SOCIAL SECURITY - MEDICARE

1991

JANUARY — JUNE

Chaos breaks out in world markets

ANDREW GILL

MAYHEM broke out in world markets yesterday as peace prospects soared and then plummeted, sending them on a hectic rollercoaster ride.

Gold fell $12 in New York to $377,25/oz and then rocketed more than $10 to close at $391,05 after US Secretary of State James Baker said talks with Iraqi Foreign Minister Tariq Aziz had failed.

Trading virtually stopped as dealers awaited news of Baker's media conference and found themselves hastily reversing positions as the news broke.

February Brent crude gained almost $2 to above $28 after losing more than $3 a barrel to $22,40 in New York when markets took heart from what they perceived to be a fruitful meeting.

News that Aziz had agreed to meet EC ministers in Algiers and a rumour that Iraq had proposed a conditional phased withdrawal from Kuwait sparked heavy selling of gold and dollars.

The dollar regained the day's heavy losses after falling three pfennigs against the mark to DM1,51 and climbing back to DM1,5345.

The Dow Jones Industrial average, which climbed 1,5% before Baker's comments, fell eight points to 2 501, while European markets gained, with London's FTSE-100 index ending 1,5% up.

Frankfurt's DAX index finished 1,6% up. A trader told Reuter: "This is nothing but speculation. Prices are being pushed up by traders whose view of time is about three minutes and whose view of long term is three days."

Analysts said earlier war was likely to push gold up for a short period, but that the resulting slackening in world growth would take its toll with decreased jewellery demand.

Middle Eastern buying has apparently diminished. On Tuesday the Jedda Bank was rumoured to have sold large amounts of gold at the higher prices. Soviet forward selling was also said to be a factor.

On the JSE the overall index ended six points off at 2 689 after a 22-point fall in the all gold index to 1 317 and a 10-point gain in the industrial index to 2 924.

Mega-merger talks take new direction

GILLIAN HAYNE

MERGER talks between UBS, Volkskas, Allied and Sage Financial Services (SFS) appeared to have taken a new direction yesterday after a special board meeting of the Allied. BIDay 10/11/91

Company insiders said the meeting was held specifically to discuss an offer from Southern Life, countering the merger negotiations.

Southern Life chairman Neal Chapman was not available for comment yesterday.

Allied chairman Norman Alborough, MD Kevin de Villiers and co-director Louis Shill, chairman of the Sage group, declined to comment on the business of the meeting.

However, it appeared that Southern had approached Allied's board seeking support for a 225c a share bid for 30% of Allied's equity.

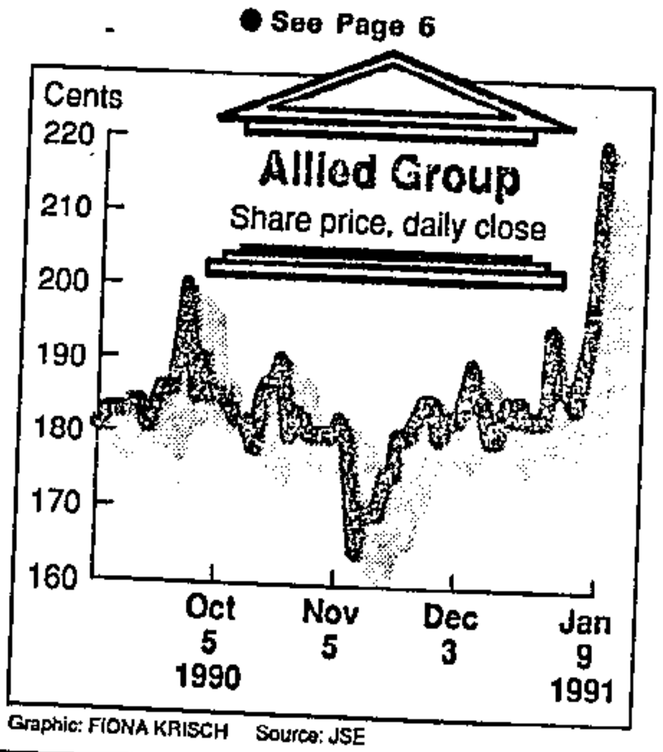
For the present Allied would continue talking to UBS and the others, said company insiders, who also suggested Shill would recuse himself over the Southern offer.

SFS owns 10% of Allied and, in its turn, Allied owns preference shares which will convert in stages into 20% of Sage Holdings' equity by 1994.

Allied had been negotiating a merger with UBS, Volkskas and SFS since September last year and the four companies' negotiators were sworn to secrecy on pain of financial penalties. The merger negotiations were expected to have been concluded by Christmas, but ran into snags.

Yesterday Allied's shares soared from 195c to 220c as 346 000 shares changed hands on the JSE. The shares had weakened slightly at the start of the year after a window-dressing rise in the dying days of 1990. As trading ended hopeful buyers were bidding 230c for the shares.

● See Page 6



Graphic: FIONA KRISCH Source: JSE

15% rise in doctors' fees recommended

299 GERALD REILLY

PRETORIA — The Medical Association of SA (Masa) has recommended a 15% across-the-board increase in doctors' consulting fees, the organisation's secretary-general Hendrik Hanekom announced yesterday.

Justifying the increase, Hanekom said doctors' practice costs had increased sharply by at least 25% above inflation.

Doctors' financial positions were becoming so critical that a breakaway from medical schemes by more of them was inevitable, he warned.

BDay 10/11/91

About 80% of doctors charge according to the Representative Association of Medical Schemes (Rams) scale of benefits.

Medical aid schemes this year will pay R24,90 for a GP consultation compared with R21,10 last year. Masa felt R36 a consultation was more reasonable.

Rams executive director Rob Speedie declined to comment until he had seen the full Masa statement.

Dairy Board receives no money from govt

Business Day Reporter

THE Dairy Board, which exports surplus dairy products, does not receive any money whatsoever from government, its agent, the Dairy Services Organisation (DSO), said in a statement yesterday.

It was commenting on a Business Day report on Tuesday that the taxpayer would have to pay about R288m this year and next to subsidise surplus dairy products, which would be exported at a massive loss.

The statement said the Dairy Board's total income was derived from levies collected from milk purchasers, producer-distributors and farm cheesemakers.

The DSO also contested the amount mentioned in the report. Giving details of how the figure should have been calculated, it projected a total export deficit of R108m to February 1992.

BDay 10/11/91

Government had never undertaken to become involved in disposing of surpluses. Its only involvement was in the fact that the Minister of Agriculture had to approve any expenses incurred by the Dairy Board.

Commenting on figures in the report, the statement said the lowest price at which butter or skim-milk powder was exported last year was R1,65/kg. The floor price fixed by the Dairy Board in February 1987 was approximately 40c/l, and not 36c/l. The floor price had not been scrapped, and was currently 45,06c/l.

The average producer price for the country reached 56c/l in about March 1989. This had not happened "overnight" when NCD began to buy milk directly from farmers in 1987.

The recommendation to scrap the floor price was received from the National Dairy Committee of the SA Agricultural Union, and not the NCD (National Cooperative Dairies).

☐ Business Day regrets the errors.

15% hike in doctors' tariffs

PRETORIA. — The Medical Association of South Africa (Masa) yesterday announced an official 15% increase in its doctors' tariffs.

And Masa secretary-general Dr Hendrik Hanekom said that although some 80% of doctors still charged according to medical schemes' scales of benefits, the financial situation of doctors was becoming so critical that a breakaway from medical schemes by more doctors seemed inevitable.

He also encouraged patients to ask their doctors for reductions in their tariffs.

The chairman of Masa's Private Practice Committee, Dr Johan Kruger, said medical schemes would not adjust their benefits to two-thirds of Masa's recommended fees, and the hike meant the gap between the two scales was now more than 50%.

For instance, Masa's recommended maximum fee for a consultation with a GP now is R55,20, while medical schemes' contracted-in tariff has been set at R24,80.

The Medical Research Council (MRC), meanwhile, has asked the public to assist a newly appointed task group in its investigations into South Africa's health status, health services, research and training.

MRC national co-ordinator Dr Derek Yach said the investigations would be used to define the future of health research in SA and to ensure that all research keeps pace with socio-economic and political changes. — Sapa and Staff Reporter

All one can do is cough up

Star 11/1/91

299

Members of medical aid schemes are generally considered to be the most privileged users of health care in South Africa. But are they? Have they become the victims of the battle between private doctors and the medical aid schemes? Medical Reporter CARINA LE GRANGE looks at the patient's conundrum.

IN THE battle between the representative bodies for doctors and medical aid schemes — the Medical Association of South Africa (Masa) and the Representative Association of Medical Schemes (Rams) — on what doctors should be paid and how much the aid schemes pay, the patient has become a vulnerable bystander.

While the two bodies remain locked in a long-distance tussle over fee scales, the patient is the sick and virtually powerless figure in-between, helplessly watching as medical care is fast slipping out of reach.

Masa accuses medical aids of no longer being able to render affordable or accessible health care, while Rams accuses doctors of over-servicing and excessively high charges.

The ordinary patient has little, if any, say in the matter.

Almost 20 percent of South Africans are members of medical schemes — a benefit provided by many employers.

Consult

Membership of the scheme is usually compulsory. Members have to comply with subscription rates required and accept the benefits offered.

When a member consults a doctor, however, the contract entered into is between patient and doctor. Despite medical aid membership, it is the patient who is responsible for paying for the doctor's services.

It is also the patient who, despite medical scheme benefits, has to pay out of his own pocket the difference between what the doctor asks and what the medical aid gives. The patient also, of course, pays subscriptions each month.

With the gap between the medical aid scale of benefit and the maximum recommended fees for doctors now at more than 50 percent, the patient has to dig deeper and deeper into his pocket.

Masa is responsible for determining doctors' fees while Rams decides what doctors should be paid.

If there are any real attempts between Masa and Rams to reach a compromise on acceptable remuneration for doctors' services, there is no public evidence of this.

This year the top general practitioner rate is R55,20 with the medical scheme payment at R24,80. Last year, when Masa's recommended top rate for a consultation with a GP was R48, a large Johannesburg multiracial practice charged R40 — of which only R21,10 was paid by the medical aid.

Masa believes a scale-of-benefit fee of R36 would be more reasonable as that would mean doctors offer a one-third discount on Masa's R55,20 fee.

Announcing their latest increase of 15 percent this week, Masa said the rise had been determined on the basis of general economic trends and business consultants' findings.

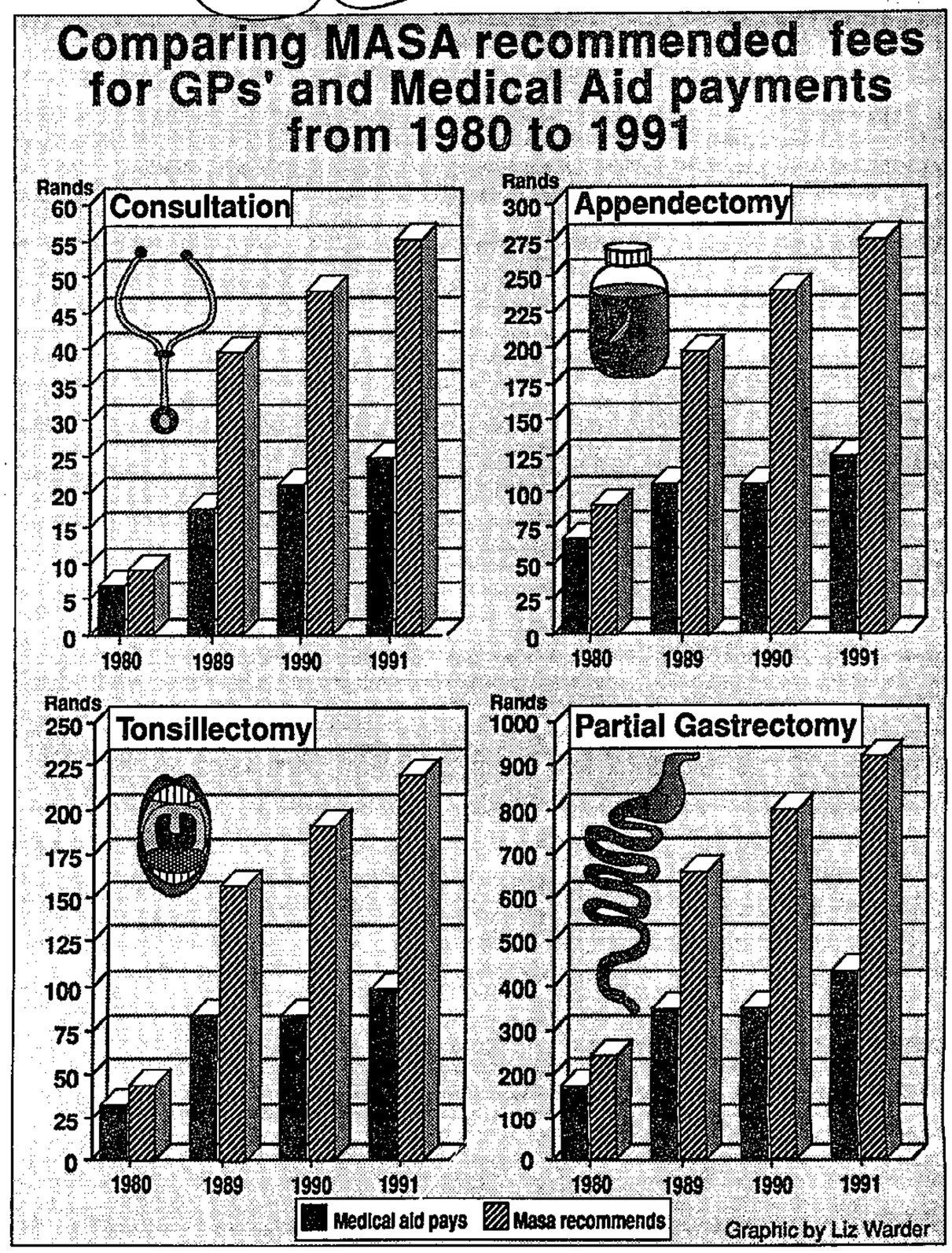
Masa secretary-general Dr Hendrik Hanekom said doctors could no longer afford to deliver quality health service at medical aid tariffs and pointed out that the latest increase was lower than the inflation rate.

However, Rams executive director Rob Speedie said recently: "We have a standing disagreement with Masa about the reasonableness of its guidelines. But it's their prerogative to determine what they should charge and ours to determine what members can afford.

"Medical aid schemes are strictly non-profit organisations and the gap is so huge that to close it would result in a huge hike in contributions."

The situation remains unsolved. A suggestion towards solving the issue has come from the National Medical and Dental Association, which said that if it were up to Namda to determine fees, it would want to sit down with the medical aid schemes so that a reasonable fee could be determined.

If such attempts by Masa and Rams have been made, they have been blatantly unsuccessful. With negotiations in the political arena in the air, there remains hope that the medical scene could also change. □



'Minimum R40' rise in Medicaid fees?

(299)

Star 11/1/91

By Carina le Grange
Medical Reporter

Medical aid members will pay a minimum of R40 a month extra on their subscriptions as a result of doctors' fee increases, the Representative Association of Medical Schemes of South Africa (Rams) has warned.

Rams said the new 15 percent increase in doctors' fees announced by the Medical Association of South Africa (Masa) on Wednesday effectively amounted to a demand for medical aids to pay 71 percent more.

It was preposterous that demands of this nature were made by the medical profession when the country was in a recession, Rams said.

It said the new consultation fees would raise doctors' gross income to at least R530 000 a year (R44 000 a month).

The new fee increases mean a consultation with a general practitioner could cost the patient R55,20 (R48 in 1990).

However, about 80 percent of doctors charge the lower medical aid-determined scale of benefit fees.

The medical aid scale of benefit payment to doctors is R24,80 (R21,10 in 1990).

In its statement Rams said: "The medical profession has demanded an effective 71 percent increase for all services, not only GP consultations. What is more, they have told us the demand is totally non-negotiable."

Masa had said that the gap between its recommended fees and Rams pay-outs had increased sharply as illustrated in the difference between the scale of benefit fee of R24,80 and the Masa fee of R55,20 for GPs.

Rams said only part of the overall picture emerged on Wednesday when Masa announced its recommended increase in fees.

"Doctors demand that the Rams scale of benefits should equate to two-thirds of the recommended Masa fees. This, for example, means that they want medical schemes to pay R36 for a GP consultation at rooms, which is 71 percent above the amount which Rams awarded in terms of its scale of benefits last year (R21,10)."

Masa was not available early today to comment.

ANC enters fray over medical fees demands

B/Day 11/11/91 299

MEDICAL aid would cost at least R40 a month extra if the medical scheme industry acceded to doctors' demands for an effective 71% increase in their payouts, Representative Association of Medical Schemes (Rams) executive director Rob Speedie said last night.

The demand represented a jump of about R1,1bn in medical schemes' total payouts this year and would raise a GP's gross income to at least R530 000 a year, he said.

His figures were based on the conservative estimate of 40 consultations a day by a doctor working at least 240 days a year.

Speedie was reacting to the Medical Association of SA's (Masa's) demand that Rams raise its scale of benefits to two-thirds of Masa's recommended doctors' tariffs.

This would mean R36 for a GP consultation, 71% more than the R21,10 awarded by Rams last year. Rams has increased its payout to doctors this year to R24,80.

TANIA LEVY

And the ANC said yesterday increased doctors' fees had put consultations beyond the reach of poor black communities which needed them most.

The Registrar of Medical Schemes said only about 6% of blacks and less than 20% of SA's total population were covered by medical aid schemes.

Reacting to the 15% fee increase for doctors recommended by the Medical Association of SA (Masa) this week, the ANC said medical expertise and preventative medicine had to be placed within reach of the majority of people at a nominal cost.

Wits Centre for the Study of Health Policy researcher Cedric de Beer said the only way SA would be able to provide affordable health care to all would be through a drastic overhaul of the public and private sectors.

Private health care in SA had few effective cost-containment mechanisms and was in the process of pricing itself out of the market.

De Beer said Masa was correct in saying it believed medical schemes' scales of benefits were too low, but that Rams was right when it said medical scheme members could not afford the fees demanded by Masa, which had recommended that GPs charge R55,20 for a consultation.

Masa Private Practice Committee chairman Johan Kruger said medical scheme payouts to doctors were now half that of tariffs regarded as reasonable by Masa.

A "breakaway" from medical aid schemes by doctors seemed inevitable, although most were still contracted in to medical schemes and compelled to charge Rams rates.

Dispensing Family Practitioners' Association chairman Dr Robert Rapiti said the organisation had advised doctors to contract out of medical schemes if they could.

However, this was not feasible for those with practices in lower socio-economic areas, where patients already found medical aid contributions crippling, he said.

From Page 1

Doctors in row with medical aid

CMH Times 12/11/91 299

PRETORIA. — The Medical Association of South Africa (Masa) yesterday strongly rejected allegations by the executive director of the Representative Association of Medical Schemes (Rams), Mr Rob Speedie, that doctors had made a "non-negotiable demand" for an increase of 71% in the scale of benefits.

In a statement, Masa's secretary-general Dr Hendrik Hanekom said the bottom line was that medical aid schemes benefits for doctors' services had decreased from 42% in 1980 to 34,1% in 1988.

"The increase in medical schemes benefits — from R24,80 to R36 — which doctors requested, was in fact closer to 45%, and it was requested on behalf of those patients who could not afford to make co-payments should their doctors be unable to continue rendering their services at the current scale of benefits," Dr Hanekom said.

He also argued that the tariff increase was not a demand but a plea that medical schemes should reduce the backlog built up in their benefits for doctors over the past 10 years.

Meanwhile, the SA Co-ordinating Consumer Council yesterday urged consumers to end unnecessary visits to doctors to keep their medical costs down.

"Unnecessary visits will inevitably cost the consumer more," said the council's director, Mr Jan Cronje.

Among the measures he recommended were for consumers to consult pharmacies about self-medication for minor ailments, insist that the doctor prescribed the cheapest generic remedies, enquire from several doctors about their fees and ask for a second opinion if in doubt about the first visit to a medical practitioner.

● In Pretoria a delegation of the Junior Doctors Association of South Africa (Judasa) yesterday met the Director-General of National Health and Population Development, Dr Coen Slabber, to discuss grievances.

A statement by the Medical Association of South Africa (Masa) issued after the meeting said it was agreed that the interests of patients and the health care industry enjoyed priority and that a commitment to a non-racial health care structure for South Africa was also a common goal.

"It is further felt by Judasa that their junior doctors' working conditions are so unsatisfactory that they cannot work in the best interests of their patients.

"The situation will deteriorate further unless students' grievances concerning remuneration, conditions of employment, working hours and overtime are attended to. A commitment to serious and immediate consideration of these grievances was made by the department," the statement said.

'Costs of medical practice high'

Star 14/1/91

By Carina le Grange
Medical Reporter

The costs of running a medical practice may be as high as 70 percent or more of the total income doctors receive, medical practitioners say.

Following the outcry over the recent 15 percent increase in medical tariffs, The Star approached three Johannesburg doctors and asked what they would consider realistic remuneration for their services. They may not be named for ethical reasons.

All three, from practices in an eastern, a western and a northern suburb, serving patients from poor, mixed and affluent areas, spoke about high practice costs.

Two doctors believe their charges should be discretionary — one believing it should depend on the length of the consultation and another on what patients could afford.

The third doctor, in the northern suburbs, said the new rate of R55,20 was "not bad".

The doctor practising in eastern Johannesburg said her fee, in her cash practice, had now risen to R30 as opposed to the scale-of-benefit fee she charged last year of R21,10, as she could no longer afford to run her practice on what medical aids recommend.

"Practice costs amount to probably 70 percent or more of my income — the costs of some items I use have risen more than 10 times over the past 10 years, and the fees have not increased by that."

She said as she practised in a poor area, she tried to accommodate her patients as most were unable to pay.

She said she felt R55,20 was "a bit heavy", with R40 to R45 being more realistic.

She did not believe Masa's suggestion that patients negotiate fees with doctors was fair as her assessment of someone's bank balance might be wrong.

A doctor to the west of the city said he charged scale-of-benefit fees, but asked patients who earned little to pay less.

"I basically subsidise their health care with what I receive from medical aid members.

"The majority of doctors are subsidising many patients in this way, and often income per patient is on average about R12,50 per consultation."

He said there was no doubt a large number of doctors earned an "enormous amount of money," and that they needed to work out what would be a reasonable amount to charge.

SA needs national health policy – Namda

Medical Reporter Star 14/1/91

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While the Consumer Council last week advised patients to "shop around" when seeking medical care, the National Medical and Dental Association (Namda) said increases in medical tariffs reflected the crisis in health care.

Consumer Council director Jan Cronje said in Pretoria consumers had almost no defence against expensive essential services.

"They cannot boycott doctors — this concerns life and death," he said.

Mr Cronje said the public should determine whether doctors were contracted in or out of medical schemes as it could mean a difference of up to 123 percent in consultation costs.

Namda said in response to the 15 percent increase in medical tariffs announced by the Medical Association of South Africa (Masa) last week that what the country needed was a national health policy.

"The rise in fees is a mere reflection of the crisis in health over the past decade. Increases tinker with the system instead of coming to grips with the rise in health care costs.

"Namda remains committed to a national health system and sees this as a solution to the health care problem," spokesman Dr Fazel Randera said.

Masa has recommended a new top rate of R55,20.

Doctors to net R2bn, says schemes director

BTP cm 14/1/91

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DOCTORS are expected to take more than 30% of the R7,5bn calculated to be spent on SA's private sector health care this year.

Representative Association of Medical Schemes (Rams) executive director Rob Speedie said this was well over R2bn, and R480m higher than last year.

He said private sector medical costs would rise by 25% from R6bn last year to R7,5bn this year.

The total payout by the medical schemes, which accounted for 85% of the total annual private sector healthcare payments, would rise by more than R1bn to R6,4bn.

"Rams is alarmed by this runaway increase in the costs of medical care, which has been caused by a persistent increase in the utilisation of medical services."

Speedie said the release of these cost increase projections coincided with Rams' decision to raise 1991's scale of benefits to doctors by 18%.

GERALD REILLY reports from Pretoria that Masa rejected the Rams claim that doctors made a "non-negotiable" demand for an increase of 71% in its scale of benefits.

WILSON ZWANE

Masa secretary-general Hendrik Hanekom said the bottom line was that medical scheme benefits for doctors' services were gradually decreasing.

The Registrar of Medical Schemes said they fell from 42% in 1980 to 34,1% in 1988. Referring to the 71% claim, Hanekom said the rise in medical benefits asked by doctors — from R24,80 to R36 — was closer to 45%.

Rams, Hanekom said, was confusing the issue by using irrelevent statistics.

He said 80% of doctors were still operating according to the scale of benefits.

The SA Co-ordinating Consumer Council said patients should:

☐ Consult pharmacists about self-medication of minor ailments;

☐ Find out from different doctors what their fees were if a visit was really necessary;

☐ Make sure the cheapest generic remedies were prescribed; and

☐ Ask a second doctor's opinion if the first one's diagnosis was doubted.

● Comment: Page 6

GPs to take a third of health-care bill

Car Trips 14/1/91

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Own Correspondent

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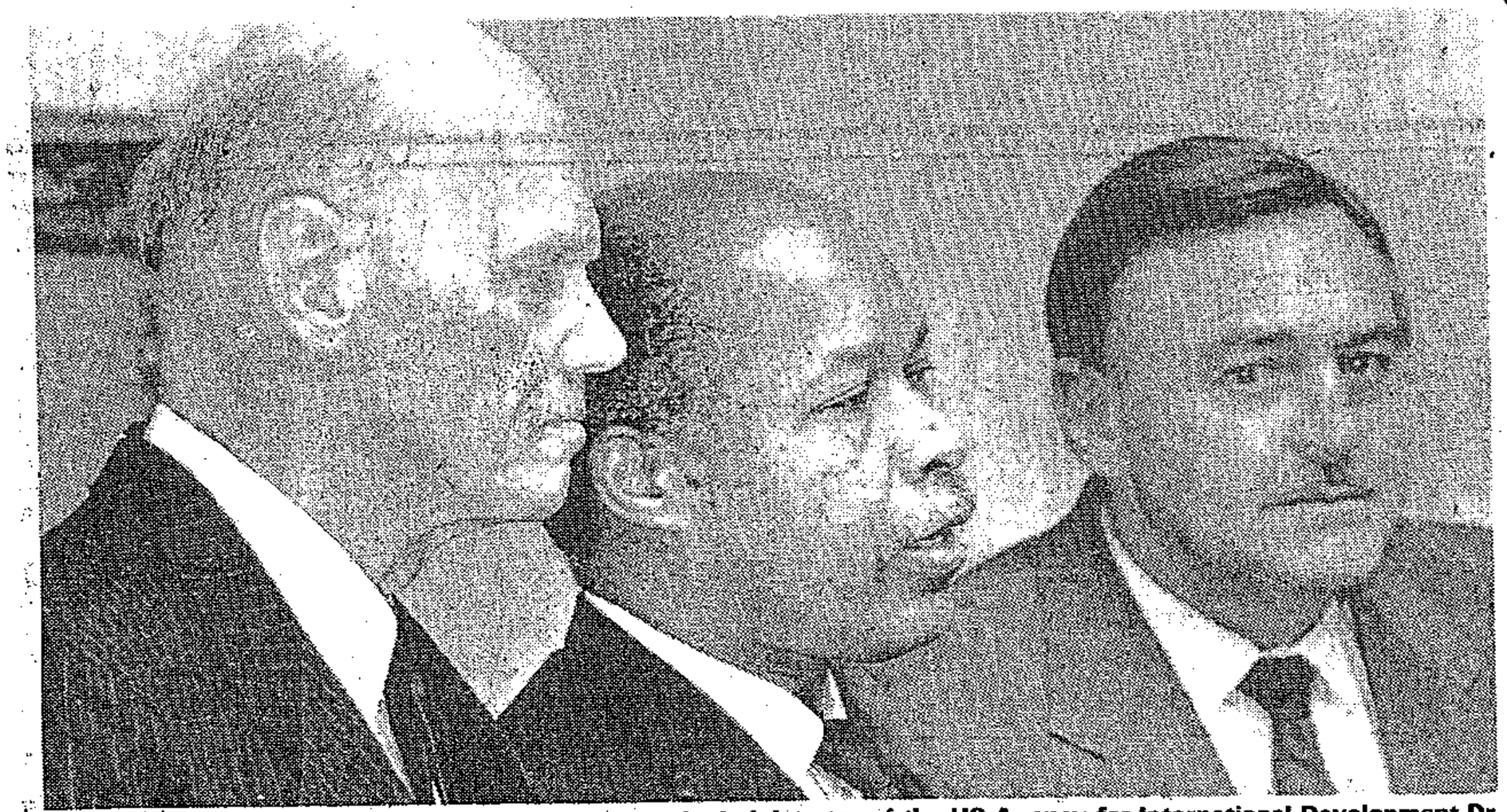
US Health Secretary meets De Klerk, Botha



US Secretary of Health Dr Louis Sullivan, centre, and administrator of the US Agency for International Development Dr Ronald W Roskens with Foreign Minister Pik Botha after their meeting in Pretoria yesterday. Picture: ROBERT BOTHA

CAPE TOWN — US Secretary of Health Dr Louis Sullivan met President F W de Klerk for talks on health issues and child welfare yesterday, and relayed greetings from US President George Bush.

Sullivan, on an eight-nation tour of Africa, was accompanied by the Administrator of the US Agency for International Development, Dr Ronald Roskens.

Speaking to journalists before the meeting, De Klerk said: "We will be talking on the issues that brought these two gentlemen to Africa and to South Africa. I will also use the opportunity to discuss the situation in general inside our country, and its prospects."

The mission will focus on efforts to bring about improvements in child survival and on the impact of AIDS, particularly as it affects mothers and children.

Earlier Sullivan met Foreign Minister Pik Botha in Pretoria and said he was pleased with Botha's message that the dismantling of apartheid was irreversible.

Sullivan said this news had been welcome because apartheid affected everything including health services, where a duplication of costs had occurred.

Botha said regional co-operation should be extended to include medical services. — Sapa.

Scheme aimed at helping patients

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Sowetan 16/1/91

THE Johannesburg Hospital's social work department has launched a scheme aimed at offering patients and their families emotional support and assisting them with practical tasks they cannot perform.

The scheme will focus on counselling, with the social workers befriending patients and paying them visits at home after they have been discharged, collecting pension funds for those who are unable to go to pension payout points and doing shopping for them.

Miss M Leketi, a social worker at the hospital, said the service had been offered to patients before but not on a non-racial scale.

Following the opening of health services to all races the hospital has had to open the scheme to include people of other races, she said.

Volunteers

She said the hospital was running a recruitment programme for voluntary workers, both black and white, to find people who would be interested in providing care and support to patients, both adults and children, for about six hours a week.

The candidates will receive training in basic counselling and communication skills to equip them to offer patients emotional support and assist with practical tasks.

They would also act as interpreters to bridge language barriers.

Applications are invited from volunteers. The closing date is February 28. The following numbers can be contacted from Monday to Friday for more information, (011) 488-3106 between 9am and noon and (011) 646-5014 between 5pm and 8pm.

New deal offered to medical aid members

Medical Reporter (299)

A medical insurance scheme has been launched in South Africa which offers a "realistic alternative to medical aids", according to its promoters.

The package offered, which is suitable for self-employed people as well as for people who wish to top up their existing benefits with company medical schemes, is aimed at "healthy families who are tired of subsidising unhealthy families," spokesman Brian Shepperd said.

"With medical aids operating on a group basis, premiums are averaged out and healthy people subsidise unhealthy people. For the unhealthy this is a benefit, but it is very unfair towards the healthy."

Mr Shepperd says the scheme is suitable for self-employed people, people who do not have compulsary company benefit medical aid or scheme members who wish to ensure they have sufficient additional funds.

Medical bills 25% up for third year

S/Times 20/1/91

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HENDRIK HANEKOM: Overheads a growing burden for the doctors

ROB SPEEDIE: The healthy subsidise the sick

MEDICAL bills will be 25% higher than they were last year, says Representative Association of Medical Schemes (Rams) executive director Rob Speedie.

The 25% increase will be the third in three years.

The collapse of provincial hospitals and the move to expensive private ones have played a role in increased health costs.

Mr Speedie says: "The proportion of benefit payouts to hospitals rose from 17% in 1978 to 22% in 1988."

In the year to June 1990, the number of private hospital beds increased by more than 20%, but the occupancy rate was at a low of 64%. The optimum is 75%.

The Medical Association of South Africa (Masa), which represents doctors, has recommended a fee increase of 15% this year. Secretary-general Hendrik Hanekom stresses that the fee structure is only a guide to members.

Dr Hanekom says: "Up to 80% of all doctors charge according to the scale of benefits put forward by the medical aids.

"The fee increase was determined with the country's economic situation in mind. But the medical profession must be financially secure to provide high-quality service."

Dr Hanekom says doctors are not solely responsible for the increase in health-care costs.

"An independent study in the Free State shows the average escalation of doctors' net income in the past three years was only 9,2%.

"Doctors are not walking away with all the money. Overheads constituted 55% of their income in 1987. They are now 60% to 65% or even more for cost-intensive practices such as pathology.

Blame

"The proportion of benefit payouts to doctors fell from 38,6% of the total in 1978 to 34% in 1988."

Dr Hanekom says some blame can be attached to the inflexibility of the Medical Schemes Act of 1967. Medaid schemes should be able to offer package deals whereby a member pays only for what he needs. That would reduce the cross-subsidisation whereby patients pay higher subscriptions for services they do not use.

Mr Speedie disagrees with the package deal, saying the patient is often unable to make a rational decision about what he needs.

"It might lower the cost of subscription for some, but it would increase the costs for the higher-risk patient. The principle of the healthy subsidising the sick is the basis of medical aid. Medaid members are getting older and 65-year-olds claim 4,5 times as much as 25-year-olds."

Problems also arise with the difference between the Masa fee guide and the Rams scale of benefits.

Dr Hanekom says the original understanding in 1967 was that medaids would pay two-thirds of doctors' fees. That was valid until 1988, but now they pay less than 50%.

"The gap is so big that many doctors will charge more."

Mr Speedie says the 1989 scale of benefits for a GP consultation at rooms was R21,10.

"Masa recommended R48 in that year, but we found that more than of 85% of GPs charged R21,10.

"Most of those who charged more asked for R32. The market determined the value of such a consultation, and we covered two-thirds of this fee. This year's 15% Masa increase brings the recommended consultation fee to R55,20."

The average annual compounded increases since 1984 amount to more than 22%. The Rams scale of benefits has risen by 17,5% and the payout on GP consultations has risen to R24,80.

"Masa has demanded we increase our scale of benefits for all medical services by 71%. That could bankrupt us."

Mr Speedie says abuse of benefits is another cause of increased subscriptions.

Capital

He claims that doctors charging according to the scale of benefits call in their patient more often.

Hospitals are capital intensive and pay in foreign currency for imports. The rand's depreciation has made these goods more expensive.

High medicine costs are another factor. Medaid payouts for medicines are 26% of the total compared with 11% in the UK.

The cost of medicines could be reduced if medaids were allowed to dispense.

The Browne Commission of 1986 noted that cheaper medicine could be obtained through collective buying. But attempts to do so were thwarted by the SA Pharmacy Board.

The commission said considerable savings to schemes and members could come from in-house dispensaries. Vested interests are often a hindrance to cost-saving measures.

Dentists have raised their fees by an average of 17%.

By DIRK TIEMANN

State must draw on private health care sector

Bloom 22/11/91

JEFFREY HURWITZ

WHEN President FW de Klerk changed the political face of SA on February 2 last year, we all knew that the political changes would affect the hospital industry. Predictably, health care quickly emerged as one of the most sensitive issues on the political agenda.

Already, changes have been made. Public sector hospitals were opened to all races (private hospitals of course have been nonracial for a long time), and the recent move to bring the House of Assembly Department of Health Services under the management of National Health Minister Rina Venter was a logical next step.

While the process of integrating the myriad other health departments into the National Health Department is up to the politicians, a more urgent case must be made for involving the private sector in the state's health care planning process.

That this has not yet been done to a meaningful degree can, on the one hand, be ascribed to the rash of health care brush fires that demanded attention, but perhaps also to a lack of understanding of the role of the private health care industry.

Speaking at the opening of the Krugersdorp Hospital recently, Venter pointedly referred to the cost of private health care. This is a bone of contention for many people who detest the notion of "luxury hotels for the sick". The fact is that private hospitals now play a vital role in maintaining and increasing standards of medical care.

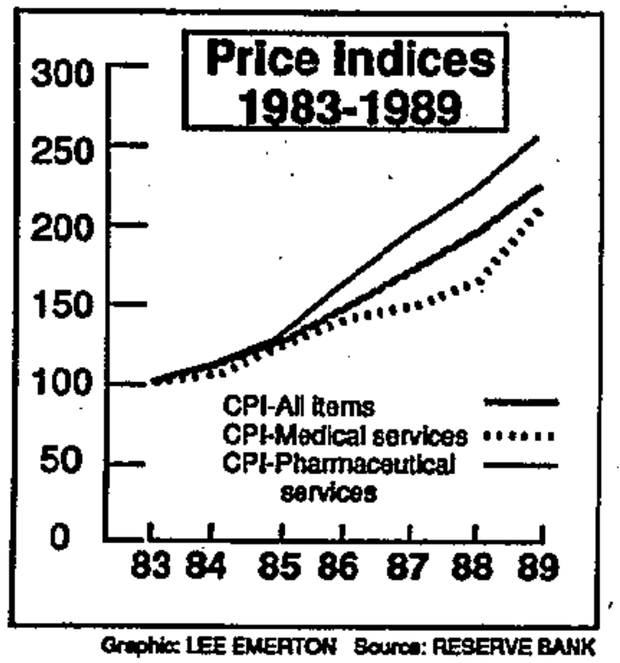
SA, as the Minister pointed out, has long been at the cutting edge of medical advances. The state is patently no longer able to carry that burden by itself. Increasingly, private hospitals are providing the environment, the technology and the money to enable medical and health care practitioners to keep SA in the forefront of advanced medicine.

The question is, do we need it? The answer is a resounding yes.

Apart from the fact that SA medical care standards are still high because a major portion of the population is willing to pay for those standards, private hospitals have become significant earners of foreign exchange, with thousands of foreign patients coming here for treatment. Now that the world is opening up to us, the flow of patients will undoubtedly increase. With private hospitals earning foreign currency, local patients benefit too.

Also, private hospitals play a vital role in ensuring that some of our best medical specialists remain in the country. For example, a prominent heart surgeon and academic recently revised his decision to emigrate because a private hospital was able to provide him with the facilities and advanced technology he needed to continue practising in SA.

Knocking private hospitals because they are profit-making businesses is short-sighted. The profit motive ensures efficient and effective management. Prof Jan Hupkes of Unisa's School of Business Leadership demonstrated this in a recent study where he found that health profession cost increases over the past six years were below the consumer price index.



Graphic: LEE EMERTON Source: RESERVE BANK

This finding may come as a surprise to consumers who may have believed that high and rising medical, dental and hospital fees are a contributory cause of high inflation in SA. Unfortunately, the same does not apply to pharmaceutical products (mainly medicines) where price rises averaged more than 20% a year over the same period. As a result the medical aid schemes have seen fit to demand a 10% discount on these items from private hospitals.

Private hospitals do not cost the state a single cent. Many private hospitals actually treat state patients at a reduced rate, where the state hospital cannot supply a particular specialised service.

Private hospital groups also contribute increasingly to education and training. Rand Afrikaans University recently opened a R250 000 high technology training centre for nurses, funded by Clinic Holdings. Private hospital groups run their own training colleges and programmes. Again, standards are high.

At the Durban nursing college, run by St Augustine's Hospital, students regularly win gold medals for academic achievement.

Clearly then, the private hospital industry is an asset to SA health care. What is needed is closer co-operation between the state and the private health industry. The urgency is demonstrated by the fact that, for instance, the neuro-surgical department at the Johannesburg General Hospital has closed down. When an indigent patient needs urgent surgery, where do they go?

Certain private hospitals have excellent facilities for such an operation, but who will carry the cost? Right now, a patient in Johannesburg who develops a brain tumour and who does not belong to a medical aid scheme has nowhere to go.

Private hospitals must be drawn into the system without delay. There is no reason why the state cannot pay for such patients to receive treatment at private hospitals. The urgency is apparent.

The time has come to create a mechanism which will allow private hospitals to assist the state in its planning and to contribute to health care management. As the Minister said: "The state and the private sector are partners."

☐ Hurwitz is MD of Clinic Holdings.

LETTERS

BUSINESS

Medical schemes under threat from flexible packages

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a/Mail 25/1 - 31/1/91

The first cracks have started to appear in South Africa's medical aid edifice with the appearance of new, flexible and cheaper schemes offering limited benefits. They look like becoming popular — to the possible detriment of the whole private health care system.

REG RUMNEY reports

MEDICAL aid schemes have begun to offer "flexible" new packages at lower rates. Typically they cover few of the humdrum medical costs such as doctors' fees and concentrate on the costs of hospitalisation and surgery.

They hold out the hope of stemming some of the medical cost spiral — but the danger is that the whole medical aid movement may come tumbling down.

What looks like replacing the conventional medical aid scheme is a flexible, limited form of medical insurance confined to a select, healthy few.

Another danger is that veteran members of medical aid schemes will not reap the benefits of having in earlier years subsidised those older and less healthy than they were.

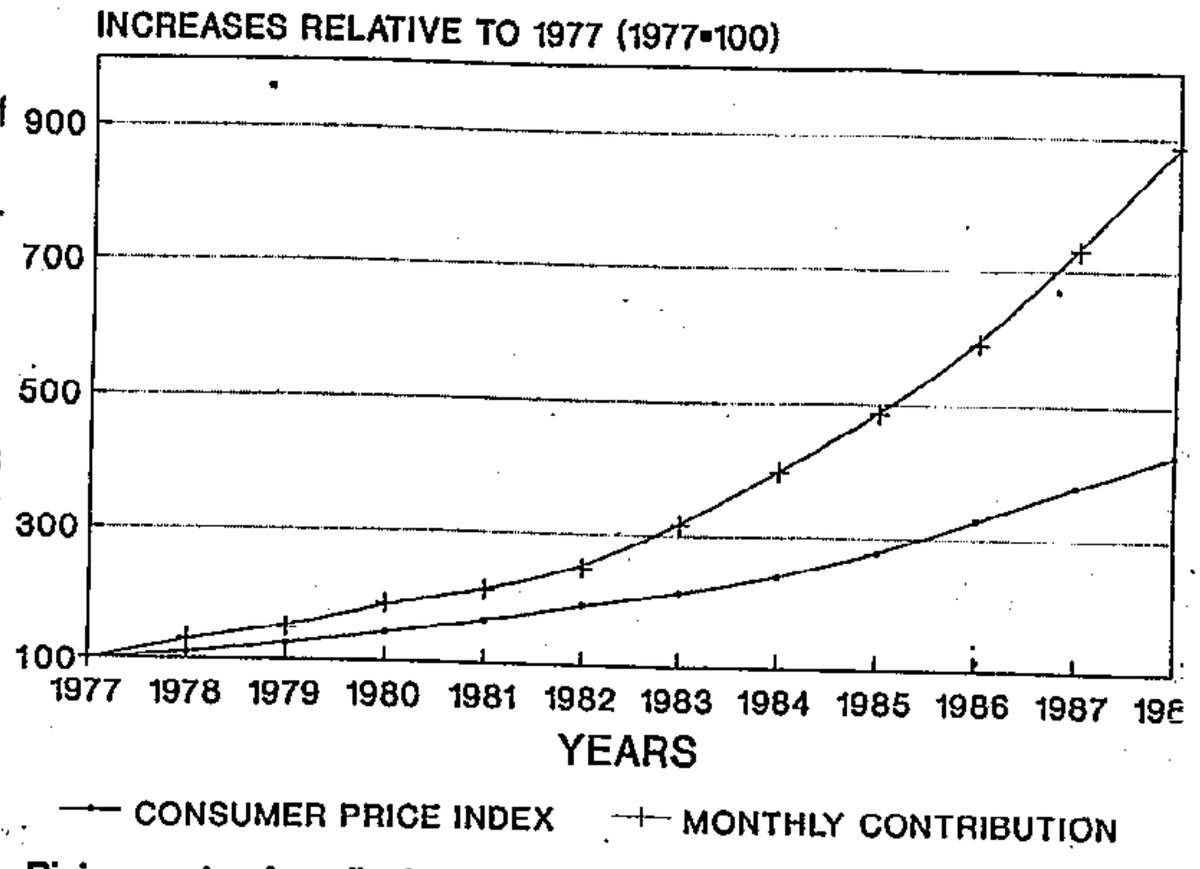
Out of the window goes the principle that has propped up the medical schemes movement for years — cross-subsidisation of the unhealthy by the healthy, and the old by the young.

Also ditched is the spreading of risk. Previously, the Medical Schemes Act limited the medical schemes as they could only determine contributions according to income and size of family.

As a result of changes to regulation 8 of the Act last year, medical aids can now take into account among other things age, claims experience, extent of cover, and period of membership.

The pressures for the change came about because increasingly medical aid members have had to cover some of the costs of their private care. Also, the promotion of risk rating and flexible packages by medical aid administrators comes after insurance companies muscled into the medical aid territory.

Insurance companies have for some time now offered a form of limited medical insurance at relatively low rates. The big difference between hospitalisation insurance and schemes run by medical aids is that payment under hospitalisation schemes is a set cash amount — say R100 a day — direct to the insured person and not payment to doctors or hospitals for the expense of a hospital stay or a consultation.



Rising costs of medical aid cover ... monthly contributions have far outstripped the inflation rate in recent years

Medical aid schemes have been able to market flexible packages for a while now, by special dispensation. Changes to regulation 8 mean they no longer need special dispensation.

Several medical aid schemes, including Profmed, Medscheme and Medicaid, offer a cover concentrating on hospitalisation and serious illness at fees lower than comprehensive medical aid schemes. They can do this as long as a minimum pay-out for such benefits as general practitioners (GPs) and specialists' consultations is also offered.

In one such medical aid hospital plan scheme the amount paid for GPs is R125 a year for each family.

However, the monthly subscription is only R184 a month for a member with three dependents, almost half the rate for a comprehensive plan covering the same number of dependents.

Medical aid administrators have argued that the Act's enforcement of a comprehensive package is a distortion of the free market. They have argued that they should be able to offer a wide range, such as those offered by insurance companies covering "catastrophes" as well as comprehensive cover. Medical aids have now in part started offering flexible packages. This is one way they could broaden membership among poorer workers who may now resist paying relatively high and ever-increasing subscriptions.

So the medical aids will be able to keep members and even find new ones.

However, medical schemes may tread warily in using their new-found freedom. Representative Association of Medical Schemes director Rob Speed acknowledges the shift to flexible risk-rating schemes holds dangers.

And he says the medical schemes movement is well aware of the dangers. It's logical that with a membership of 100 000 it's easier to cross-subsidise than with or a membership of 2 000 or 3 000.

He believes bigger schemes have a greater opportunity for implementing these packages without increasing the risk of affecting effective cross-subsidisation. And he thinks they will mean cost savings in that "overservicing" (where, for instance, doctors raise their income by encouraging more consultations than is strictly necessary) will be cut down.

Not so sanguine is the Wits Medical School's Centre for Health Policy (CHP), which is also critical of the inflationary effect of the medical schemes' "fee-for-service" system.

A CHP document on the changes on medical aid schemes stresses: "The effect of the 'flexible packages' proposal will be to do away with the subsidisation of the care of poorer members of

N. Mail

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bers. This may make economic sense for those at the top of the pile, but it undermines one of the basic purposes of medical aid schemes as we know them.

"It will also create an increasingly larger group of people for whom the state will not provide (because they are theoretically covered by medical aids) but who in fact will not have decent protection by their medical aid scheme."

CHP's Dr Johnny Broomberg adds: "The danger is that it could explode the system. The clever schemes will cream off the better risks and fracture the risk-spreading system."

The medical field lends itself to suppliers inducing demand for their services more than in other areas, particularly in South Africa, where consumers are notoriously uncritical, he argues.

Since the medical schemes guarantee payment for every service, such as every visit to a specialist or GP, the "fee-for-service" system is a strong incentive to induce demand.

Home care nursing offered

299

EVERYONE is a potential health care worker.

With medical costs rising so rapidly and hospitals overflowing, you can do yourself a great favour by taking the Red Cross Family Health Care course.

Trainees learn the important skills of caring for babies, children and bed patients, keeping the bed fresh and comfortable, maintaining circulation and breathing, reading temperatures and taking pulses, giving medication, feeding and simple procedures.

The programme gives a good grounding to nursing as a profession. Students acquire basic practical skills and the course emphasises professional behaviour.

It takes one week and classes will start as soon as there are enough people registered. It will run for as long as there is a demand at the Red Cross Training Centre, Nedbank City East, near Doornfontein station.

The course costs R60 plus R4.50 for the manual. Students should bring their own stationery. For more details phone Vivienne Ndaba at (011) 402 0758 or Maryln Williams at 873 3938.

16/1/91
31/1/91
Sowetan

Medical aid frauds increase

299

FINANCE STAFF

MEDICAL aid fraud last year amounting more than R275 million is contributing to ever increasing premium hikes. Star 2/2/91

According to Les Hollis, deputy managing director of Medscheme, five percent of what is paid out is spent on fraud.

Medical aid schemes only pay out claims and administrative costs. Thus fraud has a "large impact on claim costs," said Mr Hollis and directly contributes to spiralling premiums.

Rob Speedy, executive director of the Representive Association of Medical Schemes stated that RAMS is "extremely concerned about the impact of fraud on medical schemes."

Mr Speedy confirmed the government is moving ahead on tighter legislation and the imposition of stiffer penalties in respect of medical aid fraud.

President of the Medical Association of South Africa-Natal Coastal Region, Dr S du Toit stated that MASA "regards collusion between doctors and medical aid members in the most serious light".

PHARMACEUTICALS

DRAGGING THEIR FEET

Time is running out for the Pharmaceutical Society to avoid prosecution for breach of competition law. The society was ordered by the Competition Board to submit new Medikredit contracts to medical schemes by January 1 or risk having the matter turned over to the police (*Business* January 18).

Medikredit, a subsidiary of the society, supplies pharmacies with medicines and the pharmacies are then able to claim the cost from medical aids rather than in cash from the patients. The new Medikredit contracts are supposed to allow pharmacies greater flexibility in pricing the medicines.

David Boyce, who administers Medikredit in the Transvaal, says an addendum to the contracts that explains the new pricing formula is being sent to 3 000 contract holders from pharmacies and medical schemes. The contracts themselves are also being changed.

But major medical scheme administrators have not yet received the new contracts and some have informed the Competition Board of this in writing. The Representative Association of Medical Schemes says it won't comment until after its pharmaceutical subcommittee meets next week.

Competition Board chairman Pierre Brooks says that judging by the correspondence he has received, he is not satisfied that the society has made a concerted effort to circulate the new contracts. The old contracts violate the prohibition of horizontal price collusion and collusion on conditions of supply.

The board is adopting a new get-tough

continue →

approach. Last week Brooks said the lack of adequate enforcement measures has lessened the deterrent value of competition law. There have been no convictions for collusion since most types were outlawed in 1986.

There is no doubt that the attorney general would be reluctant to get involved in a drawn-out court case against a professional body and file criminal charges against its officers. Brooks proposes that the law should be decriminalised and administrative fines introduced. This, he says, would give the board much-needed teeth.

The Pharmaceutical Society stresses that it is not seeking a confrontation with the Competition Board. But it could be the first target of the board's new determination to enforce its rulings. ■

Star 11/2/91

Black private patients 'are being robbed'

299

Highveld Bureau

Transvaal Provincial Administration hospitals in the platteland are continuing to put black private patients — at R170 a day — into crowded dormitory-type black wards while many rooms in white wards remain empty.

This has been alleged by the Middelburg branch of the National Education, Health and Allied Workers' Union (Nehawu).

Last month Atul Patel, a doctor at Witbank Hospital, made the same claim in a statement to The Star.

Dr Patel said black private patients, who are mostly people who belong to medical aid schemes or those covered by the Workmen's Compensation Act, received the use of "greatly inferior, overcrowded facilities", while modern well equipped white wards remained relatively empty.

A spokesman for Nehawu in Middelburg said the TPA was robbing black private patients.

"It is patently unfair to charge them the same as whites when the black patient gets third class treatment and facilities for his money.

"We demand that TPA hospitals be desegregated, and that black private patients be put into the empty luxury beds of what is presently the white section."

The TPA assistant liaison director Jan Loubser commented: "Patients are not purposely segregated on racial lines, but by cultural and language affiliation."

He said he believed black private patients "get a fair deal" paying R170 a day.

"If there is no bed available at the black side then there is no problem accommodating black patients with whites."

Big leap in AIDS claimants, says report

Biggy 11/2/91

299

THE total number of claimants for AIDS insurance has increased by 75% to 96 since December 1989, a report issued by Mercantile & General Reinsurance says.

The report says a distortion of the figures reported for 1990 will occur because many late notifications for claims were received in 1990 for claims finalised in 1988 and 1989.

For this reason, the 32 new claims reported for 1990 would be expected to double once notification was received, a Mercantile & General spokesman said yesterday.

MARCIA KLEIN

Of a total of 172 policies on which AIDS-related claims have been lodged, 32 claims were lodged in 1990, which compares with 67 in 1989 and 50 in 1988.

At January 13, four of the 96 claimants were female, while there was only one female claimant in 1989.

Most of the claimants were in the 31 to 40 age group, followed by the 41 to 50 and the 21 to 30 groups. The average age of claimants was 36,7 years.

In 1990 the payout in respect of Permanent Health Insurance (PHI) monthly benefits more than doubled to R36 900, and the Occupational Lump Sum Disability benefit also increased by more than 100% to R1,3m, while total sums assured on life policies was R7,1m (R5,4m).

Of all the claims, 67% are within five years of risk commencement.

The survey says there does not appear to be any evidence of anti-selection — where applicants know they are at risk or are already affected, yet fraudulenty apply for policies — insofar as any large sums assured are concerned.

Blind kids benefit from winner's prize

Sowetan 18/2/91 (299)

WOMAN

THE bulk of *Sowetan* Woman of the Year's prize money will benefit blind children attached to a child development programme.

By SIZA KOOMA

Ruth Machobane voted the association of which she is secretary, the Transvaal Association for Black Blind Adults, as beneficiary of the R2 000 that goes to the charity of the winner's choice.

The money will enable the association to cover the tuition and transport costs of six blind pre-scholars on a development programme at the Transvaal Memorial Institute in Auckland Park, Johannesburg.

"We spent most of the association's funds on fees for some of our children who were going to university.

"We were left with only R1 000, which would not have been enough to pay for the programme," Machobane said.

The R2 000 prize money, she said, will help them augment the remaining funds to pay the R30 - R10 for consultation and R20 for fare - spent on each child a day.

The children go on the programme two to three times every week. They are trained in motor development, perception and IQ development and other skills.

"We encourage parents to take their children on this programme so that they can develop all their senses before school-going age.

"Parent participation in the consultations is also very important because we want the training to continue at home.

"If parents are there to observe how the exercises are carried out, it is easy for them to do them with the children on the days that they are not at the school," she said.

Her own prize of R500, Machobane said, will pay for her son's technical training course.

Her son is partially blind.

"He has not been able to do well in a formal school because we discovered late that he was partially-sighted.

"The visual problem affected his academic progress to an extent that I decided to take him out of school.

"Training on a skill at a technical college will give him a career that he will be able to support himself on," she said.

Horticulture is her son's favourite hobby and she hopes he will be admitted to a college in Boskop where a course is offered.

Mrs Ruth Machobane and her secretary Octavia Leisa with the cheques for R2 500, Machobane's prize for winning the *Sowetan* Woman of the Year award last year.

Britain to aid black disabled

By Mark Suzman

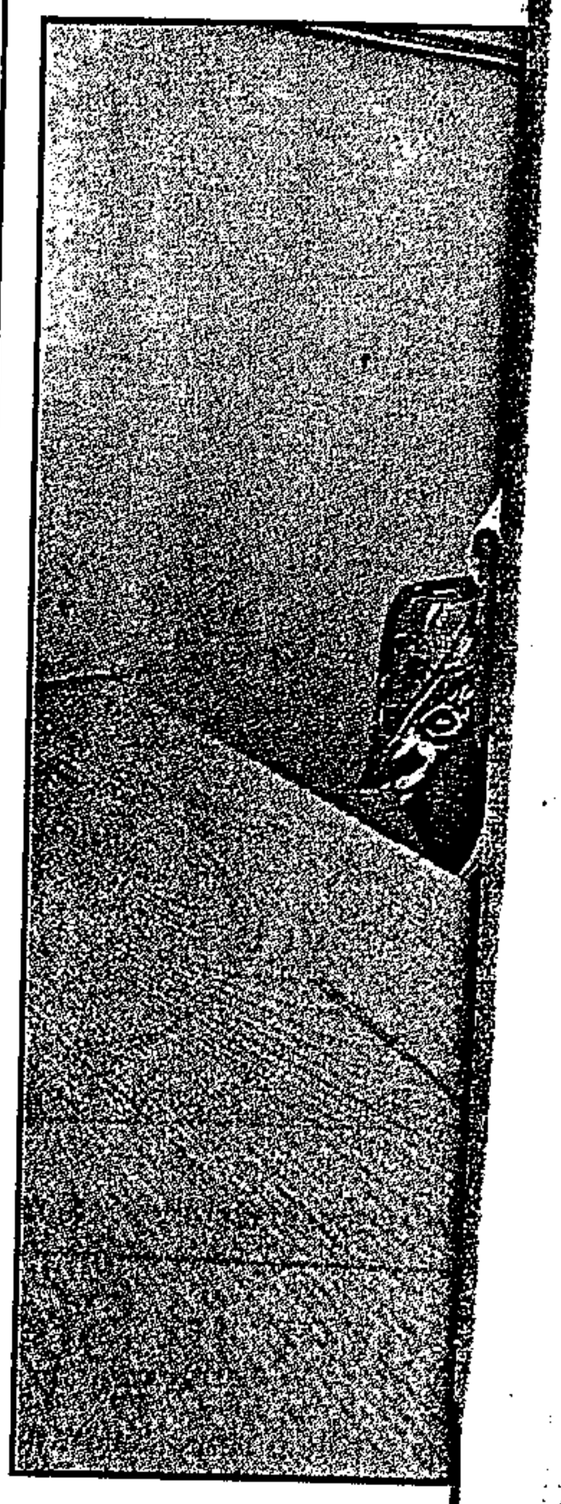
The British government will be giving R93 000 to the self-help campaign of Disabled People South Africa (DPSA), visiting British Development Minister Lynda Chalker said yesterday.

She revealed the grant during a visit to the Soweto-based Self-Help Association for Paraplegics.

The money will be used by the DPSA, an organisation run by disabled people, to help give black disabled people the confidence and skills necessary to cope with their disability.

Mrs Chalker said: "The new grant is to help disabled people set up projects and achieve full employment."

The grant will be channelled through the British charity group Action on Disability and Development.



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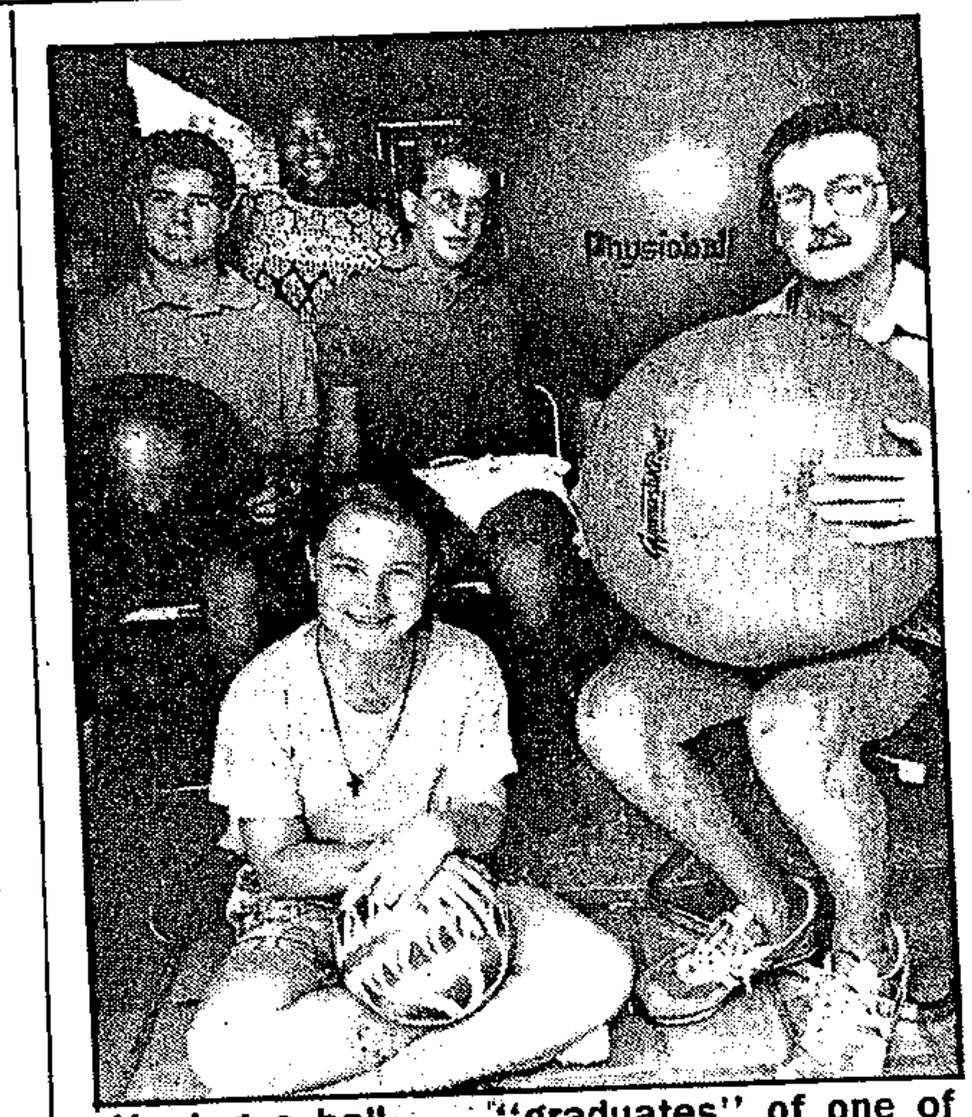


Having a ball . . . "graduates" of one of Johannesburg's most unusual schools include (clockwise, from left) Paul Hooper, Euphemia Morolo, David Pollock, Keith Rowntree and Amanda Jones. Picture: Stephen Davimes

'School' for disabled inspired by willpower

By Shirley Woodgate

Severe injuries from a car crash in September 1986 left Northcliff matriculant Robyn Strong a "hopeless case" with little hope of recovery; comatose, with the mind of a two-year-old.

But the determination of her mother, Brenda, a trip to the United States costing more than R175 000 and hours of perseverance have not only vastly improved her quality of life, but inspired the launch of a local rehabilitation centre for brain-damaged patients.

Soon the first six "students" will "graduate" from this unusual "school", each, said Mrs Strong, capable of enjoying a vastly improved quality of life.

Therapy

Most of them are victims of vehicle accidents, one a businessman, two of them university graduates, all drawn together simply under the single tag of "brain-damaged".

There is Paul Hooper (24), who was admitted with little short-term memory, unable to walk or hold a conversation, but after intensive physio, speech and occupational therapy and the help of a social worker, is now showing vast improvement in all three spheres.

Euphemia Morolo (16), who was on crutches after being knocked over by a car at the age of seven, is brought daily from Atteridgeville and will soon walk unaided.

Mandy Jones (18) has recovered so well she will soon be taken overseas on holiday.

The next course, which costs R2 000 a month, is already being booked, but Mrs Strong (telephone 011 678-1125) has place for more students.

Star 19/2/91

New Start for mentally, physically handicapped

299

By Phil Molefe

A home programme for the care and development of physically and mentally handicapped children will be launched on Thursday at the University of the Witwatersrand.

Dr Ellen Khuzwayo, Soweto community leader and social worker, will be guest speaker at the launch of the programme, initiated by the Sunshine Centre Association in collaboration with the Transvaal Memorial Institute.

Strive Towards Achieving Results Together (START) is a holistic approach to dealing with developmental problems.

It consists of step-by-step instructions to help parents and counsellors develop effective home programmes for developmentally delayed and severely physically handicapped children.

The booklets give information on topics such as hearing impairment, nutrition, sign language, toys to make from household items, definitions of medical terms and management of handicapped children.

The programme is intended for families of developmentally delayed children and medical professionals in rural areas.

● For more information, call Peter Wilson at 716-3517.

Do more for black health, State urged

By Mark Suzman

Government health programmes for the black community have had mixed results, and much more needs to be done, according to the South African Institute of Race Relations.

In its latest Social and Economic Update, the institute claims that the Aids scare has led to the neglect of other sexually transmitted diseases.

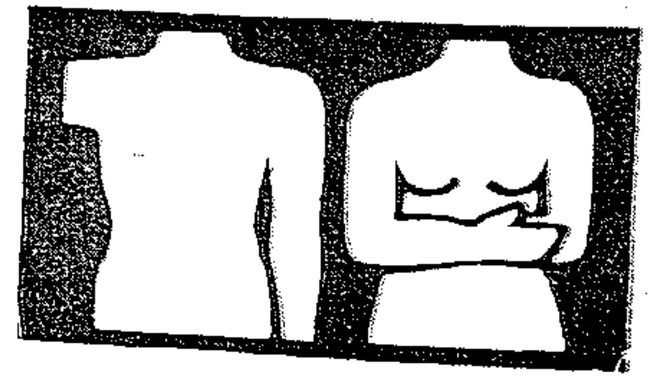
In particular, the report states that 2 million black people are permanent carriers of the hepatitis-B virus, which caused the death of 20 000 people in 1989.

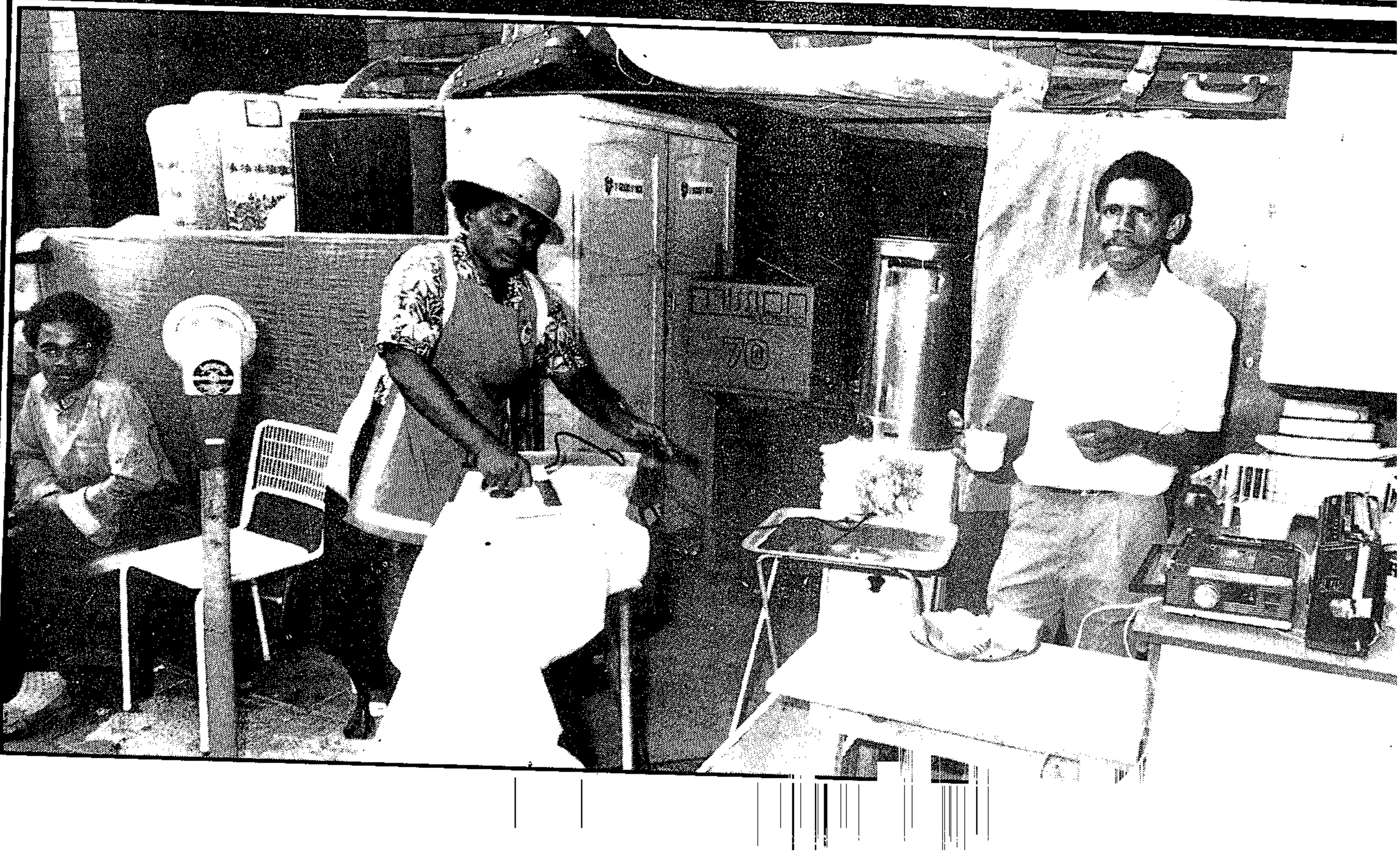
The institute also notes that the Government's Aids awareness campaign has come under heavy criticism from various organisations for being inefficient and racist.

On the plus side, however, the report acknowledges that the Government's measles immunisation programme launched at the beginning of last year has been successful.

The update also applauds the modifications to the Government's primary health care strategy, which embraces community involvement in health programmes and gives recognition to the role of the private sector and voluntary organisations in health care.

KNOW YOUR BODY





- Ilbrow residents who have been evicted from their flats.

Health in the city

New Nation (Leamy Nation) 22/2 - 28/2/91.

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Last week we looked at the history of urbanisation in South Africa. In this article we will look at the unhealthy conditions which many black tenants in the Johannesburg city centre have to endure.

Actstop is an organisation campaigning for thousands of "illegals" battling for low-cost accommodation in Johannesburg. The biggest challenge at present is to improve the quality of life in city centres and other areas. To this end Actstop has helped tenants form flat committes which discuss the various problems faced by black tenants living in the city centre. Health has become a major concern as more and more people move into the cities with their children.

Actstop has set up a working committee with organisations like the South African Health Workers Congress (SAHWCO) and the National Medical and Dental Council (Namda). The aim of the committee is to investigate the quality of life and the phycial condition of buildings in and around Johannesburg.

Tenants have become increasingly aware that if they do not do something about the dilapidated and rundown buildings that they live in, the landlords certainly won't.

"It is up to us to fight for the right to a just and equitable society and to fight for the right to bring our children up in a healthy environment," said on the tenants on the committee.

Evictions and poor maintenance are health hazards

Actstop has had some dealings with the Johannesburg City Health Department where complaints about conditions of buildings are usually reported. The health department can only act against flat owners if they violate any people moved out. This only serves to make the housing shortage worse.

Dr Nicky Padayachee of the Johannesburg City Health Department says that in all his years of office, he has no knowledge of any building in Johannesburg being declared a slum. "We would much rather impress on the owner to fix up the premises and to do so in a way as to allow the people to remain in the building."

More conservative residents of Johannesburg claim the influx of black people into the city centre increases infectious diseases. However, the increasing number of black people making their home in Johannesburg has not caused any notable increase in infectious diseases, and this is backed up by the city's Health Department.

Dr Padayachee says, however, that there is every likelihood that there has been a notable increase in social diseases such as alcohol abuse, wife battering, child abuse and sexually transmitted diseases. This is not just a feature of the influx of black people into the city centre, but rather a symptom of inner cities worldwide and also of massive unemployment.

In the interests of public health, flat owners should be required to provide for the maintenance of buildings and facilities. Poor maintenance of buildings has caused many problems. At Export House in Bree Street, a seven-year-old boy climbed into a lift shaft and was crushed to death.

Often tenants are without flushing toilets for weeks on end and have to resort to the age-old bucket system. Actstop believes it is nothing short of a miracle that there have actually been no serious outbreaks of disease in some of the building they are involved in.

Evictions can also cause health problems because no alternative accomodation is provided and families are left

Access to medical facilties

On of the major concerns of black people living in the inner city is access to medical facilities. There is no provincial hospital in the Johannesburg city centre that has a prenatal and paediatric facility for black inner city dwellers. The nearest hospital for these facilities is Baragwanath Hospital in Soweto which is at least 20 kilometres away.

Many tenants living in Johannesburg are unaware that Hillbrow Hospital does not offer these facilities. One local resident said that she had a hospital behind her and one diagonally across the road. "I just assumed in an emergency (she is seven months pregnant) that they would take me to the nearest one."

Living conditions and apartheid

Actstop believes that the authorities, far from alleviating the problem, have actually made it worse with their creation of "grey areas' which will only lead to more overcrowding and a decline in the standard of health. Apartheid has caused a housing shortage, and a lack of education and health facilities for the majority of the population. It is only through the abolition of the Group Areas Act and all other discrimatory laws that the tremendous demand for black housing will abate and living conditions improve.

This article has been adapted from an article written by a member of Actstop for the October 1989 issue of Critical Health. You can subscribe to Critical Health by

B/Day 22/2/91

Health facilities are best available

TWO new medical facilities recently opened their doors, providing Pietersburg and the far northern Transvaal region with modernised, rapid emergency and state-of-the-art medical equipment.

One of the additions to the existing health and welfare services is a privately funded 100-bed private hospital.

Pietersburg mayor-elect Nic van Oudtshoorn says a group of 50 shareholders hold R12m worth of hospital shares between them.

The second development was the establishment of a R2,8m satellite emergency services station built at the municipal airport.

Rapidly

This has enabled emergency service vehicles to respond to crisis situations rapidly — patients from outlying areas in the far northern Transvaal are often airlifted to Pietersburg for medical care.

With the opening of the new facility last year, Pietersburg is able to offer three hospitals with 864 beds between them.

Largest of the institutions is the Transvaal Provincial Administration's training hospital, which has a 750 bed capacity, 10 operating theatres and three casualty sections.

This hospital serves most of the far northern Transvaal region.

The local municipality also runs a 14-bed municipal isolation hospital and five clinics, the latter providing free services.

According to the latest statistics, more than 100 medical practitioners and 25 specialists, representing almost every specialised medical discipline, have practices in Pietersburg.

The majority of practices are located in a new medical centre just outside the central business district.

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Private health care 'a bargain'

Bloem 22/2/91 (299)

EDWIN HERTZOG

THE article by Dr Jonathan Broomberg on how "bad" private hospitals are for SA's health (Business Day, February 11) needs to be put in better perspective.

He calculates that in 1989 there was a R160m "public subsidy" for the use of private hospitals. This sum is derived from the fact that an employer's contribution to the company's medical scheme is not taxable. The employer normally contributes 50% of the total.

It is debatable whether or not taxing a service is the same as subsidising a service. If one considers all the items allowed as tax deductible company expenses (and thus as "subsidies"), medical scheme contributions of a company can certainly be regarded as highly meritorious.

It must also be remembered that it was only in 1988 that the Receiver of Revenue changed contributions to a medical scheme by employees to an after-tax expense.

Let us, however, assume that the state did subsidise private health care to the tune of R1bn in 1989 of which about R160m went to private hospitals. It must then be remembered:

☐ Employers and employees put in another R3,5bn without any form of subsidy for their private sector health care; and

☐ The state spent more than R7bn in that year (working on figures supplied for 1987 by Dr Broomberg's Centre for the Study of Health Policy as a basis) to provide health care for the remaining non-private, 80% of the population. This R7bn figure probably is a very conservative estimate, because cost figures released by the state are very often not related to real costs incurred as calculated by private sector accounting principles. This is especially true for the real costs of running public hospitals.

In these terms it can be seen that to "subsidise" private health care by R1bn and thereby achieve first world medical services for the economically active 20% of the population who belong to medical schemes, is a real bargain for the state.

If it is not available to them it will make SA a much less attractive country to live in.

To state that private hospitals employ large numbers of highly skilled staff all trained at public expense, without paying anything towards the cost of their training, is incorrect when seen in the following perspective: With an estimated turnover of about R1,6bn in 1991, the private hospital industry pays a huge amount of GST, personal tax and company tax.

If all these taxes are added up, the costs of training personnel for service in the private sector is probably a further bargain for the state. As Dr Broomberg stated, many private hospitals do train nursing and household personnel without financial assistance from the state.

It should also be asked why only the private health care sector should pay special levies for the training of personnel? What about all the attorneys, engineers, teachers, accountants, clerks, technicians and others who are also trained by state institutions and end up working in the private sector?

In a research study done in 1986, it was found that only 12% of all nurses who worked were employed by private hospitals.

It is true that prospective, fixed-fee systems lead to a lowering of health care costs.

However, it also leads to less freedom of choice for patients and doctors as well as possible under-servicing by doctors and hospitals. If a fixed amount of money is available to treat certain conditions, the incentive is to use the cheapest possible treatment. This saves money but very often also lowers standards.

In overseas countries these systems have proved to be quite unpopular to people who can afford the existing fee-for-service system.

The fee-for-service system may well lead to over-servicing, but it is not without checks and balances.

Dr Broomberg referred to the great number of MRI scanners found in the country. These machines are bought by radiologists and placed in private hospitals. Neither one of these parties, however, is in a position to refer patients to make use of the machine. Patients are referred for MRI scans by independent general practioners and clinical specialists.

If SA does have more MRI scanners than the UK it means that there is more convenience and a greater choice available to patients and doctors: every patient in the Transvaal does not need to travel to central Johannesburg to have a scan. And if there are more scanners than the market warrants, the state or other radiologists may soon be able to buy a good secondhand MRI scanner at a reasonable price.

I am not postulating that the existing private health care system in SA is without flaws. However, there are also good reasons why proposals aimed purely at curbing the cost of health care have proved to be unpopular among people who can afford more than the minimum adequate level of service.

Seeing that these people are paying for this privilege with their own money (or for at least about 80% of it in Dr Broomberg's terms) should they not be granted the system that they prefer?

☐ **Dr Hertzog is chairman of the National Association of Private Hospitals.**

LETTERS

Disabled activist helps others

WOMAN

By PEARL MAJOLA

HIS personal experience as a paraplegic and the plight of disabled people in Kagiso, on the West Rand, gave Moses Komane the drive to start the Itsoseng Disabled People's Organisation. Sowetan 22/2/91 (299)

Komane (35), an administrative clerk at the Kagiso municipal offices, had polio at the age of three. As he grew up, he was deeply concerned about the lack of facilities for paraplegics and the attitude able-bodied people had towards the disabled.

"I was lucky because my parents took me to the Margaret Ballinger Home in Roodepoort where I spent most of my childhood with other disabled children. My disability is not very severe and I can do a lot of things on my own.

"But other people are not so lucky. They are uneducated, have been subjected to all sorts of abuse because of their disabilities and cannot be employed because of their handicap. I therefore felt I had to do something for them," said Komane.

There are about 70 active members in the organisation, most of whom are unemployed and barely have an education because there are no schools for the disabled in Kagiso.

There are many more disabled children who could end up without education because of lack of schools in the area.

To overcome this, the organisation is trying to raise funds to build a school, workshop and recreation centre in the township.

"A 32 000sqm site has already been allocated to us by the council but we are struggling to raise funds to start building.

"We would like to erect two buildings on the site. One to serve as a school and the other as a workshop-cum-recreation centre where our members could be trained in certain skills during week days and use it for sports meetings on weekends.

"Apart from that, we have an on-going project through which we are trying to help children get some education until we have a school for them here," Komane said.

"Since 1985 we have been trying to get them accepted in schools such as the Philip Kuschlik and JC Merkin in Soweto. Presently there are 15 students attending in Soweto.

"We had to pay from our own pockets for their transport. Fortunately somebody heard about us and offered to provide transport.

"We also raised some funds and bought a leather sewing machine which we have given to one of our members who is an upholsterer. This gives the rest of our members a chance to work and earn a living," he said.

This Sunday, from 2pm to 10pm, there will be a contemporary jazz festival organised by Smirnoff at the Kagiso Swimming Pool. Entrance is R4 a person and proceeds will go to the IDPO.

VAT likely to be levied on medical services

299

IT now seems likely that the services of doctors, dentists and other medical practitioners will be subject to value-added tax (VAT). STJ 23/2/91

Following the publication last year of the draft legislation, VAT is expected to be implemented on September 30 this year.

The Deputy Minister of Finance has indicated that the rate of VAT will in all probability be lower than the current rate of GST and to achieve this there will have to be as few exemptions as possible.

In the draft Bill, one of the exemptions is in respect of services by registered medical practitioners. The effect of this is that a doctor would not charge a patient VAT on his consultation fee.

However, after various representations from the medical profession this position may be reconsidered. Many doctors dispense drugs and medicines and it has always been contemplated that these will be subject to tax.

The concern of doctors was that their administration, particularly relating to the input tax credit, would be unnecessarily complicated by doctors having taxable sales in respect of the medicines dispensed, but exempt consulting fees. Accordingly, it would be far easier to levy VAT on all items charged by a doctor, including his fee. This is now likely to be the position.

● The Star has produced a 20 minute audio cassette on VAT which is a concise overview of how the new VAt system is likely to operate. The tape costs only R29,95 (excl GST) and is available from The Star Promotions Department. PO Box 1014, Johannesburg 2000.

Crusader first

299

ST Times 24/2/91.

CRUSADER LIFE has introduced a stand-alone dread-disease policy to ensure that life-saving treatment does not kill financial security.

This is a first in South Africa. Anglovaal Financial Services arm Pegasus introduced the cover in Britain.

Crusader is the first to do away with the combined life and dread-disease policies. The stand-alone policy pays out up to a maximum of R300 000 covering 12 diseases, including multiple sclerosis and any terminal illness.

Health 'the community's responsibility'

Star 25/2/91

299

By Clyde Johnson
Lowveld Bureau

SABIE — South Africa in the years ahead will not be able to afford the projected dramatic health budget increases, Transvaal Administrator Danie Hough said in Sabie at the weekend.

Speaking at Sabie Hospital's 50th anniversary celebration, Mr Hough said this meant that hospitals throughout the country would have to make maximum use of available funds.

"As long as South Africa continues to have the highest road accident figure in the world, we will have a shortage of beds in intensive care units.

"And while families living in poor socio-economic conditions do not have clean water and sanitation, we will continue having too few beds for babies with gastro-enteritis."

Mr Hough also warned that as long as infant fatalities remained at present levels, dealing with population growth would continue to remain a problem.

"The more babies that die, it has been proved in underdeveloped communities, the higher the birth rate," he said.

"Unless we succeed in promoting good, clean living habits among all the people of this country there will always be patients suffering from too much drinking, too much smoking and having too little exercise."

The answer for most of the country's problems, he said, did not lie with hospitals.

"It rests with the community, and is therefore everybody's responsibility."

Sabie Hospital was the second provincial hospital to be built in the eastern Transvaal. Barberton Hospital was the first.

Dictionary for the deaf a first for SA

Sowetan 27/2/91. (299)

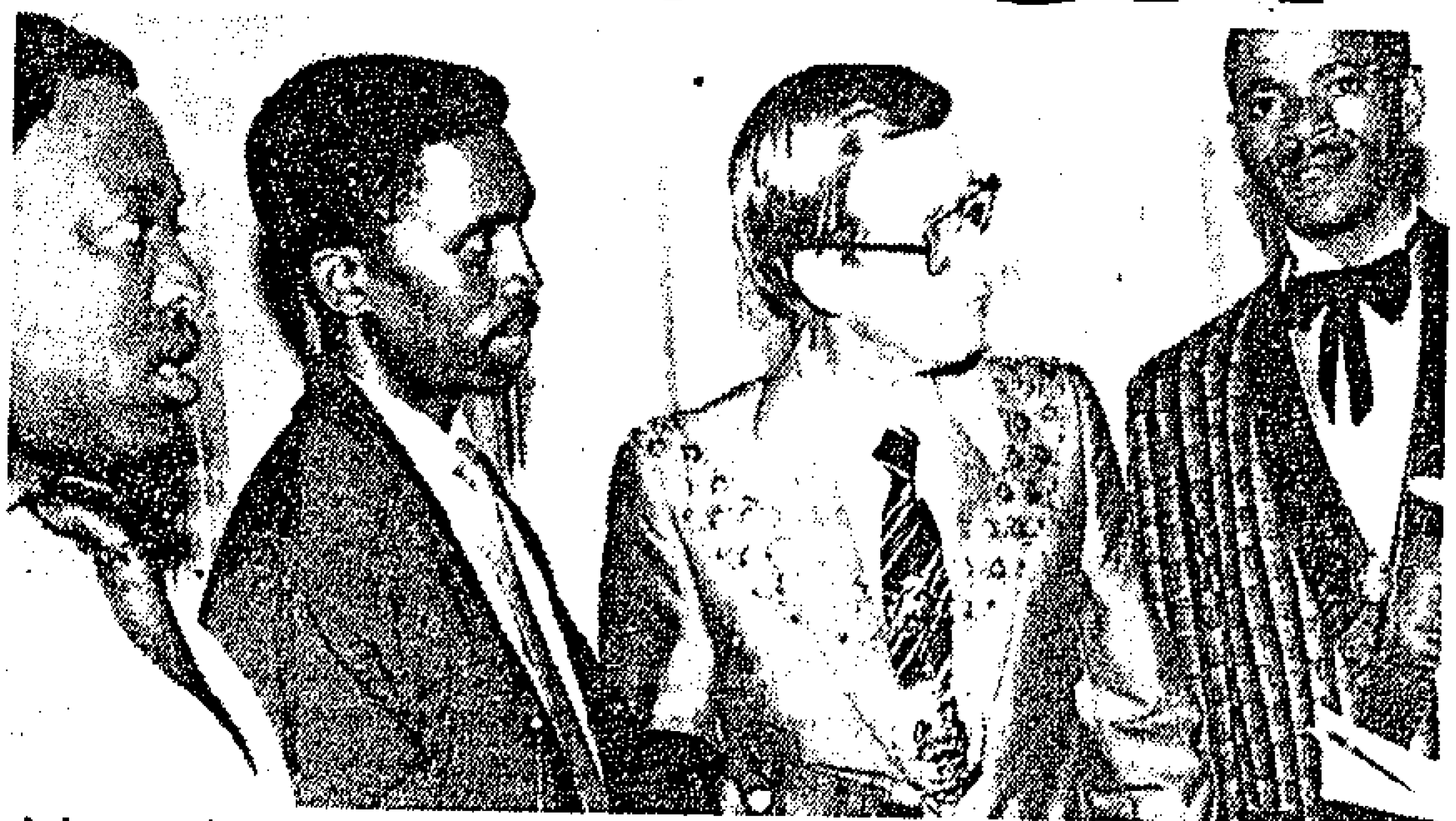
THE South African National Council for the Deaf has launched a dictionary of sign language - the first of its kind in South Africa.

The dictionary, produced over three years at a cost of about R300 000, was a joint venture between the council and the Human Sciences Research Council.

It is designed to provide a basis for communication among groups of people from a wide diversity of ethnic, cultural and language backgrounds.

"More than three million South Africans have some degree of hearing impairment," the national director for SANCD, Mrs Henna Opperman, said.

"This makes them the largest single category of disabled people in our society. More importantly is the fact that nearly all of them have 'hearing' family or friends. Ninety percent of deaf children are born to hearing parents. This emphasises the sheer scale of the social problem.



Johannesburg mayor Mr Willie Janse van Rensburg with his guests who have hearing impediments. They are, from left, Mr Josiel Makomoreng, Mr Lennox Gabashe and Mr Mishack Mndawe.

Pic: VUSI MANYONI

RANSOM												1.50	
VOGUE												1.50	
MATCHES												0.56	

Does eyesight have to be a costly affair?

South 28/2 - 6/3/91 (299)

By Chiara Carter

EYESIGHT comes expensive in South Africa, with the average price of a pair of glasses running into hundreds of rands. But does good vision have to be so costly?

Mr Gregory McGilp, the owner of an independent optical laboratory in Cape Town, says not and his price tags prove his point.

A pair of glasses which would cost about R350 if ordered through an optician, costs R150 at McGilp's laboratory, Optilab.

The laboratory also has a collection of donated frames for those who cannot afford the normal price.

However Mr Colin Tonkil, a director of the South African Optometric Association (SAOA) says fees are fixed by the South African Medical and Dental Council and anyone who is overcharged can complain to the council.

Tonkil says McGilp is breaking the law by doing the work of a dispenser without the necessary qualifications.

McGilp, an optical technician for more than 28 years, is something of a rebel in the optics trade.

He is fiercely critical of his colleagues and the way the industry is run.

He accuses optometrists of "hiding behind a professional ethos" to prevent competitors entering their turf and lowering prices.

"The client has to consult an optometrist who tests his eyes. The prescription is then sent away to one of the big laboratories. When the glasses arrive, a big fuss is made of choosing a frame. All of this involves major markups in the price of spectacles which could just as easily be bought directly from a technician," McGilp says.

"I operate from the premise that nobody has the right to deny people sight just because they can't afford it."

While frames can be bought over the counter, the dispensing of lenses remains the domain of optical dispensers and optometrists.

Among the costs often added to the final bill are dispensing fees and a fee for helping to select frames.

McGilp says the cost of spectacles could be brought into the reach of everyone if the law was changed to allow technicians to dispense glasses.

Previously optical technicians could become dispensers if they had four years' experience and passed an internal examination.

The South African Medical and Dental Council and five others are presently taking court action against a Wynberg technician whom they claim has been performing the work of a dispenser.

COSTLY AFFAIR: Dispensing and fees for helping to select frames are all included in the client's final bill PIC: YUNUS MOHAMED

South 28/2 - 6/3/91 (299)

Tonkil says McGilp is talking "absolute nonsense" in wanting technicians to be allowed to dispense glasses.

"The SA Medical and Dental Council have deemed it necessary for doctors, dentists and optometrists to be registered. Optometry is a science where it is important to know what you are doing and to be accurate.

"If anyone can set themselves up as an optometrist or optical dispenser, the public would have no protection."

"No country would allow any Dick, Tom and Harry without any academic background to deal with serious things like eye disease," says Tonkil.

What happens if one can't afford the dispensing charge, a fee for helping select frames and the cost of an eye test and of the lenses?

All are agreed that the local hospitals are overburdened and have been forced to cut back on testing.

The SAOA recently started a clinic in the city for those who are short of cash.

Tonkil says the clinic was stampeded with clients and is now expanding its services to three days a week with additional staff.

THE Ciskei government this week lurched deeper into crisis as the strike by virtually all civil servants continued.

The dispute has brought the administration to a virtual halt, including government departments and the courts.

SPRINGBOK. — No new laws about land ownership should be made after the scrapping of the Land Acts until all South Africans could elect a democratic government, residents associations of 10 Namaqualand communities said in a joint statement this week. (3)

No exemption in health care field

(299)

Star 25/4/91.

Vatcom, with one of its members dissenting, recommends that medicines and medical services be subject to VAT.

VATCOM has rejected a proposal that medical services be exempt from VAT, and has recommended they and medicines be subject to the new tax at the standard rate.

The proposal was contained in the draft VAT Bill circulated last year.

In Vatcom's report released here yesterday, it was recorded that one of its members, the CP's Parliamentary spokesman on Finance, Casper Uys, did not support the committee's recommendation.

Vatcom has also recommended — this time with no dissent — that medical aid schemes be exempt from providing other taxable goods or services such as medicine or medical services.

The report said that in terms of the draft Bill, services provided by registered medical practitioners, dentists and certain other professions would be exempt and that medicines, except those used during the consultation, and items such as spectacles, be taxed.

However, exemption of certain medical services would create administrative problems and inequities.

To illustrate, an optometrist's fees would be exempt and the sale of spectacles taxable.

Input tax not directly attributable to either activity would have to be apportioned using one of the methods commonly used such as turnover, floor space, hours or staff employed.

All these factors could increase the cost of compliance for practitioners.

It had also been said that, if they were exempted, practitioners would not be able to claim credit for input tax paid on services such as rents, rates, electricity and water.

Pharmacists had protested that zero-rating of all prescribed medicine would lead to the over-use and abuse of medical schemes, which was already a matter of grave concern.

Patients would be tempted to visit doctors for economic and not medical reasons.

Vatcom said: "The conclusion of the majority of those who made representations was the exemption for medical services should be deleted and all medical services should be taxed."

The treatment preferred by tax experts throughout the world was that medical services and medicine should be taxed, and relief should be provided through direct assistance to the needy.

"The blanket exemption, or zero-rating of medical services or medicines, is not an efficient or effective means of assisting persons who require the assistance of the State.

