedie believes the entry of insurance companies to health care helps medaids because competition will give them the incentive to consolidate and innovate.

Consolidation will give greater financial stability to the schemes as well provide a greater spread of risk.

More admissions boost earnings at Medi-Clinic

B/Day 25/11/91.

HELPED by a growth in admissions and higher operating margins, private hospital group Medi-Clinic reported an earnings boost of 32% to R12,9m from R9,7m for the half-year to September.

A dividend of 2c (1,5c) a share was declared on earnings a share of 7,6c (5,8c).

Operating income at the group, in the Rembrandt stable, rocketed 67% to R19m from R11m on a 21% injection in turnover growth. (No turnover figures were given.)

Although earnings were helped by the rise in interest received to R2,5m (R1,4m) this was more than offset by the sharp rise in the tax charge which jumped to R8,5m (R3,1m).

As the convertible debentures in issue were considered to be permanent capital, the interest charge was deducted below the earnings line.

WILLIAM GILFILLAN

This debenture interest charge, at R4,32m, was slightly down on last year's R4,34m as debentures in issue had dropped to R78,5m from R79m.

Directors said occupancy levels were satisfactory despite indications that the average length of stay by patients was dropping.

They also said negotiations to sell — under sectional title — the unutilised area of Mitchells Plain Medical Centre were at an advanced stage.

The first patients at the new Stellenbosch hospital would be admitted in April next year.

Call to save medical aids

B Day 26/11/91

299

PRETORIA — SA's top health official warned yesterday that drastic action was needed to save medical aid schemes from imminent disaster.

National Health and Population Development director-general Coen Slabber told a conference on proposed amendments to the Medical Schemes Act that 88 of the 200 registered schemes suffered operational losses last year.

Last year the schemes paid out R1,4bn more in benefits than in 1989 and it was estimated that next year's increase could be double that amount.

A factor causing great concern was the number of beneficiaries, which had grown by only 1,9% last year.

"It is clear, therefore, that something drastic has to be done to save the system from disaster," Slabber said.

A draft Bill had been compiled after

GERALD REILLY

submissions from interested parties on possible shortcomings in legislation.

Sapa reports the executive director of the Representative Association of Medical Schemes (RAMS) Rob Speedie said health care was heading for "deep trouble" unless deregulation not only of the Medical Schemes Act, but also of the health care professions, such as medicine, dentistry and pharmacy was quickly put in place.

Medical schemes were battling to contain claims costs within the limits of subscription revenue.

"RAMS approves of the proposed critical amendments to the Medical Schemes Act, namely elimination of the system of guaranteed [illegible] scales of benefit, as well as the [illegible] of maximum and minimum benefits for schemes."

Subscriptions set to leap as societies battle to survive

Medical aid shock looms

STAR 26/11/91

By Carina le Grange (299)
Medical Reporter

Medical aid members should brace themselves for an increase in subscriptions in January, as high as 40 percent, say experts.

Rates increases ranging from 25 to 40 percent for some medical schemes were implemented in October with the introduction of VAT, according to a director of Medicaid Administrators, Quentin Robinson.

"Those waiting for their annual increase in January are looking at 40 percent," he said.

Spokesmen for individual schemes confirmed yesterday that the expected increases would be "substantial", although final figures had not been decided.

It was reported earlier this year that the cost of medical aid contributions had risen by 322 percent over the past seven years, while the consumer price index had increased by less than half that — 151 percent.

Mr Robinson stressed that members of schemes which introduced annual increases in October would not face another increase in January.

To add to the gloom, the director-general of the Department of National Health and Population Development Dr Coen Slabber yesterday released figures at a conference in Pretoria on the proposed Medical Schemes Amendment Act which illustrate the sick state of the medical schemes sector.

Dr Slabber said 88 of South Africa's 240 medical schemes showed losses totalling R100 million last year. Nine were insolvent.

He said that last year medical schemes paid out R1,4 billion more in benefits than in 1989.

Reacting to Dr Slabber's opening address, the executive director of the Representative Association of Medical Schemes (RAMS), Rob Speedie, said health care was "headed for deep trouble" unless deregulation came into force.

Deregulation was needed not only in the Medical Schemes Act, but also regarding restraints on doctors, dentists and pharmacists.

Mr Speedie said Dr Slabber confirmed what RAMS had been saying for some time — that medical schemes were generally battling to contain claims costs within subscription revenue.

With virtually no increase in the number of beneficiaries last year, medical scheme expenditure on benefits nevertheless rose by an alarming 36 percent over 1989 expenditure — which resulted in medical schemes increasing their subscriptions this year to "virtually unacceptable levels".

The Star's Pretoria Correspondent reports that yesterday's conference was marked by controversy when a group of delegates called it undemocratic and demanded it be called off.

Speaking on behalf of six organisations — including the National Medical and Dental Association and the Dispensing Family Practitioners' Association — Dr Robert Rapiti said the conference, organised by Dr Slabber's department, was undemocratic as it was not representative of all organisations concerned with health care.

Dr Rapiti suggested the meeting be called off and reconvened at a neutral venue under a neutral chairman, but the conference continued after a show of hands.

'Brace yourself for a 40% rise in medical aid rates'

299

ARG 26/11/91

The Argus Correspondent

JOHANNESBURG. — Medical aid members should brace themselves for a subscription increase as high as 40 percent in January, according to experts.

Increased rates ranging from 25 to 40 percent for some medical schemes were already implemented in October with the introduction of VAT, according to Medicaid Administrators' director Mr Quentin Robinson.

"Those waiting for their annual increase in January are looking at 40 percent," he said.

Spokesmen for individual schemes confirmed yesterday that the expected increases would be "substantial", although final figures had not been decided.

It was reported earlier this year that the cost of medical aid contributions had risen by 322 percent over the past seven years, while the consumer price index had increased by less than half at 151 percent.

Mr Robinson emphasised that members who belonged to schemes which introduced annual increases in October would not face another increase in January.

Mr Rob Speedie

To add to the gloom, the Director-General of the Department of National Health and Population Development, Dr Coen Slabber, yesterday released figures at a conference in Pretoria on the proposed Medical Schemes Amendment Act which illustrated the sick state of the country's medical schemes sector.

Dr Slabber said that 88 of South Africa's 240 medical schemes showed losses of R100 million last year. Nine of these schemes were insolvent.

He said in 1990 medical schemes paid out R1,4 billion more in benefits than in 1989.

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Mr Speedie said Dr Slabber confirmed what Rams had been saying for some time — that medical schemes were generally battling to contain claims costs within the limits of subscription revenue.

He pointed out that with virtually no increase in the number of beneficiaries in 1990, medical scheme expenditure on benefits rose by an alarming 36 percent over 1989.

This resulted in medical aid schemes increasing their subscriptions in 1991 to "virtually unacceptable levels".

Med aids 'head for disaster'

CT 26/11/91 (299)

Own Correspondent

PRETORIA. — Drastic action is needed to save medical aid schemes from imminent disaster, warned the country's top health official yesterday.

National Health and Population Development director-general Dr Coen Slabber told a conference on proposed amendments to the Medical Schemes Act that 88 of the 200 registered schemes last year suffered operational losses.

Last year the schemes paid out R1,4bn more in benefits than in 1989 and it was estimated that next year's increase could be double this amount.

"It is clear that something drastic has to be done to save the system from disaster," he said.

Dr Slabber said a draft bill had been compiled after submissions from interested parties on possible shortcomings in the legislation.

Sapa reports the executive director of the Representative Association of Medical Schemes (RAMS), Mr Rob Speedie, said health care was heading for "deep trouble" unless deregulation not only of the Medical Schemes Act but also of the health care professions such as medicine, dentistry and pharmacy was quickly put in place.

"Dr Slabber has confirmed what RAMS has been saying for some time — namely, that medical schemes are generally battling to contain claims costs within the limits of subscription revenue.

"RAMS approves of the proposed critical amendments to the Medical Schemes Act, namely the elimination of the system of guaranteed payment and scales of benefit, as well as the scrapping of maximum and minimum benefits for schemes."

Private hospitals ward off recession

B|D aug 26/11/91.

WILLIAM GILFILLAN

RECENTLY announced interim and year-end results from private hospital groups had shown how well this sector had operated through the recessionary climate.

Yesterday Medi-Clinic — in the Rembrandt stable — announced interim results showing a 67% surge in operating profit to R19m (R11m) on the back of a 21% rise in turnover.

Although the 32% rise in earnings, at R12,9m, was more moderate, this increase was equally impressive after taking into account the sharply higher tax charge of R8,5m (R3,1m) endured by the group.

At the beginning of the month African Oxygen (Afrox) recorded a 29% jump in earnings to R83m for the year to September. The group is SA's second largest private hospital group.

Afrox's trading profit was up 20% to R215m on the back of a 15% turnover hike to R1m. Although it was difficult to analyse the growth of the healthcare division, chairman Peter Joubert said its contribution to consolidated profits had increased to 20% (15,5%).

President Medical Investments (Presmed), announcing its interim results, recorded operating income up 36% at R5,2m. Turnover, at R34m, was 41% higher while earnings surged 45% to R1,6m.

An industry source said Clinic Holdings, with about 2 600 beds, was the largest group and then came Afrox (about 1 900), Medi-Clinic (about 1 600) and Presmed (about 600).

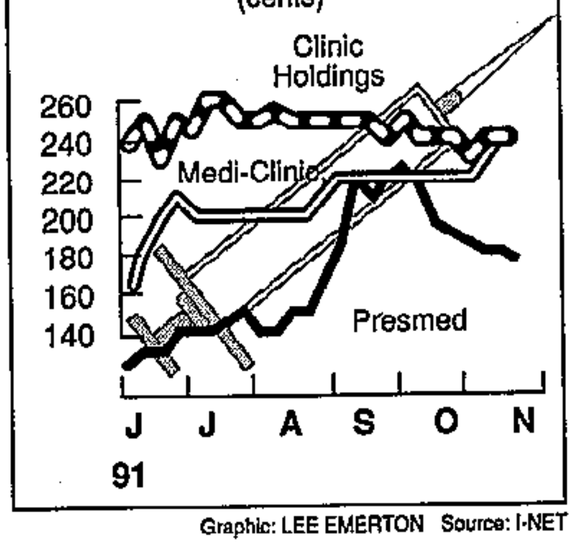
But the market had accorded the various "full" hospital groups — Clinics, Presmed, and Medi-Clinic — differing ratings. Presmed and Clinics, at about 8,8 and 9,1, had the lower price to earnings ratios whereas Medi-Clinic was given a ratio of about 12,1.

An analyst said one reason for this was that properties within the Clinics and Presmed groups were owned by outside entities who leased the properties to the hospital groups.

Medi-Clinic, on the other hand, owned the properties and so its shareholders benefit from capital appreciation in the properties.

Clinic Holdings,Medi-Clinic, Presmed

Share prices, weekly close (cents)



Graphic: LEE EMERTON Source: I-NET

Assurance on medical aids

299
B/Day 27/11/91

DAVE LOURENS

THE Representative Association of Medical Schemes (Rams) moved yesterday to reassure worried medical aid subscribers, saying it was highly unlikely any further schemes would fold.

Concerns were voiced after National Health and Population Development director-general Coen Slabbert disclosed that nine schemes were insolvent and a further 88 had traded at a loss last year.

Rams executive director Rob Speedie said schemes had taken the necessary action to guard against insolvency, but expressed his dismay at the large increases necessitated by rising expenditure.

Speedie said a managed health care system, coupled with the deregulation of the health care industry, was urgently needed to prevent medical cover being driven beyond the reach of most people.

"From December 1989 to December 1990 there was a 1,9% increase in the number of subscribers, which indicates only negligible numbers are dropping out. But if we continue to see annual increases above 25%, we will rapidly reach a stage where comprehensive cover will be unaffordable.

"The current system does not encourage any cost-consciousness on the part of either consumers or suppliers of health care products."

Speedie said the overall bill of medical schemes was driven by two elements: price of services and volume of usage.

Both of these could be held in check through a more flexible, deregulated system.

GERALD REILLY reports Speedie said the explosion of services to members of medical aid schemes would force most schemes to cut back sharply on overall benefit levels next year.

This year schemes had been forced to raise subscriptions by up to 25%. Only between 5% and 7% was due to the introduction of VAT.

Health care inflation, Speedie stressed, was running ahead of the general inflation rate of 16% by nearly 10%.

Under these conditions funds had no alternative but to reduce benefits if they hoped to stay within budget limits.

Adjustments to subscriptions were inevitable in the new year. Added to other inflated costs would be a 16% increase in doctors' scale of benefits from January 1.

Uproar over medical aid hike

Sowetan 29/11/91 (299)

THE National Medical and Dental Association has called for the disbanding of all medical aid societies following an announcement that subscription fees were expected to increase by up to 40 percent in January.

Namda's general secretary, Dr Fazel Randera, said: "Namda noted with increasing interest on the

Sowetan Reporter

one hand and distress on the other the notice given by certain medical aid societies of an impending increase."

Randera urged medical aid schemes to explain clearly the reasons for this new increase when patients were recently asked for an increase ranging from 25 to 40 percent as a result of the introduction of VAT.

"In our opinion, the medical aid societies are in crisis and are not able to respond to the inevitable increase in health care demanded by our population."

The director-general of the Department of National Health and Development, Dr Coen Slabber, released figures on the proposed Medical Schemes Amendment Act which illustrated the poor state of the medical schemes sector during a conference in Pretoria.

Dr Slabber said 88 of 240 medical schemes in the country showed losses totalling R100 million last year.

Reacting to Dr Slabber's remarks, the executive director of the Representative Association of medical Schemes, Mr Rob Speedie, said health care was headed for deep trouble unless deregulation came into force.

Speedie said Slabbert confirmed what Rams had been saying for some time - that medical schemes were generally battling to contain claims costs within subscription revenue.

More aid failures 'unlikely'

(299)
CT 27/11/91

THE Representative Association of Medical Schemes (RAMS) yesterday assured worried medical aid subscribers that it was highly unlikely that any more schemes would fold.

Concern was voiced after National Health and Population Development director-general Mr Coen Slabber disclosed that nine schemes were insolvent and a further 88 had traded at a loss last year.

RAMS executive director Mr Rob Speedie said schemes had taken the necessary action to guard against insolvency, but expressed dismay at the large increases necessitated by rising expenditure.

Mr Speedie said short term solutions would include cutbacks in benefits or the "increasingly unacceptable route" of escalating contribution rates, neither of which was "in the interests of anybody".

The proposed amendments to the Medical Schemes Act would free up the market to allow health-maintenance and preferred-provider organisations that operated on a contract basis with health care insurers to provide health care services.

Health-maintenance organisations employed all their own staff and owned pharmacies, clinics and hospitals, which gave them full control over their expenditure.

Preferred-provider organisations were independent practioners' associations contracted with an insurer on a pre-paid per capita basis.

When new legislation allowing such organisations was passed, patients would have greater freedom of choice of service, and a much lower rate of escalation of health care costs would result.