"Most people have some outlay on medical expenses, and these normally account for a modest portion of their income.

"At modest levels, this type of expense is not something that the State should have to bear or subsidise."

The poor and the aged were already eligible for aid by reduced rates at State hospitals, or tax rebates.

Applying standard VAT to all medical services would level the playing fields between different types of medicines and between the different suppliers of medicine.

It would also substantially reduce the administrative cost which the proposed exemption would have caused.

The committee had been told that if medical services and medicines were taxed, medical schemes should also be taxed.

This would mean that contributions to the scheme would be subject to VAT. — Sapa. □

VAT PRICES

Medicines and services will not escape

CAPE TOWN — Medical services, currently exempt from GST, are to fall into the tax net with the introduction of VAT — if a proposal by Vatcom is accepted.

All medicines will also be subject to VAT at the standard rate.

This amounts to a reversal of the position spelt out in the Draft Bill on VAT, which stated that services provided by medical practitioners and other members of the medical fraternity should be exempt from tax.

The Vatcom report states that the conclusion of the majority who made representations was that all medical services and medicine should be subject to tax.

Political Staff

The motivation for this was:

☐ The "playing field" for all parties supplying medicine would be level;

☐ Prescription medicines and other products used by the public for self-medication would be treated equally;

☐ There would be no discrimination irrespective of the place or circumstances of supply and

☐ Socio-economic patients did not pay anything or only a nominal amount for medical services and medicines received from the state. VAT would not affect them.

Vatcom says that the preferred treatment throughout the world is that medical services and medicine should be taxed, and relief should be given to the needy through direct assistance.

Further it adds, experience in other countries had shown the exemption of prescribed medicines led to pressure being put on medicial practitioners to prescribe medicine which would be bought over the counter.

The report states that the poor are to a very large extent assisted by provincial hospitals, state institutions and clinics where their financial position is taken into account when payment is determined.

Cost cuts by medical aid schemes infect Noristan

BIDay 5/3/91

299

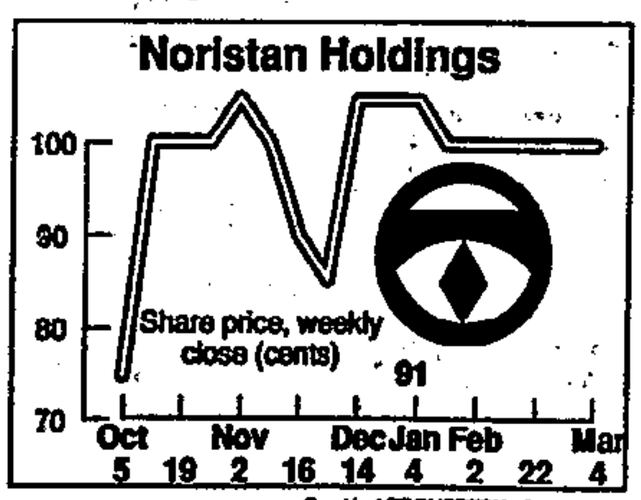
INCREASED cost cutting by state and private medical aid schemes slowed down the earnings growth of Pretoria health-care group Noristan Holdings in the six months to end December 1990.

Attributable profits lifted slightly to R3,7m (R3,6m), while earnings a share increased marginally to 6,9c (6,8c) after being diluted by an increased number of shares in issue.

However, strong demand for over-the-counter products (OTC) like Prohep, Redupon and Calmettes brought some relief and boosted turnover 33% to R51,3m (R38,7m). Tighter margins resulted in a 11% increase in operating profit to R4,6m (R4,2m).

In line with group policy no interim dividend was declared. W & A Investments has a 21% stake in Noristan.

Noristan MD Hugo Snyckers said the expansion of the core pharmaceutical business and improvements in other divisions



MARC HASENFUSS

are expected to yield material benefits in the medium and longer term.

Norimed, a 79% held subsidiary, reported an operating profit of R1,1m on the back of a turnover of R8,8m. Earnings were 40c a share.

No comparative figures were available for Norimed as the group relinquished its property interests in order to focus on health-care activities.

Norimed's long-term prospects would benefit from increasing demand for the provision of state-funded hospital services and the growth of private medical care, Snyckers said.

Noriscel, the fine chemicals division, continued to be affected by delays in fully commissioning its salicylic acid plant, and costs would continue to be capitalised until it was operational.

Computer division, Noridata, is undergoing rationalisation to adjust operations to marketplace needs, he said.

Crest Healthcare — manufacturer and distributor of medical equipment for anaesthesia, critical care and patient monitoring — performed well.

Snyckers said to expand production, storage and distribution facilities for the pharmaceuticals division, the main factory in Pretoria was involved in a R6m extension programme to be completed in July.

Hospital services cut to beat debt of R50m

CAPE TOWN — Most non-emergency hospital services in the Cape Province will be suspended during the next four weeks as the province battles to recoup a R50m budget deficit before the financial year end.

Announcing this after meeting senior hospital representatives yesterday, Cape Administrator Kobus Meiring said additional emergency measures would have to be introduced during the 1991/92 financial year to curtail a deficit expected to be as high as R200m.

These would include a 10% cut in hospital staff and services, reducing services to private patients, contracting out child-care centres, staff accommodation and catering services to the private sector and the transfer of research organisations to academic institutions.

Meiring said provincial hospitals would be expected to implement the cost-cutting measures within six months. But he warned that if they had not submitted suggestions for rationalisation by March 18, he would be forced to continue the suspension of non-emergency services beyond the financial year end.

Immediate measures would include:

☐ The suspension of all non-emergency services provided by Cape provincial and province-aided hospitals;

☐ The curtailment of out-patient visits to specialist and academic hospitals with treatment limited to emergency cases where possible;

☐ The elimination or curtailment of other services and medicine supplies; and

☐ The freezing of staff posts.

LESLEY LAMBERT

Meiring said without additional budgetary support from government during this financial year, the deficit would have been R200m rather than R50m.

"It is very clear that, more than ever before in the history of health services in this province, drastic steps are now necessary to rationalise services to an affordable level," Meiring said.

It had become necessary for the Cape Provincial Administration to reconsider its responsibility to private patients, particularly since alternative facilities were available in the private sector.

"We are taking this step because we believe the prime responsibility of the state's health services is catering for the needs of approximately 80% of the population which is dependent on the state for health services," he said.

VAT may add R410m to cost of health care

B 10 cut 6/3/91 TANIA LEVY 299

ABOUT R410m a year would be added to the private health care bill if all health care services were subjected to VAT, the medical schemes movement warned government yesterday.

Representative Association of Medical Schemes (Rams) executive director Rob Speedie said government should think twice about including all health care services in the VAT net as recommended in Vatcom's final report.

Only medicines were subject to GST but if the Vatcom report was accepted all medical services would be taxed, including consultations with doctors and dentists, medicines and surgical procedures.

This would increase the fees of the average medical scheme member by about R180 a year, Speedie said.

Medicines accounted for 27% of the R6,3bn which medical schemes would spend this year on private health care.

GST charged at the current rate of 13% on medicines generated about R220m.

But if the entire medical scheme spending of R6,3bn was subject to VAT at a rate of 10%, government would reap R630m a year — an increase of R410m.

Private health care would be put beyond the reach of more people.

Rams had recommended to Vatcom that health care services and medicines be zero-rated for VAT, Speedie said.

Medical costs to skyrocket with new VAT

CM-T-75 6/3/91 299

Staff Reporter

VALUE Added Tax (VAT) will add R1 million a day to South Africa's private health care bill, according to the Representative Association of Medical Schemes (RAMS).

This new cost will put private health care out of the reach of a growing number of people, adding a further burden to state health services, RAMS executive director Mr Rob Speedie warned yesterday.

Mr Speedie said the government should think twice about including all health care services in its proposed VAT tax net.

Pleas by RAMS for health care and medicines not to be included in the VAT tax system "have obviously not been heeded," he said.

Mr Speedie said at present, only medicines were subject to GST, which made up 27% of the R6,3 billion spent by RAMS each year, and generated R220m in GST.

He said that if the total expenditure by medical schemes — including consultations with doctors and dentists, medicines and surgery — became subject to VAT, "the state will reap R630m — or R410m more than on it's current GST system."

This increase would have to be passed on to medical scheme members who are "still reeling" from the latest rise in subscription rates. The average members medical scheme fees would rise by about R180 per annum.

Sandton to get crisis control centre

Star 7/3/91

299

By Jacqueline Myburgh

Sandton residents are going to enjoy the security of a 24-hour crisis control centre within a few months, says the vice-chairman of the Town Council's security committee, Richard Cheary.

He said the crisis control centre would be similar to the centre featured in the television programme "Rescue 911".

The centre got the go-ahead during the monthly council meeting on Monday night.

Calls to the crisi control centre, at the fire station, would be referred to the fire brigade, paramedics, ambulance services or police.

All the services would be linked by computer and would receive prompt information on all emergency calls.

MEDICAL AIDS FM 8/3/91 (299)

ANSWERING INSURERS

Speak to just about any medical aid administrator or health insurer and the answer is the same: we're not competing for each others' business. The standard response is that

Continued

medical aid benefits and health insurance are complementary.

Yet the widening gap between the cost of health care and the amount that medical aid pays has handed the insurance industry a marketing opportunity — and it's one it has been quick to exploit.

Just over four years ago, only one big insurance company, Crusader Life, was offering a major medical insurance plan. Today, at least seven companies are selling health insurance, including industry giants such as Old Mutual.

The trade journal *Cover* estimated last month that total health insurance premiums were worth at least R25m in 1989. With medical aid members forced to kick in an estimated 25%-38% more for cover this year, coupled with members' increasing dissatisfaction with the benefits they are getting, it seems likely that health insurance will continue to be one of the fastest-growing sectors in the insurance industry.

And, while both medical aid societies and insurance companies agree that, ideally, individuals should have both forms of cover, with insurance serving as a top-up for those big expenses that often leave medical aid members out of pocket, they admit that some are opting out of medical aid completely in favour of health insurance.

Financially, the insurance industry is in good health compared with medical aid societies. A study of health care commissioned by the Hollandia Reinsurance Group and conducted by Unisa professor of management economics Jan Hupkes last year concluded that to stay solvent, some medical schemes would have to increase fees drastically, independent of the cost of medical services, which are spiralling anyway. (Hupkes serves on the board of the Clinic Holdings private hospital group.)

But while medical aid contributions have increased rapidly, most health policies are subject to annual review and the premiums have the potential to increase as rapidly under adverse market conditions.

Against this background, one medical scheme is trying to bridge the gap between the Medical Association of SA's recommended rates and the scale of benefits set by the Representative Association of Medical Aid Schemes.

Durban-based National Medical Plan — which has 140 000 members and dependants and around R30m in reserves, making it the third largest commercial scheme — is offering cover for in-hospital medical services (similar to the major medical expenses covered by health insurance) above the scale of benefits. This is the first time a commercial medical scheme has offered to pay more than the maximum scale of benefits, which requires special dispensation from the Registrar of Medical Schemes.

It also has been done at no premium increase to members and has become part of the two standard policies the scheme offers.

Why now, and how can the scheme afford the extra benefit with no premium hike? GM Rob Slater is adamant that the new in-hospital benefit was not introduced in response to insurance companies selling health policies. He says various saving measures — such as a no-claim, tax-free cash bonus and employing five recently retired full-time specialists to assess charges — has made the additional cover possible.

"We weren't financially strong enough to introduce something like this a few years ago, but we are now. We also see a market for this type of cover with the gap between the scale of benefits and private rates getting wider," he says.

National Medical Plan is working on the assumption that few doctors will charge the full Medical Association rate. The scheme has found that most charge about one-third less than the rate and the scheme's payments are set on that basis.

Slater gives an example. "The Medical Association recommends that surgeons charge R3 220 for a heart by-pass and valve replacement operation. The scale of benefits provides for only R1 449, leaving the patient personally liable for the R1 751 shortfall. Our contribution is now R2 173 — R724 over the statutory rate for medical schemes."

And unless the surgeon is charging the full Medical Association fee, the extra cover should free the patient of any additional costs.

The extra cover provides the top-up facility that the insurance industry is offering and some insurers admit privately that it might take business away. National Medical Plan CE Rob Basson, while saying the new cover is solely to give extra benefits to the scheme's members, does agree that "the insurance companies took away a piece of our market and we're taking it back; it's nice, healthy competition."

That's also the view of Crusader Life manager Noel Snyman, who says that while his company's health plan is sold through the broker network and does not clash with medical aid benefits, he views National Medical Plan's new cover as "a very healthy move that should work to the benefit of consumers."

Consumers will benefit even more if other medical schemes follow suit, but that probably depends on more schemes getting their finances right first. ■

Free State hospital boss could face ethics probe

B1Dam 8/3/91

TANIA LEVY

THE Medical Association of SA (Masa) is to investigate an ethics complaint brought against the superintendent of three Free State Hospitals for practising or allowing racial discrimination.

The Goldfields Hospital Desegregation Campaign Committee lodged the complaint against Dr Gert van Zyl, regional medical superintendent of the Odendaalsrus, Welkom and Virginia hospitals yesterday.

This follows a walkout by Free State provincial officials including Van Zyl from a meeting called by the committee to discuss desegregation of the hospitals.

In its complaint to Masa, the committee said Van Zyl was bound by professional ethics contained in the 1947 Declaration of Geneva which stated doctors were bound not to allow consideration of race, religion, nationality, party politics or social standing to intervene between their duty and their patients.

Van Zyl could no longer claim that SA law forced him against his conscience to discriminate against patients because the Reservation of Separate Amenities Act had been repealed more than five months ago.

Masa Goldfields branch chairman Dr Jacques Goosen said an ethics committee would investigate the complaint. He said Masa was totally opposed to discrimination on any grounds.

The association was aware that there were administrative and logistical problems with the implementation of desegregation in Free State hospitals.

Goosen said the ethics committee at branch level had no disciplinary powers but acted as a mediating body.

Masa federal council chairman Dr Bernard Mandell said the matter would be referred to the SA Medical and Dental Council if it was felt that disciplinary action was needed.

Van Zyl said last night he had been singled out by the committee for a problem he did not control.

He said AWB supporters had threatened to kill him.

SA needs national health scheme, says researcher

299

B1Dam 8/3/91

TANIA LEVY

THE Wits Health Policy Unit has called for a compulsory national health insurance scheme as a way to provide adequate health care in a future SA.

Speaking at an international marketing management meeting this week, unit researcher Dr Max Price said it was naive to believe that opening health facilities to all races would instantly solve financial inequalities and limitations in health care.

He was responding to a statement by National Party parliamentary standing committee on health chairman Johan Vilonel, that after apartheid had been removed blacks and whites would enjoy equal access to health care.

Price said in a new SA there would not suddenly be enough funds for health.

A future government would have to find additional sources of finance for health care and this was where a national health insurance scheme could come in.

All South Africans would have to contribute to the scheme which would pay for basic medical services. Additional care would have to be privately funded.

Government would have to contribute for indigent patients.

Dismantling apartheid in hospital services could take up to 25 years, he said.

Students begin varsity sit-in

TANIA LEVY

ABOUT 60 Wits University students occupied the offices of the vice-chancellor last night as part of a class boycott to demand action regarding accommodation shortages and exclusion of failed students. B1Dam 8/3/91

Registrar Ken Standemacher issued the students with eviction notices and said they would face suspension and disciplinary action if they refused to leave.

However, vice-chancellor Robert Charlton said the students would be allowed to stay overnight if they chose to.

The Students Representative Council supported the boycott which was called by the Black Students' Transitional Committee (BSTC).

forced | PEANUTS By Charles Schulz

Johannesburg Hospital	R189 164 900
Coronation Hospital	R49 474 500
Grey's Hospital	R39 005 000

Medical waste: disposal

86. Mr M J ELLIS asked the Minister of National Health:

Whether any changes were introduced in the 1990-91 financial year by hospitals falling under the control of the provincial administrations in the system used to dispose of medical waste; if not, why not; if so, what are the relevant details? B211E

The MINISTER OF NATIONAL HEALTH:

Although the disposal of hospital waste (medical and clinical waste) is considered to be reasonably satisfactory, all provincial administrations undertook investigations to identify portential problems during the past year. These resulted *inter alia*, in the introductin of more uniform methods of disposal, increased use of standardised containers, renovation of incinerators and contracting professional firms for waste removal and disposal. However, most improvements planned are subject to the availability of funds.

Johannesburg North: service applications

106. Mr P G SOAL asked the Minister of Mineral and Energy Affairs and Public Enterprises:

Whether any applications for (a) telephone services and (b) private post boxes were outstanding in the Johannesburg North constituency as at the latest specified date for which figures are available; if so, (i) how many in each suburb falling within this constituency and (ii) when is it anticipated that the backlog will be eliminated? B291E

The MINISTER OF MINERAL AND ENERGY AFFAIRS AND PUBLIC ENTERPRISES:

(a) Yes, 512 as at 28 February 1991;

(i) and (ii) In addition to applications that are met on demand on a continuous basis where telephone numbers and cable leads are available, service will be provided as follows to waiting applicants in the areas indicated:

Exchange area	*Number of waiting applicants*	*When services are to be provided*
Bramley (includes the suburbs of Eltonhill, Winston Ridge, Kentview and Birnam)	77	Within the next three months as cable works are completed.
Rosebank (includes the suburbs of Fairway, Illovo, Melrose, Melrose North, Melrose Estate, Birdhaven, Dunkeld West, Parktown North, Parkhurst and Craighall Park)	209	Within the next five months as cable works are completed
Randburg (includes the suburbs of Craighall and Blairgowrie)	178	Within the next five months as cable works are completed.
Linden (includes the suburbs of Victory Park, Pierneef Park, Pine Park, Blairgowrie and Beaconsfield Estate)	48	Within the next five months as cable works are completed.

(b) Yes;

(i) 76 as at 25 February 1991 (Birnam Park 28 and Parkhurst 48).

(ii) The installation of additional private post office boxes at Birnam Park and Parkhurst is not possible because of the structure of the buildings. The waiting applicants at these centres can only be accommodated as and when existing boxes become vacant. Specific dates for the elimination of the backlog cannot, therefore, be furnished. It should be mentioned

that vacant private post boxes exist at Saxonwold (28), Northlands (54), Bramley (449), Parklands (300) and Pinegowrie (975). The number of vacant post boxes at Northlands has increased since last year because some renters were allocated post boxes at the more conveniently situated Pinegowrie Post Office. By arranging that a number of renters at Craighall be provided with private boxes at more conveniently located offices, it was possible to provide all waiting applicants at that office with private boxes.

Immunisation programmes

123. Mr M J ELLIS asked the Minister of National Health:

(1) (a) What sum of money was allocated to immunisation programmes in the 1990-91 financial year and (b) what immunisation programmes were undertaken;

(2) whether these programmes could be implemented fully out of the sum so allocated; if not,

(3) whether additional funds were allocated for this purpose; if so, from what source? B213E

The MINISTER OF NATIONAL HEALTH:

(1) (a) R4 150 500 and

(b) expanded immunisation programme against tuberculosis, poliomyelitis, diphtheria, pertussis, tetanus and measles,
immunisation of contacts of rabies and
immunisation against yellow fever for international travel purposes;

(2) yes;

(3) falls away.

Tuberculosis

129. Mr M J ELLIS asked the Minister of National Health:

In respect of each race group in each province in 1990, (a) how many cases of tuberculosis were (i) reported and (ii) hospitalised and (b) how many tuberculosis patients died? B361E

The MINISTER OF NATIONAL HEALTH:

(a) (i) Notified tuberculosis cases in the Republic of South Africa by Population Group and Province, 1990. (As on 27 February 1991. Notifications for 1990 are still incomplete.)

POPULATION GROUP

Province	*Indian*	*Black*	*Coloured*	*White*
Cape	32	13 587	16 960	411
Natal	453	9 247	196	75
OFS	1	9 481	633	130
Transvaal	52	13 462	487	228

(ii) Admission in a hospital with tuberculosis

POPULATION GROUP

Province	*Indian*	*Black*	*Coloured*	*White*
Cape	0	2 430	2 724	2
Natal	183	9 273	97	15
OFS	0	3 031	75	0
Transvaal	13	1 922	142	62

(b) Notified tuberculosis deaths in the Republic of South Africa by Population Group and Province, 1990. (As on 27 February 1991. Notifications for 1990 are still incomplete.)

POPULATION GROUP

Province	*Indian*	*Black*	*Coloured*	*White*
Cape	0	571	485	12
Natal	4	46	1	0
OFS	0	110	10	3
Transvaal	1	492	12	7

Own Affairs:

Sea Point: rent-controlled premises

11. Mr C W EGLIN asked the Minister of Welfare, Housing and Works:

(1) How many rent-controlled premises were there in the Sea Point constituency as at 31 December 1990;

(2) (a) how many such premises were decontrolled in 1990 and (b) what is the (i) address and (ii) description of each of the properties concerned? B154E

Probe shows fit subsidise the sick

PRETORIA — There is "improper cross-subsidisation" within medical schemes between members and employer groups who claim infrequently and those who claim excessively.

This is one of the findings of Prof George Marx of Pretoria University's Chair of Insurance, who has completed an investigation of medical aid schemes.

Marx said there should be a reduction in this "drastic cross-subsidisation" — this had been made possible by a recent amendment to the Medical Schemes Act, in terms of which a member's membership fee will be based on his past claim record.

He found ordinary members subsidised pensioner members because pensioners contributed less than a third of their claims. B1 Dem 13/3/91

He said ordinary members were becoming increasingly reluctant to continue subsidising pensioner members, because they could not afford to, and because they had no assurance that they in turn would be subsidised by ordinary members once they became pensioners. (299)

He warned medical schemes that employers might try to change from scheme to scheme in order to continue deriving the benefits of cross-subsidisation.

It had been suggested that medical aid schemes be converted to health care organisations, in order to limit those supplying medical services to an appointed panel of doctors and other providers of services.

But not all members of medical aid schemes, especially the more sophisticated ones, would be in favour of health care organisations..

Marx called for the introduction of "a low-claim bonus or rebate system based on the member's claims over a 12-month period".

He warned that increases in medical aid fees were likely to continue. — Sapa.

AWB men in court over arms caches

BLOEMFONTEIN — Two large weapons caches have been discovered in the Bloemfontein and Brandfort districts in a police investigation into Free State right-wing activities.

The investigation covered attacks on NP offices in Bloemfontein and Theunissen, an explosion at an Eskom electric mast near the Saltpan road and unlawful possession of weapons, Bloemfontein newspaper Die Volksblad reported.

Five members of the Afrikaner Weerstandsbeweging (AWB), including area leader Dirk Ackermann of Kwaggafontein, have appeared in court.

The others are Willem Etsebeth, Louis van Zyl Bill Allison and Christo Niemand. B1 Dem 13/3/91

The trial was postponed to April 3. All five were allowed bail of R1 000 each.

Free State Deputy Attorney-General Andre du Toit said the possibility was not excluded that a shotgun found on a farm near Bloemfontein was among weapons stolen in the SA Air Force headquarters robbery in April 1990, in which detained Orde Boerevolk leader Piet "Skiet" Rudolph was allegedly involved.

The appearance of two of the men was connected with a cache, including radios, on the farm Deelmiddelpoort. The radios are believed to have been stolen from the SA Defence Force. — Sapa.

ONAL

Protea Chemica

Registration number 79/06624/06

Consolidated income statement

R'000	Six months ended 28 February 1991	1990 (unaudited)	cha
Turnover	169 599	191 469	
Operating income	6 197	8 782	
Finance costs	3 270	5 225	
Income before taxation	2 927	3 557	
Taxation	1 016	1 491	
Outside shareholders' interest	56	43	
Earned for shareholders before extraordinary items	1 855	2 023	
Extraordinary items		104	
Earned for shareholders after extraordinary items	1 855	1 919	
Shares in issue (000)	46 636	46 636	
Earnings per share (cents)	4,0	4,3	
Dividends per share (cents)	–	1,5	
– interim	–	1,5	
– final			
Dividend cover (times)		2,9	

COMMENT ON THE RESULTS

The 1990 Annual Report stated that the group was unli on last year's first-half results and this has proved t Demand for commodity chemicals remains depressed general economy. The tax rate for the current period the impact of export incentives on the current lowe before taxation.

Gearing

Interest-bearing borrowings as a percentage of perm 49,9% is an improvement on the financial year-end fig August 1990.

Foreign exchange

The group covers forward on all transactions in currencies and has no uncovered positions.

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Medical aid issues studied

BIDay 14/3/91.

GERALD REILLY

PRETORIA — The issues of cross-subsidisation and low-claim bonuses in medical schemes were under intensive study, Representative Association of Medical Schemes (Rams) chairman Nic van Rensburg said yesterday. (299)

He was reacting to proposals by Prof George Marx of Pretoria University's Insurance Department that cross-subsidisation of sick patients by the healthy should be drastically reduced. Marx also recommended the introduction of a low-claim bonus or a rebate system based on a members' claims over the previous 12 months.

Van Rensburg said, however, there was no simple solution.

Eliminating cross-subsidisation totally would impose severe financial hardships on members with long-term illness and heavy medical and hospital accounts.

"The problem is where to draw the line. There might be some justification for low-claim bonuses, but all members are exposed to the risk of protracted illnesses and big accounts."

Van Rensburg said the Medical Schemes Act had recently been amended to provide for membership fees to be based on the extent of claims made during the previous 12 months.

Long delay before cutting hospital bill

Star 14/3/91 299

The management of Milpark Hospital in Johannesburg has blamed a 10-month delay in reducing a Sandown patient's bill on staff changes and a possible slip-up.

Jeff Hurwitz, MD of the Parktown hospital, said Benjamin Joseph's long wait to have his account amended after he was overcharged almost R50 for medicines was possibly an oversight by a staffer.

Another reason was that the patient might have taken up the inquiry with a staff member who had left the hospital.

"Mr Joseph also could have walked out without taking his medicine with him but normally if a patient does not take his medicine home it is sent to the dispensary and the account is credited," Mr Hurwitz said.

Mr Joseph had maintained he could not have taken 30 pain killers and various other tablets for which he was charged during the three days he was hospitalised.

"I cannot recall taking any pain killers unless I took all 30 while in intensive care overnight after the operation."

He also said the staff did not inform him that he was allowed to take the unused medicine home and wondered if other patients were told this.

Mr Hurwitz said patients were not given their account on discharge in case it had to be amended. However if a patient was not satisfied with the account the complaint could be addressed to the manager.

The hospital is part of the Clinic Holdings Group which in turn belongs to the Representative Association of Private Hospitals.

A spokesman for the association described it as coincidental that the

Star Line

JOHN MILLER

body was only comprised of Clinic Holdings Group members.

The association did not have a specific code of ethics but "ethics was part of their reputation" the spokesman said, and because of the particular composition it was easier to prescribe to its members than other associations which have many more members.

The spokesman emphasised that it was not the group's practice to overcharge.

Gerald Lewis, secretary of the National Association of Private Hospitals, which includes clinics from the Afrox group and Medi-clinic group as well as other independent hospitals, admits that overcharging is a general problem within the industry but does not believe it is a regular occurence.

He said he was also aware of a certain public negativity about private hospitals.

He said his association has more than 10 000 out of the about 13 000 private hospital beds.

He welcomed any complaints to do with any of its members. These can be addressed to himself at PO Box 456, Stellenbosch 7600, or sent to the Department of Health in Pretoria.

Each of the hospitals within the association displays a plaque and code of ethics in the reception area.

Medical aid 'cross-subsidisation' criticised

Star 299

Medical Reporter 15/3/91

Over-utilisation of medical services takes place because members of medical aid funds do not always realise they themselves are paying for these services, says Professor Georgee Marx of the University of Pretoria.

Professor Marx, of the Chair of Insurance, has investigated the latest increases in medical aid membership fees and related issues.

He found there was "improper cross-subsidisation between member and employer groups who claim infrequently and those who claim excessively".

Professor Marx said there should be a reduction in this "drastic cross-subsidisation", which had been made possible by a recent amendment to the Medical Schemes Act in terms of which a member's membership fee would be based on his past claim record.

The professor found that extreme cross-subsidisation took place between ordinary members and pensioners.

Ordinary members subsidised pensioner members because pensioners contributed less than one-third of their claims.

He said ordinary members were becoming increasingly reluctant to continue subsidising pensioners because they could not afford to and had no assurance they in turn would be subsidised by ordinary members once they became pensioners.

It had been suggested medical aid schemes be converted to health care organisa-tions in order to limit those supplying medical services to an appointed panel of doctors and other providers of services, Professor Marx said.

Hospice care comes to Soweto

Sowetan 18/3/91

SOWETAN REPORTER

A NEW service to help people with incurable diseases will be started in Soweto from April 1.

The project is called Hospice-in-Soweto which will treat about 60 to 80 patients who lie at Baragwanath Hospital awaiting death.

According to Mrs Rowena Murraybrown, development director of Hospice Association of the Witwatersrand, it is conservatively estimated that there are about 6 000 deaths a year due to terminal disease in the central Witwatersrand area.

"Of these, about 3 000 occur in Soweto. At this time, cancer is the biggest cause, accounting for over 85 percent of instances.

"However projections of AIDS cases intimate that by 1995, about 10 000 people in Soweto will die of this syndrome," she said.

Murraybrown said the incidence of AIDS was far higher among the black population and the emphasis was heterosexual rather than homosexual.

"Some 10 or more patients with AIDS are to be found at the clinics in black areas a week on average. Last year alone, some 600 to 700 babies at Baragwanath Hospital were HIV-positive at birth," she said.

Patients and families needing help from Hospice-in-Soweto can get in touch with Baragwanath Hospital, Hillbrow Hospital or Primary Health Care Centres (clinics) including the Alexandra Clinic.

The aim of the programme was to provide medical, nursing, pychological, emotional, social, spiritual, religious, economic or any other need that might arise in a family that has a terminally ill person.

Murraybrown said the service was provided on the basis of need and not on the ability to pay, to anyone regardless of race, religion or cause of condition.

The committee that is to run the Hospice-in-Soweto includes Mrs Pat Chakane, Mrs Adelaide Mahlakahlaka, Mrs Mildred Makhaya, Mrs Elizabeth Moseu, Mr Elias Ngema, Rev Paul Verryn, Mrs Christine Matli, Mrs Angie Mabena, Mrs Mildred Mdladlamba, Mrs Virginia Monnakgotla, Mrs Fikile Mlotshwa, Mr Phillip Nkwenga, Mrs Joyce Radebe, Mrs Zukiswa Shingenyana, Mrs Aggrinette Xulu and Mrs Dikgale.

Care

The idea of launching a Hospice-in-Soweto started from a need that arose from the people who held a public meeting in May 1990 at the Orlando Methodist Church.

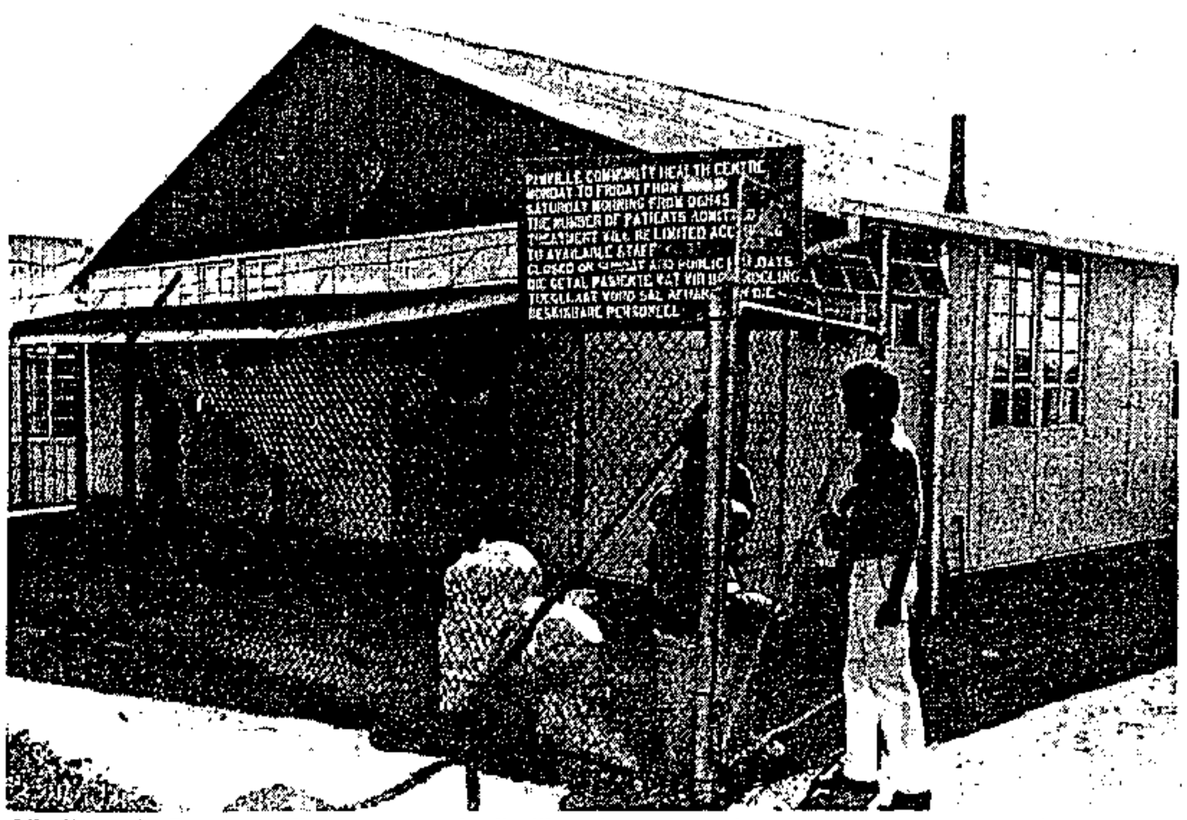
Last month, Dr George Louw, superintendent of the Soweto Community Health Services, gave permission that the unused maternity wards at the Senaoane Clinic be used to house the Hospice-in-Soweto.

People wishing to attend as out-patients will be seen by a doctor, nurse and care worker at the clinic.

An extensive home care and support network will be stablished by upgrading existing district nursing services through training in terminal care.

Murraybrown said ordinary people who volunteer to assist terminally ill people can be trained to provide effective care and support "so very neccesary" when the family faces terminal disease and death.

She said: "We further believe that through the development of careworkers we will be providing the community with a new resource of persons imbued with specific skills which will have a widespread positive impact on the quality of life of all inhabitants of Soweto."



All clinics in Soweto will accept terminally ill patients for referral to the hospice which at present is housed at Senaone Clinic.

Scaredy fish

SYDNEY - A large shark approaching three swimmers off an Australian beach on yesterday was frightened away by a rescue helicopter that hovered low over the sea.

"We had to put ourselves between the shark and the swimmers, hovering low and creating turbulence in the water to scare it away," he said by telephone. - *Sapa-Reuter*

Call for overhaul of health care system

A complete reorganisation of the administration of health care and of Government spending on it, were absolutely essential, **Mike Ellis (DP Durban North)** said in the House of Assembly yesterday.

Speaking during a debate on a private member's motion on health by **Dr J J Vilonel (NP Langlaagte)** — which expressed appreciation to the Government for the high priority accorded to health matters — Mr Ellis said there were several underlying causes for the potential collapse of South Africa's health care system, but the two most important were:

- A lack of Government spending on health.
- The "appalling structure of health care administration that has developed in this country over the years and which is racially-based, fragmented and expensive".

He proposed an amendment that the House express its deep concern at the low priority accorded by the Government to health, and call for a single health ministry.

He asked whether the Government was doing enough to counter the spread of Aids in South Africa.

In introducing the motion, Dr Vilonel said there had been a vast improvement in health care in SA but it was not enough.

He asked the Government to upgrade the priorities of primary health care, Aids, and administration fragmentation.

"There has been a vast improvement in health care in the last three decades. Health matters have received a high priority and we're thankful for that."

Dr Vilonel said the future of health services would be built on five pillars: accessibility, efficiency, affordability, acceptance and equity.

These were universally accepted principles and had pulled SA out of "the doldrums of apartheid". — Sapa.

Soweto home for mentally handicapped to open soon

Star 20/3/91

By Musa Mapisa 299

Soweto's first multi-purpose facility for the mentally handicapped, Takalani Home, is to open its doors in Diepkloof for the first 100 children and adults on April 1.

The home's organiser, John Rees, this week appealed for a donation of 100 wheelchairs, as most of those admitted were profoundly mentally handicapped and could not walk.

"We are especially looking for wheelchairs for children and we would also welcome second-hand wheelchairs which we can repair," Mr Rees said.

The facility would provide residential care for 100 profoundly handicapped people; a school for 350 people, half of whom would be offered boarding; cottages for 60 adults; and a workshop for 150 people.

Help

There will also be an "early intervention" and education centre providing day care for 90 children and two training centres for mothers and child-minders.

Takalani is a privately financed community initiative which has received grants from the Anglo American and De Beers chairmans' funds and 45 other donors.

The concept of a home for mentally handicapped children in the township was devised five years ago when Miriam Sibeko, a mother of a mentally handicapped child, enlisted the help of Soweto community leader Dr Ntatho Motlana and Germiston's Avril Elizabeth Home for the Mentally Handicapped to establish an institution to treat, train and accommodate Soweto's mentally handicapped children.

Two years ago a steering committee which had been formed to run the institution under the aegis of the Avril Elizabeth Home became an autonomous body with its own constitution, board, fundraising number and premises.

RSC requests a R26m increase

PATRICK BULGER

THE East Rand Regional Services Council has applied for a 21% increase in levy rates.

This would boost the council's income by R26,19m and was almost certain to be approved by Finance Minister Barend du Plessis, a council spokesman said.

RSC chairman Leon Ferreira told an RSC meeting earlier this week increases had become inevitable.

The services levy — which is a tax on salaries — will be increased from 0,275% of salaries paid to 0,333%; the establishment levy — a tax on turnover — will go up from 0,11% to 0,133%.

Ferreira said the increase was the minimum amount needed to reconcile income with projected expenditure, and would help meet the backlog of R1,088bn the council had set as its ultimate target.

The increase is likely to meet opposition from the 33 000 East Rand employers. The council is preparing a brochure for distribution to businesses to defuse criticism and to show what projects are being completed with their money.

The R26,19m increase is roughly in line with the R22,63m the TPA has asked the RSC to set aside as bridging finance to make up for current expense backlogs caused by township residents' non-payment of services.

Ferreira said no final decision had been taken on the bridging finance. The increase in levy rates was to make up for backlogs and was not linked to the bridging finance.

Last September the council agreed to make R27m available as bridging finance.

It went towards paying water and sewage costs as well as the partial removal of waste.

The TPA is likely to ask the council to put more money aside at the end of the month when council assistance with township running costs officially ends, the source said.

Certain capital projects were shelved to pay for the running costs.

The council's budget is R157,89m for 1991/2.

Concern over Vaal Triangle air

WILSON ZWANE

AIR pollution in the Vaal Triangle could be linked to health disorders including bronchitis, chronic coughs and other chest illnesses, a survey of 10 000 children has shown.

The survey, conducted by the Medical Research Council (MRC), said concentrations of ozone and particle matter in the area were cause for concern.

In a statement released yesterday, the MRC said the first results of its research indicated the Vaal Triangle was a "potential problematic" environment because of its varied and complex sources of air pollution. These included major industries, burning coal and pollen.

A pilot study involving 31 teenagers in Vanderbijlpark showed that in 51% of the measurements taken, exposure to "particulate matter" was higher than US air pollution health standards.

"Among other things, cigarette smoke, industry and motor vehicles contributed," they believed the extremely high levels of pollen and fungal spores in the Vaal Triangle put the allergic population of the area at risk.

Possible health effects caused by air particles included chronic coughs, bronchitis and other chest illnesses.

The Vaal Triangle Air Pollution Health Study was commissioned by the National Health and Population Development Department last year to investigate the effects of air pollution on health in the area.

The study is funded by, among other groups, the MRC, Eskom, Iscor, Sasol 1 and the National Health and Population Development Ministry.

Researchers will attempt to identify and quantify problems so that recommendations can be made to National Health and Population Development Minister Dr Rina Venter to improve the situation.

Airports to be commercialised

LINDEN BIRNS

GEORGE — SA's nine state airports could be fully commercialised by next year, Transport Minister George Bartlett said yesterday.

Bartlett said state airports would not be privatised but would probably continue to be run on a commercial basis by companies owned 100% by the state.

Bartlett was speaking at a ceremony at which George's P W Botha Airport received the Airport of the Year award.

He said full privatisation of airports was "a long way off" and that commercialisation under state control was the preferred means of making them profitable concerns.

"Airports have to offer all user airlines equal service opportunities and accommodation in landing slots, ground facilities and passenger and baggage handling services," he said.

Bartlett said a task group comprising the Dictorate of Civil Aviation and other parties with interests in the commercialisation of airports had been convened to investigate several possible models.

Barlett said full commercialisation could be expected within the next year.

In terms of the commercialisation proposals, separate companies would be set up each responsible for one of the nine state airports.

"These companies, with independent trading accounts, will be accountable for the failure or success of each airport which will have to be run according to sound business practices," he said.

Barlett likened the proposed model to the UK's previous state-controlled Airport Authority, and said the new structures would probably resemble state corporations similar to Eskom, Iscor and Sasol.

He added that the Transport Department had been preparing for the change in airport management and had called for nominations of people to sit on an Air Services Licensing Council which would be charged with implementing new policies.

SAA CE Gert van der Veer said the airline was not going to make a nomination as it was not prudent for airport users to be put in a position where they would be granting themselves licences.

'Major health care challenges face SA'

GERALD REILLY

PRETORIA — The provision of an equitable non-discriminatory health care system was one of the major challenges facing the health care sector, National Health and Population Development director-general Coen Slabber said yesterday.

Speaking at the SA Nursing Council AGM, Slabber said other challenges were AIDS, the unacceptably high population growth, rapid urbanisation, the low economic growth rate and shortage of funds.

It was decided that the future health care system had to be based in primary health care and had to provide an equitable service accessible to all.

And Nursing Council president Wilma Kotze said there was reason for grave concern about the shortage of nurses particularly in the fields of intensive care and cancer.

She said the number of nurses had risen by 2% last year.

Delegates will discuss union issues

VERA VON LIERES

THE Nactu-affiliated Metal and Electrical Workers' Union (Mewusa), representing 26 000 workers, is to hold its national congress in Johannesburg this weekend.

Mewusa general secretary Tomi Oliphant said yesterday about 350 delegates from various regions countrywide would meet to discuss a range of issues.

Mewusa is one of the 12 unions involved in negotiations in the metal and engineering industries.

It is demanding a R1,50-an-hour across-the-board increase for all employees and a minimum hourly rate of R6 for the lowest grade workers.

It is also demanding a 40-hour week and pushing for wage differentials between various grades to be eliminated.

Other demands include March 21 as a paid public holiday; an increase in shift allowances; and a minimum four weeks severance pay per year of service.

The union has also tabled demands on the training of operatives and artisans which, it says, is one of its main demands.

The next round of talks in the metal and engineering industry will take place early next week.

Professional fees for pharmacists

Own Correspondent

PHARMACISTS will now be able to earn their income from professional services rendered and not only from the sale of medicines.

Addressing delegates at the SA Association of Retail Pharmacists' general meeting this week, SA Pharmacy Council president Don Sutherland said it was important they distinguished between the fees for professional services rendered and the selling price of medicines.

"The practical implications are that the council will no longer, by way of regulation, restrict the pharmacist to the professional fee of R1,30 or R2,25," Sutherland said.

He said the mark-up on medicine might go down while the professional component could increase.

He said the pharmacist was entitled to charge fees for logistical functions; processing of prescriptions and dispensing of medicines; and advisory and informative functions.

Sutherland said although the council did not prescribe professional fees, he outlined guidelines to be taken into account.

These included the pharmacist's specialised knowledge of his own practice, the operational costs or expenses incurred in providing the professional service, the experience and expertise of the pharmacist, the time spent in rendering the service, whether the dispensing took place in normal working hours and whether the medicine dispensed was readily available.

Free health clinics to bring relief to the poor

THE Community Health Awareness Project has conducted a free health clinic in Dobsonville as part of its "aim to bring relief to the poor".

According to Chap official, Dr Oupa Mpe, 81 people aged between 51 and 80 were treated.

"A majority of patients had high blood pressure and sugar diabetes. The purpose of the clinic was to evaluate how well-controlled they were on their present medication.

"We also wanted to assess their understanding of medical problems and what difficulties can arise as a result of complications.

"The Chap team, which comprised of medical practitioners, nurses and

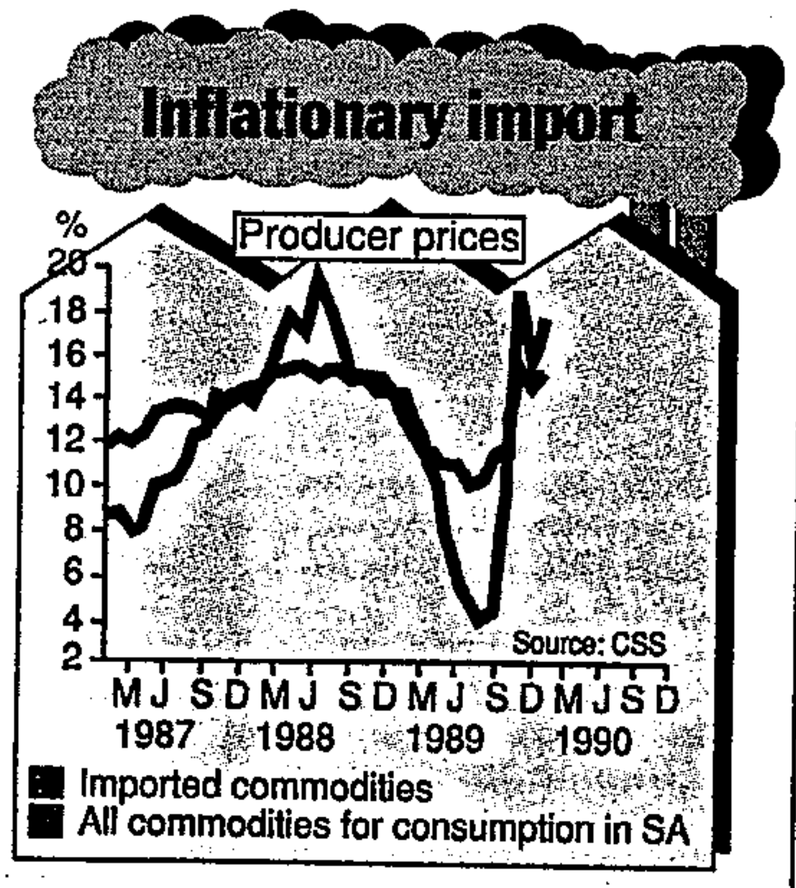
By MOKGADI PELA

paramedics delivered education about the importance of complying with therapy as prescribed by their doctors."

He said the team picked up three new cases of hypertensives which they referred for further evaluation and probable treatment. "Other complaints were associated with advanced age like joint pains and back-aches," he said.

"Chap believes that the elderly people should be given optimal health and good quality of life even in their old age.

"They deserve as much health as everybody else," Mpe said.



in the primary stage of production fell by 3% and in the manufacturing process by nearly 1%. There were also declines in:

- ☐ "Other chemical products" (weighting: 11) 0,7%; and
- ☐ Products of petroleum and coal (8) 2,2%.

Major price increases that month came in:

- ☐ Mining and quarrying other than coal (7,55) 3%;
- ☐ Non-electrical machinery (6,25) 1,3%;
- ☐ Electricity (6) 4,5%;
- ☐ Chemical and chemical products (5,6) 5%;
- ☐ Ferrous basic metal (5) 10%; and
- ☐ Paper and paper products (4) 7,5%. ■

MEDICAL AID FM 22/3/91 299

STRESSED FUNDS

Active members of medical aid schemes heavily subsidise pensioner users. If this "improper" cross-subsidisation did not take place the dues paid by active contributors would fall substantially.

George Marx, of the University of Pretoria's department of insurance and actuarial science, believes — after investigating the problem — that a possible solution lies in using pension fund surpluses to eliminate the strain on medical aid resources. It is not reasonable, he says, to expect pensioners to fund the full cost of their medical aid needs.

Civil pensioners receive an average of about R1 500 monthly. A pensioner and spouse will, on average during retirement, draw R600 monthly in medical aid benefits though they often contribute in dues less than a third of the amounts they claim. Among private-sector pensioners the position is worse, says Marx, where pensions average about R1 000 a month but medical needs are no different to those of civil pensioners.

Marx advances several ideas for reducing the strain. He notes that active members have no guarantee that they, in turn, will be subsidised when they go on pension. "There is seldom any formal or legal guarantee that medical schemes will remain financially sound." That is fertile ground for breeding resentments.

So the employer needs to consider the exclusive subsidisation of pensioners' membership. Depending on the number of pensioners, he estimates this could lead to a drop of up to 15% in ordinary dues. Marx believes it would be proper to use pension fund surpluses for this subsidy.

There has been argument in the pensions industry about who owns surpluses. Consensus now has it that surpluses belong not to current members, nor to employers, but to the pension fund itself. Yet excessive surpluses are considered undesirable (in some European countries, they are taxed.) Employers in SA can take "holidays" from pension contributions when the funding is agreed by an actuary to be excessive.

It follows that, in practice, the employer has a great deal of influence on how a surplus is used. Funding pensioners' medical needs looks socially desirable.

Marx also says the unnecessary use of services takes place because members do not always appreciate they are themselves paying for the service. He advocates the introduction of a low-claim bonus or rebate based on a member's claims over a 12-month period. ■

IN MY OPINION

RESEARCH

Why people say no to transplants

Black families refuse permission for organ donation of dead relatives more often than families of other race groups, according to a paper on demographic factors that influence consent.

Findings of the study, by members of the renal transplant unit at Groote Schuur Hospital and the department of surgery at the University of Cape Town, were published recently in the South African Medical Journal.

The study was based on records of all donor referrals to Groote Schuur Hospital over five and a half years.

The study found also that consent was more readily given if the potential donor was 10 years of age or younger, that the sex of the donor appeared to have no effect and that consent was more readily given when death was due to suicide.

The authors of the paper said that while no study had yet been done in South Africa to determine the attitudes of black people towards organ donation, a United States study had found a lack of knowledge, religious fears, fear of complication and lack of communication constituted factors that played a role.

These factors could possibly also be true of South Africa. Education of the black community coupled with the fact that more and more black patients were undergoing transplants could help to increase awareness.

Consent was more readily given if a potential donor had committed suicide, the authors felt, because "this may be seen as a last noble act by the family to give meaning to an otherwise disappointing life."

CARINA LE GRANGE

'Unwelcome' rise in private health care bill

B/Day 22/3/91 (299)

PATRICK BULGER

MEDICAL aid costs will rise by at least 8,5% because of a Budget allocation for health services that was not well received by health organisations yesterday.

Representative Association of Medical Schemes (Rams) executive director Rob Speedie said the 12% VAT rate announced on Wednesday would add R536m annually — or R1,5m a day — to SA's private health care bill.

Finance Minister Barend du Plessis' Budget allocated R8,175m to health care. Du Plessis said less than 5% of this would go to primary health care.

Speedie said the VAT rate would put health care beyond the reach of many people whom the state would now have to take care of.

"The application of VAT at a rate of 12% on health care services will make it necessary for private medical schemes to put their subscription rates up by an additional 8,5% a year on average, over and above the recent annual increases which have come through and which have hit medical scheme members hard."

Nor did the Budget please spokesmen for those beyond the medical aid schemes net. This was in spite of Du Plessis' statement that the state's role in health services would shift increasingly to providing primary health care and more affordable curative health services for the needy.

A spokesman for the National Medical and Dental Association (Namda) said a 9% increase in the state's health spending meant a 6,5% drop in real terms if inflation was taken into account.

With a 2,5% growth in population and a 12% VAT rate, it meant per capita health spending was down by about 20% on last year.

This was inconsistent with the Minister's statement about his Budget introducing equity.

"The Budget will lead to growing inequality in access to health care," the Namda spokesman said.

Wits University Centre for Health Policy Studies director Cedric de Beer said health spending had dropped in real terms.

This was especially so given that the population was increasing, ageing, urbanising and that more people were being forced to rely on public sector health facilities.

He described the Budget as "disappointing".

Lack of planning 'will hit public health services'

B/Day 27/3/91

GERALD REILLY

PRETORIA — Public health services would be unable to meet future health care needs because of a lack of long-term planning and rationalisation, Medical Association of SA secretary-general Hendrik Hanekom said yesterday.

Commenting on the large increases in Transvaal provincial hospital and ambulance tariffs announced this week, Hanekom said the fragmentation of health services continued to be the core of the problem.

In some cases, tariffs were more than doubled.

Private patients at academic hospitals will pay a 30% levy on the new daily rate of R205. H2 category patients will pay R41 instead of R10 a day at community hospitals and R52 instead of R15 a day at regional and academic hospitals.

Masa urged government to urgently move towards ending this fragmentation.

Hanekom said the increased fees were entirely unexpected.

It appeared the new TPA tariff structure had been based on the principle of extending accessibility to health services to more poor people.

"Masa, however, is concerned that a situation has developed in various public health services where it has become necessary to introduce contingency measures to maintain services and to balance budgets," Hanekom said.

Masa, he added, supported the principle that individuals should take care of their own health as far as possible.

Lost ancestral lands 'stay white'

B/Day 27/3/91.

PRETORIA — Planning and Housing Minister Hernus Kriel yesterday dashed the hopes of thousands of black South Africans by saying land seized under apartheid laws would never be returned.

In an interview in the magazine RSA Policy Review, Kriel dashed the hopes of blacks removed from ancestral lands over the past 48 years by saying people had been compensated for land taken away from them.

"It will be unrealistic to expect land to be taken away from those who, over the years, developed and sustained it," he said.

"The government believes that the future rather than the past should be looked to ...

"The whole matter must be dealt with in a constructive manner by helping people to become landowners rather than in a destructive manner by once more taking land from people."

The interview, which will be published in April, was conducted a day after the White Paper on land reforms was tabled in Parliament on March 12, triggering a sharp response from the African National Congress and other anti-apartheid groups.

Kriel said he hoped white people, scared by moves to dismantle apartheid, would accept colour was not a decisive factor in life.

"In the course of time South Africans will realise that colour is not the decisive factor in the level of people's civilisation.

"There is no question of the fact that the government is conceding to pressure.

"The reality in SA that the majority of its citizens are excluded from the highest political decision-making processes, and that all South Africans do not have equal opportunities, caused the government to reconsider its viewpoints."

He warned against high expectations, saying "people's expectations should not exceed the limits of existing realistic standards".

Kriel said the aim of the White Paper was to bring about justice to all South Africans.

Rightwing groups bent on sabotaging the scrapping of apartheid laws would not be allowed to do so.

"The government wants to appeal to people to show the same attitude in their private affairs as that which underlies the decision to repeal the Group Areas Act.

"It will be unlawful for any local authority to accept regulations in terms of which areas are reserved for specific population groups," the minister said.

"The SA government will have to monitor the situation to ascertain whether blatant discrimination still takes place.

"As a result of this, further rectifying steps could be taken in the course of time," he added. — Sapa.

Leaders 'impotent to stop violence'

B/Day 27/3/91

WILSON ZWANE

THE SA Council of Churches (SACC) this week said leaders of factions involved in the continuing township violence were impotent to halt the carnage.

In a statement, the SACC said it, in consultation with church leaders, felt there was an urgent need for the church to intervene in an attempt to stop the violence, which was escalating despite peace talks between rival political parties.

"This reality has convinced us that either the parties involved in resolving the crisis have failed or the violence has now simply gone beyond the control of the organisations themselves," the SACC said.

The organisation said it had hoped positive results would flow from recent peace talks between the ANC, Inkatha, government, the PAC and Azapo.

As its contribution to efforts aimed at ending factional violence in the country, the SACC would convene an urgent national meeting of all leaders of strife-torn communities within a week.

SIMON BARBER reports from Washington that the Bush administration has reacted to Sunday's police shootings in Daveyton with unusual vehemence, calling the incident "an unacceptable vestige of the old SA".

Officials indicated that they were angered as much by the circumstances that led to the the incident as by the police decision to open fire.

SA ambassador Harry Schwarz has sought a full report on the episode from Pretoria.

"The indefensible cannot be defended," he said. "If the police have acted wrongly there is no way I can defend it."

Meanwhile, PATRICK BULGER reports the ANC Youth League, reacting to the weekend clash, yesterday repeated its calls for an interim government and the integration of ANC forces with those of the SA security forces.

"In the interests of peace and for the sake of our country, the ANC Youth League demands of the regime that it immediately recognise the need for a neutral force to take over the control of the country during this delicate stage in our history," the statement said.

Hospital tariffs rise slammed

ANGER has greeted the Transvaal Provincial Administration's hospital and ambulance fees increase effective from Monday, April 1.

The increases would be "an interim measure" before the introduction of national uniform tariffs in April 1993, said the TPA.

Private patients at academic hospitals, who earn more than R25 000 a year, would have to pay a levy of 30 percent R61.50 over and above the normal new daily of R205. The levy would cover some medical services previously not charged for.

These tariffs are in line with medical aids scheme rates which the TPA said were still significantly lower than fees of private clinics.

Patients in the highest category, H-3, who are not on medical aid and have a family income of between R19 000 and R25 000, will now pay R103 a day (previously R60) at academic and regional hospitals. At community hospitals these patients would pay

By MOKGADI PELA and SAPA

R81 a day instead of R40.

Fees for patients without medical aid and on family incomes of between R13 000 and R19 000, will go up to R52 from R15 a day at academic and regional hospitals, and from R10 to R41 at community hospitals, according to MEC in charge of hosptals, Mr Fanie Ferreira.

He said ambulance fees would be R15 a trip for H1 patients and R20 for H2 patients and R30 for H3 patients.

Ransom

Commenting on the fees Dr Nchaupe Mokoape, deputy-president of Azapo, said health was not a saleable commodity because doing so was to hold society at ransom.

"It means those who don't have money will be literally excluded from health care facilities or at best given inferior care," Mokoape said.

Dr Fazel Randera, Southern Transvaal chairman of Namda, said the hikes in hospital tariffs were too high.

"In most instances the increases appear to be in the order of 100 percent or more. Undoubtedly, the cost of health care is increasing all the time but have the authorities taken into consideration that salaries have not kept in line with the rate of inflation."

Hardships

Dr Solly Skosana of the PAC said in the present economic hardships experienced by the dispossessed impoverished "Azanians", it was unacceptable to his organisation for medical tariffs to be raised.

Mr Rupert Lorimer of the Democratic Party said hospitals were under tremendous financial pressure leading to a deterioration in the quality of medical services.

Financial stringency will necessitate a cutback in dead wood, particularly in hospital administration.

Dr Willie Snyman of the Conservative Party said his organisation was shocked at the sharp increases which would contribute to the general increase in the inflation rate.

FOCUS: *Should pharmacists be allowed to charge for advice?*

A bitter wrangle over prescription fees

w/M cut 28/3-4/4/91

CRITICAL CONSUMER

Pat Sidley

299

THE Pharmacy Council — which is to pharmacists what the Medical and Dental Council is to doctors — will soon be applying to the Department of Health for a change to the charges pharmacists are allowed to levy. According to the council's legal spokesman, they want to replace the present prescription charge (R1,30) with permission to charge whatever the pharmacist wants in whatever way he or she wants for a service rendered.

Pharmacists say they want the change so that they can take their rightful place in the health team alongside other professionals, have their status recognised — and help to address South Africa's severe health care problems.

Their solution means if you consult a specialist physician who explains your ailment, describes the drugs he is prescribing and charges you for the service, the pharmacist will also be able to charge you for dispensing the drug and advising you how to use it — advice which you may not have solicited.

It would also mean that for the less educated, perhaps illiterate black consumer who cannot afford a doctor and walks into a pharmacy (as many millions do every day) and asks for "something for a toothache or headache", the pharmacist will be able to charge a professional fee on top of the cost of the drug sold.

According to the Pharmacy Council's spokesman, any abuses could be reported to them and they would deal with them. However, the Council is not suggesting a scale of tariffs as a guideline for the proposed system, which it supports.

The council spokesman says a pharmacist is first and foremost a professional, not a trader, and entitled to charge for services rendered. He says he believes that when this service is not competent — when for example a painkiller is prescribed for an ailment which worsens until it is life-threatening — the consumer would have recourse to the council, and to common law rights to seek damages.

Pharmacists are not allowed to diagnose or treat illness. The only people who may practise as doctors are doctors, according to the law. However the Pharmacy Council finds the lines more blurred than they seem, and pharmacists can and do determine various minor ailments and offer medicinal remedies for them.

This position was emphasised by Dave Pleaner of the Association of Retail Pharmacists who told *The Weekly Mail* that although in the past pharmacists were able to do far more than they do now, they do offer a service to check cholesterol, high blood pressure and glucose levels. These do not involve a diagnosis, says Pleaner, but an indication which may be followed by the suggestion that the customer see a doctor. Pleaner believes the pharmacist should be able to charge for this type of service.

Pharmacists have a thorough four-year university training which includes anatomy, physiology and pharmacology, resulting in a professional who knows the territory of medicines better than any other health professional. After all, says Pleaner, doctors take only a three-month course in pharmacy, yet they are allowed to dispense drugs.

University training for pharmacists has only existed for the past three years; traditionally they were trained at technical colleges, then at technikons and required few special qualifications at school-leaving level, unlike doctors. However Pleaner says there are constant upgrading courses for pharmacists available.

Neither Pleaner nor the Pharmacy Council spokesman could think of any country in the world where pharmacists could charge in the fashion proposed, although Pleaner said in the US and UK they charge prescription fees. However, in the US and UK consumers can gain from much cheaper drug costs, cut-price drug-stores, dispensing in large retail stores, generic substitution etc.

Pleaner refers this critical consumer away from the notion of higher prices or greater expense to something he calls greater "cost-effectiveness": it is better to receive a more expensive drug and good advice than advice and drugs which are cheap but do damage. With proper government and professional regulations and good training, these issues should not arise.

Whichever way one looks at it, the consumer is going to suffer. The consumer is not given the benefit of knowledge by drug companies whose package inserts are aimed at health professionals, not consumers. Doctors often omit important information and seldom believe their patients need "full knowledge" in case it scares them. The mopping up, when it is done, is done by pharmacists — but the living of these health professionals depends on profits in stores which sell fancy goods and cosmetics.

So, can consumers rely on going into a supermarket which will employ a salaried pharmacist to dispense cut-price drugs?

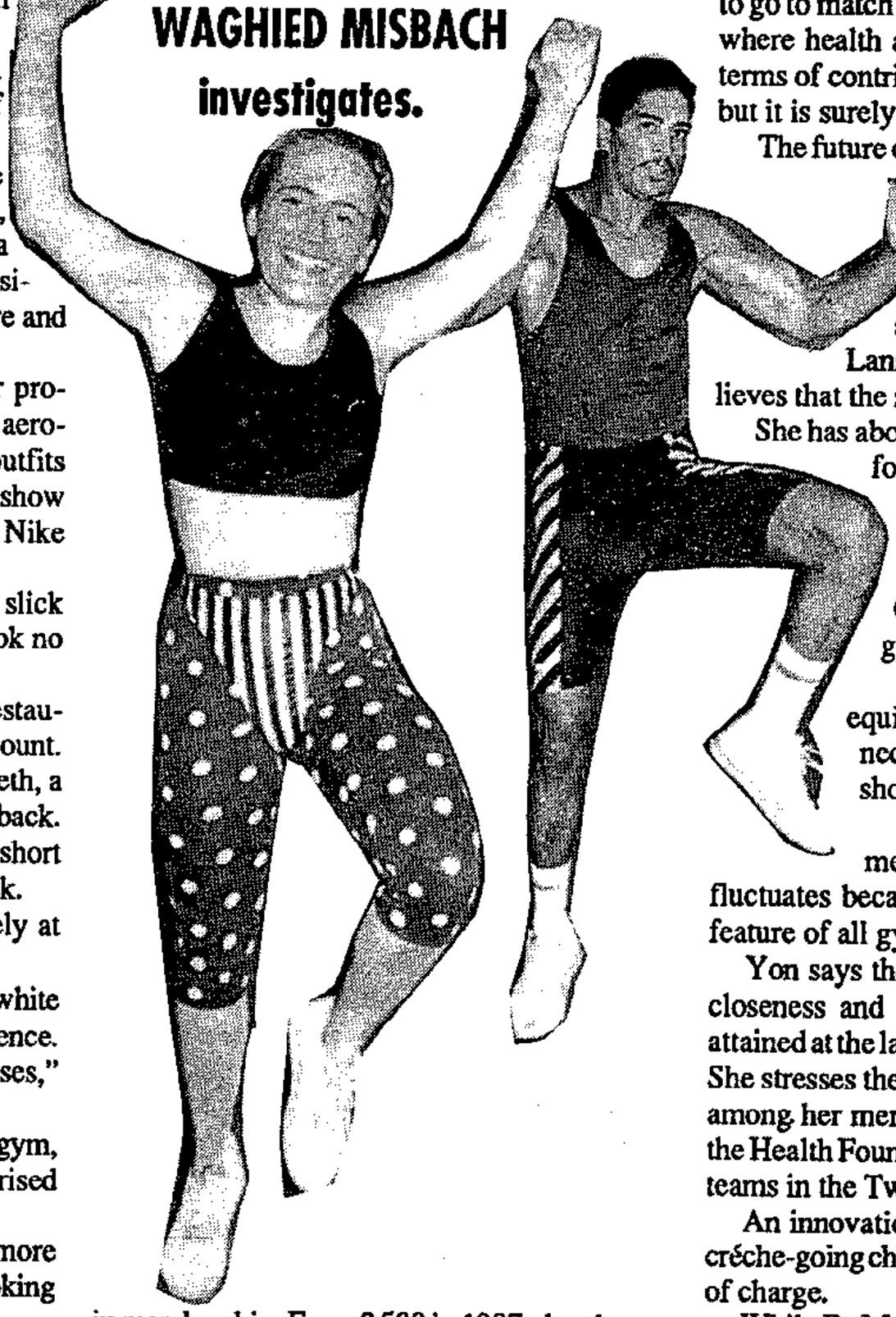
No, this scenario is illegal. Only a pharmacist is allowed to operate a pharmacy.

Perhaps if the Minister of Health is forced to entertain this proposal seriously, she could see that an independent watch-dog body is set up to check abuses, that a scale of tariffs is set and applied, that other health professionals (like public health nurses) are allowed to dispense necessary, life-saving drugs to the poorer ends of the population, and that supermarkets, under certain conditions, may cut drug prices.

Yuppie playgrounds or not — gyms are here to stay

South 28/3-3/4/91 (2400) (299) (Southside)

The health industry is booming in South Africa, today. But is it the social scene for an elite few, or the "sport" of the nineties? WAGHIED MISBACH investigates.



THE HEERENGRACHT HEALTH and Fitness Centre takes up two floors of the plush Heereengracht building in Adderley Street in the centre of Cape Town. A third floor is in the pipeline, but in the meantime members must make do with the present 6 000 square metres space available — which is divided into weight rooms, open space for aerobics, a fair sized swimming pool and showers, saunas, steam room and running track.

You can get all this for R80 to R90 a month or take the current special offer of R295 a year (cash upfront) for two people.

On the same floor is the restaurant, the Sporting Parrot, complete with health bar, health food and live parrot; the offices of a beauty therapist; a hairdresser; three physiotherapists and a Professor of Acupuncture and Chinese medicine.

An aerobics shop on the ground floor provides the narcissist with the latest designer aerobics gear — from colourful high-cut lycra outfits designed to fit like a second skin and show almost as much, to the newest Reebok and Nike gym shoes.

The management is represented by two slick young men, Gareth and Lee, who both look no older than 20.

"Hi. Pleased to meet you. Go to the restaurant. Order a cup of coffee, put it on my account. I'll be with you in five minutes," says Gareth, a tall thin man with his hair slicked straight back.

Fifteen minutes later, Lee arrives, a short stocky man, with his hair, too, slicked back.

"Is this gym not elitist and aimed solely at white yuppies," I ask.

Lee doesn't think the terms "elitist" and "white yuppies" has connotations other than excellence.

"We cater for the middle and upper classes," he says unabashed.

"We are planning an elite executive gym, with one-on-one instruction and computerised equipment," he continues.

But, there is more. "We are going to buy more equipment soon, of about R120 000 and looking at introducing aqua-aerobics."

One of the computerised cycles that Lee was talking about, costs in the region of R8500, and for large gyms, buying one, is useless.

Dr Malcolm Marrison, director of the Health Foundation, understands the negative connotations of words like "elitist".

"Yes, gyms are elitists and cater solely for the white upper class. That group constitutes one percent of the total population," he says.

He said the rich were flocking to gyms today because of the high incidence of the "white man's" ailment, heart disease.

Gyms opening up around the country indicate that the family-oriented, upmarket health centre with its additional features like restaurants and hairdressers, is here to stay.

The American Health and Fitness chain has seven gyms nationwide and are planning five more. The Heerengracht centre is its only representative in Cape Town.

The other major group, Health and Racquet Club (H&RC) has shown a phenomenal increase in membership. From 2 500 in 1987, they have a projected figure of 37 200 this year.

H&RC, too, are expected to develop another five centres in the next few years, according to H&RC co-owner Peter Gardner.

The spinoffs in gym equipment, aerobics instruction, gym clothing and footwear is expected to be staggering.

There are an estimated 600-800 gyms nationwide with about 3 000 qualified instructors, and an estimated equal number that are unqualified.

But gyms are not the only places where expansion is taking place. The Run-Walk for Life concept, started in the mid 1980s, which offers supervised group running and walking programmes, has a membership close to 10 000.

Experts say it is the tip of the iceberg of what is yet to come.

Major companies are expected to get in on the act. Already Standard Bank in Johannesburg has devoted an entire floor for a gym for its employees, with a staff of six. An estimated 800 people use the gym daily. It includes four squash courts, 15 computerised cycles, four treadmills and a full range of weight-training machines.

Profitness International, who specialises in designing and installing coorporate gyms, has completed four this year with four more being planned for next year. Each can cost about R15 000 for a company with 20 or fewer staff members, to over R100 000.

Experts say the gym industry has a long way to go to match development in the United States where health and fitness rank in the top 30 in terms of contribution to gross national product, but it is surely going strong.

The future of the small, intimate gym may lie in the balance with all the large development taking place, but Avril Yon, the owner of Zeta's Aerobic Studio, situated in a dingy building in Lansdowne Road, Cape Town, believes that the small gym has a place in the sun. She has about 40 members — all female, but for one male member.

Pat Peters, owner of Pat's Health and Fitness Centre, the only one in Grassy Park on the Cape Flats, agrees that the small gym is here to say.

"We don't need all that fancy equipment to get people fit. All one needs is a space for aerobics and showers."

Pat's studio has about 300 members, a figure that constantly fluctuates because of the high dropout rate (a feature of all gyms).

Yon says the size of her outfit guarantees a closeness and camaraderie that can never be attained at the large swanky gyms in Cape Town. She stresses the importance of health education among her members. She collected money for the Health Foundation this year and entered four teams in the Twilight Run.

An innovation at her gym is a plan to teach crèche-going children coordination exercises free of charge.

While Dr Marrison of the Health Foundation argues for a community based health system, he is adamant that the responsibility does not lie with his organisation, but with the State.

The foundation offers diploma courses in aerobics instruction and doubles as a service body to various commercial organisations that include organisations for gym owners; qualified gym instructors; sports coaches for running and triathlon; workplace fitness; fitness consultants and a community based health promotion project.

Pat Peters, however, is not impressed with the Health Foundation's work in the community.

"I've paid my membership fee of R250 a year, but got nothing out of it, beside a diploma."

"They must come out here, even if it's once or twice a year."

He says the courses being offered for gym instructors is a rip-off.

"Once you are qualified, there is no follow up. What is it for the Health Foundation to come out and bring one nutritionist with them to speak to my instructors?"

He agrees with Marrison, though, that it is necessary for the government to get in on the health and fitness act.

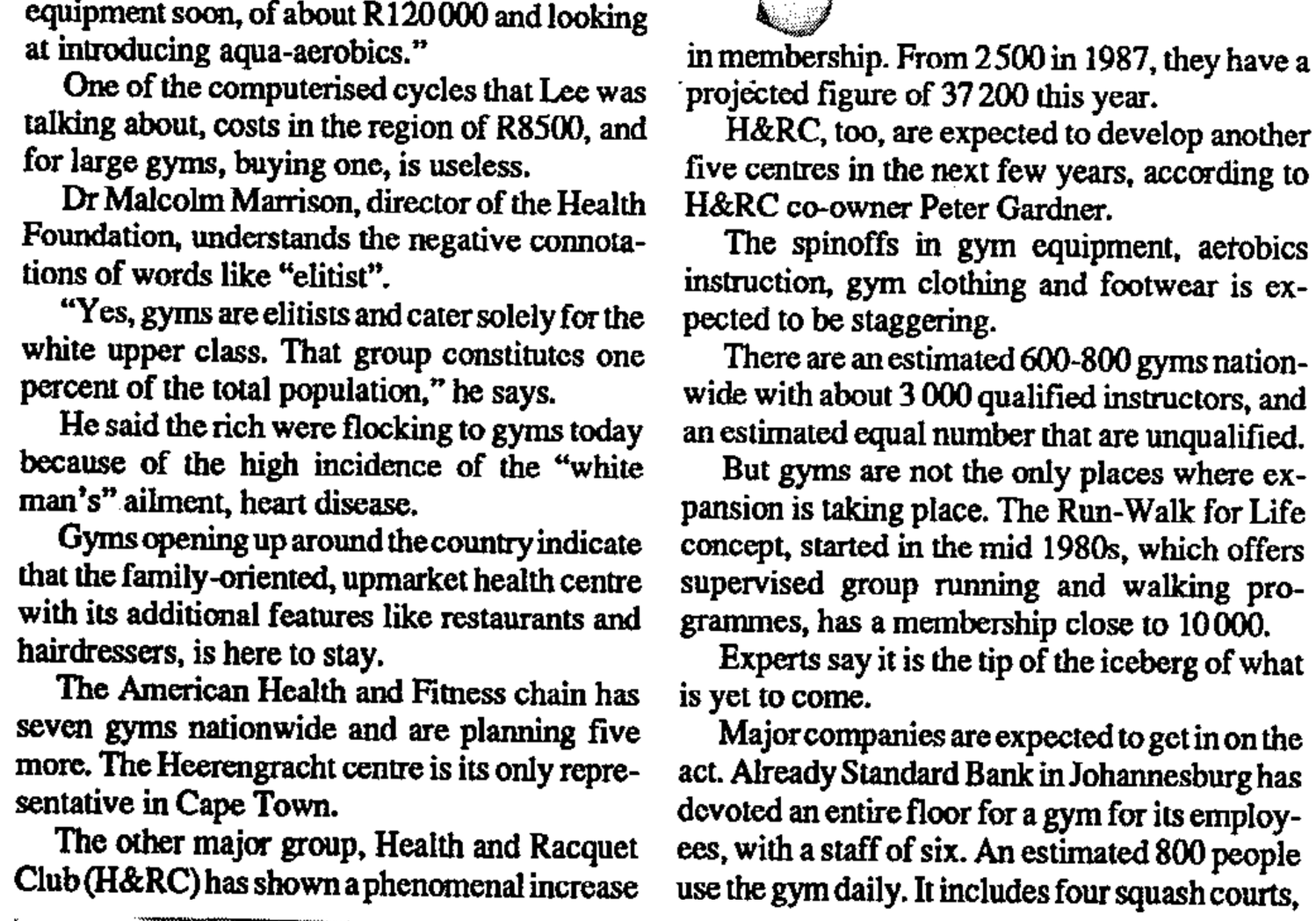
Marrison argues that gyms will change drastically in the 10 years to cater for the need of a vast amount of black sportspeople. He says there are more bodybuilders in Soweto alone than in the entire country.

He was quite critical of the "boy meet girl" aspect of many upmarket gyms.

"One of the reasons for the failure of The Point in Green Point is that their entire marketing was based on how glossy the place looked. People went there in their designer clothes and watched others exercise. Gyms are part of body image, there is nothing wrong with that. But if it is overemphasised, then it is wrong."

While small operations continue to struggle, the experts predict that the upmarket health and fitness industry will continue to boom, but only for those with the spare change in their wallets.□

ILLUSTRATION: Yunus Mahomed



The silent killers: Fear, ignorance and superstition

By PHILIPPA GARSON

A TIRED woman walks into the Hillbrow Hospital's breast clinic and patiently takes her place in the queue. Her face is drawn, she has travelled miles and she is ill — very ill.

She has a lump in her breast so big that a mastectomy is surgically impossible. And the cancer has spread to other parts of her body.

She discovered the lump in her breast a long time ago but thought it came from keeping coins in her bra. She visited a sangoma who gave her a poultice. By the time she visited the clinic the cancer had spread dangerously.

Research shows this to be a typical case study among black women living in rural areas.

Breast cancer has become a killer because of a lack of knowledge about the essentially curable disease.

Medical practitioners say most black women with breast cancer wait until the disease is advanced before they seek medical help, do not return for follow-up treatment and are thus less likely to be cured.

Dr Lesley Seymour, based at the breast clinics at Hillbrow and Johannesburg hospitals, sees a marked difference between the patients at the two hospitals. "At Johannesburg (with mainly white and Asian patients) it is unusual to find women who have not had mastectomies. At Hillbrow, the disease has spread to the extent that it is too late for surgery."

Most of the Hillbrow patients arrive with cancer that has reached stage three (the lesion in the breast is over 5cm) or stage four (the cancer has spread to other parts of the body).

"Sometimes they have enormous tumours in the breast which are difficult to treat as they have grown into the chest wall, even through into the lung."

Seymour describes this condition as a "surgical nightmare".

Seventy percent of breast cancer sufferers at Hillbrow Hospital do not return for follow-up treatment due to socio-economic conditions. People from outlying areas are too poor to pay for transport and would rather not come for treatment than risk losing their jobs. Others think they are cured after a couple of treatments.

Sister Joyce Lehoka started the breast cancer clinic at GaRankua Hospital eight years ago and says only 10 percent of their patients come while the disease is at an early stage. The hospital services mainly rural areas.

Two years ago Lehoka researched the prevailing attitudes of 100 breast cancer patients.

Almost half of them thought the lump in their breast was an abscess which "would open up, release puss and heal". Roughly 35 percent were "unalarmed", taking no immediate action. The rest saw the lump as either caused by their baby burping on the breast during feeding, keeping coins inside their bra, or a witch's curse.

One woman, who had fought with her in-laws, believed they had sent the lump to her breast. She paid a diviner to remove the lump.

Ninety of the 100 patients first consulted traditional healers, churches or the clinics when the cancer was at an advanced stage. The clinics were often slow to refer patients to hospitals with cancer-treating facilities.

Many women believed their "abscesses" had to be "doctored" by traditional healers or home-made potions which would "spit out" the pain and poison.

They are loath to have mastectomies, fearing the ancestors will not accept them if they are buried without parts of their bodies or that the removal of the left breast will affect their hearts, says Lehoka. And Venda women often bare their breasts in the hot climate and during traditional dancing.

More patients bank on their own blood

Star 28/3/91.

299

Patients scheduled for major surgery now have the option of donating their own blood before the operation if certain medical requirements are met. This will conserve blood bank supplies, and eliminate "unnecessary" fears of Aids infection.

Blood donor screening today is intense and exhaustive, with more and more tests being done to rule out contaminated blood, but "zero-risk blood supply" (for all dangers) remains unattainable.

And while Aids has transformed the world of blood banking, experts say unreasonable panic has set in.

They point out that Aids is not the only danger involved in a blood transfusion. There are other diseases, some newly evolving, or adverse allergic reactions to blood transfusion that pose a danger.

At the same time, the South African public has been reassured about the precautions taken to ensure the safest possible blood supply.

The perfect match for a transfusion is to be found in the world trend towards autologous blood — blood donated by patients for their own use.

At the 24th National Blood Transfusion Congress held in Sandown this week, the South Texas Blood Bank chief executive, Dr Norman Kalmin, spoke about trends towards autologous blood and "directed transfusion" — blood donated by a nominated donor, usually a family member.

Another trend was "intraoperative autologous transfusion", in which blood that would have been "lost" during the operation is collected, processed and returned to the patient.

Dr Kalmin, a graduate of the University of the Witwatersrand who later moved abroad, says more tests are being done on donated blood now than ever before to ensure safety.

He says although "zero-risk blood supply" for all danger factors remains unattainable, there are very few cases of Aids transmission through transfusions.

Medical science is exploring ways in which to inactivate any infectious agent in blood through heat, washing, irradiation or various chemical means.

The official launch in August last year by the Natal Blood Transfusion Services (NBTS) of its autologous pre-operative donation programme offers patients new alternatives ... and peace of mind. Other blood transfusion services, such as the Highveld Blood Transfusion Service, offer similar facilities on request.

The aim is to use autologous blood for operations when there is enough time beforehand to collect enough units. (Only one unit a week is generally collected.)

Apart from the advantage to the patient, the NBTS sees autologous blood as a way of conserving homologous blood (voluntarily donated blood banked on a continuous basis).

With autologous donors, patients are offered unique protection, as "unfounded Aids fears are allayed and any risks of allergic reactions or the formation of antibodies to donor blood are eliminated", says NBTS marketing manager Pam Larkin.

At this week's congress, Mrs Larkin outlined the criteria for autologous blood supply:

- A fixed date for surgery.
- Enough time before surgery for collecting the number of units needed.
- Health that would withstand repeated donation over a short time.

Using one's own blood is cheaper only if more than two units of blood are used, even though blood banks charge scale of benefit rates.

Mrs Larkin stresses the programme is seen as a "conservation measure rather than a programme introduced because of Aids".

The feasibility of banking blood for own use in case of emergencies is restricted by numerous factors, not least of which is that blood has a banking life of a maximum 42 days.

CARINA LE ORANGE

'Don't pay hospital fees' call

C | Press 31/3/91

By SOPHIE TEMA (299)

THE South African Health Workers' Congress (Sahwco) and the National Education and Health Workers' Union (Nehawu) have called on patients not to pay increased hospital tariffs, which they say are "malicious".

The call by the two organisations follows the announcement by the Transvaal Provincial Administration (TPA) for sharp increases in hospital fees.

The TPA said the increases were an "interim measure" before the introduction of national uniform tariffs on April 1, 1993.

Sahwco and Nehawu called on patients not to pay the increases in the light of the "appalling services" rendered to patients.

A statement by the organisations said racism was still rife in most hospitals and there had been no material change since the assurance by the Health Minister last year that health services must be "equitable, affordable and accessible to all".

The organisations called on all patients affected by the increases not to pay until the responsible authorities consulted the relevant communities.

A Sahwco spokesman said: "Sahwco, together with its fraternal organisations, has long demanded a moratorium on the increasing of hospital tariffs.

"Present increases are in complete contrast to the assurances given by the authorities that the matter will be sympathetically considered.

"The increases will no doubt overburden the poorest sections of our communities.

"Health authorities, apart from perpetuating the discriminatory system, are also guilty of the most patently incompetent services."

Towards a healthier SA

Star 4/4/91

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South Africa's health priorities for the future is the main thrust of a task force appointed by the Medical Research Council.

The group will try to determine, among other things, what changes are needed to ensure that the World Health Organisation's goal of health for all is attained and what is needed in terms of research priorities and the training of researchers.

A report will be circulated during the second half of this year, says an article in the latest issue of the SA Medical Journal.

Members of the research, academic and service sectors, as well as the general public will be asked to give oral and written input.

Anyone interested in contributing can contact the national coordinator Dr Derek Yach on (021) 932-0311.

TRENDS REPORTER

SCHEDULE

1. In these regulations "the Act", shall mean the Medical Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974), and any expression to which a meaning has been assigned in the Act shall bear such meaning, unless the context otherwise indicates.

2. The following acts are hereby specified as acts that shall, for the purposes of the Act, be deemed to be acts pertaining to the profession of clinical technology, which acts shall be performed as an auxilliary service to medicine:

(a) Clinical technology in general:

(i) The performance, in collaboration with a medical practitioner, of clinical investigative procedures with the aid of appropriate apparatus and techniques.

(ii) The performance of corrective and therapeutic procedures in collaboration with a medical practitioner.

(b) Cardiology: The performance of non-invasive special procedures and the provision of assistance to a medical practitioner in the handling of electronic apparatus used during invasive procedures for the purpose of obtaining data in order to support or confirm the diagnosis of or to identify a specific cardiac disease.

(c) Cardiovascular perfusion: The usage of extra-corporeal apparatus to support or take over the patients' circulatory and respiratory function temporarily.

(d) Critical care: The support of the medical practitioner in the handling of life-support equipment in critical care situations.

(e) Nephrology: The performance of extra-corporeal procedures in the field of nephrology, as well as apheresis with the appropriate apparatus.

(f) Neurophysiology: The performance of electrophysiological procedures, as well as tests on the brain, nervous system and muscular systems of the patient.

(g) Pulmonology: The performance of lung function examinations with the aid of electronic and computerised equipment in order to support and confirm the diagnosis of respiratory disease.

(h) Reproductivity biology: The evaluating and determining of the extent, nature and degree of infertility in couples with a view to a diagnosis by a medical practitioner, and the performance of procedures to attain a successful pregnancy.

BYLAE

1. In hierdie regulasies beteken "die Wet" die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1974 (Wet No. 56 van 1974), en het 'n uitdrukking waaraan 'n betekenis in die Wet toegeken is daardie betekenis, tensy uit die samehang anders blyk.

2. Die volgende handelinge word hierby bepaal as handelinge wat by die toepassing van die Wet geag word handelinge te wees wat by die beroep kliniese tegnologie tuishoort en as 'n aanvullende diens by geneeskunde verrig word:

(a) Kliniese tegnologie in die algemeen:

(i) Die uitvoer, in samewerking met 'n geneesheer, van kliniese ondersoekprosedures met behulp van toepaslike apparaat en tegnieke.

(ii) Die uitvoer van korrektiewe en terapeutiese prosedures in samewerking met 'n geneesheer.

(b) Kardiologie: Die uitvoer van nie-indringende spesiale prosedures en die assistering van 'n geneesheer met die hantering van elektroniese apparaat wat gebruik word gedurende indringende prosedures met die doel om data in te win ten einde 'n diagnose te ondersteun of te bevestig of 'n spesifieke hartsiekte te identifiseer.

(c) Kardiovaskulêre perfusie: Die gebruik van ekstrakorporeale apparaat om die pasiënte se bloedsomloop en respiratoriese funksie tydelik oor te neem of te ondersteun.

(d) Kritieke sorg: Die ondersteuning van die geneesheer by die hantering van lewensondersteunende toerusting in kritieke sorgsituasies.

(e) Nefrologie: Die uitvoer van ekstrakorporeale prosedures op die gebied van nefrologie asook die toepassing van aforese met behulp van die toepaslike apparaat.

(f) Nefrofisiologie: Die uitvoer van elektrofisiologiese prosedures, asook toetse op die brein, senuweestelsel en spiersisteem van die pasiënt.

(g) Pulmonologie: Die uitvoer van longfunksieondersoeke met behulp van elektroniese en gerekanariseerde toerusting ten einde die diagnose van respiratoriese siektes te ondersteun en te bevestig.

(h) Reproduktiewe biologie: Die evaluering en bepaling van die omvang, aard en graad van onvrugbaarheid by ouerpare met die oog op 'n diagnose deur 'n geneesheer en die uitvoer van prosedures om suksesvolle swangerskap te bewerkstellig.

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TRANSVAAL PROVINCIAL ADMINISTRATION

No. R. 710 **5 April 1991**

REGULATIONS RELATING TO THE CLASSIFICATION OF AND FEES PAYABLE BY PATIENTS AT PROVINCIAL HOSPITALS.—AMENDMENT

The Administrator of the Province of the Transvaal has on behalf of the Minister of Health Services, Welfare and Housing: House of Assembly, under sections 38 and 76 of the Hospitals Ordinance, 1958 (Ordinance No. 14 of 1958) (Transvaal), in so far as the administration of the provisions of those sections was assigned by State President's Proclamation No. 42 of 1989 to that Minister, read in conjunction with the written authorisation of that Minister under section 15 (1B) of the Provincial Government Act, 1986 (Act No. 69 of 1986), made the regulations contained in the Schedule hereto, with effect from 1 April 1991.

TRANSVAAL PROVINSIALE ADMINISTRASIE

No. R. 710 **5 April 1991**

REGULASIES BETREFFENDE DIE INDELING VAN, EN GELDE BETAALBAAR DEUR, PASIËNTE BY PROVINSIALE HOSPITALE.—WYSIGING

Die Administrateur van die provinsie Transvaal het kragtens artikels 38 en 76 van die Ordonnansie op Hospitale, 1958 (Ordonnansie No. 14 van 1958) (Transvaal), vir sover die uitvoering van die bepalings van daardie artikels by Staatspresidentsproklamasie No. 42 van 1989 aan die Minister van Gesondheidsdienste, Welsyn en Behuising: Volksraad opgedra is, saamgelees met die skriftelike magtiging van daardie Minister kragtens artikel 15 (1B) van die Wet op Provinsiale Regering, 1986 (Wet No. 69 van 1986), die regulasies in die Bylae namens daardie Minister uitgevaardig.

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SCHEDULE

Definition

1. In these Regulations "the Regulations" means the Regulations relating to the Classification of and Fees payable by Patients at Provincial Hospitals, promulgated by Administrator's Notice No. 616 of 12 June 1968, as amended by Administrator's Notice No. 929 of 26 June 1973, Administrator's Notice No. 341 of 17 March 1976, Administrator's Notice No. 725 of 18 June 1980, Administrator's Notice No. 341 of 17 March 1982, Administrator's Notice No. 490 of 21 March 1984, Administrator's Notice No. 454 of 27 February 1985, Administrator's Notice No. 653 of 27 March 1985, Administrator's Notice No. 415 of 26 February 1986, Administrator's Notice No. 996 of 1 July 1987, Administrator's Notice No. 1979 of 30 December 1987, Administrator's Notice No. 646 of 1 June 1988, Administrator's Notice No. 502 of 28 June 1989, Administrator's Notice No. 44 of 31 January 1990 and Administrator's Notice No. 344 of 1 August 1990 in so far as those regulations relate to members of the White population group and the hospitals referred to in paragraph (a) (ii) of State President's Proclamation No. 42 of 1989.

Amendment of regulation 1 of Regulations

2. Regulation 1 of the Regulations is hereby amended—

(a) by the insertion after the definition of "applicant" of the following definition:

" 'assets' means the total value of a person's fixed and movable assets;";

(b) by the deletion of the definitions of "family income" and "household"; and

(c) by the insertion before the definition of "Hospital" of the following definition:

" 'family unit' means a household consisting of a breadwinner with one or more dependants:".

Amendment of regulation 2 of Regulations

3. Regulation 2 of the Regulations is hereby amended by the substitution for paragraph (b) of subregulation (1) of the following paragraph:

"(b) his income and assets:".

Amendment of regulation 3 of Regulations

4. Regulation 3 (4) of the Regulations is hereby amended—

(a) by the substitution in paragraph (a) of subregulation (4) of the Regulations for the expression "5 (1) (d) (ii)" of the expression "5 (1) (e) (ii)"; and

(b) by the substitution in paragraph (b) of subregulation 4 for the expression "5 (1) (f) (ii)" of the expression "5 (1) (g) (ii) (dd) and 5 (1) (g) (iii) (cc)."

Amendment of regulation 4 of Regulations

5. Regulation 4 of the Regulations is hereby amended by the substitution for the expression "5 (1) (f) (ii)" wherever it occurs, of the expression "5 (1) (g) (ii) (d) and 5 (1) (g) (iii) (cc).".

BYLAE

Woordomskrywing

1. In hierdie Regulasies beteken "die Regulasies" die Regulasies betreffende die Indeling van, en Gelde betaalbaar deur, Pasiënte by Provinsiale Hospitale afgekondig by Administrateurskennisgewing No. 616 van 12 Junie 1968, soos gewysig deur Administrateurskennisgewing No. 929 van 26 Junie 1973, Administrateurskennigewing No. 341 van 17 Maart 1976, Administrateurskennisgewing No. 725 van 18 Junie 1980, Administrateurskennisgewing No. 341 van van 17 Maart 1982, Administrateurskennisgewing No. 490 van 21 Maart 1984, Administrateurskennisgewing No. 454 van 27 Februarie 1985, Administrateurskennisgewing No. 653 van 27 Maart 1985, Administrateurskennisgewing No. 415 van 26 Februarie 1986, Administrateurskennisgewing No. 996 van 1 Julie 1987, Administrateurskennisgewing No. 1979 van 30 Desember 1987, Administrateurskennisgewing No. 646 van 1 Junie 1988, Administrateurskennisgewing No. 502 van 28 Junie 1989, Administrateurskennisgewing No. 44 van 31 Januarie 1990 en Administrateurskennisgewing No. 344 van 1 Augustus 1990 vir sover daardie regulasies op die Blanke bevolkingsgroep en die hospitale in paragraaf (a) (ii) van Staatspresidentsproklamasie No. 42 van 1989 genoem, betrekking het.