● The Society of Dispensing Family Practitioners (SDFP) is opposed to medical aid schemes being allowed to provide health services, saying that patients must always have the freedom to choose which service provider they wish to use. — Staff Reporter, Own Correspondent and Sapa

Clinics at centre of charges row

DAVE LOURENS

THE Johannesburg municipal medical aid scheme has accused two private clinics of charging more than R100 for four disposable gowns which, it claims, should have cost just a few rands.

The clinics claim the scheme has got its facts wrong and that they have been unable to locate so cheap a gown.

Jomed vice-chairman Rhett Gardener yesterday accused private hospital chain Clinic Holdings of gross overcharging.

Gardener said serious overcharging on disposable surgical gowns at the Garden City and Rosebank clinics had been brought to his attention. Patients had been charged more than R100 for four gowns used during operations, and in one instance a patient was charged R323.

He said disposable aprons used by the Johannesburg Hospital cost only 50c each, and it was unlikely that disposable gowns cost much more.

Garden City Clinic manager Dr Andre Nel rejected Gardener's allegations. "In our endeavours to cut costs, we have gone to considerable effort to secure a local operating gown which is much cheaper than those usually used. The local gown retails at R28,40, as opposed to R80. We would be grateful if Mr Gardener could assist us in locating a gown at 50c. Unfortunately he has not been able to do so."

Medicaid Administrators MD Jeff Slome said: "Problems are certainly not confined

☐ To Page 2

Clinics

From Page 1

to Clinic Holdings; there are problems with the majority of private hospitals, stemming from the current system.

"It allows private hospitals to add all sorts of medicines and other items to patients' bills which they may or may not actually be using. The way around that is to introduce a fixed fee for certain operations, which would remove the incentive.

"There is also the problem of patients being kept in hospital for longer than necessary. This form of abuse is particularly widespread," said Slome.

Representative Association of Medical Schemes (Rams) executive director Rob Speedie said he had no knowledge of the Jomed-Clinic Holdings dispute but reports Rams had received from medical schemes indicated the loading of bills was a "fairly widespread" practice. The area of most disagreements was that of consumeables such as drugs, medicines and dressings.

"We need the automatic guarantee of payment to disappear to allow medical schemes to question accounts," said Speedie. "At the moment medical schemes have to pay up without question."

Proposed amendments to medical scheme legislation are at present before National Health and Education Minister Dr Rina Venter.

By Sabata Ngcai

'Hopeless case', so ill boy sent home

South 28/11 – 4/12/91. (299)

A MENTALLY-RETARDED Guguletu boy, who has a pipe connected from his swollen head to his bladder, has been discharged by Red Cross Children's Hopspital because he is "a hopeless case the hospital could do nothing about".

According to the boy's father, Mr Maynette Tebene, three-year-old Ndumiso Tebene was discharged by the hospital two weeks ago "despite reeking wounds and smells all over his body".

Tebene said his son, who now stays with nuns at Missionaries of Charity Home in Khayelitsha, had undergone an operation at Cecilia Makiwane hospital in Ciskei for a swollen head.

He said a long pipe, connecting from head to the bladder, was put inside his body to drain water from the head.

"As I was then living in Khayelitsha, the nuns whom I had befriended, requested that I should leave the crippled child under their care to enable myself and my wife to look for jobs.

"It was during his stay at the home that he began to contract epileptic fits and was taken to the Red Cross hospital for treatment.

"I went to the hospital and I met a doctor from Groote Schuur who was apparently there on rounds. He told me that the cause of the fits was that the pipe was dirty and had blocked.

"The doctor, whom I did not identify, promised to transfer the child to Groote Schuur for treatment. But when I phoned, on the second day of the child's hospitalisation, I was told by a female nurse that I should come and fetch my child.

"After arguing with the nurses not to discharge the critical child, he was forcibly discharged and taken back to the nuns' home .

"The child was again returned to the hospital recently because his head had swollen terribly.

"He was discharged last week, after two weeks in hospital, despite smell, wounds and pus on his chest.

"He was dumped in the nuns' home because a doctor said there was nothing he could do about him.

"I also heard that the nuns have separated him from other people because of his smell and they had put a cross necklace around his neck and prayed for his death."

A sister in charge, who could only identify herself as "Sister Bertilla", confirmed a doctor from the Red Cross Hospital said the child was very sick and "a hopeless case".

She denied they had ever separated the child from others or prayed for his death.

Dr Buwembo could only say he treated the child and he was discharged "because it was time to discharge him".

Red Cross Hospital medical superintendent, Dr. Gilbert Lawrence, said the child was treated in the hospital since he was born three years ago.

"He is blind and seriously mentally retarded.

"A team of doctors, including our senior consultant, attended to the child.

"They unsuccessfully tried to remove a membrane from the brain to facilitate the flow of water from the head.

"The only option open to the doctors was to operate on the child.

"Because of the critical condition in which he was, we felt that the operation would have fatal results.

"We then decided that we should look around for a place where he could be cared for because we saw him as a terminally ill person.

"The doctor asked the sisters, who brought the child, if they could not look after him and they agreed.

"We did not abandon the child, we did our best to help him as much as we could."

Gavin Steinhouse and provin

Bank aims to cut out virus risk

By Zingisa Mkhuma

The first privately owned autologous blood bank in South Africa, which will allow patients expecting surgery to have their blood stored, began operating this month and was launched in Sandton yesterday.

The bank will provide an autologous blood service to collect and reinfuse a patient's blood at a fee. The blood could be stored for five years.

This method of banking blood will eliminate the risk of catching the Aids virus and other viruses associated with volunteer donor blood, Professor Harry Seftel of Johannesburg Hospital said at the launch.

He said existing testing methods were not safe, as they failed to determine if donors had the HIV virus during the "window period" which can last up to a month.

Give blood

This flu won't be a claim

CHRONIC Fatigue Syndrome - or yuppie flu, as it is sometimes called - cannot be classified as a permanent disability for disability insurance claims, says the Life Offices Association.

The LOA, which commissioned research on the subject, said this week dissatisfaction had been expressed at life assurers' decisions not to pay claims under policies for permanent disability where the insured had contracted CFS.

It said it had asked Dr Paul van Zijl, senior physician in the department of medicine at Cape Town's Tygerberg Hospital, to put forward an opinion.

His report, which was co-written by Mrs JM Barnes of the University of Stellenbosch's faculty of medicine, concluded that data obtained from research across the world did not support the notion that the condition caused permanent disability.

The report said: "In no country where permanent disability insurance is sold are disability claims paid out for CFS.

"This has been established by South African reinsurers through international contacts ... which these reinsurers have."

Mr Dick Geary-Cooke, executive director of the LOA, said it would not be in the interests of the general body of existing policyholders if life assurers paid benefits out of life funds for risks that people had not insured themselves against.

"I do not know the practical implications of insuring against contracting CFS, but in principle it should be possible to design such a product once sufficient experience of the condition has been acquired.

"Existing policies that provide permanent disability cover do not provide insurance against CFS, which the medical profession does not regard as causing permanent disablement." - *Sapa.*

First meeting of Soweto disabled

A MOTHER cradles a mentally handicapped girl during a meeting last weekend of 170 disabled people, their parents and family members in Soweto. It was the first attempt to co-ordinate efforts to assist the township's quarter-of-a-million disabled people.

This staggering figure is the combined result of township violence, infections that could have been cured, conditions that could have been prevented, as well as the usual disabilities that strike any society.

According to occupational therapist Ruth Beecham, project co-ordinator of an informal action group of paramedics in the speech, physio and occupational sections of Baragwanath hospital, it wants to help the disabled ensure their rights and aims to create a network of groups in the community to work with the disabled.

At the meeting on Saturday, held at the Takalani Home near Baragwanath, the organisers called on all the disabled people to use it as a platform to raise grievances, make suggestions and personally decide how services for the disabled could be organised.

Photgraph: KEVIN CARTER

Rap hunger strikers on the brink

Beleaguered medical schemes to hike rates

W/Mail 29/11-5/12/91.

By MONDLI MAKHANYA (299)

PREDICTIONS of a 40 percent hike in medical aid subscriptions will worsen the crisis in health-care funding.

Medical aids will increase subscription rates by between 25 percent and 40 percent from the beginning of next year. However, this hike will not affect all schemes as some already raised rates by 25 percent this year. Those increasing their fees next year will be taking into account a seven percent allowance for Value-Added Tax on medical services as well as a 16 percent increase in doctors' scale of benefit due in January.

With 88 of the country's 240 medical schemes having sustained R100-million worth of losses and a further nine having gone insolvent in the past year, the increases may knock more schemes out of the market. Escalating costs will push members out of schemes thereby forcing schemes to increase rates. This vicious cycle will feed on itself until a scheme just cannot continue operating.

Adding to the medical aids' headache is the increasing involvement of insurance companies in medical care. This is bound to attract medical aid subscribers who find the cost of medical aid prohibitive and the benefits limited.

Says University of Cape Town health economist Di McIntyre: "The high cost of medical aid will force self-employed people and young, single professionals to leave it because they never use all those benefits. They will rather opt for something that will take care of a major disaster such as landing in hospital."

Cape Town-based Family Practitioners Dispensing Association chairman Robert Rapiti reckons this process will cut the "overflooded" medical aid market to its proper size.

While medical aids are undergoing a natural trimming they are putting their hopes of salvation on the passing of the Medical Schemes Bill in parliament next year.

The Bill will — among other things — do away with guaranteed payment of the medical practitioner by the patient's medical aid. Medical aids have welcomed this as they hope it will cut out on the abuse of medical aid by doctors and patients. It will also allow them to branch out and possibly establish health maintenance organisations as well as venture into medical insurance.

But the Bill's passage may be sabotaged by some doctors' associations which feel that doing away with guaranteed payment will prejudice them as they will not be party to determining what a medical aid may pay. The Bill is also coming under attack from anti-apartheid organisations — particularly those party to the anti-VAT campaign — who see it as a major restructuring that should not be undertaken during the transition period.

To reduce cost pressures medical aids are doing away with cross-subsidisation, whereby the young and healthy subsidise the old and frail. Medscheme director Les Hollis says while this is regrettable, the simple fact of escalating costs makes it necesssary to rationalise in this fashion.

Medical Aids back Venter

VIVIEN HORLER
Medical Reporter

299

ARG 30/11/91

THE umbrella body of medical schemes is backing the efforts of Minister of Health, Dr Rina Venter, over the Medical Schemes Act.

Mr Rob Speedie, head of the Representative Association of Medical Schemes, yesterday said his organisation "unequivocally and wholeheartedly supported the proposed critical amendments to the Medical Schemes Act which are vital for the good health and continuance of the country's medical schemes".

He added: "We can only commend the National Health Minister, Dr Rina Venter, for energetically tackling the problems being encountered by medical schemes."

This week the Medical Association of South Africa, the association to which doctors belong, called on Dr Venter to resign, saying it had no confidence in her ability to sort out the country's health problems.

Dr Venter said she was "not prepared to communicate via the media".

Medical aid body backs Rina Venter

299 CT 30/11/91

PRETORIA. — The Representative Association of Medical Schemes (RAMS) yesterday jumped to the defence of the National Health Minister Dr Rina Venter — who has rejected demands for her immediate resignation by major representative bodies such as the Medical Association of South Africa, the National Medical and Dental Association, the SA Dispensing Practitioners and the Freedom Foundation.

Dr Venter's resignation is being demanded amid warnings that the country's health services were on the brink of "total disaster". She said she would not resign.

She said she was not prepared to take steps in health care purely to be popular and appealed to the medical association to study the Medical Schemes Act and to offer solutions.

The controversy erupted on Thursday when the Medical Association of South Africa (Masa) federal council chairman Dr Bernard Mandell accused Dr Venter of a lack of leadership, vision and insight and a failure to address health problems.

However, yesterday RAMS said that it "unequivocally and wholeheartedly supported the proposed critical amendments to the Medical Schemes Act, which are vital for the good health and continuance of the country's medical schemes". — Sapa

INSURERS VIE FOR THE MEDICAL AID BILLIONS

The R7 bn spent on medical schemes annually in South Africa seems to be up for grabs as a growing number of insurance companies and other firms launch medical cover schemes and set about marketing them aggressively. TONY JACKMAN reports.

A FIGHT to the death between medical aid schemes and private insurers seems to be in the offing as an increasing number of firms — from insurance companies to banks and credit firms — devise their own schemes in efforts to get a chunk of the health market.

Firms are so keen to capitalise on this relatively new market that many promise guaranteed acceptance of clients on application and one goes so far as to arrange automatic debit facilities on behalf of clients — a move that proved so unpopular with potential clients that the mailshot offer was hastily withdrawn and amended.

The battle for the hearts, minds and money of the country's mortal populace is set against a background of a year of tumult for medical aid schemes. Just this week Dr Coen Slabber, director-general of National Health and Population Development, disclosed that nine medical aid schemes were insolvent and another 88 had traded at a loss in 1990, though there was an accompanying assurance by the Representative Association of Medical Aid Schemes that it was "highly unlikely" that other schemes would fold.

Slabber, meanwhile, warned that medical aid schemes were "heading for disaster" and that drastic action was needed.

As for the future, fears have been expressed that next year it will cost as much to buy medical aid cover as it will to make provision for retirement and that the medical cover provided will become skimpier as employers streamline medical benefits. It is predicted that subscription increases for medical aid schemes will be as high as 40% in January, just three months after rises of between 25 and 40% were introduced with the introduction of VAT.

The invasion into health care by insurers began this year when companies

☐ To Page 20

Tussle for medical aid money

☐ From Page 19

began offering so-called "top-up" cover to compensate for supposedly inadequate medical aid cover.

The low premiums offered immediately attracted many people disillusioned by and worried about the collapse of so many medical aid schemes.

Insurers were able to capitalise on the fact that medical aid schemes are bound by law to provide a full range of cover and may not, without permission, pay a member more than 100% of the scale of benefits.

The law also requires medical aid schemes to invest 40% of net assets in low-yield approved securities.

As the market shifts, predictions are that insurers could take over as much as 95% of the private health-care market as they aim their traditionally vigorous marketing practices at a new target. While medical schemes have waited quietly for business to come in insurance companies traditionally have been keen marketers.

Among the boldest such strategies was a mailshot sent to 70 000 potential clients by Diners Club International to promote its Med Rescue medical assistance scheme. An accompanying letter advised Diners Club members that the monthly premium offered for protection for a whole family was a discounted price of R6,87, or R68,75 a year.

The letter, signed by MD Hugh Peatling, read: "I am so sure that you will recognise the benefits of this invaluable rescue service that I have arranged an automatic debit facility on your behalf via your Diners Club card account with effect from 1 December 1991."

The next paragraph states that if the potential client is not interested, he or she is "welcome to cancel" by phoning a Johannesburg number.

Peatling, contacted by Top of The Times, revealed that this aspect of the offer had been dropped and that a second letter was about to be posted to members with a coupon to be returned if the member chooses to subscribe.