Wysiging van Regulasies

2. Regulasie 1 van die Regulasies word hierby gewysig—

(a) deur na die omskrywing van "applikant" die volgende omskrywing in te voeg:

" 'bates' die totale waarde van 'n persoon se vaste en roerende bates;";

(b) deur die omskrywings van "gesinsinkomste" en "gesinstal" te skrap; en

(c) deur voor die omskrywing van "hospitaal" die volgende omskrywing in te voeg:

" 'gesinseenheid' 'n huishouding wat uit 'n broodwinner met een of meer afhanklikes bestaan;".

Wysiging van regulasie 2 van die Regulasies

3. Regulasie 2 van die Regulasies word hierby gewysig deur paragraaf (b) van subregulasie (1) deur die volgende paragraaf te vervang:

"(b) sy inkomste en bates:".

Wysiging van regulasie 3 van die Regulasies

4. Regulasie 3 van die Regulasies word hierby gewysig—

(a) deur in paragraaf (a) van subregulasie (4) die uitdrukking "5 (1) (d) (ii)" deur die uitdrukking "5 (1) (e) (ii)" te vervang; en

(b) deur in paragraaf (b) van subregulasie (4) die uitdrukking "5 (1) (f) (ii)" deur die uitdrukking "5 (1) (g) (ii) (dd) en 5 (1) (g) (iii) (cc)" te vervang.

Wysiging van regulasie 4 van Regulasies

5. Regulasie 4 van die Regulasies word hierby gewysig deur die uitdrukking "5 (1) (f) (ii)" oral waar dit voorkom, deur die uitdrukking "5 (1) (g) (ii) (dd) en 5 (1) (g) (iii) (cc)." te vervang.

Amendment of regulation 5 of Regulations

6. Regulation 5 of the Regulations is hereby amended by the substitution for subregulation (1) of the following subregulation:

"(1) Subject to subregulation (3) every applicant shall be classified according to his or her income in the appropriate classification and tariff category as follows and as indicated in Schedule A to these Regulations, namely if he or she—

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Wysiging van regulasie 5 van Regulasies

6. Regulasie 5 van die Regulasies word hierby gewysig deur subregulasie (1) deur die volgende subregulasie te vervang:

"(1) Behoudens subregulasie (3) word elke applikant volgens sy of haar inkomste soos volg en soos in Bylae A by hierdie Regulasies aangedui in die toepaslike indelings- en tariefkategorie ingedeel, naamlik indien hy of sy:

	Classification category	Tariff category
(a) is classified as an exempted patient in terms of section 36 (b) of the Ordinance but in default of such exemption would have been classified as a party-paying patient	Hospital exempted	HG
(b) receives a pension or an allowance in terms of the Social Pensions Act, 1973	Part-paying	H1
(c) has an income of—		
(aa) not more than R7 000, in respect of a single person, or with assets of not more than R35 000	Part-paying	H1
(bb) not more than R13 000 in respect of a family unit or with assets of not more than R65 000	Part-paying	H1
(d) has an income of more than—		
(aa) R7 000 but not more than R10 000 in respect of a single person or with assets of more than R35 000 but not more than R50 000	Part-paying	H2
(bb) R13 000 but not more than R19 000 in respect of a family unit or with assets of more than R65 000 but not more than R95 000	Part-paying	H2
(e) (i) has an income of more than—		
(aa) R10 000, but not more than R15 000 in respect of a single person, or with assets of more than R50 000 but not more than R75 000	Part-paying	H3
(bb) R19 000 but not more than R25 000 in respect of a family unit or with assets of more than R95 000 but not more than R125 000	Part-paying	H3
(ii) is a person as contemplated in regulation 3 (4) (a)	Part-paying	H3
(f) is admitted as—		
an exempted patient classified in terms of section 36 (b) of the Ordinance but in default of such exemption would have been classified as a private patient	Private exempted	PG
(g) (i) has an income of more than—		
(aa) R15 000 in respect of a single person or with assets of more than R75 000	Private	P
(bb) R25 000 in respect of a family unit or with assets of more than R125 000	Private	P
(ii) (aa) is a patient treated by a private medical practitioner, irrespective of his income or assets	Private	P
(bb) is a member of a medical scheme	Private	P
(cc) is a person who is classified in terms of section 32 (1) of the Ordinance and who is treated by a private medical practitioner	Private	P
(dd) is a person as contemplated in regulation 3 (4) (b) or 4 and who is treated by a medical practitioner	Private	P
(iii) (aa) is a private patient admitted in the closed section of an academic hospital and who is treated by a medical practitioner who is in the service of the hospital	Private hospital	PH
(bb) is a person who is classified in terms of section 32 (1) of the Ordinance and who is treated by a medical practitioner in the service of the hospital	Private hospital	PH
(cc) is a person as contemplated in regulation 3 (4) (b) or 4 who is treated by a medical practitioner in the service of the hospital	Private hospital	PH.".

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	Indelings-kategorie	Tarief-kategorie
(a) 'n Vrygestelde pasiënt ingevolge artikel 36 (b) van die Ordonnansie is, maar by ontstentenis van sodanige vrystelling as deelsbetalende pasiënt ingedeel sou word	Hospitaal vrygestel	HG
(b) 'n Pensioen of toelae ingevolge die Wet op Maatskaplike Pensioene, 1973, ontvang	Deelsbetalend	H1
(c) 'n inkomste het van—		
(aa) nie meer as R7 000 nie ten opsigte van 'n enkellopende persoon, of bates van nie meer as R35 000 besit nie	Deelsbetalend	H1
(bb) nie meer as R13 000 nie, ten opsigte van 'n gesinseenheid, of bates van nie meer as R65 000 besit nie	Deelsbetalend	H1
(d) 'n inkomste het van—		
(aa) R7 000 maar nie meer as R10 000 nie ten opsigte van 'n enkellopende persoon of bates van meer as R35 000 maar nie meer as R50 000 besit nie	Deelsbetalend	H2
(bb) R13 000 maar nie meer as R19 000 nie ten opsigte van 'n gesinseenheid of bates van meer as R65 000 maar nie meer as R95 000 besit nie	Deelsbetalend	H2
(e) (i) 'n inkomste het van meer as—		
(aa) R10 000 maar nie meer as R15 000 nie, ten opsigte van 'n enkellopende persoon, of bates van meer as R50 000 maar nie meer as R75 000 besit nie	Deelsbetalend	H3
(bb) R19 000 maar nie meer as R25 000 nie, ten opsigte van 'n gesinseenheid, of bates van meer as R95 000 maar nie meer as R125 000 besit nie	Deelsbetalend	H3
(ii) 'n persoon is soos in regulasie 3 (4) (a) beoog	Deelsbetalend	H3
(f) opgeneem is as—		
'n vrygestelde pasiënt ingevolge artikel 36 (b) van die Ordonnansie, maar by ontstentenis van sodanige vrystelling as private pasiënt ingedeel sou word	Privaat vrygestel	PG
(g) (i) 'n inkomste het van meer as—		
(aa) R15 000 ten opsigte van 'n enkellopende persoon, of bates van meer as R75 000 besit	Privaat	P
(bb) R25 000 ten opsigte van 'n gesinseenheid, of bates van meer as R125 000 besit	Privaat	P
(ii) (aa) 'n pasiënt is wat deur 'n private geneesheer behandel word, ongeag sy inkomste of bates	Privaat	P
(bb) 'n lid is van 'n mediese skema	Privaat	P
(cc) 'n persoon is wat ingevolge artikel 32 (1) van die Ordonnansie ingedeel word en deur 'n private geneesheer behandel word	Privaat	P
(dd) 'n persoon is soos in regulasie 3 (4) (b) of 4 beoog en deur 'n private geneesheer behandel word	Privaat	P
(iii) (aa) 'n private pasiënt in die geslote gedeelte van 'n akademiese hospitaal is, wat deur 'n geneesheer in diens van die hospitaal behandel word	Privaathospitaal	PH
(bb) 'n persoon is wat ingevolge artikel 32 (1) van die Ordonnansie ingedeel word en deur 'n geneesheer in diens van die hospitaal behandel word	Privaathospitaal	PH
(cc) 'n persoon is soos in regulasie 3 (4) (b) of 4 beoog en deur 'n geneesheer in diens van die hospitaal behandel word	Privaathospitaal	PH.".

Amendment of regulation 7 of Regulations

7. Regulation 7 of the Regulations is hereby amended by the substitution in paragraph (b) of subregulation (1) for the expression "family income" wherever it occurs, of the expression "income";

Amendment of regulation 9 of Regulations

8. Regulation 9 of the Regulations is hereby amended by the addition of the following paragraph to paragraph (b) of subregulation (2):

"(iv) of any professional services:".

Wysiging van regulasie 7 van Regulasies

7. Regulasie 7 van die Regulasies word hierby gewysig deur in paragraaf (b) van subregulasie (1) die uitdrukking "gesinsinkomste" oral waar dit voorkom deur die uitdrukking "inkomste" te vervang.

Wysiging van regulasie 9 van Regulasies

8. Regulasie 9 van die Regulasies word hierby gewysig deur die volgende subparagraaf by paragraaf (b) van subregulasie (2) te voeg:

"(iv) van enige professionele dienste.".

Amendment of Schedule A to Regulations

9. The following Schedule is hereby substituted for Schedule A to the Regulations:

Wysiging van Bylae A by Regulasies

9. Bylae A by die Regulasies word hierby deur die volgende Bylae vervang:

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"SCHEDULE A

CLASSIFICATION AND TARIFF CATEGORIES BASED ON INCOME AND FAMILY UNIT

Family Unit	Hospital Patients				Private Patients		
	Hospital/Gratis	Part-paying			Private/Gratis	Private	Private hospital
	HG	H1	H2	H3	PG	P	PH
	An exempted patient in terms of section 36 (b) of the Ordinance classified in terms of Regulation 5 (1) (a)	A person who receives a pension or an allowance in terms of the Social Pensions Act, 1973, and has an income of—	A person who has an income of more than—	A person as contemplated in Regulation 3 (4) (a) or a person who has an income of more than—	An exempted patient in terms of section 36 (b) of the Ordinance classified in terms of Regulation 5 (1) (f)	(1) A person treated by a private medical practitioner irrespective of his income or assets (2) A member of a medical aid scheme (3) A person who is classified in terms of section 32 (1) of the Ordinance and treated by a private medical practitioner (4) A person who has an income of more than—	(1) A private patient admitted in the closed section of an academic hospital and who is treated by a medical practitioner who is in the service of the hospital (2) A person who is classified in terms of section 32 (1) of the Ordinance and who is treated by a medical practitioner in the service of the hospital (3) A person as contemplated in Regulation 3 (4) (b) and 4 and who is treated by a medical practitioner in the service of the hospital
Single		Not more than R7 000 or with assets of not more than R35 000	R7 000 but not more than R10 000 or with assets of more than R35 000 but not more than R50 000	R10 000 but not more than R15 000 or with assets of more than R50 000 but not more than R75 000		R15 000 or with assets of more than R75 000	
Family unit		Not more than R13 000 or with assets of not more than R65 000	R13 000 but not more than R19 000 or with assets of more than R65 000 but not more than R95 000	R19 000 but not more than R25 000 or with assets of more than R95 000 but not more than R125 000		R25 000 or with assets of more than R125 000	

Amendment of Schedule B to Regulations

10. Schedule B to the Regulations is hereby amended—

(a) By the substitution for the table "TARIFF OF FEES" of the following table:

Wysiging van Bylae B by Regulasies

10. Bylae B by die Regulasies word hierby gewysig—

(a) deur die tabel "TARIEWE VAN GELDE" deur die volgende tabel te vervang:

TARIFFS OF FEES

Category	In-patients		Outpatients		All hospitals			Maternity cases				Other additional costs
	Hospital		Hospital					Hospital				
								Community		Regional and Teaching		
	Community	Regional and Academic	Community	Regional and Academic	Theatre fees: Out-patients	Threatre fees: In-patients	Radiographic services	Confinement in hospital	Confinement at home	Confinement in hospital	Confinement at home	
HG	Exempted	Exempted	Exempted	Exempted	Exempted	Exempted	Exempted	Exempted	Exempted	Exempted	Exempted	Exempted
H1	R17 per admission	R21 per admission	R8 per attendance	R10 per attendance	—	—	—	R40 per confinement	R40 per confinement	R65 per confinement	R65 per confinement	—
H2	R41 per day	R52 per day	R15 per attendance	R20 per attendance	—	—	—	R41 per day (min R106)	R106 per confinement	R52 per day (min. R157)	R157 per confinement	—
H3	R81 per day	R103 per day	R25 per attendance	R30 per attendance	—	—	—	R81 per day (min. R176)	R206 per confinement	R103 per day (min R258)	R258 per confinement	—
PG	Exempted	Exempted	Exempted	Exempted	Exempted	Exempted	Exempted	Exempted	Not applicable	Exempted	Not applicable	—
P and PH	R161 per day	R205 per day	R40 per attendance	R55 per attendance	As per item 1 (b) and (c) of this Schedule	As per item 1 (a) and (c) of this Schedule	As per item 2 of this Schedule	R161 per day	Not applicable	R205 per day	Not applicable	As per items 3 to 8 of this Schedule.".

Note:

(a) Out-patient fees in respect of out-patients receiving group therapy/therapeutic exercises are payable once per month (30 days), irrespective of the number of attendances.

(b) Private patients who are specifically referred for one or more special services/examinations as determined by the Deputy Director General: Health Services from time to time, are exempted from the payment of out-patient fees if no further treatment/examination are received at te hospital. Only the services/examinations must be paid for.

(b) by the substitution for Item 1 of the following Item:

"1. Theatre fees

	Community hospitals	*Regional and hospitals*
(a) In-patients:		
Basic	R115,00	R115,00
Plus: per minute:		
First 60 minutes	R 4,80	R 6,00
More than 60 minutes	R 6,50	R 8,00
(b) Out-patients:		
Basic	R 56,00	R 56,00
Plus: per minute	R 1,40	R 1,40
(c) After-hours levy: (Weekdays from 17:00 to 07:00 and Saturdays, Sundays and public holidays);";	R 70,00 per operation	R 70,00 per operation

(c) by the substitution for Item 2 of the following Item:

"2. Radiographic Services: According to the scale of benefits of medical schemes;";

(d) by the substitution for Item 4 of the following Item:

"4. Intensive care

All private and full-paying patients, other than Category PG:

Community hospitals R388 per day

Regional and teaching hospitals R484 per day;";

(e) by the substitution in Item 5 for the expressions "R192", and "R240" of the expressions "R238" and "R298";

(f) by the substitution for Item 7 of the following Item:

"7. The supply to—

(a) private and fully-paying in-patients, including patients admitted to a closed hospital contemplated in section 58 (2) of the Ordinance, of medicine which has not been made available by the Deputy Director General: Health Services: Costs plus 100%;

(b) private and full-paying patients admitted to a closed hospital contemplated in section 58 (2) of the Ordinance, of pathological examinations or services: The scale of benefits of medical schemes;

(c) private and full-paying patients admitted to a closed hospital contemplated in section 58 (2) of the Ordinance, of professional services: 30% of the ward tariff for the full stay in the hospital."

(g) by the substitution for Item 8 of the following Item:

"8. Use of hospital apparatus:

Croupettes:

Per day or part thereof	R6,00

Incubators:

Per day or part thereof	R12,00

Oxygen tents:

Per day or part thereof	R10,00

(b) deur Item 1 deur die volgende Item te vervang:

"1. Teatergelde

	Gemeenskaps-hospitale	*Streeks- en akademiese hospitale*
(a) Binnepasiënte:		
Basies	R115,00	R115,00
Plus: per minuut:		
Eerste 60 minute	R 4,80	R 6,00
Meer as 60 minute	R 6,50	R 8,00
(b) Buitepasiënte:		
Basies	R 56,00	R 56,00
Plus: per minuut	R 1,40	R 1,40
(c) Na-uurse heffing: (Weeksdae vanaf 17:00 tot 07:00 en Saterdae, Sondae en openbare feesdae)";	R 70,00 per operasie	R 70,00 per operasie

(c) deur Item 2 deur die volgende Item te vervang:

"2. Radiografiese dienste: voordeleskaaltariewe van mediese skemas.";

(d) deur Item 4 deur die volgende Item te vervang:

"4. Intensiewe sorg

Alle private en volbetalende pasiënte, uitgesonderd Kategorie PG:

Gemeenskapshospitale R388 per dag

Streeks- en akademiese hospitale R484 per dag;";

(e) deur in Item 5 die uitdrukkings: "R192" en "R240" deur die uitdrukkings "R238" en "R298" te vervang;

(f) deur Item 7 deur die volgende Item te vervang:

"7. Die verskaffing aan—

(a) private en volbetalende pasiënte, met inbegrip van pasiënte wat opgeneem is in 'n geslote hospitaal in artikel 58 (2) van die Ordonnansie beoog, van medisyne wat nie deur die Adjunk-direkteur-generaal: Gesondheidsdienste vir verskaffing aan hierdie pasiënte beskikbaar gestel is nie: Koste plus 100%;

(b) private en volbetalende pasiënte wat opgeneem is in 'n geslote hospitaal in artikel 58 (2) van die Ordonnansie beoog, van patologiese ondersoeke of dienste: Die voordeleskaal van mediese skemas-tariewe;

(c) private en volbetalende binnepasiënte wat opgeneem is in 'n geslote hospitaal in artikel 58 (2) beoog, van professionele dienste: 30% van die saalgelde ten opsigte van die volle verblyf in die hospitaal;".

(g) deur Item 8 deur die volgende Item te vervang:

"8. Gebruik van hospitaalapparaat:

Croupettes:

Per dag of deel daarvan	R6,00

Broeikaste:

Per dag of deel daarvan	R12,00

Suurstoftente:

Per dag of deel daarvan	R10,00

Bennett MA, Servo and Beares respirator, or equivalent (in ICU, and high care ward only):	
Per day or part thereof	R95,00
CUSA	R460,00
Lasers - Argon (ophthalmic)	R143,00
Lasers - CO2 (surgical)	R184,00
Oximeters (in theatre only)	R20,00
Occutomes	R61,00
Lasers - YAG (ophthalmic)	R161,00
Lasers - YAG (surgical)	R200,00
Gastroscope (Fibreoptic/flexible only)	R30,00
Colonoscope (Fibreoptic/flexible only)	R30,00
Monitors (3 channel) in ICU only	R28 per day or part thereof
Ventilators (Bennett PR2 or equivalent)	R21 per day or part thereof
Duodenoscope (Fibreoptic/flexible only).	R30,00
Sigmoidoscope (Fibreoptic/flexible only)	R30,00
Bronchoscope (Rigid or flexible)	R15,00
Laryngoscope (except when used for intubation	R15,00
Sinoscope (Fibreoptice/flexible only)	R15,00
Oesophagoscope	R15,00
Laparoscope	R15,00
Hysteroscope	R15,00
Colposcope	R15,00
Cysto Urethroscope	R15,00
Arthroscope (with closed circuit television facilities and power tools)	R30.00
Arthroscope (without the additional tools listed above)	R15,00
Ultrasonic imaging equipment	R100,00
Urological screening table (including all radiographical equipment).	R135,00.".

Application of Regulations

11. The provisions of these Regulations shall not apply to any person—

(a) who is an in-patient on the day immediately preceding 1 April 1991; or

(b) whose admission and classification as an in-patient has been approved before 1 April 1991,

for a period ending on the date upon which he is discharged from the hospital concerned.

Commencement

12. These Regulations shall come into operation on 1 April 1991.

Bennett MA, Servo en Beares respirators, of gelykwaardige (alleenlik in ISE en hoësorgsale):	
Per dag of deel daarvan	R95,00
Cusa	R460,00
Lasers - Argon (oftalmies)	R143,00
Lasers - CO2 (chirurgies)	R184,00
Oksimeters (alleenlik in teater)	R20,00
Occutome	R61,00
Lasers - YAG (oftalmies)	R161,00
Lasers - YAG (chirurgies)	R200,00
Gastroskoop (alleenlik Veseloptika/ buigbaar)	R30,00
Kolonoskoop (alleenlik Veseloptika/ buigbaar)	R30,00
Monitors (3 kanaal) slegs in ISE	R28 per dag of gedeelte daarvan
Ventilators (Bennett PR2 of gelykwaardig)	R21 per dag of gedeelte daarvan
Duodenoskoop (alleenlik Veseloptika/ buigbaar)	R30,00
Sigmoidoskoop (alleenlik Veseloptika/ buigbaar)	R30,00
Brongoskoop (onbuigbaar of buigbaar)	R15,00
Laringoskoop (behalwe wanneer dit gebruik word vir intubasie)	R15,00
Sinoskoop (alleenlik Veseloptika/buigbaar)	R15,00
Esofagoskoop	R15,00
Laparoskoop	R15,00
Histeroskoop	R15,00
Kolposkoop	R15,00
Sistoüretroskoop	R15,00
Artroskoop (met geslotebaantelevisie fasiliteite en kraggereedskap)	R30,00
Artroskoop (sonder addisionele gereedskap hierbo genoem)	R15,00
Ultrasoniese beeldingstoerusting	R100,00
Urologiese beeldingstafel (sluit alle radiografiese toerusting in)	R135,00.".

Toepassing van Regulasies

11. Die bepalings van hierdie Regulasies is nie op iemand van toepassing nie—

(a) wat op die dag onmiddellik voor 1 April 1991 'n binnepasiënt is; of

(b) wie se toelating en klassifikasie as 'n binnepasiënt voor 1 April 1991 goedgekeur is,

vir 'n tydperk wat op die datum waarop hy uit die betrokke hospitaal ontslaan word eindig.

Inwerkingtreding

12. Hierdie Regulasies tree in werking op 1 April 1991.

FOCUS: *You can't see your medical file — but insurance firms do*

Insurance and privacy

w/mail 5/4-11/4/91.

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CRITICAL CONSUMER

Pat Sidley

SOUTH AFRICAN consumers of health services have no legal right to the information doctors have about them.

In terms of rules within the profession, doctors are obliged to tell patients of the diagnosis and treatment and to furnish some reports of tests, but these are not legal obligations.

However, the information — accurate or not — doctors have on their files can land up on insurance companies' computers and be sent to other companies wanting the information. This could affect the granting of life insurance policies, bonds and other financial transactions.

At no stage would the consumer have any legal right to see the information, to have it altered if it is wrong or being wrongly construed, or to have the information wiped out of a storage system.

The problem begins in the consulting rooms, where the doctor is making notes in a patient's file. If that doctor should botch his diagnosis, the patient would have no right to his notes — a position confirmed in a case in the Eastern Cape division of the supreme court.

A patient applying for life insurance would most likely sign a consent form allowing information in the file to be passed on to the insurance company. This can have disastrous consequences for a patient applying for life cover.

According to doctors, if the patient was tested for a venereal disease some years ago and then more recently for Aids, despite the fact that the tests came back negative, the insurance company's risks department will form a picture of a person whose lifestyle is a risk. While insurance companies spoken to this week tended to say it was "not quite so simple", this position was confirmed by Jurie Wessels of the Life Officers' Association in Cape Town — the association which represents the industry.

A misdiagnosis or misunderstanding could mean higher insurance premiums or a refusal by an insurance firm to insure a patient.

One doctor who works for an insurance company put the following scenario to Critical Consumer: Say for argument's sake every time a patient had a twinge in the chest, the doctor wrote "pneumonia" in the file as a sort of shorthand indication. Some way down the line, the information lands up in an insurance company's hands and the applicant is seen as a risk.

The premium is then loaded or the application is turned down. So the patient applies for life cover to another company, which asks about any other applications the person may have made; the information is made available by one company to the other, and the process continues.

Throughout all of this the patient/applicant may have no idea of what is happening or why.

According to the insurance company doctor, much of the information requested by and furnished to insurance firms is not necessary and constitutes an invasion of privacy. This information is not only seen by the medical officer of the company, who is bound by various oaths to secrecy — it is seen by the underwriters who assess the risk.

The industry spokesmen, who told *The Weekly Mail* several times that doctors were the best judge of the medical history of a patient and were never wrong, said underwriters had to see the information because only they, or risk assessors, could know the risks involved; doctors lacked that knowledge.

According to the industry, there are various protocols worked out between the insurance industry and the Medical Association of South Africa which govern the way in which the information may be used, but these "protocols" lack consumers' input .

The industry has a point when it states, as several of its spokesmen did this week, that nobody has a right to insurance and insurance is a business like any other. If risks are taken incompetently then existing policyholders stand to lose and their rights have to be protected too.

The industry is also emphatic that an applicant who believes an injustice to have been done can ask for the position to be corrected. But the applicant may not know what has happened.

This Critical Consumer believes that while constitutions for the "new South Africa" are being discussed, some protection of individual rights to information about oneself should be enshrined.

New fighter for disabled

Star 3/4/91

Stoep Talk

MICHAEL SHAFTO

At Lawyers for Human Rights, a young lawyer, who is blind, has set himself a monumental task; a task he is tackling in the cause of his own kind: the disabled.

Michael Tshililo Masutha has been just two months in his position as director of the Socio-economic Rights Research Unit of Lawyers for Human Rights, but already he has very definite goals. Mr Masutha's appointment was the direct result of close co-operation between HLR and Disabled People South Africa (DPSA).

The most important of these aims, says Mr Masutha, is the drawing up of a charter for the disabled. It must be produced through the democratic process and in close consultation with disabled people.

Monumental task . . . Michael Masutha.

To get the charter off the ground, he will visit the various regions, setting up workshops and conducting seminars. The purpose is to educate the disabled about their rights and encourage them to raise demands pertinent to their lives.

"I hope during the the year to assemble all this information," says Michael, "and then to draft the charter and, probably next year, to hold a national conference at which the charter will be discussed and adopted by the DPSA's national assembly."

The real value of the charter, he points out, will be as a model for future legislation affecting the rights of disabled people.

"It's the most democratic way for the disabled to participate in policy making that directly affects their rights."

Sammy Davis jun once said he had three strikes against him: he was black, one-eyed and a Jew. Michael reckons that is nothing compared to being disabled, black and a woman.

"Women are the worst hit, the most disadvantaged of all," says this soft-spoken young man who was born in Louis Trichardt.

It was his childhood experiences with suppression, the submissive way his fellow-blacks allowed racism to dominate their everyday lives, that decided Mr Masutha early on to become a lawyer.

He says the Catholic School for the Blind, run by Belgians, was even more conservative and strictured than the repressive Afrikaners of his home town.

He witnessed in anger the expulsion of Steve Kekana, now a well-known blind singer, for inadequate reasons.

"The injustice of that perhaps was the beginning of my love affair with the law."

It seemed such a simple way to define right from wrong.

Michael was a victim of cataracts at an early age. At 18 months, he lost the sight of his right eye while vision in the left was substantially reduced.

He earned his B Iuris degree at the University of the North, and his LlB at Wits.

Outspoken as he is on human rights, he cast some interesting light on the recent university boycott over the "exclusion" policy for failed students. He strongly condemned the "pass one, pass all" philosophy.

"It would make a mockery of the whole education system," he said. "You have to work for it. What I achieved, I deserved."

However, he feels that Wits could be more sensitive to the problem.

"It isn't easy to study in the middle of riots, when you are under threat of attack. There is a perception, rightly or wrongly, that certain lecturers see blacks as inferior . . .

"Both this kind of lecturer and certain white students need to know we at least deserve the chance to prove we are their equals."

Blood shortage threatens SA

Own Correspondent

Star 11/4/91

299

DURBAN — The "drying up" of blood transfusion services because of Aids has become "one of the most serious problems facing South Africa" and could eventually lead to the death of thousands of people who may need transfusions.

This was revealed by the national spokesman for blood services, John Cotterell, who said the safe donor base (HIV negative) had been deeply eroded by Aids.

Some people were terrified of Aids and had stopped donating blood, while others simply never came forward.

Bleeding in certain areas where a high number of people tested HIV positive had been stopped. Parts of Zululand, for example, had been zoned as "out of bounds" for blood-taking, with HIV-positive rates of up to six percent detected in the worst areas.

Clinics in areas which used to provide a lucrative source of blood had vanished.

A spokesman for the Natal Blood Transfusion Service (NBTS) said the aim was now "to urgently broaden the safe donor base before the situation became desperate".

The situation at the country's blood banks — including the NBTS — was described by Mr Cotterell as "very serious".

An urgent appeal has been put out by the NBTS to all donors who may have lost contact with their regional blood donor clinics to become regular donors again.

"With the escalation of the Aids epidemic, fewer people are eligible to donate blood, making it increasingly difficult for blood transfusion services to ensure an adequate 'low risk' blood supply," said Mr Cotterell.

"Lapsed donors could play an important role in meeting the shortfall by coming forward and donating more regularly.

"We hope that everyone will realise this year thousands of blood donors were forfeited for reasons other than HIV positivity: pregnant women, elderly people, those who simply stopped giving blood and so on.

"We would appreciate it if lapsed donors could contact their local blood transfusion services as soon as possible so that we can reinstate them as regular donors."

The NBTS has set aside the months of April and May to "recover" as many lapsed donors as possible.

BIDay 17/4/91.

Trauma rates rise with urbanisation

TANIA LEVY

INTERPERSONAL violence accounted for more than half the 156 new trauma cases reported daily in the Johannesburg/Soweto region, Medical Research Council Centre for Epidemiological Research director Dr John Seager said yesterday.

The high level of interpersonal violence was a particularly South African problem, although trauma rates in general increased with exposure to urban lifestyles and technology, Seager said at a Cost Effective Health Care conference in Johannesburg yesterday.

In 1984 trauma accounted for the loss of 2,43-million potential years of life. Or these 36% were attributed to unnatural causes. No diseases accounted for more than 16% of deaths; circulatory diseases were responsible for 9%.

Seager said heart disease and lung cancer were the chronic diseases which increased most with urbanisation. The incidence of chronic diseases increased when people coming into urban areas changed their lifestyles, diet and habit as they were exposed to new advertising and social pressures.

A recent study in peri-urban and urban areas of Cape Town showed that by the age of 15 nearly half of black males had become regular smokers, listing their favoured brand as the one most frequently advertised in townships.

He said urbanisation was linked to changes in mores and norms which resulted in more open attitudes to sex. This often led to an increase in all sexually transmitted diseases, including AIDS.

SA was in the early stages of the AIDS epidemic, with just more than 600 cases reported, but there were at least 119 000 people infected with HIV — 20% more than the number of tuberculosis cases treated in SA every year. This represented an enormous burden for SA's overstretched health system and planning would have to take into account the need for hospice-type care for thousands of AIDS patients in the next 10 years.

Seager said SA's total black metropolitan population would increase 130% to more than 20-million by the year 2010, placing considerable stress on already vulnerable social, health, educational and transport needs.

Instead of trying to prevent urbanisation, action should be taken to improve urban conditions and the provision of services including health care, he said.

Govt cannot 'bridge' health gap on its own

Star 17/4/91

Medical Reporter

Greater co-operation between independent health care groups and the Government would make preventive and curative services more accessible to black communities, says researcher Joe Kelly.

Mr Kelly, a researcher at the South African Institute of Race Relations, is the author of the book "Finding a Cure: The Politics of Health in South Africa".

He believes that the Government on its own cannot bridge the racial gap in the provision of health care because, although it has the infrastructure and funds, it is viewed with suspicion by many people.

Government primary health care services where provided, are often insensitive to the needs of a community, and where independent clinics are available, these are preferred to those of the State, Mr Kelly says.

Independent groups which provide health services, he says, are controlled by communities through voluntary or elected health workers. These groups have not been publicly acknowledged by the Government.

Mr Kelly suggests that the Government would be wise to take an interest in encouraging independent primary health care groups and to assist them financially as these groups aim at providing the cheapest possible services.

● "Finding a Cure: the Politics of Health in South Africa" is available at R20,08 (inclusive of postage, packing and GST) from the Publications Division of the Institute of Race Relations, Box 31044, Braamfontein 2017.

Disabled people are whole human beings

Star 17/4/97 (299)

It is time society removed the handicaps put in the way of disabled people, argues PHINDI MAVUSO of the Independent Living Centre. The following is part of an address on "Social welfare in a future state".

FIRST I would like to give a definition of the word "handicap" in disability language. It came to my attention that people have been using the word with a different meaning to that of people with disabilities.

As defined in the World Programme of Action Concerning Disabled Persons — the World Health Organisation's bible for the disabled — the word "handicap" means "a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role that is normal, depending on age, sex and social and cultural factors for that individual".

"Handicap" means a function of the relationship between disabled persons and their environment. It occurs when they encounter cultural, physical or social barriers which prevent their access to the various systems of society that are available to other citizens. Thus, handicap is the loss or limitation of opportunities to take part in the life of the community on an equal level with others.

"Handicap" is different from "disability". The attitudes of society, and social facilities such as transport and buildings which are inaccessible to the people with disabilities, are a handicap to people with disabilities.

It is very heartbreaking for me to see that disabled people are still regarded as different people. People with disabilities are complete and whole human beings. They strive for equal opportunities.

Their disadvantaged state is worsened by institutional and public attitudes — attitudes being the main factor of the under-development of the disabled. It is for this reason that we must change the society's perceptions.

It is the so-called able-bodied people who are responsible for our state of dependency by doing things for us — deciding what is best *for* us, and not *with* us.

People with disabilities want to shape their own destiny, working together with the able-bodied people. We do not want able-bodied people doing things for us.

Disabled people are victims of many prejudices. For example, it becomes a precious moment for any family when a child is born. The entire community rejoices.

However, it is not so if the child is born with a disability. The child will be shunned by the family and the community. A child born with disabilities is seen as a curse to the family — as a punishment by God for the family's sins.

It is amazing how people see someone's disability and not the person. They seem not to realise that everybody has a disability of some sort. What is different is only the degree of disability.

A person who wears spectacles forgets that he has visual impairment. Why is it that those who wear glasses are not shunned by the community like those who have artificial limbs?

It is time that disability was made transparent in our society.

Community structures, transport, education and employment must be accessible to the disabled because they are part of the community. We should not be seen as "welfare cases". □

IOC takes SA a step closer to Games

B/Day 18/4/91.

IAN HOBBS

LONDON — The International Olympic Committee (IOC) yesterday signalled that SA's return to world athletics could take place in just four months — if remaining apartheid laws are scrapped.

At the end of an IOC executive board meeting in Barcelona, president Juan Antonio Samaranch said the IOC would welcome SA's participation in the World Athletic Championships, which start in Tokyo on August 24.

Stressing that SA would have to meet the IOC proviso of removing remaining apartheid legislation, Samaranch said: "The IOC and the Olympic movement will be very happy to see SA in Tokyo next August."

The International Amateur Athletics Federation (IAAF) is sending a three-man delegation to SA on April 26.

The IAAF, the controlling body of world athletics, will have to be satisfied before it lifts the apartheid ban on athletes and admits a new, unified SA athletics body, probably at its congress in Tokyo on August 20-21. (292)

The British Amateur Athletics Board (BAAB) is campaigning for restrictions on SA athletes to be lifted as soon as possible.

Cost spiral blamed on old laws, monopolies

Star 18/4/91

Medical Reporter (299)

South Africans are spending 350 percent more on health care today than in 1983, health care specialist Greg Candy said in Johannesburg yesterday.

Speaking on "The pharmaceutical perspective" at the Executive Seminars' cost-effective health-care conference, Mr Candy, of Deloitte Pim Goldby, said the excessive spending was due to outdated legislation and creeping monopolisation in the medication industry.

Health care expenditure was considerably more than the consumer price index rise of 250 percent over the past eight years.

"Health care in South Africa is not cost-effective because restrictive legislation protects monopolies which have developed in the industry in recent years," he said.

"Similarly, the fee-for-service system keeps the cost of consultation immune to influences like supply and demand."

Mr Candy said that without some "significant changes to current legislation, further restructuring would probably be limited to consolidation of the industry into an even smaller number of players competing with a fairly static private market and a public sector emphasising primary health care".

He suggested a restructuring of the medical industry which would benefit public facilities rather than private hospitals, medical practitioners and the research-based multinationals.

This could be achieved through allowing:

- Medical aid and insurance companies to deliver health care services through "managed care" with a move away from fee-for-service.
- Group practices between medical and paramedical professionals. Inherent in this system were incentives to ensure that the population was as healthy as possible, and not the reverse, as was the case now.
- Deregulation of retail pharmacies so that they could sell certain restricted scheduled drugs without a prescription and provide the patient with generic substitutes.

Star 18/4/91.

Natal bans bleeds at workplace

Own Correspondent

DURBAN — The Natal Blood Transfusion Service (NBTS) has banned mobile blood clinics from operating in companies or at any workplace because the incidence of HIV positivity at these collection points is five times higher than blood collected from fixed transfusion centres.

This step in eliminating high-risk donor areas follows the awarding this week of R450 000 to a Pretoria woman after she received contaminated blood from the South African Blood Transfusion Services.

The ban has been instituted by the NBTS as a last-stop effort to prevent HIV-infected blood from the institution infecting anyone in Natal or KwaZulu.

NBTS director Professor Francisco Fernandes Costa yesterday said one of the last high-risk areas he could think of — blood-taking from workplaces — had now been eliminated.

Professor Fernandes Costa stressed that "every conceivable precaution" was already being taken to test every unit of blood that was issued to any patient from an NBTS source.

There was, however, no such thing as "100 percent safe blood" because of what was known as the window effect — the period of weeks and even months during which no test could detect HIV antibodies in the blood.

'Low risk from transfusion'

The risk of contracting Aids through a blood transfusion was less than one in 500 000, SA Blood Transfusion Services director Professor Anton Heyns said yesterday.

Professor Heyns was speaking after a woman received damages following an HIV-infected blood transfusion in 1987.

At the time, services were not geared to rapid testing. Since then, rapid tests had become available, he said. — Staff Reporter.

'Too much spent on private health'

Star 18/4/91

299 688 98

By Orina le Grange
Medical Reporter

Private health care "directly undermines" public health care by consuming a disproportionate share of financial and human resources, Dr Jonatlan Broomberg of the University of the Witwatersrand said in Johannesburg yesterday.

Dr Broomberg, attached to the Centre for Health Policy Studies, was delivering the closing address, entitled "Healt| care in a post-aparthed South Africa", at the Executive Seminars' cot-effective health care coiference.

In 19|9, 46,7 percent of total health expenditure was spelt on private-sector care covering little more than 20 percent of the popu|ation, he said.

The other 53,3 percent had to find the remaining 80 percent of the population.

Recen trends in public health expenditure, including the fact that the 1989 per capita expenditure was less than in 1984, suggested there was little room for budgetary expansion to health care.

"We cannot hope to improve the public health system to the required level without major increases in financial resources, and there is no possibility of getting this from the public budget. We will thus have to look at current expenditure in the private sector," he said.

Proposing an integrated public and private health care system through statutory national health insurance, Dr Broomberg said such a system would create substantial opportunities for collaboration between the public and private sectors to create equitable, affordable and appropriate health care for all.

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NEWS

And now a medical aid scheme for those in-between

A PRIVATE hospital group has introduced a new concept in health care for South Africans who are deemed to have too much money for State care but who cannot afford private hospital care.

People who earn more than R15 000 a year (R25 000 for a family) are not eligible for State care, but a salary of about R1 300 a month with no medical aid will not buy you much from a private hospital.

The new scheme, a form of health maintenance organisation common in the United States, should be in operation by the end of the year, according to Dr Ewert Bohnen of Medimo, an offshoot of Medi-Clinic Corporation, the Rembrandt Group's medical wing.

R10 000 hospital limit

Dr Bohnen believes there are 10-million South Africans in the targeted category. The scheme will be aimed at lower-income salary earners, and will be introduced with a R30 000 salary ceiling.

Like medical aid schemes, companies will be affiliated to the scheme, and employees will become members, paying a fixed monthly fee.

In return they will get what Dr Bohnen calls "total health care" from an organisation which employs doctors and other staff, and which provides consulting rooms, medicines and access to specialists, specialised facilities and private hospitals.

Unlike the system run at one time by the Railways, the doctors will be employed by the organisation, and not private doctors who fit members in among their private patients.

The employee will pay nothing more than his or her monthly fee. Hospital claims will be limited to a maximum of R10 000 for each member a year, but payments above this will be considered in special cases.

The scheme will include dental treatment and confinements, and makes some provision for paramedical services such as physiotherapy and spectacles. Members will also be paid R2 000 death benefits.

The major disadvantage of the system is that patients must go to a doctor employed by the scheme, but ideally enough doctors will be employed to give the patient a choice. Other disadvantages are that there is a potential for underservicing and inferior care, and doctors lose autonomy.

But these pifalls can be avoided, says Dr Bohnen, by establishing company medical committees made up of employees who will discuss practices and take complaints. There would also have to be peer review by doctors. The scheme is cost-effective, according to Dr Bohnen, and everybody wins.

At present the temptation exists among private doctors, who charge on a fee-for-service basis, to perform more services than necessary in a bid to increase earnings. But in a scheme such as this the doctor is paid a salary regardless of what he does for the patient.

The scheme is also to the patient's advantage, says Dr Bohnen, because there are no hidden extra fees; the organisation has a strong incentive to ensure costs do not exceed contributions; and members can put dependents not usually covered by medical aids onto the scheme, such as a granny, provided they pay the appropriate fee.

Dr Bohnen envisages a fee structure which would charge a single member R70 a month, additional adults R50 a month and minor dependents R30 a month each. Pensioners would pay the same amount. A man with a wife, three children and an elderly parent on the scheme would pay R320 a month. The employer could pay part or all of this fee.

Until recently this type of health scheme has been impossible in South Africa because with a few exceptions it has been illegal for anyone other than the State to employ a doctor. It has also been contrary to the rules of the SA Medical and Dental Council for doctors from different specialities to work together in the same practice.

But because of the rapidly escalating costs of private health care, the Medical and Dental Council has indicated that it is prepared to make exceptions to its rules in a bid to ease the private health care crisis.

The scheme has been welcomed by Dr Max Price, a spokesman for the Centre for Health Policy at the University of the Witwatersrand.

Scheme welcomed

"This is fairly typical of health maintenance organisation seen in the United States, and is I think probably the best the private sector can do to avoid soaring costs.

"But I would like to sound a couple of warnings.

"There tends to be a problem of under-servicing with these organisations. There is not much incentive for a doctor to make a night visit if he's not being paid for it.

"This problem is taken care of in the United States by litigation — doctors are very careful because they are afraid of being sued. This rarely happens in South Africa, so that if the scheme is to succeed there must be outside audits of the service by independent doctors, as well as the health committees Dr Bohnen mentioned, preferably with union representation on them to prevent workers being intimidated by doctors."

Doctors unite against new Bill

By VIVIEN HORLER, Medical Reporter

DOCTORS, angry about a "threat" in a Bill due before parliament this session, have formed an association to protect their interests in complementary medicine like homeopathy and acupuncture.

The Complementary Medical Association of South Africa is strongly opposed to the Medicines and Related Substances Control Amendment Bill because doctors believe it threatens their freedom to prescribe certain medicines for their patients.

The intentions of the Bill are not clear, said Dr Nic Lee, editor of the SA Medical Journal and a founder member of the new association. "Some clauses could be interpreted to mean that doctors may not prescribe homeopathic medicines, but when we inquired as to the definition of homeopathic medicines we were told they were the medicines prescribed by a homeopath."

Inaugural meeting

About 60 doctors joined the association at its inaugural meeting this week. They hope to be affiliated to the Medical Association of South Africa.

Dr Lee said his association saw the Bill as an infringement of individual rights when the trend in South Africa was towards greater awareness of these rights and away from restrictive legislation.

He said the Medical Association of SA also had strong reservations about the Bill.

"We urge the Minister of Health to think again and refer this Bill back to the standing committee on health for further study before it becomes law — possibly with disastrous results."

Until now, the formal medical profession has almost ignored complementary medicine, although several doctors use aspects of it in their treatment.

Perception

Dr Lee said it was time the profession took an interest in complementary medicine.

"People are interested in it and yet it happens entirely outside the profession. There was a perception that complementary practitioners were more caring and take more time than doctors who are seen as being too busy.

"We think it is time the medical profession got themselves together and took a good, objective, open-minded look at the complementary disciplines to see what makes them valuable.

"In Britain, homeopaths are usually qualified doctors who have a post-graduate certificate in homeopathy. Here, there is only one place where you can be trained, the Natal Technikon, which means that if I wanted to become a homeopath I would be taught by non-medically trained people.

"The field is very muddled in South Africa, and the medical profession has been extremely hostile."

	(a) Beds	(b)* Wards
Graaff-Reinet	37	
Grahamstown	50	
Humansdorp	12	
King William's Town	47	
Middelburg	51	
East London, Frere	95	
Port Elizabeth, Dora Nginza	34	
Port Elizabeth, Livingstone	146	
Port Elizabeth, Provincial	269	
Queenstown	102	
Somerset East	72	
Steynsburg	29	
Uitenhage	99	
Umtata, Sir Henry Elliot	14	
Walvis Bay Region		
Walvis Bay	65	
Western Cape Region		
Atlantis, Wesfleur	7	
Beaufort West	46	
Bellville, Karl Bremer	222	
Bredasdorp	25	
Caledon	42	
Calvinia	15	
Ceres	3	
Citrusdal	6	
Faure	24	
Garies	25	
George	79	
Green Point, Somerset & City	144	
Hermanus	7	
Knysna	18	
Ladismith	35	
Malmesbury	58	
Manenberg, G F Jooste	13	
Montagu	12	
Mossel Bay	14	
Oranjezicht, Volks	53	
Oudtshoorn	19	
Paarl	0	
Pinelands, Conradie	0	
Porterville	11	
Port Nolloth	2	
Riversdale	33	
Robertson	9	
Somerset West	0	
Springbok	12	
Stellenbosch	37	
South Peninsula Group		
Eaton	43	
Lady Michaelis	50	
Princess Alice	73	
False Bay	40	
Wynberg, Victoria	39	
Sutherland	7	
Swellendam	17	
Victoria West	34	
Vredenburg	12	
Vredendal	8	
Woodstock	36	
Worcester	30	
Academic Regions		
Groote Schuur Region		
Groote Schuur	0	
Avalon Treatment	22	
Mowbray Maternity	68	
Peninsula Maternity	15	
Red Cross Region		
Red Cross	0	
Tygerberg Region		
Tygerberg	242	

*Information not available.

*Information not available.

Hospitals: cost/income per patient

287. Mr M J ELLIS asked the Minister of National Health:

What is the (a) cost per patient per day and (b) income per patient per day for each hospital falling under the control of each of the provinces?

B754E

The MINISTER OF NATIONAL HEALTH:

OFS

HOSPITAL	(a)	(b)
Bethlehem		
Provincial	269,20	42,13
Phekolong	95,04	9,37

HOSPITAL	Cost/ patient/ day 1989/ 1990	Income/ patient/ day 1989/ 1990
Bloemfontein		
Universitas } National }	659,62	83,00
Pelonomi	132,92	7,59
Oranje	61,03	1,38
Bothaville	121,93	15,96
Botshabelo	165,94	3,07
Clocolan	30,78	4,04
Ficksburg	105,45	24,29
Frankfort	105,40	14,34
Harrismith	106,41	18,78
Heilbron	101,90	11,83
Hoopstad	93,02	11,89
Jagersfontein	118,44	2,74
Kroonstad		
Voortrekker	276,09	22,51
Boitumelo	124,71	8,19
Ladybrand	168,18	17,38
Odendaalsrus	126,85	24,86
Parys	89,28	17,13
Reitz	91,18	9,66
Sasolburg	319,17	10,29
Senekal	281,69	31,70
Smithfield	246,23	20,34
Virginia	106,93	44,45
Vrede	83,83	7,13
Welkom	157,39	37,56
Winburg	42,90	6,04
Zastron	89,12	2,55
Laudium	283,27	66,03
Lenasia	503,56	19,58
Louis Trichardt Memorial	217,56	103,19
Lydenburg	91,26	29,17
Middelburg	128,54	55,75
Natalspruit	102,58	11,16
Nic Bodenstein, Wolmaransstad	105,26	50,20
Nigel	108,15	39,33
Discoverers' Memorial, Florida	195,92	88,50
Paardekraal/Leratong	120,01	7,45
Paul Kruger Memorial, Rustenburg	117,56	57,48
Phalaborwa	204,66	90,14
Pietersburg	111,56	52,32
Piet Retief	69,00	13,27
Pretoria West	217,96	97,94
Rietfontein	66,71	—
Rob Ferreira	139,96	71,92
Sabie	102,81	22,11
Sannieshof	544,53	89,79
Schweizer-Reneke	82,41	15,89
Standerton	129,13	30,90
South Rand	233,39	59,28
Sybrand van Niekerk	156,86	115,94
Tembisa, Olifantsfontein	124,24	9,01
Van Velden Memorial, Tzaneen	217,41	98,92
Ventersdorp	231,56	49,02
Vereeniging/Sebokeng	102,59	21,73
Far East Rand, Springs	115,53	31,51
Voortrekker, Potgietersrus	186,82	81,03
Warmbaths	185,64	77,96
Waterval Boven	312,90	51,91
Weskoppies	48,76	1,11
Westfort	49,37	—
Willem Cruywagen, Germiston	208,79	74,15
Amajuba Memorial, Volksrust	91,19	19,17
Andrew McColm, Pretoria	230,54	34,52
Baragwanath	176,45	11,50
Soweto CHC	150,64	89,84
Barberton	129,42	32,69
Bernice Samuel, Delmas	198,23	92,36
Bethal	110,32	27,68
Bloemhof	204,57	50,39
Boksburg-Benoni	130,80	26,27
Brits	113,00	84,61
Carolina	106,52	21,41
Christiana	109,50	20,41
Coronation	194,96	8,51
Delareyville	411,10	86,35
Dr A G Visser, Heidelberg	141,83	34,22
Duiwelskloof	299,72	92,11
Edenvale	182,95	75,85
Ellisras	248,53	73,60
Elsie Ballot, Amersfoort	281,64	43,81
Ermelo	106,91	32,08
Evander	210,18	181,35
F H Odendaal, Nylstroom	115,58	9,10
Ga-Rankuwa	170,52	4,37
Gen De la Rey, Lichtenburg	223,79	115,90
Groblersdal	305,45	127,35
H A Grove, Belfast	329,20	58,63
Hendrik van der Bijl	140,31	108,72
H F Verwoerd	326,12	47,01
Hillbrow, Johannesburg	248,01	12,83
J D Verster, Koster	91,23	11,11
J G Strijdom, Johannesburg	327,28	81,61

Johannesburg	385,63	128,32
Kalafong, Pretoria	146,08	14,74
Kalie de Haas, Potchefstroom	132,34	34,48
Kempton Park	177,54	124,09
Klerksdorp/Tshepong	138,24	41,69
Witbank	132,87	57,43
Witrand	38,60	—
Zeerust	90,32	20,08

The amount for income per patient per day is estimates only.

NPA

	(a) *Cost* R	(b) *Income* R
Provincial Administration		
Addington	371	43,28
Christ the King	95	7,41
Clairwood	88	3,95
Dundee	145	17,84
E G & Usher Memorial	93	5,59
Empangeni	296	115,89
Eshowe	122	14,98
Estcourt	153	11,39
G J Crookes	121	11,49
Greytown (Provincial)	105	7,08
King Edward VIII	220	9,13
Ladysmith	106	17,78
Newcastle	235	98,50
Niemeyer Memorial (Utrecht)	118	10,96
Northdale	171	18,73
Port Shepstone	141	31,95
R K Khan	182	16,90
St Andrews	85	4,52
Stanger	120	10,78
Taylor Bequest	108	3,94
Vryheid	120	26,58
Wentworth	609	21,93

	(a) *Cost* R	(b) *Income* R
South African Development Trust		
Emmaus	101	2,43
Murchison	87	2,74
Osindisweni	91	3,24
St Apollinaris	76	2,48
Administration: House of Assembly		
Grey	227	95,98
Greytown	273	106,77
Hillcrest	60	0,33

CPA

	(a)	(b)*
NON-ACADEMIC REGIONS		
Northern Cape Region		
Barkly West	89,21	
Colesberg	79,21	
De Aar	85,42	
Douglas	80,54	
Hartswater	63,71	
Kakamas	81,17	
Kimberley	133,06	
Kuruman	94,35	
Noupoort	112,55	
Postmasburg	78,50	
Prieska	109,94	
Reivilo	93,54	
Upington	103,59	
Vryburg	110,33	
Eastern Cape Region		
Aliwal North	106,19	
Barkly East	106,61	
Bedford	85,24	
Burgersdorp	92,78	
Cathcart	108,61	
Cradock	97,36	
Elliot	96,63	
Fort Beaufort	91,82	
Graaff-Reinet	107,14	

*Information not available.

	(a)	(b)*
Grahamstown	82,89	
Humansdorp	114,93	
King William's Town	145,69	
Middelburg	114,25	
East London, Frere	146,00	
Port Elizabeth, Dora Nginza	104,69	
Port Elizabeth, Livingstone	141,12	
Queenstown	137,62	
Somerset East	81,11	
Steynsburg	80,81	
Uitenhage	123,77	
Western Cape Region		
Atlantis, Wesfleur	60,67	
Beaufort West	82,95	
Bellville, Karl Bremer	203,27	
Bredasdorp	104,28	
Caledon	138,88	
Calvinia	96,61	

Ceres	84,82	
Citrusdal	83,88	
Day Hospitals Organisation	62,49	
Faure, National Accelerator Centre	703,61	
Garies	83,43	
George	166,92	
Green Point, Somerset	210,69	
Hermanus	126,76	
Knysna	100,56	
Ladysmith	126,16	
Malmesbury	125,12	
Manenberg, G F Jooste	63,82	

*Information not available.

	(a)	(b)*
Montagu	83,59	
Mossel Bay	91,20	
Oudtshoorn	112,86	
Paarl	88,30	
Pinelands, Conradie	99,15	
Porterville	97,12	
Port Nolloth	59,10	
Riversdale	104,85	
Robertson	91,61	
Somerset West	96,27	
Springbok	106,00	
Stellenbosch	101,08	
South Peninsula Hospitals Group	152,02	
Sutherland	115,39	
Swellendam	83,73	
Victoria West	107,50	
Vredenburg	89,99	
Vredendal	65,70	
Woodstock	159,76	
Worcester	104,87	
ACADEMIC REGIONS		
Groote Schuur Region		
Groote Schuur	353,98	
RED CROSS REGION		
Red Cross	252,71	
TYGERBERG REGION		
Tygerberg	271,84	

*Information not available.

Edenvale Hospital: statistics

295. Mr D J DALLING asked the Minister of National Health:

(1) In respect of the Edenvale Hospital as at the latest specified date for which statistics are available, (a) what was the bed capacity, (b) what was the average bed occupancy rate for (i) Blacks, (ii) Whites, (iii) Coloureds and (iv) Indians and (c) how many (i) Black, (ii) White, (iii) Coloured and (iv) Indian (aa) doctors and (bb) nurses were employed;

(2) whether any (a) wards, (b) departments and (c) facilities at this hospital were closed down during the latest specified period of 12 months for which statistics are available; if so, (i) which (aa) wards, (bb) departments and (cc) facilities and (ii) for what reasons in each case?

B740E

The MINISTER OF NATIONAL HEALTH:

(1) Statistics for the period 1 April 1990 to 28 February 1991:

(a) 132 beds,

(b) statistics for the bed occupancy rate are not kept per population group. The bed occupancy rate for all population groups was 46,3%.

Admissions per population group from 1 October 1990 were as follows:

PERIOD	BLACK	WHITE	COLOURED	INDIAN
October 1990	3	334	0	0
November 1990	10	376	0	0
December 1990	8	341	0	0
January 1991	14	413	0	0
February 1991	22	342	0	0 and

No. R. 896 26 April 1991

LABOUR RELATIONS ACT, 1956

ELECTRICAL CONTRACTING INDUSTRY, TRANSVAAL.—RE-ENACTMENT OF SICK BENEFIT, PENSION AND 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 which appears in the Schedule hereto and which relates to the Undertaking, Industry, Trade or Occupation referred to in the heading to this notice, shall be binding, with effect from the second Monday after the date of publication of this notice and for the period ending 31 December 1995, upon the employers' organisations and the trade unions which entered into the said 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 said Agreement, excluding those contained in clause 1 (1) (a), 2 and 3, shall be binding, with effect from the second Monday after the date of publication of this notice and for the period ending 31 December 1995, 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 said Agreement.

ELI VAN DER M. LOUW,
Minister of Manpower.

SCHEDULE

INDUSTRIAL COUNCIL FOR THE ELECTRICAL CONTRACTING INDUSTRY AGREEMENT

in accordance with the provisions of the Labour Relations Act, 1956, made and entered into by and between the

Electrical Contractor's Association (South Africa)

(hereinafter referred to as the "employers" or the "employers' organisation"), of the one part, and the

South African Electrical Workers' Association

and the

Metal and Electrical Workers' Union of South Africa

(hereinafter referred to as the "employees" or the "trade unions"), of the other part,

being the parties to the Industrial Council for the Elcectrical Contracting Industry,

to amend the Agreement published under Government Notice No. R. 1884 of 23 August 1985 (hereinafter referred to as the "Re-enacting Agreement"), as extended and amended by Government Notices Nos. R. 2844 of 17 December 1985, R. 1974 of 19 September 1986, R. 2270 of 9 October 1987, R. 1353 of 8 July 1988, R. 2316 of 18 November 1988 and R. 886 of 20 April 1990.

No. R. 896 26 April 1991

WET OP ARBEIDSVERHOUDINGE, 1956

ELEKTROTEGNIESE AANNEMINGSNYWERHEID, TRANSVAAL.—HERBEKRAGTIGING VAN SIEKTEBYSTANDS-, PENSIOEN- EN MEDIESE BYSTANDSFONDSOOREENKOMS

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 wat in die bylae hiervan verskyn en betrekking het op die Onderneming, Nywerheid, Bedryf of Beroep in die opskrif by hierdie kennisgewing vermeld, met ingang van die tweede Maandag na die datum van publikasie van hierdie kennisgewing en vir die tydperk wat op 31 Desember 1995 eindig, bindend is vir die werkgewersorganisasies en die vakverenigings wat genoemde Ooreenkoms 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 genoemde Ooreenkoms, uitgesonderd dié vervat in klousule 1 (1) (a), 2 en 3 met ingang van die tweede Maandag na die datum van publikasie van hierdie kennisgewing en vir die tydperk wat op 31 Desember 1995 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 genoemde Ooreenkoms gespesifiseer.

ELI VAN DER M. LOUW,
Minister van Mannekrag.

BYLAE

NYWERHEIDSRAAD VIR DIE ELEKTROTEGNIESE AANNEMINGSNYWERHEID OOREENKOMS

ooreenkomstig die Wet op Arbeidsverhoudinge, 1956, gesluit deur en aangegaan tussen die

Electrical Contractors' Association (South Africa)

(hierna die "werkgewers" of die "werkgewersorganisasie" genoem), aan die een kant, en die

South African Electrical Workers' Association

en die

Metal and Electrical Workers' Union of South Africa

(hierna die "werknemers" of die "vakverenigings" genoem), aan die ander kant,

wat die partye is by die Nywerheidsraad vir die Elektrotegniese Aannemingsnywerheid,

om die Ooreenkoms, gepubliseer by Goewermentskennisgewing R. 1884 van 23 Augustus 1985 (hierna die "Herbekragtigingsooreenkoms" genoem), soos verleng en gewysig deur Goewermenskennisgewings R. 2844 van 17 Desember 1985, R. 1974 van 19 September 1986, R. 2270 van 9 Oktober 1987, R. 1353 van 8 Julie 1988, R. 2316 van 18 November 1988 en R. 886 van 20 April 1990, te wysig.

1. AREA AND SCOPE OF APPLICATION

(1) The terms of this Agreement shall be observed by all employers and employees in the Electrical Contracting Industry—

(a) who are members of the employers' organisation and the trade unions respectively; and

(b) who are engaged or employed in the Industry in the Province of the Transvaal and the Magisterial Districts of Bloemfontein and Sasolburg.

(2) Notwithstanding the provisions of subclause (1), the terms of this Agreement shall apply to apprentices and trainees only in so far as they are not inconsistent with the provisions of the Manpower Training Act, 1981, or any conditions prescribed or any notice served in terms thereof.

(3) For the purposes of this Agreement, the weekly wage rate of apprentices prescribed under the Manpower Training Act, 1981, shall be taken to be the weekly wage of such employees, and the hourly rate shall be the weekly wage calculated as above, divided by the number of ordinary hours worked in the establishment concerned.

2. CLAUSE 18.—PENSION FUND

Insert the following subclause (5):

"(5) Notwithstanding the provisions of subclause (4), where an employee, who has not been employed in the Industry before, is employed as an Elconop 1 or Labourer, he shall be covered only by the death benefit portion of the Pension Fund for the first 13 weeks of employment and, thereafter, he shall become a full member of the Pension Fund.".

3. CLAUSE 20.—CONTRIBUTIONS

(1) Substitute the following for subclause (1):

"(1) The weekly contributions of all employees to the Electrical Contracting Industry Pension Fund shall be based on the prescribed wages payable to such employees in terms of the Main Agreement of the Council, as amended from time to time, plus 20 per cent thereof, and shall be calculated at the rate of 12,5 per cent of the said prescribed wage, plus 20 per cent thereof, taken to the next higher 10 cents.

(2) Delete subclause (2).

(3) Renumber subclause (3) as subclause (2).

(4) Insert the following subclause (3):

"(3) Notwithstanding the provisions of any other clause in this Agreement or the Main Agreement of the Council, the contributions referred to in subclause (1) shall be based on a working week of 42½ hours.".

4. CLAUSE 30.—CONTRIBUTIONS

Substitute the following for subclause (1):

"(1) (a) An employer shall pay the following amounts to Elmed in respect of the undermentioned employees in their respective categories of membership per week:

[Column (1)] Category of membership	Total amount in rand per week			
	Master electricians, electricians, artisans, Elconops 3, Elconops 2, drivers, final year apprentices, apprentices with dependants, and trainees who are		Apprentices not included in Column (2)	Apprentices not included in Column (3)
	A-members [Column (2)]	B-members [Column (3)]		
M	44	38	22	19
M1	54	48	—	—
M2	60	55	—	—
M3	68	63	—	—
M4+	74	69	—	—

1. GEBIED EN TOEPASSINGSBESTEK

(1) Hierdie Ooreenkoms moet nagekom word deur alle werkgewers en werknemers in die Elektrotegniese Aannemingsnywerheid—

(a) wat lede is van onderskeidelik die werkgewersorganisasie en die vakverenigings; en

(b) wat betrokke is by of werksaam in die Nywerheid in die provinsie Transvaal en in die landdrosdistrikte Bloemfontein en Sasolburg.

(2) Ondanks subklousule (1) is die Ooreenkoms van toepassing op vakleertinge en kwekelinge slegs vir sover dit nie strydig is met die Wet op Mannekragopleiding, 1981, of met voorwaardes of kennisgewings wat daarkragtens voorgeskryf of bestel is nie.

(3) Vir die toepassing van hierdie Ooreenkoms word die weeklikse loonskaal van vakleerlinge wat kragtens die Wet op Mannekragopleiding, 1981, voorgeskryf is as die weekloon van sodanige werknemers geag en is die uurloon die weekloon soos hierbo bereken, gedeel deur die getal gewone ure wat daar in die betrokke bedryfsinrigting gewerk word.

2. KLOUSULE 18.—PENSIOENFONDS

Voeg die volgende subklousule (5) in:

"(5) Ondanks subklousule (4), waar 'n werknemer wat nie voorheen in die Nywerheid in diens was nie, as 'n Elkonop 1 of arbeider in diens geneem word, word hy vir die eerste 13 weke diens slegs deur die sterftebystand-gedeelte van die Pensioenfonds gedek en daarna word hy 'n volle lid van die Pensioenfonds.".

3. KLOUSULE 20.—BYDRAES

(1) Vervang subklousule (1) deur die volgende:

"(1) Die weeklikse bydraes van alle werknemers tot die Pensioenfonds van die Elektrotegniese Aannemingsnywerheid moet gebaseer word op die voorgeskrewe loon betaalbaar aan sodanige werknemers ingevolge die Hoofooreenkoms van die Raad, soos van tyd tot tyd gewysig, plus 20 persent daarvan, en moet bereken word teen 12,5 persent van die gemelde voorgeskrewe loon, plus 20 persent daarvan, bereken tot die volgende hoogste 10 sent.".

(2) Skrap subklousule (2).

(3) Hernommer subklousule (3) om te lui subklousule (2).

(4) Voeg die volgende subklousule (3) in:

"(3) Ondanks die voorskrifte van enige ander klousule in hierdie Ooreenkoms of die Hoofooreenkoms van die Raad, moet die bydraes in subklousule (1) bedoel, gebaseer word op 'n werkweek van 42½ uur.".

4. KLOUSULE 30.—BYDRAES

Vervang subklousule (1) deur die volgende:

"(1) (a) 'n Werkgewer moet die volgende bedrae weekliks aan Elmed betaal ten opsigte van ondergenoemde werknemers in hul onderskeie lidmaatskapskategorieë:

[Kolom (1)] Lidmaatskap kategorie	Totale bedrag in rand per week			
	Meester/elektrisiëns, elektrisiëns, ambagsmanne, Elkonops 3, Elkonops 2, drywers, finalejaar-vakleerlinge, vakleerlinge met afhanklikes en kwekelinge wat		Vakleerlinge wat nie in Kolom (2) ingesluit is nie	Vakleerlinge wat nie in Kolom (3) ingesluit is nie
	A-lede is [Kolom (2)]	B-lede is [Kolom (3)]		
M	44	38	22	19
M1	54	48	—	—
M2	60	55	—	—
M3	68	63	—	—
M4+	74	69	—	—

(b) The amount of R190,00 for an M category member, R234,00 for an M1 category member, R260,00 for an M2 category member, R294,00 for an M3 category member and R320,00 for an M4+ category member in respect of each month worked by each person who has been admitted as a member of ELMED in terms of clause 25 (1) (b) shall be paid by the Council to ELMED.

(c) Every employer referred to in clause 25 (1) (c) shall pay monthly to ELMED the amount of R190,00 for an M category member, R234,00 for an M1 category member, R260,00 for an M2 category member R294,00 for an M3 category member and R320,00 for an M4+ category member in respect of each person who has been admitted to membership of ELMED in terms of clause 25 (1) (c).

(d) Every person who has been admitted to ELMED in terms of clause 25 (1) (d) shall pay monthly the amount of R190,00 for an M category member, R234,00 for an M1 category member, R260,00 for an M2 category member, R294,00 for an M3 category member and R320,00 for an M4+ member to ELMED.

(e) The Council may reduce the amounts referred to in paragraph (d) above, but such reduced rate shall be applicable only during the lifetime of the member who has been admitted in terms of clause 25 (1) (d).".

Signed at Johannesburg, as authorised for and on behalf of the parties to the Council, this 8th day of August 1990.

B. NICHOLSON,
Vice-Chairman.

L. M. BOWLES,
Member of the Council.

G. R. J. STRYDOM,
Assistant Secretary.

No. R. 897 **26 April 1991**

LABOUR RELATIONS ACT, 1956

HAIRDRESSING TRADE, SOUTH AND WESTERN TRANSVAAL. — AMENDMENT TO SICK BENEFIT 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 which appears in the Schedule hereto and which relates to the Undertaking, Industry, Trade or Occupation referred to in the heading to this notice, shall be binding, with effect from the second Monday after the date of publication of this notice and for the period ending 31 December 1991, upon the employers' organisation and the trade union which entered into the said Agreement and upon the employers and employee who are members of the said organisation or union.

E. VAN DER M. LOUW,
Minister of Manpower.

(ii) net een salarisverhoging aan sodanige beampte of werknemer toegeken word indien sy salaris reeds gelyk is aan die voorlaaste kerf van die skaal wat op hom van toepassing is.

(7) Indien 'n salarisverhoging nie ingevolge subregulasie (4) (b), (5) (b) of (6) aan 'n beampte of werknemer toegeken word nie, is die bepalings van subregulasies (2), (3), (4), (5) en (6) *mutatis mutandis* van toepassing.

(8) Behoudens die bepalings van hierdie Regulasies word die salaris van 'n beampte of werknemer aan wie 'n salarisverhoging ingevolge subregulasie (4) (b), (5) (b) of (6) toegeken is, by die verstryking van elke verdere salarisverhogingstydperk verhoog met een salarisverhoging binne die perke van die skaal wat op hom van toepassing is.

Amptelike diensure

53. (1) Behoudens die bepalings van regulasie 54, bepaal die prinsipaal van 'n kollege die amptelike diensure van beamptes en werknemers van die betrokke kollege en sien hy toe dat hulle dit nakom.

(2) Ondanks die bepalings van hierdie regulasie, kan die prinsipaal van 'n kollege van 'n beampte of werknemer van die betrokke kollege vereis om op enige dag van die week of enige tyd van die dag of nag amptelike diens te verrig of om by sy normale werkplek of elders aanwesig te wees vir sodanige diens.

(3) 'n Beampte of werknemer van 'n kollege is nie gedurende sy amptelike diensure en tydperke van oortyddiens sonder toestemming van die prinsipaal van die betrokke kollege, van sy kantoor of werkplek afwesig nie.

(4) Die prinsipaal van 'n kollege bepaal—

(a) die etenspouse, van minstens 'n halfuur, van 'n beampte of werknemer of enige kategorie beamptes of werknemers van daardie kollege: Met dien verstande dat 'n etenspouse wat binne die amptelike diensure val nie geag word amptelike dienstyd vir die voltooiing van 'n werkweek te wees nie; en

(b) die tye waartydens die publiek vir amptelike doeleindes toegang tot daardie kollege het.

(5) (a) Indien 'n beampte of werknemer gedurende die amptelike diensure van diens afwesig is as gevolg van verlof toegestaan ingevolge hierdie Regulasies of weens ander omstandighede wat vir die raad aanneemlik is, word hy, vir die doeleindes van die voltooiing van sy werkweek, geag amptelike diens te verrig het gedurende sodanige afwesigheid.

(b) Die amptelike diensure wat ten opsigte van 'n bepaalde dag vir 'n beampte of werknemer bepaal is en wat—

(i) op openbare vakansiedag val, in die geval van 'n beampte of werknemer wat gewoonlik nie op sodanige dag werk nie; of

(ii) op 'n ander dag val wat hy gewoonlik in plaas van sodanige openbare vakansiedag van diens vrygestel is, in die geval van 'n beampte of werknemer wat gewoonlik op 'n openbare vakansiedag werk,

word geag amptelike diensure vir die doeleindes van die voltooiing van sy werkweek te wees.

Disability cover for employees essential

WITH most people underinsured against disability, SA employers should build some cost-effective form of cover against this into group assurance schemes.

Old Mutual employee benefits strategic planning manager Eric le Roux says only some of the 6 000 South Africans disabled every year are adequately insured.

"Research done by Old Mutual shows only about half of all employees who belong to group assurance schemes have some form of disability cover."

Le Roux says statistics show that an employee is just as likely to become disabled for three months or longer as he/she is to die before retirement.

Some employers are prepared to bear the cost of an employee who is not able to work by continuing to pay his salary.

"While this must be welcomed, it is also true that no employer can continue such an arrangement on a permanent basis."

He says what should be noted is that someone who becomes permanently disabled usually faces a financial crisis.

At the same time, there is a need to become reconciled to the trauma of disability.

He says many are unaware of the great number of people who become disabled.

It is also probable many people believe they can rely on state aid if they suffer such misfortune.

"Experts of welfare work have emphasised that in most cases such aid is insufficient. In addition, there are long delays before payments are made.

"The only way to satisfactorily provide for the financial independence of people who became permanently disabled is take out assurance against that risk," says Le Roux.

ERIC LE ROUX

'Curb on private hospitals needed'

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OWN CORRESPONDENT

Although less than a quarter of the South African population had some form of private health cover, an oversupply of private hospital beds was developing, the Minister of National Helath, Dr Rina Venter, said in Pretoria yesterday.

OVERSUPPLY: Dr Venter wants hospital beds curb

The private sector could therefore not be allowed to expand its hospital facilities unchecked, she said at the opening of a symposium on private hospitals here.

Even the 25 percent of the population who were members of medical aid funds and their employers could not necessarily afford to pay for increasingly escalating medical costs, she said.

While about 70 percent of available hospital beds were in State hospitals, more than 80 percent of patients were dependent on the State for health care. Star 27/4/91

"These statistics are clear proof that an oversupply of beds for private patients is developing in South Africa and that the State will have to look very carefully at the building of further hospital facilities, both by the State and by the private sector," Dr Venter said.

For this reason, the Cabinet had, in November 1989, imposed a moratorium on the erection of State hospitals.

If the private sector was allowed to expand hospital facilities unchecked, it would result in a further lowering of bed occupancy in State hospitals and lower cost-effectiveness at these institutions.

It would also place strain on the available health care workers and lead to higher medical costs, Dr Venter said.

The Department of National Health was considering 80 applications for the erection of private hospitals, but would be able to approve very few of these.

Govt pledge on medicine cost report

TANIA LEVY

GOVERNMENT was making every effort to release the report on the high cost of medicine, produced by the late Economic Co-ordination Minister Wim de Villiers, National Health and Population Development Minister Rina Venter said at the weekend.

Addressing the Pharmaceutical Manufacturers' Association in Pretoria, Venter said she had told her department to investigate possible ways to contain medicine costs in the interim.

The cost of medicine has been identified as one of the most significant factors contributing to the rising cost of health care.

She said medicine costs could be lowered by making better use of available manpower.

Other areas which had to be looked at included generic substitution of medicines under set conditions, and forming private health teams.

Handicaps are no hurdle for Doreen

IT takes a special kind of woman like Doreen Selekane to leave a well-paying profession to care for and teach mentally handicapped children without even a guarantee of a salary.

Selekane had been nursing for 18 years at Natalspruit Hospital when she decided to take up a course in psychiatric nursing in 1981.

This saw the beginning of years of tireless work to help the mentally handicapped children and their parents in Katlehong.

Her first contact with the children was when she started working as a psychiatric nurse at the hospital's out-patients department where mothers brought their children every Wednesday to see speech and physiotherapy specialists.

"The first step was to counsel mothers to accept their children. But I could not do this during office hours so I had to find time during lunch and on my days off.

"When I was on night duty, which finished at 7am, I would wait for them and only leave at 10," explained Selekane.

"As time went on I decided to leave the hospital to start a project which would allow me enough time to help these people."

It was against this background that the Zimeleni Training Centre for Mentally Handicapped Children, the first-ever institution of its kind in Katlehong, was established in 1982.

By then she had built some contact with the DET and the Witwatersrand Mental Health Society.

Because of the need in Katlehong and in recognition of her work, the DET's Special Schools section agreed to give her the post of psychiatric nurse, which had been meant for Soweto.

"But that was all they offered. There was no money to start the project, no place to start it, no staff to train the children

By PEARL MAJOLA

and I had no intention of making the parents pay for the service.

"I appealed to the Lutheran Church authorities to allow us to use an old building of theirs, to which they agreed.

"I got the mothers to help with the work which was, among other things, toilet training the children, feeding, grooming and games in between.

"Meanwhile, I was going around asking for funds to buy food, toys and whatever else we needed and I was trying to get us registered as a welfare organisation," she recalled.

However, the building had in fact been condemned by health inspectors and when they found out that Selekane was running the project there, they ordered her to move out.

This time she went to

Woman of the Week

DOREEN SELEKANE

the Methodist Church and asked for space there.

Only in 1986 did she manage to get the DET to subsidise the project. But they were only willing to take care of the mildly handicapped children whom they moved to an Old Age Home.

This meant that the profoundly handicapped children would be left uncared for.

Second

Selekane could not let that happen, so she broke her ties with the DET and started all over again, establishing her second project for mentally handicapped children in Katlehong, Tshepong Stimulation Centre.

Wits Mental Health Society accepted to pay her a salary together with the women who were helping her.

"I went on a vigorous fundraising campaign and applied for a site to build a centre. The council gave us two sites and at about the same time Otis, the lifts company, agreed to build a prefab structure for us.

"We now cater for 30 children and there are 135 more on the waiting list," she said.

However, things have not been easy for Selekane. Apart from financial problems and the personal sacrifice she is making to see that these children learn at least to feed and dress themselves, she has been subjected to many difficulties and even personal danger.

Sowetan 29/4/91

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...tive, Mr Simon Buthelezi. Pic by LEN KUMALO.

Tax-free health services urged

Sowetan 29/4/91 (299) (85)

THE Medical Association of South Africa has supported calls for the exemption of Value Added Tax on medical services.

In a statement, Masa general secretary Mr Hendrik Hanekom said: "We are extremely concerned about the cost implications for the patient should VAT be charged on medical services."

Hanekom said tax had never been charged on health services before, and VAT charges would only be an additional burden to the individual.

"About 80 percent of the population do not belong to medical schemes. They either provide for their own health care expenses, or are dependent on the State," Hanekom said.

"Because the former will have to absorb the additional costs of VAT themselves, it is highly probable that the second group will grow, thereby placing further pressure on limited State resources.

Patients

"The possibility exists also under extreme pressure to provide affordable health care. It cannot reasonably be expected of doctors and other providers of services to subsidise this tax, and the patient will inevitably have to bear the costs," he said.

"The possiblity exists that chronically ill patients and the aged will not seek care timeously because of cost considerations. This cannot be justified morally because it is the State's responsibility to ensure the accessibility to health care.

"Health is not a commercial commodity for which the consumer can budget," Hanekom added. - *Sapa*

Prima Bank Nominees (Pty) Limited
Rand Merchant Bank Limited
Saambou Bank Limited
The Board of Executors Merchant Bank Limited
Volkskas Bank Limited

(ii) The Office of the Auditor-General is at present conducting an investigation into the investments made by the SARCC and I am therefore not prepared to comment about the matter at this stage.

(2) I am not in a position to comment on this question before the findings of the Auditor-General as well as the findings of the investigation which I requested have been finalised and considered.

Specialised education: staff

*9. Mr R M BURROWS asked the Minister of Education and Training:

(1) Whether his Department has a policy dealing specifically with the allocation of staff to schools for specialised education; if not, why not; if so, (a) what is this policy and (b) what number of pupils is required before an additional teacher is supplied;

(2) whether teachers in specialised education receive remuneraion on the same basis as do teachers in ordinary schools falling under his Department; if not, why not;

(3) what is his Department's policy in respect of the provision of specialised education for physically disabled children? B872E

The MINISTER OF EDUCATION AND TRAINING:

(1) Yes.

(a) The policy is outlined in a staffing formula developed for the different types of handicapped. This formula boils down to one teaching post for every ten pupils.

(b) For each additional ten pupils a further teaching post is provided.

(2) Teachers in special education are remunerated according to the same salary scales as those applying to teachers in ordinary schools, but they also receive an allowance equal to one notch on the relevant scale.

(3) Special schools for the physically disabled are erected and maintained in co-operation with churches and other welfare organisations with the aid of departmental subsidies. Experts of the Department provide guidance with regard to the management of schools and the educational programmes followed by physically disabled children. The Department devotes the biggest possible share of its budget to the programme: Education of handicapped children.

Alleged Natal police bias: investigation

*10. Mr P C CRONJÉ asked the Minister of Law and Order:

(1) Whether a senior police officer has been appointed to investigate complaints of alleged police bias in Natal; if so, (a) (i) what is the rank and/or name of the officer so appointed and (ii) on what date was the appointment made, (b) what are the circumstances surrounding the matter and (c) what progress has been made in the investigation;

(2) whether a report on the findings of this investigation will be published; if not, why not; if so, when? B873E

The MINISTER OF LAW AND ORDER:

(1) Yes.

(a) (i) Lieutenant-General S H Schutte.

(ii) 5 September 1989.

(b) The officer was appointed to co-ordinate the investigation of, *inter alia*, allegations of police bias against members of the South African Police, and which arose from the unrest situation which was prevailing at that stage. He had, furthermore, to serve the Regional Commissioner of the South African Police in the Natal Region with advice and counsel as regards the handling of those cases.

Lieutenant-General Schutte was withdrawn from that specific duty on 2 January 1991. The task with which he was charged is still being carried out and a permanent member of the South African Police is charged therewith.

(c) Numerous cases of alleged police bias, of which the investigations were co-ordinated by the officer, were dealt with and the necessary steps were taken in this regard.

(2) No, the appointment of a co-ordinating officer in Natal is an internal departmental matter and I am not prepared to make known the reports which the officer and his successor published, and are still publishing. All the evidence that comes to the fore and which may indicate that members of the Force in Natal are guilty of partial conduct or behaviour which amounts to criminal or departmental misdemeanours, is without exception submitted to the Attorney-General or otherwise dealt with thorough means of a departmental trial.

Planning of education: gathering of data

*11. Mr R M BURROWS asked the Minister of National Education:

(1) Whether he or his Department undertakes the gathering of education data for planning purposes; if so,

(2) whether this information (a) is available on a geographical or magisterial basis and (b) is utilised or could be utilised for planning for education in specific geographic areas on a non-racial basis;

(3) whether his Department has made a calculation of the number of children who will be eligible to attend school in the event of compulsory education covering the first 7 school levels or the ages 6 to 13; if not, why not; if so, (a) what is the relevant figure and (b) how many pupils falling into the category referred to above are at school at present? B876E

The MINISTER OF NATIONAL EDUCATION:

(1) Yes, in terms of general education policy every Government department responsible for education annually supplies the Department of National Education with information pertaining to all the college and school education sectors for the previous financial year as set out in the SANEP information system.

(2) (a) The information on the school sectors is available on a geographical basis, according to 73 statistical regions.

(b) The information is used within the education sector for financing purposes, as well as for planning purposes from time to time. Although the information is available according to population group, it is not used on a racial basis within the education sector. The information has on occasion also been used for planning purposes by institutions outside education.

(3) No, it is not possible, by using the SANEP information system, to calculate what the number of children attending school would be were compulsory education to be implemented for the first 7 school levels, or for the age group 6 to 13 years.

(a) Estimates show that in 1988 there would have been approximately 5 930 000 children in the first 7 school levels in the RSA had compulsory education been in effect.

(b) In 1988, there were 5 068 926 children from Gr 1 to Std 5 in the RSA.

Right-wing violence: complaints/charges

*12. Mr L FUCHS asked the Minister of Law and Order:

(1) Whether, with reference to certain information furnished to the South African Police for the purpose of the Minister's reply, any complaints have been received, charges have been laid and/or action has been taken against any persons following an explosion and threats of right-wing violence at planned anti-apartheid marches on prisons on 6 April 1991; if not, why not; if so, (a) what was the nature of these complaints and charges, (b) against whom were they laid and (c) what action has been taken against the persons concerned;

(299) (155) (155) wlmail 3/5 - 9/5/91

Slump hits medical schemes

By MONDLI MAKHANYA

THE RECESSION and increased unemployment have begun to hit medical aid schemes.

Medical aid, being a luxury, is one of the first items which people drop from their budgets.

Sizwe Medical Fund, which has 50 percent membership on the mines, has lost a sizeable portion of its membership as a result of retrenchments. Sizwe has retrenched 21 employees as a result of rationalisation measures.

Sizwe representative Sibongile Ziyambe said the worst effect of the recession has been in cutting off of prospective business.

"Companies are downscaling costs. We now require much more effort when we market our medical aid to companies and have to spend a lot more time convincing them," said Ziyambe.

She added medical aid was not a tangible product and it was necessary to persuade people they needed it.

AMA managing director Timothy Gelman said AMA was likely to start feeling the effects of recession in the next few months. AMA has a miniscule membership on the mines but is contracted to some companies in allied industries.

"We've restructured our company for cost containment. We've created a hierarchy of medical products that will enable more people to have access to medical aid cover," said Gelman.

While unemployment may lose some medical aids members, the Wits Chamber of Commerce and Industry's scheme believes it may gain membership as result.

"When professionals lose their jobs they may decide to move into small business. So unemployment on its own can bring in members for us," said chairman Pat Corbin.

Corbin said the high cost of health care which had the effect of pushing people off medical aids in bad times, would put a burden on public health care. "We have been trying to get doctors to prescribe generics."

Pulse Medical Consultants' Louis Esterhuizen said a recession might have the effect of forcing people to take out medical aid cover.

"When recession comes people have less disposable income. People with no medical aid may therefore be compelled to get on to medical aid in order to save on the high costs of medical care," said Esterhuizen.

Health care must be free — ANC

A BILL of patients' rights should be publicly displayed wherever health care was provided and a health charter should be compiled.

Political Staff

* These proposals are contained in an ANC discussion document, entitled *Towards Developing a Health Policy* which will be debated at the ANC's national conference in June.

Health was a basic human right and this should be legally entrenched in a Bill of Rights, particularly free essential health care.

There should also be a preferential allocation of resources to promote health care within the most vulnerable sectors of the community, the document stated.

which would include the provision of all communities with clinics, community health centres and hospitals.

It would also focus on eradicating or controlling major diseases, including Aids, tuberculosis, measles and polio;

* Co-operation between health and welfare services which would form part of a single Ministry of Health and Social Services;

* The financing of health care by public funds with no one being denied health care because of a lack of money.

Sufficient funds would be created by levying taxes on those who could afford to pay them;

* The continued existence of private health care within the context of a mixed economy but an appropriate connection should be developed between public and private health care.

The document said this implied that the private sector should become part of the national health care. In the long term, most health care should be provided by the public health service and those in private practice should be attracted to the public sector;

* The creation of a national medicines policy; and

* The establishment of expert committees to investigate how the neglect of occupational health, mental health, the health of women and children, the care and rehabilitation of the disabled and dental care could be addressed.

The document noted that there was an enormous imbalance of power between health workers and their patients, and between the health service and the communities it served.

Resolve

Ways to resolve this included the display of a Bill of patients' rights, the decentralisation of health care and the development of grassroot structures to give the public a say in the formulation of health policy.

South African health services reflected all the injustices of apartheid and the different "own affairs" health services departments' increased costs and made it impossible to plan or co-ordinate health care adequately between the different ministries, the ANC said.

In spite of the repeal of the Separate Amenities Act, health services remained largely segregated with 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 time involved in travelling to the major urban centres where these hospitals are located," it said.

The Government's policy of privatisation and cuts in Government spending on health has resulted in not enough money being spent on public health services.

"About half of all the money spent on health care is caught up in the private sector, which contains half the doctors, nearly all the dentists and pharmacists, and one quarter of the hospital beds ... Yet this rich private sector only provides for about 20 percent of the population."

The provision of equitable health care should be guided by principles reflected in the Primary Health Care approach adopted by the World Health Organisation and the United Nations Children's Fund.

> ***"Health is a basic right and this should be entrenched in a Bill of Rights"***

Baby deaths pr

obe 'nearing' end

NEWS

Star 4/5/91

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SUE OLSWANG

THE Attorney-General of the Witwatersrand has given an assurance that investigations into the deaths of infants and adults believed to have been caused by contaminated "drips" will be completed by the middle of the year, 12 months after the first death was allegedly reported to the South African Police.

Witwatersrand Attorney-General Mr Klaus von Lieres said this week: "Our investigations are continuing and progressing very nicely. The investigations have to be concluded by the middle of this year."

Mr von Lieres said no decision had been made regarding possible prosecution or inquests into the 27 deaths being investigated. "One must first establish proof to indicate death by unnatural circumstances," he said.

However, the families of the adults and children who died in 1990 under mysterious circumstances — suggesting the possible implication of intravenous admixture products manufactured by Sabax, a division of Adcock Ingram — this week said they "had to impose a deadline on the Attorney-General to assure that a proper investigation took place.

Peter Soller, the attorney representing the families of eight dead adults, two dead toddlers, 24 dead infants and four "survivors", said he has given Mr von Lieres until May 7 to decide whether or not to prosecute.

Mr Soller said: "Under the Criminal Procedures Act, if he refuses to prosecute he must issue a *nolle prosequi* declaration and I can then institute a private prosecution.

"In addition, the Inquest Act states that if the Attorney-General does not wish to prosecute he must refer the matter to the magistrate in whose jurisdiction the death occurred. It is the magistrate's decision whether or not to hold an inquest."

In a statement issued earlier this week, Mr Soller said his clients "wish to make the following clear" to anyone who believed undue pressure was being put on Mr von Lieres:

- The first death was reported to the SAP in Brixton on July 26 1990. It was not known what action was taken, except that in September or October the inquest file from the magistrate in Johannesburg, who had not yet held an inquest, was forwarded to the Attorney-General.
- From the date of the first report to Brixton Murder and Robbery Squad, the police had not been able to satisfy anyone that the death or deaths were investigated timeously or at all.
- In May 1990, a parent whose child had died in Sandton in February 1990 formally notified the Sandton Medical Officer of Health of what he considered an irregular state of affairs. The Medical Officer of Health had not acknowledged receipt of the complaint.
- Minister of Health Dr Rina Venter and Minister of Health and Welfare Sam de Beer were asked to hold a public inquiry under the Commissions Act. Mr de Beer undertook to carry out an investigation starting in October last year, while Dr Venter had seemingly done nothing except acknowledge receipt of the dossier prepared for her.
- It was known that two pending inquests were stopped and sent to the office of the Attorney-General, where they had remained.

Defective

Don Bodley, chief executive of Adcock Ingram, this week said all investigations had so far indicated that "only two batches of a paediatric admixture were found to be defective".

He said the Johannesburg and Cape Town admixture pharmacies where the products were prepared were closed at the end of September last year and had remained closed.

Mr Bodley stressed that all intravenous fluids currently supplied by Sabax were sterilised in sealed form at the end of the manufacturing process and there was no exposure or danger to patients in hospitals and clinics.

- Adcock Ingram has pointed out "confusion regarding the term 'drips'," stating that this is "colloquial terminology for intravenous fluids".

Blind wait years for vital operations

Star 6/5/91

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Own Correspondent

CAPE TOWN — Blind people who have been waiting for a year for operations at Groote Schuur Hospital to restore their sight will have to wait another 12 months due to financial cuts.

In a letter to the SA Medical Journal, Cape Town University ophthalmology department head, Professor Anthony Murray, and SA College of Medicine head, Professor John Terblanche, warn that the postponement of the operations have serious implications.

About 1 500 people had cataract operations at Groote Schuur every year and the waiting list was another year long.

In the First World there was "ideally" one ophthalmologist for every 50 000 people. In South Africa the ratio was one for every 180 000 people.

The professors said that of the 217 000 blind people in the rural areas and national states, almost half were blind because of cataracts, and 22 000 more people developed cataracts each year.

"Despite the fact that blindness due to cataract is remediable, because of the lack of ophthalmologists and surgical facilties in these areas, less than 10 000 of these patients will undergo surgery this year, leaving 127 000 with remedial blindness untreated.

"At this hospital ophthalmology consulants are already working way beyond the call of duty, and worsening conditions will lead to their resignation and the gradual destruction of the department.

"Unless this crisis is immediately addressed by health care authorities, it is highly likely that our department will disintegrate and its essential services will cease."

Numsa pulls out of medical aid agreement

BDay 6/5/91 299 587

VERA VON LIERES

THE National Union of Metalworkers (Numsa) has withdrawn as a party to the metal and engineering industries medical aid fund agreement.

Both the Steel and Engineering Industries Federation (Seifsa) and Numsa confirmed at the weekend that the union would no longer take part in the fund.

Seifsa said the withdrawal followed "large-scale refusals" by Numsa members to contribute to the fund.

Numsa said its members found it too expensive and indicated they would like to see part of their money returned if use was not made of the medical facility.

Seifsa said Numsa members were now no longer eligible for membership of the Metal Industries Medical Aid Fund (MIMAF).

In its latest news letter Seifsa said Numsa decided last year to become a member of the Medical Aid Fund Agreement. Members were obliged to participate in and contribute to the fund from early November.

Only 250 members actually joined the fund.

The arrangment was abandoned early this year.

Numsa official Geoff Schreiner said at the weekend that, before considering membership, Numsa fought for MIMAF to be restructured. In particular, it fought for the fund to become a voluntary scheme because it was aware that members had diverse views on medical aid scheme membership.

The union decided to test the response of its higher paid membership in practice. When contributions became payable, most members refused to pay.

Workers were demanding state responsibility in ensuring that "access to proper health care was a right of all citizens".

VAT set to cause huge medical aid fee rise

By Jacqueline Myburgh

Medical aid subscriptions could rise by between 30 and 35 percent by the end of this year if VAT legislation remains unchanged, according to the financial manager of a firm of medical aid scheme administrators.

That means that an average monthly subscription of R400 could increase to about R520.

Kobus Stals, of Status Medical Aid Administrators, said the hefty increase would come as a result of the annual subscription increase of about 25 percent, plus the cost of VAT, which is to be levied on all medical services from October 1 when the new tax system is introduced.

Subscription fees are exempt from VAT, but Mr Stals said the cost of medical expenses paid by medical aid schemes would go up by 12 percent when VAT came on line, and this increase would have to be passed on to the member.

"Our expenses will go up, but our income will not," he said.

Medical aid schemes would therefore have to recover their expenditure on the medical services used by members through increased subscription tariffs.

Although VAT will be 12 percent, the subscription increase will be only about 10 percent since some medical aid expenses such as medication are already subject to GST.

Cancer services crippled by shortage of finance

wlmail 10/5 – 16/5/91

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By CARMEL RICKARD: DURBAN

THE National Cancer Association, crippled by a severe shortfall in funds, faces the grim prospect of closing its laboratory, leaving many thousands of women around the country without access to early, affordable cervical-cancer tests.

Director of the Natal branch of the association, Theony Szidat, said this week that the region was operating on a budget R1,5-million less than was needed. Only a skeleton staff could be employed to offer the hospicare, education and self-help programme services for which the association has become known.

Szidat said one of the services most threatened was the laboratory to screen papsmears, based in Durban but serving family-planning clinics around the country and Namibia. Until recently the test was offered free of charge, but the association has been forced to charge R3 a slide. As a result, 20 000 to 30 000 fewer women had the test because they could not afford it.

This was cause for great concern since the family-planning clinics tended to serve women from lower-income brackets, who were most at risk from cervical cancer, she said.

If they did not have regular papsmear tests — which detect precancer changes in the cells — they ran the risk of detecting the disease too late.

"Closing down our laboratory would put some 50 000 to 60 000 women at risk every year."

Szidat estimates the association needs about R150 000 to keep the laboratory going. The funds would have to come from the public since the Natal Cancer Association does not receive any state funds.

A number of other projects of the association are also under threat, or are being put on hold until the financial situation improves.

For example, the budget for grants to families of cancer victims decreased from R40 000 last year to R12 000 this year.

"This is alarming, because very often these people lose their jobs after being diagnosed as having cancer," Szidat said.

"We have tried to provide them with bridging finance until they can obtain a government disability grant. We used to be able to give them a grant for three months. But because of the shortfall in our finances, we can now give grants only for one month — and then only if we feel they are desperate cases, if they really have no other financial resources to can call on.

"For most, all we can offer is a food parcel and then refer them to the social welfare department for further help."

Home for disabled a dream come true

Cpress 12/5/91

By LULAMA LUTI (299)

PERSEVERANCE by Daveyton residents in their efforts to establish a home for the disabled has finally paid off.

The official opening of the first wing of the Elethu-Daveyton Cheshire Home last weekend is a dream come true for its first four residents and for the nearly 50 others who will join them when the home is complete next year.

The home, taking shape on a 6 000 square metre plot donated by the Daveyton Town Council, was extensively vandalised last year but survived to accommodate its first four residents two months ago.

Named after Group Captain Leonard Cheshire VC – the founder of numerous homes for the disabled internationally, it is only one of its kind in South Africa. The other one was opened in Soweto last year and there is another home in Natal.

The home, which will R2,5-million, is funded by private companies and by donations from the local business community.

Chairman of the Benoni Action Group for the Disabled, Patrick Mabunda, told *City Press*: "The necessity for this type of home cannot be overemphasised.

"People due to be discharged from hospitals have already applied for accommodation at the home, as have many others staying with their families at East Rand townships."

For resident Agnes Mbuyisa, 27, life will never be the same again. She was all smiles as she told *City Press* how "things will be easier now.

"Life at home was difficult, especially when there was no one to wheel me around.

"I could not fetch water for myself, and although I can cook, it was a difficult process."

The home is designed to provide independence and privacy for residents. All of the 10 single rooms completed are comfortably furnished with built-in wardrobes, beds, tables and chairs.

The home, which will cost R2,5-million, is funded by private companies and by donations from the local business community.

Daveyton social worker, Maggie Pooe, said there was a "tendency to make such institutions dumping grounds. But this home will not cut ties between residents and families".

Victor Gamani is one of the four lucky people to be admitted to the Daveyton's Chesire Home for the Disabled – 50 other people will move in next year.

■ Pic: Lesley Hlakati

Mystery disease ravages Natal's village of hunger

By DERRICK LUTHAYI

TWENTY-four-years ago Nomusa Tembe was born a normal, healthy child.

She spent her childhood as all little girls do – playing at being a normal adult and dreaming of a family of her own.

But unlike most other normal girls, Nomusa's dreams were shattered at the age of seven by a mystery disease that left her a cripple.

Today Nomusa must use a stick to keep herself upright and even so cannot walk more than five metres without a rest.

"When I move my joints become painful. Sometimes they are so sore I have to crawl about," Nomusa told *City Press*.

Nomusa is one of about 2 000 women in the northern Natal village of Mseleni afflicted by the mystery disease – aptly named Mseleni Joint Disease (MJD) by the doctors at Mseleni hospital.

What baffles hospital doctors is why the disease affects women more than men, and usually those aged from five to 20. People affected by it cannot walk upright or forward. They can only walk sideways like crabs.

Hospital superintendent Dr VG Fredlund said the disease was first noticed in the "early 1960s, when girls aged 14 to 16 primarily were afflicted".

He said the disease has been diagnosed as a form of arthritis affecting the joints – mainly the hips.

"Research so far does not show us a cause for it. We do not know why the disease is confined to the Mseleni area. There is no trace or history of it in other parts of the country.

"There are many patients in an advanced stage of the disease and we cannot keep them all in the hospital. Because of this we have set aside special days for treating them as out-patients.

"We are trying to get hip replacements, but because of financial problems we can only manage an average 24 operations at R1 500 each a year.

Fredlund is worried there may be a connection between the disease and the high rate of malnutrition in the area.

"We are exploring trench gardening for vegetables and we have introduced a pilot scheme to use waste water so villagers can grow vegetables at their homes."

Fredlund said at some homes the scheme was being "hindered by a lack of manpower due to the number of family members suffering from MJD and consequently unable to plough".

Social worker Mandla Dludlu said many people were "eating wild plants because of the food shortage".

"Many would have died of starvation already had Operation Hunger not come to the rescue," he said.

Suffering ... Nomusa Tembe is one of 2 000 women crippled by a mystery disease found only in the Natal village of Mseleni.

Assegai issue 'may be resolved soon'

B 10 am 13/5/91

BILLY PADDOCK

CAPE TOWN — Government was confident of resolving the impasse over the carrying of assegais at political rallies and other "non-cultural" events.

A senior source said the May 9 ultimatum had come and gone and government had managed to find a way through.

And despite ANC deputy president Nelson Mandela having put the negotiations on hold until Thursday — by when government is called upon to ban the public brandishing of spears — negotiators believed they would find ways to keep the talks on track.

Negotiators were also confident they would be able to overcome the ANC's reluctance to participate in the summit on violence which is two weeks away.

One source said while President F W de Klerk may not have consulted Mandela about holding the summit, he had not set the agenda or prescribed a programme.

The programme and agenda still had to be planned with the parties involved.

De Klerk's job of finding a way to persuade Inkatha president Mangosuthu Buthelezi to accept the ban on assegais has been made that much more difficult by the weekend decision by Zulu chiefs that they would never compromise on the carrying of traditional weapons and the ANC Youth League's statement that it gave "unqualified support" to the ANC's initial seven-point ultimatum.

Last week Buthelezi warned government that any ban on spears would not be tolerated by Zulus and could spark even greater violence.

It is understood De Klerk would be involved in a fresh round of consultations with Mandela and Buthelezi this week.

Government negotiators started a fresh round of shuttle diplomacy at the weekend trying to arrive at a deal whereby spears would only be allowed at strictly cultural events such as KwaZulu's Shaka Day celebrations.

What was really required was that Buthelezi and Mandela meet each other and thrash something out, a source said.

What government needed was for the two leaders, or their representatives, to meet-.Negotiators were keeping close contact with Mandela and Buthelezi in order to resolve the impasse.

One source said the Summit on Violence would also enable the two parties to thrash out a joint approach on preaching peace.

He said while there was an urgency for government to resolve the assegai issue they did not understand why they were given an absolute deadline of seven days.

● Comment:Page 6

Govt defends VAT on medical services

299

Binary 13/5/91

TANIA LEVY

VAT was imposed on medical services after the Medical Association of SA objected to government's initial proposal that these services be exempt, deputy Minister of Finance and National Education Theo Alant said in a statement at the weekend.

The imposition of VAT on medical services has been criticised, with the Representative Association of Medical Schemes estimating that it would add R410m a year to SA's private health care bill.

The average medical scheme member would have to pay an extra R180 a year, over and above annual increases.

Alant said government's initial draft bill had exempted medical services from VAT, although medicines would remain taxable.

The Medical Association of South Africa (Masa) had objected to this proposal, saying doctors would have to pay more tax on costs than at present. They would either have to absorb additional costs and make less profit or increase their fees.

Alant said Masa had estimated the cost of medical services would increase by no more than 7% as result of VAT.

PEANUTS

By Charles Schulz

Getting on with life by helping others

(299) Star 14/5/91

They're as different as odd socks.

The rotund little Frenchman, with his twinkling eyes and accent so full of burrs it almost makes your skin itch, and the thickset South African, who looks as though he might have propped the scrum in his time.

Dirk Lamprecht (50) suffers from central blindness. This means he sees your face — or whatever he looks at directly — as a blurred outline. His peripheral vision is fine, but, he says with a shrug of inevitability, his eyesight keeps deteriorating a little more each year.

Helping

The shrug means he has come to terms with it. There are more important things in life, like helping others, and he is getting on with it.

And yes, he *has* been physically adventurous in his time, although that doesn't include propping the scrum. He has run the Comrades, has parachuted from a plane to win a bet with his wife and at the Rand Show this year, did a bungi jump.

He and Paul de la Hay du Pausel, a former native of Mauritius, who has lived in South Africa for the past 10 years, run a charitable programme known as "Computer Literacy for the Blind".

They met quite by accident when Mr Lamprecht took a 5 km walk one day to the Honeydew post office. The little Frenchman was intrigued to hear that Dirk, after a single hour's lesson in computers, had taught himself and because of his own condition was keen to launch an operation aimed at helping the blind become "computer literate".

Mr Lamprecht used to be a rep in Durban, but with the continued deterioration of his sight, he was pensioned off.

His interest in computers came as a result of his wife's "insistence on getting me off my backside and into something useful".

Mr du Pausel, a senior member of Lions Club International, was a member in Madagascar for many years and one of the earliest members in this country when the organisation was launched in 1955. He immediately saw how Lions could help, and began to punt for support for Dirk Lamprecht's project.

Exciting challenge . . . Daniel Sebeo (left), Dirk Lamprecht (standing) and Paul de la Hay du Pausel.

The two have great dreams for the project, to which they devote endless time without so much as a cent's remuneration. The Lions Club, through its US operation in particular, will in time be able to pour considerable funds into the project, but for the moment the two are looking for as much local support as they can find.

Typical of the projects Computer Literacy for the Blind tackles is the case of Daniel Sebeo (21), of the Mangosuthu Tech in Durban. He was sent to Mr Lamprecht by Anglo American. Mr Lamprecht works with him twice a week in concerted sessions of five hours, and what he has achieved with Daniel, totally blind from birth, seems little short of miraculous.

Stoep Talk

MICHAEL SHAFTO

"I want to make as many blind people as I can computer literate," he says. "I won't necessarily get them a job but it gives them another string to their bow."

Through his training, warm understanding of the problems of the blind and dogged perseverance, Dirk, with the help also of the SA Council for the Blind, has managed to place a number of people in employment in computer-related fields. No obstacle is too great.

One of his current pupils, who is a B Comm graduate, lost his sight through diabetes, then had both legs amputated as a result of poor circulation, and has recently had a kidney transplant.

"What I need to help him is a lap-top — a portable."

This is the immediate concern of Messrs du Pausel and Lamprecht. If there is any firm out there thinking of scrapping computers, please think again. Donate them to Computer Literacy for the Blind; let these two gentlemen have them reconditioned. Their aim to is have five and a "lap-top". This will enable Mr Lamprecht, after the initial lessons, to allow four pupils at a time to take a computer home with them and allow him to take his "lap-top" to them to continue lessons.

Already Lions have spent R30 000 on equipment that crowds Mr Lamprecht's small townhouse.

Instruct

It includes voice synthesisers which instruct the blind operator on how to proceed. Their next step is to acquire a Braille printout machine. Already Mr Lamprecht has permission from magazines such as Cosmopolitan, Femina and Style to make Braille printouts of articles in demand among the blind.

As he says: "It's a big mountain with lots of precipices, but it's a wonderfully exciting challenge."

Mr Lamprecht's telephone number is (011) 678-1669.

POLITICS

Responsiblity for health services to be on three levels

Bldaily 14/5/91. BILLY PADDOCK (299)

CAPE TOWN — Responsibility for health services is to be divided among central, regional and local authorities, each with their own budget, Health Minister Dr Rina Venter said yesterday.

Releasing details of planned restructuring of health services during debate on her budget, she also indicated government's concern about the brain drain.

She said Cabinet had approved an urgent investigation into the feasibility of supplementing salaries by allowing limited private practice in the hope that this would stem the tide. This would take three months, she said.

The restructuring, a result of the investigations the late Wim de Villiers conducted, provided for health functions to have the most effective level of government and budget for each line of service, she said.

Earlier, she told a Press conference some progress in this restructuring could be realised in about two years, but the whole plan would take 10 years to complete.

Budgets for the seven tertiary complexes, incorporating 13 academic hospitals, would be divided between them.

Each complex would be entitled to generate and raise its own funds, she said.

Central government would be responsible for developing national policy and standards, the planning of resources and monitoring and financing of health services.

The restructuring included:

- All primary health care functions being devolved to local authorities with the six authorities responsible for these services to be consolidated into a single authority. Provincial administrations would have to help develop the ability to provide services at local level where they were lacking.

The devolution of primary health care was to be a community responsibility as much as possible.

- Maximum management autonomy for academic hospitals resulting in management and control of the seven complexes being transferred from the provincial administrations to a manager and a supervisory board.

Venter said those local authorities (mainly black) that could not supply the required services or expertise could call on neighbouring (white) authorities to help out.

Government rethinking VAT on medical costs

Star 15/5/91

By Derek Tommey

The Government may change its decision to impose VAT on medical services.

It is understood that after strong representations from various medical bodies it has agreed to reconsider its original proposal.

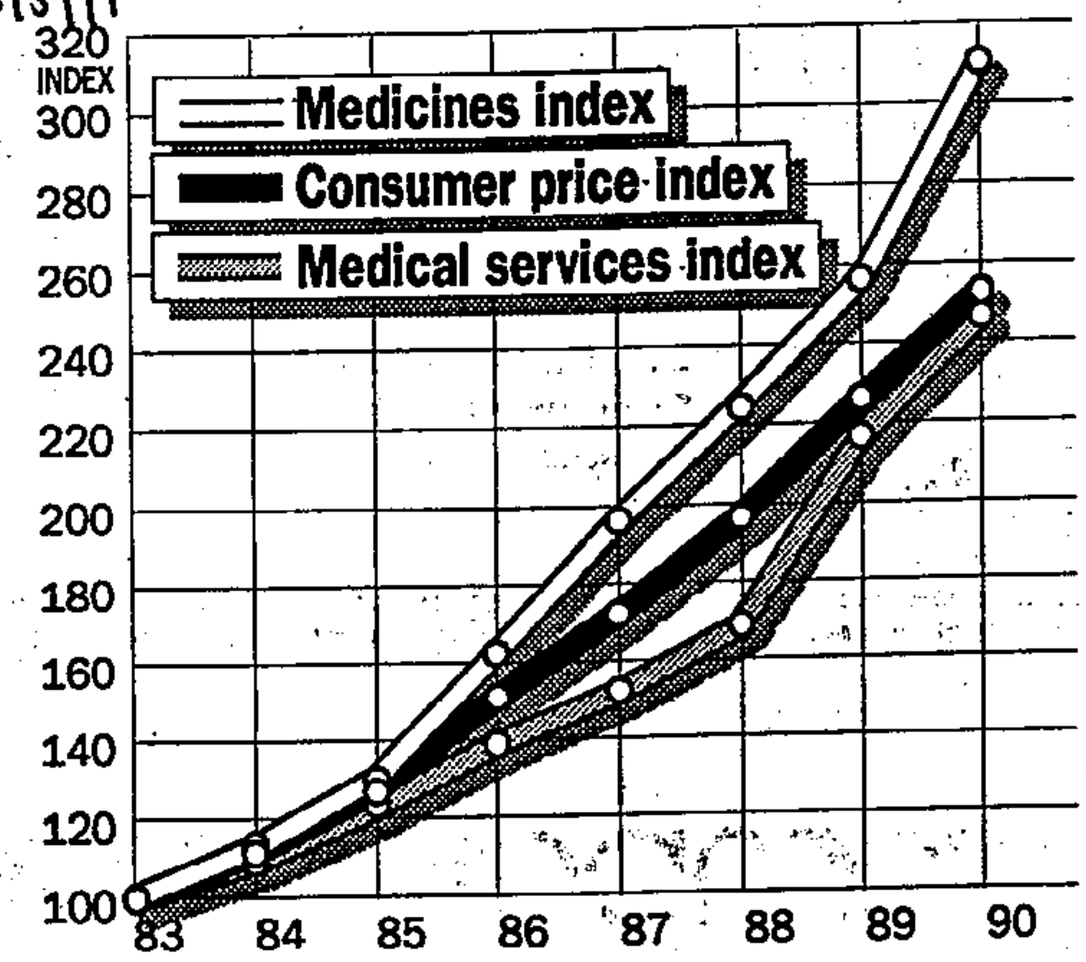
Medical officials are hopeful that the Minister of Finance Barend du Plessis will make an announcement on the matter within the next few days.

The Medical Association of South Africa (Masa) said earlier this month that it would fight the Government to prevent the introduction of tax on their services.

The Government has been heavily criticised by many bodies for its plan to put a 12 percent tax on all medical services.

One objection is that these services — which include charges by doctors, dentists, opticians, and other medical staff, and fees by hospitals and nursing homes — have never been subject to GST.

The imposition of VAT on these services will, therefore, open up an entirely new source of revenue.



VAT at 12 percent on medical services would be a heavy blow. Medical services are one of the few items whose cost has not exceeded the consumer price index, according to calculations by Professor Jan Hupkes of Unisa. In contrast, since 1983 the price of medicines has been rising at a compound rate of 20 percent a year.

To some extent this is in conflict with the idea that the change from GST to VAT is supposed to be "tax neutral".

The individual is not expected to pay more tax when VAT is introduced than is paid at present.

But this will not be the case if VAT is imposed on medical services.

Another objection is that VAT will make even more expensive what are already costly services.

Medical services account for two-thirds of the total medical bill.

The imposition of VAT could add hundreds of millions of rands to the nation's medical bills.

This, together with the expected inflationary increases in medical costs, could raise medical aid fees next year by up to 30 percent.

A third objection is that such taxes should not be imposed on essential services, especially as much of the higher costs will fall on the poorer section of population.

Opponents of VAT have called for medical services to be zero-rated.

Under this system, all VAT paid in the manufacturing process is refunded.

Failing that, they want medical services to be exempt from VAT.

This means that VAT is not imposed on the final price, with suppliers of medical services receiving no refund on the VAT they have already paid.

The medical profession is bitterly opposed to the imposition of VAT and has been engaged in intensive lobbying to have it revoked.

(299) (EB)

Medi-Clinic nets R21,9m

Business Day 05/91

SEAN VAN ZYL

HIGHER occupancy levels at Medi-Clinic's hospitals enabled the Rembrandt Group's hospital services subsidiary to lift attributable profits 10% to R21,9m for the year ended March.

Medi-Clinic has disclosed earnings of 12,9c (11,8c) a share of which a final dividend, marginally down on the previous year, of 2,5c (3c) a share has been declared. However, the combined interim and final dividend of 4c a share exceeded 1990's total dividend payout by 33%.

While turnover was not disclosed, the company has indicated a 40% increase on the previous year's revenue. Income at operating level showed growth of 52% to R24,7m (16,1m).

The company was able to negotiate higher tariffs from the Representative Association of Medical Schemes (Rams) last year.

Despite the strong growth on the pre-tax level, a tax bill of R7,45m at 26% reduced income available for distribution to R21,7m from R19,9m the previous year at which stage no tax was payable due to start-up losses incurred.

Van Wyk said a new hospital was being built in Stellenbosch which was expected to be completed by May next year. Medi-Clinic's seven hospitals showed improved occupancy levels for the 1991 trading year.

Van Wyk noted that earnings were expected to improve further for the current financial year.

Medical VAT stays 'with Masa support'

BIDay 15/5/91 299

BILLY PADDOCK

CAPE TOWN — VAT on medical services would remain and was in keeping with representations from the Medical Association of SA (Masa) to Vatcom, Deputy Finance Minister Theo Alant said yesterday.

In a statement he said that as a result of Press reports he wanted to place the issue in perspective.

Government's proposals in the draft VAT Bill last year were that medical services be exempt from VAT, but that medicines remain taxable.

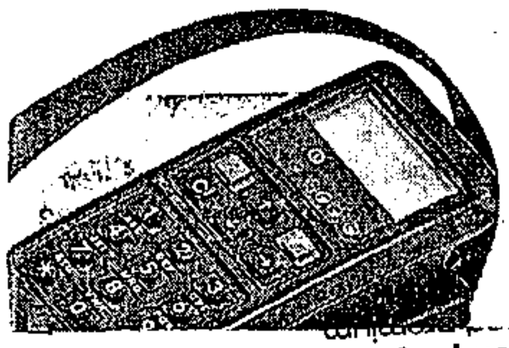
In its representations, Masa said if fees were to be exempt from VAT practitioners would not be entitled to a credit for the input tax they would pay and would thus have to absorb the extra costs.

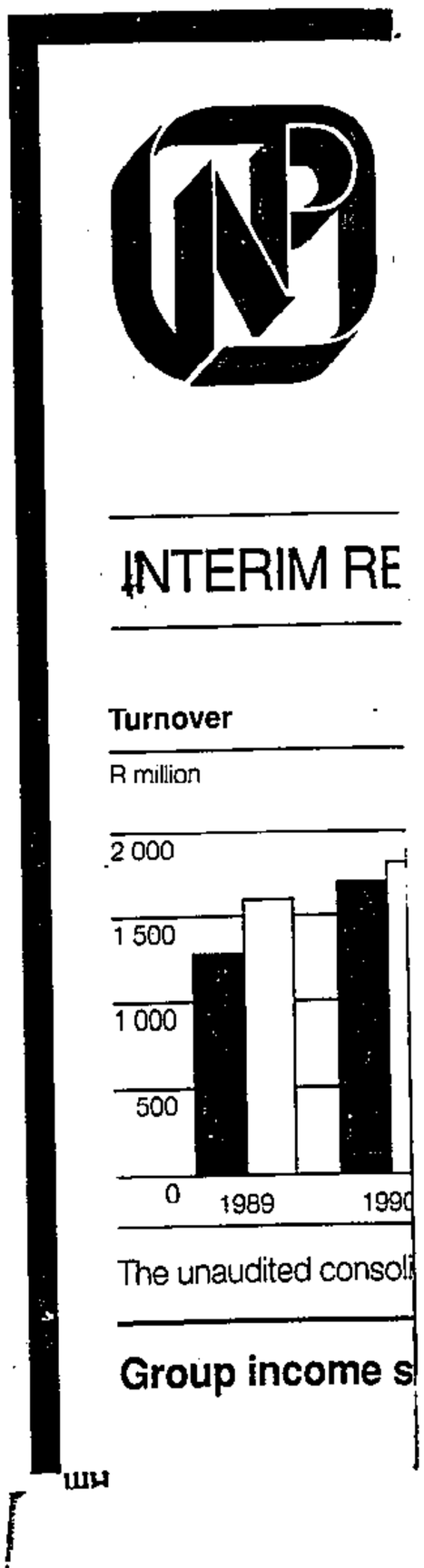
The credit would apply in the case of zero rating or standard rating.

He said Masa asked for services to be zero rated, but if that was not the case, it would prefer the standard rate to an exemption.

He said Masa presented a typical example of a medical practitioner's financial statements, showing that costs of medical services would increase by no more than 7% as a result of VAT "provided practitioners passed on the full benefit of input tax to their patients".

Alant said the cost of all medicines would decrease by one percentage point because VAT was being imposed at 12% instead of the 13% of GST.





'Quiet catastrophe' in health care

299

GERALD REILLY

PRETORIA — SA was facing a "quiet catastrophe" as child mortality rates continued to soar and nutritional problems worsened, National Health and Population Development director-general Coen Slabber said yesterday.

Speaking at a forum on primary health care, Slabber said another aspect of the catastrophe was an increasing incidence of diseases of poverty. One example of this was tuberculosis, he said.

He said SA had the means to combat these problems.

Slabber said it was children who bore the heaviest burden of poverty.

This was happening because progress was slowing down.

"This last decade of the 20th century has for many become the decade of despair," he said.

Pitfalls that had plagued efforts in the past had to be avoided.

The major pitfall was trying to develop communities without their participation and involvement.

Slabber warned that if a significant proportion of the SA population was consigned to continuing poverty, frustration would cast a long shadow of violence and tension over the entire country.

He also warned that health care resources would remain limited.

To be successful, a primary health campaign had to be backed by adequate housing, basic education and literacy programmes.

What was needed were achievable, large-scale, low-cost, high-impact and politically attractive plans, he said.

Medics worried by VAT threat

HEALTH FILE

By MOKGADI PELA

THE Medical Association of South Africa has expressed concern about the cost implications for the patient should VAT be charged on medical services.

The organisation has instead, called for the zero rating of health services.

Masa secretary general Dr Hendrik Hanekom this week urged parliament go heed calls from various sources not to proceed with its implementation.

He said Masa had accepted the Government's intention of spreading taxation more evenly by means of VAT.

"However, since health services were not taxed before, there is no question of a redistribution of the tax load," Hanekom said.

He cited the implications of charging VAT on medical services as: 80 percent of the population do not belong to medical schemes.

They either provide for their own health care expenses or are dependent on the State.

"Because the former will have to absorb the additional costs of VAT themselves, it is highly probable the second group will grow, thereby placing further pressure on limited State resources."

* The private sector is under pressure to provide affordable health care. It cannot be reasonably expected of doctors and health care workers to subsidise "this tax".

A possibility exists that chronically ill patients and the aged will not seek care timeously because it is the State's responsibility to ensure accessibility to health care.

Hanekom said health was a basic right of every individual.

"It is not a commercial commodity for which the consumer can budget," he said.

A woman with a heart of gold

Sowetan 20/5/91. (299)

Woman of the week

LYDIA SEKATI

IT takes immense courage for a mother to leave the comfort of her home to care for other people's children in a place like a hostel.

It takes even more courage for a woman to do this voluntarily.

Mrs Lydia Sekati is one such woman.

Sekati, who has two children of her own, has for a long time been concerned about the welfare of mentally retarded children.

It all started in 1986 when her nephew was deserted by his wife. The woman left him with three children, one of whom was a mentally handicapped two-year-old boy.

The children moved in with her. But she was soon to discover that she could not cope.

She then took the boy to a social worker, hoping he would be sent to a special school.

By PEARL MAJOLA

But there was no such a facility in Sebokeng.

There was a long queue of people with the same problem waiting to be helped by the social worker.

It was after observing this that she decided to do something for the poor children.

Bedroom

"It always saddened me to see mentally retarded children locked in bedrooms of their own homes and uncared for because people don't have the patience to wipe the saliva that oozes out of their mouths uncontrolably or clean them when they wet their pants.

"My children are normal and they can do things for themselves. They can tell me when they are not feeling well.

"But these poor children here cannot speak or think for themselves, somebody has to do it for them."

With the help of a local social worker, Sekati managed to raise a donation of about R20 000 to start a centre for the mentally handicapped children in the township.

The Lekoa Council allocated her an unused bungalow at the Sebokeng Women's Hostel which she later converted into a centre for the children.

The converted bungalow is divided into two nine-bed dormitories, a kitchenette, a playroom, and a small office-cum-TV room furnished with a filing cabinet, a small table, three chairs and a portable black and white TV set.

Some of the money she raised was used to buy the beds, linen, a stove, a fridge and some toys.

In January 1987 the Lebohang Centre for Profoundly Mentally Retarded Children was born.

Sekati has networked with other organisations such as Operation Hunger who now provide soup for the children.

"Initially there were 24 children at the centre but the number dropped to 18 when three of the children were taken by their parents. Three have since died.

"The parents pay R70 a month mainly for food. They clothe the children although we do have clothes which have been donated to us.

"The centre closes during the festive season to alllow the children to visit their families," said Sekati.

"Some parents wanted the centre to provide day-care facilities. But I suggested that they should be boarders here because transporting them would be expensive.

"Their parents, who needed to work but could not because they were looking after them, could also be able to find jobs and generate some income.

"Two parents offered to help me at the home and since then we have two additional people who are working with us," she said.

Between the five of them, the women clean the home, wash the children, cook and feed them and do the washing.

The four women are paid for their work, but Sekati does it on a voluntary basis.

She only visits her two daughters twice a week.

The council has now allocated them a three-hectare piece of land while the British Consulate has promised to help with the building.

Sekati has big plans for the new centre.

"It will cater for about 100 children. We already have 80 on our waiting list and I know the social worker has another long list of children waiting to be placed in special schools or in homes," she said.

"If there are more children than we can take, I hope we will be able to start a day-care facility for them.

"I also hope that we will be able to get a physiotherapist and other professionals to volunteer to help us."

Readers are urged to write in and submit nominations for Woman of the Week. Our address is PO Box 6663, Johannesburg 2000 or phone us at (011) 474-0128.

WOMAN

☆ ☆

Eiret

Daveyton gets disabled home

Soweten 21/5/91 299

THE second Cheshire Home for the physically disabled in a black township has been officially opened in Daveyton.

It is also the first ever facility of this kind in the area.

The Elethu-Daveyton Cheshire Home has room for 10 physically disabled people from the township at a cost of about R7 500 a month.

Guest speaker at the opening function and one of the people involved in the initial planning of Elethu, Mrs Makie Pooe, said she hoped families of disabled people would not

By PEARL MAJOLA

abandon them there but would visit them and continue loving them.

"I got involved with this project because I had fallen in love with disabled people. Unfortunately I could not continue my involvement because I had study commitments, but I still have great interest in the progress here," she said.

"I hope that management and residents will work hand in hand and it will not be management doing things for the residents."

Appeal

She appealed to the community to "make the home respectable". Hardly a year after it opened, the home was vandalised.

Last year, Soweto Cheshire Home in Moroka became the first home for the physically disabled to be opened in a black township. It was opened by the founder of the Cheshire Homes Movement, Group Captain Leonard Cheshire, who was visiting South Africa from Britain.

The movement's first project was started in Britain in 1948 when Cheshire heard about a dying ex-serviceman who had nowhere to go after being discharged from hospital. He took the man into his home and nursed him until his death.

Today there are over 300 Cheshire Homes worldwide catering mainly for disabled people.

Medical schemes not testing for HIV virus

299 Star 21/5/91

Medical Reporter

Medical aid members do not have to submit to HIV screening prior to being accepted as members of the schemes, according to spokesmen of two major administrators of medical aid schemes.

Managing director Jeff Slome of Medicaid and deputy managing director of Medscheme Les Hollis indicated that pre-screening was not taking place at present when questioned on the policies of medical aids with regard to HIV-positivity.

"We are not testing any, although testing may take place at employer levels — and we would not know," Mr Slome said.

He added that although it was suspected that medical aids were paying for the health care of Aids patients, only symptoms, such as pneumonia, were reflected on accounts.

Mr Hollis said testing "was really in the hands of the employers" as initially the impact on the workpace was greater than on medical schemes.

Mr Slome said a problem facing medical schemes was that Aids had not been declared a notifiable disease.

At present the policy was to keep people on the schemes although, in terms of their rules, some schemes may be in a position to exclude certain benefits with regard to Aids treatment.

In the case of medication, schemes only paid the maximum amount allowed per member — despite the fact that treatment for Aids or HIV-positive people with AZT amounted to more than R1 000 a month.

Mr Hollis said the policy was "loose at the moment" because it took such a long time to establish if a member had Aids and because accounts made it difficult to identify if a patient had the disease.

He said while the matter was of concern to medical aids, most of the known cases were treated by State or provincial services.

Coloureds. Very soon the majority of the students at this university will be Blacks. There can be a great upheaval if that institution remains under the control of the hon the Minister of Education and Culture of this House.

Mr P NAIDOO: Mr Chairman, if it is accepted that the birth of a new South Africa is a process and not an event, then changes to apartheid-inspired structures should occur in tandem with the process. Postponing vital changes until the formalisation of the process will merely result in an accumulation of problems.

The restructuring of the administration of the country's education structures will be a clear indication that progress towards a new South Africa need not be held up by the interminable search for a negotiated political settlement. In taking steps such as this, the Government provides evidence that it is breaking with the apartheid past and is entirely committed to change. Education is one of the spheres in which there has been a gross distortion in the spending of public money and there should be no illusions about the problems any future administration will face in eliminating these backlogs.

Education offers scope for the changes contemplated in this interpellation. However, the Government should be alert to the dangers of making far-reaching decisions on its own. It would be wise to offer places on its policy advice committees to all major groups so that the changes have the widest possible support. Persisting with the notion that education is an own affair will merely hinder attempts by the Government to normalise our educational institutions. By initiating changes now, we will succeed in depoliticising education.

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, I want the hon the Minister to take a message to the hon the State President: The stubborn attitude of the Government in its refusal to adjust apartheid structures within the tricameral Parliament, is going to have very far-reaching political consequences. The implications are that the Government is providing certain forces outside Parliament with the ammunition they require to destroy the political movements that have chosen to use the institution of Parliament in the programme for peaceful evolution in this country.

HOUSE OF DELEGATES

I accept that there are practical difficulties. As the hon the State President said during his Vote, there was a change in attitude regarding a super Cabinet. The hon the State President went soft on it. What I am appealing for today—I know the hon the Minister does not have the authority to respond—is for him to convey this message to the hon the State President on this issue alone. I request the Government to go soft on this issue. [Time expired.]

The MINISTER OF NATIONAL EDUCATION: Mr Chairman, I want to say again that changes will be made. The hon the State President has said so. It will come. However, it has to come as the result of negotiations in which those parties outside Parliament, that the hon the Leader of the Official Opposition referred to, will also have an opportunity of taking part. I think that is democratic. I think it is correct and fair.

It is because we have set our minds on this course of action, that the whole of South Africa will be represented around the table, negotiating a future for South Africa. It is also there that we shall decide about a new structure. I suggest it is presumptuous of us within the tricameral system to sit down to devise a new system for the RSA.

It is presumptious of us to determine the future. I suggest that we take the honourable and royal path, the democratic path, of entering into these negotiations and coming up with a new system in due course.

Debate concluded.

QUESTIONS

†Indicates translated version.

For oral reply:

General Affairs:

Carnage on roads: penalty points

*1. Mr M F CASSIM asked the Minister of Transport:

(1) Whether his Department has conducted any research into the system of penalty points employed in certain countries in an attempt to reduce the carnage on roads; if not, why not; if so, with what results;

(2) whether he intends introducing such a system or any other measures with a view to reducing the number of instances of excessive speeding and of traffic rules being disregarded on our roads; if not, why not; if so, (a) what measures and (b) when;

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

D132E

The MINISTER OF TRANSPORT:

(1) Yes, the Department of Transport has appointed the Council for Scientific and Industrial Research (CSIR) to research the penalty points systems in use in countries such as the Republic of Germany and the United States of America, with the objective to compile such a system which will take local conditions in the RSA into account. The results of this research are expected to be made available during the latter half of 1991.

(2) Yes, the intention is to introduce a penalty points system to all vehicles and drivers, in addition to goods vehicles, their drivers and operators as envisaged in the White Paper on National Transport Policy.

(a) The Road Traffic Act, 1989 (Act 29 of 1989) already makes provision for the Minister of Transport to prescribe, by regulation, the content of registers to be maintained by various authorities.

The introduction of the National Traffic Information System (NaTIS) will enable the administration of the penalty points system, together with the recording of collisions and outstanding offences, in the case of untraceable offenders. The NaTIS will also allow a law enforcement officer direct access from the roadside to the traffic offence record of a driver, *inter alia* for the identification and possible apprehension of a previously untraceable offender at the time of committing a further offence.

(b) Tenders have already been invited for the supply and maintenance of the NaTIS and are expected to be awarded during July 1991. It is expected that the offences module of the implementation programme of the NaTIS, will become operational during 1994. This will allow time to resolve anticipated problems to match the new system and the present situation.

(3) No.

Security officer: shooting in East London

*2. Mr M RAJAB asked the Minister of Justice:

(1) Whether, with reference to his reply in the House of Assembly to Question No 367 on 14 May 1990, the investigations into the shooting of approximately 39 persons by an East London security officer, whose name has been furnished to the Minister's Department for the purpose of his reply, have been completed; if not, why not; if so, what is this persons' name;

(2) whether the Attorney-General has reached a decision on the matter; if not, when is it anticipated that a decision will be reached; if so, what is the decision?

D133E

The DEPUTY MINISTER OF JUSTICE:

(1) No. The investigation is in the final stages. An investigating team of the South African Police is in the process of finalising certain instructions.

(2) No. The Attorney-General, Grahamstown indicates that it is anticipated that a decision concerning a possible prosecution will be reached within the next few weeks.

High cost of medicine: report

*3. Mr M RAJAB asked the Minister of National Health:

(1) Whether she or her Department has received a report on an investigation undertaken by the late Minister for Administration and Economic Co-ordination into the high cost of medicine; if so, what are the findings and recommendations contained in the report;

HOUSE OF DELEGATES

(2) whether this report will be made public; if not, why not; if so, (a) when and (b) in what manner;

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

D134E

The MINISTER OF TRANSPORT (for the Minister of National Health):

(1) Yes, the recommendations of this report are at present being evaluated by a committee of Ministers;

(2) at this stage it is not possible to say what steps the government will take;

(3) falls away.

Mr M RAJAB: Mr Chairman, arising out of the reply given by the hon the Minister, may I draw his attention to the fact that my question specifically asks what the findings and the recommendations of the report were.

The MINISTER OF TRANSPORT: Mr Chairman, I think the hon member is referring to the second part of his question. The answer of the hon the Minister of National Health is as follows: At this stage it is not possible to say what steps the Government will take, because at this time they are still evaluating this report drawn up by the late Minister for Administration and Economic Co-ordination.

Tala Valley: hormonal herbicides

*4. Mr N JUMUNA asked the Minister of Agriculture:

(1) Whether his Department intends, as a result of the controversy surrounding hormonal herbicides in agriculture, to determine why vegetable farmers in the Tala Valley are quitting; if not, why not; if so, when;

(2) whether he will make a statement on the subject of hormonal herbicides?

D147E

The MINISTER OF AGRICULTURE:

(1) Yes. Officials in the Department of Agriculture and in the Department of Agricultural Development are investigating all possible factors affecting the vegetable production of farmers in the Tala Valley.

(2) Yes. A scientific information day on this subject will be held at the Cedara Agricultural College, Pietermaritzburg, on 3 June 1991, at which meeting I will make a statement based on all the facts available.

State pension schemes: privatisation

*5. Mr E JOOSAB asked the Minister of Finance:

(1) Whether he intends privatising any State pension schemes; if not, why not; if so, (a) which pension schemes and (b) when;

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

D148E

The DEPUTY MINISTER OF FINANCE:

(1) I recently announced that a committee of experts from the private sector had been appointed to advise the Government on the best future structure and siting of the Government Pension Funds. Until the Committee has finalised its business and the Government has considered its recommendations, no conclusive answer can be given to the honourable member's question.

(2) No.

Lenasia: squatter/transit camp

*6. Mr D K PADIACHEY asked the Minister of Planning, Provincial Affairs and National Housing:

(1) Whether the squatter camp situated in Lenasia Extensions 9 and 10 has been declared a transit camp; if so, when;

(2) whether all the conditions for a squatter camp to be declared a transit camp have been complied with in regard to the above-mentioned camp; if not, why not; if so, what are these conditions;

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

D149E

The DEPUTY MINISTER OF PLANNING, PROVINCIAL AFFAIRS AND NATIONAL HOUSING:

(1) Yes. 28 November 1990.

(2) Yes. The conditions have been complied with. It must be declared in the Official Gazette by the local authority. That has been complied with. It was, however, established at a later stage that the land description, according to the Deeds Office, is not correct.

The matter is being investigated urgently with a view to rectifying it.

(3) No.

INTERPELLATION

Own affairs:

The sign * indicates a translation. The sign †, used subsequently in the same interpellation, indicates the original language.

Housing consultant: hours of work/payment

1. The LEADER OF THE OFFICIAL OPPOSITION asked the Minister of Housing:

(a) How many hours of work had the housing consultant performed since his appointment up to the latest specified date for which information is available and

(b) how much was he paid during this period?

D159E.INT

The MINISTER OF HOUSING: Mr Chairman, in the 13 departmental housing projects—excluding 21 local authority projects—at present under construction, we employ 15 housing consultants who all work at a percentage fee and not at an hourly rate. I therefore have to accept that the hon the Leader of the Official Opposition is referring to the financial and management consultant, Mr D V H Hall, who was the subject of questions in this House on 19 March 1991.

If this is correct, the information requested is 910¼ hours and R136 537,50 up to 15 May 1991. In evaluating this information, certain factors have to be considered carefully. These involve the effective time worked, the cost of the time and the benefits thus derived. The consultant during the period worked an average of 63 hours per week, which is well above the average working week of the senior staff in the Public Service.

During this period the consultant had to evaluate commitments of R539 million and prioritise them; evaluate the Housing Development Board's submissions and approvals of R127 million; advise on the affordability of commitments and potential savings; advise on the regularising of work procedures and tender evaluations; initiate new structures to manage projects; advise on the Housing Development Fund expenditure for 1991-92 and the next two years; advise on cost-saving methods, advise on procedures to recover outstanding debt; and advise on the economics of projects to be started.

During the period the consultant, through his expertise in analysing the R127 million worth of projects mentioned saved the Administration an identified R11 255 000. The savings to date can thus be calculated at 8,8% of the project cost or 82 times the fees paid to date. In housing terms this means an extra 400 homes for our people. If we can continue in this we way, will be able to squeeze close to 900 extra housing units out of our available funds for housing. This must be considered as favourable to the Administration.

I would like to briefly indicate the savings that were made, but unfortunately I do not have the information here. A list with the break-down of the figures of the exact savings can be made available to hon members who are interested.

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, it is unfortunate that this interpellation has come up in the middle of the housing debate, but I do not think there was any negative intention. It is a question of public accountability which is the main issue.

I want to place on record that I am not going to pass judgement on the decision to appoint a consultant. As I indicated during the debate on housing, I shall comment only at the end of the financial year.

However, what we must place on record is that savings as a result of thorough scrutiny by architects and our quantity surveyors at our head office have been an ongoing exercise from the time a housing department was established in South Africa. I remember in the times of the SA Indian Council one official boasted that, as a result of thoroughly examining the plans, he was able to suggest certain reductions to local authorities, and in one particular project—without the appointment of a consultant—there was a reduction of R2 million in the overall allocation.

'Demand for private health care will fall'

Own Correspondent

SOUTH AFRICA'S private sector health service would be forced to restructure "radically" in the future, Wits Health Policy Unit researcher Dr Max Price said in Pretoria yesterday.

Addressing 200 delegates at the annual Pharmaceutical Society of SA conference, Dr Price said the privatisation of the last decade was "history", and predicted that demand for private health care would level out.

Private sector health was unable to contain the escalation of costs which had escalated medical aid contributions by up to 20% above the inflation rate.

Dr Price believed the market for medical aid — and therefore private sector health care — had reached a plateau, and could even decline.

Govt 'still silent' on hunger strikers

BIDay 22/5/91

WILSON ZWANE

THERE was little hope that five hospitalised prisoners — who enter the 22nd day of their hunger strike today — would be released in the near future, Hunger Strike Committee lawyer Willie Hofmeyr said yesterday.

Hofmeyr said since the release of one of the prisoners, journalist Rafiq Rohan, from Cape Town's Somerset Hospital on Monday there "has been no word from the government on the remaining prisoners".

He said government should take "drastic action" if the situation was to be resolved. "The prisoners cannot wait to be released." The five prisoners include ANC guerrilla Gordon Webster, who collapsed on Sunday. Hofmeyr said they were "very weak and cannot go to the toilet by themselves".

He said demonstrations "in solidarity with the prisoners" would be held this week — with Parliament targeted for mass action tomorrow.

Rohan was due to take part in a "candlelight demonstration" outside the Somerset Hospital last night.

A former Post Natal news editor, Rohan was released from hospital on Monday night after a senior doctor had warned that he was in danger and had suffered slight organ disorders.

Sapa reports Rohan said he was fully aware of the risks when he started the protest, adding: "I was not concerned about what happened to me physically. I knew I could destroy organs, but all I wanted was to secure my release".

Rohan said he had been suffering from an ulcer.

Meanwhile the ANC's southern Free State region yesterday called for a stayaway, fast and one-day consumer boycott today to show solidarity with the hunger strikers.

Cosatu's western Cape region will decide on a possible general strike later this week.

SA urged to be 'AIDS-friendly'

JONATHON REES

BIDay 22/5/91

A GOVERNMENT organisation said yesterday homosexual men and women should be referred to as "alternative sex practitioners" and prostitutes as "commercial sex workers".

A glossary of "AIDS-friendly" words was published yesterday by the National Health and Population Development Department's AIDS Unit.

Unit head Dr Manda Holmshaw said experience in other countries had shown scare tactics in AIDS education did not work, so words which tended to victimise or stigmatise people should be replaced with more sensitive and informative terms.

"Person with AIDS" had become an internationally recognised, and more accurate and acceptable, alternative to "AIDS sufferer" or "AIDS victim".

The term "promiscuity" was moralising but "multi-partner lifestyle" laid no blame, Holmshaw said.

'Radical changes likely' in private health sector

BIDay 22/5/91

TANIA LEVY

SA's private health sector would be forced to "quite radically" restructure in the future, Wits Health Policy Unit researcher Dr Max Price said in Pretoria yesterday.

Addressing 200 delegates at the annual Pharmaceutical Society of SA conference, Price said the privatisation of the past decade was "history" and he predicted that demand for private health care would level out.

The private health sector was unable to contain the escalation of costs which had resulted in medical aid contributions rocketing seven to 20 points above the inflation rate.

Price said he believed that the market for medical aid — and therefore private sector health care — had reached a plateau and could even decline.

The reasons were the anticipated continued rise in costs, changes to the Medical Schemes Act which allowed flexible packages and risk rating, and the threatened deregulation of the insurance and medical aid industries.

These changes could end cross-subsidisation in medical aid schemes.

Our Cape Town Correspondent reports that Barbara Gie, a member of Groote Schuur Hospital's costing committee, told the conference the hospital had cut last year's expenditure on medicine by R3,3m, nearly 10%.

Medical aid membership costs soar

Star 25/5/91 299

DEREK TOMMEY

THE cost of belonging to a medical aid society has quadrupled in the past seven years, Dr Jan Hupkes, Professor in Management Economics at Unisa said in Pretoria yesterday.

However, he said the medical aid funds were not the cause of the increases but the victims of higher medical costs.

Addressing the SA National Consumer's Union he said that the average medical aid membership fee had risen 322 percent since 1983 while the cost of medical services had risen 149 percent, the consumer price index 152 percent and the cost of medicines 211 percent.

He said the fact that medical services had shown the smallest price increase was because they had not been subject to GST. He expressed the hope that the authorities would take this into account when considering imposing VAT on these services.

Some people in the health care industry claim that the steep increase in medicine costs is partly the result of the State buying two thirds of the country's medicines and paying only one third of the cost. The man in the street who bought one-third of the country's medicines had to pay two-thirds of the cost. These allegations are being invetigated by the Monopolies Commission.

But the main reason for the rise in medical aid costs has been the increased demand for curative health care.

Dr Hupkes said that more attention must be paid to providing preventative health services such pure water, better hygiene and adequate food, clothing and housing.

Medics can claim for their inputs

By IAN CHAMBERS, tax consultant, Fisher Hoffman Stride

Sunday Times Business Tues 26/5/91

WHEN the draft legislation was released for comment in July 1990, medical services were exempt from VAT.

This meant that although medical practitioners would have to pay VAT on the acquisition of all of their supplies, including capital equipment, because they were supplying an exempt service, they would not be entitled to claim a VAT input tax for any VAT paid.

Furthermore, any goods necessary for and subordinate and incidental to the supply of the services in a hospital or nursing home or services provided in any clinic conducted by a local authority would also have been exempt.

On the other hand, the supply of medicine after consultation would have been subject to tax.

This initial decision to exempt medical services and so relieve practitioners of the administrative burden of VAT would have been an administrative nightmare in the case of a dispensing practitioner who would be supplying both taxable and exempt goods.

Under current legislation, sales tax is levied on certain goods used by the medical profession. With a wider VAT base, several of other services are subject to VAT but not to sales tax.

They include rent, electricity, water and professional services. This means the practitioner would be faced with higher costs without being able to claim any input tax credit, resulting in either reduced profitability or increased fees.

In areas of high capitalisation costs, essentially pathology and radiography, these practitioners would be most adversely affected.

As a remedy, Vatcom proposed that the exemption be withdrawn and all medical services be subjected to VAT. Medical-aid schemes on the other hand are defined as financial services and are exempt. Medical-aid contributions will not attract VAT.

The recommendation was accepted by the Government and was included in the Bill passed by in Parliament last week. This places the medical profession in exactly the same position as any other, such as law, accountancy and architecture.

Consequently, the fees that medical practitioners charge will be subject to VAT, but at the same time they will be entitled to claim an input tax credit for the acquisition of all supplies they buy to provide their services.

At the same time, rent, electricity, water and professional fees will now be subject to VAT. They are not subject to GST. VAT will have to be paid, but will be recovered.

The medical practitioner will merely have to fund this VAT until such time that he submits his VAT return.

WOMAN

City officials are taking health to the people

Soweten 29/5/91

THE process of taking health services to the people by the Soweto City Health department has been made more efficient with the introduction of a sophisticated mobile clinic unit worth R93 000.

The unit is fully fitted with a fridge for injection vials and other medicines which have to be kept cold, a microwave oven for warming children's feeds when necessary, a consulting cubicle, a toilet and bathroom facility, two examination beds and lots of cupboard space for files and other equipment.

The team

The health care team, consisting of a community health care nurse, an immunising sister, a clerk and a weigh lady, visits different squatter camps around Soweto everyday providing mainly child health services like immunisation and treatment of minor health problems like diarrhoea or rash.

By PEARL MAJOLA

"The primary health care concept is that no woman should have to travel more than five kilometres to a health institution because research shows that if it is further than that she will not go," explained Dr Ngokoana Khomo of Soweto City Health.

Free

"We have 10 clinics in Soweto but with the mushrooming squatter camps, the only feasible way of rendering health services effectively to them is by mobile clinics.

"The advantages of a mobile clinic are that the services are free of charge compared to the R8 consultation fee mothers have to pay at the clinics and it requires less staff than a fixed clinic," she said.

"Unlike an ordinary van (which was used before the new unit), this particular unit we have will render a private and comprehensive service to individual patients.

It has a consulting cubicle and the nurses do not have to load and unload equipment every time they have to go out.

Awnings

"We can also fit awnings to it to provide shelter against the sun or rain for patients," she added.

The service reaches about 30 000 squatters and the team sees about 80 patients a visit and up to now the team has done an immunisation coverage of 70 percent.

Checks

In addititon to the mobile clinics, the primary health care nurses do home visits and there is an annual one-month "raking campaign" during which they go from house to house checking on the immunisation state of all children under the age of seven.

The new unit was first used last week at the Kliptown squatter camp.

Hospice plays vital role – Hough

Staff Reporter 299 92 Star 29/5/91

Between 17 500 and 20 000 South Africans died each year from terminal illnesses, of whom about 6 000 were on the Witwatersrand, according to Transvaal Administrator Danie Hough.

Opening the National Hospice Week at a ceremony at the University of the Witwatersrand's Great Hall in Johannesburg on Monday night, Mr Hough said it was a human necessity for people to be together and to share in love and fellowship at times of suffering.

The Hospice organisation played an important role in health care, he said, and stressed the need to maintain the rapport between family, patient, and hospital staff in order to meet the patients needs.

Caring

"We still don't know what the effects of Aids is going to be. Without Hospice, these patients would have to be cared for by their families. Therefore I am proud of the Hospice's unique achievements," he said.

Wits Chancellor Professor Robert Charlton said Hospice played a significant role the country could not ignore.

Hospice was the source of caring in a world in which very few families had been left untouched by sickness, he said.

It reassured people that death was not always painful and lonely, and that pain and suffering could be relieved through modern techniques, he said.

The opening was attended by the mayors and deputy mayors of Johannesburg, Soweto, Midrand, Alberton, Roodepoort, Bedfordview, Krugersdorp, and Midrand.

The Anglican Bishop of Johannesburg, Duncan Buchanan, blessed the occassion.

Running of services needs close examination

B Day 29/5/91 (88) (299)

THE running of private health care and hospitals is not viable and needs to be re-examined, says National Association of Private Hospitals president Brian Davidson.

Davidson, whose organisation represents 76% of beds in private hospitals and 82% of hospitals, says it is important that private hospitals remain for those who demand their services and cannot afford them.

The way to ensure this is to create an effective national system for the 80% of the population that do not use private hospitals.

The private and public sectors must work together to ensure that health resources are optimised.

A main objective for private hospitals is to have a growing private sector providing cost effective and efficient care.

The current method of funding, medical aid schemes, is becoming far too expensive and great savings can be made.

This, he says, is through managed health care, either through preferred provider organisations or health management organisations (HMO).

The impression that private hospital costs are excessive results from comparisons between private and public institutions' costs. This is misleading because public sector facilities are highly subsidised.

Doctors opt for more cost-effective measures

BDay 29/5/91

WITH most private hospitals charging in excess of medical aid scale of benefits, doctors seem to be becoming more cost aware.

They are increasingly opting to use more cost-effective facilities, such as day clinics, says Medicaid Administrators (MA) director John Cowlin.

A private hospital's tariff is almost double that of a day clinic for an equivalent procedure.

This compares to a case where medical aid schemes guarantee payment to a hospital which submits its accounts within the scale of benefits.

The existing structure of private fees for service or third-party payer system has a lot to recommend it, he says.

It provides for a wide choice of doctors, access to specialists, ethical medication, hi-tech diagnostics and modern hospitals.

Cowlin says the proliferation of expensive, hi-tech diagnostic and therapeutic equipment is a source of concern for medical aid schemes.

For instance, there are 14 magnetic resonance scanners in the UK and 15 in SA.

The same situation exists for other equipment, such as litho-trypters.

These hospitals can be described as five-star hotels with an aseptic bias, he says. The only disadvantage is the cost involved.

Cover

Cowlin says this type of private health care will continue to occupy an important, albeit diminishing, niche for the forseeable future.

Medical aid schemes are able to provide comprehensive long-term cover for members by cross-subsidisation in their funds.

The insurance principle of the young insuring the old and the healthy the ill remains valid.

When evaluating insurance packages "one must remember medical aid-type insurance is long term.

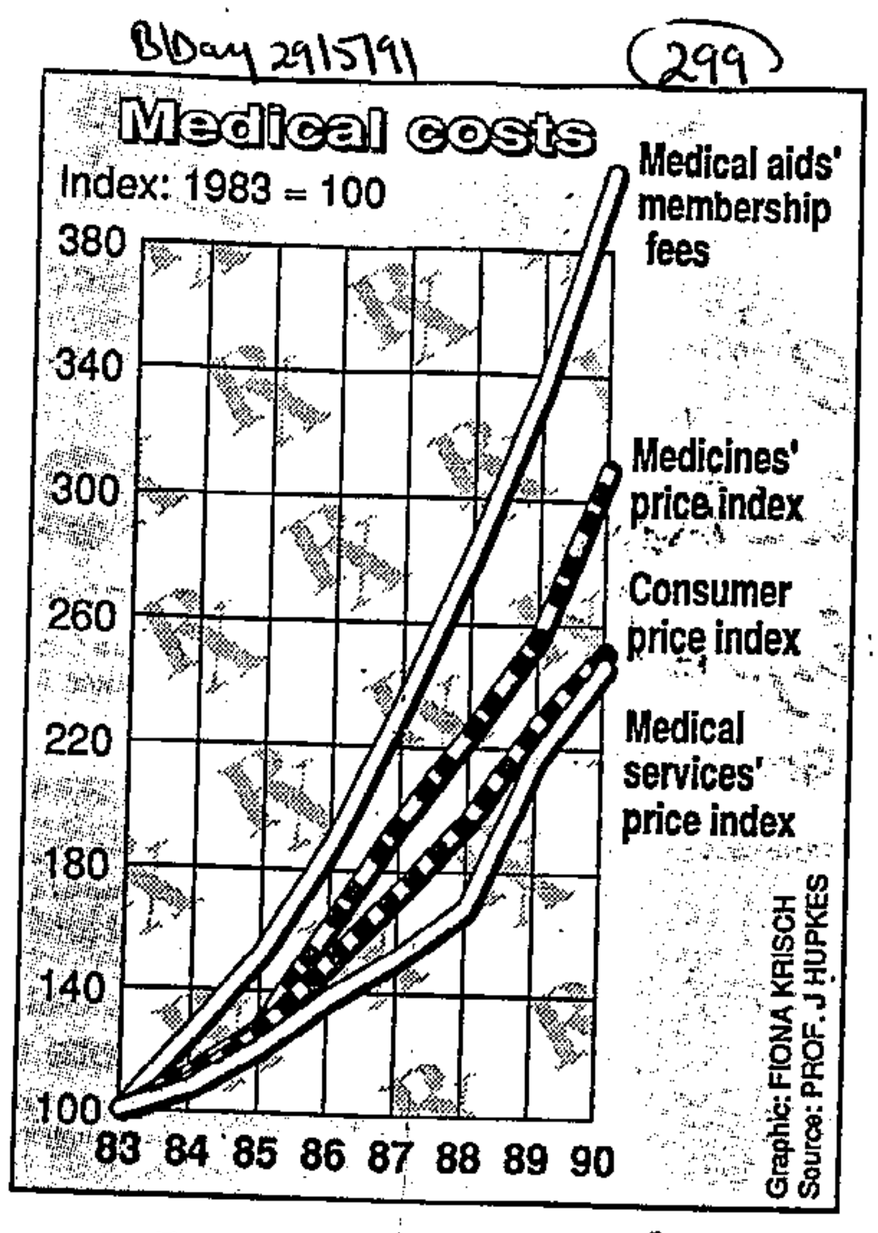
"The Medical Schemes Act provides for what is known as continuation members.

"These are people who have been members of one or other medical aid scheme throughout their lives and when they reach retirement they have to be kept on as members."

He says the importance of this provision is illustrated by the fact that 40% of individual health care allowances are spent in the last 18 months of a pensioner's life.

"Insurance companies, which are permitted to set premiums on the basis of the claims experience of a particular group, can insure the lowest-risk individuals in a society."

Membership of these policies can be revised and insurers can terminate the insurance if the member moves into a high-risk category.



Bridging the gap for the less wealthy

WHILE there has been an increase in the number of privately run hospitals catering for those who can afford their services, escalating costs and the lack of a clear national health policy are leading to a breakdown in essential health services for the less well-off majority.

Old Mutual's employee benefits department says the crisis in government health care facilities has focused attention on the discrepancies in medical care available to South Africans of different social standings.

The cost spiral has also pushed up employers' contributions to medical aid schemes from 2,5% of the wage bill in 1970 to 7,5% currently.

Employee benefits assistant GM Henk Beets says a major problem is that while 70% of whites are covered by some form of medical aid, only about 6% of the black population is.

Paved the way

For most South Africans, state or provincial hospitals remain the only source of health care.

Medical schemes' problems in coping with the rising cost of medical services has paved the way for insurance companies to enter the health care industry, providing both supplementary cover and lower cost alternatives.

The advantage of this type of cover, which pays a benefit in the event of major surgery, dread disease or hospitalisation, is that it brings expensive and private health care within reach of the average South African.

Insurance companies could make use of both their risk-pooling ability and their administrative experience.

Beets says health insurance covering major medical expenses can be more cost-effective than the provision of full medical aid cover.

New and cheaper model needed urgently Rams

SA NEEDS new models of health care delivery and it needs them quickly, says Representative Association of Medical Schemes (Rams) executive director Rob Speedie.

He says the industry cannot continue under the current cost spiral and more cost effective ways to deliver services and benefits to consumers are needed.

One way is through managed health care, which he says seems a strong future possibility.

Such schemes are already in existence in the form of medical benefit schemes. One example is VaalMed in Vanderbijlpark which has 24 general practitioners and its own hospital and pharmacy.

He warns that the implementation of cost effective schemes should not be done at the expense of health care.

They should also not interfere with the freedom of choice that medical aid schemes offered.

Another means of cutting costs is to implement no-claim and low-claim bonuses for members of schemes. Preliminary experiments show substantial cost savings could be effected.

The move should, however, not interfere with the basic principle of cross-subsidisation, he says.

Meanwhile, Clinic Holdings executive chairman Barney Hurwitz says medical aid societies are causing an inflationary spiral in the hospital industry because of their payment of bills to patients instead of hospitals.

Hurwitz heads the country's biggest private hospital group —it has 12 hospitals —which, he says, suffers because of the size of its accounts book.

Payment for treatment and consultation is made directly to patients who would rather spend the money on buying other things than paying their debts, he maintains.

The cost of keeping such a large accounts book has to be passed on.

BARNEY HURWITZ

He recommends the system, which amounts to hospitals giving patients free credit, be changed by government legislation.

Speedie says some medical schemes do pay direct to the hospitals but those that do not have every right to do as they are doing.

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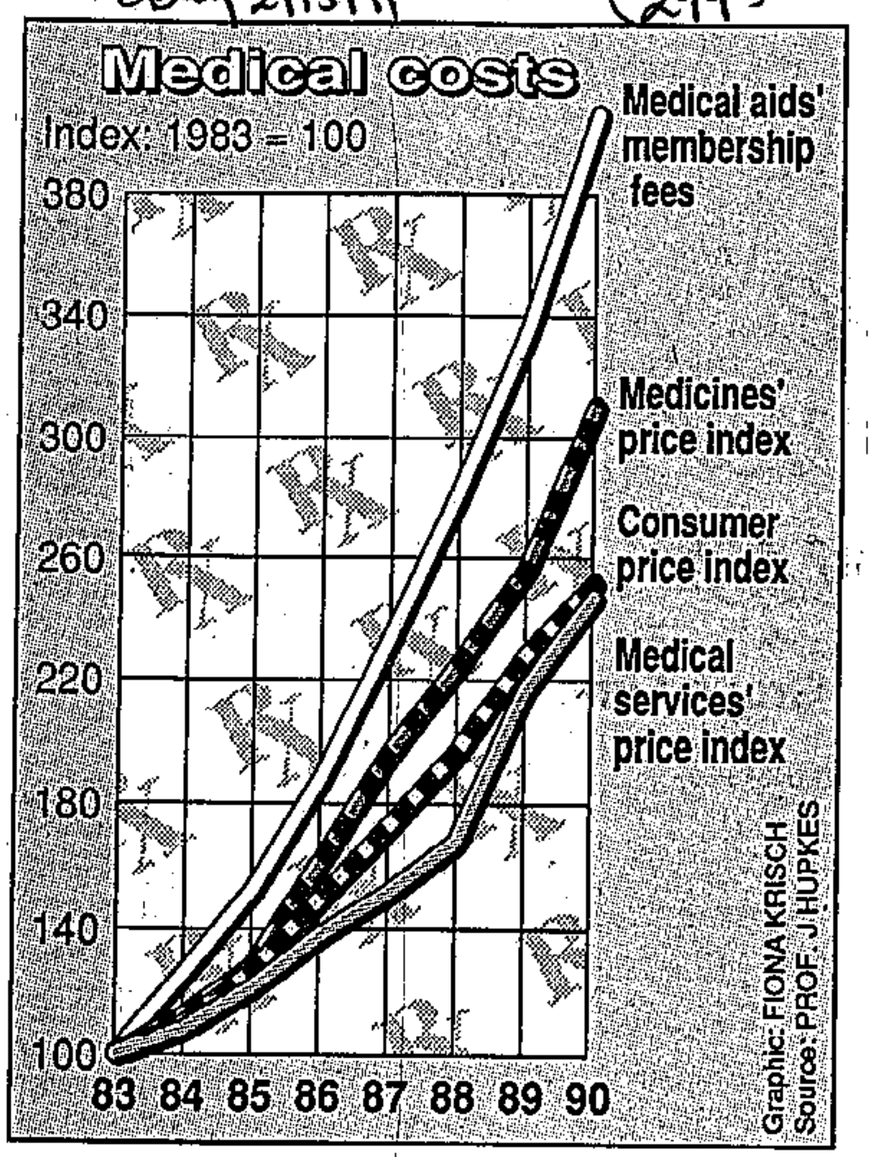


Bridging the gap for the less wealthy

BDay 29/5/91 98

WHILE there has been an increase in the number of privately run hospitals catering for those who can afford their services, escalating costs and the lack of a clear national health policy are leading to a breakdown in essential health services for the less well-off majority.

Old Mutual's employee benefits department says the crisis in government health care facilities has focused attention on the discrepancies in medical care available to South Africans of different social standings.

The cost spiral has also pushed up employers' contributions to medical aid schemes from 2,5% of the wage bill in 1970 to 7,5% currently.

Employee benefits assistant GM Henk Beets says a major problem is that while 70% of whites are covered by some form of medical aid, only about 6% of the black population is.

Paved the way

For most South Africans, state or provincial hospitals remain the only source of health care.

Medical schemes' problems in coping with the rising cost of medical services has paved the way for insurance companies to enter the health care industry, providing both supplementary cover and lower cost alternatives.

The advantage of this type of cover, which pays a benefit in the event of major surgery, dread disease or hospitalisation, is that it brings expensive and private health care within reach of the average South African.

Insurance companies could make use of both their risk-pooling ability and their administrative experience.

Beets says health insurance covering major medical expenses can be more cost-effective than the provision of full medical aid cover.

Medical care costs rise by modest 115%

B1Day 29/5/91 (299)

WHILE the cost of medical care rose more slowly than general prices in SA, medicine prices spiralled over the six years to 1989.

This finding may come as a surprise to consumers who believe rising medical, dental and hospital fees are a contributory cause of inflation, says Unisa management economics Professor Jan Hupkes.

Slowed

In fact, medical service costs have slowed down inflation.

At the end of the six-year period, the medical services price index was 10% below the annual change in the Consumer Price Index (CPI).

Medical service costs (including medical and dental fees, private sector hospital tariffs and private nurses fees) rose by 114,9% over the six years, compared to a 124,9% rise in general prices.

In addition, prices for medical services rose at a slower rate than general services in the economy, except in 1989, when some medical services costs were boosted by an increase in nurses' pay.

In contrast, inflation for pharmaceutical products was over 30% above consumer price inflation during the six-year period.

Pharmaceutical prices (including the prices of medical, surgical, sanitary and allied products) surged by 156,6%.

Hupkes says the rise in pharmaceutical prices is due to the large imported component of pharmaceutical products.

But this is not the total answer, he says.

A more likely cause is the state tender system on medicines and its inflationary impact on retail prices for medicine.

Hupkes says despite the relatively low rises in medical service prices, medical aid membership fees have risen substantially.

This demonstrates that medical service charges could not have been the main reason for such increases.

A more likely reason is that members made more use of medical services on a per capita basis and fees were pushed up by the rises in the prices of medicines.

The six-year trend in the price of medical services and general prices contradicts normal trends in developed countries.

In a developed economy, services price inflation normally rises faster than inflation in general.

Rise

The reason for this is that as an economy develops, the demands for services rise, pushing up prices.

This happened in SA during 1984-85, but the trend was reversed in the following years, with general price inflation rising faster than services prices.

Hupkes says the most likely explanation for this is that the prices of goods were harder hit by a weakening rand and GST increases than service prices were.

Provision of care to broaden

B10 ay 29/5/99

THERE will be more emphasis on the provision of health care to the majority in the future SA, says Norwich Life deputy MD John Beak. (299)

Speaking on the outlook for health services and health insurance he says this, together with an emphasis on housing and education, is going to strain government finances.

This will lead to a tightening up on who will have access to subsidised treatment.

It will also provide a gap for business enterprises to offer medical care on a profit-making basis, as is already happening, and the trend is likely to accelerate, he says.

Private hospitals will be an important facility for a section of the population, but state provision of medical care will, for many years, remain the major provider of health services.

One of the problems medical aid societies face is the way they calculate their charges, he says.

"A member's contribution will depend on the number of dependants he has and his salary."

He says the first criterion is acceptable but the second "does not make that kind of sense".

The usage of medical services, and hence claim rates are dependent on the person's age, yet medical aid societies do not make an allowance for this, he says.

This has led to cross subsidisation — the healthy subsidising the sick.

It has not yet proved to be a problem because, by and large, the only provider of medical insurance has been the medical aid movement, he says.

However, with the entry of the insurance companies, this is no longer so.

Insurance companies, particularly the life offices, try to charge the rate for the risk.

He says insurance companies taking the cross subsidisation route leave themselves open to being undercut by competitors.

"The medical aid societies are going to have to face this fact, otherwise the insurance companies will pick out the eyes of their business," he says.

Equitable system is a future priority

299

DEMAND for a cheaper, more rational and equitable health service system is likely to increase, says Medical aid Administrators director John Cowlin.

He says the deterioration of state and provincial health services is more by design than accident. BDay 29/5/91

"Around 15 years ago, the state realised it could no longer afford to provide subsidised health care for most of the population.

"By a process of omission, the state and provincial facilities were allowed to deteriorate to the point where they now are."

As a result, there are millions of South Africans who cannot afford health services or medical aid.

This is because they remunerate hospitals on a "retrospective cost reimbursement basis" and have little control over their claims experience.

This, coupled with the rendering of accounts by private hospitals on a fee-for-fee basis, has caused an escalation in the costs of running these institutions, he says. 29/5/91

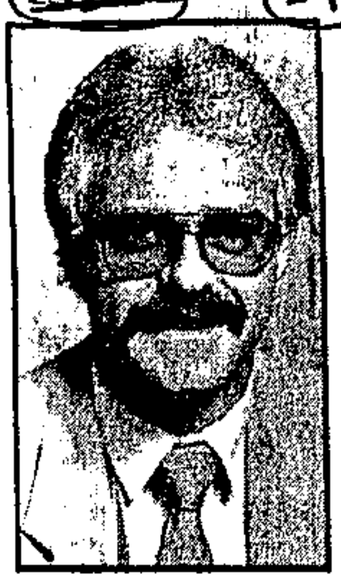
There has been an average annual increase of 26% over the last nine years in hospital benefits paid per beneficiary.

Medicaid has spent large amounts of money researching alternative health-care dispensing services.

Cowlin says managed health care will take the form of a modified medical benefit scheme, a health maintenace or a preferred provider organisation.

All medical services will fall into the tax net

Star. 30/5/91.



VAT AND YOU

This is the thirty-first and final article in the series by André Meyburgh, consultant with chartered accountants KPMG Aiken & Peat.

The Value Added Tax Act, in what appears to be a complete turnaround from the provisions set out in the Draft Bill, now subjects all the services of a medical practitioner to VAT.

In the Bill's original form, all medical services would have been exempt. In effect, the medical practitioner would have had to carry the burden of VAT on all supplies he bought to service his practice.

From September 30, all medical services become taxable at the standard rate of 12 percent.

Before or by that date, medical practitioners whose practices generate "taxable supplies" above the threshold of R150 000 a year will have no option but to register as vendors.

They will have to levy tax at the standard rate of 12 percent on every medical bill presented to patients, and will have to pay this across to the Receiver of Revenue on due date.

However, they will also now be able to claim all "input taxes" paid to their suppliers as "input tax" credits.

This means that the introduction of VAT will lead to an immediate rise in the cost of medical expenses for the patient.

It will also immediately affect the cash flows of most medical practitioners since, in most instances, patients are granted credit and the practitioner from September 30 will have to pay to the Receiver of Revenue all VAT due on services supplied in the tax period in which they were performed.

In addition, medical practitioners will find their practices burdened with largely the same administrative duties, including the collection and payments of VAT, that will be placed on other vendor businesses.

Exception

There is an exception — practitioners probably will be spared the need to issue tax invoices since all medical services will be rendered to the end-users in the VAT chain, namely the patients, who would have no tax use for them.

The inclusion of doctors in the indirect tax system underlines once more that VAT will follow the man in the street from birth (hospitalisation and other medical expenses) through illness to the day he is buried.

But the VAT Act has not singled out the medical profession for taxation purposes. Its reach brings all professional services into the tax net (there simply are no exceptions).

So, for the first time since GST was introduced in 1978 as the first form of indirect taxation, professions such as accountants, attorneys, quantity surveyors, architects, management consultants and the like will have to collect VAT on the fees they charge, provided their annual "taxable supplies" exceed R150 000 a year.

In the case of vendor-to-vendor transactions, the burden to a certain extent may not be too onerous.

Vendor firms using outside professional services will be able to claim the tax paid on fees as an "input tax" credit and set this off against "output taxes".

It is the man in the street once again who will feel the financial squeeze from September 30.

For the first time, he will have no option but to pay VAT on bills received for every professional consultation he needs or initiates, be it for the design and building of a house, doing his tax returns, obtaining legal advice, or seeking a divorce.

Auditing

Like medical practitioners, the vendor professions will be saddled with the administration burden that accompanies VAT, which is likely to be another factor that will lead to increased fees as professions seek to recoup at least some of the extra cost of handling VAT.

The very nature of consulting or professional services makes it important to look at the transitional period.

Let's use auditing services as an example.

Should the audit of a vendor company's records span the implementation date of September 30, an apportionment of the audit fee would have to be made to ensure that work in progress completed before VAT Day does not attract VAT.

The Act specifically prohibits payment of fees in advance for work started before September 30 and completed well after that date to escape payment of VAT — for example, a three-year professional service contract which spans the transitional period.

The sudden application of extra cost, which could be as much as 12 percent on fees hitherto free of indirect taxation, may tempt a company to pay the fee in advance.

Should such an attempt be made, and if such payments are not customarily made in this way, then the advance payment will attract VAT as if it was made on the implementation date (this same penalty will apply in the case of advance payments made for short-term insurance contracts).

If any professional contract also involves intermediate goods and these are held in stock at September 30, it would be wise to take stock on September 29.

The reason: the value of the GST paid on the stock will qualify as an "input tax" deduction in the VAT system.

There will therefore be at least some benefit when VAT is introduced.

This series, updated and expanded to include graphics of how VAT works plus an easy-to-understand glossary of the most common VAT terms, will be the basis of a booklet to be published jointly by The Star and chartered accountants KPMG Aiken & Peat within the next few weeks. Priced at R20 plus GST, it can be ordered from The Star Promotions, PO Box 1014, Johannesburg 2000.

Complaints close school for disabled

ACTIVITIES have been suspended at a Soweto school for the physically disabled because teachers fear for their lives.

The JC Merkin School for the Disabled — a state-subsidised special school owned by the Association for the Physically Disabled (APD) — was closed indefinitely last Wednesday after complaints by parents and pupils of ill-treatment, poor facilities, teaching and food, and demands that senior staff be dismissed.

Community organisations — including the South African Democratic Teachers' Union (Sadtu), the Congress of SA Students and the Soweto Education Crisis Committee — have held placard demonstrations outside the school.

Sadtu spokesman Oupa Mpetha told *The Weekly Mail* the school's governing body had not responded to memoranda outlining their grievances.

But APD director Guy Houghton denied that any written representations had been made, and said the school had been closed at the request of teachers, who complained of harassment and intimidation.

"Pupils are using this opportunity to defy their teachers, and the teachers fear for their safety," he said.

Negotiations are under way to resolve the deadlock. At full strength, the school accommodates 190 pupils, whose ages range from seven to 23.

The sickness in our health services

AIDS and increasing poverty require South Africa to act now to prevent what could become Crimean War conditions in its hospitals.

There is a real danger of even the best hospitals becoming overcrowded and dirty, with patients on the floor and a few desperate under-trained doctors and nurses, short of drugs and equipment, concentrating on less serious cases, while the hopeless are left to their own devices.

Some argue that these conditions are already found in South Africa.

For First World patients with jobs and medical aid membership, conditions today are still good by international standards. That's what makes the downside so terrifying.

According to Dr Max Price of the Centre for Health Policy at the Wits Medical School, South Africa spends about 5,6 percent of gross national product on medical services, compared with the United States's 14 percent and the UK's 7-8 percent. He says the South African figure is appropriate for a country at this stage of development.

Emergency

But the 20 percent (mainly white) of private patients on medical aid consume 56 percent of medical services, with the 80 percent of indigent patients sharing the remaining 44 percent. Private patients thus get five times more per head of the medical cake than those dependent on the public sector.

The sins of the apartheid hospital system are well chronicled — emergency cases turned away because of skin colour, Baragwanath overflowing and the Johannesburg Hospital half empty, citizens of Lebowa turned away from a hospital on the Gazankulu border across the road because they are not Gazankulu citizens, Wits doctors walking out of the JG Strijdom because of racial admission policies, half the medical graduates of Wits and Cape Town emigrating — it goes on endlessly.

South Africa has 14 departments of health — one each in 10 homelands, three in "own affairs" and one "general affairs". Each has its own minister with limousine and an expensive bureaucracy. But thousands of patients don't get basic health care.

South Africa is in desperate need of a national health-care policy. DAVID CARTE explores some possible options

In remote rural areas people die of minor ailments such as appendicitis and gastro-enteritis — simply because they cannot get to hospital on time. So an important part of reform and democratisation will be extending the ambulance and communications system.

Of course, health is a global problem and it is more an economic than a technical problem. Modern technology can prolong life — provided someone is prepared to pay.

So, even in the UK, whose national health system is envied, people die while waiting for kidney dialysis machines and for operations. Health is Britain's hottest political issue. It is a nightmare in the US, where many a patient has been bankrupted and about 35-million Americans have no health cover at all.

What, then, should South Africa be doing to deal with this growing crisis?

Recently, white provincial hospitals were opened to all races. And in Parliament two weeks ago, Health Minister Rina Venter announced far-reaching reforms in administration.

She wants to "democratise" health by devolving administration to local communities. Primary health care (not requiring hospital treatment) will be entrusted to local authorities. Secondary health services will be the responsibility of regional authorities, with provincial administrations remaining in control of the nine development regions.

The seven academic hospital complexes are to be granted "maximum management autonomy". The proposed changes have been welcomed — but everyone agrees they are only a first step.

Dr Venter admitted this week that the government was aware of problems with the present fragmented system. Its proposed reforms will be based on "affordability, accessibility, equity, efficiency and adaptability". She says the present constitution determines the extent to which services can be unified.

Dr Venter adds that the supply of doctors and nurses has stabilised and the problem today is one of distribution rather than of numbers.

Competition

The ANC, meanwhile, has its own ideas on health policy — free medical treatment for all, funded largely by taxpayers. Private medicine will be allowed to co-exist in competition with public medicine.

The ANC argues: "For a people to be healthy, they must earn enough money for a decent life and work in safe and clean conditions ..."

It bases its health model on the primary health care approach of the World Health Organisation which sees health as a basic human right to be entrenched in a Bill of Rights.

"Of course health care cannot be free. The government will have to pay ... The private sector must become part of the national health system. This means that in the short term it will be necessary to find ways to regulate the very high cost of private health care ... It will be necessary to attract into the public sector many of those health workers who have chosen private practice."

The ANC advocates affirmative action in the training of doctors and nurses and compulsory service in depressed areas.

Wasteful

Dr Price is critical of the growing private sector dominance of health. One reason private patients get a disproportionate slice of the medical cake is that private doctors and hospitals are too eager to operate and are wasteful — because this is profitable.

Patients, he says, do not resist excessive medical costs — because they are too ignorant to question the doctor, and, "because the medical aid pays". As a result, medical aid tariffs have outstripped inflation for years.

Possible solutions? One is a national health insurance scheme permitting the patient freedom to select doctors and hospitals.

If we don't find a cure, our hospitals may face Crimean War conditions

Dr Price advocates a "capitation" system under which doctors and primary health care practices would be paid a fixed amount in advance by the national health insurance scheme for each patient registered with the practice.

An option would be for private hospitals to be paid a global budget for the year. Another possibility would be for the NHIS to negotiate discounted rates with private hospitals.

Medical audit teams and the professional ethic would ensure that they did not scrimp to the detriment of patients.

Many reform permutations are possible. Dr Pierre Brooks of the Competition Board says competition between doctors, hospitals and pharmacists can be sharpened to the patients' benefit.

Some life assurers contend that members of medical aid societies should be permitted to opt out and switch to medical insurance covering only expensive procedures. That way, thousands of trivial procedures and piles of paperwork could be eliminated.

But Dr Price says this would cause private health care to crash.

"In medical aids, the healthy subsidise the sickly and the young subsidise the old. Those who need care can afford it only because they are being subsidised. With insurance, the sickly would fall out of the system because they would carry the full cost of their ill-health, while those who don't need care will qualify for it."

The Wits policy group says a free market in health care is impossible. But private sector hospital operators, such as Dick Williamson of Afrox Health Care, argue that they should be able to continue serving those on medical aid, while the state looks after the indigent. Private hospitals could also undertake hospital management for the state.

Mr Williamson says more and more blacks are coming on to medical aid. Soon 35 percent of South Africans will be covered. Professional review can be used to prevent over-treatment.

David Tabatznik's 40-hospital Lifecare Group, which looks after thousands of indigent psychiatric and TB patients for the state for about R35 per day per patient, may have a model for the state for the future.

Its costs and mark-ups are closely monitored by the state, which has to be satisfied that it cannot do the job more cheaply itself.

Shortcoming

Dr Venter says the private sector will always have a role to play. It will be a partner of the public sector which will buy services from the private sector if it can deliver them more cost-efficiently.

One shortcoming in the way that Dr Venter is tackling the present health problem is that, unlike her colleagues in education, she does not appear to be consulting "the people" or their liberation movements about her plans. To avoid the destructive fallout that has occurred in education, it might be advisable to start talking now.

Disabled will get a lift from Project Daphne

CIT 4/8/91.

(299)

SEA POINT probably has more disabled people than any other suburb in Cape Town: plans are in hand to organise a team of volunteers willing to give up a little time helping improve the quality of life of the handicapped.

One of the main organisers behind the scheme is Mrs Bruna Brooke-Sumner, who is anxious to establish Project Daphne.

This name, she said, was "a play on words meaning 'disabled people in the home need energy'"

She stressed the serious side to the founding of Project Daphne: she already had a list of about 30 people who were desperately seeking help with their disabilities.

First meeting

"Unless one is disabled and a wheelchair victim or a stretcher case, there is no transport any more those handicapped who need to go to hospital.

"They are entirely reliant on helpers and that's where we come in. We know that there is a desperate need in Sea Point to help these handicapped people.

"Many cannot get on a bus or a taxi if they have to visit a doctor. Volunteers giving up a little time could do so much to enrich the life of these peole, while knowing that they were doing something to help others in the community."

She said there were branches of Project Daphne operating at present in Somerset West, Stellenbosch, Constantia, Plumstead, Rondebosch and in Sea Point, which appeared to be the area in desperate need.

Mrs Brooke-Sumner added: "We will have our first meeting in Sea Point on June 17 and a disabled person has kindly offered us his home in Mutley Road, Sea Point, for the occasion. He said that just as he was disabled and needed help, this was a way that he could help us."

Non-racial

She said the organisation hoped to establish a Sea Point office which would regulate calls and inform members of Project Daphne of the names of people requiring help.

"Project Daphne is non-denominational, non-racial and helps all age groups. Volunteers are asked to give up a morning or afternoon of their time to help others less fortunate.

"The work is voluntary and we do not run cake sales or fund-raising drives but would appreciate help from other organisations."

She felt that an after the first meeting in Sea Point an office would be a top priority.

□ For more information call Mrs Bruna Brooke-Sumner at (021) 686-6778.

Medical schemes face 'disaster'

B/Day 5/6/91.

LINDA ENSOR

CAPE TOWN — The medical aid industry is headed for disaster unless cost increases are drastically cut, says Sanmed GM Nick du Preez.

Sanmed, a subsidiary of Sanlam, yesterday reported an operational loss of R8m for 1990 due to cost increases which resulted in a 38% increase to R357,9m in the benefits paid to members. In comparison premium income only rose 28,5% to R349,5m.

Medscheme MD and Southern African Association of Medical Schemes chairman Keith Hollis said the higher than anticipated cost increases had hit the industry generally and had resulted in medical aid schemes either reporting losses or break-even positions. This, together with the introduction of VAT in October, would probably result in a further hike in premiums which have risen by an average of 23% this year.

Use of services had been higher than expected, Hollis said, and added VAT was expected to add between 7% and 9% annually to the costs of medical aid schemes.

Du Preez says the future ability of the industry to fund future benefits has been placed in jeopardy. "Firstly there is the question whether the industry can really afford the modern high technology as applied in this part of the world, and whether there are enough paying people requiring the specialised services.

"Secondly, members in general show little concern for the cost situation. The general attitude seems to be that in view of their contributions members have the right to utilise services indiscriminately, notwithstanding the costs involved."

On average nearly R3 000 was paid by Sanmed to each member in 1990, a 27% increase on the 1989 amount, which Du Preez says reflects the continued increase in the cost and use of medical, dental and hospital services, as well as of prescribed medicines.

Sanmed's largest increase in benefits last year was for hospital benefits which rose 44%. Membership at end-December stood at 361 350.

Call for less costly private health care

B1 Daily 6/6/91

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TANIA LEVY

THE private health sector needed to expand its market by offering a more affordable service to more South Africans, National Association of Private Hospitals (NAPH) chairman Brian Davidson said in an interview yesterday.

He said sociopolitical changes in SA and the increasing unaffordability of medical care would stimulate debate in the next 18 months about how to restructure SA's health system.

Medical aid schemes were becoming increasingly unaffordable particularly for the 80% of the SA population which relied on state health services. But instead of feeling "doomed" by the unviability of medical schemes, the private health sector should see it as a challenge to find ways to make their services affordable to more people, he said.

He said there were about 6-million medical scheme members and this number was not growing. The private health sector had to find a way to attract at least some of the remaining people in the country.

Various models of managed health care were being considered as a way to provide more affordable private health care, he said.

The fundamental principle of managed care was that a third party controlled the amount of care delivered rather than the price paid. This ensured better use of resources, making the system more cost-efficient and affordable. Managed health care would be self-funding, probably through employer contributions.

Davidson believes a managed care system initiated by the private health sector would be welcomed by government. Public health services could then concentrate on serving the truly indigent.

Private hospitals should continue to exist for the economically advantaged section of the public. If SA failed to provide this kind of care and slipped into the state of many other African countries — which had practically no health care at all — these people would leave and SA would lose their skills and investment.

He said the NAPH welcomed Health Minister Rina Venter's recent announcement of a moratorium on private hospital licences and the private sector's inclusion in a forum to discuss a future health system for SA.

Big losses for medical plans

Star 6/6/91

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Medical Reporter

More medical schemes are set to report losses due to record benefit payouts, say health experts, pointing to large increases in health costs.

Sanmed, Sanlam's medical aid subsidiary, this week said it had spent R357,9 million on benefit payments to members last year. An operational loss of R8 million was reported.

This reflected the rise in the cost and use of medical, dental and hospital services, added to those of prescribed medicines, Sanmed said.

Hospital services showed the largest increase of 44 percent.

All medical schemes must report their results by the end of June, and comparative figures for other schemes could not be obtained this week.

Southern African Association of Medical Schemes chairman Keith Hollis said the industry had been hit by higher-than-expected cost increases.

Sanmed general manager Nick du Preez questioned whether the medical scheme industry could afford modern high-technology as applied locally.

Representative Association of Medical Schemes executive director Rob Speedie said use of medical services had unquestionably increased.

The first probe into the secretive world of mental homes in 15 years

Mental hospital in Randfontein ... shielded by law from public scrutiny for 15 years, following a 1975 press exposé
Photo: KEVIN CARTER

Behind the asylum walls

w/mail 7/6 - 13/6/91

THE *Weekly Mail* this week takes the lid off a 15-year scandal: the conditions in private psychiatric hospitals for blacks. We found a story of neglect by people who are paid by the state to look after the mentally ill — and make their profits by cutting corners on the level of care.

The last time these institutions were exposed to the public was in 1975. After that the Mental Health Act was amended to keep these conditions from the public eye.

Now, however, *The Weekly Mail* has taken a fresh look at Randfontein and Millsite sanatoria, both owned by Lifecare Clinics (Pty) Ltd, and found:

●Allegations from staff of a high death rate through negligence or winter cold. At least 35 mentally retarded children and youths died at the Millsite Sanatorium between July 1988 and November 1990 — 24 of them as a result of pneumonia, tuberculosis and other respiratory complaints.

●Physically disabled patients without crutches or wheelchairs and receiving little or no assistance. In one case, *Weekly Mail* reporters saw a blind women having to be led to the toilet by a women with only one leg, dragging herself along the floor.

●Chronic understaffing, with sometimes as few as six nurses looking after 300 patients and, in one case, only two full-time and two part-time psychiatrists for more than 3 000 patients.

●Poor food and allegations from staff that some patients are malnourished. Children were seen being fed bread crumbs and crusts mixed in a foul-smelling brown liquid for supper.

●Inadequate clothing, with only a few patients supplied with shoes, jerseys or pyjamas and none given underwear. Most children sleep with no sheets and only one blanket.

●Child patients sharing beds.

●A special well-kept ward which is the only one shown to visitors, where babies each have their own cots with proper sheeting and blankets.

Lifecare has issued a detailed denial of these allegations. (See Page 2)

When these institutions were exposed in *The Sunday Times* 15 years ago, the government promised to build five new hospitals to replace them. These were never built — and the patients are still kept in old mining compounds.

Full story: See overleaf

BEHIND THE MENTAL HOSPITAL WALLS, A TRAGEDY OF NEGLECT AND UNDERSTAFFING

An atmosphere of general neglect

'If a patient dies, his space will soon be filled.' **CISKA MATTHES** visits a black psychiatric hospital and finds health workers eager to expose what they consider to be unacceptable conditions

IN a ward of the Randfontein Sanatorium a woman missing a leg drags herself across the floor, leading an old blind woman to the toilet.

The blind woman pulls up her dress and squats in the passage but jumps up when a nurse yells at her from the distance. The nurse does not attempt to assist either woman.

Two old women pass slowly, dragging a third by her armpits and knees, as if she were dead. Her old hospital uniform is pulled up, revealing bruises on her bare legs and buttocks. She is wearing no underwear.

"That one can't walk either," a nurse comments, adding "but they care for each other like mothers."

The ward is packed with low iron beds, about 20cm apart. There are no cupboards and no chairs.

This is the ward for the crippled and the blind in Randfontein Sanatorium, a black psychiatric hospital in the Transvaal. It is owned by Lifecare Clinics (Pty) Ltd, a private company hired by the government to provide psychiatric care.

The Weekly Mail visited Randfontein Sanatorium for female patients as well as Millsite Sanatorium for children and males. At both hospitals several healthworkers seemed eager to expose what they felt were unacceptable conditions. Lifecare has strongly denied most of their allegations, including those confirmed by eyewitness accounts of *Weekly Mail* reporters.

For instance, no wheelchairs or crutches appeared to be readily available for crippled patients. But, according to Lifecare, "all crippled patients do get wheelchairs or crutches, except for those who are unable to use them".

The sanatorium buildings are old, brick mine compounds, with low corrugated iron roofs. Outside, patients lie around on the concrete yard.

Staff members said the patient death rate is exacerbated by general negligence, but these cases are seldom properly investigated.

"If a patient dies, who cares," one of the workers commented. "There is a waiting list and his space will be filled again soon enough."

In April this year, for example, a male patient in Millsite was burnt beyond recognition while lying on his bed in the hospital war. Staff only detected the fire when it was too late.

A Lifecare representative confirmed that a male patient died in a fire in April. "The staff immediately notified the police, the fire brigade and Lifecare management and their swift action prevented the fire from spreading. The police are investigating the cause of the fire — thought to have been started by the patient (or patients) smoking in the ward."

The death rate is high in winter, health workers claimed, because of poor conditions in the hospitals.

- There is no hot water, and many sections lack heating.
- The hospital provides no underwear; many patients have no shoes, jerseys or pyjamas.
- The diet is poor, consisting of dry bread and porridge for breakfast, and hot meals that are tasteless and watery.

But according to Lifecare: "All patients are issued with vests, daywear, jerseys and pyjamas. They are given two pairs of shoes per year. Some patients prefer not to wear them or barter them for tuckshop money or cigarettes."

A psychiatrist, who worked for Lifecare until recently and visited Millsite once a week, said that in general conditions were acceptable. "The main complaint I would make is that the medical staff is too small and the nurses know too little about the patients," he said.

Health workers at Millsite and Randfontein said the patients are made to work because of the staff shortage. During night duty, for example, there are only five or six nurses to take care of a ward with up to 300 patients, many of whom are epileptic or incontinent.