Adcock prescription for better health care

5/Times (Buss) 1/12/91 299

By JULIE WALKER

COMBINED efforts from the State and private sectors are required to form a health care policy for South Africa.

This is the view of Adcock Ingram chairman Robbie Williams.

The pharmaceutical group's annual report was published this week.

Mr Williams says there is scope for joint efforts in under-used State hospitals where competitive services and facilities can be made available on a market-related approach.

In this way, the private sector could help to reduce the State burden.

Cost effectiveness in health care could be improved in many ways.

Mr Williams suggests more responsible prescribing behaviour by medical practitioners.

Deregulation would encourage price competition and the responsible use of medicines should be encouraged by a programme of education in self-medication. This would allow pharmacists to dispense certain scheduled medicines.

Mr Williams says the community pharmacist would be able to provide a wider range of medicines and extend his professional advisory role in several areas to the greater benefit of the health-care delivery system.

Cost-effective new therapies should be included in the general purchase list for State institutions. They could lead to considerable savings because they would reduce the time spent by patients in hospital.

Finally, people should accept greater responsibility for their health.

"South Africa simply cannot afford a national health system based on the universal right to free health care irrespective of the economic status of the recipient.

The availability of a choice of funding options in any medical-aid scheme and allowing the major health insurers to compete freely is a preferable route to cost control.

Notwithstanding the problems challenging the pharmaceutical industry, Adcock Ingram expects reasonable organic growth. Combined with new products, it should ensure satisfactory growth in the year to September 1992.

Deaf builders erect 4 rooms at school

Sunday Times Reporter

A TEAM of deaf, unskilled workers are building four workshop classrooms at the School for the Deaf in Khayelitsha after receiving a donation of more than 15 000 calcium silicate bricks from Calsica Bricks.

"We had to construct these buildings ourselves because of the school's dire financial circumstance. There is an urgent need for such facilities," said Mr Richard Nieder-Heitmann, the principal of Noluthando School for the Deaf.

"Under the Department of Manpower's Job Creation Scheme, we were able to provide work for 15 unemployed deaf people. The project would not have been possible without the generosity of Calsica."

The foreman, Mr Cozben Ncana, who is also deaf, has practical building experience and instructs the deaf workers in sign language. The bustling building site is usually silent — almost like watching television with the sound turned off — as the enthusiastic workers go about their tasks. Mr Nieder-Heitmann explained that although most of the workers had hearing aids, they were unable to use them because of the prohibitive cost of new batteries and repairs.

Sewing

"Once completed, the workshop will be used to train male pupils in welding and woodworking and females in hairdressing, domestic science and sewing. Evening classes will be held to train deaf adults."

Noluthando is the first school in the Western Cape for Xhosa-speaking, hearing-impaired children.

Mr Nieder-Heitmann said the school had 60 pupils, but it was envisaged that 300 would eventually be enrolled.

The institution plans to build a para-medical centre, a parents' guidance clinic and sports facilities as well as residences for 200 pupils.

Day scholars commute by schoolbus from Khayelitsha, Guguletu, Mfuleni, Langa, Nyanga and Crossroads.

Blind busker turned down

CP Correspondent

THE blind guitarman of Mangaung in Bloemfontein has finally been thrown out of the Floriet Mall – his favourite spot

Ishamail Mbelo, 44, affectionately known as "Mr Guitarman" was last week found guilty at Bloemfontein Magistrate's Court of disturbing the peace and using an amplifier without the consent of the Bloemfontein municipality.

He was fined R90 or three months' imprisonment conditionally suspended for three years.

This means he will be arrested if he plays in the mall during the next three years.

Several managers of shops in the mall said it was a pathetic situation for businesses to complain that his music was driving them crazy. Although it could not be confirmed, it is widely believed a manager of a shop in the sprawling mall called the police and laid the charge.

City Press asked traders in the mall if they believed the blind musician's music was a nuisance, as the court found.

Milady Store's B Greyes said she had no sympathy for the blind man, adding that he could now play in the Hoffman Square where he could still earn money.

A spokeswoman at Edgars stores said the music had not affected them at all, but she knew some of the shopkeepers in the mall often complained.

Some shop owners in the mall said it was unfair for the business community to treat Mbelo in the manner they did because he was also fending for his family.

A Bloemfontein municipality spokesman said many complaints had been received over the past four years.

In order to appease everyone the shopkeepers, in conjunction with the muncipal security department, agreed that Mbelo should shift to a different designated spot in the mall every hour.

Despite all this, Mbelo did not comply and after further numerous complaints action had to be taken.

Mbelo, who has an unemployed wife and two children to support, lives on money from passers-by as well as a meagre disability grant from the Department of Home Affairs.

Sympathisers at the trial expressed dismay at the council's attitude in depriving a disabled man of the opportunity to fend for his family the only way he could.

Health groups reject new Act

Sowetan 2/12/91 (8) (299)

THE National Medical and Dental Association and the Dispensing Family Practitioners Association have rejected the new Medical Schemes Amendment Act.

They have also called for the immediate suspension of any further moves to implement the Bill.

"We recognise (in the Act) a desperate measure intended to save the imperilled medical schemes industry," Namda and DFPA said in a joint statement at the weekend.

This followed a meeting between them at the University of Cape Town on Friday.

It is clear the medical schemes industry is in a crisis and they are facing an urgent need to economise on spiralling expenses.

The new Bill, however, would have serious repercussions for both providers of health care and for patients - the majority of which will adversely affect health care currently available to many of South Africa's poorest citizens.

The two organisations said the Bill would result in the introduction of extended privatised health care in the form of Health Maintenance Organisations and the expanded involvement of insurance companies in health care.

"The Bill will also have repercussions on our already overburdened public sector health services, by forcing those patients with chronic illness or disability onto State hospitals, and placing greater demands on State services to pick up the health needs of those likely to be jettisoned by the new-look medical schemes," the statement said.

The changes, they said, would add up to a badly-planned attempt to restructure the health care arena and this will have far-reaching implications for a future health service in South Africa.

"This has all been done without adequate consultation with those parties affected by the changes.

"We reject such attempts to force inadequate solutions onto the health services.

"In line with the approach to negotiations over the political and constitutional future of South Africa, we insist on a moratorium on all legislation that seeks to restructure the South African health sector by stealth," the statement said.

The government's approach to dealing with the crisis has demonstrated its inability to appreciate the importance of democratic participation in the formulation of health policy. It reflects a lack of concern for the health needs of South Africa's people.

Namda and DFPA called on the progressive health sector and mass-based organisations to oppose the Bill's implementation until thorough consultation had taken place. - Sapa

Medical bodies unite against Bill

STAR 3/12/91

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By Carina le Grange
Medical Reporter

The National Medical and Dental Association and the Dispensing Family Practitioners Association at the weekend added their voices to others in the medical profession rejecting the amendments to the Medical Schemes Act.

Namda and the DFPA also called for the immediate suspension of the Bill's implementation.

In joining the Medical Association of South Africa (Masa), they further fuelled the controversy around the proposed amendments, and put doctors and the medical schemes industry on a collision course.

The Representative Association of Medical Schemes (Rams) last week gave its unequivocal support for the proposed amendments to the Bill and came out in support of Health Minister Dr Rina Venter.

Masa last week triggered controversy around Dr Venter when it called for her resignation, accusing her of "lacking leadership and failure to take appropriate action in solving critical issues".

Masa earlier rejected amendments to the legislation "in their entirety".

Rams executive director Rob Speedie said the amendments were vital for the good health and continuance of the country's medical schemes.

He said the debate over the Act had been going on since 1987 and that all interested parties had had more than adequate opportunities to express their views.

However, Masa argued that not enough time had been allowed for comment.

It said the amendments afforded medical schemes unlimited monopolistic powers over the use of services.

Namda and the DFPA said the Bill would force patients with chronic illness or disability on to State hospitals and place greater demands on State services to pick up the health needs of those likely to be jettisoned by the "new-look medical schemes".

Unhealthy time for med-aid

(299) CT 3/12/91

Own Correspondent

JOHANNESBURG. — Current and future changes to SA's medical aid industry and its system of health service will force employers to take a radically new look at health benefits for workers.

So says Mr Leon Lewis, MD of financial consultants Alexander Forbes, in the company's quarterly magazine.

"If the current rate of healthcare escalation continues, the burden of healthcare costs as a percentage of total payroll will double in less than 10 years."

Medical aid costs were increasing by 25% a year, while pension costs were growing by about 15%.

Lower-paid members would not be able to afford their contributions and would be forced to withdraw from schemes, he said.

Younger members would find medical aid increasingly unattractive and withdraw.

"The growing cost pressures within the industry are likely to reduce the extent of the subsidy applicable to pensioners and will force many pensioners to leave the system.".

Mr Lewis said the introduction of the Medical Schemes Amendment Act would make it more important for companies to have clearly defined strategies concerning healthcare.

Irrespective of what sort of social security system might develop under a new political dispensation, medical aid schemes would continue to exist, although their format and the number of employees they cover could depend on future legislation.

Safest blood is your own

299

Sowetan 4/12/91

By GRACE RAPHOLO

FEARS of transmitted diseases such as Aids have led to a new option of blood transfusion called the autologous system.

The system essentially entails the collection, storage and use of a patient's own blood for himself.

The medical director of the Highveld Blood Transfusion Service Institute, Professor GT Nurse, said the system allowed a patient who anticipated transfusion - for instance, when one was due to undergo surgery - to donate blood to himself, provided his general health was satisfactory.

He said the autologous transfusion provided a way to stem the spread of the HIV.

He said there was a "window period" in which there was a delay between the time when the person contracted the virus and when it could be detected in blood. This period usually lasted about three months.

He said this was a great problem for the organisation because they could not say with absolute certainty that blood was not HIV positive.

"The blood can test negative now but positive three months later," Nurse said.

The system was based on the idea that the safest blood was the patient's own.

Although there had been no reported cases of HIV transmission through transfusion of properly tested blood since testing started in 1985, receiving one's own blood was a safer option, Nurse said.

He said the patient had to be approved by his medical practitioner as suitable for autologous donation before referral to the Blood Transfusion Service.

But, he said: "Autologous donation ought not to be used as an insurance against emergency situations. It should only be used when there will be a definite need for blood."

Citing advantages of the autologous system, Nurse said blood transfused into the patients was absolutely compatible because it was the patient's own.

Clinics overcharge — surgeon

STAR 4/12/91

By Jacqueline Myburgh

Allegations of massive overcharging by private hospitals have been made by a top eye surgeon, Dr Edward Epstein, who is now retired.

A private investigation of his patients' accounts revealed incorrect charges amounting to 25 percent and in some cases 50 percent of the bill.

Dr Epstein was a world-renowned specialist in cataract surgery.

His allegations follow two claims that members of Jomed, Johannesburg's municipal medical scheme, had been overcharged by private clinics. This was denied, but sources claimed clinics were making between R1 500 and R2 000 per operation by "padding accounts".

Dr Epstein discovered that in the cases of three private clinic groups, patients were grossly over-charged. In most cases, "mistakes" he discovered were refunded by the hospital.

The over-charging included:

- Charging a patient for two and a half days in hospital instead of two.
- Billing "hi-tech" apparatus as being used in a sterile theatre and thereby also charging a theatre fee, though the apparatus was in fact used in a non-sterile room.
- Charging for 500 ml of an antiseptic solution when only between 20 ml and 50 ml was used.
- Charging for "disposable" instruments when normal ones were used. Thus an instrument costing R300 which is used over and over again each day is charged as disposable — at R104 per patient.
- Adding disposable knives on to accounts for operations in which they could not be used.
- Charging for surgery with an expensive laser — the Yag — while the cheaper one — the Argon — was in fact used.
- Charging a patient for two needles and one syringe for every injection, saying two needles were required to prevent infection. Dr Epstein said no doctor used two needles.

The amounts involved might seem small, but it all added up, he said. He blamed the current system of account payment for its abuse. Accounts were submitted directly to medical aid schemes by the hospital, and the patient and doctor were often denied access to them.

The medical scheme assessor often did not know what was used in the hospital and, if there were queries on any items, the patient was forced to pay for them, he said.

A type of "conspiracy of silence" among doctors has developed over the issue, according to Dr John Cowlin, managing director of Zandfontein Clinic and a director of Medicaid medical aid administrators.

"Doctors with rooms in private hospitals refuse to vet patients' accounts because they fear eviction," he said.

Dr Epstein claimed he had experienced this victimisation: After several queries about "mistakes" on his patients' accounts, he had been told to leave the clinic.

The National Association of Private Hospitals (NAPH), which represents 11 500 beds, has said the complaints of overcharging could not be addressed since none had been lodged with the association.

Graham Anderson, executive director of the Clinic Holdings Group, which is not represented by NAPH, rejected Dr Epstein's claims, saying he would welcome an investigation.

He said "nine times out of 10", account errors were found to be in favour of the patient and that if a doctor queried items he had not used, they could have been used by the nurse, anaesthetist or another doctor. He said errors were often "finger errors" made on the computers.

- Allegations of overcharging at private clinics have prompted the Medical Association of SA (Masa) to launch an investigation into the situation, director of Professional Services Dr Martin de Villiers said. Medical aid schemes suspecting overcharging have been asked to forward the accounts to Masa.

Steelpoort sold for R5,25-m

STHR 5/12/91.

Pretoria Correspondent

A last minute bid by Johan du Plessis, son of former Minister of Manpower Pietie du Plessis, to save his Northern Transvaal town Steelpoort from being auctioned yesterday, was dismissed by a Pretoria Supreme Court judge.

Steelpoort was sold for R5,25 million at a public auction.

The town, situated on the farm Goudmyn, includes a number of businesses, three banks, a post office and a garage.

The property was purchased by Peter Quinton on behalf of a finance company.

On Tuesday, Mr du Plessis brought an urgent application after hours to halt yesterday's auction which was arranged by joint liquidators of the liquidated J P L du Plessis Beleggings (Steelpoort) (Pty) Ltd, the company formed by Mr du Plessis and his father.

Mr Justice Botha dismissed the application with costs as well as an application for leave to appeal.

The judge also refused to suspend the public auction.

In an affidavit, Mr du Plessis said after the liquidation in October liquidators informed creditors last month that Steelpoort, or the remainder of the farm Goudmyn 337 measuring 7 082 456 ha was to be auctioned yesterday.

Mr du Plessis said he was shocked at the advertisement of the proposed auction and the short notice given.

Mr du Plessis claimed the property of 7 082 456 ha and improvements were worth R13 185 000.

(291)

Paraplegics in Tembisa get R70 000

STHR 5/12/91

The Disabled People of South Africa (DPSA) organisation and the Canadian Embassy yesterday donated R70 000 to the paraplegics of Tembisa.

DPSA spokesman Friday Mavuso said his organisation had donated R40 000 and the Canadian Embassy R30 000.

"The money will be used to buy a fence for a factory site donated to the disabled by the Tembisa council as well as to provide other infrastructure," he said. — East Rand Bureau.