"In some areas there are no cleaners at night," one of the health workers said, "and there the better patients must clean up the faeces and urine that others may have dropped on the floor. Patients have been dehumanised totally. The nurses can make them do anything. They work like robots."

Commenting on the work issue, a Lifecare representative said: "The practice of allowing patients to do jobs for money (including occupational therapy) was discontinued years ago. Many patients resented losing their 'jobs' and a few (less than two percent) have been allowed to do voluntary work in the laundry or kitchen, although this places an extra burden on staff in terms of supervision. They are then paid from the occupational therapy budget."

Staff members mentioned the nurses' jargon: patients that are called "good" are the "workers". They are given extra food, or they receive shoes, and some earn a few rand per month. The patients that are too ill to work are called "lazy"; they are neglected.

Patients are also divided into "clean patients" and "wet and dirts", who are seldom washed.

"They smell very bad. They are repulsive, so you shout at them and you push them away when they approach you," said a health worker, who added there were no baths in many sections.

"The nurses have to push them under the cold water. Some patients get a fright and run away. The nurses just leave them. For them, that's minus one problem."

Because there is so little supervision, patients injure themselves or fight with each other, health workers said.

Patients in the two sanatoria are all "certified" and classified as chronic — psychotic, retarded or senile.

Some have been in the care of Lifecare and its predecessors for decades, according to staff members, and have been moved around the country from one institution to another. "Sometimes patients try to escape, because they dream of going back to their families."

With only four psychiatrists (two part-time) and no psychologists for the 3 000 or more patients of Millsite, little therapy is provided other than medication, staff members said: "When a patient is 'difficult', he is simply given extra medication."

They claimed there is no rehabilitation programme.

Lifecare commented: "It is true there are four psychiatrists at Millsite. There are only 200 qualified psychiatrists available in South Africa. In addition, until recent legislation changed this, no private hospital could employ doctors or psychiatrists."

They added that they will soon be getting two more psychiatrists from overseas, and three more have been approached.

But psychologist Melvyn Freeman, from Wits University's Health Policy unit, stated that many of these "chronic" psychiatric patients could be cured: "Perhaps a minority should indeed be under custodial care, but the majority of them are made into custodial patients. They should receive proper treatment, including medical and psychological care."

The psychiatrist who used to work for Lifecare rejected this: "Lifecare's patients are given all help that exists."

Lifecare is the biggest private owner of psychiatric hospitals in South Africa. It accommodates about 9 000 state patients, all of whom are chronic. Millsite and Randfontein sanatoria cater for about 4 000 black patients. Lifecare makes its profit from what the government pays for the care for the patients: according to Lifecare, less than R50 per patient per day.

In 1975 several newspapers exposed conditions at Lifecare hospitals (at the time called Smith, Mitchell and Co), alleging that they were "making millions out of madness". The reports included allegations that patients worked for over 11 hours a day and slept on grass mats on the floor in converted mine compounds. The present-day hospitals are on the same sites.

The government at the time promised to build five new state-run hospitals in order to dispense with the services of Smith, Mitchell and Co. But these hospitals have never been built.

Instead, the Mental Health Act was amended in 1976 to prevent conditions in psychiatric hospitals from being publicly discussed and criticised.

Lifecare said it had "initiated substantial changes in the facilities since the late 1960s when the state asked (us) to take over and manage such facilities". The claim they were making millions was "absolute nonsense".

Barefoot patients meander through a hospital garden. Due to the secrecy which surrounds mental institutions, photographer KEVIN CARTER had to hide on the roof of a nearby building to take this picture

The children who died in care

By GAVIN EVANS

AT least 35 mentally retarded children and youths died at the Millsite Sanatorium between July 1988 and November 1990 — 24 of them as a result of pneumonia, tuberculosis and other respiratory complaints.

This information was provided by a Millsite healthworker, who said the patients were between five and 27 years old. *The Weekly Mail* has obtained independent verification of this claim.

The healthworker said this reflected only about two thirds of the total number of children who died in this period. Many died at the Leratong Hospital, while several others have died at the Millsite Sanatorium over the past six months.

Pneumonia and bronchial pneumonia were the most common causes of death listed. Tuberculosis, asthma, bronchitis and pulmonary oedema were also common. Other causes listed included epilepsy, septicaemia, anaemia, "natural causes" and "sudden death".

The staff member, who asked not to be named, said cold conditions and inadequate food were mainly responsible for the high number of deaths due to respiratory problems.

"First, the heating system is not adequate. There's not enough hot water, and the bathroom and dining room are too cold. What makes it worse is that the patients wear very thin clothes, and most don't wear shoes.

"Second, the food is inadequate and there is a problem with malnutrition, and this lowers their resistance".

■An acute shortage of psychiatric help
■The wards where only the fittest survive
See overleaf

BEHIND THE MENTAL HOSPITAL WALLS, A TRAGEDY OF NEGLECT AND UNDERSTAFFING

SA's 6-m mentally ill face a shortage of psychiatrists

w/Mail 7/6- 13/6/91.

299

Nearly 6-million South Africans suffer from mental illness, but there are far too few psychiatrists and psychologists to treat them.

By GAVIN EVANS

NEARLY 400 000 South Africans are believed to be suffering from serious mental disorders but there are only 1 131 psychologists and 322 psychiatrists registered to treat them.

According to the World Health Organisation, one percent of any population is likely to be suffering from a seriously incapacitating mental disorder at any time and 10 percent at some time in their lives.

Psychologist Melvyn Freeman, from Wits University's Community Health Department, says that based on conservative estimates, 15 percent of South Africans (nearly 6-million people) are suffering from mental illness, with one percent (up to 400 000) being classified as serious.

This would suggest a ratio of psychiatrists to seriously incapacitated patients of 1:1 250 (compared with 1:190 in Britain and 1:80 in the United States).

This shortage is made even more severe by the fact that most of these specialists are working in the urban, private sector — and many of those registered with the South African Medical and Dental Council have in fact emigrated recently.

"Eighty percent of the population have to rely on state health, yet only about 100 psychologists are employed by the state sector. The situation is even more chronic in the homelands where 20 psychologists serve a population of about seven million people," says Freeman.

According to the Department of National Health, 21 643 patients are currently in state or provincial psychiatric hospitals, state-subsidised hospitals for chronic patients owned by Lifecare and other private psychiatric facilities. This does not include patients receiving treatment in private or provincial general hospitals or those in the "independent homelands".

In addition, there were 556 171 patient visits to 700 psychiatric clinics or outpatient departments during 1989.

A major problem, says Freeman, is the duplication of mental health facilities under apartheid.

"Patients are often transferred from a provincial hospital to 'own affairs' community care on discharge, causing wasteful duplication and bureaucracy with consequent prejudice to patient care.

"For example, a white patient from Krugersdorp who is discharged from the nearby Sterkfontein Hospital will have to travel to Johannesburg to be treated because Sterkfontein, a provincial institution, can't provide community services. Instead these are provided by 'own affairs' structures for whites, Indians and coloureds, and general affairs for blacks — and white own affairs community services don't yet exist in Krugersdorp."

There are currently plans to do away with the 'own affairs' system and introduce a three-tier system of academic, provincial and local mental health care.

The majority of patients resident in mental hospitals are certified in terms of the Mental Health Act.

In addition to patients deemed incapable of consent, and the country's 1 209 State President's prisoners (those committed to a mental hospital on the order of a criminal court) there are several thousand others who are involuntarily confined to mental institutions because they are deemed to be mentally ill.

Concern over rising medical costs

Staff Reporter

Star 7/6/91

(299)

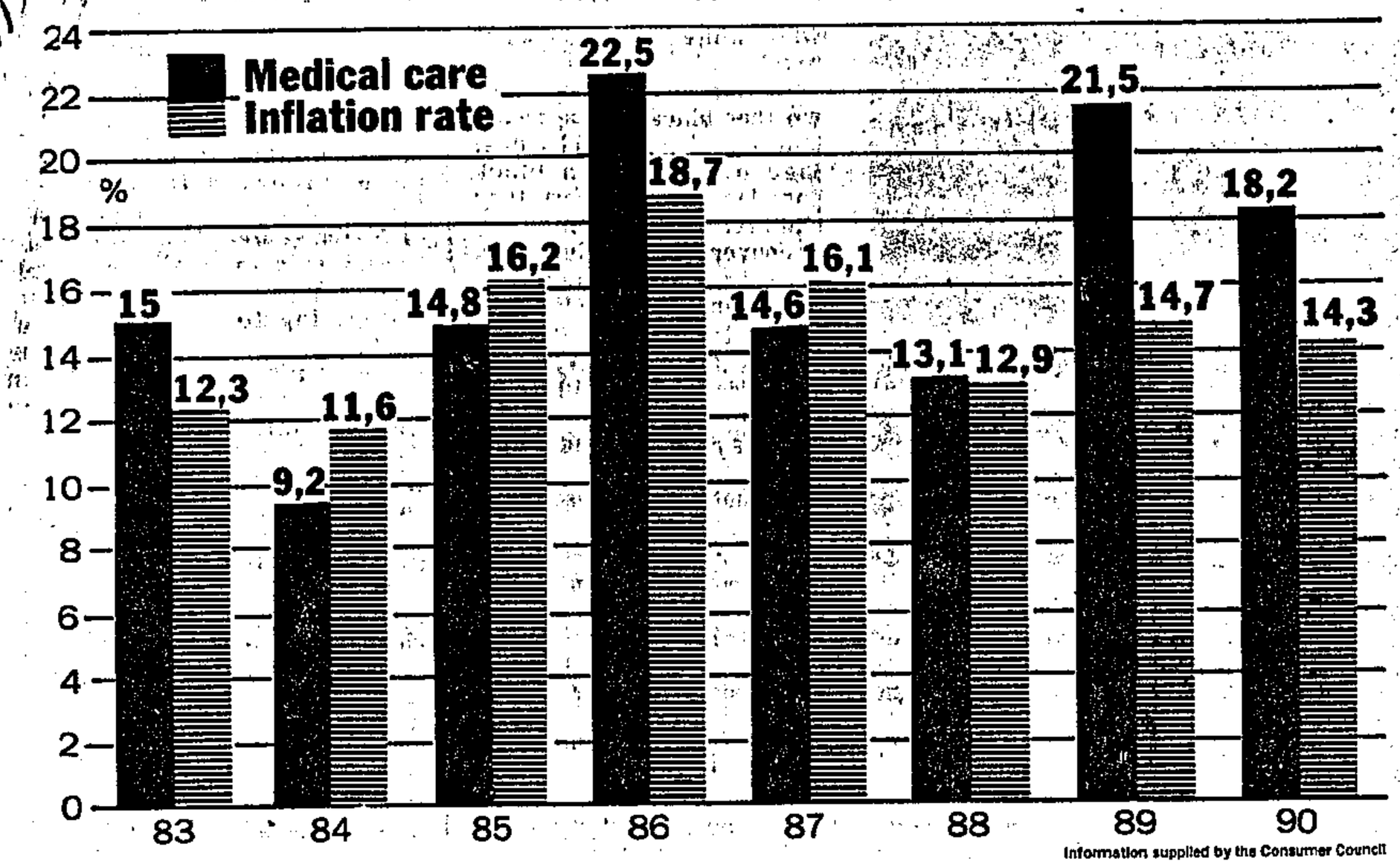
The cost of medical aid contributions has risen by 322 percent in the past seven years, while the consumer price index (CPI) increased by less than half that amount in the same period, the SA National Consumer Union (Sancu) has revealed.

The problem of rising costs of medicine and medical services was discussed at Sancu's general meeting on May 24.

Professor J Hupkes of Unisa said that during the period 1983 to 1990, the cost of medical services had risen by 149 percent and that of medicine by 241 percent. The CPI increased by 151 percent.

This meeting preceded an announcement by Sanlam's medical aid subsidiary, Sanmed, that its members had received a record R2 357,9 million in benefit payments during 1990.

The average payment of nearly R3 000 per member reflected the continued rise in the cost and utilisation of medical, dental and hospital services, plus those of prescribed medicines, Sanmed said.



Information supplied by the Consumer Council

At the Sancu meeting, Professor Hupkes urged the union to investigate the imbalance of prices, particularly in the light of the fact that the State purchased two-thirds of pharmaceutical goods at a third of the price, while the consumer bought one-third at two-thirds of the price.

Urgent attention would also have to be given to general health care in future, with preventive health services remaining in the hands of the private sector.

The State had the responsibility, however, to control health care services and to halt interference as soon as it became counter-productive.

Some 80 percent of South Africans were dependent on the State for health care services, while 20 percent enjoyed medical aid coverage, the chief director of planning at the Department of Health and Community Development, Dr J Kotze, said at the meeting.

The State's recommendations regarding cost control of medicine and supplies include generic substitution, regulation of production promotions, a possible basic list of medicines, inquiry into the State tender system, maximum medical aid prices for specific medicines, and the dispensing of schedule 1 to 4 medicines by pharmacists.

The high cost of medicine and medical services remained a disturbing issue, Dr Kotze said.

PresMed is confident of 20% growth

LIZ ROUSE 299

PRESIDENT Medical Investments (PresMed) is confidently forecasting a compound annual earnings growth of over 20% for the next five years, says chairman Naude Bremer in his annual review. BIDaily 10/6/91

This objective should be achieved through PresMed's strategy of entering into partnership agreements with medical practitioners and medical aid societies, thereby promoting cost-effective utilisation of facilities. By increasing occupancy levels, PresMed is assured of higher profitability, says Bremer.

The day clinic concept is recognised by the medical aid movement for the contribution it makes to containing medical costs. By equipping its hospitals with the latest technology, they facilitate the performance of an increasing number of operations, doing away with high overheads.

Two new private hospitals in Bedfordview and Rustenburg are due to start up this year. The expansion programme will place substantial short-term demands on the group. The debt to equity ratio of 44,9% at the end of February 1991 will therefore rise.

A conservative dividend policy is being maintained (the past year's 5c dividend was covered 4,5 times by earnings of 22,3c a share) as PresMed has to use internally generated funds to finance part of its expansion.

Soaring costs 'threaten medical aid'

Bloan 11/6/91 (299)

GERALD REILLY

PRETORIA — Soaring treatment and medicine costs, together with benefit demands, posed a serious threat to the viability of medical aid schemes, Unisa economist Prof Jan Hupkes said yesterday.

He was reacting to a claim by Sanmed GM Nic du Preez that the medical aid industry was heading for disaster.

Hupkes said schemes were under tremendous financial pressure and many were underestimating the certain escalation of claims from a fast-ageing population.

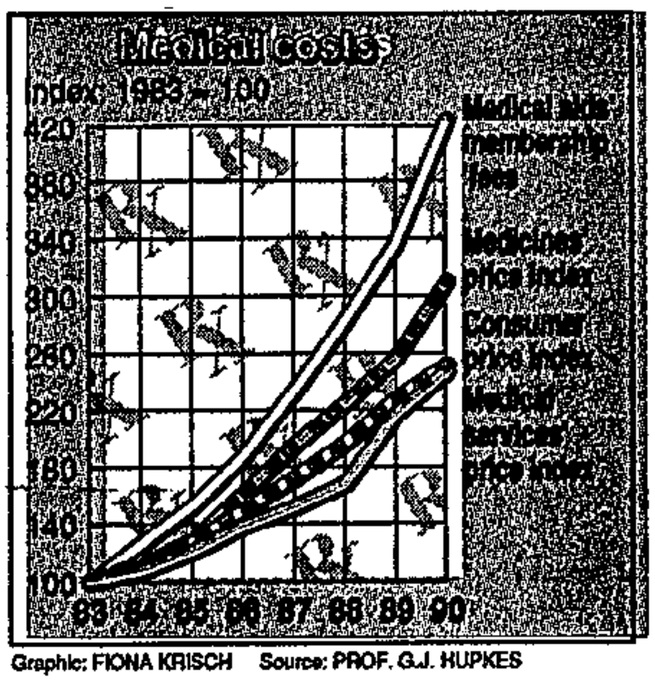
It was estimated that demands for benefits from people over 65 had trebled, he said.

Further pressure was being exerted on schemes by new medical techniques and hi-tech operations.

To accommodate these a system of additional "catastrophe" insurance was needed.

Hupkes added that taking into account current membership fee levels and a spiralling demand for services, the financial strain on funds could become intolerable.

Representative Association of Medical Schemes (Rams) executive director Rob Speedie said he did not want to be alarmist but he expected the 1990 statistics would show that all schemes were going through "hard times".



Graphic: FIONA KRISCH Source: PROF. G.J. HUPKES

Speedie said he could not comment on Du Preez's claim that the industry was facing disaster until the relevant 1990 financial figures were available.

Membership growth however had been dampened by the recession. In 1989 growth was 5% compared to 6% the previous year.

A Medical Association of SA (Masa) spokesman said medical schemes' subscriptions had greatly exceeded the consumer price index during the '80s.

Payout for doctors' services per beneficiary decreased gradually in relation to the payouts for other services — from 40% (1977) to 34% (1989). Hospitalisation payouts rose from 17,5% to 21% and medicines from 25,3% to 26%.

Registrar of medical schemes J Langeveld said in 1989 the 200 registered schemes had an income of R4,5bn from 2,1-million members, with total benefits paid out during the year of R3,885bn.

HOUSE OF DELEGATES

QUESTIONS

†Indicates translated version.

For written reply:

Own Affairs:

Truro House: request for transfer

31. Mr K PANDAY asked the Minister of Education and Culture:

(1) Whether a certain person, whose name has been furnished to the Minister's Department for the purpose of his reply, requested to be transferred from the library in Truro House; if so, what is the name of the person in question;

(2) whether a senior official of his Department was mentioned as one of the reasons for this request; if so, (a) what are the circumstances surrounding the matter and (b) what were the other reasons;

(3) whether he will identify the senior official in question; if not, why not; if so, what is his name;

(4) whether the reasons advanced by this person were investigated; if not, why not; if so, with what result?

D129E

The MINISTER OF EDUCATION AND CULTURE:

(1) Yes.
As furnished. An open identification will prejudice the good name of the person concerned as the purport of the rest of the questions has not been established by the Administration.

(2) No.
(a) and (b) fall away

(3) and (4) Fall away.

Disability grants cancelled/terminated/reinstated

35. Mr H M NEERAHOO asked the Minister of Health Services and Welfare:

(a) How many disability grants were cancelled or terminated during the period 1 January 1990 to 30 April 1991 and (b) (i) how many of these grants have been reinstated as a result of (aa) reviews and (bb) appeals and (ii) in respect of what date is this information furnished?

D142E

The MINISTER OF HEALTH SERVICES AND WELFARE:

(a) 4 178.

(b) (i) (aa) 1 959.
(bb) 14.
(ii) 28 March 1991.

Education expenditure

44. Mr M RAJAB asked the Minister of Education and Culture:

(a) What amount was spent by his Department in 1990 on (i) salaries of teachers and principals, (ii) salaries of administrative staff, (iii) salaries of inspectorate and executive officials, (iv) salaries of any other specified staff, (v) capital expenditure, (vi) supplies and services, (vii) equipment and (viii) other items and (b) what percentage of the total education expenditure by his Department in 1990 does each of the above amounts constitute?

D187E

The MINISTER OF EDUCATION AND CULTURE:

(a) (i) R634 518 457
(ii) R 28 831 304
(iii) R 12 244 338
(iv) R 5 072 728 (Service Workers)
(v) R 15 530 114
(vi) R 44 456 579
(vii) R 12 146 190
(viii) R 85 819 281

(b) (i) 75,68%
(ii) 3,44%
(iii) 1,46%
(iv) 0,61%
(v) 1,85%
(vi) 5,30%

(vii) 1,44%
(viii) 10,22%

The above are provisional figures in respect of expenditure for the 1990/91 financial year. Final figures will only be available after the finalisation of the Appropriation Account. Figures are not maintained in terms of a calendar year.

Management training: amount spent

45. Mr M RAJAB asked the Minister of Education and Culture:

What (a) amount and (b) percentage of the education budget of his Department was spent on management training during the latest specified 12-month period for which figures are available?

D188E

The MINISTER OF EDUCATION AND CULTURE:

(a) R41 682 : For the period 1 April 1990 to 31 March 1991.

(b) 0,005%

Sewing now, reaping tomorrow's hope

South 6/6-12/6/91. (299)

By Sabata Ngcai

THROUGH THEIR circumstances, many disabled people are often forced to live in the shadow of the community, battling to survive financially on meagre disability grants.

However, in Guguletu a group of wheelchair-bound people have refused to submit to such a fate. Exercising initiative, they formed the Vukuhambe Self-Help Co-operative, which manufactures duvet covers, kitchen curtains and bedspreads.

Situated in a backyard shack at the corner of NY1 and NY2 in Guguletu, Vukuhambe is a project aimed at promoting self-sufficiency and self-awareness among the disabled.

It started as a burial society in 1982 and became a co-operative five years later.

The 17-member staff use a tiny corrugated iron shack, packed with sewing material and five machines, for their sewing room. A sense of pride and optimism pervades this co-operative.

"I am delighted to be here, where everything belongs to everybody," said Nathaniel Somana. The staff work in turns, as the sewing room is unable to accommodate every one at once.

While some members are working, the others wait outside, even if it's raining.

Yet, despite its modest success, Vukuhambe is comparatively unknown in the community.

"I thought it was a creche," remarked a passing Guguletu resident when she saw sewing machines through an open door.

According to Maxwell Hlomela, the co-operative's liaison officer, the media do not pay enough attention to the plight of the disabled.

"We contacted SATV several times and invited them to visit our place, but they failed to turn up," he said.

The Vukuhambe project now requires financial assistance to erect a new building in which to accommodate all its disabled workers. The co-operative hopes to build on a site in Section 1, but so far no funds have been forthcoming.

However, the American embassy and the South African National Council for the Blind have donated sewing machines.

Svenmill factory in Parow has donated sewing material, while Federated Timbers and the Foundation for Justice and Peace have assisted with building material.

At present, Vukuhambe depends on contributions from its members. Profits are shared once a month among all the members, according to the production of each. Hlomela has appealed to the business community for financial assistance .

"Those who contribute to the welfare of the disabled can be proud that they are helping disadvantaged people to help themselves," he said.

Despite recession, private clinics in city are still busy

Star 13/6/91 (R) 299

By Mark Suzman

Despite the recession, private clinics and hospitals are maintaining occupancy levels even though medical aid fees no longer cover full costs.

Fears that the high cost of private medicine coupled with declining personal incomes might lead to a reduction in services at some health care institutions have proved unfounded and most groups are weathering the recession.

According to Carl Grillenberger, managing director of Presmed, one of the major medical groups, while there has been no increase in occupancy rates, they have stayed at an acceptable 65-70 percent level.

"Given the existing medical aid tariffs we now need a high occupancy to make ends meet, but so far we are doing fine," he said.

And Les Hollis, deputy managing director of Medscheme medical aid, says despite lower income and higher prices, there has actually been an increase in the number of people choosing private health care over provincial hospitals.

"There's been a very definite surge towards private medicine over the last 18 months, but it's difficult to say whether this will continue or not in the future," he said.

Although he was not positive as to the reasons for the switch, Mr Hollis observed that part of the move was probably attributable to the public perception of "chaos" in the operation of provincial hospitals.

These sentiments were echoed by Graham Anderson, executive director of Clinic Holdings which, among other hospitals, runs the Park Lane, Milpark and Rosebank clinics.

"The recession might well hurt, but people always need medical care and at the moment only the private sector can provide it properly."

Rembrandt's MediClinic, which runs a number of clinics including Sandton and Morningside, and Afrox, which controls the Lady Dudley and Brenthurst, have also reported good results over the last year.

Apartheid still rules at Sterkfontein

W/mail 14/6-20/6/91.

CISKA MATTHES visited a state mental hospital — where apartheid is rife, and conditions depend on the colour of a patient's skin (299)

AT THE state-run Sterkfontein Hospital for the mentally ill, near Krugersdorp, black patients are showered six at a time in a dark, concrete-floored room, with windows that are mere holes in the wall, without glass.

And, according to staff, patients have to wait naked for the communal shower and make do with limited hot water.

The white patients, on the other hand, can shower by themselves in comfortable cubicles.

When the black dormitories are full, patients sleep in the unpainted, ice cold concrete "side rooms" intended for isolation, with only a thin mattress on the floor and a hole high in the wall.

In one white ward *The Weekly Mail* visited, side rooms have been carpeted and converted into visitors' rooms with curtains.

After an application for a visit to Sterkfontein was rejected by the Transvaal Provincial Administration (TPA), access was gained without the management's knowledge.

Sterkfontein, like all such institutions, has been hidden from the public eye since the Mental Health Act was amended in 1976 after a *Sunday Times* exposé of mental health conditions.

The Weekly Mail spoke to several health workers at the institution, who were all eager to help expose the segregation and discrimination among black and white patients and staff.

The "white" section near the entrance to Sterkfontein immediately gives the visitor a positive impression of the hospital. It includes a large recreation hall, a beauty parlour, and clean, well-kept wards for about 500 patients.

The black wards, at the back of the premises, have broken windows — black with dirt — and no heating. Housing 700 patients, they are said to be old military barracks.

"If you aren't crazy yet, you'll certainly become so there," a visitor said of the black section.

Despite announcements by Health Minister Rina Venter earlier this year that segregation in hospitals would be abolished, at Sterkfontein there are only three "mixed" wards.

Black patients are admitted to the observation ward in the white section — but stay here only temporarily. Some are also admitted to the white rehabilitation ward — but must meet three strict criteria. A health worker said these patients must have matric, speak English, and be able to "adapt well to the environment". These requirements do not apply to white patients.

Patients in black wards often have to do gardening, work in the kitchen or laundry, or help bathe patients. The white wards have their own employed gardeners, according to staff members.

Health workers claimed that black patients who are discharged have to find their way back home using their own resources, in their unwashed clothes. Sometimes nurses take collections to raise money for poor patients to get home. According to staff, the hospital provides the necessary funds for white patients to get home.

The Weekly Mail visited Sterkfontein on a cold winter day. In one of the black wards many patients stood outside, in ragged pyjamas and gowns, hugging themselves to keep warm.

Standing in the courtyard in front of the dormitory doors in the last rays of sunlight, at 4.30pm, they waited to be put to bed.

Patients have to go to bed early because the night duty nurses are understaffed — two or three for up to 100 patients — a healthworker explained.

They had just been served a simple, one-pot meal in the dining hall, a shed outside in the courtyard, with no doors and broken windows. Patients squeeze in on narrow, wooden benches along "tables" made of brick and concrete.

The food is carried in from a distant "black" kitchen, in stainless steel pots, a staff member explained. Food from the "white" kitchen is transported in heated vans to the white wards.

Black staff members are negotiating with management about the discriminatory conditions, and are being backed by the National Education, Health and Allied Workers' Union (Nehawu).

Nehawu is not recognised by Sterkfontein's management, and no concrete progress has been made yet, because the complaints are not acknowledged.

One of the complaints is that black registered nurses in the white ward often have difficulty delegating duties to white junior nurses.

Furthermore, black nurses face general understaffing in the black wards, which forces them to do work such as gardening and cleaning.

In a crowded black ward, eight nurses may look after 80-100 patients, whereas in a white ward the same number may take care of about 40 patients, health workers said.

The treatment of black patients consists merely of medication, staff claimed, except for those who have occupational therapy, whereas the white section has social workers and psychologists to provide therapy.

Still, according to a psychiatrist who used to work at Sterkfontein, "there is deprivation across the colour line, although the black patients are, of course, far more disadvantaged.

"Nothing will happen until the people with the resources start representing the patients. They are easily forgotten and neglected," he said.

The TPA said it would not be able to respond to *The Weekly Mail's* allegations until members of its top management had been consulted. They would only be available next week.

However, TPA deputy director Jan van Wyk, said that the TPA had always followed an "open" policy on health matters to keep the media and the public informed.

He asked *The Weekly Mail* to substantiate all allegations made by members of staff, "so that an investigation can be launched.

"We do not react to speculative — so-called 'hearsay' — matters. All matters officially reported will be investigated fully," he said.

STILL SEGREGATED ... The neat, well-kept 'white' areas of Sterkfontein Hospital give a good impression to the visitor. The 'black' wards, former military barracks, are hidden at the back of the institution Photographs: GUY ADAMS

SPECIAL INVESTIGATION ... ... THE SHOCKING CONDITIONS IN MENTAL INSTITUTIONS

Sanatorium gets a quick facelift after Mail exposé

wlmail 14/6-20/6/91

(299)

Last week The Weekly Mail exposed the grim conditions of black patients at Millsite Sanatorium. This week the media were invited on an official tour of the hospital — and found a hasty paint job had been done.

By LINDA RULASHE and CISKA MATTHES

RANDFONTEIN'S Millsite Sanatorium for the mentally retarded underwent a dramatic facelift this week.

Within hours of *The Weekly Mail's* exposé on the hospital last week, all patients were ordered to the storeroom to be fitted with shoes.

The shoes had been there all the time, although they had been refused to patients only days before, staff members said.

Furthermore, new blankets, long petticoats, nighties and possibly even underwear would be ordered. Staff members were instructed to ensure that all patients had four blankets.

After years of fruitless complaints, wall-heaters and facilities for hot water have now been promised.

After the weekend all staff members received a letter, signed by Lifecare managing director Melvylle Malkin, saying that "the group and its board of directors has taken the matter very seriously, and would like to assure staff members that every attempt is being made to correct wrong impressions created by this article".

"Mind you, correcting impressions, not conditions," one health worker pointed out. Another said, sceptically: "Usually, not long after all the upheaval we're back to square one ... or maybe there will be just a small long-term improvement."

After last week's *Weekly Mail* reports of alleged maltreatment and poor conditions, management gave a media tour of the hospital to try and set the record straight.

Nurses were allegedly told: "Please, *maak julle mooi vir ons* (Make yourselves pretty for us)" — as *The Star*, *Beeld* and Radio 702 had also accepted the invitation to visit the hospital.

Staff told *The Weekly Mail* that there were elaborate procedures for official visits. Patients had to stay inside, and dustbins had to be kept inside.

The Weekly Mail had reported that children slept several-to-a-bed in stuffy, crowded wards where the air was filled with a stench of urine. There was a shortage of shoes and most patients walked around with dirty, calloused feet. Their clothing was inadequate, and many children wore thin and dirty khaki tops and trousers.

This week patients were wearing new shoes and jerseys, new heaters and bedding had been allocated in some wards and the smell of fresh paint was evident when the tour party walked through some areas. Two workers could in fact be seen putting finishing touches to an outside wall as we left.

Health workers claimed that besides the recent issuing of clothes, sheets, and toys, meals had been improved to include "well-cooked vegetables".

Management said provision of these essentials depended largely on staff making specific requests.

Patients sat outside, clapping in rhythm to songs during sessions with nurses to "restore awareness of self, reinforce their beingness and improve their levels of understanding".

Disputing allegations of maltreatment, regional Nursing Service manager Rian Venter warned that mental retardation was a sensitive area and seeing patients of this nature tended to be a "shock to the system".

Giving details of the care hospital staff gave, Venter said the death rate — which was 41 and not the reported 35 between July 1988 and November 1990 — was not unusual and could, in fact, be "considered as normal".

"The death rate is no different locally and internationally," he said.

A "full audit" was held into the deaths and if negligence was found to be the cause, the member of staff would be dealt with accordingly.

Adjoining the sanatorium is Baneng Hospital, where children are housed.

Whereas children were crowded on the floor before, the few that lay on the floor were spread out on mattresses.

Physiotherapist Diane Baumgartner said she would like to see provision made within the Mental Health Act for greater community involvenient.

Baumgartner and occupational therapist Joy Blackburn expressed concern about the protection of patients, adding that while people were free to arrange a tour of the place, they did not want a situation where patients would just be "gawked at".

Venter added that despite certain ominous-sounding provisions in the Act, people were invited to visit and outings were often arranged for the children.

"Children are isolated in our hospital to bar them from social interaction that could harm them. This is a practice to protect the certified individual and his or her identity," he said.

PROPOSED AMENDMENT TO RULE 4.310.5 OF THE JOHANNESBURG STOCK EXCHANGE

"14.310.5 The holder of a cash-settled option who exercises the option or where such option is automatically exercised, shall incur the same charges as the buyer or seller of an option. In calculating these charges, the premium shall be [taken as the closing price for the series of option on the exercise settlement date] based upon the intrinsic value of the option which shall be defined as the difference between the exercise price and the settlement price. The assigned writer shall not incur any charges.".

(14 June 1991)

VOORGESTELDE WYSIGING VAN REËL 4.310.5 VAN DIE JOHANNESBURGSE EFFEKTEBEURS

"14.310.5 Die houer van 'n kontant-vereffenings-opsie wat die opsie uitoefen, of waar sodanige opsie outomaties uitgeoefen word, sal aanspreeklik wees vir dieselfde vorderings as die koper of verkoper van 'n opsie. By die berekening van hierdie vorderings, sal die premie [bereken word as die sluitingsprys vir die reeks van opsie op die uitoefeningsdatum] gebaseer word op die intrinsieke waarde van die opsie wat gedefinieer sal word as die verskil tussen die uitoefeningsprys en die aflossingsprys. Die toegewysde skrywer sal nie vir enige vordering aanspreeklik wees nie.".

(14 Junie 1991)

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NOTICE 517 OF 1991

DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

The following Draft Bill is hereby published for general information and comment. No decision has been made on any principle or provision of the Bill.

Any comments and representations thereanent should be submitted in writing to the Director-General: National Health and Population Development (Registrar of Medical Schemes), Private Bag X828, Pretoria, 0001, not later than 31 July 1991.

General explanatory note:

[ ] Words in bold type in square brackets indicate proposed omissions from existing enactments.

— Words underlined with solid line indicate proposed insertions in existing enactments.

BILL

To amend the Medical Schemes Act, 1967, so as to delete certain definitions and to define or further define certain expressions; to extend the compulsory furnishing of statistics to schemes controlled by the State under other legislation; to change the name of the Central Council for Medical Schemes to Council for Medical Schemes; to alter the constutition of the said council; to further regulate disqualifications and vacating of office of members of the said council; to make provision for the said council to advise the Minister of National Health on medical schemes matters; to further regulate delegatory powers of the said council; to abolish the Medical Schemes Fund and to transfer its funds, rights and liabilities to the Representative Association of Medical Schemes; to regulate the payment of fees; to make provision with regard to powers of delegation by the registrar; to make provision for the payment of registration fees; to abolish the provisional registration of schemes; to further regulate the provisions relating to the name under

KENNISGEWING 517 VAN 1991

DEPARTEMENT VAN NASIONALE GESONDHEID EN BEVOLKINGSONTWIKKELING

Die volgende Konsepwetsontwerp word hierby vir algemene inligting gepubliseer. Geen definitiewe besluit oor enige beginsel of bepaling van die Wetsontwerp is al geneem nie.

Belanghebbende persone word uitgenooi om kommentaar daarop en vertoë daaromtrent voor of op 31 Julie 1991 voor te lê aan die Direkteur-generaal: Nasionale Gesondheid en Bevolkingsontwikkeling (Registrateur van Mediese Skemas) Privaatsak X828, Pretoria, 0001.

Algemene verduidelikende nota:

[ ] Woorde in vet druk tussen vierkantige hake dui skrappings uit bestaande verordeninge aan

— Woorde met 'n volstreep daaronder, dui invoegings in bestaande verordeninge aan.

WETSONTWERP

Tot wysiging van die Wet op Mediese Skemas, 1967, ten einde sekere woordomskrywings te skrap en sekere uitdrukkings te omskryf of nader te omskryf; die verpligte verstrekking van statistieke uit te brei na skemas deur die Staat onder ander wetgewing beheer; die naam van die Sentrale Raad vir Mediese Skemas te verander na die Raad vir Mediese Skemas; die samestelling van genoemde raad te verander; die onbevoegdhede en ontruiming van amp van lede van genoemde raad verder te reël, voorsiening te maak vir genoemde raad om die Minister van Nasionale Gesondheid te adviseer aangaande mediese skema aangeleenthede; delegasiebevoegdhede van genoemde raad verder te reël; die Fonds vir Mediese Skemas af te skaf en sy fondse, regte en verpligtinge aan die Verteenwoordigende Vereniging van Mediese Skemas oor te dra; die betaling van gelde te reël; voorsiening te maak met betrekking tot delegasiebevoegdhede van die registrateur; voorsiening te maak vir die betaling

which a scheme may be registered; to further regulate the provisions relating the benefit funds; to further regulate the matters for which a registered scheme shall provide in its rules; to further regulate the provisions relating to investments by registered schemes; to further regulate the constitution, functions, powers and duties of the Representative Association of Medical Schemes; to further regulate the functions, powers and duties of the registrar relating to the financial stability of registered schemes; to further regulate the provisions relating to accounting and the auditing of accounts of medical schemes; to further regulate appeals to the said council; to further regulate the provisions relating to scales of benefits and to do away with the system of compulsory payments of accounts direct to suppliers of services; to further regulate the rendering of accounts by suppliers of services to members of medical schemes; to further regulate certain prohibitions regarding membership of, dependants of members of and claims against more than one registered medical scheme; to do away with provisions regarding ethical rules and disciplinary equiries; to further regulate offences and to increase the amounts of fines; to provide for admissions of guilt and administrative penalties; to further regulate matters for which the said Minister may make regulations; to delete the provisions relating to the application of the Act to Namibia; to amend the Medical, Dental and Supplementary Health Service Professions Act, 1974, the Nursing Act, 1978, and the Associated Health Service Professions Act, 1982, so as to bring the provisions thereof relating to charges by practitioners in terms of those Acts in line with the relevant provisions of this Act; and to provide for matters connected therewith. (299)

BE IT ENACTED by the State President and the Parliament of the Republic of South Africa, as follows:

Amendment of section 1 of Act No. 72 of 1967, as amended by section 1 of Act No. 95 of 1969, section 1 of Act No. 49 of 1972, section 1 of Act No. 43 of 1975, section 1 of Act No. 51 of 1978 and section 1 of Act No. 59 of 1984

1. Section 1 of the Medical Schemes Act 1967 (hereinafter referred to as the principal Act), is hereby amended—

(a) by the insertion before the definition of "council" of the following definition:

"'Association' means the Representative Association of Medical Schemes established by section 23A";

van registrasiegelde; die voorlopige registrasie van skemas af te skaf; die bepalings betreffende die naam waaronder 'n skema geregistreer mag word, verder te reël; die bepalings betreffende voordelefondse verder te reël; aangeleenthede waarvoor 'n geregistreerde skema in sy reëls voorsiening moet maak, verder te reël; bepalings betreffende beleggings deur geregistreerde skemas verder te reël; die samestelling, werksaamhede, bevoegdhede en pligte van die Verteenwoordigende Vereniging van Mediese Skemas verder te reël; die werksaamhede, bevoegdhede en pligte van die registrateur betreffende die finansiële stabiliteit van geregistreerde skemas te reël; die bepalings betreffende die rekeninge en die oudit van rekeninge van skemas verder te reël; om appèlle na genoemde raad verder te reël; die bepalings betreffende voordeleskale verder te reël en om weg te doen met die stelsel van verpligte betalings van rekeninge deur skemas direk aan diens-verskaffers; die verstrekking van rekeninge deur diensverskaffers aan lede van mediese skemas verder te reël; sekere verbodsbepalings betreffende lidmaatskap van, afhanklikes van lede van en eise teen meer as een geregistreerde mediese skema verder te reël; weg te doen met bepalings betreffende etiese reëls en tugondersoeke; misdrywe verder te reël en die bedrae van boetes te verhoog; voorsiening te maak vir erkennings van skuld en administratiewe strawwe; aangeleenthede waaroor die genoemde Minister regulasies mag uitvaardig verder te reël; bepalings betreffende die toepassing van die Wet op Namibië te skrap; die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1974, die Wet op Verpleging, 1978, en die Wet op Geassosieerde Gesondheidsdiensberoepe, 1982, te wysig ten einde die bepalings daarvan wat betrekking het op vorderings deur praktisyns ingevolge daardie Wette, in ooreenstemming met die betrokke bepalings van hierdie Wet te bring; en om voorsiening te maak vir aangeleenthede wat daarmee in verband staan.

DAAR WORD BEPAAL deur die Staatspresident en die Parlement van die Republiek van Suid-Afrika, soos volg:

Wysiging van artikel 1 van Wet No. 72 van 1967, soos gewysig deur artikel 1 van Wet No. 95 van 1969, artikel 1 van Wet No. 49 van 1972, artikel 1 van Wet No. 43 van 1975, artikel 1 van Wet No. 51 van 1978 en artikel 1 van Wet No. 59 van 1984

1. Artikel 1 van die Wet op Mediese Skemas, 1967 (hieronder die Hoofwet genoem), word hierby gewysig—

(a) deur die omskrywing van "aanvullende gesondheidsdiensberoep" te skrap;

Medical Scheme Act to be amended

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ET 17/6/91

PRETORIA — Draft amendments reviewing the Medical Scheme Act were made public in a Government Gazette on Friday, the department of National Health and Population Development announced.

In a statement released in Pretoria, the department said as a result of representation from various quarters, the department had endeavoured over a period of time to bring about "meaningful" amendments to the Act in order to address problems.

The department explained that the various representations argued that the Act was too rigid and contained unreasonable measures.

"In spite of repeated invitations, only a few useful and concrete proposals, on which fair and defendable amendments could be based, were received," the department said.

It also said the Central Council for Medical Schemes had recently taken the initiative to formulate extensive draft amendments based on information at its disposal.

"Interested persons are invited to submit comments on the proposed draft amendments before July 31, 1991," the department said.

The sweeping changes in fringe benefit taxation will impact strongly on medical aid schemes, says AMA's chief operating officer, Timothy Gelman.

The company, which falls under the Southern Life umbrella, administers 10 medical aid schemes including Anglo American, Rennies and AECI.

Gelman predicts that, caught in the vice-grip of VAT and the latest amendments, the A/B income group will place tremendous pressure on their corporate employers to provide innovative and flexible medical aid schemes. — Sapa

Probe into industry control

Political Staff

THE ANC has investigated the nationalisation of the pharmaceuticals industry and is considering the iron and steel and building materials industries for possible state control.

ANC economics spokesman Mr Khetso Gordon brought the controversial issue back into debate at an ANC media briefing for parliamentary journalists at the weekend when he announced that the organisation had identified the pharmaceutical and iron and steel industries for possible state control.

The ANC, he said, had already conducted a feasibility study into creating a state-controlled pharmaceutical utility.

It is believed that the ANC is also considering nationalising other industries which provide, or are involved in the provision of, basic services such as health, housing and electricity.

The route the ANC is most likely to favour for the pharmaceutical industry is the formation of a new body within the state Health Department to sell basic generic drugs required for primary health care — 160 of which have been identified by the World Health Organisation

Health services war 'being won'

B Day 17/6/91

GERALD REILLY

PRETORIA — The long war of attrition waged against fragmentation of health services is almost won, says the 1991 annual report of the Medical Association of SA (Masa).

However, it said the escalating crisis in private health care had to be seriously addressed by Masa.

Masa, the report indicated, was alarmed at the continued drain of doctors from the public health sector.

The sector was groaning under escalating demands and could deteriorate to a stage where it would no longer be able to provide adequate health care for an expanding population, it warned.

The crisis in the public health care services was compounded by the loss of medical manpower resulting from extreme dissatisfaction with remuneration and working conditions.

Masa was giving specific attention to the critical shortage of full time doctors but enrolment was hampered by lack of career advancement opportunities.

According to the Association of Full-time Specialists of Wits University, 60% of specialists at the Baragwanath, Coronation and Johannesburg General hospitals were considering resigning because of inadequate remuneration packages.

The report said the executive committee was greatly concerned at the potential for conflict and intimidation resulting from continued racial segregation in the health services. (299) (68)

Guidelines placed the responsibility for the administrative, logistic and social implications of implementing the "open hospital" policy on hospital superintendants.

However, there was little or no support for superintendants who, with doctors employed in the hospitals, often faced large scale intimidation and threats.

"While the executive committee appreciates the problems the Minister of National Health and of Health Services is experiencing in implementing the policy of opening hospitals to all races, it cannot tolerate the continuing existence of apartheid in SA hospitals," the report added.

survey of the requirements is being undertaken under the direction of the Department of Transport, taking fully into account the guidelines, such as cost effectiveness, priorities, economic growth and job creation, which were spelt out by the hon the State President concerning the allocation of these funds. These needs will be set off against other priorities determined on a similar basis, such as socio-economic infrastructure, before final allocations will be made.

(3) It is still to be decided whether or not there will be further statements. All allocations will be handled according to normal accounting procedures and will therefore be subject to final parliamentary approval.

†Adv J J S PRINSLOO: Mr Chairman, arising from the reply of the hon the Minister, has the sale of the strategic oil reserve already begun; if so, when, and if not, when is it intended to begin?

†The MINISTER: Mr Chairman, the strategic oil reserve is administered, which means that from time to time sales are effected and replenished by purchases.

There is not a fixed reserve which remains constant and is then sold at a particular starting-point. Various reasons necessitate the administration of that reserve and the administration will be directed in such a way that approximately R1 billion's worth of stock will be sold, from which these funds can then be obtained. [Interjections.]

†Adv J J S PRINSLOO: Has the sale of this approximately R1 billion's reserve already begun?

†The MINISTER: I must again tell the hon member that it is a process. [Interjections.]

†The CHAIRMAN OF THE HOUSE: Order!

†The MINISTER: Sales and purchases are made continuously. These purchases and sales are administered in such a manner that in time to come sufficient reserves will be sold to generate R1 billion. [Interjections.]

†Adv J J S PRINSLOO: Mr Chairman, further arising from the hon the Minister's reply, surely he does not want to profess that they are going to sell R1 billion's worth of the reserve now and then later in the year or a while later again buy R1 billion's worth? [Interjections.] Will he not consider telling us whether this process of reducing the strategic oil reserve by selling it, has already begun or not? [Interjections.]

†Mr J H VAN DER MERWE: Come, tell us the truth!

†The CHAIRMAN OF THE HOUSE: Order! What is the hon member for Overvaal insinuating?

†Mr J H VAN DER MERWE: Mr Chairman, I am merely encouraging the hon the Minister to tell the truth. I am not insinuating that he is not telling the truth.

†The CHAIRMAN OF THE HOUSE: The hon the Minister may proceed.

†The MINISTER: In saying to the hon member that the reserves are administered, it means that sales are effected from time to time. Yes, these sales will increase as and when necessary, but purchases are also effected on a continuous basis. This administration process is simply directed in such a manner as either to fulfil our requirements, or to sell a surplus, from which the funds for this special job creation programme are obtained. [Interjections.]

†Dr P J GOUS: Mr Chairman, further arising from the reply of the hon the Minister, we would like to know how much of this billion has already been collected and is now available for expenditure. Can the hon the Minister give us a figure on that?

†The MINISTER: Mr Chairman, that is information which is not released. [Interjections.]

Posmed subsidy: all races

*5. Mr J CHIOLÉ asked the Minister for Economic Co-ordination and Public Enterprises:† B1179E

(1) Whether he has indicated that the subsidy of the Department of Posts and Telecommunications for Posmed for 1992 will only be paid if Posmed is opened to all races; if not,

(2) whether such a step is being considered; if so,

(3) whether any provision has been or will be made for alternative medical benefits for

Posmed members should they refuse to agree to a racially integrated scheme; if not, why not; if so, what are the relevant details?

The MINISTER FOR ECONOMIC CO-ORDINATION AND PUBLIC ENTERPRISES:

(1) and (2) Yes, Posmed was informed on 14 March 1991 that its subsidy for 1992 will not be paid if its membership is not opened to all race groups within six months of the commencement of the current financial year, that is 30 September 1991;

(3) yes, provision will be made for present Posmed members who have no objection to belonging to a scheme which is open to all population groups. There are several alternative arrangements that can be considered, such as the establishment of a new medical scheme open to all race groups or the integration of the existing members of Posmed who so desire with one of the three other medical schemes serving Post Office officials and whose membership is already open to all race groups, namely Bonitas, Sanitas and Pro Sano. There is no sound reason why officials should not belong to an open medical scheme and existing members of Posmed who do not wish to join such a scheme may, if Posmed decides against opening, remain with that scheme or join another scheme of their choice, but they cannot rely on financial support from the Department for medical expenses.

†Mr J CHIOLÉ: Mr Chairman, further arising out of the reply of the hon the Minister, will he give us an indication of how many offences involving what amount, he is aware of which occurred in respect of the other medical funds that do in fact make provision for open membership, with specific reference to the Black medical fund? [Interjections.]

†The MINISTER: Mr Chairman, if the hon member would care to have that question placed on the Question Paper, I should be glad to furnish him with a reply.

†Mr J CHIOLÉ: Mr Chairman, further arising out of the reply of the hon the Minister, will he please give us an indication of the extent to which the other funds are being funded in comparison with the White fund?

†The MINISTER: Mr Chairman, if the hon member would care to have that question placed on the Question Paper, I should be glad to obtain the information.

†Mr J CHIOLÉ: Mr Chairman, further arising out of the reply of the hon the Minister, I would just like to know whether he will confirm that Post Office officials were responsible for Posmed's coming into being, and whether or not it is an outonomous body. [Interjections.]

†The MINISTER: Mr Chairman, Posmed came into being because the Post Office contributes R2 for every R1 which its employees contribute. All the other medical funds are funded on the same basis. The fact is that the Post Office follows a personnel policy which does not leave any room for racial discrimination.

†Mr J H HOON: That is forced integration.

†The MINISTER: No, it is equal opportunities. [Interjections.] If the hon members want to make race an issue in every situation, we want to tell them that as far as the personnel policy of the Post Office is concerned, it does not apply. We treat our members on an equal basis. We have no problem subsidising all our members' contributions to a medical fund. The only basis on which we are prepared to do so, is that other employees are not discriminated against on a racial basis. [Interjections.]

This gives the employees of the Post Office every opportunity to have access to full medical services. [Interjections.] There are various schemes of which the obligations as well as the benefits differ. Employees therefore have a choice, and we shall continue on the same basis, but we cannot allow discrimination on the basis of colour.

†Mr J CHIOLÉ: Mr Chairman, further arising out of the reply the hon the Minister has just given, will he therefore confirm that this drastic step was taken because his request in this regard had been turned down at Posmed's general meeting on 25 October 1990?

†The MINISTER: Mr Chairman, at the general meeting which the hon member is referring to, 78 of Posmed's 50 000 members were present. [Interjections.] The board unanimously recommend the opening-up of the fund. A circular in

which the chairman of the board strongly recommended this decision, was sent to all of Posmed's 50 000 members and I have no doubt that the greater majority of Posmed's members

†Mr J H HOON: Test them!

†The MINISTER: We are testing them now by way of a vote. [Interjections.] 50 000 ballot-papers have been sent out.

†The CHAIRMAN OF THE HOUSE: Order! The hon member for Pretoria West put a supplementary question to the hon the Minister. If hon members are not interested to hear the reply, the hon the Minister need not go to the trouble of answering the question. The hon the Minister may continue.

†The MINISTER: Mr Chairman, the problem with the hon members is that they wear one pair of spectacles only, the spectacles of colour. They perceive everything in South Africa in terms of Black and White. [Interjections.] If we continue on that basis, there is no future in this country.

We shall have to start putting values first. We shall have to start separating the opportunities which people want to utilize in a work situation from the racial context in terms of which the hon members are so fond of perceiving everything. We changed the personnel policy of the Post Office on that basis so that there can be a mutual desire among White, Black and Brown employees to put the interests of the Post Office first and, in this way, to render the best service to the public—a public that is not White only but which includes all population groups.

†The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, further arising out of the hon the Minister's reply, may I ask if it is discriminatory in any way if one pays the same subsidy to others who wish to be integrated than one pays to a White Posmed.

†The MINISTER: We in the Post Office follow a personnel policy according to which colour cannot be a dividing line, because the issue of race in South Africa has already become one of the dividing lines which divide people to such an extent that conflict and racial conflict are threatening our future.

†Dr F HARTZENBERG: That is not true!

†The MINISTER: Yes, of course it is true!

†The LEADER OF THE OFFICIAL OPPOSITION: Now you are penalizing the Whites!

†The MINISTER: We are not penalizing the Whites. The hon the Leader of the Official Opposition cannot construe this as a penalizing of Whites.

†HON MEMBERS: Of course!

†The MINISTER: No, that is absolute nonsense, because people are paying the same contribution for the same benefits.

†The LEADER OF THE OFFICIAL OPPOSITION: And you are subsidizing the "bontes"!

†The MINISTER: No, there is a variety of medical schemes. If the employee is asked to pay a smaller contribution, the benefits of that scheme to which he is entitled, are also fewer. The employee can therefore choose whether he wants to belong to a medical scheme which offers a greater variety of services, but then he must also be prepared to make a greater contribution. On the strength of that contribution the Post Office is then prepared to make a contribution of R2 for every R1 which the employee contributes.

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

Neighbouring states: airports for military purposes

*6. Mr J H VAN DER MERWE asked the Minister of Foreign Affairs:†

(1) Whether any airports that can be used for military purposes are being built in neighbouring states of South Africa at present; if so, (a) in which neighbouring states and (b) what are the particulars of these airports;

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

B1180E

The MINISTER OF FOREIGN AFFAIRS:

(1) (a) and (b)

Botswana: An airport which could be used for military purposes is in the process of being built at a site approximately 40 km north-west of Gaborone.

Zimbabwe: According to available information Fylde Airforce Base in Zimbabwe

is at present undergoing extensions and upgrading.

(2) No, not at this moment.

Military courses: attendance by ANC members

*7. Mr J H VAN DER MERWE asked the Minister of Defence:†

(1) Whether any members of the ANC have attended military courses together with members of the South African Defence Force in Bloemfontein since 1 January 1991; if so, (a) how many ANC members and (b) what courses have they attended;

(2) whether it is the policy of the Government that ANC members may become members of the Defence Force?

B1181E

The MINISTER OF DEFENCE:

(1) No. (a) and (b) fall away.

(2) No. The hon member is referred to my reply in this House to question number 1 of 24 April 1990.

Cape provincial hospitals: amount saved

*8. Miss M SMUTS asked the Minister of National Health:

With reference to her reply to Question No 20 on 23 April 1991, what total amount was saved as a result of the reductions in services introduced at Cape provincial hospitals from 4 to 27 March 1991?

B1190E

The MINISTER OF NATIONAL HEALTH:

Preliminary figures indicate a saving of R16 557 997.

*9. Mr J van Eck—Law and Order. [Withdrawn.]

SAP action at Old Crossroads

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

(1) Whether any persons were killed or injured as a result of action taken by members of the South African Police off or on Lansdowne Road, Old Crossroads, on or about 24 May 1991; if so, how many;

(2) whether the action taken by the Police included shooting; if so, (a) why did the Police resort to shooting and (b) what calibre of ammunition was used;

(3) whether any of the persons injured in the shooting are to be charged with any offences; if so, what are the details in this regard?

B1192E

The MINISTER OF LAW AND ORDER:

(1) Yes, one person was killed and three persons injured.

(2) Yes.

(a) As the furnishing of any answer to the question will be in anticipation of the outcome of the investigation and judicial actions which will result therefrom, it would be inapt to react thereto at this stage.

I therefore kindly request the hon member to abide by this, so that the judicial process, which is already in progress, can take its course.

(b) AAA Shotgun ammunition.

(3) Yes, three persons were charged with public violence. They are at this time in hospital where they are receiving treatment for their injuries.

Squatter settlements established/planned in Tvl

*11. Mr P G SOAL asked the Minister of Planning, Provincial Affairs and National Housing:

(1) How many settlements (a) have been established, and (b) are in the process of being planned, in the Transvaal under section 6A of the Prevention of Illegal Squatting Act, No 52 of 1951;

(2) in respect of what date is this information furnished?

B1193E

The MINISTER OF PLANNING, PROVINCIAL AFFAIRS AND NATIONAL HOUSING:

(1) (a) 5

(b) 0

(2) 10 June 1991.

responsibility to construct the road is that of the municipality.

However, all the arguments and all the data provided in the debates in respect of the Chatsworth second access road far outweigh those in respect of the Shallcross link road. If one has money to allocate to local government bodies in respect of building a road, absolutely no priority can be attached to the Shallcross link road when compared to the Chatsworth second access road. [Time expired.]

Mr P I DEVAN: Mr Chairman, I have a short answer to this long-drawn-out issue. If bridging finance was not made available for the Shallcross link road, it would not be developed in the foreseeable future. Hence I complimented the hon the Chairman of the Ministers' Council the other day on funding its construction.

The second access road is a different kettle of fish. For the information of the hon the Leader of the Official Opposition, even if bridging finance is made available here and now, the second access road will not be built along the Coedmore Reserve Route. It is a great pity that the hon the Leader of the Official Opposition did not put it to the test by offering bridging finance for its development when he was administering the House of Delegates, because there was probably a remote chance of succeeding at that time.

The problem with the second access road is not finance, but the siting of the road. The hon the Leader of the Official Opposition is aware of the long history relating to the second access road. The question dogging the second access road is not money, therefore the question falls away.

The MINISTER OF HOUSING: Mr Chairman, we would all like to see all roads built. However, the second access road to Chatsworth was vetoed by the Stainbank family who donated the nature reserve, and the cost of implementing the alternative road plans, which were discussed with hon members of this House in confidence, is enormous and could only be undertaken by the authority responsible for that kind of work if it had that kind of financial resources. Therefore one cannot equate one with the other.

I also want to mention, as far as the second access road is concerned, that the hon the Minister of Local Government and Agriculture and I have been conducting negotiations and we intend to meet with the province shortly, when the session is over, to pursue this matter further.

We have not let it lie. We realise that such a road is necessary and we are addressing this problem on an urgent basis. It is hoped that we will be able to give the community some information as soon as we have made further progress in this direction.

The MINISTER OF LOCAL GOVERNMENT AND AGRICULTURE: Mr Chairman, I must honestly say that I am surprised by this interpellation raised by the hon the Leader of the Official Opposition. I say this advisedly and with due respect. The fact is that the hon the Leader of the Official Opposition is a member of a multiparty advisory committee. In March, when this committee met, he raised the issue of the costing and financing of this project. An explanation was offered to him at that particular meeting.

The issue of the link road as well as that of the second access road were on the agenda at a subsequent meeting on 4 April 1991. There was unanimity concerning this particular approach and also concerning the fact that we should proceed with the second access road as well. The basis on which we were to proceed with the second access road was also explained, as were the difficulties that we had experienced. The alternative proposals were also explained to hon members at that meeting. I believe we wanted to work in unity and harmony across the party-political divide. Why, then, bring this up as if to create divisions here when we had such harmony at that meeting?

The second access road is expensive. Even the Durban City Council has said that the amount of money required for even the alternative plan is so large that negotiations will have to take place with various other State agencies, including the central Government itself, to ensure that the second access road is built. Nobody denies the fact that the hon the Leader of the Official Opposition is right. The second access road is an important arterial road that is required for the people of that particular region. Therefore we

must not spare any effort in achieving that objective. I think that scoring points in this particular regard is nonsensical, because the funds of the Housing Development Board will not be able to sustain the total cost, even with the best will in the world, of providing bridging finance for the second access road.

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, are the hon member for Cavendish and the hon the Minister of Local Government and Agriculture not aware of the fact that in their presence we were given new plans and a new drawing of the new direction of the second access road? This was done approximately 10 months ago. [Interjections.] The plans were shown to us. [Interjections.]

The MINISTER OF LOCAL GOVERNMENT AND AGRICULTURE: It was on 4 April 1991.

The LEADER OF THE OFFICIAL OPPOSITION: Even if it was on 4 April, I am sure that if a massive commercial development was being planned next to the new road, bridging finance would have been provided. If one wants to talk about priorities, the cost in respect of the new plans contained in the new drawings will be more or less the same as that in respect of the Shallcross link road. Even if it means R10 million . . . [Interjections.] It is not a question of sucking up to people, but of what lies next to the road. The question is: What is the motivation? [Time expired.]

The MINISTER OF HOUSING: Mr Chairman, the hon the Leader of the Official Opposition wants to know what lies next to this new road that is being prepared. It is a cemetery, which is available for use by anybody. [Interjections.] I just want to reiterate that studies are being done and I hope one day we will have the results here.

The road which has been authorised, linking Chatsworth Central with Shallcross, will certainly take the pressure off the Higginson Highway. That road in fact meets with the Sarnia arterial road, which in turn goes right through to Edwin Swales. In the case of an emergency, people from there can go to Merebank, Jacobs and Durban.

When we plan something, we do not take instructions from any nightclub. We are doing this because a local authority, the DSB, wanted this road. That is why we are doing it. I am not interested in who benefits from it, apart from the public. Some will benefit and some will not. It all depends on how one approaches this thing.

However, I am not answerable to any individual businessman as far as this road is concerned. I responded to a request made by the DSB and I can also tell hon members at this point in time that the local authority, the city council of Durban, is working out how this whole matter may be resolved to the satisfaction of the House of Delegates, because the city council of Durban and the DSB will each accept responsibility for their share.

What we have done, is to bring some relief where it is possible. Where it is difficult or impossible, we make the effort, as the hon the Minister of Local Government and Agriculture has indicated. We will try our best to do it, but again I want to reiterate that we are not building roads because there are certain businesses there. As I said, the only thing that will be next to this second access road to Chatsworth is a cemetery. That can be a business for some people, and nobody will stop one from becoming an undertaker.

Debate concluded.

QUESTIONS

†Indicates translated version.

For oral reply:

Own Affairs:

Precedence given to Questions Nos 4 to 6 on Own Affairs:

Certain organisation: request for financial assistance (299)

*4. Mr E JOOSAB asked the Minister of Health Services and Welfare:

Whether his Department has received a request for financial assistance from a certain organisation, the name of which has been furnished to the Minister's Department for the purpose of his reply; if so, (a) when, (b) what (i) were the reasons for and (ii) was his

Department's response to this request and (c) what is the name of this organisation?

D206E

The MINISTER OF HEALTH SERVICES AND WELFARE:

On 19 March 1991 the Dean of the Medical School at Cape Town addressed the Chief Directors of Own Affairs and Local Authorities and requested them to:

(i) financially assist the Hospice Movement who deliver extensive terminal care services and bereavement counselling to anyone regardless of their race, age or religious affiliation;

(ii) promote this concept within their own communities to alleviate the demand for hospital beds and to reduce the cost per bed at a hospital of ±R315 to ±R150 at a hospice;

(iii) to assist their communities to care for the terminally ill at home.

Considering that the St. Lukes Hospice in Cape Town and the Highway Hospice in Durban attend to all peoples, it was decided to assist financially until our own services can be fully implemented.

On the above grounds and on compassion and as these organisations are registered welfare organisations employing social workers, the Department subsidised these institutions.

(a) N/A.

(b) (i) N/A.

(ii) N/A.

(c) Highway Hospice — Durban

St. Lukes Hospice — Cape Town.

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, arising out of the hon the Minister's reply, is it not correct that neither he nor his department received any request from these organisations?

The MINISTER OF HEALTH SERVICES AND WELFARE: Sir, my answer is clear. The request came from the dean of the medical faculty. As was alleged during the debate, the Hospice Association has dealt with 15 Indian patients up to now. However, as from yesterday one does not talk about Indians, Coloureds and Whites any more.

St Luke's has dealt with at least 50 patients with names of Indian origin in Cape Town.

Durban-Westville: dental faculty

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

(1) Whether his Department has received a request from the University of Durban-Westville to establish a dental faculty; if so, (a) when and (b) in what manner;

(2) whether approval has been obtained from the Treasury to finance this project;

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

D208E

The MINISTER OF HEALTH SERVICES AND WELFARE:

(1) Yes. A request was made to the then Department of Indian Affairs. The Oral and Dental Training Hospital was established in 1979 by mutual agreement between the Department of Indian Affairs, Department of Health and the University of Durban-Westville to train Dental Therapists and Oral Hygienists with the intent that this could serve as an infrastructure to a future Dental Faculty in Natal.

(a) The Ministers' Council in January 1986 obtained Cabinet approval, in principle, to update the existing facility to a fully fledged DENTAL FACULTY.

(b) In writing.

(2) No. Treasury prioritising and approval can only be obtained when the following documentation prepared by the Administration: House of Delegates and the University of Durban-Westville jointly, and approved by the relevant National Authorities are submitted to Treasury for evaluation:

(a) *Administration: House of Delegates*

Hospital norms prepared by the Department of Health Services and Welfare and ratified and approved by the Department of National

Health and Population Development. Approval was obtained in accordance with the above on 7 April 1989 for a 61 Dental Chair Hospital.

(b) *University of Durban-Westville*

The academic needs and norms must be prepared and submitted to the National Department of Education for ratification and approval.

This documentation is awaited.

(3) Yes. At an appropriate time.

Administration: HoD: number of air tickets for staff

*6. Mr D K PADIACHEY asked the Minister of the Budget and Auxiliary Services:

(1) Whether the number of air tickets available to members of the staff of the Administration : House of Delegates who are stationed in Cape Town during the Parliamentary session is to be increased; if so, (a) when and (b) by how many;

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

D211E

The MINISTER OF THE BUDGET AND AUXILIARY SERVICES:

(1) No

(a) and (b) fall away.

(2) No.

Serviced land: utilisation policy

*1. Mr K PANDAY asked the Minister of Housing:

(1) Whether it is the policy of his Department that all serviced land should be utilised fully as soon as possible; if not, what is the policy in this regard;

(2) whether he will allocate serviced land to small private developers in order to speed up the utilisation of such land; if not, why not; if so, what are the relevant details?

D195E

The MINISTER OF HOUSING:

(1) Yes.

(2) Yes. Small private developers are free to submit their tenders when tenders are invited for the construction of houses and further provision is also made for their valued contribution by undertaking assisted self-help housing projects as we have done in Buffelsbosch and Shallcross where they are playing a very important role.

Certain person: duties/accommodation

*2. The LEADER OF THE OFFICIAL OPPOSITION asked the Minister of Education and Culture:

(1) Whether an official of his Department was sent back to Durban from Cape Town on or about 8 February 1991 to perform his duties as a superintendent of education; if so, why;

(2) whether this official was recently brought back to Cape Town; if so, (a) when and (b) what are his duties in Cape Town;

(3) whether this official is residing at a hotel in Cape Town; if so, what is the daily cost to the State of (a) his accommodation and (b) any other allowances paid to him?

D204E

The MINISTER OF EDUCATION AND CULTURE:

(1) Yes, but not on or about 0 February 1991. The precise date was 18 February 1991.

The official was required in Durban to assist the two Acting Chief Superintendents of Education (Management) until they could undertake their duties without further assistance. This became even more necessary with the retirement of a senior Chief Superintendent of Education (Management) with effect from 1 February 1991.

Whilst at Head Office, the official referred to at the very outset, continued to liaise between the Department and the Ministry.

(2) Yes, for two periods.

(a) 10 May 1991 to 23 May 1991 *and*, 1 June 1991 to 6 June 1991, giving a total of 18 days.

VAT ruling 'not final'

B|Day 19/6/91.

299

PRETORIA — Government had not closed the door on the issue of imposing VAT on medical services, says Medical Association of SA (Masa) federal council chairman Bernard Mandell.

At a news conference yesterday, he said this had been made clear in discussions with Finance Minister Barend du Plessis and National Health Minister Rina Venter. Both attended the council's AGM yesterday.

Du Plessis said the issue should not be argued on the basis of the morality of taxation. The financial realities confronting government had to be taken into account.

Mandell said the council had made clear its concern about any proposed move which made health care less affordable and less accessible. That would be a tax on illness, he said.

Yesterday's meeting was one of several with government on VAT and efforts would be made to arrange further discussions with the Ministers, he said.

He said Venter was aware of the urgent need to stop, or at least slow down, the drain of doctors from the public sector.

Doctors were leaving at an increasing rate for private practice and for other countries.

GERALD REILLY

The drain of "excellence" from academic medicine was critical.

However, the crisis could not be resolved by permitting limited private practice at academic hospitals, which was being investigated by Venter. Limited private practice had been rejected by the Masa council as a way of augmenting full time practitioners' salaries.

Limited private practice would lead to neglect of indigent patients and of teaching and would threaten essential research.

"We believe it is the responsibility of government to ensure the salaries and conditions of service of public sector doctors are acceptable enough to retain their services."

□ Our Cape Town correspondent reports that a Finance Department spokesman said yesterday employees whose medical aid subscriptions were paid by their companies as a perk, would not be directly affected by the new fringe benefit taxes.

However, the introduction of VAT on medical services would result in a 7% to 8% increase in costs and a corresponding increase in medical aid subscriptions.

which still exists on farms, dating back to feudal times. They will not get away with this in future."

No guarantees for doctors

JOHANNESBURG. — Doctors and other medical practitioners should not be guaranteed direct payment by medical schemes, according to a Medical Schemes Draft Amendment Bill published for comment in the Government Gazettte on Friday.

The Bill says statutory enforced direct payment by medical schemes should be scrapped because it led to "over-utilisation, over-servicing and abuse of benefits".

● Medical aid: No perks tax, Page 9

CT 19/6/91

For the past two days she has been seen kissing and holding hands with actor Jason Patric.

1989/90—financial year	R415 000
1990/91—financial year	R5 000

(b) Funds voted by Parliament.

(c) (i) None

(ii) 31 March 1991

(2) Dependent on the availability of funds as voted by Parliament.

OFS: Votes Health services/community development

434. Mr L F STOFBERG asked the Minister of Planning, Provincial Affairs and National Housing:†

Whether, with regard to the Province of the Orange Free State: Estimate of Expenditure for the Financial Year ending 31 March 1992, he will subdivide the amount of (a) R510 946 000 under Vote 2—"Health services", and (b) R327 366 000 under Vote 4—"Community development", according to aims; if not, why not; if so, what are the relevant details?

B1139E

The MINISTER OF PLANNING, PROVINCIAL AFFAIRS AND NATIONAL HOUSING:

In order to give a meaningful reply to the question, my Department enquired as to the meaning thereof and it was indicated that the purpose of the question was to obtain the information per population group.

(a) The amount of R510 946 000 under Vote 2—"Health Services" is provided for all population groups and cannot be subdivided per population group.

(b) The amount of R327 366 000 under Vote 4—"Community Development" has been provided solely for the Black community.

Vote No 26: Main Division 6

437. Mr A P OOSTHUIZEN asked the Minister of Planning, Provincial Affairs and National Housing:†

Whether, with regard to Vote No 26—Planning, Provincial Affairs and National Housing, he will subdivide the amount of R601 439 000 under Main Division 6—"Urban development and housing aid", according to aims; if not, why not; if so, what are the relevant details?

B1143E

The MINISTER OF PLANNING, PROVINCIAL AFFAIRS AND NATIONAL HOUSING:

In order to give a meaningful reply to the question, my Department enquired as to the meaning thereof and it was indicated that the purpose of the question was to obtain the information per population group.

The amount of R601 439 000 under Main division 6—"Urban development and housing aid" under Vote—Planning, Provincial Affairs and National Housing had, as indicated in the aim—and programme description on page 26-14 and 26-15 of the printed budget which was tabled in Parliament, a bearing on the Black community. The only exceptions the amounts of R101 102 000 and R90 000 000 which are respectively indicated in the budget as interest subsidy on private loans and redemption of private loans. These amounts are utilised to honour loan obligations which were entered into some years ago on behalf of all population groups.

Province of Cape of Good Hope: Vote 3

438. Mr W A BOTHA asked the Minister of Planning, Provincial Affairs and National Housing:†

Whether, with regard to the Province of the Cape of Good Hope: Estimate of Expenditure for the Financial Year ending 31 March 1992, he will subdivide the amount of R1 821 391 000 under Vote 3—"Hospital and Health Services", according to aims; if not, why not; if so, what are the relevant details?

B1144E

The MINISTER OF PLANNING, PROVINCIAL AFFAIRS AND NATIONAL HOUSING:

In order to give a meaningful reply to the question, my Department enquired as to the meaning thereof and it was indicated that the purpose of the question was to obtain the information per population group.

The amount of R1 821 391 000 under Vote 3—"Hospital and Health Services" is provided for all population groups and cannot be subdivided per population group.

Province of Transvaal: Vote 7

440. Mr W J D VAN WYK asked the Minister of Planning, Provincial Affairs and National Housing:†

Whether, with regard to the Province of Transvaal: Estimate of Expenditure for the Financial Year ending 31 March 1992, he will subdivide the amount of R1 372 332 000 under Vote 7—"Community Development", according to aims; if not, why not; if so, what are the relevant details?

B1146E

The MINISTER OF PLANNING, PROVINCIAL AFFAIRS AND NATIONAL HOUSING:

In order to give a meaningful reply to the question, my Department enquired as to the meaning thereof and it was indicated that the purpose of the question was to obtain the information per population group.

The amount of R1 372 332 000 under Vote 7—"Community Development" has been provided solely for the Black community.

Province of Transvaal: Vote 4

441. Mr W J D VAN WYK asked the Minister of Planning, Provincial Affairs and National Housing:†

Whether, with regard to the Province of Transvaal: Estimate of Expenditure for the Financial Year ending 31 March 1992, he will subdivide the amount of R2 336 764 000 under Vote 4—"Health Services", according to aims; if not, why not; if so, what are the relevant details?

B1147E

The MINISTER OF PLANNING, PROVINCIAL AFFAIRS AND NATIONAL HOUSING:

In order to give a meaningful reply to the question, my Department enquired as to the meaning thereof and it was indicated that the purpose of the question was to obtain the information per population group.

The amount of R2 336 764 000 under Vote 4—"Health Services" is provided for all population groups and cannot be subdivided per population group.

Province of Cape of Good Hope: Vote 10

442. Mr W A BOTHA asked the Minister of Planning, Provincial Affairs and National Housing:†

Whether, with regard to the Province of the Cape of Good Hope: Estimate of Expenditure for the Financial Year ending 31 March 1992, he will subdivide the amount of R653 595 000 under Vote 10—"Community Services", according to aims; if not, why not; if so, what are the relevant details?

B1148E

The MINISTER OF PLANNING, PROVINCIAL AFFAIRS AND NATIONAL HOUSING:

In order to give a meaningful reply to the question, my Department enquired as to the meaning thereof and it was indicated that the purpose of the question was to obtain the information per population group.

The amount of R653 595 000 under Vote 10—"Community Services" has ben provided solely for the Black community.

Free settlement areas proclaimed

443. Mr P G SOAL asked the Minister of Planning, Provincial Affairs and National Housing:

(a) How many free settlement areas have been proclaimed since the promulgation of the Free Settlement Areas Act, No 102 of 1988, (b) where are these areas situated, (c) what is the size of each, (d) how many persons are living in each of these areas and (e) in respect of what date is this information furnished?

B1150E

The MINISTER OF PLANNING, PROVINCIAL AFFAIRS AND NATIONAL HOUSING:

(a) 13.

(b) and (c)

Areas already proclaimed	*Size*
1. Midrand (Country View) (Transvaal)	479 ha
2. Windmill Park (Transvaal)	60,4 ha
3. Warwick Avenue Triangle (Natal)	8,9 ha
4. Diepsloot (Transvaal)	880 ha

Govt seeks changes in medical benefits

TANIA LEVY (299)

DOCTORS and other medical practitioners should not be guaranteed direct payment by medical schemes, according to a Medical Schemes Draft Amendment Bill published for comment in the Government Gazette.

The Bill says enforced direct payment by medical schemes should be scrapped because it leads to "over-utilisation, over-servicing and abuse of benefits". B1Day 19/6/91

Guaranteed payment for services rendered by a priviliged few could not be justified.

A system which protects a small group of professionals — such as doctors and dentists — and the private hospital industry from incurring bad debts was unjust because other professionals such as accountants, nurses and engineers did not enjoy this privilege.

The Bill, which was published on Friday, also proposes the repeal of the legal requirement for a scale of benefits.

The Representative Association of Medical Schemes (Rams) should draw up a scale of benefits as a guide only. Schemes would then determine whether they wanted to pay the suggested scale of benefits or determine their own, says the Bill.

Huge rise in health care costs under focus

BILLY PADDOCK

CAPE TOWN — Health care costs in SA have increased by more than 350% in the past eight years because of outdated legislation and "creeping monopolism" in the medication industry, Deloitte Pim Goldby health care specialist Greg Candy says.

His research into the pharmaceutical and medical industry gave strong credence to the ANC position that primary health care was far too expensive.

"In the pharmaceutical industry, for example, a handful of manufacturers and wholesalers, along with 6 000 dispensing doctors, have a vested interest in maintaining the high cost of medication. Generic substitution, which would have the effect of reducing an overregulated industry, is heavily restricted," he said.

The ANC said at the weekend it was investigating generic substitution for ethical drugs with a view to the state producing 160 drugs identified by the World Health Organisation as necessary for good primary health care.

Candy said South Africans were spending 350% more on health care than in 1983 (equivalent to 6% of GDP), which was "considerably more than the CPI increase of 250% over the same period".

He said health care in SA was not cost effective as restrictive legislation protected the monopolies. Similarly, the fee-for-service system kept consultation costs "immune" to market influences.

Benefit

The medical industry needed to be restructured to benefit consumers and providers of cost-effective health care, rather than private hospitals, medical practitioners and research-based multinationals.

He said this could be achieved by:

- Medical aid/insurance companies owning and operating hospitals, developing "managed care" and moving away from fee for service;
- Group practice between medical professionals promoting this system — they could contract to provide health care needs for a fixed, prepaid fee; and
- Deregulating retail pharmacies by relaxing legislation governing schedules and generic substitution. This would shift emphasis towards generic products, and pressure multinational companies to reduce margins. In this way drug retailers could have a greater influence on manufacturers, especially if they consolidated their "purchasing muscle".

He said alternative delivery systems, such as Preferred Provider Organisations (PPOs), could reduce health costs by increasing consumers' leverage. PPOs would help government reduce its exposure to escalating costs, especially in the areas of drug purchase, distribution and dispensing.

Contracting out some health services to the private sector could assist health authorities in streamlining the infrastructure far more rapidly than if they attempted to do this themselves, he said.

Outdated laws 'keep health costs rising'

Political Staff

THE cost of health care in South Africa has increased by more than 350%, more than 40% higher than the Consumer Price Index (CPI), in the past eight years because of outdated legislation and creeping monopolism in the medication industry, says Deloite Pim Golby health-care specialist Mr Greg Candy.

Research he had done into the pharmaceutical and medical industry had given strong credence to the ANC position that primary health care was far too expensive, Mr Candy said.

"In the pharmaceutical industry, for example, a handful of manufacturers and wholesalers, along with 6 000 dispensing doctors, have a vested interest in maintaining the high cost of medication.

"Generic substitution, which would have the effect of reducing an over-regulated industry, is heavily restricted," he said.

The ANC said at the weekend that they were investigating generic substitution for ethical drugs with a view to the state's producing 160 drugs identified by the World Health Organisation as necessary for good primary health care.

Mr Candy said South Africans were spending 350% more on health care than in 1983, which was "considerably more than the CPI increase of 250% over the same period".

He said local health care was not cost-effective because restrictive laws protected monopolies.

Similarly, the fee-for-service system kept the cost of consultations "immune" to influences of the market system, like supply and demand.

He said the industry needed restructuring to allow consumers and providers of cost-effective health care to benefit, rather than private hospitals, doctors and research-based multinationals.

In this way drug retailers could have greater influence on manufacturers, especially if they consolidated their "purchasing muscle" and this in turn would benefit the larger wholesaler who could be the vehicle for consolidating retail purchasing power.

No way out for mentally ill

w/mail 21/6-27/6/91.

299

The plight of a man incarcerated in a mental hospital against his will, raises questions about the committal process, reports GAVIN EVANS

"THIS regards the blindly stupid and illicit incarceration of the writer in a mental hospital, without authority; and the criminal, absolutely unethical behaviour of the so-called medical profession of the Republic of South Africa."

With these words a 49-year-old father of two, former businessman and current mental patient begins an eight-page diatribe about how he was committed against his will to a Transvaal provincial mental hospital and why he has not been able to get out.

After a lengthy exposition on his worldly achievements, intelligence and good character, he gets to the point: He was incarcerated because he had evidence that the KGB had tried to penetrate the National Intelligence Service via MI5, who were also involved in setting up the CCB. As a result, there was "intelligence interference" in his marriage. His late father, also a foreign agent and acting under orders from a British subject, conspired with unethical doctors to have him certified as a paranoid schizophrenic.

Writing about himself he says: "The writer has always enjoyed excellent mental health, evidenced by his *joie de vivre*, energy, activity, efficacy, achievements, irrepressible humour, optimism and active good sincere human relations. He has never suffered from delusions nor halucinations.

"Accusations of such have been unfounded and completely unevidenced and would be completely annihilated by the hard evidence, and many, many witnesses, which the writer could bring to bear if he had the opportunity..."

While his refutation of the doctor's diagnosis is open to question, his account of his committal and the limited channels for appeal make more sense.

He says his father obtained a letter from his doctor recommending "internment and intensive drug therapy". Later, after a fight with his father, he was taken by the police to be examined by the district surgeon.

A Germiston magistrate ordered his committal to the mental hospital, without his having seen the contents of the doctor's letter, his father's recommendation or the magistrate. He was prescribed a drug, Pimozide, and then treated with drugs against his will.

After appealing to the attorney general and hospital superintendent, he was allowed out. But after several attempts to contact the National Intelligence Service and police, his return to Weskoppies was ordered and he spent 29 months in a chronic ward, "with no treatment whatsoever".

"On average the writer saw a doctor for about 10 minutes in two months," he says.

Applications to see the hospital board and its chairman were initially refused. Later he got to see the board, which refused his unconditional discharge but moved him to another ward and allowed him to go out on weekends.

He says he wants to sue for damages, but can't until his original certification order is rescinded.

In a recent article in the *South African Journal of Human Rights*, psychologist Lloyd Vogelman, attorney Nicholas Haysom and academic researcher M Strauss argue that one of the catalysts behind the current certification process was the assassination of Dr Hendrik Verwoerd, which led to a "concern to protect society from the mentally ill, informed in the late sixties by reawakened primal fear of the deranged lunatic".

The committal process, they argue, is essentially an administrative — rather than judicial — procedure, relying on the diagnosis of doctors. "The consequences of a faulty diagnosis are severe, and there is much evidence to suggest that psychiatry has not yet reached a stage where faulty diagnosis is unlikely."

Any adult who believes another person should be committed to a mental institution may apply to a magistrate for an order — and the application may be accompanied by a medical certificate.

The magistrate, who does not need to examine the person himself, calls for the assistance of two doctors, who provide him with a written examination of the person. If no psychiatrists are available, he may rely on the medical certificate supplied by the applicant.

He may then order the committal of the person to a mental institution as a patient — the reception order authorising the detention of the patient for up to 42 days.

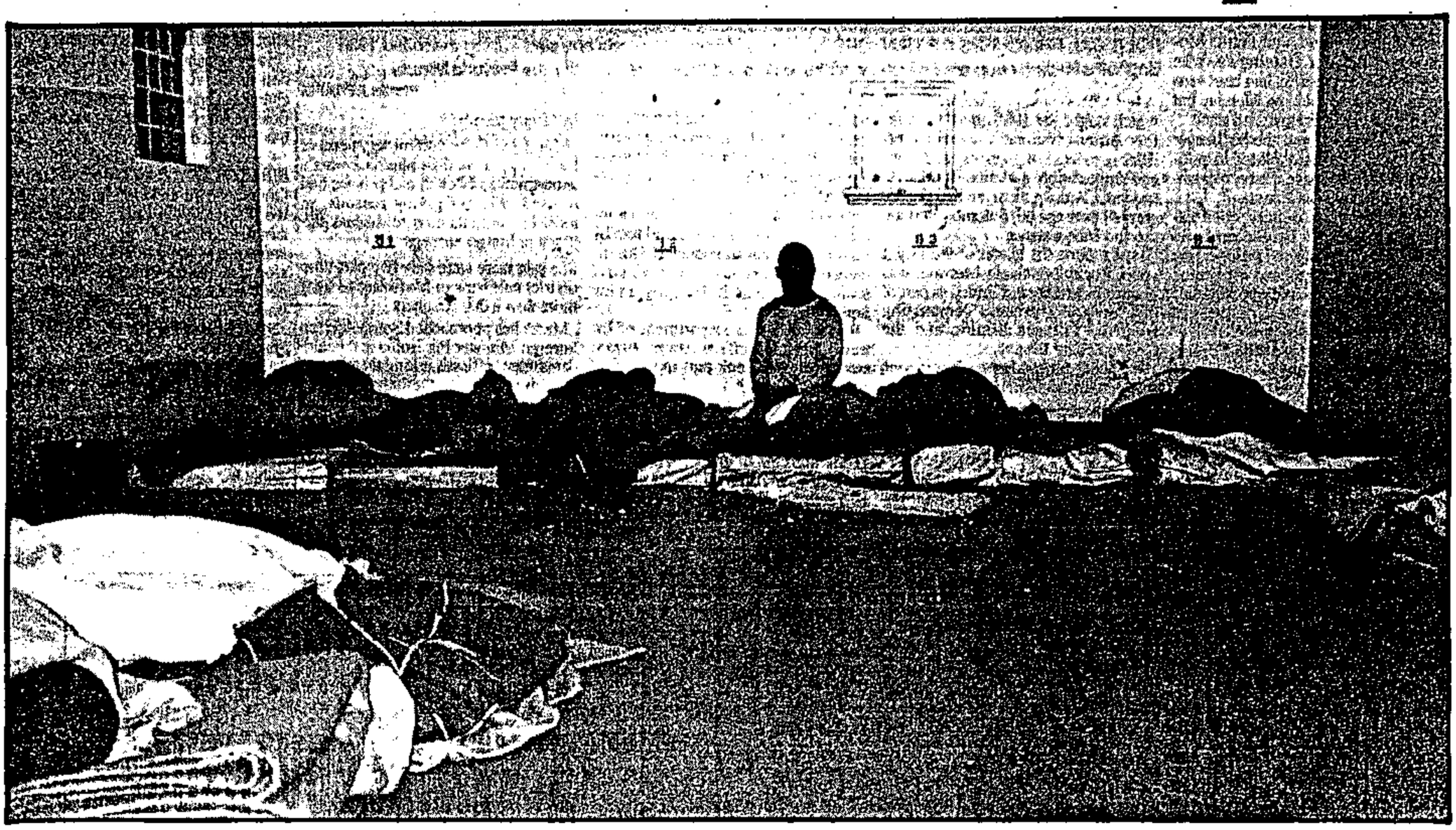
A hospital doctor's report is then sent to the attorney general, after which a judge examines the reports in chambers and may order the further indefinite detention of the patient. After this, discharge is dependent on the doctors, hospital board and superintendent of the hospital.

There is no legal provision for patients to contest their detention and they have no right to refuse treatment — including drugs and shock therapy.

A major problem faced by psychiatric hospitals is the number of certified patients who escape. According to figures released in parliament, at Sterkfontein alone 513 patients "escaped, broke out, absconded or were allowed to go on leave and did not return" between 1986 and 1990.

Inside the bleak cell of despair

w/mail 21/6-27/6/91.



DICKENSIAN STARKNESS ... the MB-ward at Weskoppies is home to 20 men, some of whom have lived there for decades Photo: GUY ADAMS

This week The Weekly Mail secretly gained access to another major mental institution in the Transvaal — the state-owned Weskoppies. CISKA MATTHES reports

w/mail 21/6-27/6/91.

299

IN A locked, bare room of Weskoppies psychiatric hospital, about 20 black patients sleep on thin mattresses on a dirty concrete floor.

Above each mattress a number is painted on the dirty yellow walls: "B1, B2, B3..." — short for "Bantu 1", and so on. Paint is flaking off the walls.

Heads and feet stick out from under heaps of old blankets, close together, without sheets or pillows.

The patients get up elatedly when *The Weekly Mail* reporters enter the ward. They all want to shake hands.

"We are hungry, madam," says one. Another begs, "Please, miss, can I go home? I'm OK in my head now."

Staff claim that the patients are given clean blankets only once a month, and change their clothes only once every four days.

Several of the barred windows are broken, letting in the freezing mid-winter air.

Two buckets of water are placed in the middle of the room with three cups — after 3.30 in the afternoon, it is all the patients will have to drink until breakfast the next morning. They have no food during this period.

The room is filled with a rancid smell of urine; in the corner stands a row of old toilets without seats, shielded only by a low wall. In an adjacent enclosure, a blocked urinal is almost overflowing. Wet patches dot the rough concrete floor.

In this "MB-ward" ("Male Bantu") of Weskoppies, some of the patients have lived for years, even decades, health staff said.

They are black State President's Patients (SPD) who were sentenced by the courts to treatment in a mental institution; they were declared not accountable for deeds that range from general aggression to murder.

The Weekly Mail spoke to several of Weskoppies' health workers who felt it was time to expose the problem.

Staff said the only "therapy" black patients receive is medication — none of them receive any individual psychotherapy. Group therapy is given only to those who are about to be discharged.

Few of the black SPD patients are ever discharged; many may stay until they die. "It is a matter of control, not cure," one worker commented.

The health staff claimed that the approximately 100 black SPD patients of Weskoppies were seen by the psychiatrist briefly once every two or three months.

If the hospital staff — and ultimately, the psychiatrist — judges a patient cured, a discharge procedure may be started.

The health staff claim it is a complicated, bureaucratic procedure that is not often started.

For a discharge a "custodian" — preferably a relative — is needed to take responsibility for the patient.

The problem is that relatives are often not willing to be the custodian, as the patients may have assaulted family members. Social workers are continuously discouraged to sign as custodians by management, the health staff claim.

"The management says it is far too dangerous," they say. They acknowledge that it is not certain whether a patient can be rehabilitated to face the outside world. He may not be able to handle the stress.

But the hospital, they add, doesn't even give patients a chance, and seldom are they allowed to go home on leave.

The health workers claim the white SPD patients are given a chance to go home on leave more often; supposedly even for up to one month.

Furthermore, health staff claim some patients can't leave as they live too far away and receive too little travelling money to get there.

White patients always get sufficient resources to go home, the staff said; and are escorted all the way. Black patients though, may be just "dumped" at a station, they said — and may not be able to cope with the stress.

According to a mental health worker Weskoppies was "racially integrated" in January this year. However, this does not relate to accommodation of patients — merely the medical staff is no longer divided into two separate teams.

Some workers claim though, that even this integration has not yet taken place.

Although there are several newly-built black wards that are said to be quite comfortable, the majority of the approximately 1 300 black patients still stay in the overcrowded old wards, with poor facilities.

Meanwhile, the approximately 1 800 white patients are said to enjoy comfortable conditions; and *The Weekly Mail*, visiting the warm white wards — with some private rooms — spotted a white woman patient peacefully playing the piano in the patients' dining hall.

— In 1 murder 1 person was charged, found guilty and given the death sentence.

— In 1 murder 5 persons were charged and found not guilty.

— In 5 murders 31 persons were charged. The trials have already commenced and have not, as yet, been finalised.

— In 1 murder 1 person was charged. He escaped and a warrant for his arrest has been issued.

— In 1 murder 4 persons were charged. One person was found guilty and given the death sentence, 2 persons were found not guilty and the charge against another person was withdrawn.

In all these instances the persons were charged with murder.

In the remaining 93 alleged deaths the information which the hon member furnished is insufficient. No record can be found of these alleged deaths. Should the hon member have more information at his disposal, it will be appreciated if he will convey such information to the Commissioner of the South African Police or myself.

Because conflict between opposing groups has been rampant for some years, furnishing the names of persons who have been charged in these cases, are to be charged or against whom the charges have been withdrawn, could result in revenge actions being taken against such persons and/or their next of kin.

It is, therefore, not in the interest of law and order to make public the names of these persons. I trust that the hon member will appreciate this point of view.

Certain women's organisation: funding received from Govt Dept

484. Miss M SMUTS asked the State President:

(1) Whether a certain women's organisation, the name of which has been furnished to the Office of the State President for the purpose of his reply, received any funding from the Bureau for Information, the South African Communication Service or any other Government Department at or after its inception; if so, (a) what is the name of this organisation, (b) which body or bodies provided this funding and (c)(i) what are the amounts involved and (ii)(aa) on what date and (bb) to what purpose was each such amount provided;

(2) whether these amounts were provided subject to any conditions; if so, what conditions? B1249E

The STATE PRESIDENT:

(1) and (2) The hon member is referred to my replies in Parliament on 5 March 1991, 12 March 1991 and 9 April 1991. I reaffirm once again the point of principle, namely that denials in certain cases may lead to a situation in which later refusals to provide information in other cases because it would not be in the public interest to do so, could be construed as admissions.

Commuter trains to Jhb: arrangements for Soweto passengers

486. Mr G C ENGEL asked the Minister of Transport:

(1) Whether, since a date early in June 1991, certain trains travelling from Vereeniging and Oberholzer to Johannesburg and back during peak morning and evening commuter times, no longer pick up passengers in Soweto; if so, since what date;

(2) whether this has been done to ensure that the trains in question are kept essentially White; if not, why has it been done;

(3) whether alternative arrangements will be made for those Black commuters travelling between Soweto and Johannesburg who have been affected by this step; if not, why not; if so, what alternative arrangements;

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

B1251E

The MINISTER OF TRANSPORT:

(1) No.

(2) and (3) Falls away.

(4) No.