Row over moves on Medical Schemes Act

STAR 5/12/91 (299)

By Carina le Grange

The medical aid scheme industry and doctors' professional bodies have clashed heavily over the Government's proposed amendments to the Medical Schemes Act of 1967.

The Medical Association of SA (Masa) has rejected the proposals in their entirety, while the National Medical and Dental Association, the Dispensing Family Practitioners' Association and certain other health bodies not only rejected the amendments, but called for an immediate suspension of the Bill's implementation.

The Representative Association of Medical Schemes, however, has given the Bill its unequivocal support.

Rams and Masa have both set out some of the reasons for their views on proposed legislation which would affect almost a fifth of the population.

Rams said:

Executive director Rob Speedie said the main reason why Rams welcomed the amendment was an economic one:

The amendments are deregulatory, they free medical schemes and enable them to be more innovative in the range of products which they can offer. This is going to encourage competition among medical schemes and the insurance industry on an equal footing.

This competition is currently prevented by the system of prescribed minimum and maximum benefits which must be offered by medical schemes and which curtails their freedom to offer paying more than 100 percent of the scale of benefits.

Schemes may also not offer plans where a member pays excess, such as in paying the first R100 of expenses in return for lower subscriptions. At present, schemes have to pay from the "moment the metre starts ticking".

Rams believes this kind of competition would be good for the consumer.

The Bill would enable medical schemes to enter the supply side of the market and to become providers of health care in tandem with being financiers of health care, which Rams welcomes.

This should also result in greater competition on the supply side of the market, and therefore more efficiency in an economic sense. It would contain costs and keep privately funded health care affordable.

Masa said:

Secretary-general Dr Hendrik Hanekom said: The medical profession agrees that there is a need for changes to the system, but believes it should not be considered only from a cost-minimising point of view. Before deregulation is introduced, the State must first spell out its reponsibility to poorer patients and ensure that a suitable minimum service is guaranteed for them.

It is Masa's opinion that the draft legislation is an attempt towards cost minimisation and to "sanction" alleged over-use and abuse of the system.

It offers no assurances to those who use schemes responsibly that future or existing benefits might not favour the healthy and the young above the old, the poor and the chronically ill.

The proposed abolition of compulsory direct payment to providers of services, as well as the abolition of the pre-emptory scale of benefits, implies that medical schemes would no longer be compelled to guarantee payment and to offer benefits at a certain minimum for a specific service.

Patients unable to pay for medical services for which the benefits are limited, or non-existent, could be forced on to the already overburdened State health service.

Masa could support managed health-care services as one option to health care provided, inter alia, they were not operated for financial exploitation, patients were not forced into such a system without other options, and there was no interference with doctors' clinical judgment.

The reconstitution of Rams would give Rams monopolistic powers. It would also not be democratically representative of medical schemes since their membership to Rams would be mandatory. This is in conflict with the principle of freedom of association.

Fm 6/12/91

What's the prognosis for Venter?

Balancing competing interests is possibly one of the most difficult responsibilities of any Cabinet Minister.

This is particularly true for Health Minister Rina Venter. Of all the portfolios, health must rate as one of the most challenging in crisis-wracked SA. Aids, declining standards of health care — particularly at provincial hospitals — and escalating medical costs burden all. Even the relatively affluent white population is increasingly unable to afford essential treatment. Medical practitioners complain that patients refuse to take their proper dosages of medication because they can't afford the cost.

It is against this backdrop that her attempts to amend the Medical Schemes Act must be evaluated. If she succeeds, her efforts will go a long way towards deregulating the over-regulated medical schemes sector. An end to guaranteed payment and scales of benefits will certainly force health providers and patients to think twice about ordering every possible test for a migraine.

Opening up the industry to allow medical schemes to provide health services — run hospitals, employ doctors, pharmacists and other practitioners — will no doubt also serve as an incentive to health providers to be more efficient. Certainly, it will introduce competition.

Understandably, doctors are suspicious of the amendments. The proposals clearly threaten their absolute discretion in dispensing services. The Medical Association of SA (Masa) says the proposals give medical schemes unlimited monopolistic powers to control the use and provision of medical services. Masa also argues that risk-rating will discriminate against the poor, aged and sickly.

Certainly, Masa is correct when it accuses Venter of providing only an ad hoc solution to a national crisis but, given that money saved by the self-sufficient private sector can be reallocated to the needier sectors relatively quickly, Venter needs to be commended for her initiatives.

This, of course, doesn't mean she can rest. On the contrary, she must push ahead with reforms — particularly deregulation — even if this meets with votes of no confidence and calls for her resignation. Vested interests will always resist attempts to deregulate, even if these are in the long term advantageous.

Where Venter needs to be criticised is in her unwillingness to debate with interest groups in the press.

This is a remnant of Nationalist government, an era when Cabinet Ministers considered themselves accountable only to higher authority. ■

HEALTH-CARE INDUSTRY

Doctors don't like this prescription

The age-old battle between doctors — who provide the medical services — and medical schemes — who pay the bills — has degenerated to the point where practitioners are calling for the head of Health Minister Rina Venter, who supports deregulating the strictly controlled medical-schemes industry.

The Medical Association of SA, the National Medical and Dental Association and the SA Dispensing Practitioners have accused Venter of lacking leadership at a critical juncture for the health-care business. But most of all, they have attacked her support of proposed amendments to the Medical Schemes Act.

The legislation seeks to end guaranteed payments and scales of benefit. It also would scrap the maximum and minimum benefits for schemes. But most contentious is the amendment that would allow medical aid schemes to provide health-care services. In a nutshell, schemes would be able to run hospitals and pharmacies and employ doctors, nurses and other practitioners.

Needless to say, that does not go down well with dentists and doctors.

Medical Association chairman Bernard Mandell believes that the proposals would give medical schemes unlimited powers to control the use and provision of services. "The proposals are an ad hoc crisis-management attempt to address an escalating problem in only one particular area of health care. Our overriding concern is that the Bill does not address the strong and urgent need for efficiency and equity in the entire health-care system."

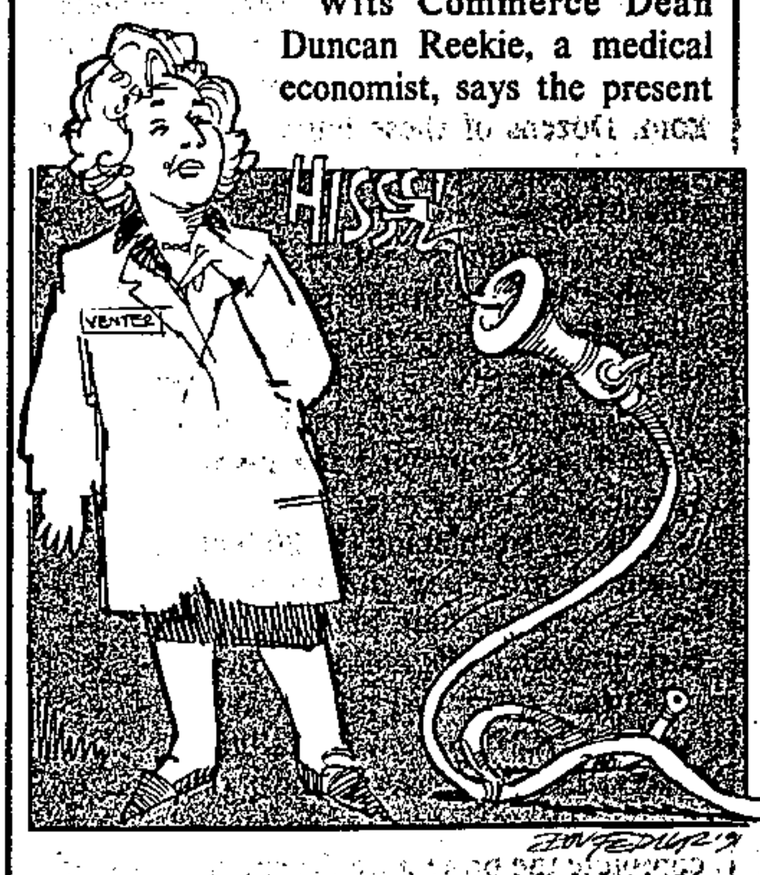
Rob Speedie, executive director of the Representative Association of Medical Schemes, favours the proposed deregulation because he believes it will cut the cost of health care dramatically.

He says the current fee-for-service system is more costly than a health maintenance scheme — which could be run by medical schemes — because doctors and patients trust that some "faceless" medical scheme will foot the bill. He blames overuse of health-care services, abuse by patients and health-care providers, and runaway costs of medicine and services for the current financial crisis in health care.

Medical schemes reportedly paid out R1,4bn more in benefits last year than the previous year, while the number of beneficiaries of schemes grew by only 1,9%. And the Department of Health said last week that 88 of SA's 200 registered schemes suffered operating losses last year — nine are said to be insolvent.

The Medical Association would like to make its own amendments to the Medical Schemes Act. In a detailed memorandum attacking the proposed legislation, it says the current scale of benefits is not a reasonable compensation for medical services.

Speedie, however, stresses that the scale is intended to provide affordable benefits to members, rather than reasonable compensation to doctors. "The scale of benefits is based on our rates. We don't print money, we can only spread it as far as reasonably possible."



Wits Commerce Dean Duncan Reekie, a medical economist, says the present system offers patients and doctors no incentive to cut costs. "One needs a system where doctors and patients know they will lose if they overprovide services."

Reekie suggests that a health maintenance programme can act as an incentive to doctors to be cost-efficient. He says doctors also will be wary of underproviding care. "Otherwise, patients will either keep coming back — which will increase costs and lower profits — or employers will take their business elsewhere. The incentive must therefore be not to overprovide or underprovide."

The association is not dead-set against the idea of managed health-care systems. Its memorandum supports such a concept, provided they are not operated for "financial exploitation" and they don't prevent or discourage medical practitioners from acting in the best interest of their patients.

Speedie retorts that doctors make money from their practices and he can't see why health-care programmes shouldn't be allowed to do the same. He nevertheless stresses that no medical scheme in SA operates for gain. "If medical schemes run health-care programmes, the profit motive could be eliminated. Of course this poses a threat to vested interests, but costs of care would be reduced.

"Our concern is not with doctors' earnings — if they work hard, they are entitled to make money." The problem, he says, is that there is now no incentive to eliminate waste and abuse. There's also little competition. In this regard, the Bill makes massive strides.

While the association admits that there are advantages to be gained from the legislative proposals — improved financial positions for schemes, tailoring packages to meet individual preferences, competition between medical schemes and insurance companies leading to innovation and improved efficiency, and incentives to discourage overuse of services — it says the disadvantages are greater. "The increased use of risk-rating will result in a strong shift towards designing packages for healthier, younger people. The old, poor and more sickly will be discriminated against and responsibility for the indigent will shift on to the State."

Speedie disagrees. He says the increased use of risk-rating will lead to greater efficiency and less abuse. "Only people who misuse and abuse the system will be penalised. To say that sick people will be penalised is not true. Cross-subsidisation will continue to apply as it does in every insurance system." He says the burden of the indigent has always been carried by the State. "They have never belonged to schemes."

Considering the tentative way in which government moves toward deregulation, it doesn't seem possible that Venter is moving too fast or too far. If the goal of medicine is to get it to as many people as possible in the least expensive way possible, then the only answer can be to give the practitioners some competition. ■

MEAT DEREGULATION

Where's the beef?

Just two months ago government seemed ready to free the tightly controlled meat industry. With consumers angry at soaring prices, and producers lost in a maze of restrictions, deregulation was in the wind.

"The industry has now matured sufficiently to allow for freer competition and the increased availability of meat supplies at all markets," said Agriculture Deputy Director-General Chris Blignaut (*Business & Technology* October 25).

But the wind has now turned against deregulation. Government is apparently capitulating to bureaucrats, wholesalers, abattoirs and other vested interests in the R7bn-a-year meat trade. The Committee of Enquiry into the Deregulation of the Meat Industry was appointed by government five years ago and

continued →

Tembisa disabled given R70 000

Sowetan 6/12/91 299

THE Disabled People of South Africa organisation and the Canadian Embassy this week donated R70 000 to the paraplegics of Tembisa.

A spokesman for the DPSA, Mr Friday Mavuso, said his organisation donated R40 000 and the Canadian Embassy R30 000.

The money will be used to buy a fence to enclose a factory site donated to the disabled by the Tembisa Town Council, also to provide other infrastructures, Mavuso said.

Funds

He added that everything was going according to plan and the factory would be built next year on the donated site, which is situated in Esangweni Section.

Mavuso said several companies had pledged to provide funds for the building of the factory.

- Sowetan Correspondent.

Ditch Medical Schemes Act amendments, says academy

STAR 6/12/91.

By Carina le Grange
Medical Reporter (299)

The proposed amendments to the Medical Schemes Act should be scrapped and urgent attention should be given to drafting alternative proposals, the South African Academy of Family Practice and Primary Care said in a statement yesterday.

The decision was taken at an executive committee of the academy on Wednesday.

The crisis in health care has been highlighted by opposing views on amendments to the Medical Schemes Act held by the medical profession, which rejected the proposals out of hand, and the medical schemes industry, which welcomed them.

Though the academy, which also represents the interests of patients, called for the scrapping of the proposals, it agreed that alternative proposals were needed in order to provide high-quality primary health care.

The academy is the largest academic medicine body in the country, and overall caters for about 9 000 members since it includes both family practice doctors in the academic field as well as general practitioners in private practice.

The national president, Professor Bruce Sparks, told The Star that the body primarily represented the interests of patients and communities as it was involved in the maintenance of standards through education and the improvement of the health of communities in various parts of the country.

Professor Sparks added: "We agree that a rethink is necessary as health care is in dire straits — but it needs greater collaborative planning between the deliverers of health care, the patients and medical schemes so that everyone's agenda is accommodated without jeopardising standards.

"Not everyone has access to medical schemes and we are concerned that many people would have no access to health care. If the amendments go through, some practitioners may expect cash payment from patients if direct payment is not guaranteed."

He said the proposals implied that a lot of the decision-making of health care would be in the hands of medical schemes which would then make clinical decisions.

This would come about if there were no direct payment of accounts, since it meant the schemes would decide what should be paid and what not.

"That means taking decisions of a sort on appropriate health care," Professor Sparks said.

"Our concern is patient care and we are very concerned that this may affect it. We need adequate payment for promotive and preventive care — not only for curative care," he said.

Pharmaceutical Association executive director John Toerien yesterday said it was totally unfair to blame Minister of Health Dr Rina Venter for soaring health costs.

Mr Toerien entered the controversy over health care in South Africa by calling for a "reasonable round-table debate" to find a solution.

"The introduction of a new health care strategy is surely not the responsibility of the minister but that of the Cabinet as a whole, because there are major financial implications."

He added that the medical schemes industry was only part of the total health care delivery industry and should therefore be addressed within the total strategy. (Less than 20 percent of the population belongs to medical schemes although this sector uses about half of the total expenditure on health.)

● The Johannesburg Chamber of Commerce and Industry has welcomed the proposed amendments and said they were necessary for the survival of the medical aid industry and therefore for the ability of employers to continue to provide health care needs for their employees.

Doctors' fury over Rina's bid to slash health bills

S/Times 8/12/91 (299)

By CHARLENE SMITH

DOCTORS are fighting a proposed new law which would allow the establishment of medical care systems that have proved they can slash medical costs by almost half.

Such schemes, claim their supporters, could extend medical aid benefits to 11-million more South Africans.

Anger at the proposed law is at the root of the recent demand by the 12 500 doctors in the Medical Association of South Africa for the resignation of Dr Rina Venter, the Minister of Health.

The draft Medical Schemes Act — which has been rejected in its entirety by Masa — would for the first time allow medical schemes to contract only with doctors or medical services that are prepared to operate within affordable rates.

It would also spur the establishment of what is called Managed Health Care Systems, also known as Health Maintenance Organisations.

These systems involve the setting up of medical facilities and personnel by medical schemes themselves. Each patient has a budget and doctors, who are paid a flat salary, earn incentives for keeping below budget. Patients also have incentives not to over-use medical services.

DR RINA VENTER
Call for her resignation

Diagnose

This would mean doctors would have to diagnose more carefully — and prescribe, or refer, more prudently. Patients, for their part, would have to use medical services more sparingly.

Two of these schemes are in operation in South Africa, although theoretically forbidden by law, and have shown dramatic cost cuttings.

● Vaalmed, in the Vanderbijlpark area, has 20 000 members and operates at about 60 percent of the cost of traditional medical service costs, reports a recent SA Chamber of Business paper.

Costs of medicines are also greatly reduced because it buys in bulk directly from manufacturers. Average prescription costs under conventional medical aid schemes are R77. At Vaalmed they are R34.

This means a major reduction in costs for the member. Vaalmed charges patients in the highest earning brackets — an income of more than R2 500 a month — R351 for a member with three dependants. This includes a cost hike of 11 percent to members in January next year — or R175,50 after the employer has paid his half of the fee.

Conventional medical aid schemes charge between R600 and R1 000 a month.

● A Medicaid health maintenance organisation in Pietermaritzburg which consists of rooms for doctors, nurses and

Doctors' fury at Rina

S/Times 8/12/91 (299)

□ From Page 1

a pharmacy, has shown savings of about 40 percent in health care costs. Here too, there are also massive savings on medicines — in some cases up to 60 percent — because it stocks generic or non-brand name products.

Again, the cost to the member is dramatically reduced. Medicaid's cost to a member with three dependents is between R250 to R310 a month — of which 50 percent is normally paid by the member's employer.

Greg Candy, a health care specialist at auditors Deloitte Pim Goldby, says recent figures released by a local health maintenance organisation show its annual increases in fees over the pastseven years have been 16 percent, "whereas (those for) medical aids have been 22 percent". He says this shows health management organisations can reduce the cost of health care by up to 40 percent.

Mr Quentin Robinson a director of Medicaid, says income earners in the R40 000 to R50 000 per annum category will soon not be able to afford medical aid — his estimation is supported by other industry sources.

He says health maintenance organisaions are the way of the future for around 11-million employees, who are presently not covered by medical assistance schemes.

Dr Bernard Mandell, federal council head of Masa, was reluctant to elaborate on the dispute with the Minister this week. However, he denied that the association's stand supported vested interests.

In an 11-page critique of the draft bill, Masa says it generally supports Managed Health Care Systems (or health maintenance organisations) but in two pages of warnings against such systems, and the concomitant strengthening of medical aids, says it would be against any systems that operate for "financial exploitation".

It wants state responsibility for the provision of health care clearly defined. It does not want "Managed Health Care Systems granted special monopolistic powers by statute, which may be used to irreplacably destroy valuable existing health care delivery infrastructures".

Bid to make med-aid easier

(299)
09/12/91

By PETER DENNEHY

HEALTH MINISTER Dr Rina Venter said yesterday that her intention in changing the laws about medical aid was to make it more affordable and accessible.

She was "walking through a minefield", as the proposed changes were extremely sensitive, and a variety of powerful interest groups were affected.

She could not vouch for the accuracy of some supporters' estimates that a new Act, still being negotiated, would bring medical assistance of some sort within reach of 11 million employed South Africans who now have no cover.

Yet "we are certainly trying to make it more accessible", she said.

The Medical Association of South Africa (Masa), which represents a large slice of the medical profession, has rejected her Draft Medical Schemes Act.

Dr Norman Levy, who serves on the local Masa executive committee, said one change would be that medical aid schemes could run their own medical establishments, in order to cut costs.

"This will cut costs, but it will also cut quality. It would not be so bad if these establishments had to be run by doctors. Instead, financial considerations will be paramount to their administrators," he said.

Fundamental problem

Under the proposed new Act, old benefit societies like the one the railways used to have could be started again. Beneficiaries of these would have to go to a particular appointed doctor, who worked on a fixed salary.

"Masa brought a lot of pressure to bear for the railways' scheme to be changed, and five or six years ago it did become a proper medical aid scheme."

Dr Levy said Masa did not believe the proposed legislation solved the fundamental problem of medical aid rates declining to about half of what most doctors charged.

Dr Venter said she was determined to change the law, because it needed to be changed. However, she did not have the final Bill in her hands.

"I am still expecting a report-back from a forum or conference held on Monday. Masa was present there. It was on their request that I organised the forum."

Dr Venter said she had visited Vaalmed, a sort of medical benefit scheme regarded by the SA Chamber of Business (Sacob) as a forerunner of what the proposed new legislation will usher in.

She said she supported giving patients as much free choice as possible. Some had criticised the proposed Bill for falling short in this regard.

Doctors want reform, but not at cost of health

STAR 10/12/91

By Carina le Grange

Several organisations representing the medical profession have rejected proposed amendments to the Medical Schemes Act, despite their belief that the health care system in South Africa is in need of change.

The SA Academy of Family Practice and Primary Care said it believed change was necessary — but that it needed greater collaborative planning between the deliverers of health care, the patients and the medical schemes, so that everyone's agenda would be accommodated.

The Medical Association of SA (Masa) believed the amendments were drawn up mainly from a "cost minimisation" point of view with no guarantee of a suitable minimum health service for poor patients.

The National Medical and Dental Association and the Dispensing Family Practitioners Association believe the Bill will have repercussions for the "already overburdened" public-sector health services, by forcing those patients with chronic illness or disability on to State hospital services.

Two of the most controversial issues proposed in the amendments, and opposed by doctors, are the abolition of compulsory direct payment by schemes to the providers of services, and the abolition of prescribed minimum benefits which members now enjoy.

Compelled

These changes implied that medical schemes would no longer be compelled to guarantee payment or to offer benefits at a certain minimum for a specific service, Masa has said.

The academy said that if the amendments went through, some practitioners might expect immediate cash payment from patients if direct payment were not guaranteed. Doctors might also raise fees to cover the possible loss of payment.

The abolition of the fixed scale of benefits, as now determined by the Representative Association of Medical Schemes (Rams), could also result in each of the 260-odd medical schemes determining their own rates for specific services, doctors have said.

The academy has said the proposals implied that much of the decision-making of health care would be in the hands of medical schemes, which would also be making clinical decisions since, in the absence of direct payment, it meant the schemes decided what should be paid for and what not.

Another issue is the proposed reconstitution of Rams, which is seen as a move to give it monopolistic powers. Since membership of Rams would be mandatory, it would not be democratically representative of medical schemes and this would be in conflict with the principle of freedom of association, medical bodies have said.

Disabled find the going really tough

STAR 10/12/91

299

By Rochelle Gosling-Hughes

The Star Christmas Hamper

If life is tough for the poor and unemployed, how much harder it must be for those in similar situations who are physically disabled.

The Daveyton Association for Physically Disabled (DAPD) has requested Christmas hampers to tide its disabled over hard times.

Sechaba Lebenya, community developer of the DAPD in the Transvaal, said the request was contradictory to their usual approach but the association was forced by lack of resources to ask for hampers.

He said the association aimed to "give people the fishing rods rather than the fish". He explained that the association tried to teach its people to fend for themselves and to generate their own income. It was important that they did not become dependent solely on "handouts".

The DAPD serves as a central office for the East and Far East Rand physically disabled. Most are dependent on disability grant pensions. Local welfare departments and health clinics will be involved in the distribution of hampers where there are no welfare services.

Mr Lebenya, who was temporarily disabled after a road accident, has dedicated his life to making the lives of these people a little easier. He said it was important not only to deal with economic issues but loneliness and social integration as well.

Temporary workshops exist in Ratanda near Heidelberg, and Tokoza near Alberton. Here the disabled are paid for each contract job they complete successfully. The areas covered also include Delmas, Nigel, Brakpan, Germiston, Boksburg and Benoni.

The workshops are not restricted to those with spinal injuries but also cater for deaf and blind individuals.

Mr Lebenya said most of the people concerned lived in squalor.

Judging how the present economy had hit the man in the street, one could imagine how it had affected those with no income whatsoever, he said.

Mr Lebenya has appealed for hampers while recognising there were financial constraints which might limit the number of hampers that the fund would have originally allocated to the DAPD.

He said in distributing hampers they would give priority to individual needs as they were aware of the socio-economic factors surrounding each case.

The Star Promotions department has to deal with more than 20 000 requests for hampers and they keep coming. Try tonip a little off your budget this year and send it to: Xmas Hamper Fund, Box 1014, Johannesburg 2000.

Paralysed man sacked, evicted

Soweton 11/12/91 (299)

Crash victim needs home

A PARALYSED Soweto man has claimed he was sacked and evicted from his company house without compensation after working for the company for 13 years.

Mr Isaac Ntongolo (41) who worked for Village Reef Gold Mine, an Anglo Vaal subsidiary, was in a car accident in September 1989 which paralysed him.

Operation

He underwent a spinal cord operation at Rand Mutual hospital and spent a year in hospital.

"They said they could not do anything because I was not injured at work," Ntongolo said.

"They said they had spent R70 000 on the wheelchair and medical expenses and that there was nothing left for me.

"Later I was told to leave the company house because I was no longer working. I refused to move until they forced us out. There was nowhere I could go. I cried a lot when I remembered how faithfully I worked for the company for such a long time," he said.

Village Main Reef Gold Mine personnel officer Mr Dion Badenhorst said his company did all it could to help Ntongolo.

"We bought him a R10 000 wheelchair, paid R70 000 for medical expenses and gave him R3 000 for a house deposit," he said.

He said Ntongolo stayed in the company house free for two years after the accident.

"There was nothing further we could do because he was not injured at work," he said.

Today Ntongolo, his wife and three children temporarily live in a "house" about the size of a train compartment.

There is virtually no space for anything other than his bed. They do their cooking in the adjoining house.

Pension

Their only source of income is the R235 Government pension he receives each month.

Sometimes the Soweto Association for the Physically Disabled gives him food packages. His wife does not work.

"What we need more than anything else now is a place of our own where we will not bother anybody," Ntongolo said.

West Rand hospice needs funds urgently

299

STAR 11/12/91.

Staff Reporter

Hospice-in-the-West, an independent organisation which for the past 10 months has been rendering free services to terminally ill patients on the West Rand, this week appealed for donations from the public.

Director Marisa Wollheim said her organisation, an affiliate of the Hospice Association of South Africa, depended on volunteers in its work and faced a bleak new year as "funds are drying up".

Calendars

"We have started with fundraising in the area by selling tapes, calendars and Christmas cards at our Krugersdorp offices, but this is not enough," said Mrs Wollheim.

"Next year we will need more volunteers as we plan to create hospice sub-committees for each area on the West Rand."

Patients cared for by Hospice-in-the-West were from Roodepoort, Krugersdorp, Randfontein, Carletonville, Westonaria, Magaliesburg and Kagiso.

The hospice body has two full-time staffers and a few volunteers.

The organisation has been rendering services in pain control and pain management, symptom control and nutritional guidance.

The hospice body has also been providing basic nursing, Mrs Wollheim said.

Families

"We had also been making available caregivers to families," she said, adding: "We have attended to about 80 families since being established."

Donors and volunteers should write to: Hospice-in-the-West, Box 1694, Krugersdorp 1740.

Telephone inquiries can be made on (011) 953-4863 or (01382) 131.

STAR 11/12/91.

Clinic's bill over R1 000 too much

299

By Jacqueline Myburgh

The delivery of baby Amy Duke in the Park Lane Clinic in January could have cost her parents almost R1 400 more than they paid, had it not been for her father Neil's vigilance.

Mr Duke, an electrical technician, said the account from the private hospital contained errors amounting to more than R1 000 and when he queried certain items, the Park Lane credited the account without fuss.

"How many people aren't checking their accounts and are paying more than they actually owe?" he asked.

Mr Duke's story comes amid accusations from various quarters that "mistakes" in private hospital bills are in fact deliberate over-charging. Clinics have denied such practices.

Errors on the account for Amy's delivery included:

- A charge of R900 for disposable stitch cutters — neither Mrs Duke nor her baby received stitches.
- R350 nursery fees — Amy was never in the nursery; she was in the neo-natal unit from birth and received a separate account.

Mr Duke's initial account was R2 947,86.

Clinic Holdings, which owns the Park Lane, has rejected the suggestion that "mistakes" on hospital bills are deliberate.

"Like in any other businesses, mistakes do occur," executive director Graham Anderson said. "But if they are brought to our attention we correct them."

Mr Anderson expressed regret that incidents of overcharging were regularly reported in the press, but that the frequent "undercharging" on accounts was never reported.

But Medscheme, the administrators of Mr Duke's medical aid, are concerned at regular reports of errors on private hospital bills.

Managing director Keith Hollis said rigorous checks conducted on all accounts revealed many mistakes.

Medical aid claims too high, says Rina

B1D ay 12 12/12/91. (299)

SOUTH Africans are the world's biggest medical aid claimants and there is no encouragement for the consumer or supplier to act less wastefully, says National Health and Health Services and Welfare Minister Dr Rina Venter.

Speaking at the Golden Achiever Awards in Johannesburg last night, Venter said the aged and pensioners were worst affected by spiralling costs resulting from this practice.

She pointed out that the spreading of the risk of health care was until now one of the principles by which medical aid schemes operated. However, there was a growing resistance to the practice which expected the young and healthy to subsidise the aged and chronically ill.

"If this resistance to the present system becomes established, other methods will have to be found to subsidise the aged."

Several investigations had been launched to promote methods of limiting the rising costs of medicines, Venter said.

She said discussions would be held with interested parties in February about possible remedial steps. These included:

☐ A system of accepting and implementing "a maximum medical scheme price" by medical schemes;

☐ The acceptance of the principle of a single base price determined by volume purchased by manufacturers;

☐ The payment of pharmacists and dispensing doctors to be decided by a professional dispensing fee and not by a percentage added to the cost of the medicine; and

☐ The introduction of parallel importation of certain medicines.