Medical aid societies

490. Mr M J ELLIS asked the Minister of National Health:

(a) How many medical aid societies are there in South Africa and (b) in respect of what date is this information furnished?

B1255E

The MINISTER OF NATIONAL HEALTH:

(a) and (b) There were 198 medical schemes registered in terms of the Medical Schemes Act, 1967, as at 25 June 1991.

Apart from the five medical schemes controlled by the State under other legislation, referred to in section 2 of the Medical Schemes Act, 1967, there were also 40 schemes registered in terms of the Labour Relations Act, 1956, as at 25 June 1991.

Health in RSA: division of total amount budgeted

491. Mr M J ELLIS asked the Minister of National Health:

(a) What total amount has been budgeted for health in South Africa in respect of the latest specified 12-month period for which figures are available and (b) how much of this amount has been earmarked for (i) primary health care, (ii) secondary health care, (iii) tertiary health care and (iv) any other specified division?

B1256E

The MINISTER OF NATIONAL HEALTH:

(a) The total amount budgeted is R8 130 370 000 and

(b) only the total amount is available. The financial information is presently constructed in such a way that it cannot be subdivided into amounts for primary, secondary and tertiary health care.

Training of medical doctors: cost per annum

492. Mr M J ELLIS asked the Minister of National Health:

(1) What is the cost *per annum* of training a student to become a medical doctor;

(2) how many medical doctors were in (a) private practice and (b) State employ in each of the provinces as at the latest specified date for which information is available?

B1257E

The MINISTER OF NATIONAL HEALTH:

(1) The cost per student is estimated at R25 000—R30 000 per year;

(2) the number of medical practitioners in each province in (a) private practice and (b) Public Service—June 1990:

Province	*Private Practice*	*Government*
Transvaal	5 745	2 981
Cape	3 267	2 258
Natal	1 950	1 122
Orange Free State	689	472

Certain bank: SA Rail Commuter Corporation

493. Mr W U NEL asked the Minister of Transport:†

(1) Whether, with reference to his reply to Question No 7 on 30 April 1991, he will now furnish information on how much money the South African Rail Commuter Corporation invested with a certain bank, the name of which has been furnished to the Minister's Department for the purpose of his reply; if not, why not; if so, (a) how much, (b) on what terms, (c) who took the decision to make the investment and (d) what is the name of the bank concerned;

(2) whether, in the light of either possible losses of money as a result of the above-mentioned investment or possible delay in recovering the funds so invested, he will take steps to supplement the funds of this corporation; if not, why not; if so, (a) what steps and (b) when;

(3) when is the report of the Auditor-General in this regard expected;

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

B1258E

The MINISTER OF TRANSPORT:

(1) The matter is *subjudice*, but certain information will however be provided.

Med-aid groups at death's door

Star 22/6/91. (299)

DEREK TOMMEY

PLANS are afoot to help reduce the rapid growth in medical expenditure which is threatening the existence of the country's medical aid societies.

But the same plans could result in medical aid fund members having to pay substantially more from their own pockets for health care. And it could also lead to a marked drop in the earnings and profits of doctors, dentists, pharmacists and and other suppliers of medical services.

The plans are contained in a draft Bill published by the Government which contains its proposals for streamlining the medical aid movement and cutting costs.

Benefits paid by these societies are running at around R3,9 billion a year and escalating rapidly, having risen more than 350 percent in the past eight years.

There are fears in Government and industry circles that any further cost acceleration could bankrupt the medical aid societies and leave more than 6 million people without private medical care.

Undecided

The Government says that no decision has been taken on any principle or provision published in the draft Bill. But industry sources believe it will be hard for the Government not to implement the Bill in view of the parlous financial state of most medical aid schemes.

The draft Bill contains several major changes which will drastically change the doctor-patient relationship.

It proposes that medical aid societies need no longer abide by the "tariff" of fees determined by agreement between the medical profession and the medical schemes.

Instead the societies themselves will be allowed to draw up their own scale of fees.

Then, as members can be made responsible for paying their own medical bills, the member can discuss with his doctor whether the society's scale of fees will be acceptable.

If this is so, there will be no problem. But should the fee not be acceptable, then the member will have the choice of doing without the medical treatment, trying to find someone who will undertake the treatment at the prescribed rate or pay the extra himself.

Insurance companies have already spotted this potential market and many now offer medical insurance that guarantees to pay the difference between what the medical aid pays and what is charged.

The prospect of a medical aid fund member "shopping around" is not one that will delight the medical profession.

But Mr Henk Beets, assistant general manager in charge of employee benefits at the Old Mutual, makes the point that it would help to develop a greater attitude of cost-consciousness among members of medical schemes and strengthen the supplier-patient link.

This link is currently much weakened by the existence of a guarenteed direct payment system to suppliers.

He points out that in no other areas does the employer guarantee his employee's bills.

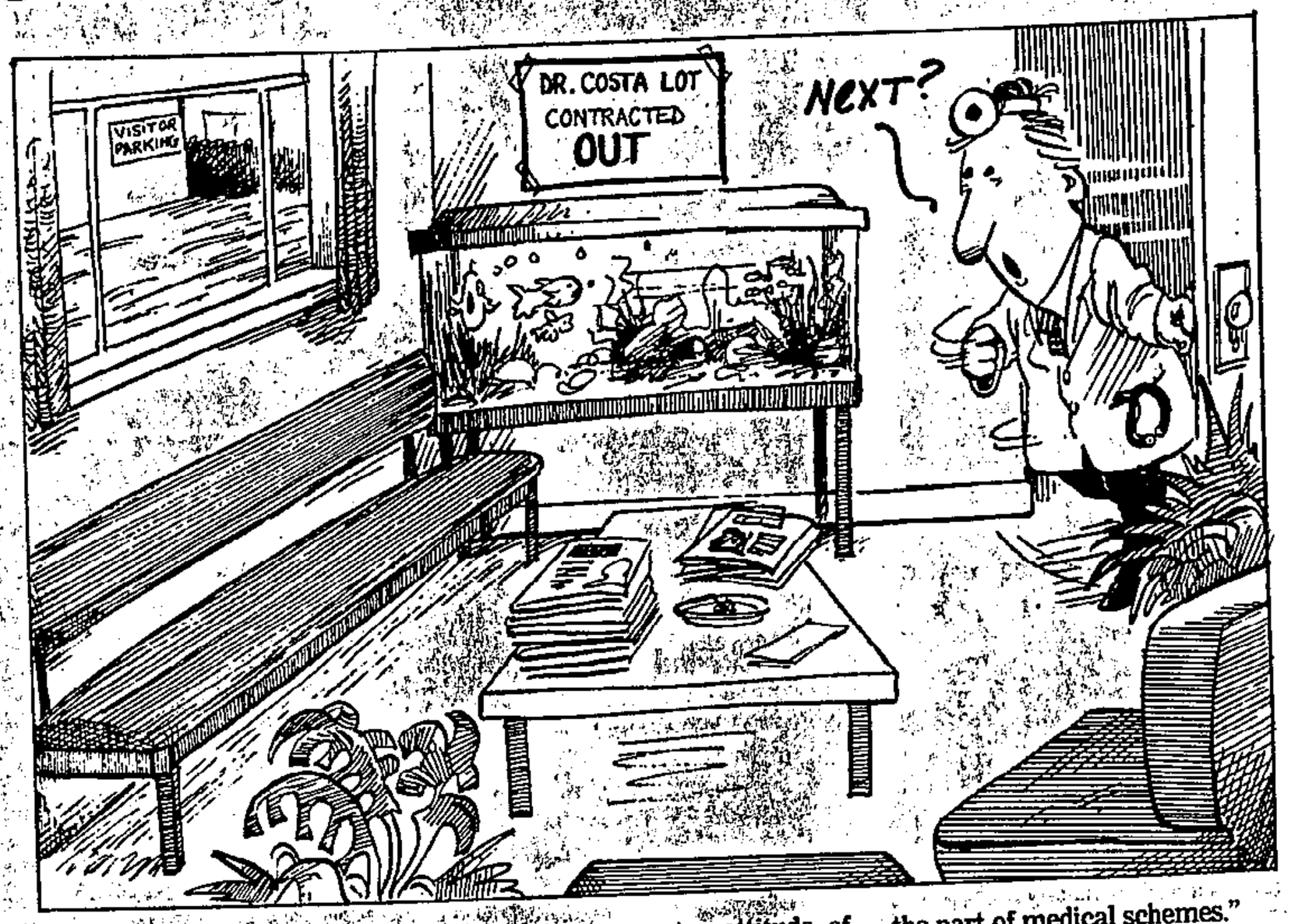
Another important proposal in the draft Bill is the removal of minimum and maximum benefit levels.

This will give employees and employers far greater flexibility to decide how to structure benefit levels, said Mr Beet. Members, through their employee groups, may then be able to choose the level of benefit best suited to their needs. They would be able to decide not only at what level to establish the benefit but whether to exclude certain items from being covered.

"From an industry point of view, this proposed change will also allow for increased product development and innovation on the part of medical schemes."

However, he warns against the increased flexibility creating situations where individuals are under-insured in an effort to reduce costs.

The draft Bill also provides for medical schemes establishing and operating pharmacies, clinics and hospitals. However, a change in the Pharmacy Act will be also be necessary before medical schemes will be able to own pharmacies.



Let taxn

IN a final look at retirement an nuities and the role they play retirement planning, I will co centrate on that formula th seems to confuse many people.

But before I do that, once aga a summary of the advantages an disadavantages of RA's.

● The most important advanta is that it is a very tax-efficie investment. In terms of curre legislation the taxman pays

Drastic cutbacks loom for Western Province Blood Transfusion Service as slashed hospital funding and a worldwide drop in demand for blood have left it in dire financial straits.

VIVIEN HORLER

Medical Reporter

Employees face salary increases of just five percent and no annual bonuses as the service struggles to break even after its most serious financial loss in the past 50 years.

The annual financial statement, released this week, showed a loss of almost R700 000 on a turnover of R27 million.

At its annual meeting the chairman of the executive committee, Mr Peter Day, said the service would have to make drastic cutbacks before the end of the year.

Medical director Dr Arthur Bird said the service, which is incorporated not for gain, was suffering mainly as a result of the financial plight in which the provincial hospitals found themselves.

"Groote Schuur and Tygerberg hospitals are our biggest customers, taking 65 percent of our products. When they are forced to cut back we feel the drought. This year Groote Schuur has cut its consumption of red cell products by between 10 and 20 percent."

The service had also been affected by a worldwide slump in demand for blood products.

"I think the advent of the HIV virus drew the attention of doctors to the risks of blood transfusions, which exist as they do for any medication, and they began to look at using blood more advisedly."

Dr Bird said while the service did not have to pay for the blood donated, it faced costs in collecting, transporting, testing, storing, cross-matching and delivering its products.

"The problem is that a drop in demand for blood products does not mean much of a drop in our expenses. We need much the same size staff as ever, to run a 24-hour service, the same technologists, the same equipment.

"We're incorporated as an organisation not-for-gain, but we're not for loss either. We need to charge to cover our expenses, and when budgeting we aim for a modest five to 10 percent profit annually for development, to cover increasing salaries and for capital expenditure.

"We provide products to three major referral hospitals — Groote Schuur, Tygerberg and Red Cross Children's Hospital — who do sophisticated procedures and who need products from us that are quality-assured."

In an effort to cut costs the service had frozen as many posts as possible, and hoped to cut its staff by about eight percent through attrition.

"We are trying not to retrench or to make people redundant, which is why bonuses may be cut and salary increases, due in July, may be about five percent only.

"The alternative is retrenchments."

Dr Bird said he believed the drop in demand for blood products had bottomed out, and the service would have to adjust itself to the current level of usage. "But trying to see into a crystal ball to predict the future of South Africa's health services is like looking into a muddy pond.

"I do believe, however, that with the audits and the discipline we're applying, we should be back in the black next year."

Big rise in use of gold for jewellery

BRENT VON MELVILLE

THE use of gold for local jewellery manufacture has more than doubled since the scrapping of the ad valorem tax and the reduction in the required added value content of jewellery last year.

Last year, SA's level of gold fabrication was 15t. Ten tons were used in electronics, dentistry, industrial coin manufacture and 5t in jewellery manufacture, a jump of 138% over the 2,1t used the previous year.

But former Chamber of Mines president Clive Knobbs says that level is not nearly high enough.

"On the world stage of gold jewellery fabrication SA remains a very small player, accounting for only 0,6% of total world usage of gold for jewellery," Knobbs said at the opening of the recent Jewellex '91 at Kempton Park.

Knobbs said jewellery exports from SA to the western world were valued at R10m last year. Local jewellery purchases by foreign tourists visiting SA was a massive R150m.

The problem in SA was that jewellery was purchased mainly for adornment rather than as an investment. He said there was considerable scope for expansion of the local market by promoting gold jewellery as investments.

Council for Mineral Technology (Mintek) president Aidan Edwards has said SA should aim for 100t of gold jewellery by the end of the century. That could earn up to R1bn a year in foreign currency and create thousands of jobs.

Flexibility in medical benefits

DARIUS SANAI

PROPOSED changes to medical aid structures will mean patients will have to pay for treatment before being reimbursed and companies will be able to shape benefits privately.

These conclusions were presented over the weekend in an analysis of proposed changes to the Medical Schemes Act by Old Mutual's Employee Benefit Centre.

"In the proposed new system, members of medical schemes may be made responsible for paying all their medical accounts themselves. Members would then claim from their medical scheme," the analysis says.

Old Mutual Employee Benefits assistant GM Henk Beets says the proposed changes will also give employers and employees far greater flexibility in deciding how to structure benefit levels.

One of the most important of the proposed changes is the removal of current minimum and maximum benefit levels, says Beets.

"Members, through their employee groups, may then be able to choose the level of benefit best suited to their needs."

The removal of the guaranteed payment system, whereby the supppliers pay doctors directly for treating patients, will result in much stronger links between patients and suppliers, he says.

However, Beets warns that some patients may be lured into saving money by drawing insufficient medical cover on the new scheme, and discovering to their detriment that their costs will not be paid.

Business criticises aims of city council's budget

DARIUS SANAI

THE Johannesburg Chamber of Commerce and Industry (JCCI) has strongly criticised the city council for aiming last week's budget increases at business targets.

JCCI CE Marius de Jager at the weekend expressed his "grave concern" about the possible effects of the city budget.

He was responding to a statement on Thursday by council management committee chairman Ian Davidson that the city's budget should "in some small way attempt to redress the imbalance" in the state Budget between business and private individuals.

Davidson said business would shoulder the lion's share of the council's increase in spending of 25%.

Chamber of Commerce President Mike Cato dismissed Davidson's comments as "a lot of nonsense".

"He has no right to cast himself as some kind of an equilibrium maker between the federal and local budgets," he said.

The budget was "upsetting" because it would penalise business, Cato said.

De Jager said the decision contradicted the council's policy of encouraging business investment in Johannesburg.

"It will mean that businesses thinking of moving here will decide they are better off in Maritzburg, Durban, or Pretoria."

He added that while nearby municipalities such as Midrand were offering incentives to business to relocate there, the Johannesburg council's action would act as a disincentive.

"The decision is a bad one given the objectives the council has set out of attracting companies."

"It is not the role of the local authority to redress what it perceives as imbalances in the state Budget."

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US grants R2-m to fight Aids

By MONK NKOMO

THE United States yesterday pledged donation of R2 million to help develop and support a nationwide Aids education programme in South Africa.

US Ambassador to South Africa, Mr William Lacy Swing, signed the agreement to present R2,3 million to the Progressive Primary Health Care Network (PPHC) at a function held at the US embassy in Pretoria.

Swing announced that the first cheque for R1,2 million would be presented immediately and the balance would be paid after six months.

The grant is expected to support the establishment and operation of Aids prevention programs in the Southern and Western Transvaal, Natal and the Western Cape.

Partial support will also be granted to the National Office of the Progressive Primary Health Care Network.

Organising health care for all

New Nation (Learning Nation) 28/6-4/7/91. 299

Many people, including organised workers, know that health care in South Africa is in a crisis. Apartheid capitalism has resulted in many black working class people, and especially people in rural areas, not having access to adequate health care.

Many people believe that the crisis in health care will be solved when apartheid is removed from the law books. On 17 May 1990, the Minister of National Health and Population Development, Dr Rina Venter, made a statement in parliament that apartheid in hospitals is dead. But has this statement improved the health care needs of all South Africans?

It is more than a year since Dr Venter removed apartheid from hospitals. But reports of racial discrimination in hospitals in the Orange Free State confirm that apartheid is not completely dead in hospitals. Nationally, little progress has been made in admitting black patients to hospitals that were previously for "whites only". This process is slow, inconsistent and uneven.

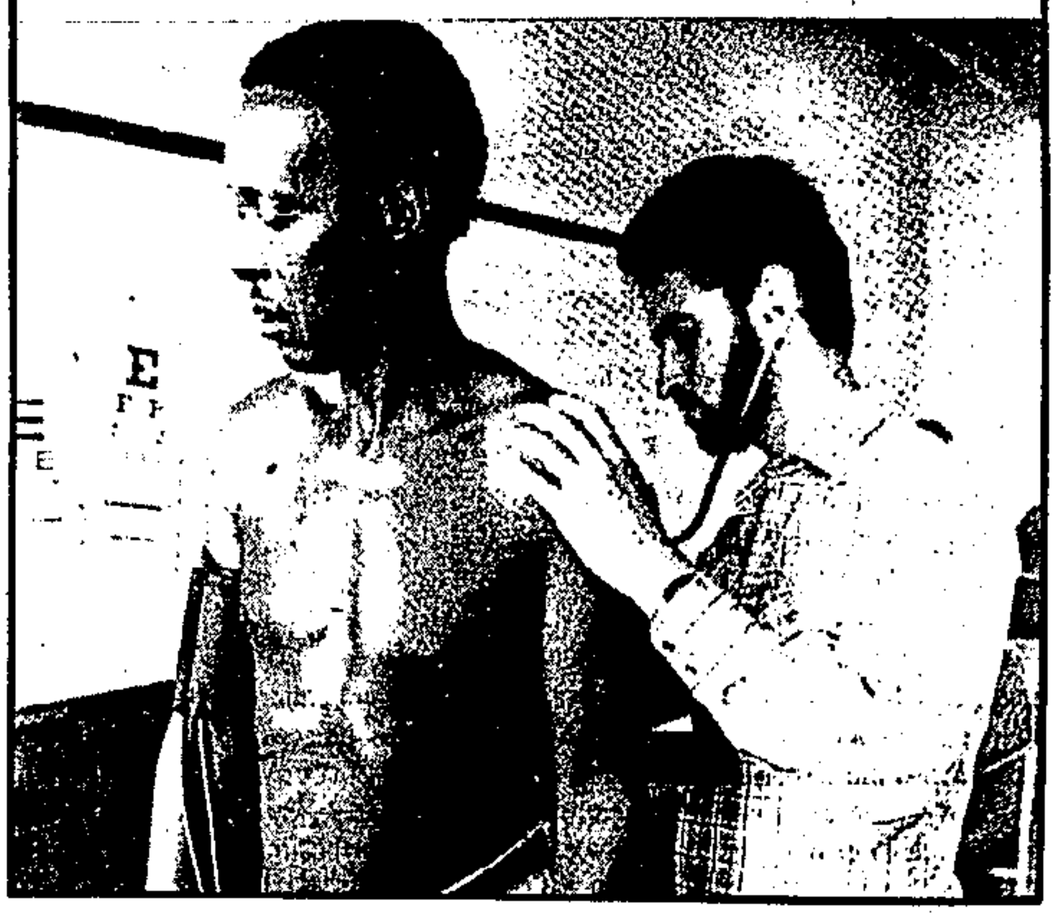
Even if black people were allowed to use all hospitals, the health care crisis would not be solved. **Health for All** will only come about when we understand why people become sick. Let us look at the story of Joe to understand how poverty makes people sick.

Joe's story

Joe is a migrant worker. He lives in a hostel in Alex. Joe earns R400 a month. He sends R100 a month home. Often Joe does not have enough to eat. He shares a small room with 15 other people. The floors are made of cement, the windows are broken and the roof leaks. There are not enough toilets in the hostel. Often the toilets are blocked or they leak. There are not enough taps and showers for people to wash themselves or their clothes.

Last year Joe got TB. He went to hospital for treatment. When Joe returned to the hostel, he soon got sick again, because his living conditions were so bad. So Joe is back in hospital again. Now he worries - what is going to happen when he goes back to the hostel? Will he get sick again?

Joe, like many other people, gets sick often because he is poor. In South Africa, because of apartheid capitalism, it is black people who are the poorest and who get sick the most.



Privatisation of health services

In South Africa, like many capitalist countries, the government spends more money on curing or making people better when they are already sick. They spend very little money on trying to stop people from getting sick in the first place. Now the government says it does not have enough money to pay for health services any more. So hospitals do not have enough money. Hospitals are trying to cover their costs by cutting down on medicines and putting up their fees.

Another way that the government is trying to solve the problem of money for health care is by privatising health services. They are saying that the business or private sector must take over the hospitals so that hospitals will be privately owned. The government says that the business sector must try to make a profit out of hospitals and health services.

There are already many private doctors and hospitals. Most people cannot afford to use them. With privatisation, more hospitals will become privately owned. By privatising health services, the government is handing over its responsibility to provide health care to the private sector. The government is saying that health care is not a right which all people have. The government is saying that good health care is only for people who can pay for it. But we must say that good health care is a right that every person in society should have.

Organising for better health

For a long time the working class has fought for a better life. The South African working class has a long and rich history of struggle. The struggle for better wages, better housing, better education and liberation are all part of the struggle for a better life, and therefore, better health.

Now that apartheid is beginning to be removed from the law books, this does not mean that we must stop the struggle for better health. The struggle needs to continue until the day that we have health care for all. The most effective way to continue the struggle is by organising for better health. Let us look at some ways of organising.

Hostel Dwellers Organise

Hostel life has many problems. People in hostels are often lonely and bored. They live far away from their families and there is nothing for them to do at week-ends. So many hostel dwellers spend their time drinking in smoky shebeens. To fight their loneliness, hostel dwellers often find lovers in the townships. Many people get sick from drinking too much - or they get sexually transmitted diseases like Aids.

The government and employers do not want to get rid of hostels and build family housing. Instead they are building expensive houses which most people cannot afford. Some hostels dwellers have started to fight for better health care. **In the Western Cape, workers in the hostels started an organisation called the Western Cape Hostel Dwellers Association - WCHDA.**

The aims of the Western Cape Hostel Dwellers Association are to fight for:-

* the right of workers to live with their families near their workplace
* the improvement of the hostels
* adult education and cultural activities for hostel dwellers
* better relations with township residents.

One of the projects which the Cape Hostel Dwellers has started is a health project. This project helps hostel dwellers with their health problems. The health project also helps workers fight for better living conditions.

Organising in the townships

Many township residents have also started to organise. People are forming residents' organisations to fight high rents, lack of electricity, untarred roads, lack of proper sewerage and running water and the shortage of housing.

The shortage of houses has forced many people to build shacks and squatter camps. People in squatter camps are also organising to fight for houses. But until they get houses, they are fighting for running water, sewerage and other conditions which will improve the standard of living in the squatter camps themselves. These conditions will improve people's health.

Organising for better health care

Health workers and community organisations are also fighting for better health care. They want the state to make improvements in hospitals and clinics.

These organisations won one battle when the government was forced to open hospitals to all in May 1990. They also want the government to stop increasing hospital and clinic fees.

Health workers' organisations have also formed a group called the **Progressive Primary Health Care Network**. The aim of this group is to organise for better health care together with community organisations.

Unemployed workers do not have enough money for medical treatment. Together with the National Unemployed Workers Co-ordinating Committee (NUWCC) they are demanding free medical care for the unemployed.

Organising in the union

Workers, through their unions, are also fighting for better living and working conditions. The unions have won many battles over the past few years. They have won better wages for their members, maternity benefits and safer working conditions.

The struggle for better health does not stop with the removal of apartheid in hospitals. Health care, both preventative and curative, need to be improved in such a way that it will benefit the majority of people in South Africa. This will only happen when we put pressure on the government to realise that health care is a right and not a privilege.

This article was prepared for Learning Nation by the Workplace Information Group (WIG). Their address is P.O.Box 5244, Johannesburg, 2000. Phone 337-9413/4/5/6.

SOCIAL SECURITY — MEDICARE ~~CHILDCARE~~

1992

JANUARY — AUGUST.

Teaching communities by role playing . . . members of the Cleto Saporetti Foundation rural nutrition education programme in Stellenbosch start work when farmhands come in from the fields.

Spicing up the diet message

STAR 2/1/92 (299)

The do's and dont's of correct diet can be a bit dry. One way of spicing up messages on nutrition for rural communities is through the innovative use of role playing.

This is being done by members of the Cleto Saporetti Foundation, which has developed a rural nutrition education programme serving the entire Stellenbosch district, an area of 850 sq km.

"Role playing has been found to be an effective means of nutrition education," says foundation director Dr Geraldine Mitton.

Demonstrations are given at clinics and in farm packsheds to workers after a hard day in the fields. Performances are both entertaining and informative, she says.

The programme promotes healthy lifestyles and initiates self-help projects in the community.

The operational team includes a doctor, a dietician and four nutrition educators who have completed a diploma course in nutrition organised by the House of Representatives.

The nutrition educators are members of the community in which they work. This is an essential contribution to the programme's success, says Dr Mitton.

"They understand the community's needs, and are able to identify problem areas."

The educators have earned a reputation as effective lecturers and demonstators, and are in great demand by service organisations, schools and the Department of Agriculture.

They have been the sole nutrition lecturers for the past three years for the Stellenbosch students health service organisation (Uskor). During 1990, more than 70 farms were visited by the educators as part of the Uskor rural farm project.

The foundation's vegetable garden competition for farm workers has become an annual event, attracting an increasing number of entries.

"Gardeners can share or sell their vegetables to neighbours," says Dr Mitton. "Weeding and watering provide exercise for older members of the family."

The Cleto Saporetti Foundation was created in 1986 and is financed from the estate of the late Cleto Saporette. Its main activities include research, data collection and the teaching of all aspects of preventive health and community nutrition education.

MARIKA SBOROS

Student will tee off for blind people

STAR 2/1/92 (29)

Pretoria Correspondent

In a bid to develop sport for the visually handicapped, a member of Pretoria's blind community will tee off at Zwartkop for a game of golf on Monday.

"The long-term goal is to develop the sport for blind people and enable them to participate in international tournaments," said Adriaan Meyer, a partially blind student at the University of Pretoria.

Mr Meyer's dream of promoting sport for the blind community began five years ago.

He approached the SA National Council for the Blind with his proposal to actively promote sport for the blind commmunity and was offered its support.

The games of golf Mr Meyer will be playing over the next few days are "a campaign to develop an interest in the sport among visually handicapped people and draw sponsors to support the project".

Mr Meyer will play at the Zwartkop Country Club on January 6, 7, 8 and 10 and at the Irene Country Club on January 9 and 12.

With the continued co-operation of the National Council for the Blind and sponsors, he aims to develop gymnastics training, starting with children in Transvaal's schools for the blind.

"From there, I would like to extend the project to include other sports," he said.

AIDS FM 3/1/92 299

Corporate posers

Some guidelines for companies to follow in the Aids era about to descend on us have been prepared by Sanlam's group benefits division.

First sketching the likely situation: about 5m infected in 10 years' time and no cure in sight — Sanlam's *Insight* newsletter argues that far too few companies have yet formulated a policy for the problem and others are not facing up to practicalities, which include:

☐ Additional costs in maintaining levels of employee benefits, including medical aid, disability cover and group life cover;

☐ Disruptions in the workplace as Aids-related sickness sets in and deaths increase;

☐ The cost of educating employees about Aids;

☐ Increased training costs, the result of higher labour turnover; and

☐ Higher taxes because of the cost burden carried by government.

Apart from facing up to budgetary problems, Sanlam says, every employer needs a corporate policy dealing with not just Aids but all life-threatening diseases. "Broadly speaking, it should seek to avoid discrimination against those infected and respect their productivity. It should avoid moralising while at the same time exhibiting compassion. Most of all, it should be proactive."

Components of the policy, Sanlam suggests, could include:

☐ Education of the work force about Aids, its consequence and avoidance;

☐ Provision for counselling;

☐ Confidentiality of any medical data, especially the results of HIV tests;

☐ A policy to accommodate fellow workers who refuse to work with Aids sufferers;

☐ A policy decision on the separation of carriers of potentially dangerous diseases such as TB, from HIV carriers; and

☐ A ruling on the question of continued rights to medical aid and disability benefits.

Any policy must be discussed and agreed with employee organisations, then explained to every employee whom it could affect. Otherwise, Sanlam warns, "the firm opens itself to the possibility of actions against it in, as yet, uncharted legal territory." ■

Health care in crisis

STAR 4/1/92 (299)

MAGNUS HEYSTEK
Finance Editor

SPIRALLING health care costs escalating at an annual 25 percent in recent years, are threatening to put adequate medical care out of the reach of all but the very rich.

Already a large part of society, particularly blacks, coloureds and Asians are not covered by any medical aid and this situation is expected to worsen unless rocketing medical costs are brought under control.

Medical costs have become the fifth largest expense in the consumer price index (CPI) for the average person, with a weighting of over five percent, according to the latest figures supplied by the Central Statistical Service.

It has overtaken fuel as a major expense item and is only topped by housing (with a weighting of 14 percent), food (18 percent), transport (14 percent) and clothing (seven percent).

As a result of the sharp increase in medical aid contributions many lowly-paid employees are opting out of medical aid funds.

According to the latest available figures from the Registrar of Medical Schemes 68,8 percent, or 3,4 million, out of the total white population of 4,9 million people are currently covered by medical aid schemes.

However, for the other racially-defined groups the picture looks even worse. Only 33,8 percent (313 000) of an estimated 928 000 Asians have medical aid cover, with the percentages for coloureds and blacks even lower at 30,2 and 5,5 percent respectively.

Company cost

For most companies too the cost of medical aid schemes is becoming a major expense.

According to Leon Lewis, joint managing director of actuaries Alexander Forbes and the chairman of Medicaid Administrators, medical aid costs to companies could soon overtake pension fund costs if current trends continue.

Pension fund costs are generally escalating in line with the average rate of inflation of 15 percent, but the burden of health costs as a percentage of the total payroll will double in less than ten years.

For companies the escalation of medical aid costs has a number of consequences, Mr Lewis says:

- As the medical aid system relies on a great deal of cross-subsidisation, younger employees who present a better risk are increasingly reluctant to continue to subsidise older members with a poorer risk portfolio.
- Companies have to reassess their commitment to employees in terms of the extent to which they are prepared to finance healthcare.
- Healthcare programmes are absorbing an ever increasing percentage of total renumeraton. As this trend continues lower paid members will not be able to afford their contributions and will be forced to withdraw from the medical aid.
- Despite the significant increase in the cost of and benefits provided by medical aid schemes, many providers of healthcare services are charging rates far in excess of tariffs.

Medical aid members are therefore forced to pay an ever-increasing portion of the medical aid costs out of their pockets due to the "gap" between the scale of benefits used by medical aids and the costs charged by doctors, hospitals and specialists.

Topping up insurance

Insurance companies have recently entered this particular field in a big way, marketing "top-up" health insurance schemes.

Mr Lewis points out that the medical aid industry has historically provided cover for pensioners at significantly subsidised rates.

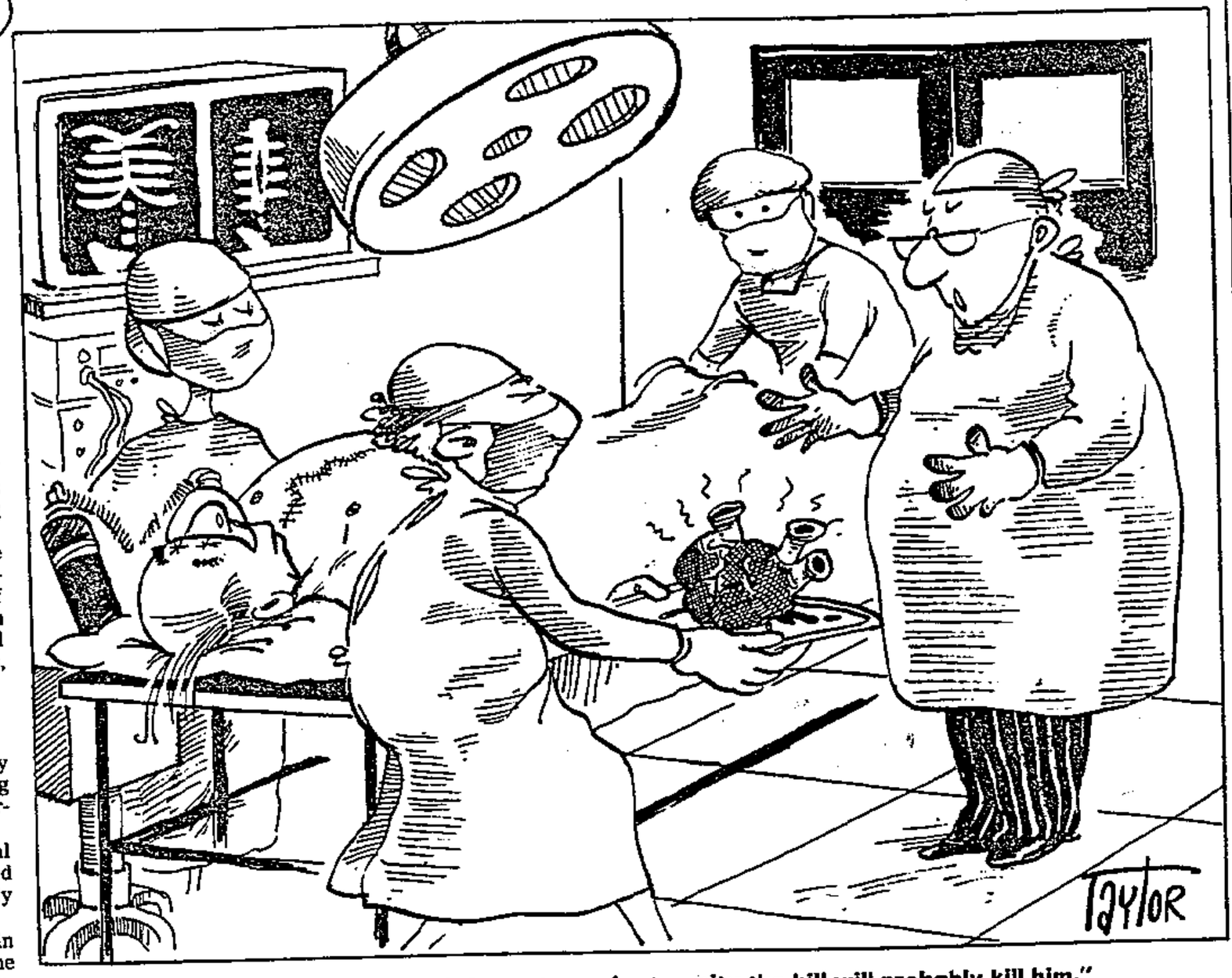
"The growing cost pressures within the industry are likely to reduce the extent of the subsidy applicable to pensioners and will force many pensioners to leave the system," he says.

The rapidly emerging Aids disease is also likely to cause enormous problems. Conservative models for the likely spread of Aids in in this country suggest an HIV infection rate of about 25 percent among active employees by the year 2010.

Studies based on this assumption conclude that about 50 percent of all expenditure on healthcare will be for Aids-related problems by that stage. Current expenditure on Aids is zero.

Proposed changes to the Medical Aid Schemes Act, which include the removal of scale of benefits, could alter the situation positively, Mr Lewis says.

It would enable medical aid schemes to have greater flexibility as far as benefits, design and limits of the system are concerned and could reduce the widespread abuse of the system.



"Well, Mr Jones survived his heart transplant — pity the bill will probably kill him."

Clean out portfolio rubbish

MR JGM of Witbank writes: Recently you advised Mrs RF of Johannesburg to sell "bad" shares and to "put the money to better use in other areas".

Attached is a list of shares obtained by us on the advice of some "expert stockbroker". I shall be obliged if you will provide me with your recommendations on which shares to keep and which to sell.

If you have any other share suggestions please feel free to advise which shares to purchase.

The shares are (with quantities held in parentheses): Eersteling (4 200), Ergo (100), Joel (100), Spescom (10 000), Rand Leases (1 500), Samancor (500), Hiveld (500), RCA (10 000), Ostrey (21 000).

retiring in about four year's time. Both my husband and I are sixty.

At the current exchange rates the above sum would be more than R60 000.

As the Bank rate in England is now 9 to 9,5 percent, I don't think it is such a good idea to invest for such a small return while the properties in the Cape are going up in price and the interest received on the money won't cover the expected increase in prices.

I think this is a sound idea but meanwhile my husband dithers and cannot make up his mind and all the while prices are going up in the Cape.

If we ask our London Bank to transfer the above money to our bank in

Personal Finance:

Questions and answers

DO you have any queries on financial and investment matters? Do you feel that you are not getting objective financial advice? If so, then write to MAGNUS HEYSTEK, c/o Money Matters, The Saturday Star at P.O. Box 1014, Johannesburg, 2000. All letters will be treated in confidence.

Medical schemes link up

B Day 6/1/92

DAVE LOURENS

(299)

MEDICAL schemes Affiliated Medical Administrators (AMA) and Natal Medical Plan (NMP) have merged their administrative operations, creating an umbrella structure caring for 250 000 members and their 625 000 dependants.

While the merger consolidates AMA's position as SA's second-largest medical scheme administrator, NMP is to retain a separate identity.

AMA chief operating officer Timothy Gelman said AMA was repositioning itself, moving from being purely a medical aid administrator to being a provider of health care solutions.

Gelman described the repositioning as a shift from simple health funding towards establishing a partnership between consumers, suppliers, funders and the community as a whole.

AMA believed customers would benefit from the establishment of a "value chain" which structurally promoted efficiency and effectiveness in the provision of health care services.

NMP CE Rob Basson said the relationship would "maintain the unique identification of NMP while allowing current and future members to enjoy the advantages of nation-wide service and economies of scale in product development and technology".

AMA administers 10 other medical schemes, including those of Southern Life, Anglo American, Anglo Mines, AECI, Metal Box and the Rennies group.

Medical scheme giants merge

CT 6/01/92 **Own Correspondent** (299)

JOHANNESBURG. — Medical scheme giants Affiliated Medical Administrators and Natal Medical Plan have merged their administrative operations, creating an umbrella structure caring for 250 000 members and their 625 000 dependents. The merger consolidates AMA's position as South Africa's second largest medical scheme administrator, but NMP is to retain a separate identity.

Medical schemes fall by wayside as costs soar

BIDay 7/1/92 299

THE number of medical aid schemes in SA has dropped from more than 300 seven years ago to about 240 this year as medical costs continue to soar well above the inflation rate.

Representative Association of Medical Schemes (Rams) executive director Rob Speedie said the decline was partly due to mergers between schemes due to market forces.

The benefit of merging smaller schemes lay in creating larger risk pools, without which schemes found themselves restricted in terms of their ability to offer their members a variety of benefit plans.

Registrar of Medical Schemes Ellis Langeveld said he feared medical subscriptions would continue to rise above inflation, and expected the number of schemes to drop further with mergers remaining the order of the day.

DAVE LOURENS

"There has been an evolutionary trend towards mergers lately as schemes seek to widen their risk pools," said Langeveld. "The idea is to spread the risk."

National Health and Population Development director-general Coen Slabbert lent urgency to actions to spread risk more evenly when he told a conference on proposed amendments to the Medical Schemes Act recently that nine schemes were insolvent and a further 88 had traded at a loss in 1990.

SA's second largest medical scheme administrator, Affiliated Medical Administrators, at the weekend announced an administrative merger with the Natal-based National Medical Plan.

Last month three major non-white schemes, the predominantly coloured Pro Sano Medical Aid Scheme, the mainly black Bonitas Medical Funds and the mostly Indian Sanitas Medical Scheme, announced a federation of the three schemes, Bonprosan, to function as an "interim organisation for the purpose of unifying state employees within a single medical aid structure".

Sanitas chairman Pat Samuels said: "All Bonprosan is trying to do is to plan ahead by pooling resources now."

Rams predicted medical aid schemes would probably pay out an average of R275 a member a month this year, compared with R220 last year and R98 in 1987.

Last year the controversy caused by the steep increases in medical aid subscriptions was further compounded when the doctors' representative body (the Medical Association of SA) demanded an effective 71% increase in doctors' payouts.

Med aid mergers 'order of the day'

CT 7/1/92 (299)

Own Correspondent

JOHANNESBURG. — The number of medical aid schemes in South Africa has dropped from more than 300 seven years ago to about 240 this year as medical costs continue to soar.

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Friday Mavuso gets top award

(299)

Sowetan 9/11/92

By JOSHUA RABOROKO

THE chairman and manager of the Self Help Association of Paraplegics (Soweto), Mr Friday Mavuso, was given the Rotary Club of Sandown's highest award for his achievements in providing work for the disabled.

The Paul Harris Fellowship award was presented to Mavuso by Mr Bevil Dustan, president of the club at a special luncheon in Sandton.

Mavuso received the award for his determination and "indomitable" spirit in establishing a self-help centre for paraplegics in Soweto.

Packaging

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. Unskilled work such as packaging is also undertaken.

In presenting the award, Dustan said: "The Rotary Club of Sandown wishes that you be recognised specifically for your concern for others less fortunate than yourself.

"To have acquired, through force of circumstances, the determination, dedication and a continuing desire to assist your fellow disabled indeed makes you a fortunate man."

The Shaps centre was formed by Mavuso after he was paralysed when a bullet lodged in his spine after 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 his dream of giving other disabled people an opportunity to earn a living.

Mavuso said: "We run a professional operation. All goods in the factory are insured on behalf of our customers.

"We are proud that the standard of our work can compete with the best on the open market."

Shift to primary health care

Radical govt plan to curb medical costs

B/Day 10/1/92 (299)

NATIONAL Health Minister Rina Venter yesterday unveiled radical new government plans to stop rampant medical inflation and restructure the national health care system strongly towards primary health care.

Venter's proposal yesterday for a "medical Codesa" at which the proposals will be discussed drew a positive response from all sections of the health care sector, including her staunch opponents such as the National Medical and Dental Association (Namda) and the Medical Association of SA (Masa), which recently spearheaded calls for her resignation.

A broadly constituted forum will discuss Venter's wide-ranging proposals on February 28.

The proposals aim at making health care cheaper and more accessible to lower income groups.

They include granting pharmacists greater professional discretion by allowing them to supply schedule three and four drugs without doctors' prescriptions. Pharmacists can supply only unscheduled and schedule one and two drugs on their own initiative. The proposals would also allow dispensers greater freedom to sell cheaper generic medicines in place of brand-name equivalents.

Another proposal is to introduce a single exit price on sales by pharmaceutical manufacturers. Single exit prices would restrain manufacturers from giving certain medicine suppliers an unfair advantage by preventing them from offering

DAVE LOURENS

medicines to various suppliers at different prices. At present some dispensing doctors can obtain medicines more cheaply than pharmacists.

If implemented, the proposals would accelerate the move towards a primary health care orientation by making medical care more cost-effective and more readily available to lower-income groups.

Allowing pharmacists greater discretion will help to reduce the demands on doctors in treating more routine ailments.

Venter also proposed removing restrictions on parallel importing. Current legislation prevents the importation of medicines manufactured in SA. Anomalies exist where, for example, some SA-manufactured medicines are available more cheaply in Gaborone than in Johannesburg.

Namda described the forum as a positive step, and pledged its support.

Director David Green said Namda accepted Venter's sincerity.

"This forum will represent a great step forward if all interested parties are able to participate and government takes their views seriously. If the forum reaches consensus, I cannot see the government acting in the opposite direction."

Green agreed the forum represented a shift in emphasis towards primary health care, and said he felt it was the right way to go.

Masa, which represents about 13 000 of

☐ To Page 2

Medical costs

B/Day 10/1/92 (299)

☐ From Page 1

SA's 24 000 doctors, said it was "prepared and eager to participate in any forum aimed at solving current problems relating to health services".

Secretary-general Hendrik Hanekom said Masa shared Venter's concern about rising health care costs, but insisted that quality health care should not be jeopardised because of cost considerations.

Any changes to health care delivery had to be in the patients' interests, and cost minimisation measures must not be introduced to protect vested interests.

Representative Association of Medical Schemes (Rams) executive director Rob Speedie said: "We welcome what the Minister is doing and will be keen to participate. Any possible steps which can be taken in the consumer's interest to reduce the costs of medicine must be welcomed and pursued."

SA Association of Retail Pharmacists president William Bannatyne said he supported the forum and praised Venter's attempts to draw various health care professions into consultation with each other.

Bannatyne especially welcomed the proposal to allow pharmacists more freedom to dispense schedule three and four drugs without doctors' prescriptions.

"In the new SA we will have to make optimum use of our trained health care professionals. We expect objections on the grounds that pharmacists are not trained to diagnose, but if there is more acceptance of the extended role of pharmacists the onus is on the pharmacist to ensure he is suitably qualified to fill that role."

Director of the Centre for Health Policy at Wits University Medical School Cedric de Beer said it appeared Venter was trying to encourage more cost-effective use of health care and to encourage more rational drug prescription, and the centre would support most of the proposals.

The rescheduling of schedule three and four drugs was appropriate, but it needed to be conducted with great caution.

Outrage over barring of blind girl

STAR 10/1/92

Pretoria Correspondent (299)

Support is growing for the parents of a blind five-year-old girl who has been refused admission to the all-white Prinshof School for the Visually Impaired.

"We are determined to get her enrolled and a lot of influential people are working on this," a family friend, Professor Jan Robbertze, said yesterday.

He said the school's refusal on Wednesday to enrol Aadila, who is classified "Indian", "showed how much apartheid there still is in this country".

P Peach, the school's principal, has said the decision not to enrol her was based on the school's existing admissions policy. No decision on changing this policy had yet been made.

"But this is about a child who will suffer irreparable damage if she is deprived of the stimulation she needs," Professor Robbertze said.

"The pre-primary year is the most important in a child's school life."

He said support for Aadila had come from concerned people in legal, psychological and other circles, and financial backing for their efforts was available through the Robbertze Youth Trust of which he is chairman.

Aadila's parents, who have asked not to be named as they are a "mixed" couple, have said the Prinshof School is the only suitable school in the Transvaal.

"It's not as if we have a choice, the only other schools are in Natal and the Cape, and we can't just uproot and go," her mother said.

Dr William Rowland, executive director of the South African National Council for the Blind, has expressed concern over the family's predicament, saying the council did not believe race should feature at all in services to the blind.

A spokesman for the Department of Education and Culture, House of Assembly, said the decision on the admission of pupils of different race groups to Prinshof School had been devolved to the school's management council.

Seminar to focus on medical costs

STAR 10/11/92

Pretoria Bureau

Health Minister Dr Rina Venter has invited the medical fraternity to discuss ways in which the cost of medicine and medical services can be curtailed.

Interested parties are to take part in a forum in Pretoria on February 28 to discuss the following matters:

- Whether the substitution of medicines registered by the Medicines Control Council should be allowed under certain conditions.
- Whether a system of maximum medical aid pricing should be accepted and implemented.
- Whether the principle that the patient is responsible for part-payment of the cost of medicine at the time of dispensing should be accepted and implemented by the medical scheme.
- The principle of a single exit price based on volume purchased being accepted by the pharmaceutical manufacturers.
- Whether the remuneration of the pharmacist and dispensing medical practitioner should be by way of a dispensing fee and not a percentage mark-up.
- Whether the principle of pharmacist-initiated therapy should be accepted.
- Whether greater professional discretion should be granted to pharmacists by the rescheduling of certain schedule 3 and 4 medicines.
- Whether the parallel importation of certain medicines should be implemented.

HEALTH CARE (299)

About 70 percent (3,4-million) out of a total of 4,9-million whites are currently covered by medical aid schemes, according to the latest available figures from the Registrar of Medical Schemes. An estimated 34 percent (313 000) of nearly 928 000 Indians have medical aid cover and 30 percent of coloureds are covered.

The figure for blacks who have medical aid is only five percent.

w\Mail 10|1-16/1/92

Tough remedy for medical aid abuse

(299) ARG 11/1/92

DI CAELERS, Weekend Argus Reporter

MEDICAL aid members have come in for a dressing down from fund administrators for their careless attitude to the exorbitant cost of health care.

As the controversy over the Medical Schemes Amendment Bill rages, administrators say members' abuse of medical facilities has forced "strong-arm tactics" to cut costs that have escalated at an annual 25 percent in recent years.

But the Medical Association of South Africa (Masa), the professional association to which most doctors belong, has rejected the bill out of hand.

It says the bill makes adjustments on a cost-minimisation basis without looking at the need for efficiency and equity in health care.

The director of Medscheme medical aid administrators, Mr Les Hollis, said many schemes were already curtailing general practitioner visits but that cases which required constant check-ups were handled on merit.

The restrictions on members were a punitive measure but, he said, "either we shift costs to the member or we stop him using medical facilities as often".

Medicaid Transvaal's chief executive officer, Mr Quentin Robinson, said: "People used to wonder how much it would cost before deciding to see a doctor. Now they just think, 'What the hell, medical aid will pay!' "

He blamed this attitude on the present system of the "third party payer" in which the member used the facility and the medical aid society, or a third party, footed the bill. As a result the member did not feel the effect of the cost.

A major bone of contention is the proposed introduction of health maintenance organisations (HMOs). Medical aid administrators and the Representative Association of Medical Schemes (Rams) punt these as a dramatic cost-saving measure, but Masa says they result in a drop in standards of health care and remove freedom of choice for patients.

HMOs, or Managed Health Care 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.

Mr Hollis said that under a system of HMOs, members were obliged to visit an appointed doctor. If they wished to continue visiting their own doctor it would be at their own expense.

"That must be an economic decision rather than a patriotic one. People must make a choice which suits them financially."

Another point of concern is that medical aid patients will have to pay medical bills up front if the draft legislation is approved. The legislation proposes that medical aids no longer pay doctors or medical service suppliers direct, but deal only with patients who will be reimbursed according to the set medical aid scale of benefits.

Masa has said that a system where monies are paid directly to a patient could lead to them spending their benefits on things other than medical bills. It believes that offering patients no-claim bonuses would prove more effective as a means of addressing the problem of abuse of benefits.

Mr Robinson said Medicaid "has sympathy" with the point of view that upfront payment would cause too much hardship and "may prohibit certain sick people from acquiring facilities". But HMOs were a sure way of ensuring a patient's health was looked after.

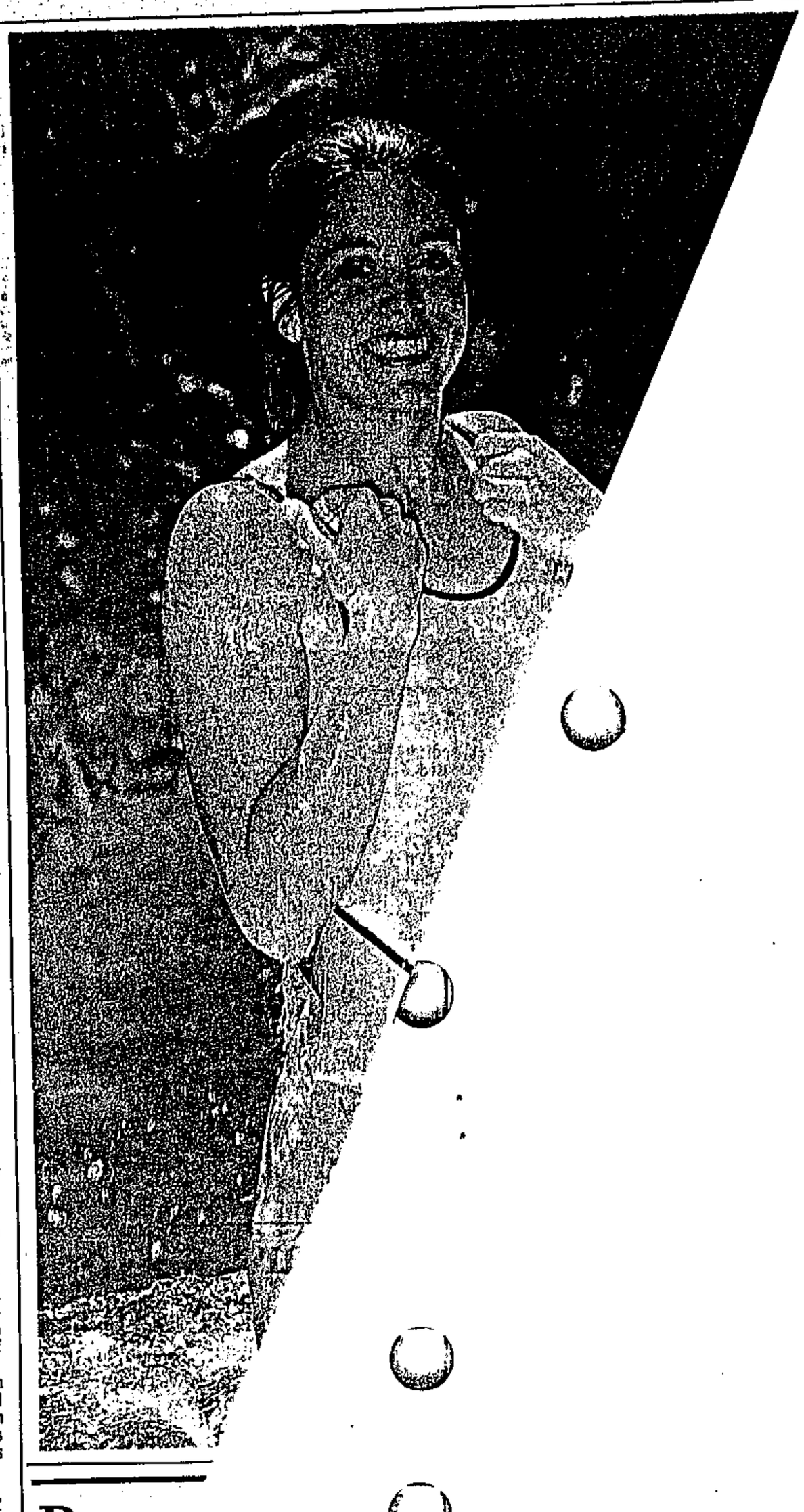
Meanwhile, the Registrar of Medical Schemes, Mr Ellis Langeveld, has expressed the fear that medical subscriptions will continue to rise above inflation. He also predicted that the apparent trend towards mergers between medical aid schemes would continue.

The number of medical aid schemes in South Africa has dropped from more than 300 seven years ago to about 240 this year. Rams' Mr Speedie said the decline was a result of market forces.

His view is that it is a good thing to be seeing the emergence of larger schemes for the following reasons:

■ Larger risk pool. Medical schemes provide a form of insurance and, Mr Speedie says, it is a well-established principle of insurance that the broader the risk pool, the better the underwriting.

■ The more members a scheme has, the more innovative it can be in terms of offering a variety of products. In this way the member gains the advantage by being in a position to exercise more freedom of choice.



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New State health policy

Sowetan 17/1/92

299

THE ANC and an influential welfare lobby group, the Co-ordinating Committee on Welfare Policy, are expected to react today to a far-reaching working document on the State's welfare policy.

The document, released by National Health Minister Dr Rina Venter this week, contains two significant concessions - racial parity and a single welfare authority - long demanded by progressive lobby groups.

It was drawn up after discussions with various interest groups and individuals over the past two years.

Comments on the working document will be accepted up to April 30.

The document states that equal social welfare grants for all races will be phased in by April 1 1996.

The document proposes one umbrella body to control all welfare departments.

On the contentious issue of finance, the document urges the State to allocate more funds for welfare.

Sowetan Correspondent

It says the business sector should be involved in welfare programmes and a comprehensive strategy must be developed to obtain maximum financial help from communities.

Donations

The State should be urged to exempt welfare donations from tax, according to the discussion document entitled "Points of Departure in Developing a New Social Welfare Dispensation for the Republic of South Africa".

It stresses that the development of an appropriate welfare dispensation is the joint responsibility of the State and the private sector and not the sole task of the Government.

RINA VENTER

Race row over special school

PLANS to start a school for mentally handicapped black children in Durban have triggered threats from the far-right and petitions from residents against the move.

Residents of Woodlands and Montclair are doing everything in their power to block the sale of the old Kenmont School premises. The school is earmarked to become the Ningizimu School for about 90 mentally handicapped children.

An anonymous right-winger has also threatened trouble if the new school opens.

But Dr Tina Jonker, director of the Durban Mental Health Society — the governing body of schools for the mentally handicapped — said plans to buy the school with R2-million put up by the Department of Education and Training were going ahead. It would cost about R5-million to build a new school.

Dr Jonker said the many objections were based on "misconceptions and ignorance".

On the other hand, Woodlands Civic Association chairman Bob Steyn said: "We have held meetings about the issue and I have heard that thousands of residents are signing petitions against the move. These will be sent to the government."

The chairman of the Democratic Party in the area, Mr Fred Jenkin, is drumming up support for the new school.

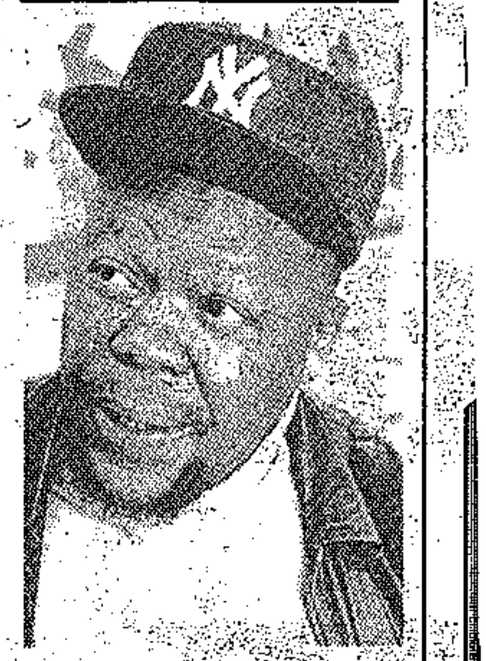
Mr Jenkin said the leaders of the drive against the new school were creating "fantasy fears".

"Their modus operandi is identical to their attacks in 1991 on certain creches in the community. Their targets once again are children and their motives are racially based," he said.

By RYAN CRESSWELL

ST Times 19/11/92

BUSINESS



FRIDAY MAVUSO

Infirm hurt by lack of work

ABOUT 80 small entrepreneurs - mostly disabled people - at the Self Help Association for Paraplegics in Soweto have been retrenched as South Africa's economy refuses to recover.

The situation could become severe for the disabled if the economy does not increase dramatically to provide new jobs, Shap's chairman and manager, Mr Friday Mavuso, said this week.

Entrepreneurs who manufactured products for major mines were laid off as a result of the closure of some mines and the downturn in the economy.

"It was sad to take this action, but we were forced to retrench them because the mines were no longer sub-contracting us to manufacture materials for them. This has greatly affected our turnover in the past few years," Mavuso explained.

Their turnover of R100 000 a month was reduced to R50 000 in the past years.

Violence has also contributed. Two of their vehicles costing more than R120 000 were hijacked by thugs in Soweto.

He appealed to major companies, black political organisations and trade unions to support the disabled by sub-contracting them.

Shap had received more than 500 applications from paraplegics who needed jobs he said. The sad thing was that black organisations did not support them.

"There is a lot they can do to help us help ourselves. We need support," Mavuso said.

"We are tired of being called disabled and want to create jobs and contribute to the country's economy."

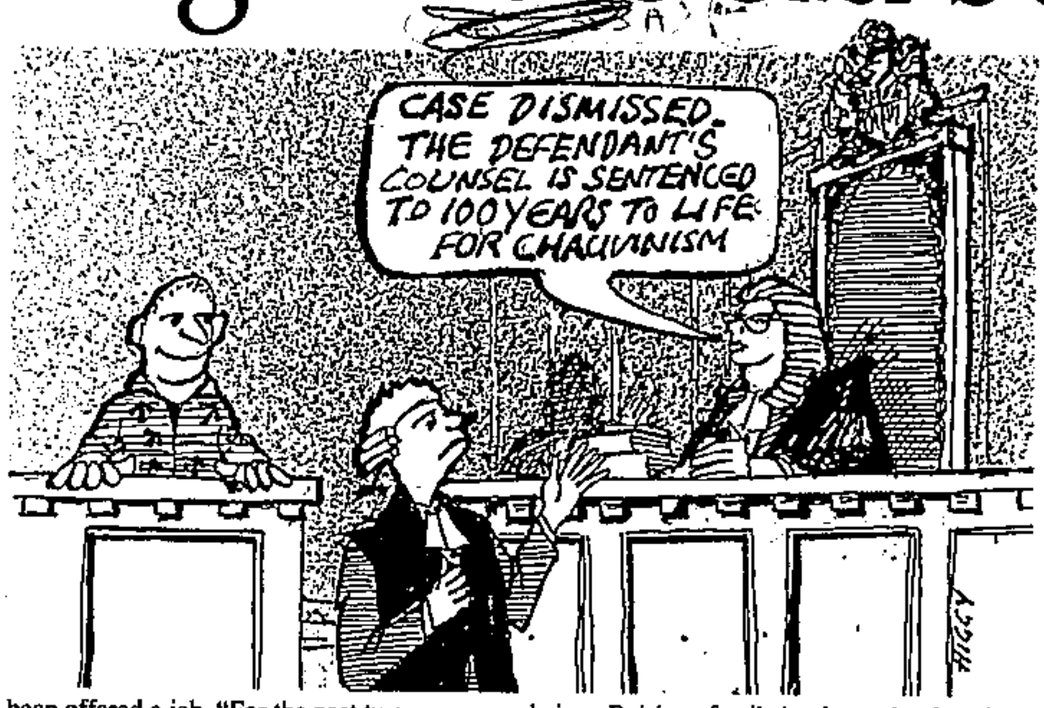
He said that Shap would embark on campaigns to motivate members to create jobs. This included canvassing disabled people at hospitals, an "aggressive education drive" and fund-raising projects.

He appealed to all disabled pupils to take Shap bursaries so they could educate and better themselves.

Glass ceilings in the old boys' club

WMail 24/1-30/1/92.

Do women lawyers have to drop their briefs to get any briefs? **PORTIA MAURICE** *looks at the struggle for equality in the legal profession*



SOUTH AFRICAN women lawyers may no longer have to resort to dressing up in drag as did Portia in Shakespeare's *Merchant of Venice*, but they still have to fight discrimination in a male preserve which won't bend to their needs.

• In a wide survey conducted by *The Weekly Mail*, frustrated women lawyers complained of the "glass ceiling" which hinders promotion for many women in the corporate world. But chauvinism appears to rear its ugly head more viciously in law, said to be one of the most conservative professions.

The structure of law firms breeds nepotism and bigotry, some say. "It's like an old boys' club with the senior partner as autocrat," said one woman. "Everybody kowtows to his whims and fancies and women are not taken seriously. They behave as though they possess you."

Difficulties faced by professional women are overshadowed by those of their shopfloor counterparts. But their battle for sexual equality is a lone one — fought across the boardroom table on the strength of individual performance and assertiveness. Many women lawyers are vulnerable and insecure, creating what one calls a "syndrome of apology and abject gratitude for being allowed in". For this and ethical reasons, few sources would be named for this article.

One attorney says South Africans have been fed the mythology in television programmes like *LA Law* that all are equal within the law. Although Americans may be more comfortable with women lawyers, she says, South Africans have followed the British role model of "pin-striped gentlemen with bowler hats".

In law school, women are now more equally represented than they were 10 years ago but only a handful end up practicing. Eager graduates seeking articles of clerkship are likely to be sent from pillar to post whether or not they wear pants, because of economic recession. It's two years of slog and grovel, any lawyer will tell you. But, many claim, women are still the last choice. If you're black, it's even worse.

One prominent Johannesburg firm refused female applicants this year. Of three women who recently completed their articles only one has been offered a job. "For the past two years we took only women," said a partner at the firm. "Now there's an imbalance. What if they all fell pregnant at once?" He believes there are many "excellent" women lawyers, but that they "expect too much sympathy. I think they sometimes go on the offensive when it's not really necessary", he says.

Some female candidate attorneys feel undermined. "If responsibility is likely to be delegated, the males get it all," said one. "You can be very diligent and do your best — all you get is telephone calls and requests to make tea. You're just a glorified messenger."

A successful advocate tells the story of how she went searching for a job seven months' pregnant. "I went for an interview with this huge stomach and from the look on their faces I told myself 'girl, there's no way you're going to get this job'. My grades were good, but they had a mental block against me."

A glance through the lists in the Hortors Legal Diary shows a smattering of "Ms's" in a sea of other names which one assumes to be male because there are no honorifics. These are the partners — the top layer of decision-makers in any firm. In most cases, women comprise less than 10 percent of partners, although there are exceptions. Of about 720 South African advocates, only 65 were women in 1990 and fewer than 10 of them black too. Justice Leonora van den Heever of the Orange Free State Provincial Division is the country's only female judge.

The crux of the matter is that women lawyers, it seems, are defined more as potential wives and mothers than as competent and intelligent human beings. Raising a family is relegated to the sphere of the private, and little support is forthcoming from the firm.

"I had just married and the first question I was asked at my interview was whether I was considering having children," said one. And another: "Even if you say you have no plans, they don't take you seriously because they think you won't be 'alive' for a period of your career."

The bottleneck really tightens as women reach their 30s, and are forced to juggle a double shift or make hard choices between career and family.

Very few law firms surveyed had structured maternity policies, and women were left to negotiate ad hoc arrangements on their own. Some get good deals — six months paid leave and flexitime for a while thereafter. But others just leave or foresake having children for fear of taking the gamble. There are no job guarantees.

It's a tough job and women lawyers end up being more male than men, offering each other little support. Many follow sexual stereotypes — either with an extra dose of aggression to prove they can make it in a man's world or useing the dollybird image to curry favour. "Many believe that because they are able to cope they don't need to worry about the rest. The result is competition rather than solidarity," said an advocate.

Clients are often patronising: many women lawyers tell of how they are assumed to be the boss' secretary when they answer the telephone. The tone on the other end of the line is one of palpable disappointment, they say.

Sexual soliciting is rife. It is alleged many women "prostitute" themselves to get ahead. Although life at the Bar is a little more comfortable, some male attorneys are said to trade their "briefs" for a sexual favour. "He may pass his cases on to you regularly but if you refuse his lunch and dinner invitations he disappears off the scene," said one advocate.

"You are under pressure to conform — if you don't get yourself a sponsor or mentor, you may not get briefs." Female advocates also often get pigeon-holed into family and criminal cases and seldom get a shot at commercial suits.

Responses from males in the profession varied from indifference to intolerance. Die-hard campaigners were not found. "They go off and have children and sometimes they come back. If they have been satisfactory, we accept them back," was the typical response of one senior partner.

Things are not as bad as they used to be though. South Africa saw its first female attorney in 1926 but American judges of that time left no room for colleagues of the other sex. "The peculiar qualities of womanhood, its gentle graces, its quick sensibility, its tender susceptibility, its purity, its delicacy, its emotional impulses, its subordination of hard reason to sympathetic feeling, are surely not qualifications for forensic strife. Nature has tempered women as little for the juridicial conflicts of the courtroom as for the physical conflicts of the battlefield," one US judge said.

Today, as more and more women enter the profession, something will have to give. But change is very slow in coming. It is accepted that law practice does not stop at lunchtime, so half-day shifts are no real solution.

Only one firm surveyed, Bell, Dewer and Hall, had creche facilities at work to assist parents. This, said a lawyer there, saves working women from mothering over the phone and allows them the choice to breastfeed. "It's very easy and relatively inexpensive to set up," she said. "All it needs is the commitment to assist your staff."

Another option being explored is job sharing or joint filing systems. Women set up their own firms and share clients' files, covering for each other on a roster system and allowing them to spend time with their young ones.

One pioneer said such systems would be able to cater for the "wealth of talented women sitting at home and wasting their degrees". Although joint filing is a little less practical, the extra effort affords parents the best of both worlds.

"The answer is for us to get together and create conditions conducive to ourselves," she said. The question is, should women have to leave top firms in order to accommodate their needs? Or should the legal profession bend towards a co-operative and sensitive ethic which regards all as equal and children as a societal responsibility?"

LETTERS

Will the 'new' SA's anthem be sung by an all-male choir?

■THE relative absence of women at the Convention for a Democratic South Africa (Codesa 1) and among the working groups that began work this week, calls into question the commitment to non-sexism in the Declaration of Intent signed by the participants.

The concern expressed by the management committee at the lack of participation by women comes strangely from an all-male group composed of senior leaders of the very organisations that are responsible for the situation, but failing to give consideration to the matter when nominating their own delegations to the various Codesa structures. The African National Congress, Democratic Party, Inkatha Freedom Party, National Party and the South African government are among the all-male delegations, with a few women as advisers.

Do they want us to believe that there is not a single woman among their groups who is capable of speaking in the working groups, or serving on the steering committees? Is the anthem of the "new" South Africa to be sung by an all-male choir?

Apartheid South Africa has been characterised by successive minority governments condescending on occasion to receive representations from the majority black population of matters of concern to them. Is Codesa setting the scene and the precedent for male leaders in the "new" South Africa "agreeing" to receive representation from the majority population of our country — who are women?

That is not the kind of South Africa that so many women have struggled to achieve. — **Barbara Masekela, Nosiviwe Mafisa, Gill Noero, Baleka Kgositile, Lulu Xingwana and Frene Ginwala.**

■ON A fairly frequent basis people send me clippings from South Africa. My circle of South African contacts is fairly wide and these are not always like-minded.

However, more often than not the piece sent bears your imprimatur. This can only mean that, reviled or appreciated, you are being more often quoted than any other newspaper source in South Africa.

My congratulations, though it must sometimes be very lonely for you. — **Bryce Courtenay, Australia (Bryce Courtenay is author of the best-seller, *The Power of One*).**

■ACCORDING to an article in the *Citizen* of December 18, a Saudi-South African joint venture bank has opened a branch in Cape Town after the one in Durban, to serve and cater for the economic and financial needs of the Muslim community.

This is taking place in a country where all banking institutions cater for all citizens, including Muslims, irrespective of colour or religion.

This religious discrimination is being practised where the blacks are looking to the future for a share in the economic wealth of the "new" South Africa. — **CK, Durban**

■I READ the article on "The Thoughts Industry" *(WM* January 3-9), by Evans, Van Niekerk and Stober with interest. This kind of information-based overview piece can be very valuable. I think the opportunity was sadly missed, however.

I am no longer on the board of the Inkatha Institute. As you mention I have joined the Human Sciences Research Council (HSRC), but I am also associated with the South African Institute of Race Relations (SAIRR), the Institute for Multi-Party Democracy and the Urban Foundation.

It is absurd to suggest, as the article does, that "most" senior HSRC officers are Broederbonders. I am sure there are some members, but unless the Broederbond has become so varied as to span virtually the entire (non-violent) political spectrum in South Africa, they represent a very small minority at all levels in the HSRC.

I think the "Thoughts Industry" stereotyped many of the organisations reviewed. John Kane-Berman of the SAIRR, for example, has always insisted on an impartial review of organisations and events in the publications of the Institute.

For a long time, however, he and colleagues, including myself, had a growing concern that some of the pressure and mobilisation strategies of the democratic movement, while understandable, could lead to impoverishment, fragmentation of communities and to counter-reactions which would finally produce endemic violence.

Saying these things does not mean that Kane-Berman is anti-African National Congress or that we in any way endorse the violent counter-reactions and vigilantism, while in any event are often beyond rational debate.

The main problem with the "Thoughts Industry", however, is underscored by a recent article in *The Star* by Patrick Laurence.

He points out how rapidly old political divisions are disappearing and new, unexpected antagonisms and alliances are emerging. The classifications in your review cannot possibly survive the transition. — **Lawrence Schlemmer, HSRC, Pretoria**

●We did not suggest Prof Schlemmer was a Broederbond member and, in fact, commended several groups he is associated with (CPS, UF and the IMPD) for the role they are playing and their neutrality. We also did not say all HSRC research was Broederbond/government-inspired though clearly the HSRC has been used by the Broederbond in the past. We stand by our comment that SAIRR director John Kane-Berman has shown partiality towards Inkatha and against the ANC. Prof Schlemmer should note we also criticised the Human Rights Commission for bias towards the ANC. — The Editors

Letters should be addressed to: The Letters Page, The Weekly Mail, PO Box 260425, Excom 2023. The editors reserve the right to edit for clarity and space.

HEALTH CARE CRISIS ...

Will the Bill rescue the medical aid crisis?

The medical aid schemes, hit by rising costs and rising contributions, see their salvation in deregulation.

REG RUMNEY

outlines the free-market solution to the health care crisis

EVERYONE who is the member of a run-of-the-mill medical aid scheme will have noted with increasing concern the rise in monthly contributions.

The reason is simple: the medical aid schemes, which are non-profit organisations, must pass the bulk of rising medical costs on to their members.

Clearly, the medical aid schemes must keep a cap on costs to survive. If they don't their members will desert them for "self-insurance" and the medical insurance increasingly provided by life assurers.

The medical schemes pin their hopes on, among other things, the Medical Schemes Amendment Bill.

Last week Dispensing Doctors lashed out at the Bill. The more mainstream and conservative Medical Aid Association of South Africa (Masa) has rejected the Bill in its entirety.

What do the medical schemes see in the Bill?

Firstly, Representative Association of Medical Schemes director Rob Speedie is puzzled by Masa's outright rejection of the Bill.

"There are many good reasons, a lot of public interest stuff, why the Bill should not have been rejected in its entirety. It doesn't make sense." Among other things, the Bill gives a better deal from medical schemes and expands criminal provisions not revised since the Act was first passed.

What the Bill does promise is to give the medical schemes greater flexibility to tailor schemes.

Medical aid schemes are regulated by law. Schemes cannot refuse to pay for any medical service charged at the "scale of benefits", under the "guaranteed payment" mechanism. They also cannot limit the amount paid. If the scale of benefits for a GP consultation is R50, the medical aid must pay the full R50. This is known as the "first-rand-cover" principle.

So another way of capping cost is to do away with the "first-rand-cover" principle.

But in a sense, this is merely another way of limiting benefits, which the schemes can do anyway to some extent now. They have to cover all illnesses — but they can limit cover to the minimum specified.

Schemes have already introduced restrictions, for example on the number of GP consultations. Some have paid for certain drugs only if prescribed off the Maximum Medical Aid Price list. Also, the Act has already been changed to give greater flexibility.

Up until 1989 medical aid subscriptions could only be determined with reference to a member's income and the number of his dependants, and the benefits were virtually standard.

After 1989 the medical aids have been allowed to "risk rate" their members, taking into account such factors as previous claims experience and age, as well as other factors.

What the Bill will do is pave the way for Health Maintenance Organisations, which the medical schemes movement sees as crucial for keeping a lid on costs. Basically, these are designed to make medical practitioners accord cost as well as their patients' well-being a high priority.

"It's established without doubt," says Speedie, "that the few HMOs running in South Africa provide acceptably good quality health care at two-thirds of what it costs a medical aid scheme with a good range of benefits offering freedom of choice."

One of the prime reasons for this is the saving on medicine costs.

Those medical aids, such as Transmed, which do run their own pharmacies, do save big sums.

Medical aid schemes are prevented from doing so under the Pharmacies Act of 1977, which prevents a pharmacist from working for anyone other than another pharmacist. Those schemes which already ran pharmacies were exempted.

This is a stumbling block to medical aid schemes forming proper HMOs. And Speedie points to it as a need for further deregulation of the whole health care system.

The Competition Board has already investigated health care, with a specific focus on medical aid schemes, and has issued an interim report, circulated to those who made submissions. The report takes issue with practices that are at the heart of the medical aid system, such as the scale of benefits, guaranteed payment, and maximum and minimum benefits payable, as being contrary to the operations of a free market. It didn't recommend anything be done about them because they are already enshrined in legislation.

Speedie says the Competition Board examined only half the problem. It should have broadened its scope to include the medical professions. It has already made recommendations about freeing up other professions, such as doing away with fixed fees and allowing advertising.

So the Medical Schemes Amendment Bill is an important piece of deregulatory legislation, says Speedie. But it won't by itself help if it can't put groups of different practitioners together.

The Pharmacies Act is one hurdle. But permission to form HMOs must now come from the South African Medical and Dental Council. It is not automatic.

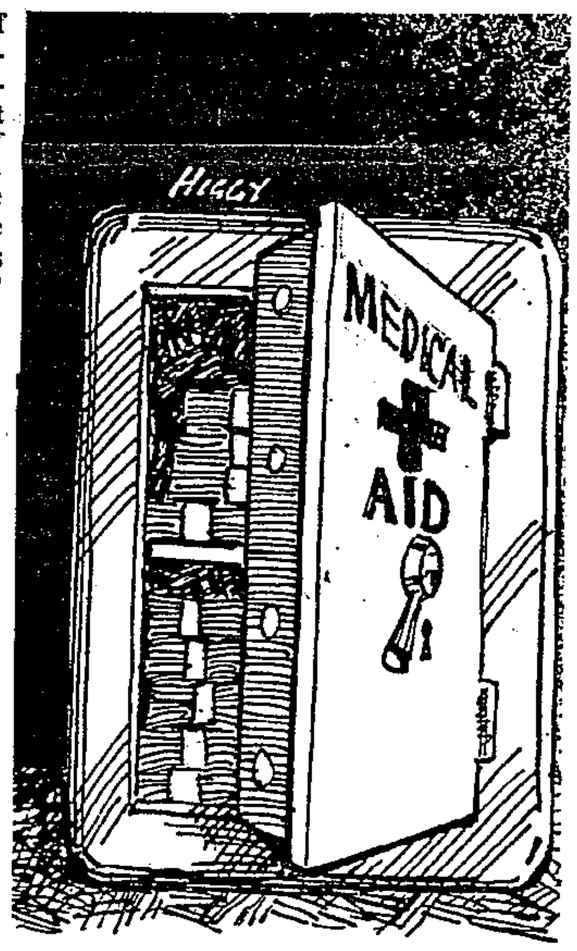
And yet when it comes to the increasing encroachment of the insurers, Speedie recommends more government intervention rather than less to help the medical aids.

Insurers, he says, are engaged in "niche marketing" and cherry picking from the market.

They are offered as a "top-up" to cover the gap between what the medical schemes pay and the actual cost.

The medical schemes would like to get into the market of providing disaster insurance as well. Again, the law does not allow the medical scheme to provide more than 100 percent of the scale of benefits, though the Central Council for Medical Schemes can give an exemption from this rule. This has been done, says Speedie, and the medical schemes are fighting back. The insurers are not registered as medical aid schemes and can operate outside the provisions of the Medical Schemes Act. This means they are free from the social policy elements of the Act. For instance, a baby born to a medical scheme member is automatically admitted to membership of the scheme from the day of birth. If you go on to pension, a medical scheme is obliged to keep you on. And so on.

Medical aid schemes can compete with insurers, says Speedie. But the insurers should have to carry that social policy burden as well.



The rich get healthier

The Centre for Health Policy (CHPS) estimates total health care spending in South Africa in 1989 was about R12-billion (or nearly six percent of gross national product, a measure of the nation's wealth).

Around half this was spent on private health care. The private sector employs, according to the CHPS, about 50 percent of all doctors, 90 percent of all dentists, many nurses and most pharmacists.

Around 25 percent of hospital beds are found in the private sector.

Scheming fo

Inexorably a health care crisis moves nearer and nearer in South Africa. But it looks as though certain big decisions will at last be forced.

REG RUMNEY *reports*

IT'S common cause medical care for most of the population, particularly the rural poor, has never been up to much in South Africa. So to talk of a "crisis" might betray a certain city-based, middle-class, white way of looking at things.

According to the Centre for Health Policy, the private sector consumes nearly half of all health care resources. Yet it provides largely curative, as opposed to preventative, care to only one-fifth of the population.

But even for the relatively privileged one-fifth a crisis is approaching.

The nub of the problem is the financing of health care particularly, but not only private sector health care.

Central to private health care are the medical aid schemes. Generally, the schemes, which finance the medical costs of many whites, have worked well.

There are two big problems. Firstly, they do not cater for enough of the population. And it seems unlikely they can ever do so.

Recent official comparative figures provided by the Registrar of Medical Schemes show the schemes cover 68,8 percent of whites, and only 5,5 percent of the black population. The registrar only deals with schemes that have to register under the Act, so the coverage in both cases must be higher, around one million more in total. Some big medical schemes are excluded. Medicaid Administrators chairman Leon Lewis, referring to these figures, believes medical aids are not designed for low-income earners, as he present figures show.

"The medical industry," he writes in the latest issue of *Alexander Forbes Quarterly*, "is better suited to cater for the needs of the higher paid portion of the population." Since an estimated 40 percent of the population is unemployed, medical aid schemes can clearly not cater for them. Secondly, rising medical costs have begun to imperil the entire system.

The structure of the health care system in South Africa does not lend itself to keeping a lid on costs.

Guaranteed payment together with third-party payments mean there is little incentive to contain costs. On the contrary, there is evidence that it leads to a "perverse incentive" by medical practioners or health care suppliers such as doctors to overservice and for patients to overuse services.

To pay for this medical aid contributions have risen steadily (See graph).

Not too far in the future, medical schemes will have to contend with the cost of Aids. This will hit them hard, but apart from raising contributions or limiting benefits they cannot now make provision for the illness.

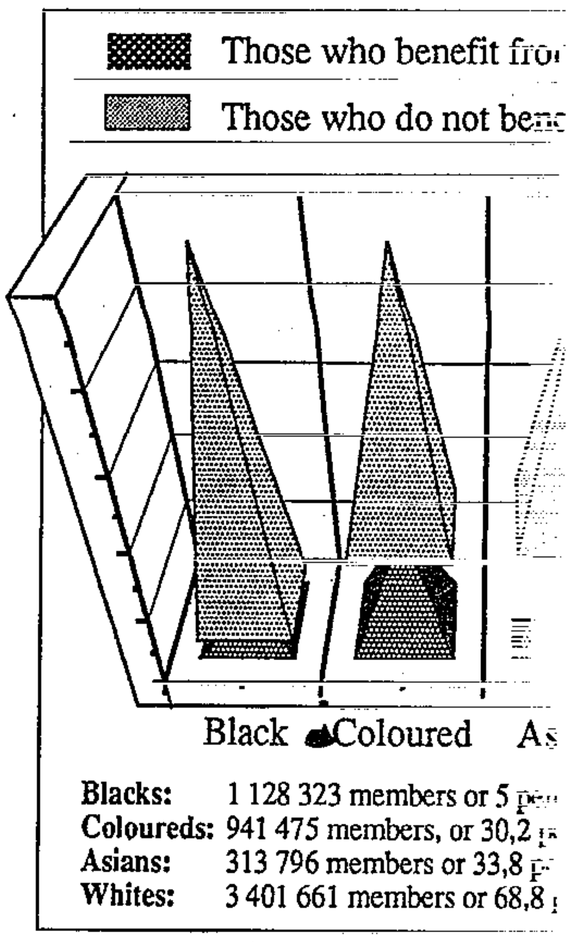
The insurance industry had been hungrily circling the slowly sinking ship for some time. Legally unable to offer medical aid-type insurance, insurers first began to sell "top-up" insurance packages, promising to supplement the medical schemes.

Typically these would offer "disaster" or "dread disease" insurance. They would pay out a fixed sum, say R25 a day, to the person insured for every day of hospitalisation. Since it was paid to the insured and not to the hospital, it did not break the law. But it was the thin end of the wedge.

It wasn't long before medical insurance was aiming at providing medical insurance for the "good risks", young and the healthy who aren't likely to suffer the fate of living too long.

	Products	Entry Ages
Liberty Life	Medical lifestyle	15 to 65 years or 15 to 75 years or life.
Crusader Life	Hospital Plan	18 to 65 years
Commercial Union	CU MED	18 to 65 years
Old Mutual	Flexicare	18 to 75 years
Sanlam	The Hospital Policy	19 to 65 years
Norwich	Medical Security Plan.	15 to 64 years
Sage Life	Hospital Pay Plan	18 to 65 years

The table compares the medical insurance



Blacks: 1 128 323 members or 5 p
Coloureds: 941 475 members, or 30,2
Asians: 313 796 members or 33,8
Whites: 3 401 661 members or 68,8

Whites still benefit most from medical aid

Medical aid schemes have worked more because of cross-subsidisation. The young and healthy subsidise the old and sick. Insurance, on the other hand, allows for "risk rating". Those who pose a higher risk to insurers pay more, those rated as lower risks pay less.

Changes in 1989 to the Medical Schemes Act allow risk rating. The even

Money rolls in ... ar

Weekly Mail Reporter

THE money paid out by medical aid schemes and the amount members had to pay in far outstripped the number of new medical aid members in 1990.

Provisional figures from the Registrar of Medical Schemes show that the number of beneficiaries of medical aid schemes rose by 1,9 percent in 1990 compared to 1989.

The growth, from 6 075 312 beneficiaries (members and their dependants) to 6 188 028, applies only to schemes registered in terms of the Medical Schemes Act. Some large schemes, such as Transmed, don't have to register. So another estimated 1,1-million should be added to that number.

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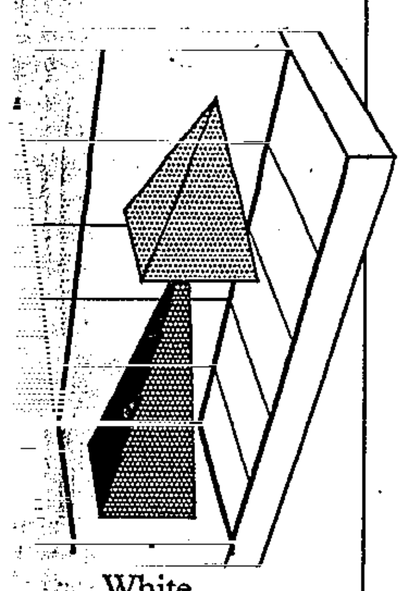
Daily Benefit	Waiting Period	Policy Advantages	Policy Excesses	Medical Needed	Maternal Benefit
R400 per day.	After 3 day hospital stay.	Choice of two benefit levels. Extended Cover benefit available. Contract garuanteed renewable.	H.I.V positive payments cease after one year. A "No Claim" bonus not available.	Yes.	Available within one year of policy date.
R25 toR200	After 3rd day.	Accidental Death cash payout of up to R50 000 . Policy offers several versions. Fewer claims increase cash value.	No AIDS benefit. "No Claim" option not available. No conversion option.	No.	Available one year after inception.
R300 per day.	None	Offers Med Evac, a crises service. Option of other benefits eg. surgery.	No AIDS benefit. "No Claim" bonus not available. No conversion option. Professional sport players excluded.	Yes.	Pays out after one year only.
R100 to R400	After 3rd day.	Policy extends to a range of products. Also has hospital, nursing and a medical benefit. Offers a "No Claims" bonus.	Individual ratings are calculated and with factors such as smoking etc, taken into consideration.	No.	
R75 to R400	After the 3rd day.	Has supplementary benefit which covers prolonged stay. Has option of adding a Surgery benefit at extra cost.	Immediate cancel if tested H.I.V positive. "No Claim" bonus not available.	Yes.	Available 2 years after inception.
R75 to R400	After the 4th day.	Can attach hospital benefit to a basic policy. A.I.D.s benefit of 10% the total sum assured. Conversion option.	No payout for pre-existing illnesses and H.I.V positive testing. "No Claim" bonus not available.	Yes.	Pays out after 1 year of inception of policy.
R100 to R400	After the 3rd day.	Offers a three level cover. A 30% bonus available if policy holder has not been hospitalised in the past three years. AIDS benefit of one unit.	Policy payout period is increased to 8 days if holder is admitted for pregnancy or mental illness. No conversion option.	Yes.	Available 1year after inception of piolicy.

...ets offered by some of the major insurance companies

...medical aid schemes
...from medical aid



White

...of black population
...of coloured population
...of Asian population
...of white population

...radical Medical Schemes ...Bill now circulating for com... go much further and allow med...emes much greater flexibility. ...al schemes are confident they ...ve a free-market answer to the ...by capping costs through such ...isms as Health Maintenance ...ons.

The medical profession itself doesn't have an answer. Centre for Health Policy researcher Jonathan Broomberg argued as early as 1990 that the Representative Association of Medical Schemes' free-market solution was the wrong prescription for health care in South Africa.

It would only make for the kind of competition between health insurance companies that prevails in the United States. And there 37-million North Americans, many of them earning a decent living, cannot afford any kind of health insurance.

Competition and risk rating is already possible because of the 1989 changes to the law. But the Medical Schemes Amendment Bill, if passed, will bring that future to pass even quicker.

The Bill, Broomberg argued, will also get rid of one of the pillars of medical aid in South Africa — guaranteed payment.

The going of the guarantee could mean a hike in medical fees. Around 85 percent of general practitioners charge at the medical aid scale of benefits, because this guarantees them payment. Also, many patients whose bills are now neatly forwarded straight to the medical aid would have to pay up front, as those of us who patronise non-scale-of-benefit doctors already do.

Rams director Rob Speedie says that doctors have mixed feelings about the guarantee of payment. With the passing of the scale of benefits, the central bargaining over fees with a co-ordinating body of medical schemes such as Rams will go too.

Doctors will then find themselves having to negotiate separate agreements on fees and terms of payment with hundreds of individual schemes and insurers — in short, chaos.

Administration costs would rocket.

All of these proposals would create more problems than they would solve, according to Broomberg. They retain the worst aspects of the present system — fee-for-service payment and the third-party payer arrangements. At the same time they threaten to destroy the only good aspects of the system. These are the administrative efficiency and bargaining power of a co-ordinated system of payment, access to a comprehensive package of care largely free at the point of service, and risk sharing and cross-subsidisation between members.

What the proposals will do is ultimately leave many medical scheme members without enough medical cover as risk-rating and benefit limiting really takes off.

These people will be thrown on to the already overburdened public sector. At the same time, the private sector will have found a way to extract as great or even greater share of the money South Africa spends on health — while taking on progressively less of the burden of providing health care for the population.

The crisis comes at an opportune time for those advocating an overhaul of the entire system.

Both the doctors and the medical schemes movement are merely baling water out of a damaged ship, believe Broomberg and his colleagues at the CHPS.

Broomberg has argued persuasively that what we need is a new ship — a national health scheme of some sort.

...out and out

...ast the amount paid out in ...1990 rose by 36,2 percent, ...inflation rate, as measured ...r price index, of 15,5 ...ption income rose by 29,7 per...

...aid schemes try to balance ...coming in against that going ...any surplus being paid into a ...fund.

...income, mainly interest on ..., rose by 53,6 percent, for a ...ease in income of 31,1 percent. ...schemes had to dip into ...make up a shortfall between ...ions received and benefits

Low-cost state-run care is ANC's aim

The African National Congress is considering a national health scheme, reports **FERIAL HAFFAJEE,** *who interviewed the new head of the ANC's department of health*

STATE-RUN low-cost medical care is on the cards if an African National Congress government comes into power.

This is the message of Ralph Mgijima, the recently returned exiled doctor the ANC has chosen to head its department of ealth.

"Financing such a service is a crucial aspect," says Mgijima. To fund healthcare, the ANC is considering implementing a national health insurance scheme.

It would ensure that a health tax would be kept separate from other taxes. The system will operate like unemployment insurance where employed people each make a monthly contribution to the scheme.

Contributors will be able to claim free medical attention, both preventative and curative, from the scheme.

But with unemployment reaching 40 percent, it would be difficult for the employed to subsidise all the unemployed and the indigent.

To alleviate the burden, Mgijima says the organisation is also considering dedicated taxes — taking a percentage off cigarette revenue, for example — as another way of subsidising health insurance.

Mgijima is quite honest about the ANC's plans being a littly hazy at present. Its policy will be further ironed out at a conference in Cape Town later this month.

To determine its policy, says Mgijima, the ANC is looking at various health models: Cuba for its work in reducing infant mortality, Canada for the successful operation of the national health insurance scheme and Britain for the way it has drawn private practioners into the National Health Services.

Mgijima sees a co-operative relationship with private practitioners: "Private practitioners are a vital part of the health services, because the government is not providing a comprehensive delivery of health services," he says.

And even when there is a national health service, private practitioners will still play an important role — although this role will become more co-operative with the state.

Attempts will be made to draw private doctors into the health service. But there will be checks on medical charges and a limit on the amount of doctors able to open in any one area.

Instead, the ANC is likely to offer incentives to doctors to open surgeries in the rural areas and some townships where doctors are few and far between.

And Mgijima is quite clear that dispensing doctors will be able to continue their work. He says they fill a vital hole in black communities where there are often no pharmacies.

Traditional healers, birth attendants and alternative medical practices will all find recognition under a new health service. So will alternative medicines, now relegated to the backwaters of "muti" and "herbal remedies".

To keep the costs of medicine down, an ANC government will introduce an essential drugs list. The national health service will only be able to prescribe off this list. He explains that this measure keeps the cost of medicine down as well as prevents unnecessary prescription.