Earlier yesterday Venter met a Medical Association of SA (Masa) delegation in Pretoria. In a statement after the meeting she said the structure of health services was unaffordable and a balance would have to be achieved between a sophisticated medical model and a broad health approach.

In reponse to Masa's request for inclusion in the policy-making process, Venter indicated that quarterly meetings with Masa'a executive committee could be arranged to ensure direct access to the Minister. Liaison with the department by way of the professional forum was viewed as important.

Venter told Masa she had been given the task of restructuring the health service and ensuring it was brought within the financial ability of the state. — Sapa.

AIDS 'may force insurance firms to switch investments'

SHARON WOOD

SOARING AIDS-related claims in the next decade could force life assurers, the major investors on the stock exchange, to switch from equity investment to liquid assets, research by African Life Assurance deputy GM Hugh Roberts shows.

"SA may not be able to rely on the life industry for the expansion of capital," he said. B1D ay 12/12/91

Life assurers held about 50% of their assets in equities, 20% in property and the balance in capital and money markets.

Roberts said this was one of many potential scenarios illustrating the effect that AIDS could have on the economy.

AIDS would probably reach the peak of its cycle in about 15 years' time, when there could be 1 500 deaths a day from the disease. At present 300 people were contracting the HIV virus daily, he said.

Old Mutual chief actuary Theo Hartwig disagreed: "The impact of AIDS on life assurers' investment holdings will be relatively small and there will be no large-scale switching of assets," he contended.

The proportion of the population holding life insurance was small and claims could be paid out of current cashflow.

Companies more involved in the third-world sector of the SA market would be worse hit, he said.

Roberts countered that the policies sold in these markets contained a higher investment element and carried a lower mortality risk.

"In any event, company medical aid schemes and pension funds which cater to all sectors of the population will be among the first to be affected," he added.

The economic implications of the AIDS crisis were far-reaching, both in the public and private sectors, Roberts said.

The government budget could be stretched to its limit because it would have to bear the health costs and this, in turn, would have inflationary consequences.

The impact of AIDS on SA's labour force would be more severe for semi-skilled and skilled labour. Unskilled labour could be rapidly replaced because of SA's high population growth.

Employers should rather look at changing pension packages to reduce the cost of AIDS deaths to their companies.

New Bill to provide 'cheaper' health

CAPE TOWN — Health Maintenance Organisations (HMOs), which are to be encouraged in terms of proposed legislation, will provide a much cheaper form of health care service than medical aid schemes, says Quentin Robinson, director of Medicaid, one of only two schemes operating a form of HMO in the country.

Robinson said years of unchecked abuse by medical practitioners and patients had seen a dramatic leap in the cost of some medical aid membership fees, with some schemes charging monthly subscriptions of between R600 and R1 000.

Own Correspondent

He said Medicaid had proved that the cost of medical services and medicine could be slashed by half by operating HMOs.

Although there was no choice in which doctor a member could visit or what medicines were dispensed, the concept had kept costs down.

The HMO concept has prompted Health Minister Rina Venter to introduce a draft Medical Schemes Act which seeks to provide affordable health care for 11-million people.

The Bill, which has been rejected by the Medical Association of SA (Masa), will allow medical aid schemes to contract only with doctors or medical services prepared to operate within affordable rates.

Robinson said doctors contracted by the scheme would receive incentives if they kept consultations down and dispensed medicines only when necessary.

He said this week's "hoo-haa" by Masa over the draft act promoting the scheme was the result of the "vested interests" of many doctors.

FOCUS: *How private hospitals make a profit*

Blowing the whistle on the gravy train

W Mail 13/12 – 18/12/91. (299)

CRITICAL CONSUMER

Pat Sidley's weekly advice on what to buy ... and what to avoid

A VERY ill 80-year-old man in Johannesburg, a mere fortnight away from his eventual death from cancer of the pancreas, was subjected to a battery of the most expensive and sophisticated tests and procedures by a phalanx of doctors attached to his private hospital.

The tests were all carried out in the same group of private hospitals, but necessitated trips in ambulances to various appliances. And he would have been spared countless other uncomfortable procedures if anybody had listened to his own private physician. The physician knew the end was close and had suggested simply making the patient comfortable till the end.

One of the reasons why nobody listened involved the inevitable hopes and pressures of a family resistant to the notion that the patriarch was dying — but another reason was that the elderly physician was not hooked into that particular private hospital chain, and had no financial incentive in forcing the dying man through extra tests.

The other doctors, however, all operated their lucrative private practices out of the group of hospitals — which in turn owned all the expensive equipment, which needed frequent use to recoup the capital expense and considerable running costs.

One of the tests involved the use of a Magnetic Resonance Imager (MRI) scanner, a piece of equipment which costs many millions of rands in capital outlay and maintenance. There are at least 13 in private hospitals and clinics in this country and two in public or state-owned hospitals. This is considerably more than there are in the United Kingdom, which has some 60-million inhabitants compared to our 38-million.

What's more, those with access to such equipment here total six or seven million — or some 18 percent of the population. This defies rational medical explanation in an environment where there is not enough money, for instance, to give every woman a pap smear to detect cervical cancer.

Describing how this happens helps to explain some of the extraordinary spiralling costs in medicine. It's a tale, too, of corruption and questionable ethics — and the main victim, of course, is the health consumer of the nation.

The private hospitals, many of which have spent millions of rands sprucing up their image, need to have their facilities used in order to make a profit — their *raison d'etre*.

To do this, they rent space to doctors, often at subsidised low rentals. The doctors are expected to keep the hospital beds full and to use the expensive equipment, which has been bought partly to attract doctors who like to have the use of fancy hi-tech equipment. Of course, patients play a role in this too because it is comforting to know that fewer mistakes will be made when the Cat-scan or MRI scanner is used to diagnose a problem.

An example is the scam offered to pregnant women in the form of a "deal" on the use of the Ultra-sound scan. This equipment, when used appropriately in the diagnosis of problems, can save the lives of mothers and their unborn children. For the pregnant woman, in turn, there is little more exciting or comforting than to be able to see the developing baby's heart beating in her uterus, to watch the miniature arms and legs moving and to know that there is a life inside.

Many women are offered the opportunity of having three scans during their pregnancy, with a de-escalating price for each scan. In normal pregnancies one scan is sufficient (and often not even necessary) — three, however, approaches the level of satisfying the doctor's pecuniary needs with no medical justification whatsoever.

Doctors locked into these arrangements with hospitals find themselves unable to get off the gravy train or blow its whistle without severe consequences. A well-known eye specialist in Johannesburg has waited until his retirement to disclose the problems to the press.

If a doctor does not keep the beds full or use the equipment, he may find that his rental has gone up or that the lease is simply not extended. Many doctors actually own shares in the companies which own the hospitals and so, along with the fact that they gain in any event from the charging for hospital visits and the diagnostic charges for equipment, they stand to gain from their dividends when the hospital chain makes money.

Keeping hospital beds full means that often procedures are carried out which are either not necessary at all or do not require a bed in a hospital. And it often involves keeping patients in hospital a couple of extra days, so that the hospital and the doctor can gain from the costs involved.

Many of these practices are denied by the perpetrators, who give other (plausible) explanations for them. But whatever the cause, they drive costs up, have broken the backs of many medical aids and have made life slightly more comfortable for the hospital owners and many doctors.

Mthoba at it again

299

CPress 15/12/91.

Art for disabled at new heights

CP Correspondent.

SOWETO playwright and head of Fuba's arts department, James Mthoba, has collaborated with an ensemble of disabled actors to establish a three-dimensional theatre for the sighted, the blind and the deaf and dumb.

Curtain calls

Mthoba is working on a new production, *Lavisa*, which features deaf and dumb actors and is opening at the Market Theatre in February.

The play is a sequel to *Mehlondini*, which was performed by a blind cast to several curtain calls at home and abroad for two years.

Though it is difficult to work with the disabled, Mthoba has a positive attitude that the new production will be of the calibre and success of its predecessor.

"Unlike actors with five senses, the blind lack one sense – sight – so before making them move on stage, a director should first learn their natural movements in everyday life.

"It is even more difficult to work in theatre with the mute since their major problem is verbal communication," said Mthoba.

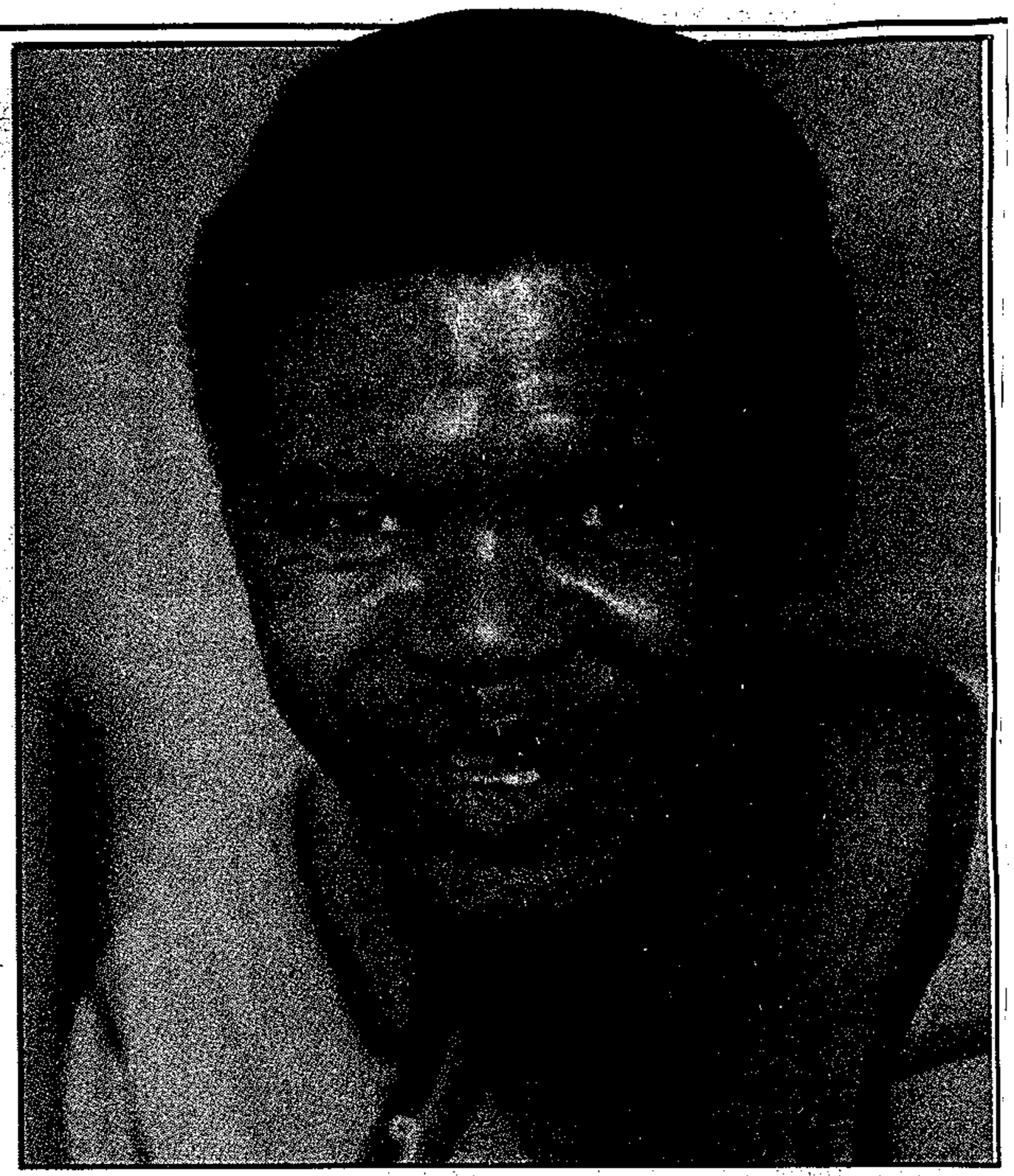
A playwright wanting to work with the disabled had to move away from the tendency of creating theatre for them, but should collaborate with them according to their feelings and see how they wanted to express themselves in their world, Mthoba said.

"I was moved by the captivating display by disabled actors who superseded their able-bodied counterparts in the film *Children Of A Lesser God*, and could not help feeling that I would be very happy to perform in any production of their making and do everything they demanded," added Mthoba.

Sponsorship plea

But all his pleas for sponsorship from the business sector and the community have fallen on deaf ears, he said. He is at present rehearsing his blind cast at a school in Mofolo, Soweto and the deaf and dumb group has been granted space at the Market Theatre.

His hopes are to be sponsored for the building of a theatre for the disabled.



James Mthoba is looking for sponsors to help establish a theatre for the able, disabled and mute. Pic: PETER SETUKE

Thank you, Friday Mavuso!

CP Reporter

FRIDAY Mavuso's many years of alleviating the plight of the disabled in Soweto has been recognised.

Sandown Rotary Club has bestowed the organisation's highest club-level award on him for his achievements.

Mavuso is chairman and manager of the Self Help Association of Paraplegics, in Soweto (SHAP).

The Paul Harris Fellowship award was presented to Mavuso this week by club president Bevil Dustan at a special luncheon in Sandton for his determination and "indomitable spirit" in establishing the centre.

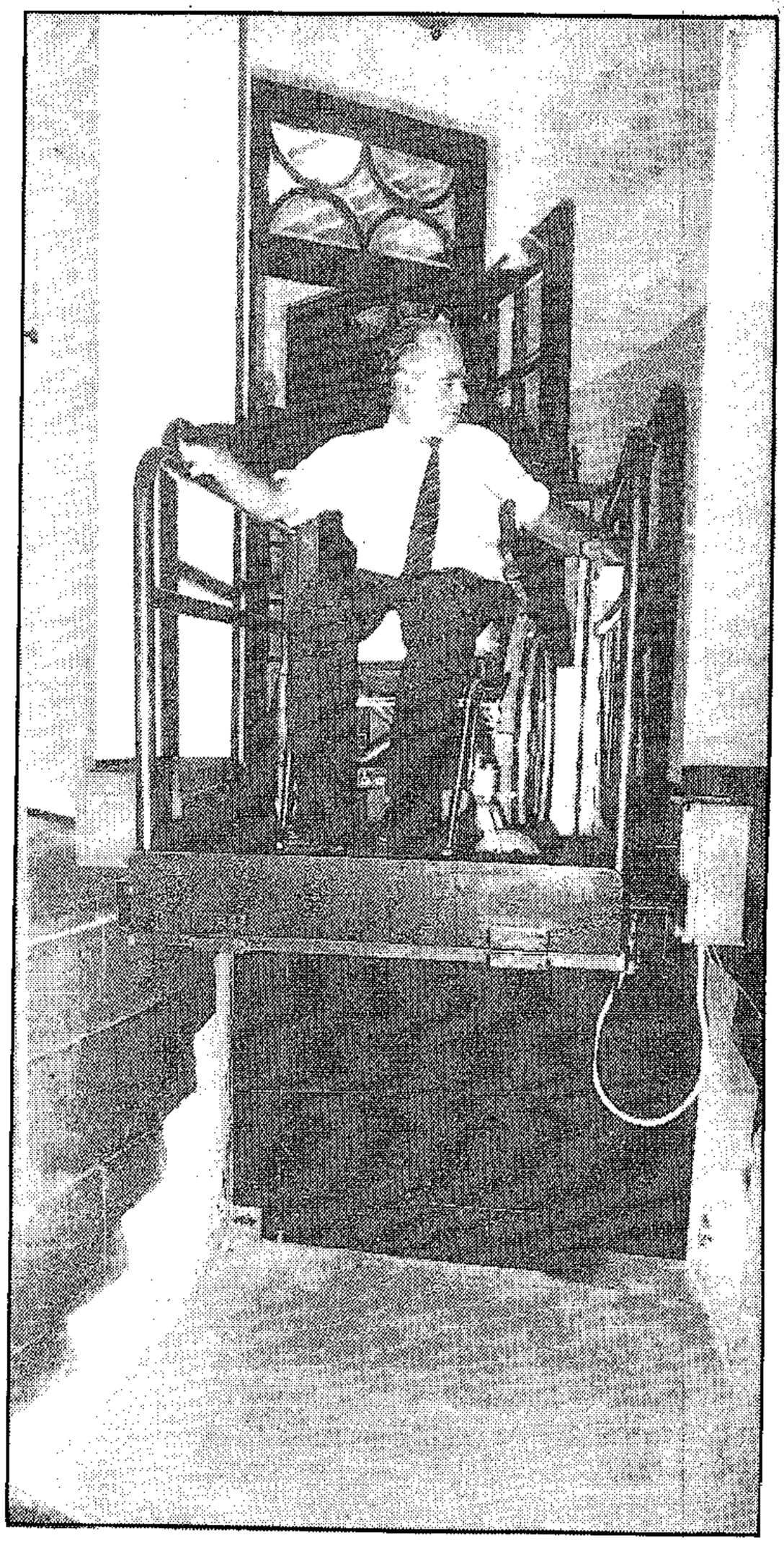
The centre provides employment for a workforce of 100 with skills ranging from camera and slide projector repair to the assembly of underground lighting cables and the manufacture of canvas bags for banks. Much unskilled work, such as packaging, is also undertaken.

RECOGNITION ... Mavuso holds up the Paul Harris Fellowship award.

Mavuso started the Shap centre after he was paralysed by a bullet which lodged in his spine during a shooting incident.

After a protracted civil action against the authorities, the courts decided in his favour and he used the settlement money to rebuild his own life and to fulfil his dream of giving other disabled people an opportunity to earn a living.

Inaccessible . . . Neville Cohen finds that the door to the toilet provided for the disabled at the Technikon Witwatersrand is kept locked.



Great help . . . the mechanical lift which has been installed at the Johannesburg Library is a boon to physically disabled people such as Neville Cohen.

Planners give scant

By Shirley Woodgate

There is no room at the loo at the Technikon Witwatersrand for wheelchair-bound people.

And, despite the inclusion of regulations in the National Building Act (1986) governing facilities for the physically disabled, these people will still have problems getting up the front stairs for "A Slice of Saturday Night" at the revamped Alhambra Theatre complex.

It is impossible for them to press the lift button to get to the ninth floor of the Johannesburg Hospital. It would also be a severe strain obtaining money from certain automatic tellers and downright embarrassing to do business at most banks with high counters.

Chareen Grobler, public relations officer for the National Council for the Physically Disabled in South Africa, and paraplegic Neville Cohen recently went walkabout in the city to see how facilities had improved over the last 10 years.

"We do not ask for anything special, merely the same rights that our able-bodied friends have to education, culture, sport, transport, the law courts or any other facility," said Mr Cohen, as he bounced his wheelchair on to the road from an unramped pavement on the corner of Sauer and President streets.

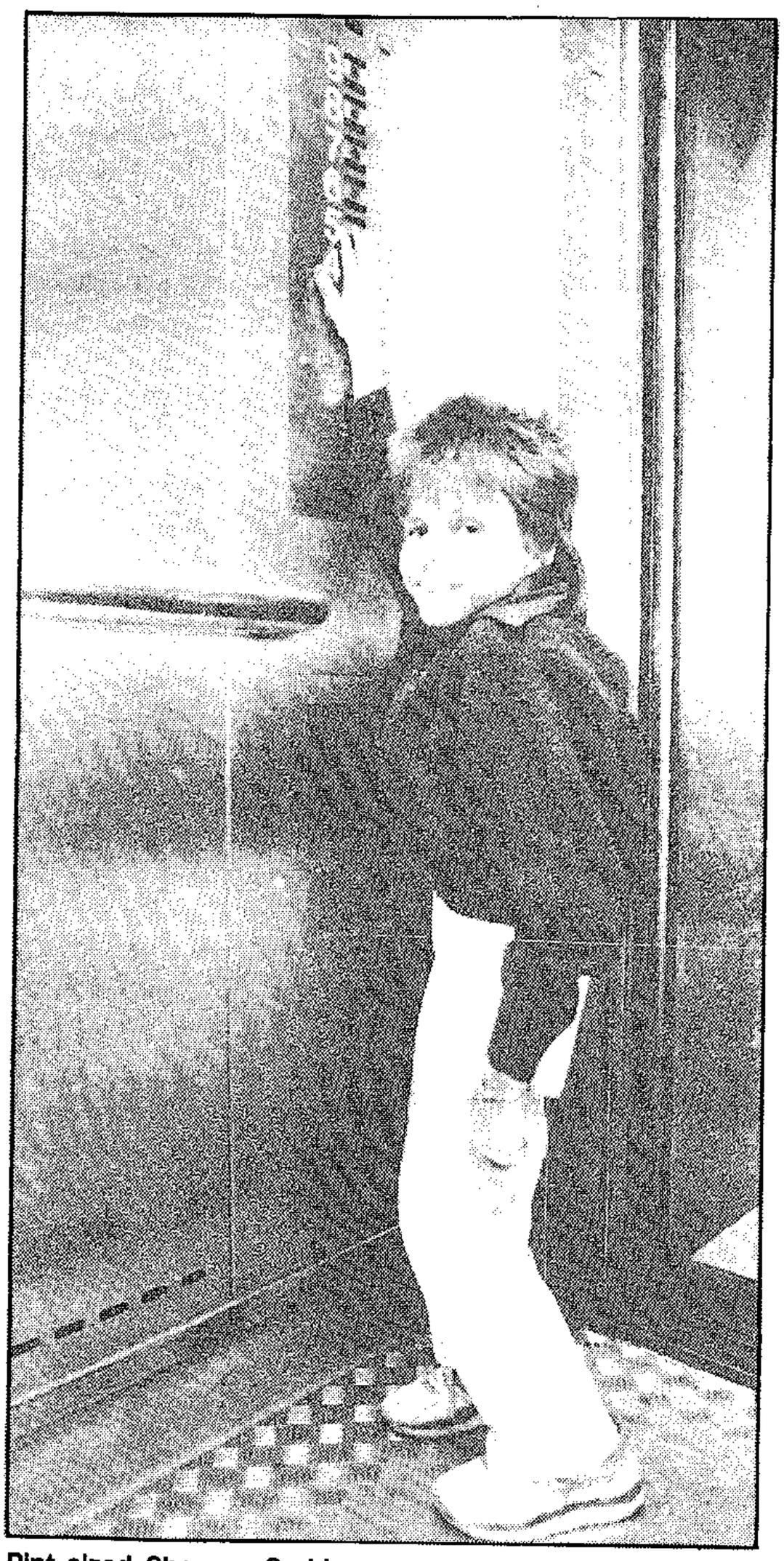
A leading member of Disabled People South Africa, a privately funded pressure group focusing on problems of physically disabled people, he said: "There is no reason for ignorance about the needs of the disabled."

Backed by a team of attorneys who are preparing to take their first case to court, the DPSA has an open-door policy for discussing problems in providing proper facilities.

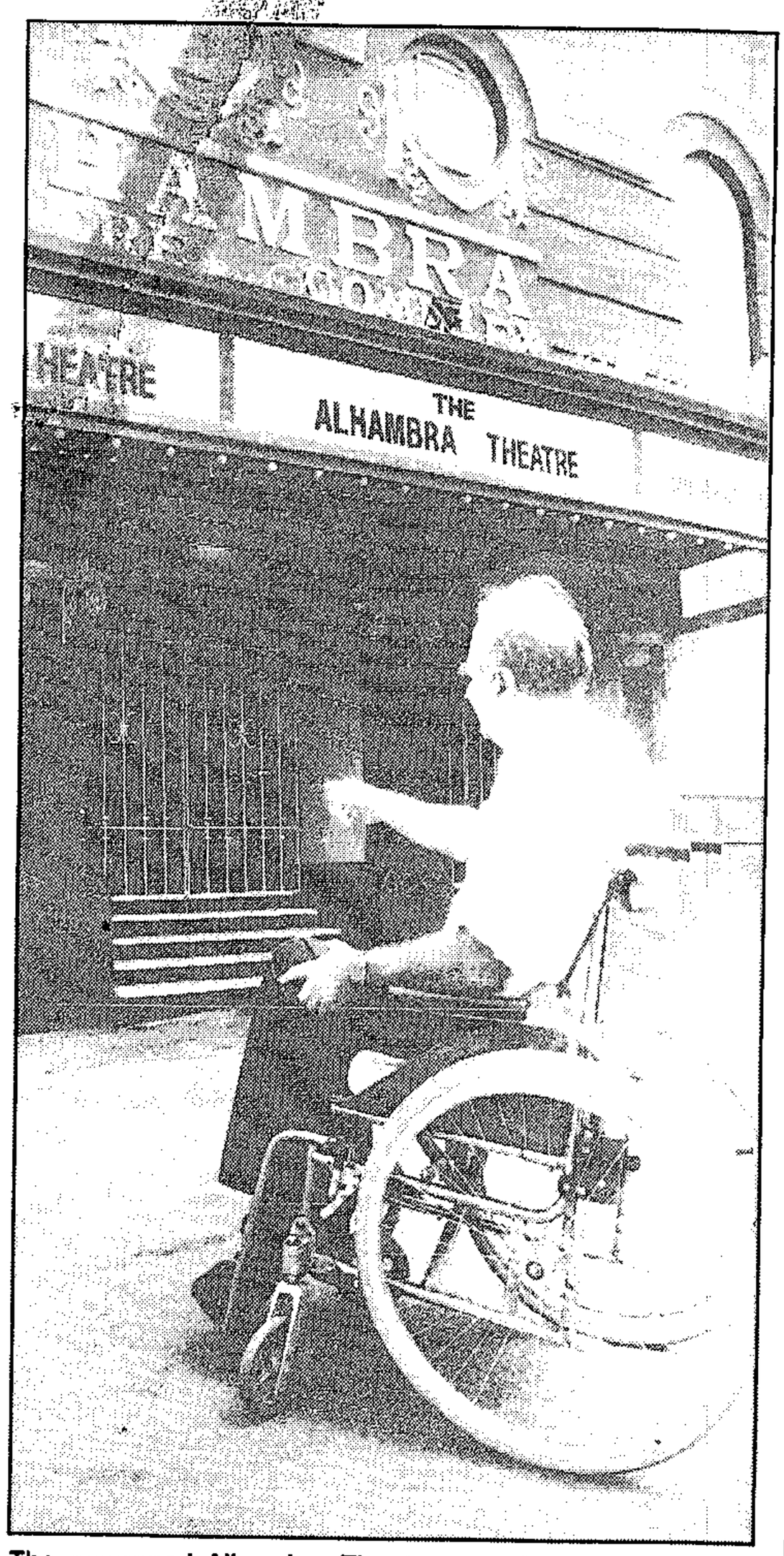
"In America, the Disabilities Act stipulates that every building or mode of transport must be made accessible within the next 20 years," said Miss Grobler.

She added: "We want such regulations allowing us equal access to society at large in the new human rights bill."

Starting at the technikon, Mr Cohen wheeled his chair into the new multimillion-rand complex and encountered a locked door at the only toilet provided for disabled people.



Pint-sized Chareen Grobler . . . can make it alone to the sixth floor of the Johannesburg Hospital, but the three upper floors are out of bounds.



The revamped Alhambra Theatre complex . . . no access through the front door, and no signs indicating an alternative entrance.
Pictures: Jacoob Rykliff

thought to disabled

The inquiries desk referred him to the public relations office opposite, which closes after hours. Rumour has it that the key is shared by some top officials.

The R10 million Civic Spine was billed as a "people place" — but the only toilet facilities provided for those in wheelchairs are in two inaccessible caravans.

When the Civic Spine restaurants open, the loos will be out of bounds because of the stairs.

The provision of a special lift for the disabled at the nearby public library is a shining beacon, and the DPSA plans to ask for parking in front of the library to compensate for the lack of parking near the Spine.

"Hostile, but slowly becoming user-friendly to the disabled," is Mr Cohen's description of the city environment.

This is despite vast strides made since South Africa's Year of the Disabled in 1986.

The changes affect not only about 500 000 physically disabled (the figure five years ago) but also thousands of elderly people.

Last month, an item on the agenda at the Johannesburg City Council meeting listed facilities for the disabled — a breakthrough, according to Mr Cohen, who said this was probably the first time these problems had been addressed at that level.

Parking is provided at major new shopping centres but these bays are often unavailable as there is nothing to stop able-bodied motorists from sneaking into the wider bays provided for unloading wheelchairs.

Rand Afrikaans University allows wheelchair students what Mr Cohen calls "an undignified entrance" through the back door. The steps leading up to the Rissik Street post office make this national monument out of bounds.

He said the National Building Act covered accessibility to buildings, vertical and horizontal movement inside buildings, seating accommodation and toilet facilities for all buildings of a certain size.

"If properly designed, little additional cost is involved in providing facilities for the disabled," added Mr Cohen.

But both agreed that what was needed was a final stamp on all building plans saying the premises were accessible for disabled people.

Medaid plea to level the field

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STAR 18/12/91

Medical Reporter

Medical schemes are being hampered by outdated legislation which gives insurance companies an unfair advantage, says Medicaid Administrators managing director Jeff Slome.

He said the schemes were already hampered by considerable increases in medical expenses and that legislation was undermining their stability.

"Insurance schemes are being legally allowed to skim the cream off the top of our market, while we have our hands tied by legislation and are unable to do anything about it," he said.

He said insurance products had a role to play in the health care market, but they were allowed to exclude bad risks, while medical schemes were obliged to accept all risks.

This was an indication that the "playing fields are not level" and a change in legislation was the only way to solve the crisis.

Medical schemes ended up with a majority of members who have health problems or who were elderly and infirm while the insurance companies were able to draw young, healthy and low risk members.

"Schemes should be allowed to market medical insurance packages and adopt a completely different approach to the rating of contributions."

Mr Slome said the State should subsidise pensioners' contributions to enable them to afford private care.