"We will promote local drug manufacturers," says Mgijima, "and decrease the volume of imported drugs.

"The crisis in medical aid is the result of abuse by doctors and members," says Mgijima. Urgent negotiations are needed to break the vicious cycle of abuse and rising costs of medical aid, he says. And he is quite clear that checks will be imposed on medical aid schemes.

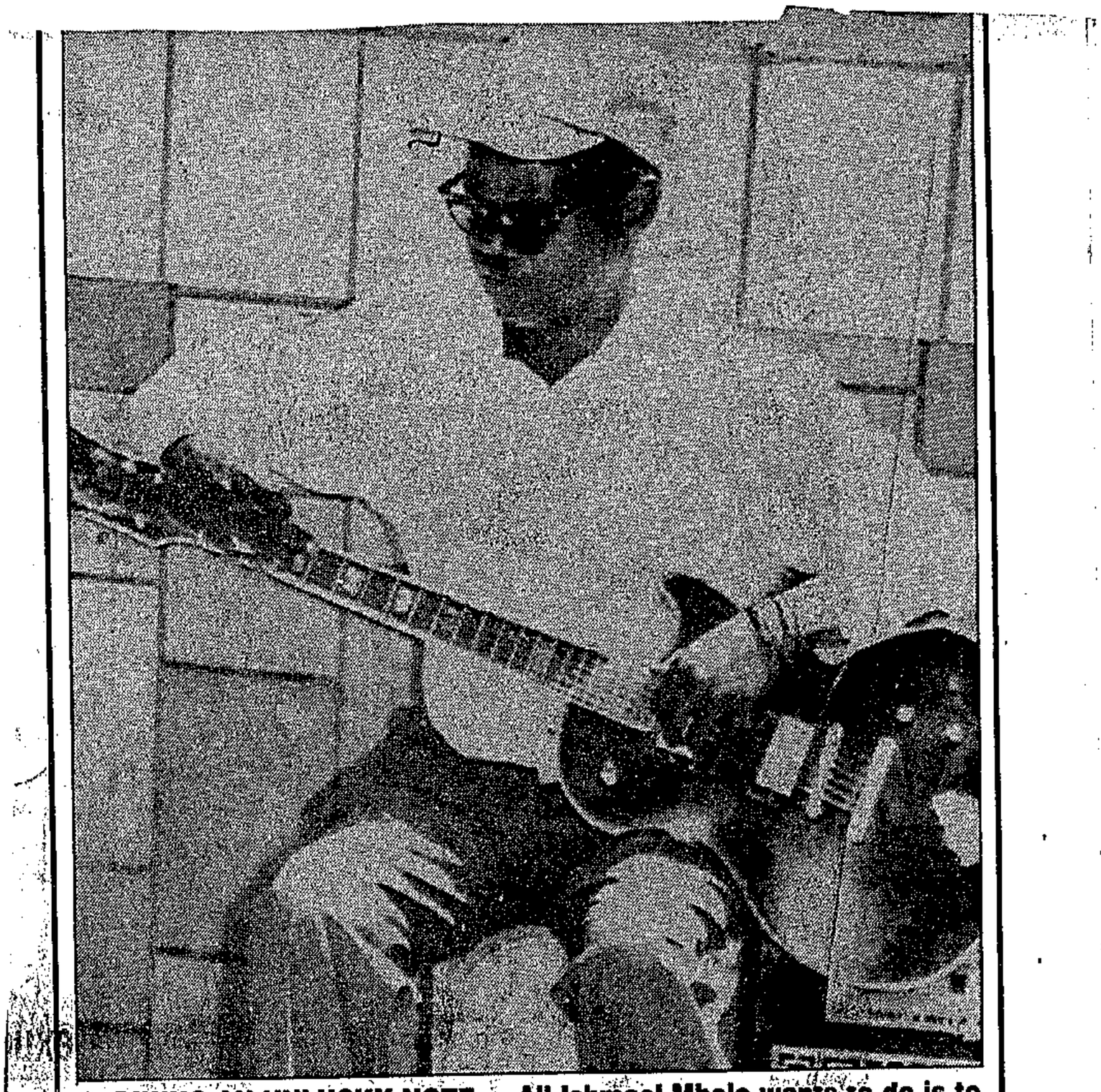
"But these will not be coercive, they will be negotiated with all concerned parties."

He also says that another way of reducing dependence on medical aid schemes is to "load the national health insurance with benefits to draw people away from medical aid".

The ANC last week responded angrily to the call by Rina Venter, Minister of Health and Welfare, for a forum to discuss the spiralling cost of medicines.

Mgijima says that the ANC, the Congress of South African Trade Unions and the South African Communist Party have called for a forum on health to discuss restructuring.

"Venter is restructuring at will. Her forum is isolationist. She must place a moratorium on restructuring," he says.



STRIKING AN UNLUCKY NOTE .. Ali Ishmael Mbelo wants to do is to make a living, yet he suffers constant harassment from bureaucrats.

Row over blind man's busk

City Press 26/11/92 (299)

CP Correspondent

THE plight of a blind guitarist could spark a major confrontation between the ANC and the Bloemfontein council.

Sympathisers of the well-known blind guitarist, who has been summoned to appear in court, have started signing a petition calling on the city traders and the council to reconsider their action against the man.

Ishmael Mbelo, 40, of 775 Moshoeshoe Road, Kagisanong, makes his living busking in the city's streets.

Recently fined R90 or three months' imprisonment for disturbing the peace and using an amplifier without the permission of the Bloemfontein council, Mbelo has again received three written notices to appear in court with the option of an admission of guilt fine of R100 in each case.

"This is a vendetta against a poor blind man trying to make a decent living," a sympathiser told City Press.

Mbelo, who for many years has been playing his amplified guitar in the Floreat Mall, moved to another spot after his conviction.

People interviewed by City Press felt it was "very unfair" for the Bloemfontein Council to harass the blind man, who can only support his unemployed wife and two children by entertaining shoppers in the city.

The ANC southern Free State region also condemned action against Mbelo "in the strongest terms".

"We in the ANC are convinced that Mbelo is being harassed not because he is disturbing the peace, but because of blatant racism against a struggling man who is obviously popular with his supporters.

"Mbelo is a blind man and a family man. Removing him from his favourite spot could break him. The business people have the means of making a living and they should leave Mbelo to make a living the only way he can."

The ANC called on traders to stop "victimising a person whose only offence is singing for the people".

"We will demand that all the charges and fines imposed on him be withdrawn immediately," the statement said.

Health care debate must look beyond the private sector

CHERILYN IRETON

THE need for a new health care system and national drug policy is being overshadowed by a tussle for a greater share of the private sector medicine market.

Players outside government and quasi-government health services who are keen to extend their influence include drug manufacturers, drug wholesalers, pharmacists, dispensing doctors and private clinics and hospitals.

Official statistics are hard to come by, but it seems this "private sector market" accounts for only 30% to 40% of drug sales in volume terms while drawing about 80% of total expenditure.

In spite of the size and significance of the public sector drug market, its problems — particularly in the availability and distribution of medicines — receive little public attention. Instead, the debate on high medicine costs has centred around private sector issues — such as the role of the pharmacist, generic substitution and the misuse of medical aid funds — many of which are underscored by considerations of turnover and market share.

Powerful lobbying by players in the medicine market has meant many of these issues have remained deadlocked over the past five years. But government, attempting to address rising health care costs, plans to discuss them next month at a national forum hosted by National Health Minister Rina Venter.

There are mixed feelings about the forum. Several parties, including the ANC, say it is not the time for government to be moulding new policies, particularly those that address only one small facet of health services. Others are impressed that Venter has moved away from autonomous decision making and is actually negotiating future policy.

The success of Venter's forum could, however, rest on the profile of delegates. Venter has issued a blanket invitation to interested parties and several organisations are already reassessing their attendance in light of the restricted agenda. Wits University Centre for Health Policy director Cedric de Beer warns that those who eventually sit around the table may represent only narrow interests; there may be no one to represent the interests of the consumer and to raise issues that lie outside the private sector debate. These include the integration of government's 14 departments of health and the privatisation of services, which appears to have been put on ice.

Drug policy matters include the question of distribution of medicines to rural areas, homelands and squatter camps. "Although there is the infrastructure to buy the drugs there doesn't seem to be the infrastructure to distribute them," De Beer says.

Fellow Wits researcher Bada Phasari argues that any forum looking to make health care cheaper and more accessible to low-income groups should, by definition, be looking at the interests of the consumer. "This forum seems to be based on the interests of the providers of health care services such as the pharmaceutical manufacturers, drug wholesalers, pharmacists and dispensing doctors."

He believes the so-called crisis in the retail market is not only about the cost of drugs but also about the fact that many players' profit margins are under pressure. This could distort any debate.

Venter has identified eight issues for her agenda. They are that:

- ☐ Substitution of prescribed drugs by cheaper "generic" alternatives be allowed under certain conditions;
- ☐ Pharmacists be given a wider role and be allowed to dispense schedule three and four drugs without a doctor's prescription. Schedule three includes drugs that need to be repeated for chronic cases of illness like epilepsy while schedule four are those not allowed to be repeated without another prescription;
- ☐ Pharmacists be allowed to initiate therapy;
- ☐ Pharmacists and doctors be given a fixed fee for drugs dispensed and not a percentage markup;
- ☐ Medical aid patients be responsible — at the point of sale — for part of the bill for dispensed medicines;
- ☐ Manufacturers have only one sale (or exit) price for their products, thus preventing huge discounts to selected parties;
- ☐ Medical aid schemes accept a system of maximum medical aid pricing; and
- ☐ Imports of products already produced locally be allowed.

The state tender system is not up for discussion but it is unlikely that Venter will be able to keep it from being debated. The same applies to transfer pricing — a practice where multinational companies pay their offshore affiliates inflated prices for active ingredients used in the local manufacture of their products.

The agenda may also still be influenced by the contents of a document, "Your options on health care", to be presented to government next month by the Pharmaceutical Manufacturers' Association (PMA). The recommendations were drawn up after a forum on the health care delivery system held by the PMA in November. Delegates included the ANC.

The PMA's suggestions are likely to focus on ways of making health care more cost-effective and will include input on restructuring medical aid schemes — which it believes encourage overusage and abuse of the health care system — restrictions on free health care, the scrapping of the tender system and the need for one state health department.

This last point is one which the ANC argues strongly. It foresees a unified, nonracial health system where all services fall under the responsibility of a single authority. Central to its proposals is that all services be accessible and affordable.

An extension of this is the belief that a national drug policy is needed to deal with problems of availability, distribution and the price of drugs. The ANC believes an essential drug list needs to be drawn up to ensure there are enough medicines at every health care facility. It also envisages maximum use of generic drugs.

Government has already been formulating a national medicines policy and says good progress has been made. It sees next month's forum as one step towards a broader, national medicines policy.

But once the forum is over, Venter will have to consider whether to risk drawing up and implementing the new policy while Codesa is busy negotiating political and economic dispensations. If she does press ahead, the challenge, particularly on the medicines front, will be to bring together the private and public health sectors — those players that prosper from providing health services to those South Africans that can afford it, and those players who battle to serve those who cannot.

Singing the blues . . . Bomakele Mbelo earns more in business areas.

Blind busker has nowhere to play

STAR 28/1/92.

299

Staff Reporter

A Star reader last week offered to pay a R100 admission of guilt fine of a blind street guitarist facing court action in Bloemfontein next month after "disturbing the peace" by using his amplifier in the city's Hoffman Square.

The Johannesburg reader, who did not want his name published, said he wanted to assist Bomakele "Ishmael" Mbelo (44) "because I want to try to avoid the 'old' South Africa".

The caller said he could not help wondering whether Mr Mbelo had been arrested because he was black or because he was disturbing the peace.

Mr Mbelo ekes out a living by serenading passers-by with a ready tune and a battered guitar. On a good day he makes about R8 with which to support his unemployed wife and two children.

The taxi fare to and from the square eats into the wandering minstrel's daily takings though, and each night he takes home a maximum of five rand.

Since moving to the Hoffman Square beat early this year, Mr Mbelo has received two warnings from the municipality for "disturbing the peace". Then last Tuesday, he was issued with a summons.

He will appear in court on February 17 as he can't afford the R100 admission of guilt fine.

"The municipality said I can't stay here. They say I must go and play there with the black people and not here in town. They said I had no permission to play here. But I get a better income from the white people. They have more money," lamented Mr Mbelo in halting Afrikaans.

Last November, while strumming outside the nearby Floreat shopping centre, Mr Mbelo received a fine of R90 or three months in prison for the same offence.

A spokesman for the Bloemfontein City Council said complaints regarding Mr Mbelo had come from shop owners who "have to listen to his music from morning to evening".

The spokesman said there was a municipality restriction on the use of amplifiers in open areas in the city centre.

POLITICS

ANC unveils its national health service plans

B1 Day 29/1/92

KATHRYN STRACHAN

THE ANC's health department has launched a campaign for a halt to all restructuring of health services by the state, the organisation's health director Ralph Mgijima said yesterday.

He accused government of being undemocratic and of acting unilaterally in restructuring health facilities. He expected the campaign to have widespread support.

Mgijima said the organisation had adopted formally the principle of a national health service with a single Department of Health which would regulate the private sector.

Although the private sector was a vital part of health care, Mgijima said that in the future it would become less necessary as the service provided by the public sector improved. Attempts would also be made to draw private practitioners into the public sector.

At present the private sector used almost 50% of health care resources but provided care for only 20% of the population. These resources were heavily concentrated in urban areas.

Mgijima added that the ANC had resolved that essential health services would be free at the point of delivery and that ways of providing additional funds for public health services would be established.

One of the methods being considered was a national health insurance scheme. There would be a health tax kept separate from other taxes.

All employed people would make a compulsory monthly contribution and contributors could claim free medical attention from both the public and the private sectors.

To further alleviate the burden the organisation intended implementing dedicated taxes — taking a percentage off alcohol and cigarette taxes, for example.

PresMed banks on day clinic

(SI Times Biz) 26/1/92

By IAN ROBINSON

DAY clinics will play an increasing role in the changing health-care scene.

This is the rationale behind the acquisition by President Medical Investments (PresMed) of Zandfontein day clinic in Morningside, Sandton, says managing director Carl Grillenberger.

Presmed's R7,5-million rights issue through convertible debentures has been fully subscribed.

The money will be used mainly to increase the group's private hospital and day clinic facilities.

PresMed's facilities are contracted into the medical aids' fee structure.

PresMed manages eight day clinics and five hospitals. The next steps in the company's expansion programme are construction of a day clinic in Kempton Park and opening of the Witbank day clinic.

Healers want to put muti on medical aid

B Day 27/11/92 (299)

KATHRYN STRACHAN

COMPANY medical benefits will face new challenges if traditional healers are recognised as bona fide health practitioners by authorities and the corporate world.

Unionists said last week that companies were coming under increasing pressure from workers to recognise their traditional forms of medicine — which would mean the world of the sangoma with his bones and herb potions would become a very real part of a manager's daily concerns.

Saccawu spokesman William Dichaba said traditional healers were a vital issue for his union's members. He said some companies had already accepted the legitimacy of healers and were experimenting with granting sick leave that was prescribed by them.

Wits University health researcher Melvin Freeman said 80% of black people had consulted traditional healers at some time.

It was estimated that there were more traditional healers than modern health care practitioners, including nurses.

Representation has been made by traditional healers' associations to the National Health Department for some form of registration, but nothing has been done yet.

Representative Association of Medical Aid Schemes (Rams) spokesman Rob Speedie said one medical aid scheme had already accepted claims for traditional treatments and others were to implement the same policy soon. The major problems lay in organising traditional healers and making practical arrangements.

Traditional Healers Council secretary general Pip Erasmus said healers had been organised for the last six years and had a strict code of ethics.

Govt hints at non-racial local elections next year

B/Day 29/1/92

CAPE TOWN — It was unlikely that the 1993 municipal elections would be like those of 1988, which were racially based, Local Government Minister Leon Wessels said yesterday.

The final negotiations for future structures of local government would be conducted nationally, though government still encouraged local talks, he told a news briefing.

"We are negotiating structures for central goverment at national level, but at the same time putting together structures for local government at national level," Wessels said.

"The final negotiations on future structures of local government will be national."

There had been more negotiations on local level than anywhere else.

"That set of negotiations will continue without undermining the spirit of negotiations at a national level.

"We are in favour of these negotiations, and are encouraging people to set up joint structures with mutual consent."

Negotiations at Codesa, however, would ultimately decide the law of the land and whether there ought to be one city, one tax base.

Wessels said the dynamics of urbanisation in SA had simply overtaken the ideology of apartheid.

The country needed a vision on how to provide space and shelter for all South Africans, but government, faced by budgetary constraints, could not do this alone.

Government was waiting for two reports to be released shortly which would deal with the formation of a comprehensive housing policy for the whole country.

These were the President's Council report on urbanisation, and the SA Housing Commission investigation into all aspects of housing in this country.

Wessels reiterated government's commitment to working in tandem with the public and private sectors, as well as with local communities.

A task group of the SA Housing Commission had set out to establish the facts about housing needs, and these were awesome. — Sapa.

Black schools back to normal

PRETORIA — Normal schooling is proceeding in most black schools in the country despite isolated incidents in the Transvaal and Free State since the reopening of schools under the Department of Education and Training, according to a DET spokesman.

DET national spokesman Geoff Mkawakwa yesterday said some Transvaal and Free State schools were disrupted when pupils demanded full pass rates.

National enrolment figures were not yet known.

Schools affected by the "pass one, pass all" campaign were Prudence Secondary in Naledi, Soweto; Tiyelelani in Soshanguve, Pretoria; and Dr Reginald Cingo Secondary in Kroonstad. The situation was normalised after meetings with parents.

However, disruptions still affected other schools.

Meanwhile, the Duduza Education Co-ordinating Committee yesterday slammed the DET for allegedly failing to address problems at schools in the East Rand township. — Sapa.

Probe into cost of medicine

KARIN FRANKEN

THE high cost of medicine is being addressed by the introduction of a five-year SA National Drugs Action Programme (Sandap). B/Day 29/1/92

Commissioned by the Health and Population Development Department, Sandap was formed to stabilise drug prices and ensure that essential medicines were made affordable. Cape Town University's pharmacology department headed the project.

Prof Peter Folb, of UCT's Medical School, said Sandap was started last August, but during the prior period numerous groups concerned with health care had offered their support and input for the programme.

A Health Department spokesman said five basic principles — affordability, accessability, equitability, cost effectiveness and acceptability — would be essential for better health care services. Asked if the issue of cost effectiveness of medicines received enough attention from Sandap, the spokesman said: "There are no simplistic solutions to the high cost of medicines in SA, and all possible solutions have been investigated."

Another issue the UCT team intends resolving is that of traditional and herbal medicines.

US Speaker unfair — Schwarz

STAR 31/1/92 299 65 351

By Hugh Roberton
Star Bureau

WASHINGTON — A brief reference to South Africa by the Speaker of the US House of Representatives, Thomas Foley, has drawn a sharp reaction from the South African ambassador to the US, Harry Schwarz.

Mr Foley, a member of the Democratic Party, made the remark in his response to President Bush's State of the Union address to Congress.

Criticising Mr Bush for having evaded the health care crisis, he said: "Few Americans realise that the US and South Africa are the only economically advanced nations that do not guarantee the health care of their people."

History

In his response, Mr Schwarz said that presumably because of its apartheid history, South Africa had been brought into the US domestic political debate, "to my mind most unfairly and irrelevantly".

South Africa could not be described as an economically advanced country to be equated with the US.

South Africa devoted "vast resources" to meet the health needs of its people — in fact more than 6,4 percent of the country's GNP, Mr Schwarz said.

"Many other countries which could have been quoted by the Speaker do not compare favourably with South Africa," he said.

'Medical Codesa' call

299

STAR 5/2/92

Medical Reporter

South Africa needs a "medical Codesa" to address the problems experienced in the health sector, Society of Dispensing Family Practitioners executive member Dr Eddie Sarlie says in the body's latest newsletter.

Medical politics was out of step with mainstream politics and needed a forum for negotiation and consultation.

"While Parliament remains an important platform for policy statements by the Government, its function is now little more than technical. The real decisions on key issues will undoubtedly be taken by Codesa." Dr Rina Venter wanted to effect major changes to health care and to impose her will on the medical fraternity.

Dr Sarlie was writing in reference to the forum the Minister has called to discuss the rising cost of medicine and medical services, as well as amendments to the Medical Schemes Act.

"We cannot and will not accept any major restructuring of health legislation in SA without proper consultation and negotiation," he said.

To address problems like fragmented health services, lack of facilities, high cost of health care, and VAT on medical services, a "medical Codesa" was needed.

HELP ON THE LINE: A Lifeline counsellor assists a caller

Life Line to open in Gugs

South 6/2-12/2/92 (299)

By Sabata Ngcai

GUGULETU residents will soon have access to personal counselling when Life Line opens its newest office at the Uluntu Centre in April.

Previously Cape Town's black residents had not made use of the project's counselling service and no Xhosa-speaking counsellors were trained to assist their communities with their often shattering personal and emotional problems.

But, largely due to the organisation's attempts to reach out to black communities, 18 counsellors have now been trained to assist their community with problems ranging from suicide to murder.

Life Line, established by the Methodist Church in 1963, has 200 centres worldwide and 17 in South Africa. The organisation began its work in the Western Cape in 1968.

"Despite the fact that our training course was open to all, we failed to draw people from the townships due to the inconvenient times and places where we operate, the fees charged and the lack of transport," said Life Line executive director, Mr Andy Laurens.

However, last year Life Line's office was inundated with calls from township residents with problems. There were no Xhosa-speaking counsellors to assist them.

Life Line's training course equips counsellors to assist callers with — among other problems — rape, suicide and murder.

Normally trainees are expected to pay R180 for each of the first two courses, but the first batch of township counsellors have been offered the course free of charge.

"They hadn't known about the course until we made contact with them and we are trying to make it acceptable to their community," Laurens said.

"In future we will charge a minimal fee, depending on the trainees' financial circumstances."

The 18 township trainees from Langa, Guguletu, Nyanga and Khayelitsha attend classes at the Uluntu Centre once a week in the evenings and weekends to allow employed people to attend.

The newly-graduated counsellors will work from April, initially under the guidance of an experienced counsellor.

Laurens said training would be ongoing and aspirant counsellors need not wait until April before applying to do the course.

A Guguletu trainee counsellor said it was important for people to learn how to behave in their family and community life.

"Counselling teaches people to cope with problems they encounter in life and not to think about committing suicide when confronted by such problems."

Comprising 350 trained volunteer counsellors and six paid administrative staff members, Life Line operates for 24 hours every day at its Cape Town centre.

Educate parents to cut hospital costs

PARENTS should be taught how to recognise and deal with acute respiratory infections in children, thus avoiding unnecessary hospital visits.

Dr Karen Wolmarans, who won the Triomed Scholarship for Medical Research, says about 20 percent of the out-patients who visited the Red Cross Children's Hospital in Cape Town could have been managed at home without medication.

"Acute respiratory infections, particularly pneumonia, are very serious in children and the death rates in South Africa are up to 270 times higher than those recorded in Western Europe.

"At the same time, many of the out-patient visits are for trivial infections which could be managed without antibiotics at home," Wolmarans said.

Managing director of Triomed Dr Pietman Botha said Wolmarans' suggestion was important to child health in the country. - *Sowetan Reporter.*

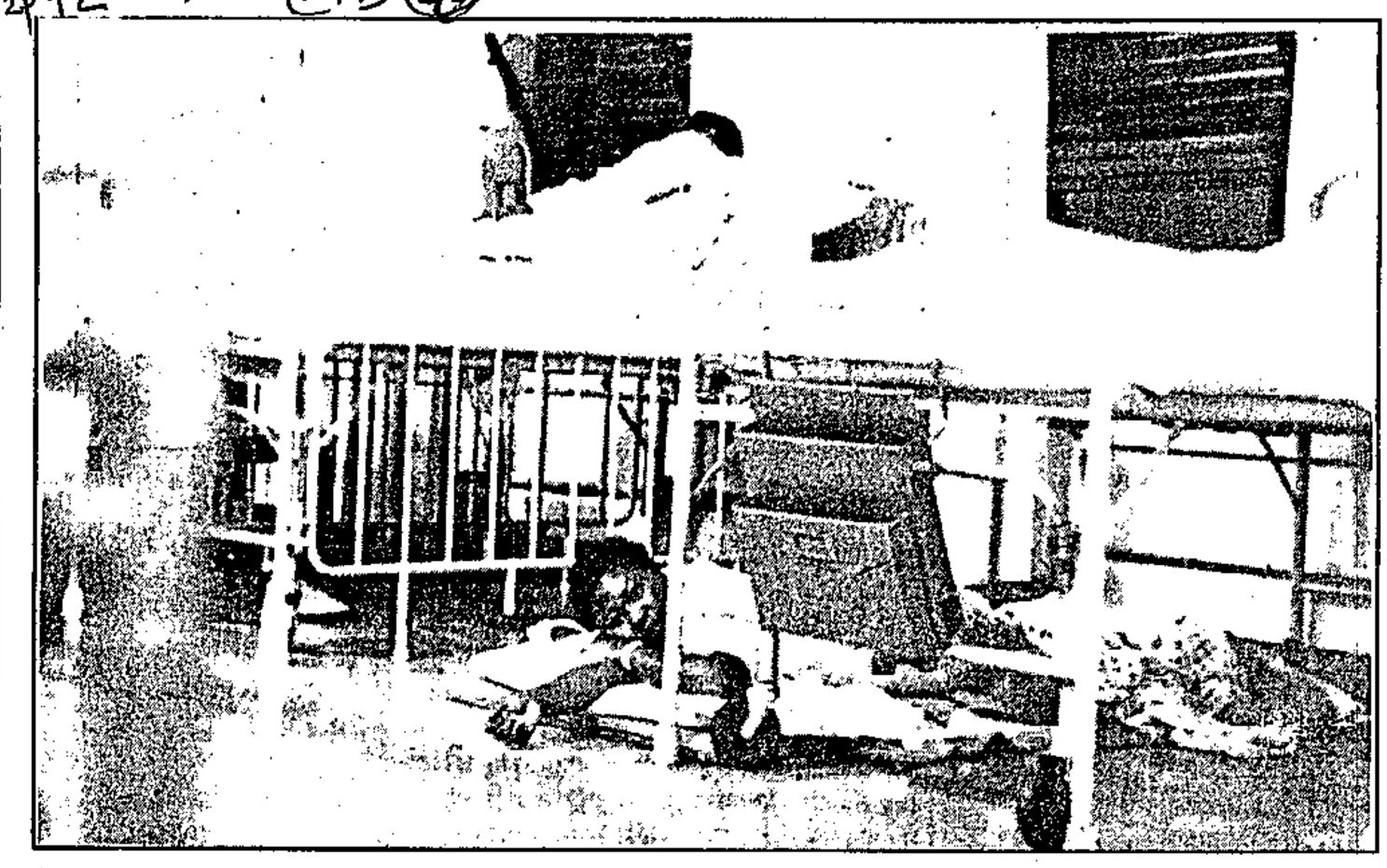
HEALTH MATTERS

HEALTH AND HEALTH CARE

New Nation (Learning Nation) 7/2 - 13/2/92 (299)

Welcome to the Health Matters page for 1992. Many of our readers have told us that they like the health page and find it very interesting. Thank you for your support.

In 1992, we are going to try to make our health page more interesting. We are having a meeting with a large number of health organisations to identify what the important issues are. We also need your help. We want you to write to us and to tell us what you think are the important health issues and what you want to learn or debate about.



Privatisation

Health and health care have become topics for much debate in many countries. Health and access to health care are major problems for many people in the world. The trend in many capitalist countries is to move away from state health services and towards privatisation. This means that these governments want to relinquish responsibility for health care, and hand this over to the private sector. Privatisation has resulted in many people being without adequate health care in many places. This trend is particularly strong in the USA and many European countries.

Health and health care in South Africa

South Africa is a very unhealthy place to be. Many people live in poor conditions and do not have access to the resources which make people healthy.

People are unhealthy because they do not have enough food to eat, they often do not have jobs, and they are often paid very low wages. Many people live in overcrowded townships, with poor housing and without clean water and sanitation. All of this means that people get sick.

When people get sick, they do not have access to decent health care. They do not have access because health services are expensive and unequally divided in a number of ways. This means that when people get sick, they often get worse because they either can't afford, or are too far away from health care services.

Why do people not have access to good and affordable health care?

There are more services available in the urban areas than there are in the rural areas. People who live in rural areas are often very far away from health care services. There are also more hospitals, clinics and doctors in the cities than anywhere else, because the government does not provide free health care for people. Health services which the government does provide are inadequate and overcrowded and are often very far away from where people live.

People also get sick because much more money is spent on curing rather than preventing disease. The government talks a lot about being committed to primary health care, but we see very little evidence of this.

Apartheid and Health

There are more and better services available to whites and rich people. This is because the government spends more money per person on health care for whites, which means that whites have always had access to better quality public services than anyone else. Public services for blacks are often overcrowded and do not have the same quality of equipment and services as the white hospitals.

Health care is also inadequate because the government spends a lot of money on maintaining apartheid in health. A few years ago the government announced that all facilities were to be opened to all. This is not what is happening. Public services throughout SA are still largely operating on the basis of race.

Money is also wasted because the government spends a lot of money maintaining 14 different departments of health, one for each homeland, whites and the tricameral system of "own affairs". This wastes an extraordinary amount of money which could be used to provide better care for everyone.

Capitalism and Health

Rich people are able to get better care, because they are able to pay for Medical Aid schemes. Medical Aid schemes help them pay for private health care. Private care is often better than the care the government provides. This is because the government has for a long time now, tried to reduce its responsibility to provide health care for the people. The government has allowed public sector services to deteriorate and has kept raising the costs of care in public hospitals. They have been trying to force people out of the public sector and into the private sector. This has all been part of their privatisation initiative.

Private services are very expensive and out of the reach of most people. The only way that adequate, affordable and accessible care can be provided for people, is through a National Health Service, provided by the state. A service which provides free care for all the people in a democratic and accountable way.

Women and Health

There are not adequate services for women and children. Women, especially black women, do not have access to appropriate health services for themselves or their children. Family planning services have usually provided inadequate and inappropriate care. They offer a limited range of contraceptives and women are often given unsuitable contraception which can affect their health and their ability to have children in the future.

Women do not have free access to simple cancer tests of the breasts and the womb; tests which can save thousands of lives. Many thousands of women also risk their lives and their health every year in SA, by having illegal, backstreet abortions, because the law only allows very few women to have safe abortions.

The government also does not meet its commitment with regard to the needs of children. Many black children get sick and die because they do not get immunised against certain diseases such as polio. Children get sick and die from simple diseases which can be cured. They die because their parents do not have access to health services for their children. Thousands of children die every year from starvation.

Workers and Health

Workers often get sick at work. Many workers are exposed to dangerous substances such as lead and asbestos. Very few workplaces have medical services on the premises. Even when these do exist they are often more concerned with productivity than the health of the workers. The law is inadequate as it doesn't provide enough protection for workers.

AIDS is a disease we hear a lot about. This new disease will make many people sick and die. We need to tackle this problem now. There are a number of problems related to this, one of which is literacy. Many people cannot read or write and they do not have access to education or the media. This makes mass education about AIDS very difficult. The government has not done enough to combat the spread of AIDS in ways which people can understand. During the year we hope to debate these issues and also run articles on AIDS education.

These are just some of the problems. There are many others. Learning Nation will try to address many of these issues during the course of 1992. We need your help. Please write to us and tell about the health problems you have experienced. Also tell us about the things you would like us to write about on the health page.

New medical aid claims scheme mooted (299)

The country's six largest medical scheme administrators, representing 120 medical schemes serving 3,3 million members and dependants countrywide, have agreed to investigate a countrywide electronic data interchange system (EDI) for the submission and payment of medical aid claims.

The impact of EDI on the private-sector healthcare payment system would be dramatic, said Philip Freer, spokesman for the new association which represents AMA, D and E Administrators, Medicaid Administrators, Medscheme, Old Mutual Health Benefits and Sanmed.

EDI would provide the country's 400 hospitals and clinics, 4 800 specialists, 9 500 general practitioners, 3 000 dentists, 1 800 physiotherapists and 6 000 paramedical services with a standard means of submitting their claims information directly from health vendors' accounting offices throughout the country, Mr Freer said.

STAR 10/2/92

The advantage to medical aid members was that they would not have to submit claims to their medical schemes. — Sapa.

Patients may lose the right to choose their own doctors

299

Medical Reporter STAR 11/2/92

Patients may lose the right to choose which doctor they go to for treatment if the Government passes the amendments to the Medical Schemes Act, the chairman of the Dispensing Family Practitioners Association (DFPA), Dr Robert Rapiti, said yesterday.

He was speaking after his organisation and other medical bodies had placed an advertisement this weekend concerning "shocking health care news".

The group included the Dental Practitioners Association, the SA Dispensing Practitioners Association and the Islamic Medical Association.

He said the organisations paid for the advertisement with the assistance of some drug companies which did not want to be named.

The establishment of Health Maintenance Organisations (HMOs) was only one of the aspects of the amendments to which they objected, he said.

Among other medical bodies which have rejected the amendments is the Medical Association of South Africa. Medical schemes have, however, "unequivocally" welcomed the amendments to the Act.

All the statements made in the advertisement referred to the implications of the provision to establish HMOs contained in the amendments to the Medical Schemes Act which is yet to come before Parliament.

These include the loss of choice of doctor.

HMOs allow medical schemes to establish practices which would employ among others doctors, specialists, dentists, pharmacists and nurses and to have their own hospitals.

This would provide a single point of health care delivery which would be more cost-effective, medical schemes have claimed.

Patients would be obliged to use the services of the HMO — or would have to pay out of their own pockets if they chose to go for private medical care.

If a medical aid established an HMO, members would have to see doctors on the HMO panel.

This could force private practice doctors — who often subsidised the care of the indigent and poor through care of the richer patients — out of existence, Dr Rapiti said.

The care of the poor would then be thrown back to an already over-extended public health service.

He said doctors employed in HMOs would have dual responsibility — to the patients as well as to the company. The latter would expect their doctor to contain costs and would provide the incentives for doctors to use cheaper medicine or to con- tain costs in their own ways. This was not in the interest of the patient.

"Private doctors only do what is the best for the patient," he said.

A spokesman for the Representative Association for Medical Schemes could not be reached for comment yesterday.

High-tech medical payment scheme

299

ST 11/2/92

Staff Reporter

THE introduction of a high-tech electronic data interchange (EDI) system could revolutionise the private health-care payment system as dramatically as ATMs revolutionised South African banking.

This is according to Mr Philip Freer, spokesman for the Electronic Medical Data Interchange Association, the new body aiming to introduce the system.

The system, used to standardise the submission and payment of medical-aid claims, is being investigated by the country's six largest medical-aid scheme administrators but nothing will be done until their clients have been consulted.

Mr Freer said that the big advantage to medical-aid members was that they would be relieved of submitting claims to their medical schemes and the whole claiming procedure would be speeded up.

Medicine price 'out of control'

Sowetan 11/2/92

THE PRICE of medicines in South Africa has become more expensive than anywhere else in the world and is rocketing out of control.

The situation has become so serious that a forum on the high cost of medicines in the private sector will be held by the Department of National Health and Population Development in Pretoria on February 28.

The president of the Natal Coastal Branch of the Medical Association of Natal, Dr Mark Schreiber, said yesterday:

"A large proportion of the population can simply no longer afford private health care or the cost of medicines."

Various aspects of and possible solutions to the problem will be discussed at the conference, which has been called by the Minister of Health, Dr Rina Venter.

The executive director of the South African Association of Retail Pharmacists, Mr Dave Pleaner, confirmed that all the relevant bodies had been asked for their input.

"The Minister has invited comment on what steps can be taken to implement various factors which will help curtail the cost of medicine."

According to Pleaner, Venter had identified various points which would be discussed and which could - if implemented - contribute "a great deal to reducing the cost of medical services as well as medicine".

Among them:

The ability of a pharmacist to substitute medicine with cheaper generics;

A scheme whereby there was a maximum medical aid price for certain drugs;

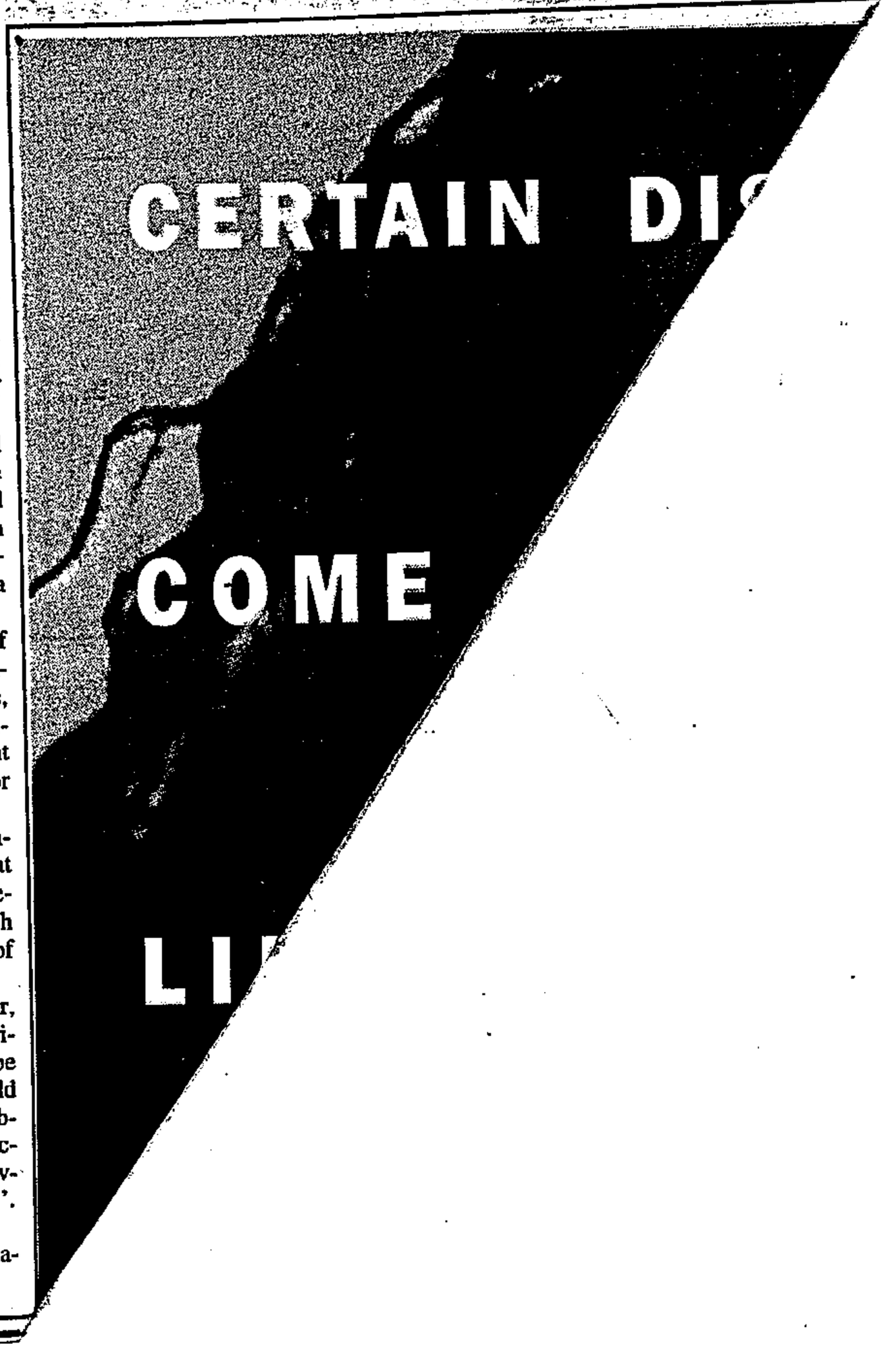
A levy by a member of a medical aid scheme to make the patient aware of the cost of medicine;

A single exit price from the manufacturers. Pharmacists would then not have to buy drugs at a higher price and would not be forced to load the end price;

"Old-fashioned counter-prescribing," which meant that the pharmacist could prescribe for illnesses that should eventually clear up, such as influenza.

Medical aid schemes would pay the pharmacy bill instead of the full consultation; and

The whole question of why some multi-national drugs are more expensive in South Africa than the same drug in another country. - *Sowetan Correspondent.*



Partially deaf spurn group's offer of fi

STAR 12/2/92

Stoep Talk

MICHAEL SHAFTO

Professor Reuben Musiker is puzzled. An affable fellow who has become an institution at Wits University, he recently retired as head of the university libraries after a career as a librarian spanning almost 40 years.

But that has nothing to do with his state of mind, the twig of a frown that creases the skin between his brows.

Indeed, he is quite happy to be bowing out, knowing the libraries are in the capable hands of his successor Heather Edwards.

He will be assisting the library with fundraising and other projects, so in this area his life is just fine.

Struck

What has Professor Musiker puzzled is the reluctance of people with impaired hearing or the partially deaf to let others who suffer a similar affliction help them.

The professor knows what it is all about. He was struck down by a virus that left his hearing badly impaired, as a young man.

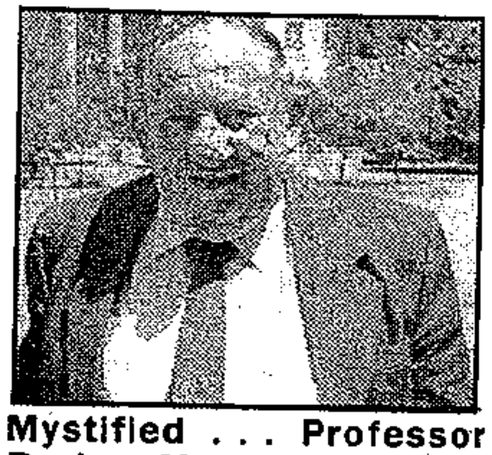
"I was 17. One day I woke up and there was nothing ... just a soundless void. Terrifying. To us, naturally, it seems more of a curse than blindness."

Ever since, Reuben has dedicated his life to helping others similarly afflicted. He is secretary-treasurer of the Self-Help Association for the Hard-of-Hearing (SHHH).

Having suffered from his hearing impairment for the past 43 years, he knows how others feel.

"But I'm mystified," he admitted this week.

"Just a few years ago I ran a small advertisement in the newspapers: 'Do you have a hearing impairment?



Mystified ... Professor Reuben Musiker can't understand why people with impaired hearing don't ask for help.

Are you interested?' I got immediate response. Two hundred people came forward. Today our membership has dwindled to less than 50.

"What is it — are they shy or embarrassed, or vanity? We at the ass tion can help."

SHHH is a volunteer sociation that caters hearing impaired pe their relatives and frien

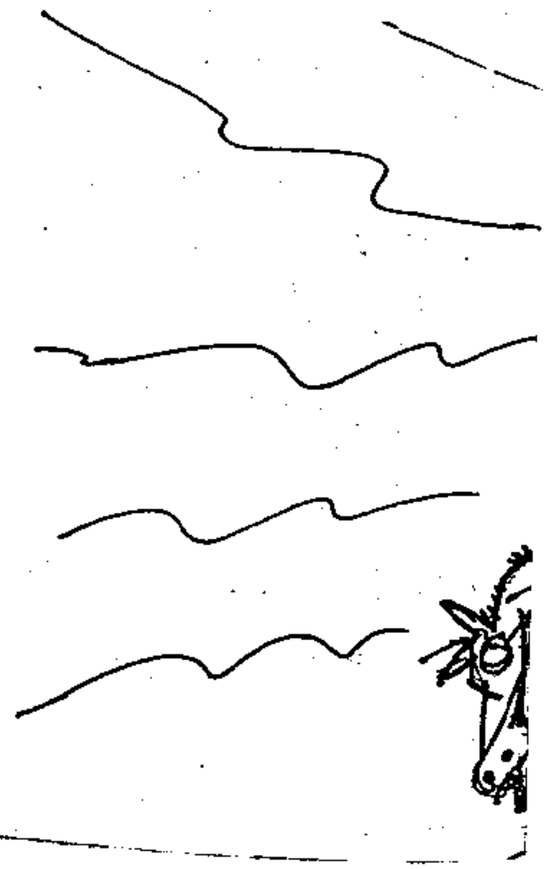
It is a non-profit, ed tional support organis devoted to the welfare interests of those who c hear well but are neve less committed to partic ing in a hearing world.

"It is not an organis that caters for the d says Professor Musiker.

"There are several or sations that cater for t who can't hear at all. members don't use sign guage but do employ hea aids and other assistive vices such as those attac

to refuse to participate in a w stay-away.

Reports claimed that the we end before the planned stayaw the then chief of the police Soweto had gone to address t hostel residents and asked the whether they had come all t



JCCI slams dispensing doctors' ad

THE Johannesburg Chamber of Commerce and Industry intends lodging a complaint with the Advertising Standards Authority over the placing of an advertisement by dispensing practitioner associations protesting against proposed changes to the Medical Schemes Act.

The JCCI charged the advertisement was "one-sided" and "inaccurate".

The chamber said opposition from dispensing doctors was understandable as the changes would introduce "an element of competition".

JCCI CE Marius de Jager said in a statement: "The truth is the Act will deregulate medical aid schemes, enabling them to create medical aid packages for members to choose from according to their needs."

He said the Act would also allow medical aid schemes to participate more fully in the provision of health care, "substantially reducing the cost".

The JCCI said the advertisement "alleges the proposed changes will lead to an end to private practice, the emigration of doctors and dentists and the loss of the patient's option to consult the doctor of his choice".

"This is simply not true," De Jager said.

"Members of a medical aid will be able to continue to visit the doctor of their choice, if they so desire and are prepared to pay the excess.

"If they want to use more cost-effective services, they will be able to do so through the medical aid."

De Jager said the advertisement was "emotionally distasteful, alarmist . . . and an insult to a . . . dedicated profession". — Sapa

JCCI to take ad to authorities

(299)

CT 12/2/92

JOHANNESBURG. — The Johannesburg Chamber of Commerce and Industry intends lodging a complaint with the Advertising Standards Authority following the placing of an ad by dispensing practitioner associations protesting against proposed changes to the Medical Schemes Act.

The JCCI — which operates a medical scheme for many of its members — charged the advertisement was "one-sided, misleading, inaccurate and emotionally charged . . ."

The JCCI argued proposed changes to the act were "absolutely necessary for employers to continue providing medical care for their employees at an affordable level".

It added that opposition from the dispensing doctors was understandable as the changes would introduce "an element of competition".

The ad, said Mr Marius de Jager, chief executive of JCCI, was "emotionally distasteful, alarmist . . . and an insult to a . . . dedicated profession".

"We are curious to know the 'contributing sponsors' of the advertisement, and challenge the associations to reveal them," said Mr de Jager. — Sapa

Row over medical aid advert

299
Star 13/2/92

Medical Reporter

The Johannesburg Chamber of Commerce and Industry intends lodging a complaint with the Advertising Standards Authority following the publication of an advertisement in a Sunday paper this weekend which protested against proposed changes in the Medical Schemes Act.

JCCI condemned the advertisement and called it one-sided, misleading, inaccurate and emotional.

The advert was placed by the Dispensing Family Practitioners Association, the Dental Practitioners Association, the SA Dispensing Practitioners Association and the Islamic Medical Association.

It focused on the provision for the establishment of health maintenance organisations contained in amendments to the Act.

JCCI chief executive Marius de Jager said the changes to the Act were absolutely necessary in order for employers to continue providing affordable medical care for employees.

"Medical aid members would continue to be able to visit the doctor of their choice if they so desire and are prepared to pay the excess.

"Opposition from dispensing practitioners is understandable as it adds an element of competition and will remove the guarantee that the medical aid will pay," Mr de Jager said.

HEALTH MATTERS

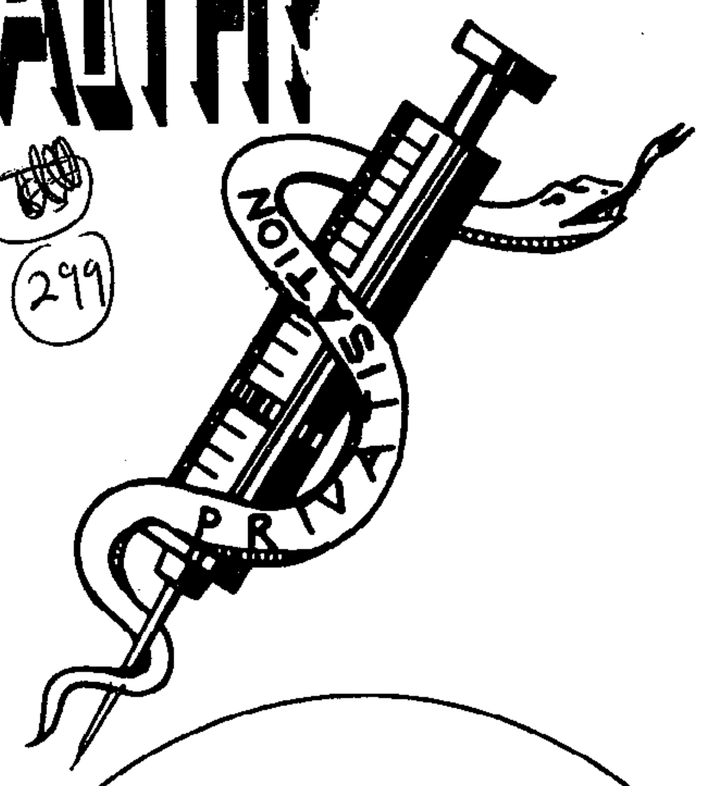
WHAT IS HEALTH?

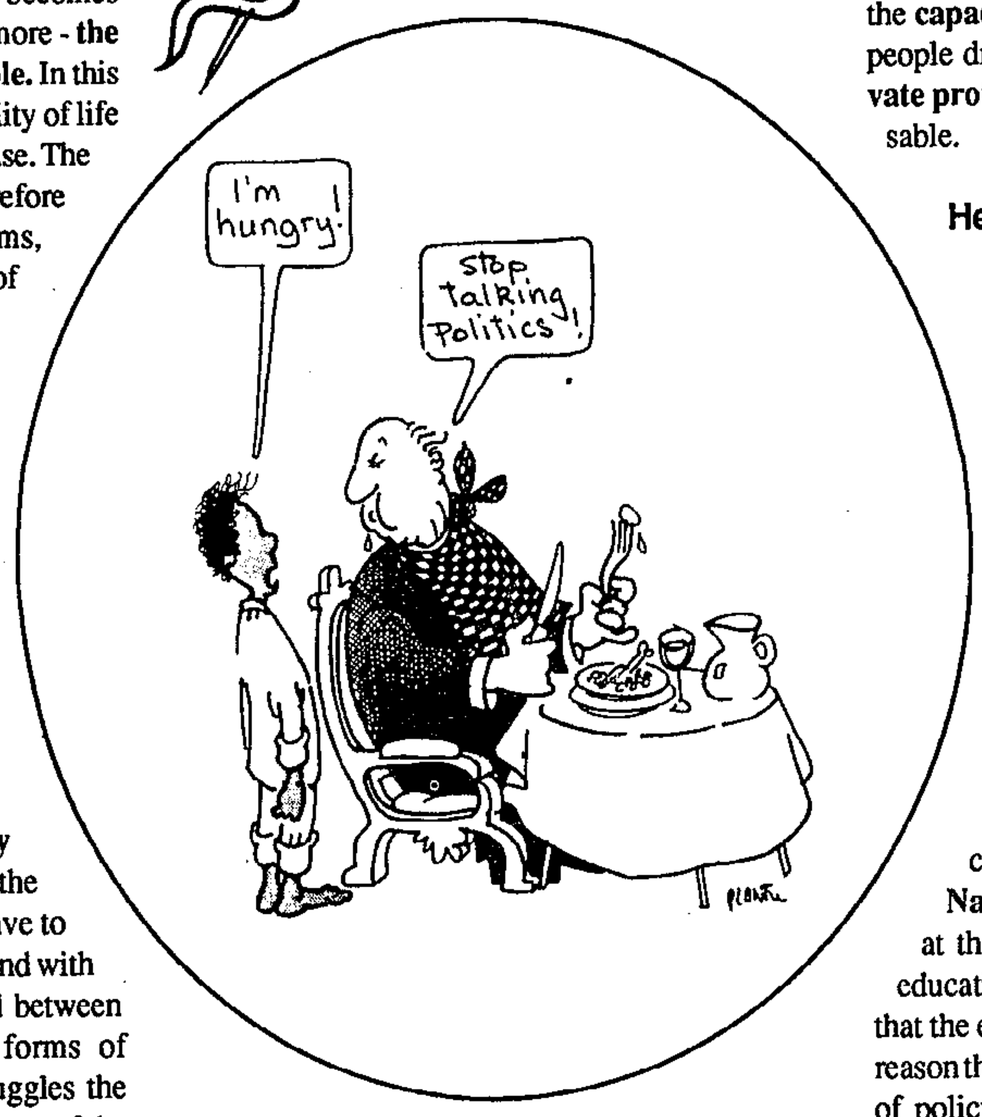
New Nation 14/2 - 20/2/92
(Learning Nation)

299

When we think of such a question we often relate our answer to ourselves directly and our *own* experience of combating disease. As a result we think of health as something to do with the **absence of ill-health** and something that is solved for us by a doctor or a hospital or a traditional healer such as a sangoma. This sense of health is important for us as individuals and as people concerned about our families and friends.

When however we think of the population as a whole, of countries and regions then health becomes a concept that expresses something much more - **the state of well-being of the people as a whole.** In this broader sense health is an index of the quality of life of a people and not only the absence of disease. The term, health, as used on this page will therefore include looking at individual health problems, but will mainly look at health as a measure of the **quality of life of the people**. In this sense health includes everything from the quality of people's housing, to their diet, to conditions in the workplace as well as the extent to which widespread diseases such as TB and gastro-enteritis have been eradicated.





Health and the Development of Society

The key to understanding the development of society lies in looking at how society is **organised to produce the goods necessary to sustain life** (food, shelter, travel etc). In the struggle to produce these goods people have to enter into some relation with one another and with nature. The struggle amongst people and between people and nature produces different forms of organisation. In the process of these struggles the health of the people changes and is a measure of the quality of the organisation of society.

At the same time improvements in the struggle against diseases have a direct bearing on the organisation of society as these improvement can, for instance, decrease the rate at which people die and thus cause **population increases** which require changes in society to accommodate these increases.

So, for instance, the changes brought about by the **second industrial revolution** in capitalist Europe at the end of the 19th century such as the development of the **refrigeration** of food and the invention of new **medicines** and vaccines caused major changes in people's lifestyles. Although the fact that capitalist Europe had vast discrepancies of wealth, meant that different classes experienced these improvements unevenly, overall the standard of living of millions of people improved. Most importantly, the **death rate (mortality rate)** dropped dramatically and the population of the cities of Western Europe and North America went up by millions. These increases in turn forced people to emigrate to new countries which pushed up the European population in other countries in Asia, Africa and America.

We can see, therefore, that to speak of health in the wide sense involves looking at things like mortality rates, population increases, the changes in eating habits of the people, changing residential patterns, as well as, of course, the changes in disease patterns.

Health and the Inequality of life in Capitalist Society

When we look at the spread of diseases in capitalist society we find that different strata and classes have different disease experiences. In the main the rich suffer from diseases associated with **over-rich eating habits** and the tensions of running businesses or offices and professional work. They therefore are prone to heart problems, ulcers, gout etc. The working class and the poorer people suffer from widespread social diseases such as kwashiorkor, tuberculosis and rickets which are associated with **bad eating habits housing and sanitation**.

But more than this, look at the relation between the spread of particular diseases and class is the fact that the broader definition of health we are employing here includes the fact that the rich have access to better air (their houses are mostly in suburbs away from the city pollution); they have the means to spend on health foods; they can afford gyms for exercises and they have more leisure time to either exercise or just relax. In addition to the fact that health care in capitalist society is a **commodity** which can best be afforded by the rich, the quality of life of the rich, and therefore their health, is better.

Earlier on we spoke about the great changes and improvements in health brought about at the end of the 19th century in Europe and North America. Today we however have the strange situation that further developments in health technology - from food storage and processing to the inventions of new medicines and advances in medical science - **are not improving the overall quality of life of the people as a whole.** In fact in the country which has won more Nobel Prizes for medicine than any other, the USA, the scale of epidemiological diseases (those brought about by poor environment and living conditions) is increasing. This look at health illustrates one of the major contradictions of capitalism - as a society it has the **capacity** to improve the quality of life of all its people dramatically, and yet the need to make **private profit** for the rich makes that capacity unrealisable.

Health and the Question of Policy

The political changes which are taking place in South Africa today will not only impact on health and health services, but health will be an important measure of just how much these changes have really improved the quality of life of the people of South Africa. Questions such as: how do we ensure that all South Africa's people have access to good quality and free/affordable healthcare? will have to be combined with questions about living standards, wages, housing and the environment to ensure that the quality of life which has been enjoyed by a small class can be attained by all. Proposals about a **National Health Service** are being put forward at the same time as calls for free, compulsory education and a Macro-economic Forum to ensure that the economy can guarantee jobs for all. For this reason there is much attention being paid to questions of policy in the mass movement in South Africa today; in other words what strategy should the people's organisations follow to ensure that the demands of the struggles over the last 40 years are realisable at the level of political power, housing, education, jobs and health services.

To the extent that health is the measure of the overall quality of life of the people, the issues raised on this page in our future editions will not only help our readers deal with current health problems but with the all the proposed policies that organisations are putting forward in South Africa.

Learning Nation would like to hear from you about questions you would like to raise on this page and issues you feel should be raised around the broad view of health. Write your views/questions in the space provided and send them to Learning Nation, PO Box 11350, Johannesburg, 2000.

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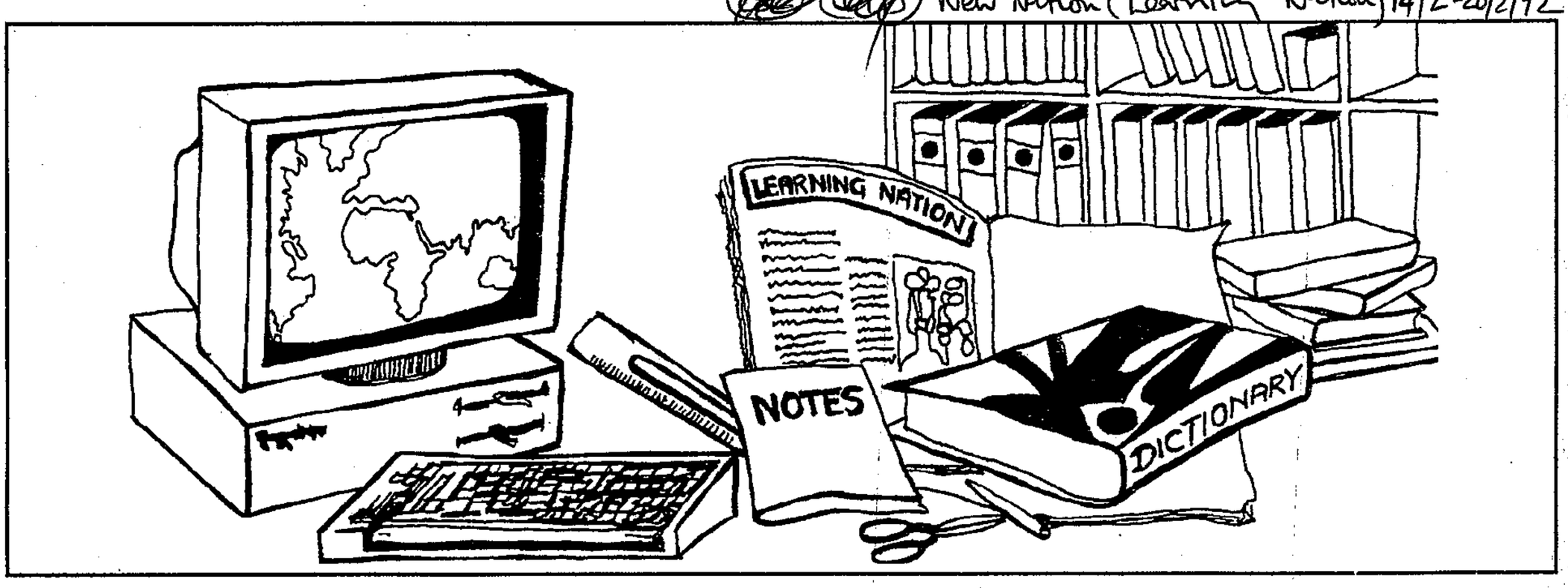
RESOURCES

A Student's View on Poor Career Awareness

New Nation (Learning Nation) 14/2-20/2/92



After I matriculated in the late 1980's, I read some books and articles from which I got more information on careers. In addition I talked to different people in different professions and also to students at the tertiary institutions. Lastly I talked to pupils and some matriculants about their future plans concerning their choices in terms of careers.

I was hurt to discover that the majority of the pupils and matriculants do not even know how to choose a career. They also lack information on different career fields. As a result, both groups are desperate and lack confidence in education. Although this might be a personal problem, it is also a social problem.

I decided to find out the possible causes of the problem, my aim being to help those studying in rural areas, especially the peasants and working class children. But I hope this essay will also be beneficial even to those studying in urban areas.

Bishop Mugoba of the Methodist Church once said, "The word impossible is only found in the dictionary of fools". I do not want to comment on that but leave it up to the reader to interpret. Some students are made to believe that some subjects are difficult for them. So students are also taught fear. The students' talents are hidden and they are not discovered, nor improved. Students do not have facilities like libraries and resource centres. They are also abused psychologically in their early years and they grow up like that. Lastly there are poor parent-child relationships. But there may be other causes or reasons than these I mentioned.

The education which is offered to blacks is ineffective. It does not equip blacks with the necessary skills for life. Most students graduate with unemployable skills. It also keeps us dependent.

Even the conditions under which they study are not encouraging. There is also a shortage of dedicated, talented, successful and skilled teachers. This makes one doubt if there is any white person who will allow his/her child to be taught by a teacher who graduated from a black college of education. I do not mean what you might think. But I mean some teachers do not bother themselves to study after they obtain their diplomas. It is therefore a problem which needs to be looked at critically. Because, for the future of the nation, the quality of teachers is important. If this problem is not addressed, the nation is facing a crisis.

It is not always that people are unable to do well, but the inability is also caused by unawareness. For example, there was once a guy who did the general subjects at school. After matriculating with an exemption, he wanted to do electrical engineering. The money was available and the institutes for training are open. His aggregate symbol was also impressive, but the subjects blocked his way. He was very desperate and therefore resorted to teaching. Will he succeed in the teaching field? Think of the children he is going to teach!

There is also a lady who selected courses like Anthropology in her first year of study a university. Her aim was to become a senior secondary school teacher. After September she discovered her courses were irrelevant for what she wanted to be because they are not offered as subjects at high school. So she wasted her time, money and efforts studying so hard.

Most students in rural areas are not exposed to different career fields. They do not see people who work in areas of work other than a very few like nurses, teachers and clerks.

In 1988, the Department of Manpower in my place initiated a programme of careers exhibitions. The programme took five week days in May. So I was lucky to be among those who went to the careers exhibition. Remember it was meant for students doing matric. Imagine taking a student at matric level to a careers exhibition for the first time in his/her school life! I was so confused that I did not know which one was best for me. All the career officers painted their career fields so bright as if there were no disadvantages at all. What choice do you think you would make if you found yourself in such a situation? That is how some students make wrong choices and wrong decisions which affect them in their future. Well, the programme is all right but that is not enough. I mean, it should start at least at Standard Six level.

Then again, there was a guy who passed matric with very good symbols. One factory owner decided to send the guy to university for the benefit of his factory. The factory was very impressed with his results and also knew that he came from an underprivileged family. The factory owner talked to the guy, showing him all the benefits he would enjoy if he agreed. Well to the young man, that was like manna. The young man agreed and signed the agreement. After some weeks he discovered other alternatives by which he could finance his studies and which had less obligations than the one he had already signed. He blamed himself for something he could not change. I think one needs to think more than once before taking a decision.

There are some students who want to follow some bright careers. They are discouraged by being told that they will have to study a lot before they qualify. That is done in a way which raises fear which has a psychological impact on the students. Moreover, that is done without first consulting the students as to why they do not perform well. The youngsters should not be discouraged from making choices without firm reasons which are convincing. It is easier to destroy than to build.

There is a problem in some schools. Some teachers tell students that subjects, like Maths, are difficult. So the students also think that that is true as well. As a result, lack of confidence makes the subject more difficult and leads to the students not performing well. For instance the problem with Maths is the shortage of Maths teachers and the fact that most students do not have the basics. There is also a lack of study skills programmes.

The other problem is that many schools do not offer career guidance. Now let us think of a student from such a school; she or he doesn't even know where to start in order to choose a career which will match his or her own needs, interests or abilities. Unless some measures are taken, our society is facing a disaster. And moreover the matriculants will continue to live miserable lives, even in the future South Africa. Guidance is necessary in order to have a successful, skilled workforce for industry and also to have the best professionals in the new South Africa.

Lindile Ndabeni
Khanya College, Johannesburg

Hospice Care is a free service to patients with terminal illnesses

STAR 20/2/92 (88) (299)

In a recent issue of **Pharmacy Today** Stan Henen, vice-chairman of the Hospice Association of Southern Africa, describes the functions of a hospice.

I have been disturbed by bits of "disinformation" and incorrect perceptions of Hospice Care that reach my ears. It is important that these be dispelled.

The most important one to dispel concerns the costs of Hospice Care. There is no charge for Hospice Care unless the patient is a member of a medical aid, in which case the medical aid will be billed for professional services rendered.

Religion

Families that can afford to pay are offered the opportunity to do so. They may choose to make a donation to offset the costs of providing Hospice Care. However, Hospice Care is provided on the basis of "**NEED ONLY**" **AND NOT "ABILITY TO PAY"**. No one is denied Hospice Care because they cannot pay for it.

Hospices are not religious, neither do they deny religion or spirituality. The religious and spiritual needs of the patient and family are met as, and when, they arise. The Hospice Association of Southern Africa sets standards of care which are adhered to by all member Hospices.

Requests for Hospice Care will be accepted when the call comes from the patient and immediate nuclear family, the patient's attending medical practitioner, the hospital or social worker. In all cases it is important that, if the request comes from a non-medical source, the patient's doctor supports the request and provides a medical report.

When the call does not come from the family, the request for Hospice Care must be supported by the family. It is the responsibility of the referring officer to discuss this with the family and obtain their permission to call for Hospice Care.

Hospice Care is for those people who have a terminal illness, ie any disease which is progressive and most likely to cause the death of the patient. (There are, however, one or two Hospices which do not care for terminally ill Aids sufferers).

The best time to introduce a patient to Hospice Care is at the time when the curative option is no longer the most viable option.

Hospice is NOT a service of last resort. The Hospice team can make a meaningful contribution to the quality of life of the patient and the family through the facilitation of intro-family dynamics, supportive Hospice-at-Home nursing services, alleviation of symptoms and Day Care and outpatient facilities.

Rather call Hospice too soon than wait until all the wheels come off! It is particularly distressing to receive calls from family members desperate for the help, support and guidance that Hospice can give only to be told that "It's not time yet!"

Nurse

Hospice Care is primarily a community outreach programme. Hospice-at-Home services are co-ordinated by a fully trained professional nurse who is under direction of the patient's medical practitioner.

The nurse co-ordinates the Hospice team which includes other care-givers, who together strive to meet the needs of the patient and family. The Hospice medical officer is available as a consultant to the attending physician and will provide direct medical care, if and when called upon tc do so.

For details on Hospice in your area, telephone (011) 884-4636.

Bitter pill, say doctors about medical aid plan

South: (Southside) 20/2 – 26/2/92 (299)

COULD YOUR health end up being decided in the boardrooms of big business? This is the debate inflaming people involved in medical services, prompted by the Medical Schemes Amendment Bill which is due to be passed during the current parliamentary session.

The Bill has arisen out of the needs of cash-strapped medical aid schemes, threatened with the loss of business by rising medical costs.

Under the new scheme, medical aid companies will no longer reimburse patients for bills paid to family doctors. Instead, provision of health care will rest with Health Maintenance Organisations (HMO) administered by the companies.

The draft legislation and its consequences are being sold to the public as a way of cutting medical aid contributions that are threatening to rise beyond the means of most employers and employees.

Dr Robert Rapiti, chairperson of the Dispensing Family Practitioners' Association (DFPA), says people are being kept uninformed about the most worrying effect of the new plans — medical aid subscribers will not be able to be treated by the doctor of their choice.

Mr Robin Melville, who works in medical aid schemes administration, denies the patient would have no choice of doctor. He admits the choice will not be as wide as a present, but says patients could still choose from a number of doctors contracted to the HMO.

Rapiti fears doctors will become salaried employees of a profit-making concern, and could be offered incentives by their employers to cut down on costs — which will cause them to compromise on the quality of their treatment and the medicines prescribed. He points out the possibility of hospitals falling under direct control of big business and considering their operating costs rather than the quality of care.

"Big business is seeing health in monetary terms," he says , "not in personal terms, not in terms of service."

Melville believes the workings of the HMO are misunderstood by South Africans, who fail to distinguish between the benefit schemes formerly operated by large businesses and industries, and the modern HMO system such as now operates in the United States.

Under the American system, which is what South African medical aid companies will probably adopt once the Bill becomes law, doctors are not employed by corporations, but contracted on a freelance basis to a particular HMO. The doctor will contract to treat HMO subscribers at a rate negotiated between the HMO and the doctor.

Rapiti also fears that the HMO system will bring about the demise of the family practitioner, which could encourage South African doctors to emigrate.

A source in the medical aid business says the presence of HMOs will have no adverse effect on family doctors. "There is nothing to stop a family doctor from having a private practice at the same time as contracting to an HMO. Family doctors could even benefit.

"We may however see the demise of the dispensing doctor. Medicines from an HMO are far more competitive owing to bulk buying."

The HMO system has been operating for 20 years in the United States. According to Rapiti, the system is unpopular, with no more than 14 percent of the US population subscribing to HMO services.

In December the DFPA and the National Medical and Dental Association (Namda) issued a statement rejecting the Medical Schemes Amendment Bill and called for the immediate suspension of any further moves towards the Bill's implementation.

The statement condemned the bill as a "badly planned attempt to restructure the health care arena," and one which was implemented "without adequate consultation with those parties affected by the changes".

While the DFPA continues to campaign against the new legislation by means of newspaper advertisements, Melville joins others in the medical aid business in assuring that in South Africa there will be "a place in the sun for the HMO". □

JUSTIN PEARCE

DEPARTEMENT VAN MANNEKRAG

No. R. 523 **21 Februarie 1992**

WET OP ARBEIDSVERHOUDINGE, 1956

BIOSKOOP- EN SKOUBURGBEDRYF

VERBETERINGSKENNISGEWING

Onderstaande verbeterings aan Goewermentskennisgewing R. 3138 wat in *Staatskoerant* No. 13684 van 20 Desember 1991 verskyn, word hierby vir algemene inligting gepubliseer:

1. In die Afrikaanse teks van die bylae:

"1. GEBIED EN TOEPASSINGSBESTEK VAN DIE OOREENKOMS

In subklousule (4) (a), vervang 'Met dien verstande dat dit nie ten opsigte van die bepalings van klousules 20 en 24 van die Vorige ooreenkoms van toepassing is nie' deur 'Met dien verstande dat dit nie ten opsigte van die bepalings van klousules 17 en 19 van Goewermentskennisgewing R. 2184 in *Staatskoerant* No. 12747 van 14 September 1990.'

2. In die Engelse teks van die bylae:

"1. AREA AND SCOPE OF APPLICATION OF THE AGREEMENT

In subklousule (4) (a), vervang 'Provided that this shall not apply in respect of the provisions of clauses 20 and 24 of the Former agreement' met 'Provided that this shall not apply in respect of the provisions of clauses 17 and 19 of Government Notice R. 2184 in *Government Gazette* No. 12747 of 14 September 1990'."

No. R. 574 **21 Februarie 1992**

WET OP ARBEIDSVERHOUDINGE, 1956

ELEKTROTEGNIESE NYWERHEID, NATAL: WYSIGING VAN SIEKTEBYSTANDSFONDSOOREENKOMS

Ek, Pieter Gabriel Marais, Minister van Mannekrag, verklaar hierby—

(a) kragtens artikel 48 (1) (a) van die Wet op Arbeidsverhoudinge, 1956, dat die bepalings van die Ooreenkoms (hierna die Wysigingsooreenkoms genoem) wat in die Bylae hiervan verskyn en betrekking het op die Onderneming, Nywerheid, Bedryf of Beroep in die opskrif by hierdie kennisgewing vermeld, met ingang van die tweede Maandag na die datum van publikasie van hierdie kennisgewing en vir die tydperk wat op 30 Junie 1993 eindig, bindend is vir die werkgewersorganisasie en die vakverenigings wat die Wysigingsooreenkoms aangegaan het en vir die werkgewers en werknemers wat lede van genoemde organisasie of verenigings is; en

(b) kragtens artikel 48 (1) (b) van genoemde Wet, dat die bepalings van die Wysigingsooreenkoms, uitgesonderd die vervat in klousules 1 (1) (a) en 2, met ingang van die tweede Maandag na die datum van publikasie van hierdie kennisgewing en vir die tydperk wat op 30 Junie 1993 eindig, bindend is vir alle ander

DEPARTMENT OF MANPOWER

No. R. 523 **21 February 1992**

LABOUR RELATIONS ACT, 1956

CINEMATOGRAPH AND THEATRE INDUSTRY

CORRECTION NOTICE

The following correction to Government Notice R. 3138 appearing in *Government Gazette* No. 13684 of 20 December 1991, is hereby published for general information:

1. In the Afrikaans text of the schedule:

"1. GEBIED EN TOEPASSINGSBESTEK VAN DIE OOREENKOMS

In subclause (4) (a), substitute 'Met dien verstande dat dit nie ten opsigte van die bepalings van klousules 20 en 24 van die Vorige ooreenkoms van toepassing is nie' for 'Met dien verstande dat dit nie ten opsigte van die bepalings van klousules 17 en 19 van Goewermentskennisgewing R. 2184 in *Staatskoerant* No. 12747 van 14 September 1990'."

2. In the English text of the schedule:

"1. AREA AND SCOPE OF APPLICATION OF THE AGREEMENT

In subclause (4) (a), substitute 'Provided that this shall not apply in respect of the provisions of clauses 20 and 24 of the Former Agreement' with 'Provided that this shall not apply in respect of the provisions of clauses 17 and 19 of Government Notice R. 2184 in *Government Gazette* No. 12747 of 14 September 1990'."

No. R. 574 **21 February 1992**

LABOUR RELATIONS ACT, 1956

ELECTRICAL INDUSTRY, NATAL: AMENDMENT OF SICK PAY FUND AGREEMENT

I, Pieter Gabriel Marais, Minister of Manpower, hereby— 299

(a) in terms of section 48 (1) (a) of the Labour Relations Act, 1956, declare that the provisions of the Agreement (hereinafter referred to as the Amending Agreement) which appears in the Schedule hereto and which relates to the Undertaking, Industry, Trade or Occupation referred to in the heading to this notice, shall be binding, with effect from the second Monday after the date of publication of this notice and for the period ending 30 June 1993 upon the employers' organisation and the trade unions which entered into the Amending Agreement and upon the employers and employees who are members of the said oganisation 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 clauses 1 (1) (a) and 2 shall be binding, with effect from the second Monday after the date of publication of this notice and for the period ending 30 June 1993 upon all employers

werkgewers en werknemers as die genoem in paragraaf (a) van hierdie kennisgewing wat betrokke is by of in diens is in genoemde Onderneming, Nywerheid, Bedryf of Beroep in die gebiede in klousule 1 van die Wysigingsooreenkoms gespesifiseer.

P. G. MARAIS,
Minister van Mannekrag.

BYLAE

NYWERHEIDSRAAD VIR DIE ELEKTROTEGNIESE NYWERHEID (NATAL)

SIEKTEBYSTANDSFONDS

OOREENKOMS

ooreenkomstig die Wet op Arbeidsverhoudinge, 1956, gesluit deur en aangegaan tussen die

Electrical Contractors' Association (South Africa)

(hierna die "werkgewers" of die "werkgewersorganisasie" genoem), aan die een kant, en die

South African Electrical Workers' Association

en die

Metal and Electrical Workers' Union of South Africa

(hierna die "werknemers" of die "vakverenigings" genoem), aan die ander kant,

wat die partye is by die Nywerheidsraad vir die Elektrotegniese Nywerheid (Natal),

om die Ooreenkoms gepubliseer by Goewermentskennisgewing No. R. 1658 van 19 Augustus 1988 (hierna die Herbekragtigingsooreenkoms genoem), soos verleng en gewysig by Goewermentskennisgewings Nos. R. 1213 van 9 Junie 1989, R. 395 van 23 Februarie 1990, R. 1494 van 29 Junie 1990, R. 1873 van 10 Augustus 1990, R. 1231 van 30 Mei 1991 en R. 2274 van 20 September 1991, te wysig.

DEEL I

1. TOEPASSINGSBESTEK VAN OOREENKOMS

(1) Hierdie Ooreenkoms moet nagekom word deur werkgewers en werknemers in die Elektrotegniese Nywerheid (Natal)—

(a) wat lede van onderskeidelik die werkgewersorganisasie en die vakverenigings is; en

(b) wat betrokke is by of in diens is in die Nywerheid in die provinsie Natal, uitgesonderd enige gedeeltes van daardie gebied wat binne die selfregerende gebied KwaZulu val.

(2) Ondanks subklousule (1), is hierdie Ooreenkoms nie van toepassing nie op—

(a) werknemers in diens van die werkgewers in subklousule (1) bedoel wat, hoewel hulle ingevolge die geregistreerde bestek van 'n vakvereniging wat 'n party by hierdie Ooreenkoms is lede van so 'n vakvereniging kan word, nie lede van so 'n vakvereniging is nie;

(b) werknemers, uitgesonderd dié in diens van werkgewers in subklousule (1) bedoel.

2. SPESIALE BEPALINGS

Klousule 9 van Deel 1 van die Ooreenkoms gepubliseer by Goewermentskennisgewing No. R. 2827 van 30 Desember 1983, soos gewysig en herbekragtig by Goewermentskennisgewings Nos. R. 2481 van 16 November 1984, R. 992 van 23 Mei 1986 en R. 2069 van 26 September 1986 (hierna die "Vorige Ooreenkoms" genoem), soos van tyd tot tyd gewysig, herbekragtig en verleng/hernieu, is van toepassing op werkgewers en werknemers.

and employees, other than those referred to in paragraph (a) of this notice, who are engaged or employed in the said Undertaking, Industry, Trade or Occupation in the areas specified in clause 1 of the Amending Agreement.

P. G. MARAIS,
Minister of Manpower.

SCHEDULE

INDUSTRIAL COUNCIL FOR THE ELECTRICAL INDUSTRY (NATAL)

SICK PAY FUND

AGREEMENT

in accordance with the provisions of the Labour Relations Act, 1956, made and entered into by and between the

Electrical Contractor's Association (South Africa)

(hereinafter referred to as the "employers" or the "employers' organisation"), of the one part, and the

South African Electrical Workers' Association

and the

Metal and Electrical Workers' Union of South Africa

(hereinafter referred to as the "employees" of the "trade unions"), of the other part,

being the parties to the Industrial Council for the Electrical Industry (Natal),

to amend the Agreement published under Government Notice No. R. 1658 of 19 August 1988 (hereinafter referred to as the Re-enacting Agreement), as extended and amended by Government Notices Nos. R. 1213 of 9 June 1989, R. 395 of 23 February 1990, R. 1494 of 29 June 1990, R. 1873 of 10 August 1990, R. 1231 of 30 May 1991 and R. 2274 of 20 September 1991.

PART I

1. SCOPE OF APPLICATION OF AGREEMENT

(1) The terms of this Agreement shall be observed by employers and employees in the Electrical Industry (Natal)—

(a) who are members of the employers' organisation and the trade unions, respectively; and

(b) who are engaged or employed in the Industry in the Province of Natal, excluding any portions of that area falling within the Self-governing Territory of KwaZulu.

(2) Notwithstanding the provisions of subclause (1), the terms of this Agreement shall not apply to—

(a) employees employed by the employers referred to in subclause (1) who, whilst being allowed in terms of the registered scope of a trade union which is a party to this Agreement to become members of such a trade union, are not members of such a trade union;

(b) employees other than those employed by employers referred to in subclause (1).

2. SPECIAL PROVISIONS

The provisions of clause 9 of Part I of the Agreement published under Goverment Notice No. R. 2827 of 30 December 1983, as amended and re-enacted by Government Notices Nos. R. 2481 of 16 November 1984, R. 992 of 23 May 1986 and R. 2069 of 26 September 1986 (hereinafter referred to as the "Former Agreement"), as amended, re-enacted and extended/renewed from time to time, shall apply to employers and employees.

3. ALGEMENE BEPALINGS

Klousules 3 tot en met 8 en 10 tot en met 16 van Deel I van die Vorige Ooreenkoms, soos van tyd tot tyd gewysig, herbekragtig en verleng/hernieu, is van toepassing op werkgewers en werknemers.

DEEL II

4. KLOUSULE 3: BETALING VAN SIEKTEBYSTAND

Vervang klousule 3 (1) deur die volgende:

"(1) Behoudens die bepalings van klousule 15 (4) van Deel I en behoudens die bepaling dat betalings nie 150% van die voorgeskrewe minimum loon mag oorskry nie, is siektebystandsvoordele soos volg aan lede betaalbaar:

Lede met minder as 12 maande diens

Aantal werkdae afwesig	Voordeel
3	1 dag @ 60% van werklike loon.
4	2 dae @ 60% van werklike loon.
5	5 dae @ 60% van werklike loon.
6	6 dae @ 60% van werklike loon.
7	7 dae @ 60% van werklike loon.
8	8 dae @ 60% van werklike loon.
9	9 dae @ 60% van werklike loon.
10	10 dae @ 60% van werklike loon.
11	9 dae @ 60% van werklike loon plus 2 dae @ 50% van werklike loon.
12	8 dae @ 60% van werklike loon plus 4 dae @ 50% van werklike loon.
13	7 dae @ 60% van werklike loon plus 6 dae @ 50% van werklike loon.
14	6 dae @ 60% van werklike loon plus 8 dae @ 50% van werklike loon.
15	5 dae @ 60% van werklike loon plus 10 dae @ 50% van werklike loon.
16	4 dae @ 60% van werklike loon plus 12 dae @ 50% van werklike loon.
17	3 dae @ 60% van werklike loon plus 14 dae @ 50% van werklike loon.
18	2 dae @ 60% van werklike loon plus 16 dae @ 50% van werklike loon.
19	1 dag @ 60% van werklike loon plus 18 dae @ 50% van werklike loon.
20	20 dae @ 50% van werklike loon.

Vir elke daaropvolgende dag afwesig moet die lid 50% van sy werklike loon ontvang.

Lede met 12 maande of meer diens

Aantal werkdae afwesig	Voordeel
3	3 dae @ 70% van werklike loon.
4	4 dae @ 70% van werklike loon.
5	5 dae @ 70% van werklike loon.
6	6 dae @ 70% van werklike loon.
7	7 dae @ 70% van werklike loon.
8	8 dae @ 70% van werklike loon.
9	9 dae @ 70% van werklike loon.
10	10 dae @ 70% van werklike loon.
11	9 dae @ 70% van werklike loon plus 2 dae @ 50% van werklike loon.
12	8 dae @ 70% van werklike loon plus 4 dae @ 50% van werklike loon.
13	7 dae @ 70% van werklike loon plus 6 dae @ 50% van werklike loon.
14	6 dae @ 70% van werklike loon plus 8 dae @ 50% van werklike loon.
15	5 dae @ 70% van werklike loon plus 10 dae @ 50% van werklike loon.
16	4 dae @ 70% van werklike loon plus 12 dae @ 50% van werklike loon.

3. GENERAL PROVISIONS

The provisions contained in clauses 3 to 8, inclusive, and 10 to 16, inclusive, of Part I of the Former Agreement, as amended, re-enacted and extended/renewed from time to time, shall apply to employers and employees.

PART II

4. CLAUSE 3: SICK PAY BENEFITS

Substitute the following for clause 3 (1):

"(1) Subject to the provisions of clause 15 (4) of Part I and subject to the provision that payments shall not exceed 150% of the prescribed minimum wage rate, sick pay benefits shall be payable to members as follows:

Members with less than 12 months' service

Number of days off work	Benefit
3	1 day @ 60% of actual wage.
4	2 days @ 60% of actual wage.
5	5 days @ 60% of actual wage.
6	6 days @ 60% of actual wage.
7	7 days @ 60% of actual wage.
8	8 days @ 60% of actual wage.
9	9 days @ 60% of actual wage.
10	10 days @ 60% of actual wage.
11	9 days @ 60% of actual wage plus 2 days @ 50% of actual wage.
12	8 days @ 60% of actual wage plus 4 days @ 50% of actual wage.
13	7 days @ 60% of actual wage plus 6 days @ 50% of actual wage.
14	6 days @ 60% of actual wage plus 8 days @ 50% of actual wage.
15	5 days @ 60% of actual wage plus 10 days @ 50% of actual wage.
16	4 days @ 60% of actual wage plus 12 days @ 50% of actual wage.
17	3 days @ 60% of actual wage plus 14 days @ 50% of actual wage.
18	2 days @ 60% of actual wage plus 16 days @ 50% of actual wage.
19	1 day @ 60% of actual wage plus 18 days @ 50% of actual wage.
20	20 days @ 50% of actual wage.

For each subsequent day off, the member shall receive 50% of his actual wage.

Members with 12 months' and more service

Number of days off work	Benefit
3	3 days @ 70% of actual wage.
4	4 days @ 70% of actual wage.
5	5 days @ 70% of actual wage.
6	6 days @ 70% of actual wage.
7	7 days @ 70% of actual wage.
8	8 days @ 70% of actual wage.
9	9 days @ 70% of actual wage.
10	10 days @ 70% of actual wage.
11	9 days @ 70% of actual wage plus 2 days @ 50% of actual wage.
12	8 days @ 70% of actual wage plus 4 days @ 50% of actual wage.
13	7 days @ 70% of actual wage plus 6 days @ 50% of actual wage.
14	6 days @ 70% of actual wage plus 8 days @ 50% of actual wage.
15	5 days @ 70% of actual wage plus 10 days @ 50% of actual wage.
16	4 days @ 70% of actual wage plus 12 days @ 50% of actual wage.

Lede met 12 maande of meer diens	
Aantal werkdae afwesig	Voordeel
17	3 dae @ 70% van werklike loon plus 14 dae @ 50% van werklike loon.
18	2 dae @ 70% van werklike loon plus 16 dae @ 50% van werklike loon.
19	1 dag @ 70% van werklike loon plus 18 dae @ 50% van werklike loon.
20	20 dae @ 50% van werklike loon.

Vir elke daaropvolgende dag afwesig moet die lid 50% van sy werklike loon ontvang.".

Soos gemagtig, vir en namens die partye by die Raad, op die 5de dag van November 1991 te Durban onderteken.

B. CARR,
Voorsitter van die Raad.

T. EVANS,
Ondervoorsitter van die Raad.

L. A. DICKASON,
Sekretaris van die Raad.

No. R. 582 **21 Februarie 1992**

WET OP MANNEKRAGOPLEIDING, 1981

INTREKKING VAN DIE OPLEIDINGSKEMA VIR DIE AKKOMMODASIE-, SPYSENIERINGS- EN DRANK-KLEINHANDELBEDRYF EN INSTELLING VAN OPLEIDINGSKEMA VIR DIE GASVRYHEIDSBEDRYWE

Ek, Pieter Gabriel Marais, Minister van Mannekrag, handelende kragtens artikel 39 (5) en 39 (6) van die Wet op Mannekragopleiding, 1981—

(a) trek hierby Goewermentskennisgewing No. R. 2439 van 28 November 1986, soos gewysig deur Goewermentskennisgewing No. R. 2410 van 10 November 1989, met ingang van die datum van publikasie hiervan, in: Met dien verstande dat die bepalings van klousules 8 (1) en 8 (2) van die Skema gepubliseer by die genoemde Goewermentskennisgewing van krag sal bly tot en met 29 Februarie 1992; en

(b) verklaar hierby dat die bepalings van die Skema wat in die Bylae hiervan verskyn, met ingang van die datum van publikasie hiervan vir 'n tydperk wat op 28 Februarie 1997 eindig, bindend is vir alle werkgewers en werknemers wat betrokke is by of in diens is in die Gasvryheidsbedrywe in die Republiek van Suid-Afrika.

P. G. MARAIS,
Minister van Mannekrag.

BYLAE

Die Opleidingskema vir die Gasvryheidsbedrywe, hierna genoem "die Bedryf", is ingestel deur—

die Federated Hotel, Liquor and Catering Association of South Africa (FEDHASA);

die Catering, Restaurant and Tearoom Association (CATRA);

die Verenigde Klubs van Suid-Afrika (ACSA); en

die South African Chef's Association (SACA),

Members with 12 months' and more service	
Number of days off work	Benefit
17	3 days @ 70% of actual wage plus 14 days @ 50% of actual wage.
18	2 days @ 70% of actual wage plus 16 days @ 50% of actual wage.
19	1 day @ 70% of actual wage plus 18 days @ 50% of actual wage.
20	20 days @ 50% of actual wage.

For each subsequent day off, the member shall receive 50% of his actual wage.".

Signed at Durban, as authorised, for and on behalf of the parties, this 5th day of November 1991.

B. CARR,
Chairman of Council.

T. EVANS,
Vice-Chairman of Council.

L. A. DICKASON,
Secretary of Council.

No. R. 582 **21 February 1992**

MANPOWER TRAINING ACT, 1981

WITHDRAWAL OF THE TRAINING SCHEME FOR THE RETAIL INDUSTRIES OF ACCOMMODATION, CATERING AND LIQUOR AND ESTABLISHMENT OF TRAINING SCHEME FOR THE HOSPITALITY INDUSTRIES

I, Pieter Gabriel Marais, Minister of Manpower, acting in terms of sections 39 (5) and 39 (6) of the Manpower Training Act, 1981—

(a) hereby withdraw Government Notice No. R. 2439 of 28 November 1986, as amended by Government Notice, No. R. 2410 of 10 November 1989, with effect from the date of publication hereof: Provided that the provisions of clauses 8 (1) and 8 (2) of the Scheme published by the said Government Notice shall remain in force up to and including 29 February 1992; and

(b) hereby declare that the provisions of the Scheme which appears in the Schedule hereto, shall be binding with effect from the date of publication hereof for a period ending on 28 February 1997, upon all employers and employees who are engaged or employed in the Hospitality Industries in the Republic of South Africa.

P. G. MARAIS,
Minister of Manpower.

SCHEDULE

The Training Scheme for the Hospitality Industries, hereinafter referred to as "the Industry", has been established by—

the Federated Hotel, Liquor and Catering Association of South Africa (FEDHASA);

the Catering, Restaurant and Tearoom Association (CATRA);

the Associated Clubs of South Africa (ACSA); and

the South African Chefs' Association (SACA),

HOUSE OF ASSEMBLY

QUESTIONS

†Indicates translated version.

For written reply:

General Affairs:

Number of taxpayers

20. Mr K M ANDREW asked the Minister of Finance:

What was the (a) number of individual taxpayers in each income category, (b) tax assessed in each income category expressed as a percentage of total tax assessed, and (c) total amount of tax assessed in each income category, in respect of the 1988-89, 1989-90 and 1990-91 tax years, respectively?

B40E

The MINISTER OF FINANCE:

(a), (b) and (c) See attached schedule under cols. 233 and 234.

Capital gains/tax-free income

36. Mr G C ENGEL asked the Minister of Finance:

In respect of the latest specified tax year for which information is available, (a) what is the amount of capital gains recorded by (i) individual and (ii) corporate taxpayers and (b) what is the total amount of tax-free income or allowances, by category, granted by the Government?

B105E

The MINISTER OF FINANCE:

(a) (i) Individuals: The information is not available.

(ii) Corporate taxpayers: R1 770 171 694

(b) Tax-free Income: R11 259 500 187

Allowances granted in terms of the Income Tax Act, 1962:

Marketing allowance (section 11*bis*) R879 260 109

Economic Development (section 21*ter*) R31 169 927

Films (section 24F) R50 371 727

Sponsorships (section 18B) R16 249 117

Leasehold Improvements (section 11(g)) R40 177 484

Note:

(1) The allowances represent only those granted to companies and close corporations. Allowances granted to individuals, are not available.

(2) All the amounts (excluding the sponsorship allowance) relate to the 1990-tax year, and represent 55% of the total number of companies and close corporations, registered for tax purposes.

(3) The allowance in respect of sponsorships represents allowances approved during the 1989/90 financial year.