Emergency union

Paramedics, firemen and other emergency personnel recently launched the South African Emergency Services Union. The fledgling union is investigating the possibility of establishing an Industrial Council and members will receive various benefit schemes like funeral cover and extended illness cover.

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...erce International ... had reached a tentative... end of next week. The workers were dismi... ... bracket ... ... to stasse...

Medical schemes 'must change or face collapse'

IF PROPOSED amendments to the Medical Schemes Act were not carried out, the high inflation rate affecting schemes would continue until the system collapsed, Affiliated Medical Administrators chief operating officer Timothy Gelman said yesterday.

Gelman has just returned from a fact-finding mission to the US to assess the appropriateness of different forms of health care insurance.

"I am totally convinced a managed health care system is an absolute must for this country," Gelman said in an interview.

"A managed health care system focuses on preventative and primary health care, which is exactly what this country needs.

"Under the present system medical aid is beginning to get too expensive for most people."

DAVE LOURENS

Under managed health care systems, health insurers provide patients with their own doctors and hospital and pharmaceutical services.

Attempts to amend the Medical Schemes Act by National Health Minister Rina Venter sparked calls from the Medical Association of SA — which represents about 13 000 doctors — for her resignation.

The Representative Association of Medical Schemes backed the proposed amendments, saying without them medical aid subscriptions could rise by up to 40% in the new year and many schemes could go insolvent.

Gelman said the US health care system was structured similarly to SA's, with the same factors responsible for driving up costs; mainly over-utilisation of services and inappropriate use of expensive technology.

In the US, managed health care had increased its market share to 15%, up from 4% in 1977, and projections were that by 1997, 90% of the US population would be covered by managed health care schemes.

"Health care pushes up the cost of labour enormously. Health care makes up between 15% and 20% of the employee's cost to his employer," said Gelman.

Under the current system, prices are determined by set tariffs with guaranteed payments. The suppliers of health care maximise their profits by maximising use of the system, and medical schemes pay for everything.

"Under the current system, it pays to keep the patient in the system as long as possible. In a managed health care system, it pays to get the patient healthy and out of the system as quickly as possible," said Gelman.

Members of managed health care systems experienced 40% fewer hospital admissions and saved up to 28% on health care costs compared to the current system, he said.

Police swamped

GERALD REILLY

PRETORIA — The SAP has been inundated with applications from matriculants seeking admission to the four police training colleges, a spokesman says.

By end-November 15 000 had applied, but SAP colleges could accommodate only 4 000 in each of the two six-month courses. Many of those failing to gain admission were given clerical jobs.

For the first time all four colleges will be multiracial. Previously the Pretoria College was for white recruits, Bishop Lavis in the Cape was for coloureds, Hammanskraal for blacks, and the Durban College for Indians.

Inkatha official killed in attack

MARITZBURG — The Inkatha chairman for Table Mountain, Thomas Mshoki Gcabashe, was shot dead on Tuesday — three days after an attack on his brother Elliot, an Inkatha leader at nearby Maqongq.

Police said Gcabashe, 45, was shot five times in the neck and shoulder as he drove into his property. His brother is still in a serious condition in hospital.

Police are investigating the possibility that it is a "copycat" killing, saying the circumstances of the shooting closely resemble the manner in which ANC-aligned Chief Mhlabunzima Maphumulo was shot dead on February 25, our Durban correspondent reports.

Inkatha central committee member David Ntombela said yesterday Gcabashe's murder, when seen with recent attempts on the lives of his brother, KwaZulu deputy minister of works Velhapi Ndlovu, and Abdul Awetta of Imbali over the past few days, made it clear "the campaign to assassinate Inkatha Freedom Party leaders is intensifying".

In another incident on Tuesday, also near Maritzburg, two KwaZulu special constables were arrested in connection with a murder. Police said the men had allegedly shot and fatally wounded a man in Imbali.

Police witnessed the shooting. The men fled into the property of a "prominent" member of the KwaZulu government, but were eventually arrested. — Sapa.

Inflation 'a death knell for Med Aids'

Own Correspondent

JOHANNESBURG. — If proposed amendments to the Medical Schemes Act were not carried out, the high inflation rate affecting schemes would continue until the system collapsed, Affiliated Medical Administrators chief operating officer Timothy Gelman said yesterday.

Gelman has just returned from a fact-finding mission to the US to assess the appropriateness of different forms of health care insurance.

"I am totally convinced a managed health care system is an absolute must for this country," Gelman said in an interview.

"A managed health care system focuses on preventative and primary health care, which is exactly what this country needs.

FM 20/12/91.

Dr Venter's prescription

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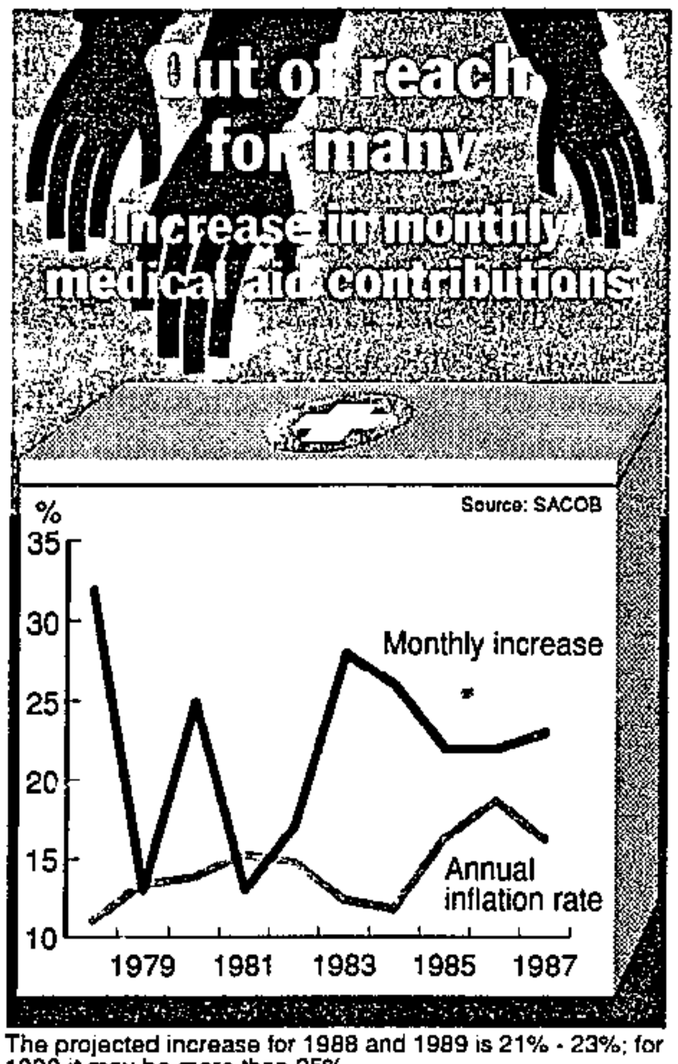
Deregulation of the medical closed shop would begin to meet the challenge

Judging by recent calls for Health Minister Rina Venter to resign, you'd think she was an intern who had left a scalpel in a patient's stomach. Objections to her have come from what looks on the face of it to be a powerful lobby — people such as the Medical Association of SA (Masa), the National Medical & Dental Association, the SA Dispensing Practitioners, and others.

Venter is accused of lacking leadership and failing to deal with admittedly critical problems facing health care — in particular, spiralling costs. Health-care services in the public sector continue to deteriorate fast in the face of increasing demand by a growing number of impoverished — but also increasingly politically empowered — claimants.

In the private sector, almost half of the medical aid schemes report operating losses totalling around R100m for 1990 as they battle to contain claim costs within the limits of subscription revenue. Medical scheme expenditure on benefits rose by an alarming 36% over 1989, which resulted in subscriptions for 1991 being increased by over 25%. Many members are reviewing or even surrendering their policies.

Venter's critics come mainly from this sector — within the commercial health-care delivery system — and their accusations smack of self-interest. Certainly, she hasn't presented a cure-all grand national plan to redress the gross imbalances of the public health service, an apartheid legacy, but she has made certain proposals which, if implemented, will go a long way towards deregulating health care and introducing competition in a sector that over the years has embraced a closed-shop mentality.



The projected increase for 1988 and 1989 is 21% - 23%; for 1990 it may be more than 25%

Critics have found particularly objectionable her support of amendments to the Medical Schemes Act to end statutory guaranteed payments and scales of benefits, which are said to encourage the overuse of health-care services. Her most far-reaching and controversial innovation, however, is an amendment that would allow medical schemes to provide health-care services themselves — that is, run hospitals and employ doctors, nurses and other practitioners at fixed salaries to cater for members' needs.


Venter

Doctors see this as a threat to their absolute discretion in dispensing services, and are concerned that medical schemes could acquire unlimited powers to control the use and provision of services. Says Masa health policy director Reg Magennis: "The involvement of medical schemes in the employment of medical practitioners holds the danger that the requirement placed on schemes to minimise costs could translate into an improper pressure on professionals to conform to the cost-saving dictates of lay people."

So doctors see in Venter's proposals a dilution of their professionalism. Magennis warns that the involvement of medical schemes in employing practitioners will partially destroy the scope for the financial cross-subsidisation practised by some doctors serving both affluent and poorer communities. The poor will be thrown back into the inadequate State sector, increasing the ultimate burden on the taxpayer.

But Venter and supporters of the amendments say that health maintenance schemes run by medical schemes have proved cheaper than the current fee-for-service system that offers no incentives to doctors — or patients — to be cost-effective.

Rob Speedie, executive director of the Representative Association of Medical

continue — P.T.O.

She's a Saint!

'Mum' to kids for 10 years

(299) (2990)

Clpres 22/12/91

By ELIAS MALULEKE

ASNATH Monaheli does not believe there are mentally retarded children. And after listening to this 67-year-old grandmother you begin to see her point.

This Pretoria Media Club (PMC) 1991 Achiever of the Year has been looking after mentally retarded children for more than 10 years.

Although she has 11 of these children at present, she has lost count of how many she has battled to give a decent life over the years.

Until this year, Monaheli never earned a salary for the 10 years of her work. It was self-sacrifice.

Most of the children she has taken under her wing at Thusanong Day-care Centre in GaRankuwa, Pretoria, since 1980 have been placed in educational institutions for training.

"Our bond remains in spite of the separation. They phone to ask if they can return or come to visit me. My phone never stops ringing and I am happy because they have something they can look forward to," said Monaheli.

"I see only the glow of brightness in my children. They are, in fact, underprivileged and not mentally-retarded because they can also do things like children with normal IQs if given the chance."

She started the centre after her own two grandchildren, born to her only son and his wife, a nursing sister, became handicapped and they could not find suitable places for them.

A third child of the couple is also mentally handicapped.

Other mothers dumped their children at her house, without helping, and then in 1982 a Catholic Church social welfare officer suggested she use the GaRankuwa Community Hall during the day and offered to help pay for the children's food.

10 YEARS OF SERVICE ... Asnath Monaheli has devoted her life to caring.

The church then moved the centre to a rented house where they erected a two-roomed prefabricated hut.

The house was later donated to the centre by the government but the church pulled out, leaving Monaheli high and dry.

"The community formed a committee and raised funds on our behalf," said Monaheli.

"The centre has again been taken over by the Catholic Church and, for once, I am earning a small salary."

Her R5 000 prize money from the PMC Award will not go into her pocket. It will be used to help the children.

Medical aids plan to join forces

THREE major medical aid societies held a conference in Gordon's Bay last week where they agreed to plan for a single major medical aid body in line with the anticipated democratic South Africa of the future.

The three medical aids schemes are the largely "coloured" Pro Sano Medical Aid Scheme, the largely "black" Bonitas Medical Funds and the predominantly "Indian" Sanita Medical Scheme.

Pro Sano, Bonitas and Sanitas already form a loose federation called "Bonprosan" — but now they want to combine more firmly their organisational, administrative and policy-making powers, they say.

A joint statement was signed by the three chairmen, Professor Paul Luthuli of Bonitas, Mr Cyril Beukes of Pro Sano and Mr Pat Samuels of Sanitas.

In it they say that Bonprosan will be used from now on as an "interim organisation for the purpose of unifying state employees within a single medical aid structure that would offer various health care services to its members".

The statement said Bonprosan had already written to the Minister of Health Services, Mrs Rina Venter, about its plans and had also held discussions with the officials responsible for health matters in the KwaZulu government and in in the ANC.

It also plans to meet with other medical aid organisations such as the Public Service Medical Aid Association (PSMAA) and the Post Office Medical Association (Posmed).

"We need a new approach to medical aid schemes in the new South Africa and all Bonprosan is trying to do is to plan ahead by pooling resources now already," said Mr Samuels.

● Meanwhile, Mr Solly Fourie, the branch manager of Medscheme, the administrators of Pro Sano and other affiliated medical aid schemes, said the ombudsman programme launched a year ago under the direction of educationist Mr George Strauss, has saved medscheme "millions of rands".

would be involved in a housing project in Thsepiso, an area between Sharpeville and Boipatong.

Madise said the agreement was signed at a news briefing on Tuesday. "The agreement stipulates that the community should not be left out of the project ... it should be involved." He could not give the size of the project nor the date on which it would start.

...day broadcast, the Queen "Next February will see the 40t niversary of my father's death a my accession.

"Over the years I have tri follow my father's example a serve you the best I can. You given me in return your loyalt

US study finds SA's health policies lacking

B1Day 27/12/91 (2'19)

DAVE LOURENS

SA COMBINES the worst health consequences of industrialisation and poverty — a high incidence of heart disease among whites and widespread preventable diseases among blacks, a new US study has found.

Economic progress, it says, needs to be coupled with effective financing and management if the health status of SA's people is to improve.

The study, conducted by the SA Medical Research Council in conjunction with the Washington-based Kaiser Family Foundation, found that health policy was shaped mainly by political considerations rather than national health priorities.

Although an effective national primary health care system could significantly improve the population's health status relatively quickly, a 10% annual economic growth rate would be needed to eliminate poverty within the next decade.

SA currently spent 5,8% of its GNP on health care, compared to the World Health Organisation's (WHO) minimum standard of 5%. A disproportionate amount of this expenditure went to white health care.

SA had enough hospital beds to serve the entire population, but urban areas had a surplus while rural areas were neglected. There was a surplus of 11 700 beds for whites but a shortfall of 7 000 for blacks.

The WHO recommended an ideal bed/population ratio of 1:200. In SA there was one bed for every 150 whites, but only one bed for every 260 blacks.

To resolve these disparities, the bureaucracy of health administration needed to be disentangled, and access to health care needed to be rationalised, with particular emphasis on removing discrepancies between rural and urban facilities.

While the need for substantial reform in the national health system was accepted by government and non-government health sectors, its nature was disputed.

The study said the state believed those who could afford to pay for care should do so, freeing more funds to subsidise state patients. The non-government sector, including liberation movements and left-wing medical groups, believed fees for service care promoted unequal care, and the existence of a private sector undermined the public sector by offering higher salaries and better working conditions.