Total budgetary allocation: National Health

46. Mr M J ELLIS asked the Minister of National Health:

(1) What was the total budgetary allocation for health matters, including additional appropriations and amounts recovered from other Government Departments for agency work, for (a) each province, (b) each of the self-governing territories, (c) each of the own affairs administrations, (d) the South African Development Trust and (e) the Department of National Health and Population Development for the period 1 April 1990 to 31 March 1991;

(2) what are the estimated figures in each case for the period 1 April 1991 to 31 March 1992?

B87E

Continue — p 2351 6 D

ANALYSIS OF THE NUMBERS OF TAXPAYERS AND TAX ASSESSED IN INCOME GROUPS

Taxable Income Group R	TAX YEAR 1990 Number	TAX YEAR 1990 % Total	TAX YEAR 1990 Tax R'000	TAX YEAR 1990 % Total	TAX YEAR 1989 Number	TAX YEAR 1989 % Total	TAX YEAR 1989 Tax R'000	TAX YEAR 1989 % Total
LOSS	23 062	1,31	0	0,00	28 116	1,25	0	0,00
0 – 5 000	218 236	12,38	3 479	0,02	225 958	10,03	5 525	0,04
5 000 – 10 000	25 866	1,47	12 560	0,08	68 622	3,04	23 648	0,17
10 000 – 15 000	79 293	4,50	53 494	0,36	344 415	15,28	241 596	1,73
15 000 – 20 000	122 928	6,97	180 601	1,21	348 167	15,45	552 710	3,96
20 000 – 25 000	221 147	12,54	603 924	4,03	254 812	11,31	749 746	5,37
25 000 – 30 000	197 133	11,18	847 852	5,66	212 805	9,44	952 022	6,82
30 000 – 35 000	175 599	9,96	1 067 565	7,12	173 634	7,70	1 079 842	7,74
35 000 – 40 000	149 054	8,45	1 185 407	7,91	139 477	6,19	1 133 740	8,13
40 000 – 45 000	121 147	6,87	1 201 123	8,02	104 812	4,65	1 052 511	7,55
45 000 – 50 000	95 975	5,44	1 144 753	7,64	81 044	3,60	976 596	7,00
50 000 – 60 000	127 731	7,24	1 901 011	12,69	103 045	4,57	1 541 797	11,05
60 000 – 70 000	72 227	4,10	1 374 603	9,17	56 966	2,53	1 091 731	7,83
70 000 – 80 000	40 814	2,31	952 635	6,36	33 770	1,50	791 021	5,67
80 000 – 90 000	25 119	1,42	696 297	4,65	20 913	0,93	582 514	4,18
90 000 – 100 000	16 513	0,94	530 006	3,54	13 322	0,59	428 786	3,07
100 000 – 150 000	32 661	1,85	1 394 960	9,31	27 842	1,24	1 196 460	8,58
150 000 – 200 000	9 373	0,53	616 357	4,11	8 271	0,37	545 544	3,91
200 000 – 250 000	4 057	0,23	357 774	2,39	3 404	0,15	300 277	2,15
250 000 – 300 000	1 892	0,11	208 693	1,39	1 608	0,07	178 519	1,28
300 000 – 350 000	983	0,06	129 951	0,87	889	0,04	117 048	0,84
350 000 – 400 000	675	0,04	104 592	0,70	547	0,02	83 783	0,60
400 000 – 450 000	422	0,02	74 996	0,50	319	0,01	57 018	0,41
450 000 – 500 000	281	0,02	55 960	0,37	221	0,01	44 545	0,32
500 000 +	846	0,05	285 791	1,91	677	0,03	222 600	1,60
	763 034	**100,00**	**14 984 384**	**100,00**	**2 253 656**	**100,00**	**13 949 579**	**100,00**
	Data I.R.O. 83,34% of all registered taxpayers are reflected in this table				Data I.R.O. 94,02% of all registered taxpayers are reflected in this table			
	Statistics in respect of taxpayers of earning less than the applicable standard income tax on employees (SITE) limit are not available and therefore not reflected in these figures.							

Taxable Income Group R	TAX YEAR 1991 Number	TAX YEAR 1991 % Total	TAX YEAR 1991 Tax R'000	TAX YEAR 1991 % Total	Number
LOSS	9 921	1,19	0	0,00	23 062
0 – 5 000	92 214	11,08	1 263	0,01	218 236
5 000 – 10 000	5 608	0,67	4 657	0,05	25 866
10 000 – 15 000	18 401	2,21	13 362	0,14	79 293
15 000 – 20 000	31 241	3,75	42 539	0,45	122 928
20 000 – 25 000	41 162	4,94	86 305	0,90	221 147
25 000 – 30 000	43 617	5,24	141 377	1,48	197 133
30 000 – 35 000	42 198	5,07	203 099	2,13	175 599
35 000 – 40 000	49 358	5,93	326 613	3,42	149 054
40 000 – 45 000	82 170	9,87	697 792	7,31	121 147
45 000 – 50 000	82 964	9,97	855 544	8,97	95 975
50 000 – 60 000	127 081	15,27	1 665 726	17,46	127 731
60 000 – 70 000	78 912	9,48	1 349 629	14,15	72 227
70 000 – 80 000	47 133	5,66	1 001 993	10,50	40 814
80 000 – 90 000	27 122	3,26	693 092	7,26	25 119
90 000 – 100 000	16 210	1,95	483 267	5,07	16 513
100 000 – 150 000	27 157	3,26	1 077 181	11,29	32 661
150 000 – 200 000	5 570	0,67	345 735	3,62	9 373
200 000 – 250 000	2 054	0,25	171 915	1,80	4 057
250 000 – 300 000	932	0,11	97 861	1,03	1 892
300 000 – 350 000	495	0,06	61 799	0,65	983
350 000 – 400 000	290	0,03	42 725	0,45	675
400 000 – 450 000	181	0,02	30 185	0,32	422
450 000 – 500 000	104	0,01	19 854	0,21	281
500 000 +	403	0,05	127 071	1,33	846
	832 498	**100,00**	**9 540 584**	**100,00**	**1 763 034**
	Data I.R.O. 53,61% of all registered taxpayers are reflected in this table				Data I.R.O.
	Statistics in respect of taxpayers of earning less than the applicable standard income tax on employees (SITE) limit are not available and therefore not reflected in these figures.				

The MINISTER OF NATIONAL HEALTH:

	R'000	R'000
(1) (a) Provincial administrations:		
Provincial Administration of the Orange Free State		
Provincial Administration	473 576	
Additional Allocation	53 418	
Department of National Health and Population Development	16 585	
Administration: House of Assembly	27 030	
Department of Education and Training	550	
Department of Development Aid	18 933	
Total		590 092
Provincial Administration of Natal		
Provincial Administration	972 167	
Administration: House of Assembly	48 854	
South African Development Trust Areas	54 294	
Department of National Health and Population Development	17 892	
Total		1 093 207
Provincial Administration of Transvaal		
Provincial Administration	2 295 022	
Administration: House of Assembly	198 611	
Department of National Health and Population Development	50 000	
Department of Development Aid	11 348	
Total		2 554 981
Provincial Administration of the Cape of Good Hope		
Provincial Administration	1 953 300	
Administration: House of Assembly	71 767	
South African Development Trust Areas	2 331	
Department of National Health and Population Development	42 024	
Total		2 069 422
(b) Self-governing territories:		
KaNgwane		61 513
GaZankulu		104 667
KwaZulu		436 898
QwaQwa		60 865
Lebowa		156 458
KwaNdebele		9 407,
(c) Own affairs administrations:		
Administration: House of Representatives		107 814
Administration: House of Delegates		36 454
Administration: House of Assembly		534 072,
(d) South African Development Trust Areas		91 399
		and
(e) Department of National Health and Population Development		486 895;

(2) (a) Provincial administrations:

Provincial Administration of the Orange Free State		
Provincial Administration	552 879	
Additional Allocation	38 320	
Department of National Health and Population Development	18 450	
Administration: House of Assembly	29 230	
Department of Education and Training	1 105	
Department of Development Aid	19 362	
Total		659 346

	R'000	R'000
Provincial Administration of Natal		
Provincial Administration	1 082 214	
Administration: House of Assembly	54 427	
South African Development Trust Areas	59 721	
Department of National Health and Population Development	21 805	
Total		1 218 167
Provincial Administration of Transvaal		
Provincial Administration	2 506 997	
Administration: House of Assembly	254 312	
Department of National Health and Population Development	54 000	
Department of Development Aid	14 599	
Total		2 829 908
Provincial Administration of the Cape of Good Hope		
Provincial Administration	2 135 189	
Administration: House of Assembly	71 545	
South African Development Trust Areas	4 128	
Department of National Health and Population Development	44 000	
Total		2 254 862
(b) Self-governing territories:		
KaNgwane		79 142
GaZankulu		137 003
KwaZulu		504 000
QwaQwa		71 585
Lebowa		206 005
KwaNdebele		17 831
(c) Own affairs administrations:		
Administration: House of Representatives		169 851
Administration: House of Delegates		41 553
Administration: House of Assembly		623 630
(d) South African Development Trust Areas		115 570
(e) Department of National Health and Population Development		693 268

Hospitals: total amount allocated

57. Mr M J ELLIS asked the Minister of National Health:

(1) What total amount, inclusive of the original amount and all additional allocations, did the responsible province allocate to the (a) Groote Schuur Hospital and its satellites, (b) Tygerberg Hospital, (c) Universitas Hospital, (d) Witwatersrand hospital complex, (e) H F Verwoerd Hospital, (f) academic hospital falling under Medunsa and (g) King Edward VIII Hospital for the period 1 April 1990 to 31 March 1991;

(2) what are the estimated figures for the period 1 April 1991 to 31 March 1992;

(3) how many authorised so-called academic beds are available to each of the universities associated with the above hospitals?

B145E

The MINISTER OF NATIONAL HEALTH:

(1) *Provincial Administration of the Cape of Good Hope*

(a) R359 192 076,

(b) R319 409 501,

Provincial Administration of the Orange Free State

(c) the information regarding the Universitas Hospital cannot be given separately from the National Hospital because these two hospitals are seen as a unit.

The total amount allocated to the two hospitals for the period 1 April

Continued

SADF: suicide attempts/suicides

68. Lt-Gen R H D ROGERS asked the Minister of Defence:

How many (a) members of the Permanent Force, (b) national servicemen and (c) members of the Citizen Force/Commandos (i) attempted to commit and (ii) committed suicide in 1990 and 1991, respectively?

B158E

The Minister of Defence:

1990

	(a)	(b)	(c)
(i)	40	163	3
(ii)	7	20	2

1991

	(a)	(b)	(c)
(i)	43	129	18
(ii)	10	5	4

Black townships: actions of troops

69. Lt-Gen R H D ROGERS asked the Minister of Defence:

(1) Whether any official complaints were lodged with the South African Defence Force in 1991 regarding the actions of troops in any Black townships; if so, (a) how many, (b) on what dates and (c) what was the nature of the complaints in each case;

(2) whether these complaints have been investigated; if not, why not; if so, what were the findings in each case;

(3) whether any action has been taken as a result; if not, why not; if so, what action?

B159E

The MINISTER OF DEFENCE:

(1) Yes.

(a) 24.

(2) and (3) Yes.

(b)	(c)	
18 Jan 91	Alleged assault.	Member tried in civilian court. Found not guilty.
20 Jan 91	Alleged assault.	Plaintiff instituted claim of R500.
12 Feb 91	Alleged assault	Case investigated and withdrawn due to a lack of evidence.
7 Mar 91	Seven members charged with murder and attempted murder.	Case postponed until 26 Mar 92.
1 May 91	Two members charged with murder and assault.	Member tried in civilian court. Found not guilty.
1 May 91	Shooting incident. Civilian wounded in the foot.	Member tried in civilian court and found guilty.
4 May 91	Three members charged with attempted murder.	Case postponed until Mar 92.
4 May 91	Shooting incident. One civilian kiled and one wounded.	Trial date has not been determined as yet.
5 May 91	Alleged assault.	Lebowa Police investigated the case. No prosecution.
24 May 91	Three members charged with attempted murder at Hazyview.	SA Police still investigating the case.
24 May 91	Three members charged with attempted murder at Marite.	SA Police still investigating the case.
21 Jun 91	Alleged disturbance of the peace.	Case investigated by Lebowa Police. Plaintiff withdrew the charge.
5 Jul 91	Alleged assault.	Lebowa Police investigated the case. No prosecution.
14 Jul 91	Alleged rape and pointing of a firearm.	Member tried by civilian court and found not guilty on both charges.
19 Jul 91	Injury sustained after tearsmoke had been fired.	Plaintiff instituted a claim of R5 000. Claim is still receiving attention.
20 Aug 91	Seven members charged with 18 cases of assault.	Case tried by civilian court and postponed until 23 Jul 92.
25 Aug 91	Three members charged with alleged robbery, pointing of a firearm and theft.	Members tried by civilian court and found not guilty.
25 Aug 91	Civilian allegedly wounded.	Lebowa Police investigated and found that the person was not shot by a member of the SADF.
25 Sep 91	Alleged assault.	Members tried in civilian court and found guilty.
12 Oct 91	Complaints received that members searching a hostel, broke doors, windows and lockers. Charges of theft, assault and general vandalism were also made.	Matter investigated. Complaints found to be groundless.
14 Oct 91	Alleged assault.	Lack of evidence. Charges dismissed in court due to lack of evidence.
20 Oct 91	Shooting incident. Civilian wounded.	SA Police investigated case and referred it to the Attorney-General for decision.
29 Oct 91	Alleged murder.	Case dismissed in court due to lack of evidence.
15 Nov 91	Alleged assault.	Plaintiff withdrew the charge.

HOUSE OF ASSEMBLY

Own Affairs:

Budget for health services: amounts spent

17. Mr M J ELLIS asked the Minister of Health Services and Welfare:

(1) What amount of her Department's budget for health services and welfare was spent by (a) her Department itself and (b) other Government Departments as agents for her Department for the period 1 April 1990 to 31 March 1991;

(2) what are the estimated figures for the period 1 April 1991 to 31 March 1992?

B85E

The MINISTER OF HEALTH SERVICES AND WELFARE:

Vote 8: Health Services

(1) (a) R172 020 047

(b) R362 051 509

(2) (a) R204 683 000

(b) R418 947 000

(In respect of Vote 7: Welfare, the Department does not make use of the services of agents.)

White pupils: African languages

24. Mr K M ANDREW asked the Minister of Education and Culture:

(a) How many White pupils at Government schools (i) wrote and (ii) passed the Standard

continued

February 1992

Are our medical aids racist?

ST Times (CM) 23/2/92 (299)

AMONG the many complaints about medical aid costs these days is one that some readers of this column find hard to stomach.

Why, they ask, do "whites" pay higher subscriptions in most medical aid schemes, even though they earn the same salaries?

That question was posed this week by Mr Howard Bloch of Johannesburg, though he is by no means the only reader who wants an answer.

"I work with a black executive who earns more than I do. But he pays half my medical aid contribution," said Mr Bloch, who sent me the Commercial and Industrial Medical Aid's rate card to prove his point.

According to the rate card, the medical aid fee for a white or Asian member with two dependants earning more than R2 000 a month is R610 a month.

Coloured members in exactly the same circumstances pay R404 and black members R305.

But this discrimination works in two ways. I have colleagues who claim they are being discriminated against — or at the very least patronised — because they pay less than white or Asian members.

Why this discrimination, I asked Mr Rob Speedie, executive director of the Representative Association of Medical Schemes (RAMS)?

"Because it's justified," he told me. "The cost of claims from coloured and black people is significantly lower.

"Where they live, they often don't have access to specialists, and they can't get off work as easily to pop off to the doctor.

"Medical aid schemes are setting rates which mirror claims patterns — and these tend to work out along racial lines."

However, he admitted that differences in claims patterns were becoming less marked.

Mr Keith Hollis, managing director of a company that administers many medical aid schemes, confirmed the claims differentials.

"For every R100 a white or Asian member claims, coloured members will claim R70, and black members R50 to R60," he said.

"Any medical aid scheme that charged the same for all members would be ripping black members off."

The Registrar of Medical Schemes, Mr Ellis Langeveldt, said he believed subscriptions based on race would gradually disappear.

"Differentiation will come on claims experience — some medical schemes are already doing this," he said.

"Age could become a factor, for instance. These days, particularly with subscriptions becoming more expensive, young people are beginning to resent having to subsidise the elderly — which older people did happily when they were young."

I'm of Welsh descent — I wonder if my medical aid will investigate whether we Celts claim less than, say, those with Italian ancestry.

KHOUSES

Live-in law

COUPLES who live together have been advised to have a contract and will drawn up to regulate financial and other aspects of their relationship.

The latest edition of the legal magazine, De Rebus, recommended that additions be made to specific eas of the law, as it no significant recog- protection for

Policy to cover medical costs of accident victims

299
ST Times (CM) 23/2/92

A NEW insurance package covering all medical costs incurred by motor accident victims is to be launched by Host Policlinics and IGI.

This was announced by the managing director of Host Policlinics, Dr Jaap Huisamen, at the sod-turning ceremony for a 60-bed private hospital with 24-hour casualty and trauma facilities at NI City in Goodwood.

NL City Policlinic represents an initial investment of more than R26 million and is being financed by Syfrets in its first entry into the health-care sector.

The hospital expects to be ready to admit its first patients in January.

Dr Huisamen pointed out that medical aid funds generally provide no cover or only limited cover for victims of motor accidents.

"Motor accident victims are expected to seek assistance from the MVA Fund, which is financed through a levy on petrol.

"As we are all aware, this fund is now the subject of a commission of inquiry following allegations of fraud, bungling and reports that it is effectively bankrupt.

"These circumstances have meant that most accident victims are taken directly to state hospitals for treatment.

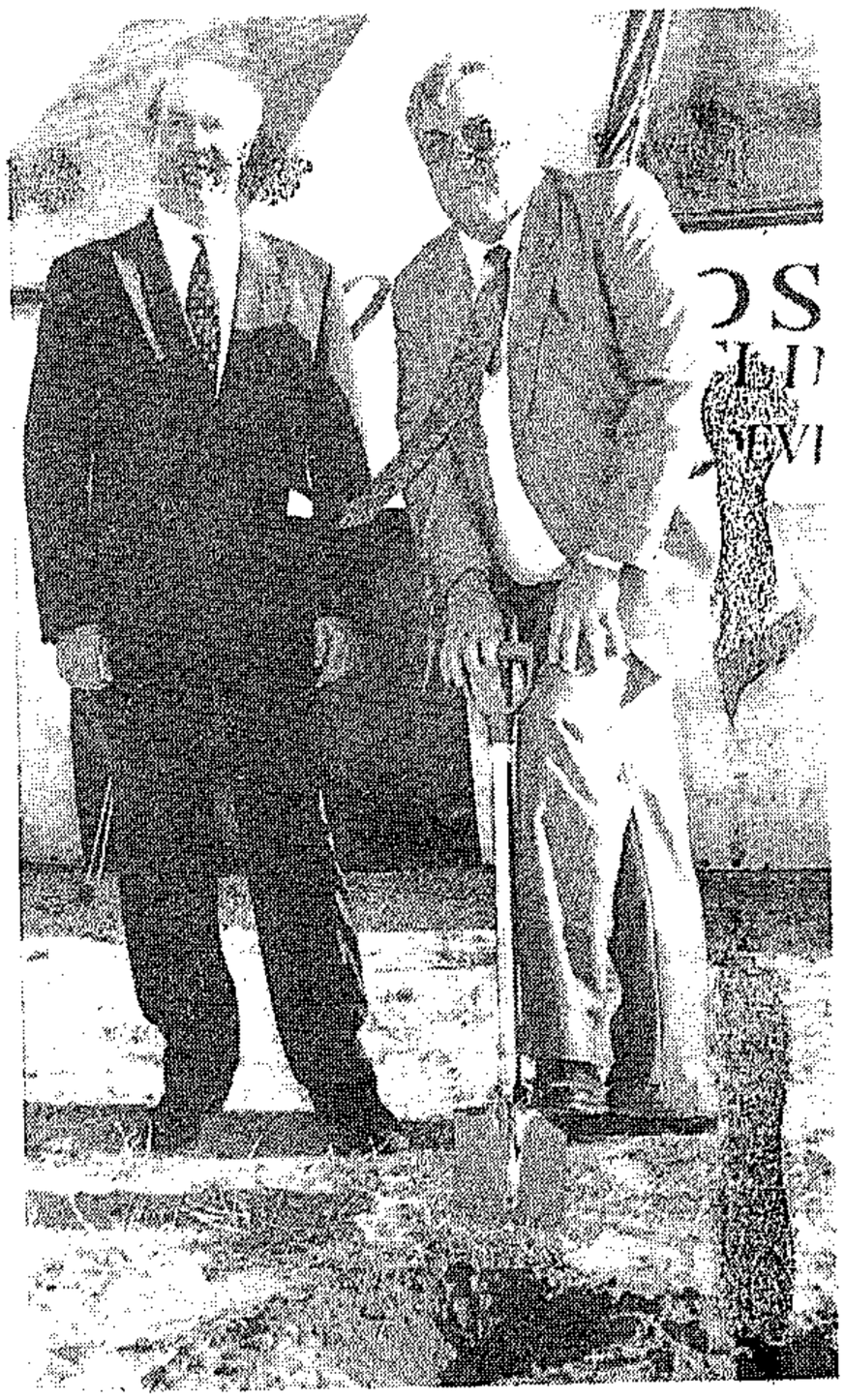
"It is noteworthy that about 25 percent of all beds in state-run hospitals in the Cape are occupied by motor accident cases."

Studies indicated that less than 10 percent of the total costs incurred — expected to be about R325 million this year — were likely to be recovered by the state.

"In an effort to address these shortcomings, Host Policlinics, together with major insurance group IGI, has designed a special new insurance policy called Accimed to cover all medical costs incurred by motor accident victims," said Dr Huisamen.

"Accimed is a comprehensive insurance package which will immediately indemnify all policyholders against all medical expenses arising from their involvement in a motor accident anywhere in the world.

"It should therefore provide an inducement to private hospitals to establish full-time casualty and emergency treatment services."



NEW HOSPITAL ... Mr Dawie le Roux (right), MEC responsible for the Department of Hospital Services in the Cape Provincial Administration, turns the sod to mark the start of building operations at a R26 million 60-bed private hospital with 24-hour casualty and trauma facilities at NI City in Goodwood. With him is Dr Jaap Huisamen, managing director of Host Policlinics, responsible for the development of NI City Policlinic.

Forum boycott

HEALTH organisations yesterday repeated their resolve not to attend Health Minister Rina Venter's forum on costs of medecines. The ANC health department and the National Health Unity Forum objected to the lack of consultation and the narrow focus of the agenda. Venter has said previously the forum was to one of a series.

B10 Sun 27/12/92

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Medical bodies shun health summit

'Venter ignoring our proposals'

STAR 28/2/92 (55) (299)

By Helen Grange
Pretoria Bureau

Several medical bodies have publicly distanced themselves from today's Department of Health summit addressing the high cost of medicine.

Their absence is expected to seriously undermine the Government's efforts to gain unity in a bitterly divided medical fraternity.

The ANC's department of health, the National Health Unity Forum (NHUF) and the Dispensing Family Practitioners Association have refused to attend on the grounds that the topic is too narrow and that the State unilaterally convened the forum and set the agenda.

The NHUF is an umbrella body for the National Medical and Dental Association, the National Progressive Primary Health Care Network, the Organisation for Appropriate Social Services in SA, the Health Workers Society and the SA Health Workers Congress.

The ANC and NHUF, in a joint statement this week, said National Health Minister Dr Rina Venter "appears consistently to ignore definitive proposals made by ourselves regarding the future health dispensation of our country".

In addition, the statement said, the agenda for the forum had been predetermined by the State, with an inadequately narrow focus.

The venue, date and participants had also been determined solely by the State.

Any restructuring in the health care system needed the necessary approval of Codesa, and the notion of a "piecemeal approach" to solving the health crisis was therefore rejected.

"To this end, we propose a meeting between all the key players to jointly determine the terms of reference for an envisaged forum addressing the crisis," the statement said.

The Dispensing Family Practitioners Association criticised the forum for not addressing the issue of a health care system, saying the cost of medicine was only one aspect of the whole question.

Valuable time was being wasted by not addressing the other aspects.

Despite the refusal by these organisations to attend, there has been an overwhelming response by individuals and other medical bodies to the forum, a Department of Health spokesman said.

The Pharmaceutical Association would attend the forum, but would express serious reservations about its structure and purpose, a spokesman said.

"The most important question of medicine cost-effectiveness doesn't appear on the agenda, and we believe that apart from being unrepresentative, it will be a waste of time. We will however be there to put our views across," the spokesman said.

Topics to be discussed today include:

- A maximum medical aid price for certain drugs.
- A part payment/levy by a member of a medical aid scheme on medicine purchases.
- Pharmacists being given greater professional discretion in prescribing palliative drugs for self-limiting illnesses, such as flu.

endowed with magical powers, he is pursued by his spirit friends, who are reluctant to let

For a time he lived very sim
ply, sleeping where he could an
continuing to write poetry, shor

Autistic child barred from special school

AN autistic child from Blue Downs in the Cape has been barred from one of the city's only two schools for autistic children because of his race.

The condition of autism occurs in about one in every 10 000 births.

Kirk Stevens, 2, was identified as suffering from autistic features last week by the Red Cross Children's Hospital developmental clinic, his father, Andrew Stevens, said this week.

On medical advice, Stevens immediately inquired about the chances of having his son enrolled at Rondebosch East's Vera School for Autistic Children.

"But I was stone-walled because my son is coloured," he said.

Stevens said he and his wife, Stacey, were relieved that they had finally established Kirk's condition, but were disgusted at their son's exclusion from Vera.

His son was enrolled at Cape Town's other special school, the Alpha School for Autistic Children in Retreat, on Monday.

Stevens said he wanted to send his son to Vera even if it meant extra money, because it was more convenient travelling to Rondebosch than Retreat. Also, the facilities were better.

Chairman of Vera's governing body Patrick Normand said the school was governed by rules.

Vera principal Dr Marinus van Rooyen said a meeting would be held on Wednesday between the governing body and the Department of Education and Culture and the subject of an open school would be discussed.

Red Cross Children's Hospital medical superindendent Dr Rodney Marshall said the hospital was opposed to all forms of discrimination, but the "crush" on medical services meant children had to be referred to any school available. – Sapa

Call to deregulate the health sector

B Day 2/3/92

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KATHRYN STRACHAN

PROPOSED amendments to the Medical Schemes Bill would go a long way towards containing the soaring cost of medicines, National Health Department director-general Coen Slabber said at the weekend.

Addressing a forum convened by National Health Minister Rina Venter to discuss the cost of medicines in the private sector, Slabber said there was considerable support for deregulation in the health sector.

Representative Association of Medical Aid Schemes executive-director Rob Speedie said the expenditure of medical schemes had increased by 34% last year, and that the only way to contain these costs was to allow more deregulation.

Deregulation is seen as the answer to escalating costs in health care as it promises to give medical schemes greater flexibility to negotiate packages with doctors, pharmacists and clients and to tailor programmes.

The Bill aims to do away with fixed fees and amend the scale of benefits and maximum and minimum benefits payable as these are seen as contrary to free market principles.

Slabber said the forum had also accepted that pharmacists, despite being the most accessible health care practicioners, were the most underutilised and that they could provide a lot more in terms of primary health care. It was agreed they should be given more authority in terms of diagnosing and dispensing medicines.

The main discussion at the forum centred around granting pharmacists greater professional discretion by allowing them to supply schedule three and four drugs without prescriptions. Pharmacists can supply only unscheduled and schedule one and two ng dispensers greater freedom to sell cheaper generic drugs in place of brand name equivalents was also agreed on.

Another issue discussed was introducing single exit prices on sales by pharmaceutical manufacturers. Single exit prices would restrain manufacturers from giving certain medicine suppliers an unfair advantage by preventing them from offering medicines to suppliers at different prices. At the moment some dispensing doctors can obtain medicines more cheaply than pharmacists.

Venter proposed removing restrictions on parallel importing. Current legislation prevented importation of medicines manufactured in SA. Anomalies existed where, for example, SA-manufactured medicines are available more cheaply in Gaborone than in SA.

Slabber said it was unfortunate that left wing health organisations had elected not to attend as they would have made a positive contribution, but admitted the Department were on a "learning curve" in dealing with consultation. It is expected there will be more "talks about talks".

Medical Association of SA secretary-general Hendrik Hanekom said that if the department wanted to affect change it needed the support of all parties involved. He said the department needed to take greater care in the process of arranging such forums to ensure all groups were represented.

Slabber said proposals to reduce the high cost of medicines would be circulated to all groups concerned for consensus, including those which stayed away from the forum.

The recommendations would then be put to Venter and discussed at a meeting in October. Then the recommendations could be incorporated into a National Medicines Policy.

'Education will remain segregated'

By Carina le Grange

For the next 50 years, most children in South Africa would continue to be educated on a racially segregated basis due to the fact that they lived in segregated areas, educationist Dr Franz Auerbach said in Pretoria yesterday.

Dr Auerbach said one of the ways in which the education process could promote mutual respect and tolerance would be integration at school level.
whether the education system could teach children to live meaningfully.

He was one of the speakers on the first day of the national conference of the National Council for Mental Health.

The aim of the conference is to prepare a strategy for the formulation of a child mental health policy to be presented to Minister of National Health and Population Development Dr Rina Venter.

But Melvyn Freeman of the Centre for Health Policy at the University of the Witwatersrand questioned whether it was appropriate to present Dr Venter with the strategy "as if she should restructure (child mental) policy at this time".

"We must think of where we want to be going with a representative strategy — not only to this constituency (the conference) but also to a wider one.

"It is not enough to have representatives from (progressive) organisations like the National Education Co-ordinating Committee and the Organisation for Appropriate Social Sciences to say that this is a representative meeting," Mr Freeman said.

Earlier, he had said it was not necessary to be too pessimistic on the outlook for child mental health, since SA would get a new government that would care for people's needs.

He said the best way to improve mental health was to effect changes in educational, political and economic structures.

Franz Auerbach . . . need to promote mutual respect.

HEALTH CARE (299)

Cutting drug prices

Health Minister Rina Venter has been accused of offering only piecemeal solutions to health-care problems. But her latest proposals to contain medicine costs in the private sector — largely by deregulating the pharmaceutical industry — have elicited a surprising degree of consensus among key players in health care.

Even her staunchest critic, the Medical Association of SA, was satisfied that the proposals taken at last week's forum "were arrived at in a responsible manner." But it has expressed serious reservations about Venter's lack of an overall action plan and the absence of some interest groups.

Likewise, the Pharmaceutical Manufacturers' Association, which before the forum suggested the conference would be nothing more than an "ad hoc fix," stayed for the discussions. = FM 6/3/92

Venter's latest proposals come after her recent recommendations to deregulate the Medical Schemes Act. If implemented, they would allow schemes to provide health-care services, employing doctors, nurses and practitioners. It is believed such a move would cut health-care costs by as much as 40% and end

doctors' absolute discretion in providing health care. Not surprisingly, many of her recommendations were not well received by doctors.

The reforms she proposed to the pharmaceutical industry are just as far-reaching. Based largely on the findings of the Browne Report, published in 1986, Venter's recommendations to curb medicine costs include the greater use of generic substitutes, maximum medical aid pricing, patient responsibility for part-payment of medicines, greater pharmacist-initiated therapy and parallel imports of certain medicines.

There is no doubt that Venter is delaying proposing a new national health-care policy, at least until October. In his opening address at the forum, Health Director-General Coen Slabber stressed that the department was dividing the problem into smaller units, to be managed at individual forums.

But the cost of medicine in the private sector warrants urgent attention. Slabber says medicine prices are high compared with the main Western countries. "It is distressing that pharmaceutical expenditures are decreasing as a percentage of all health expenditures in developed countries. This is not the case in SA," he adds.

There was general consensus at the forum that substituting medicines with generic equivalents is an option to curtail costs.

While participants stress that the responsibility for substitution rests with the practitioner, pharmacist and patient, no consensus was reached on whether the doctor would have the final say in allowing substitution.

A proposal is that the Medical Council should list medicines that cannot be substituted. The pharmaceutical association suggests cost-effectiveness rather than the price of a medicine should be considered when making the decision to use a substitute. For example, it suggests a brand or patent medicine could keep you out of hospital whereas a cheaper generic might only ease symptoms.

No agreement could be reached on a system of "maximum medical aid pricing" which would see medical schemes limit the amount they would pay for certain substances. Delegates concurred that Venter's proposed amendments to the Medical Schemes Act would resolve this issue.

Consensus was reached on the concept of a single exit price based on the volume purchased, but it was agreed that such a policy would be difficult to police.

This recommendation is geared primarily towards pharmaceutical companies that give massive discounts to doctors who buy only small quantities of drugs, compared with the far higher prices paid by retail and wholesale chemists for larger quantities. The Competition Board says this practice encourages doctors to push certain brands solely for their own gain.

The forum rejected Venter's proposal that pharmacists should be remunerated by way of a professional fee and supply medicines to the public at cost. Here it was felt that advertising would keep down prices.

The Pharmacy Council recently allowed pharmacists to charge a "reasonable fee" while the Pharmaceutical Society of SA (the professional body) set this amount at a maximum of R7,62 per item plus an additional amount to recover costs (rent, salaries).

The belief in the sector is that people will shop around for the best prices. Representative Association of Medical Schemes CE Rob Speedie, however, questions whether this will in fact happen. He suggests it is difficult to shop around for medicines.

Venter's proposal to give pharmacists more opportunities to initiate therapy was also accepted. But it was decided that medical schemes should be free to choose whether to allow such claims as part of their scale of benefits to members.

The forum decided that rescheduling medicines should not be the way to grant pharmacists greater professional discretion, but access to certain schedule three and four medicines should be allowed under stipulated conditions.

The forum was willing to consider the parallel import of certain medicines provided costs could be lowered and passed on to consumers. The need for strict quality control was stressed in view of the increasing incidence of counterfeit medicines.

Speedie emphasises that more work needs to be done on the Pharmaceutical Act: "It is meaningless to free medical schemes without allowing pharmacists to work with people other than pharmacists. You cannot have fully fledged health maintenance organisations while schemes cannot employ pharmacists. Until then, pharmacists will hold a monopoly over medicine prices." ■

FOCUS: *Women needn't pay for the pill. Is the news as good as it sounds?*

The pill for the people

W/mail 6/3-12/3/92. (299)

CRITICAL CONSUMER

Pat Sidley's weekly advice on what to buy ... and what to avoid

FROM April 1 women will be able to bypass doctors and get their contraceptive pills directly from pharmacists — and paid for by the state.

This new policy represents the Department of National Health and Population's drive to bring primary health care to the majority of South Africans — although some will interpret it as a move by the department to stop people having babies. It will also be seen to be a hasty decision made before other more crucial primary health care needs have been addressed — and before the department has considered possible repercussions raised by its current move.

Thousands of women will no doubt be cheering at the prospect of not having to cough up anywhere between R30 and R130 for a visit to a doctor plus the cost of the pill. Admittedly, the department's decision is not primarily intended for those women who can afford to visit private doctors regularly.

There are several conditions attached to pharmacists dispensing the pill and initiating the treatment without a doctor having been consulted. They have to attend a course in family planning run by the department and pass an exam, before they will be licensed to give out the pill. They will be required to take a medical history from each woman who wants contraception. And they will have to find out, among other things, whether there is a family history of breast or other cancers, blood clotting, migrains, heart attacks — and if the consumer smokes.

Pharmacists will take blood pressure, but any other tests will have to be referred to doctors or clinics. A consumer will have to be able to prove to the pharmacist that she has had an annual check-up, including a pap-smear.

The state no longer takes free pap-smears — a blow to women who will now be encouraged to stop having babies because they no longer have to pay for the pill, but not to look for signs of cervical cancer which is easily cured.

Pharmacists who engage in this new system will act as agents of the Department of National Health and Population Development and will be offering a service to the community similar to that performed by the department's family planning clinics.

Information taken from consumers will have to be recorded and kept up to date — and confidential. Pharmacists will have to consider the fact that women will not want to discuss their medical history at the counter of a pharmacy. The pharmacist will either dispense the pill — supplied by the Department of Health — or suggest some other method of contraception if the pill is thought to be unsuitable.

Pharmacists may not charge for pills supplied by the department, but may charge a professional fee for the service, as laid down by the Pharmacy Council.

There appears to be nothing stopping pharmacists from collecting pills from the department and then selling them.

According to the pharmacists approached, there is no clarity on whether they will be able to dispense — and charge for — the pill from their own stocks to consumers who do not have a prescription.

Some say they will sell their own stock without prescription. One pharmacist bluntly told this Critical Consumer that he did not see why he should have to take a medical history and give away the pill to women who could afford to pay. And he questioned why he should not sell his own stock to those without prescriptions and who could afford to pay.

Pharmacists were uncertain whether they could dispense the controversial contraceptive drug, Depo Provera, without prescription. Depo Provera is usually given in injection form and lasts for several months, but has several serious side-effects. This drug is used in the Third World for women who may not be able to take the pill for a variety of reasons, for example, they live in rural areas far from pharmacists and hospitals or they are forgetful.

The policy is also not clear on who is responsible if the consumer becomes ill after taking the pill? Will the consumer will be able to sue the pharmacist as she might have done her doctor had he or she prescribed it?

The new system is open to abuse. Some pharmacists may be tempted to complete the course, pass the exam and become registered to dispense the pill. They could then refuse to take on the state's consumers and make money out of women they deem able to afford a professional fee and the cost of non-government stock. In the family planning clinics, the option on being charged and ripped off does not arise.

This Critical Consumer and the Consumer's Association in Britain did a similar study on pharmacists seeking more professional discretion and greater professional fee-charging ability. We found that far too many pharmacists behaved like salesmen, selling the most profitable remedy at the physical and health expense of the consumer.

Your money must work even harder this year

WITH salary increases likely to lag inflation significantly, employees will have to make their 1992 income work harder than ever before. STAR 7/3/92

Martin McAusland, personal financial planning manager at Price Waterhouse Meyernel, advises all earners to carefully plan their expenditure and investments as most will be living on less money (in real terms) than in 1991.

"Fringe benefits are much the same as cash income now, so people have to look at other areas of maximising the performance of earnings before and after taxation.

"Companies should assist in this process by appointing compensation committees to ensure that staff are being remunerated as tax-effectively as possible," he says.

Mr McAusland says individuals should make full use of their subsistence and entertainment allowances, make sure car allowances are raised, split income that is earned outside SA, and take full advantage of retirement annuity and tax-free interest limits.

"Salary-earners and employers should consider dropping traditional medical aid schemes in favour of a combination of catastrophe cover and medical savings schemes.

"This alternative will become popular as it allows people to provide for their own needs instead of just being a member of a large centralised premium and payout mechanism," he adds.

Mr McAusland advises anyone depositing money to ensure that the institution being paid complies with the recently introduced Deposit Taking Institutions Act.

On a brighter note, Mr McAusland is confident that interest rates will fall by up to 2 percent during the year, bringing relief for consumers on mortgages, leases, credit cards and instalment credit agreements.

Dying man in payout wrangle

A DYING man says he will picket the East London offices of an insurance company which is fighting a court order to pay out the money he needs to stay alive.

"I don't care what Southern Life does," said Mr Roy Johnson, who has suffered since mid-1990 from a rare and deadly genetic disorder.

"I've got nothing to lose. I'll take a placard down there and hold a one-man demo outside their front door. Maybe that won't go down too well," said the former businessman whose health is rapidly deteriorating. ST Times 15/3/92

Kill

"I'm feeling terrible. My lungs are giving me a hard time, but that's only to be expected."

"It's like breathing fire, a burning sensation which never goes," he said. The disease — alpha-one antitrypsin deficiency — will eventually kill him.

Southern Life was ordered to pay out R105 000 plus interest, but it is withholding payment pending the outcome of an appeal. Without the money, Mr Johnson cannot afford life-preserving medication which must be imported from France.

He has also been deprived of monthly disability payments of R3 000 from another insurance giant, Liberty Life, which has cancelled several life policies as well.

By BILL KRIGE

Without supplies of the French drug, Mr Johnson will die — perhaps before the appeal by Southern Life against a judgment in his favour is heard later this year.

His last injection was a month ago and, despite Southern Life's declared intention to find ways to help him meet his medical costs, no money has been forthcoming. 299

The executive director of Southern Life, Mr Chris Liddle, said the company had an obligation to its policy holders to see the court appeal through to the end.

"While we have a case for not paying the lump sum, we are willing to try to assist Mr Johnson in this real-life drama, in terms of medication," he said.

An offer to help with Mr Johnson's medical costs (a three-month supply of the drug costs R28 000, of which his medical aid paid R20 000) still stood.

Payout

He said the delays were the fault of lawyers, not the company.

Liberty Life, which paid R200 000 to Mr Johnson before cancelling the rest of his policies, including a R3 000 monthly disability payout, could not discuss Mr Johnson's case until after the appeal, said public affairs divisional manager Sven Forssman.

prisoners are not tolerated either and offenders are dealt with severely.

(b) (i) and (ii)
63 Members were charged in public courts due to complaints of assault on prisoners. Of these, 39 members were found not guilty whilst 24 members were found guilty.

(2) (a) 200 Members stood trial in terms of Prisons Regulation 71(1)(hh) read together with Section 53 of the Correctional Services Act, 1959 (Act 8 of 1959) on counts of assault on prisoners. Of these, 144 members were found not guilty whilst 56 members were found guilty and were sentenced in terms of Section 53(2) of the Correctional Services Act.

In respect of 889 complaints, no substance could be found after thorough investigation to lay charges against any member of the Department. Furthermore, the Attorney-General refused to prosecute in 153 cases. On 31 December 1991, the remaining cases were still being dealt with.

(b) Inquiries in terms of the stipulations of Prisons Regulation 77(1) to determine the suitability of members to remain in service, inter alia led to the dismissal of one member against whom an offence of assault on a prisoner was recorded.

(c) Besides sentences imposed in terms of Section 53 of the Correctional Services Act, 1959 (Act 8 of 1959) during departmental trials, members were seriously warned against such actions and were made aware of the implications thereof on their careers. Furthermore, such inadmissible conduct is duly considered in the competence evaluation of such members.

Insulin: representations

107. Mr M J ELLIS asked the Minister of National Health:

(1) Whether she has received any representations from individuals and/or organizations with regard to the high cost of insulin required for the treatment of diabetes; if so, (a) from whom or what organizations and (b) what was the nature of these representations;

(2) Whether she has been notified of any medical aid schemes that do not cover the cost of insulin required for such purposes; if so,

(3) whether she will furnish the names of these medical aid schemes; if not, why not; if so, what are their names;

(4) whether she intends taking any steps to make insulin more freely available to diabetics; if not, why not; if so, (a) what steps and (b) when;

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

B267E

The MINISTER OF NATIONAL HEALTH:

(1) Yes,

(a) four members of the public and the South African Diabetic Association, and

(b) the excessive increase in the price of insulin and requests that

(i) diabetics without a medical aid scheme may purchase the medicine at cost price at the provincial hospitals;

(ii) diabetics with a medical aid scheme who exceed the maximum may purchase the medicine at cost price at the provincial hospitals;

(iii) price control on medicine be instituted;

(iv) a maximum limit on life-saving medicine be instituted; and

(v) insulin be exempted from value added tax;

(2) no;

(3) falls away;

(4) no, insulin is but one of a variety of life-saving medicines and to exclude insulin at this stage is not appropriate. There was, however, a forum on the high cost of medicine on 28 February 1992. It is expected that steps which flow from the forum will address this type of problems;

(a) and (b) fall away;

(5) no.

Prison warders: killed/injured

111. Mr D J DALLING asked the Minister of Correctional Services:

(1) Whether any prison warders were (a) killed and (b) seriously injured by prisoners in 1991; if so, (i) how many and (ii) in which prisons;

(2) whether any prisoners were (a) killed and (b) seriously injured by fellow prisoners in that year; if so, (i) how many and (ii) in which prisons?

B275E

The MINISTER OF CORRECTIONAL SERVICES:

(1) (a) No.

(i) No member of the Department of Correctional Services was killed by prisoners during 1991.

(b) Yes.

(i) and (ii)

Fifteen (15) members of the Department of Correctional Services were seriously injured by prisoners during 1991 at the prisons mentioned below and a further twenty five (25) members received medical treatment, consultations for minor injuries sustained as a result of assaults by prisoners:

Barberton
Beaufort West
Brandvlei
Durban
Groenpunt
Losperfontein
Middelburg (Cape)
Modderbee
Robben Island
St Albans
Victor Verster
Voortrekkerhoogte

(2) (a) Yes.

(i) and (ii)

Available information indicates that twelve (12) prisoners were killed by fellow-prisoners at the following prisons: Bethal, Goedemoed, Groenpunt, Johannesburg, Krugersdorp, Modderbee, St Albans Maximum, Pretoria, Stellenbosch, Leeuwkop and Pollsmoor. However, these inquests have not yet been finalized.

All deaths in prisons in respect of which a medical practitioner is unable to certify that the prisoner died as a result of natural causes, are reported to the South African Police or a magistrate for the necessary investigations. Inquests into every case where death is ascribed to unknown or unnatural causes, are instituted in terms of the stipulations of the Inquest Act, 1959 (Act 58 of 1959) and at the same time departmental investigations are also undertaken.

(b) Yes.

(i) and (ii)

The Department of Correctional Services regards every complaint of an assault, no matter how petty, in a serious light. Prisoners are daily given the opportunity to lodge any complaint or request, and preventative measures, for example the reallocation of sleeping quarters or working places, are instituted should it appear that there is reason to believe that a prisoner is threatened.

In cases of injuries which are related to complaints of alleged assault, a suitable entry is made in a complaints register and/or a register of injuries and in addition to the necessary medical treatment which may be administered or prescribed by the medical officer, a departmental inquiry is instituted into the alleged assault. Where such a complaint is substantiated suitable disciplinary action is taken in terms of Prisons Regulation 99 in the case of minor assaults, while complaints of serious assault are reported to the South African Police without delay for investigation in order that the legal process may take

cont....D

Provincial ... are ... site for ... boxes for ... residing ... De ... wood ... var... is ... 430

(1) Yes

planned for ... 1993.

...ice with ... planned for ...ane 1993.

...000 additional boxes ...alled during 1992/93.

...*sfontein*—1 000 additional ...es will be installed during 1992/93.

Pierre van Rynveld—1 000 additional boxes will be installed during 1992/93.

Hennopsmeer —Negotiations are in progress to procure new accommodation in which 8 350 boxes will be provided.

Post office: Bramley

*6. Mr P G SOAL asked the Minister of Posts and Telecommunications:

Whether, with reference to the reply to Questions No 342 on 21 May 1991, any progress has been made in regard to the construction of the post office and postmen's depot in Bramley, Johannesburg; if not, why not; if so, what progress? B341E

The MINISTER OF POSTS AND TELECOMMUNICATIONS:

No. In view of the capital cost of the project and other priorities alternative options to solve the accommodation problems were researched. In the process an agreement was concluded with the lesser of the present post office premises to provide more spacious and upgraded accommodation in the existing complex, which should be available by the end of this year.

New questions:

Public telephones: repair costs

*1. Mr P G SOAL asked the Minister of Posts and Telecommunications:

(1) What was the estimated cost of repairing public telephones in the Republic during the latest specified 12-month period for which information is available;

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

B372E

The MINISTER OF POSTS AND TELECOMMUNICATIONS:

(1) R15 734 841 for the period 1 April 1991 to 30 September 1991

(2) Yes. I would like to request the general public not to damage Telkom SA's public payphones on purpose and to assist the company with information regarding the damaging of the apparatus by vandals. The payphone service meets the needs of persons who do not have a private telephone service at their disposal and who need to make emergency calls. It is also the most effective communication medium for persons who are travelling and wish to keep in contact with their residences, family members and employers.

Telkom SA requests the public regularly through the media to support the Company in their efforts to combat vandalism.

VAT on medical services: pensioners

*2. Mr M J ELLIS asked the Minister of Finance:

(1) Whether he has received representations from any organizations to remove value-added tax on medical services for pensioners; if so, from which organizations;

(2) whether he is considering the matter;

(3) whether he will make a statement on the matter? (299) B376E

The MINISTER OF FINANCE:

(1) Representations have been received from organizations requesting the removal of value-added tax on medical services but none of the representations appear to relate only to medical services for pensioners.

(2) The matter is not being considered at this stage.

(3) The decision to impose VAT on medical services was not taken lightly. In the original proposals which were released by the Government in June 1990 for comment, it was proposed that medical services be exempt from VAT. The Medical

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Association of South Africa in its representations to VATCOM requested a zero-rating, but this request could not be accommodated as it would not only have reduced the tax base, but would also have placed practitioners in a better position than they had been under the GST system as they paid GST on their purchases. The Association stated that it preferred the standard rate to an exemption and it was accordingly decided to follow this route.

Provision has been made both within and outside the tax system to provide targeted relief for medical expenses incurred by pensioners. More than 80 per cent of our population is treated in State and provincial hospitals and local authority clinics. These institutions are heavily subsidized and approximately 90 per cent of their expenditure is financed out of State revenue. The nominal charges paid to these institutions by pensioners and others for the medical treatment and which covers approximately 10 per cent of the costs have been exempted from VAT. The income limits of the means tests which allow persons to qualify for the subsidized services were increased when VAT was introduced to R27 492 and R16 500 for families and single persons, respectively. A greater number of pensioners therefore qualify for this concession. (299)

The facilities referred to above are generally not available to pensioners in the higher income brackets but they are entitled to income tax relief for their medical expenses. Pensioners over the age of 65 years may claim all the medical expenses they pay as a deduction. Pensioners of 65 years and younger may claim a deduction in respect of all medical expenses which exceed 5 per cent of their taxable incomes. The income tax relief as a result of the deduction exceeds the benefit they would have enjoyed had the medical expenses been zero-rated and it further targets the relief to those pensioners who have the highest medical expenses.

Air pollution: new policy

*3. Mr M J ELLIS asked the Minister of National Health:

(1) Whether her Department is at present involved in the drafting of a new policy for the control of air pollution; if so, (a) when did it commence drafting this policy and (b) when is the policy likely to come into effect;

(2) whether there has been any delay in the drafting of the policy; if so, what were the causes;

(3) whether she will make a statement on the matter

B377E

The MINISTER OF NATIONAL HEALTH:

(1) No, (a) and (b) fall away;

(2) falls away;

(3) no.

Alternative national service

*4. Mr L FUCHS asked the Minister of Defence:

Whether, with reference to the reply to Question No 3 on 26 February 1991, any additional form of alternative service (a) has been introduced and/or (b) is envisaged for persons refusing to serve in the South African Defence Force; if so, what is the nature of this alternative service? (354) B378E

The MINISTER OF DEFENCE:

(a) and (b) No.

Automation of farm lines: Hoedspruit

*5. Mr P G SOAL asked the Minister of Posts and Telecommunications:

Whether, with reference to the reply to Question No 5 on 28 May 1991, it is still the intention to (a) commence the automation of the farm lines in the Hoedspruit area during April 1992 and (b) complete the project during the first half of 1993; if not, (i) why not and (ii) when is it anticipated that the project will be (aa) commenced and (bb) completed?

B379E

The MINISTER OF POSTS AND TELECOMMUNICATIONS:

(a) Yes; has already begun.

(b) No;

(i) Due to an unexpected increase in demand, the project cannot be com-

Spending on health services rises by 22%

Bl Daily 19/3/92

Own Correspondent 299

CAPE TOWN — Spending on health services, excluding the TBVC states and salary improvements, has been increased by 22% to R9,928bn. Much of this increase has been allocated for National Health, which rises to R1,169bn from R634,2m.

Finance Minister Barend du Plessis said the steadily rising cost of health services had meant the structure and nature of health delivery had to be reviewed urgently.

Notwithstanding the existing constitutional limitations still influencing reforms in the health service system, certain important functional adjustments in service delivery were already being made, focused particularly on the expansion of primary health care and a partnership service between the public and private sectors.

Considerable progress, he said, had already been made in transferring the provision of all primary health care services to local authorities and the necessary funds for these services would be supplied to local authorities by the Department of National Health and Development.

He said that as academic hospitals accounted for a significant portion of the health budget, it had become urgently necessary that the cost effectiveness of these services be improved.

To this end, the task of operating each of these institutions on a business basis would be entrusted to an executive manager with the necessary management and financial expertise.

□ A further R440m has been budgeted for special targeted aid schemes under the Nutrition Development Programme.

Of the R220m allocated last year, R110m has been paid or is in the process of being paid — a total R35,6m has been paid to non-government organisations. Applications totalling R59m have been approved by the Department of National Health and Population Development and are in the process of payment, with applications for a further R5,4m now being processed, and R10m has been budgeted for state clinics operated by local authorities.

Relief over increase in health care

By Carina le Grange

The 22 percent increase in spending on health — amounting to R9,93 billion — was a much needed increase, Centre for Heath Policy director Cedric de Beer said yesterday.

Mr de Beer said "on the face of it" he welcomed the increase since the increase in the previous Budget was very low.

"What is important, however, was how the funds were targeted. One hopes it would improve services to the most needy and not simply disappear into administrative costs."

The transfer of primary health care services to local authorities should be with the proviso that they should not be expected to provide all the finance, Mr de Beer said.

Dr Ralph Mgijima of the ANC health secretariat said the increase in health spending was welcomed, depending on how it was spent.

The ANC said in an official brief response that allocations to health, education, housing in this year's Budget speech appeared to be "broadly appropriate".

The organisation added however that the central issue was the way these allocations were spent and managed.

"We have no faith in the ability of the departments responsible for these areas to deliver the services in an effective and efficient way," the ANC said.

● The Medical Association of SA said it welcomed the shift in emphasis towards community oriented expenditure.

Masa secretary general Dr Hendrik Hannekom said he trusted the health services allocation of R9,928 billion would contribute towards increased access to health care by the estimated 40 percent of the population not taken care of by the current system.

Health services to increase by 22pc

CAPE TOWN — Health services will cost more than R9,9 billion, a rise of 22 percent on last year. But this does not include provision for salary improvements.

The steadily rising cost of health services has meant that the structure and nature of health delivery must be urgently reviewed, said Barend du Plessis. STAR 19/3/92

The provision of all primary health care services will be transferred to local authorities to secure greater community involvement.

Academic teaching hospitals are to operated on "a business basis" and each institution will be run by a business manager.

Medical services VAT to stay

STAR 2/3/92 2/99

Representations from organisations for Value Added Tax on medical services to be removed were not being considered at this stage, Minister of Finance Barend du Plessis said in the House of Assembly yesterday.

Replying to a question by Mike Ellis (DP Durban North), he said the representations did not appear to relate specifically to medical services for pensioners alone.

Mr du Plessis said more than 80 percent of the population received treatment in State-funded hospitals, where pensioners and others paid nominal charges which were exempt from VAT.

Pensioners in the higher income bracket were entitled to income tax relief for their medical expenses.

People aged 65 and older could claim all medical expenses as a tax deduction.

Mr Du Plessis said the Medical Association of South Africa (Masa) had initially requested a zero-rating on all medical services. This could not be accommodated because it would have reduced the tax base, and general practitioners, who previously paid GST on purchases, would be placed in a better position.

Masa then indicated that it preferred the standard VAT rate to an exemption and this course of action was accordingly followed. — Sapa.

PHARMACEUTICAL INDUSTRY

Upjohn's philosophy

The battle to contain health care costs is not unique to SA, nor is the realisation that deregulation offers the most workable solution.

Geoffrey Rogers, Upjohn Pharmaceutical's corporate vice-president for Europe, says countries around the world are trying desperately to contain soaring health care costs, but to date, no regulatory system has worked. Rogers was in SA last week on a brief visit to inspect Upjohn's Isando plant, which is being renovated but, for now, not expanded.

Says London-based Rogers: "Methods geared at regulating the supply and demand of health care in Europe and parts of North America — for example closing hospitals and having long waiting lists for minor surgery — have been particularly unsuccessful."

Expressing support for many of the recent proposals made by Health Minister Rina Venter to deregulate the medical and pharmaceutical industries, Rogers says there is an international trend towards having patients in the private sector accept a greater responsibility for their medical bills. This trend is likely to see the advent in SA of health maintenance organisations, which have cut medical costs by as much as 40% in some countries.

In this regard, Venter's proposed amendments to the Medical Schemes Act pave the way for medical schemes to provide health services — run hospitals and employ doctors and other practitioners. With this move, doctors' absolute discretion in providing health care would end.

The high cost of medicine locally has come under the spotlight in recent weeks. Government says medicine prices are higher here than in most Western countries and that medicines make up 26% of the benefits paid out to members of medical schemes. Rogers, whose company is the 10th largest pharmaceutical firm in the US, with more than US$3bn in sales last year, says that internationally, this figure is around 10%.

Rogers

He is of the opinion that many things could be done to reduce the cost of medicine in SA. "Government could reschedule certain drugs from prescription medicines to pharmacy-only medicines, provided they are safe for public use and can be safely used for long periods without referring back to doctors regularly." He says this was successfully done in the US with the painkiller Ibuprophen.

Pharmaceutical companies have long opposed the widespread use of generic-substitute medicines — unsuccessfully in the US and, so far, more successfully here — but Rogers says generic substitutes should be allowed, provided they meet the same standards as their branded and more expensive equivalents. He, nevertheless, stresses the importance of strict controls in the manufacturing and distribution process to guard against counterfeit medicine. He stresses that doctors should have the final say in prescribing branded or generic medicines.

It's long been argued that deregulating the pharmaceutical industry in SA is meaningless without allowing pharmacists to work for non-pharmacists. The idea is that retail stores, such as Pick 'n Pay and Clicks, could open their own pharmacies and use their buying power to discount medicines.

This happened in the US in the Seventies and prices came down drastically. Once again, Rogers says he's not opposed to this in SA, as long as controls can keep counterfeit medicine off the market and ensure the wide availability of medicine. ■

Mother to every child

Sowetan 23/3/92 ~~218~~ 299

Women

By SIZAKELE KOOMA

She cares for the helpless

WHEN pensioner Morongoa Mothiba realised she had nothing to do with her open days, she volunteered to run a school for mentally handicapped children in rural Sebayeng, outside Pietersburg.

Mothiba offered to mother and train the children, although she had no proper training to run the rehabilitation programme, whose need was identified by community developers.

There was no place to accommodate the children and no facilities to carry out the rehabilitation programme.

But Mothiba would not be deterred. Once she had found a quiet spot in the veld she started the school under a tree with 12 children.

Skills

She taught handicrafts, gardening, art and writing, physical exercise, simple communication skills, perceptual skills and socialisation.

Affectionately known as Aunt Nelly to the children, she also played the role of cook, nurse, messenger, physiotherapist and speech therapist. Her own domestic worker assisted her with running errands such as fetching water, washing dishes and feeding the children.

On realising her dedication and self-sacrifice in her venture, a Good Samaritan offered her a room to operate from during bad weather. She brought along her own furniture - chairs, a carpet, a gas cylinder, pots and plates.

Working

She still had to use her home as a storeroom for groceries sponsored by Imqualife Children's Fund in Johannesburg. The groceries was augmented with the vegetables she grew in her yard.

Mothiba involved parents in a working committee to help raise funds.

Today, five years later, the school is registered and subsidised. Bana ba Thari Mental Health School, as it is called, boasts an enrolment of 25 children, three teachers and a cook.

The children are now able to bath themselves, make their beds at home and do gardening in the school yard. Some can even write their names.

Mothiba's services were recently rewarded when she was honoured as the Glodina-Procare Award winner for 1991. She says she will not rest until all the needs of the school, like classrooms, transportation, electricity, telephones, a workshop, rest rooms, bathrooms, a storeroom, an office and proper sanitation, are met.

All you need to know about medicines

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Sowetan 24/3/92

By SELLO RABOTHATA

THE *Reader's Digest* has published a book which is aimed at helping the ordinary family understand the everyday use of medicines and drugs.

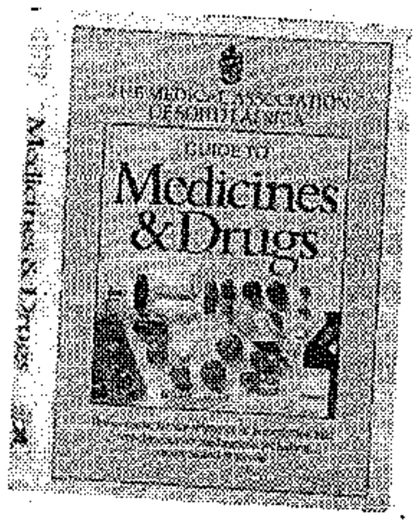
The Digest says research shows that 10 percent of all admissions to hospitals is for the treatment of drug-related conditions.

The book says it is largely due to the misuse of drugs and medicine through lack of knowledge of how they work and also, more often, how they react when taken in conjunction with alcohol or other treatment.

Information

"Guide to Medicines and Drugs", a new complete family reference book, was compiled by *Reader's Digest* in conjunction with The Medical Association of South Africa. It aims to tackle the issue of drug information.

Drugs are not only effective substances, but are also powerful chemicals that can have harmful effects if not used correctly.



Mr Christopher Walton, the books division editor-in-chief, said the guide was compiled by experts under the supervision of Dr Nick Lee, editor of the *SA Medical Journal*, and double-checked by doctors and pharmacists to ensure that information given was factually correct.

He said: "We wanted to ensure we presented the layman with a clear, easy-to-use guide. There was a definite gap in the market for a book such as this one. This is the first of its kind and we are confident it will become an essential family reference - a lifesaver."

The book is divided into four sections, the first two give an account of how drugs affect the body systems and how the main classes of drugs work.

Dosage

The main section gives in-depth information about 199 widely-used drugs, including the effects the drug has, potential problem areas, and what to do in the case of a missed dosage. Other sections include an index of drug and propriety names, a colour identification guide to commonly prescribed tablets and capsules, as well as information on vitamins and drugs of abuse.

The book is available from *Reader's Digest* or through major retail outlets and costs R94,58.

Minister to open Takalani

Sowetan 27/3/92

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THE Takalani School for the Mentally Handicapped will be officially opened by the Minister of Education and Training, Mr Sam de Beer tomorrow.

The school, which has a boarding home, was built by the Anglo American and De Beers Chairman's Fund at a cost of R7 million. The running costs and staff are funded by the DET.

Takalani is the first school to cater for the mentally handicapped in Soweto, a city with an estimated 15 000 handicapped people.

Takalani admits 200 children, many of whom are residents in the home.

●Meanwhile the Natalspruit Upjohn Hospital School was officially opened this week.

The school, sponsored by Upjohn Pharmaceutical with the blessing of the DET, caters for children who are hospitalised. A full-time teacher and principal, Mrs Idlette Matetoa, said she taught children from Sub A to Standard 5.

This helps the children to catch up easily with their peers when they are discharged from the hospital.

A new loan scheme for students has been set up the Ernest Oppenheimer Memorial Trust, First National Bank and the University of Witwatersrand.

EDMT will pump about R500 000 into the scheme each year until 1995 with FNB as security for loans approved under a Student Loan Indemnity Fund Scheme.

Mr Bobby Godsell, Professor Jerry Steele, Professor Robert Charlton and Mr Pat Lamont

FOCUS ON EDUCATION

June.

Interested pupils should give the name of their schools, their locations, the classes they are doing and the accounting topic they would like to cover.

Details should be sent to Mr Phillip Mmutle, Abasa, Box 5282, Johannesburg, 2000 or at (011) 331-6923.

Subsidise

Wits will select needy students according to its normal criteria. The interest will be used to subsidise the interest charged on individual loans. Repayments will be structured to suit individual students and may be spread over 10 years.

Students must apply for the loans at the Milner Park branck of FNB with a letter of introduction from Wits.

●The Education and Development Trust will hold a series of Career Planning Workshops for youth leaders this winter.

The two-day workshop will train representatives of student bodies, companies, youth clubs, service clubs and other community organisations to run carrer workshops for the youth.

They cover self-assessment study and career options as well as job-seeking skills. They will be held betwen April and June.

For more details contact EDT's training co-ordinator, Muriel Connell at (011) 976-4788.

●The Association of Black Accountants of South Africa invites Standard 9 and 10 commercial pupils to a winter school in

Degree of hope as blind riot victim gets job offer

STAR 28/3/92

LIFE has become a little brighter for Danny Kekana, of Diepkloof, who lost his sight in 1977 after being shot during a riot in Soweto.

Against tremendous odds, Kekana went on to earn a Masters degree in sociology, but was unable to find a job.

However, after reading about his plight in a recent Saturday Star article, several people telephoned to offer employment.

One of them, Aziz Jardine, an assistant training co-ordinator for The Community Based Development Programme, a non-profit organisation linked to the Wits Business School in Johannesburg, offered Kekana a job in his company after seeing the article.

"We run a certificate programme teaching people management skills for community-based organsations. With Kekana's academic skills, he could become a facilitator.

OVERCAME THE ODDS: Danny Kekana.

CAROLINE HURRY

"We have invited him to attend some of our lectures to gain a clearer sense of the programme and our methodologies.

"We're also exploring the possibility of training him in other areas. Kekana's research skills are very advanced and we're looking at several possibilities.

"Right now we're keen to get him interacting with people because that's what he really wants to do. Very often blind people have perceptions sighted people don't have, and were he to become involved in teaching, the possibilities are endless," he says.

Kekana says he can't wait to start. "The work Mr Aziz is offering is ideal for me. I love working with people.

"I'm already starting to feel more confident and optimistic and I'm very grateful to the Saturday Star for bringing this about.

"Too often blind people are relegated to the background, in spite of our capabilities, but now I feel excited for the future," he says.

Medical cover must for Africa travellers

5 Times (BUSS) 29/3/92 299

ANGELS WITH WINGS ... two Medstar ICU nurses and their equipment on standby at an airport near Johannesburg

SOUTH Africans who travel into Africa regularly on business or who stay there for extended periods would be unwise to do so without medical insurance.

George Novis, sales manager for Medstar in Johannesburg, which provides a 24-hour, go-anywhere service to evacuate ill South Africans out of African countries, says people living in foreign Third World states for any length of time face a number of potential medical problems not necessarily encountered at home.

Archaic

"In most African countries if a worker falls seriously ill he should be evacuated as soon as possible to receive the best medical attention available. If not, he could well die."

If First World medical attention is required there are few places in Africa where this can be found with the exception of South Africa.

Mr Novis says that in most countries north of the Limpopo medical facilities range from non-existent and archaic to downright dangerous.

"It is common practice in Africa to re-use disposable needles, and many of the medicines — if available — have expired. Because of this and the high risk of AIDS, we never use anything that is available locally, taking all our consumables — including blood — and equipment with us. "It is a fact that 80% of the foreign patients we fly into Johannesburg are HIV-positive, and for this reason our nurses and doctors wear gloves, masks and goggles while attending to them."

He said a lack of foreign exchange in most African countries meant that they either didn't have hi-tech equipment or the money or skills to adequately maintain it.

Basics like X-ray machines and CAT scanners are invariably "out of order" so the diagnosis of the sick or injured in usually under-assessed.

"For this reason we normally fear the worst and take a full range of miniaturised aircraft-compatible ICU equipment — worth about R2-million — on board even for what may sound like a relatively minor problem," said Mr Novis.

However, the difficulties don't end there. Getting into smaller towns at night can be prearranged, but there have been cases where the aircraft flew to a strip but couldn't land. In one instance because the flares used to light the runway had been stolen, and in another where airport staff were drunk.

Another major problem for Medstar is getting a patient to the airport for evacuation. "There are few ambulances in Africa. In a recent case we had to transport a subscriber in a commercial vehicle to the airport because the country does not have an ambulance," Mr Novis said.

In 1991 Medstar evacuated patients from Kenya, Congo, Malawi, Angola, Mozambique, Zaire, Zambia, Zimbabwe and Botswana, most of whom were suffering from industrial or vehicle accident injuries and a variety of infections.

Medstar has a team of ICU nurses who are also aeromedically trained, as well as trauma specialist doctors on 24-hour standby. It also has direct access to a wide range of specialist doctors if required.

Policy

A variety of aircraft are at Medstar's disposal, ranging from Learjets, turboprops and helicopters, depending on requirements and circumstances.

People who plan to travel into Africa or neighbouring countries can take out a travel-assistance policy, available from most travel agents, from R90 to R130 for a stay of one to three weeks.

Companies who have staff travelling regularly into Africa can take out a corporate annual policy either through their brokers or from Mr Novis at (011) 838 6311.

The emergency service is also available to anybody on request subject to financial guarantees.

Rina Venter quizzed over report which 'didn't exist'

Staff Reporter (299) (20)

The Pharmaceutical Manufacturers' Association (PMA) yesterday called on National Health Minister Dr Rina Venter to release a report on the cost of medicines which she has said "doesn't exist" or "is incomplete". STAR 21492

The PMA made the call after a financial magazine this week quoted extensively from the De Villiers Report into Privatisation and the Cost of Medicine, compiled by the late Dr Wim de Villiers, the former Minister of Economic Co-ordination.

PMA executive director John Toerien said yesterday Dr Venter had told Democratic Party MP Mike Ellis last year in Parliament, by way of an interjection, that the De Villiers report did not exist.

He said this year she told Mr Ellis, also in Parliament, that the Cabinet had decided not to release the report as Dr de Villiers had died before it was complete.

Mr Toerien said since the report was not available to the public, the PMA was not able to comment directly on aspects raised in the magazine until Dr Venter lifted the confidential tag.

Dr Venter . . . asked to explain discrepancy.

"The Minister also needs to explain why she told Parliament one thing when she must have already known that the report, whether it was incomplete or not, actually existed," he said.

"The fact that portions of it have now been published makes it imperative that role players in the health care debate, as well as the media, be provided wth copies so that privatisation and the alleged high costs of medicines can be placed in perspective."

Dr Venter could not be reached for comment last night.

HEALTH MATTERS

FINANCING HEALTH CARE

New Nation (Learning Nation) 3/4-9/4/92 (299)

Today's article looks at various health financing options and the debates around them.

In the foreseeable future, South Africa won't be able to allocate sufficient resources to the health sector to satisfy basic needs. Therefore it is important that resources should be used in the most effective way possible.

Many different factors have contributed to the poor state of South African Health Services: Apartheid policies, inadequate planning, and little coordination between health policy making and financing.

In South Africa, there is a mixed private and public health sector. This has led to problems, since the private sector provides health care to about 21% of the population, yet uses nearly half the resources allocated to health care. This inequality between the private and public health services immediately leads to the question of how a new health system's finances should be arranged.

Curative vs preventative Health Care

People have immediate need of health care which cures and rehabilitates (To rehabilitate means to bring back to a normal life.)

However, such a service needs to be accompanied by preventative services. If not, the demands on the curative services will remain as heavy as they are now and make demands on the financial resources of the country. There is never a clear limit to peoples' health needs. However, there is always a limit to what a country is willing or able to finance. Thus, realistic health resource planning must take into consideration economic as well as health factors.

Who should finance health services?

The two sources of financing for health care are the private and public sectors.

The most important private sources are the individuals who pay for services, either directly to the service provider or indirectly through medical aid schemes that are supplemented by contributions from employers. But in a country with a high rate of unemployment, this method cannot fund health care for an entire nation.

Insurance companies have also recently started providing financing to cover certain medical expenses, but, again the majority of people are unable to participate in this because their income is too low.

The public sources of financing are tax revenue and a national public health insurance system that is regulated by the government.

Exploring the options

The options for financing health can thus be divided into three categories:

1. **maintaining the social system as it is now and keeping the private and public sectors separate;**
2. **implementing a national health service;**
3. **financing the private and public health system through a centralised financing system.**

Empty ward in a private hospital

1. Separate private and public health services

One option is to maintain the separate private and public health sector. With this option, the private sector will be competing with the public health services. But, because the present private sector is so powerful, it will undermine the public health sector. There are many problems with this option because it will continue the present system of unequal services, with the private sector catering for a mostly white minority, while using most of the health resources.

2. National Health Service

Under a national health service, the private and public sector are 'employed' by the state. People practising in the private sector are paid a salary according to the number of patients they see. An advantage of this is that health care is more equitably distributed. In some neighbouring countries, banning of private practice has resulted in a 'black market' in private health care.

Another result could be that many health professionals may leave the country. It is argued that if a national health system is implemented immediately in South Africa, these two possibilities are likely to result. This would then undermine the health service sector as a whole. If they do not leave, the employment of all the health professionals by the state will place an almost impossible burden on the public health budget.

However, there are many advantages to a national health service. A national health system increases the possibility of community participation and control. Because of decentralised decision-making there is more accountability to the people. It ensures that a high standard of health care is available to all people and that affordable medicines are made available (often cheaper than in many other countries). Community services and health promotion activities are encouraged by this system.

Another very important advantage is that the administration costs of the National Health Service will decrease.

3. National Health Insurance

In this system, the public and private sectors both contribute to a central fund that is managed by a national body, usually the health authorities. The health authorities will have control over the development and functioning of both the public and private health sectors. This system is commonly known as the national health insurance system.

It is claimed that through this system, each individual will then receive equal health services, but this applies only to the most basic health services. Other more costly care is often available only to people who have extra private medical insurance cover.

The Way Forward

Many progressive health organisations have supported the call for a national health system. There are also others in the non-progressive, traditional health sector who share the view that in the end a national health system would have the most benefits for the health of the nation. However, when considering the organisation of current health care structure, the National Health Insurance system has been proposed as an interim measure that would make transition to the national health system easier.

In this period of planning and policy development, many political parties are actively engaged in debates such this one around health policy. Politicians are beginning to realise what an essential and important role health plays in the well-being of a nation, and that health and health-related issues feed into other areas of public life.

SKILLS FOR LEARNING

Building Sentences 1

This week we start a series on how to write well. The material in these articles has been adapted from the book *Write Well* published by Sached/Ravan.

How long should sentences be?

Sentences in English can be long or short. How long should your sentences be?

1. Read the following sentence and decide for yourself if it is too long or too short.

Although the match had been cancelled because the field was still soaking wet from the previous night's rain, the youngsters of the under-11 soccer teams, who had been practising hard in the holidays, were so keen to play that the coach found it difficult to convince them that the ground would be damaged if they played on it while it was wet, and that they should do keep-fit exercises instead.

What happened when you read this long sentence? Maybe you did not understand it very well. Maybe you forgot what the beginning was about before you got to the end.

A whole article or story with such long sentences would probably be too tiring to read. It would also be too difficult for some readers to understand. So a good writer should not use too many very long sentences. Consider your readers. You should make your writing fairly easy to understand.

What about short sentences?

Short sentences are usually clear and easy to understand.

2. Read the following story. All the sentences are very short.

I remember, I was young. Our neighbour had a peach tree. The tree was in his yard. This tree used to bear peaches. The peaches were sweet. They were juicy. They were yellow. The peaches were a temptation. They tempted all the children. The children were in our street.

What happened when you read the story? You probably understood it easily because the sentences were short and easy.

But did the story flow smoothly? Or was it jerky, with too many stops and starts?

You probably agree that the story was jerky, too full of stops and starts. This stopping and starting can be very irritating to the reader.

When you write, you should join the ideas so your story flows smoothly. You should not have too many short jerky sentences.

3. Now read the sentences below. The writer has tried to join the ideas smoothly into longer sentences. Do you think the writer has made an improvement?

I remember, I was young and our neighbour had a peach tree and it was in his yard. This tree used to bear peaches and the peaches were sweet and juicy and yellow. These peaches were a temptation and they tempted all the children and the children were in our street.

The writer has joined some ideas together to form longer sentences. But he has only used one joining word - the word and.

The sentences sound a bit smoother now. But the sentences still contain a lot of repetitions (ideas that are repeated). Also the sentences sound a bit childish because **and** is used too often.

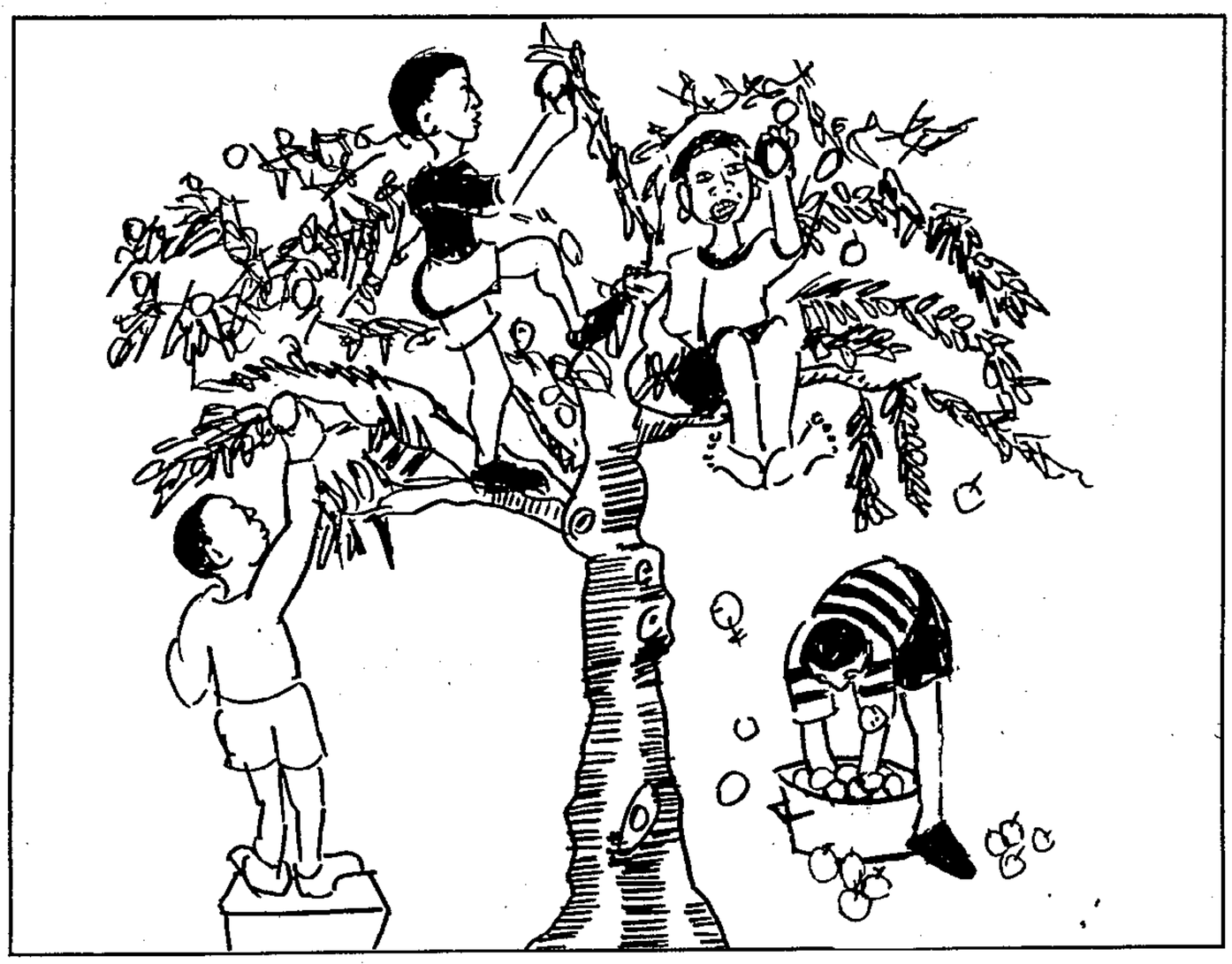
Good writers do not rely on **and** to do all the work of joining. They use many different joining words, such as **who, that, because, when**.

4. Now read the story of the peach tree again. The writer has tried to join the sentences more smoothly.

I remember when I was young our neighbour used to have a peach tree in his yard. Every year this tree used to bear sweet, juicy yellow peaches that were a temptation to all the children in our street.

The story is still clear and easy to read. But now it flows more smoothly because the ideas are joined well.

The writer has
★ used different joining words
★ cut out unnecessary repetitions



Variety in Length

Does this mean that all our sentences should be of medium length?

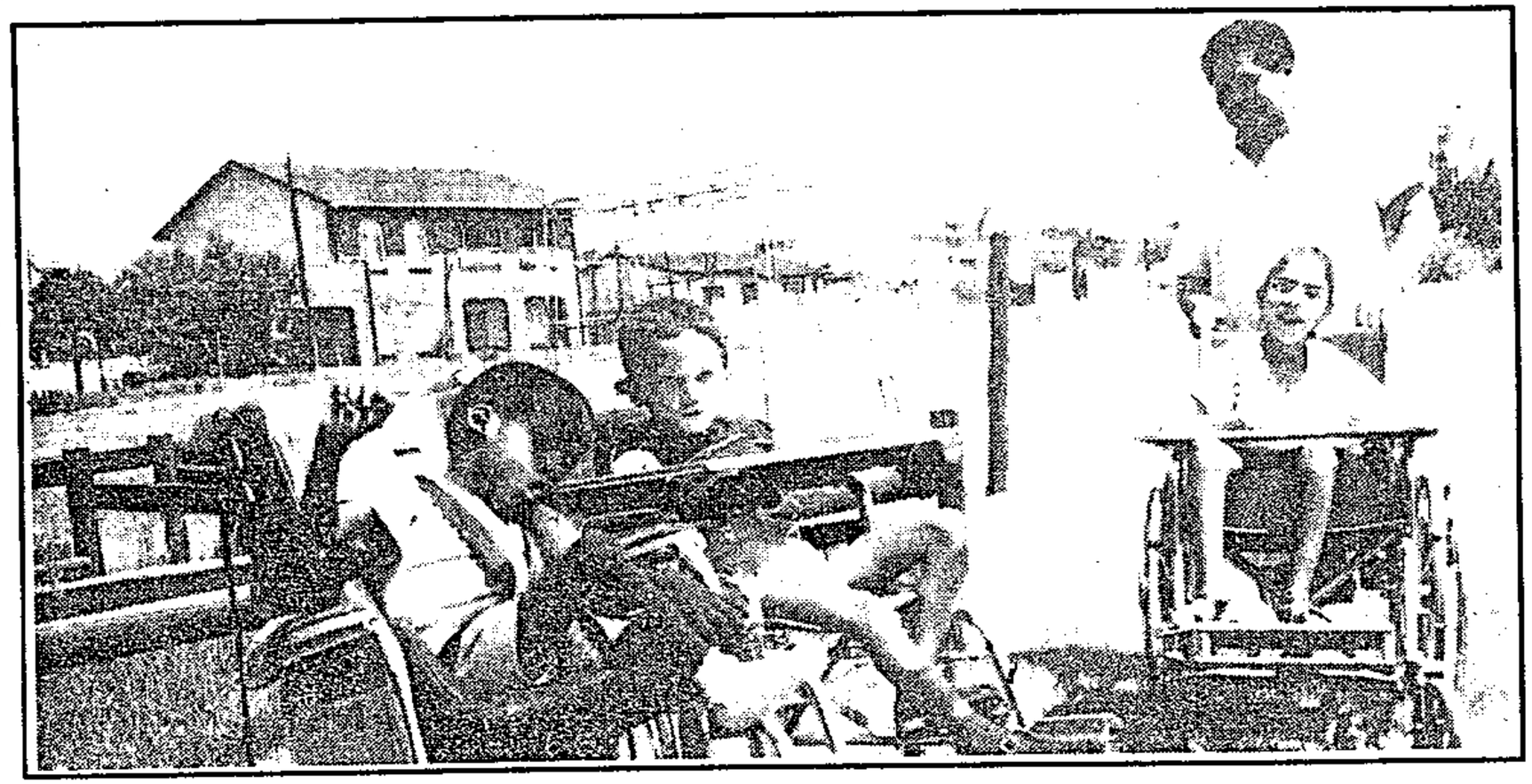
No, your sentences should not all be the same length. You should have variety - some long, some short, some medium. But try to avoid very long sentences. They are difficult for most readers. And try to avoid too many short sentences because they make your writing jerky.

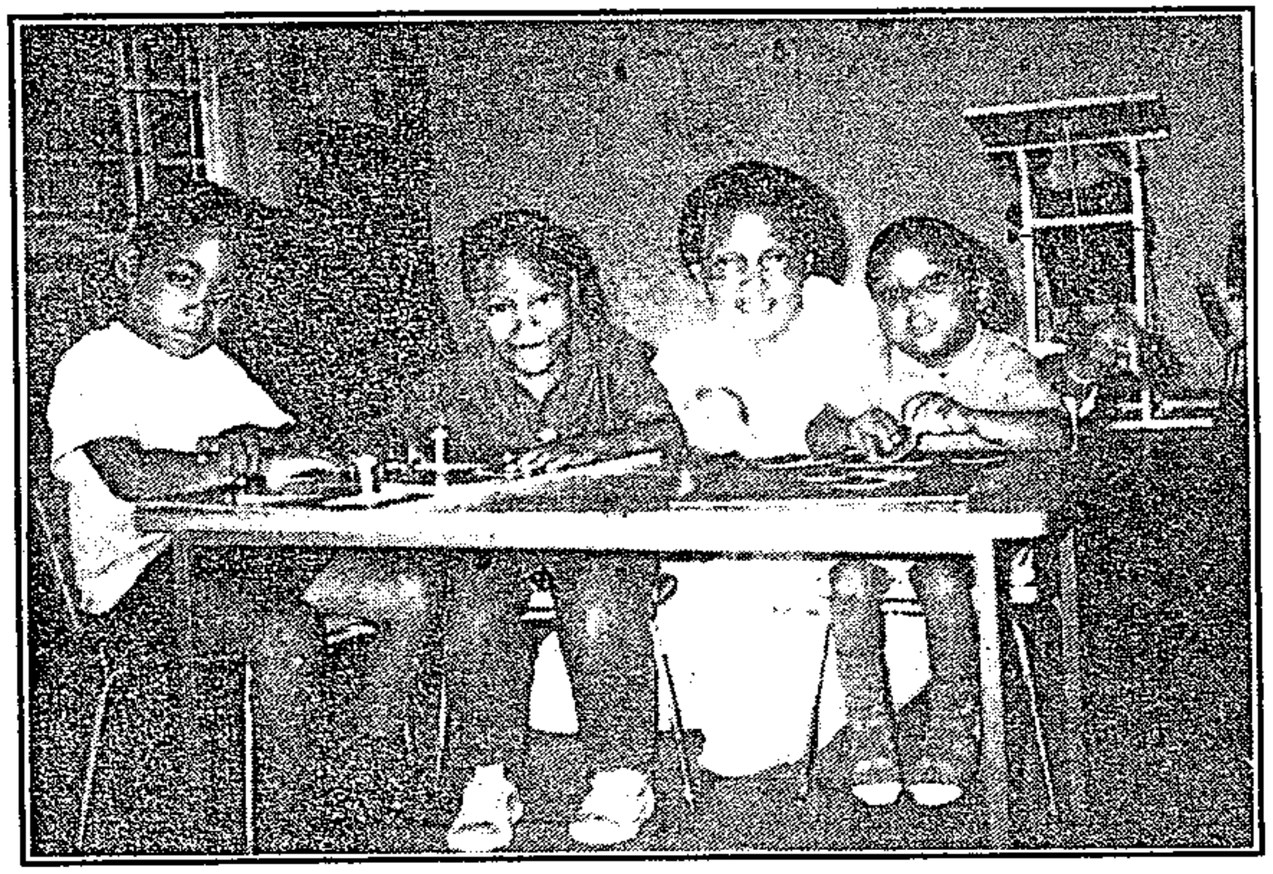
Which joining words?

There are many joining words with many different meanings. Writers must choose their joining words carefully. They must use the correct joining words to give the meaning they want.

Over the next seven weeks, you will learn about various different ways of joining ideas.

Next week, we will look at joining sentences with who, which and that.





ABOVE: Children enjoy a break in the sun. RIGHT: A teacher, Mrs Josephine van Zeeburg, trains a group of children in motor activities, eye to hand co-ordination and stimulation. The children are (from left): Adrian Visagie, Zain Ewents and Rhys Wilson.

FOCUS EDUCATION

Children raise R50 000 for school

299 Soweten 3/4/92

By MIKE TISSONG

SCHOOLCHILDREN have raised more than R50 000 and provided temporary relief for a school for handicapped people in Eldorado Park which faced closure because of a lack of funds.

The Harvey Cohen Centre, which provides care and training for about 200 mentally and physically handicapped adults and children, has considered the option of closure, but will do its best to survive, one of the teachers, Mr Yunus Cassim, said.

The director of the centre, Mrs Dorothy Cornelius, said schoolchildren in Eldorado Park and Coronationville had helped tremendously in selling tickets for a car competition.

The draw to choose the winner will be held at Highgate shopping centre in Industria tomorrow at 11am.

The car, a Mazda 323 sedan, was donated by V&R Engine Spares.

Other prizes are a lounge suite, a microwave oven, a TV and a car radio.

Members of the community and staff of the school have embarked on several other fund-raising activities for the year.

Cornelius has written letters to hundreds of professionals in the Johannesburg area seeking assistance for the school.

Very few have responded.

She said the school served people from the Bosmont, Coronationville, Westbury, Noordgesig, Riverlea, Eldorado Park, Kliptown and Soweto areas.

"We also run a hostel which provides a place to stay for handicapped children from as far as the Eastern Transvaal and the Free State."

She said their monthly expenditure exceeded R50 000 which includes salaries for a physiotherapist, an occupational therapist, a social worker, qualified teachers, child care workers and non-teaching staff.

"Our transport costs are high because we provide three buses which travel more than 500km a day over the vast areas served.

"Our students are provided with two meals a day because they leave home at 6am and return at about 4.30pm.

"The centre is almost entirely dependent on fund-raising and donations for its existence. We receive a negligible annual subsidy from the authorities and we will not relent in our efforts to increase this subsidy.

"For the last few years we have barely managed to cover our expenses. In such a desperate situation where the survival of the centre is at stake, we have no choice but to appeal to the kindness of members of the community."

Staff and other supporters of the school will be appealing for donations at Eastgate shopping centre in eastern Johannesburg on April 23. A street collection will be held in Johannesburg on April 28 and 29.

...but at the moment any job – save prostitution – will do.

...mak- ...some- Others are paid with forged notes and fighting

Hard times force the blind to beg

By FRED KHUMALO

WHEN 80 blind workers went on strike at an Umlazi home for the blind last May, little did they know the trouble and poverty they were courting.

Now, 11 months later, the workers from eNduduzweni Place for the Blind in Umlazi are still without work and money. They are so desperate that some of them have resorted to begging in the street.

"But people have no money to give to beggars these days," said Kenneth Majozi, a resident at the home.

"You would be lucky to come back home with three rand. It's tough." City Press 5/4/92

The workers embarked on a strike last year when Geoff Hilton-Barber, the director of the Natal Society for the Blind, introduced a "piece rate" scheme which meant they were to be paid according to productivity.

The workers saw the scheme as an effective reduction of their R60 weekly wages and withheld their labour, calling Hilton-Barber to the negotiating table.

No deal

Hilton-Barber refused to negotiate with the Paper, Print, Wood and Allied Workers' Union (Ppwawu), the union representing the workers.

He told City Press this week that when he introduced the "piece rate" he was trying to alleviate the problems of the institution which lost R500 000 in the 1991 financial year. "You can't go on paying high wages when there is no productivity."

Hilton-Barber said when the situation became desperate, he decided to hand the institution over to the KwaZulu government's Department of Welfare and Pensions.

Eric Mhlongo, KwaZulu secretary for the Department of Welfare and Pensions, said he was not ready to comment on when exactly his department would take over control of the facility.

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Sharp criticism for TPA hospital tariff increase

(286) (299)

STAR 9/4/92.

Staff Reporter and Sapa

The impending country-wide 12 percent increase in provincial hospital tariffs has been sharply criticised by political organisations and parties.

The Transvaal Provincial Administration announced yesterday that the increase comes into effect on May 1.

It will generate a R30 million income for the TPA in the coming year, according to MEC Fanie Ferreira.

Mr Ferreira said during a debate on the Transvaal Provincial Budget that all four provinces had decided to increase hospital tarrifs by 12 percent at the same time.

Democratic Party health spokesman Mike Ellis said while there was sympathy for the provinces due to cuts in health finance allocations, it was also not possible to condone the increase.

Mr Ellis pointed out that the increase would hit hardest the poorer section of the community — who had nowhere else to go but to provincial hospitals and who already suffered financial constraint.

ANC Secretary for Health Dr Ralp Mgijima said any form of restructuring in the health sector was unacceptable until a much broader consultative forum was established to deal with the issue.

National Education Health and Allied Workers' Union (Nehawu) assistant general secretary Neal Thobejane said the increase was "unacceptable" as the majority of blacks "cannot even afford the present tariffs".

The TPA also announced a drop in TPA's ambulance tariffs in rural areas from May 1.

This follows protests by rural communities.

According to the TPA, ambulances were charging R3 a kilometre from the point of departure of the ambulance in Johannesburg or Pretoria to the rural town to pick up the patient and back to the ambulance depot.

Under the new tariff system a patient would be charged for the distance from where he was picked up to where he was dropped off.

He said the other three provinces — Free State, Natal and the Cape — would introduce similar revised tariffs.

Eldos centre nets R53 000

SO Weekend 9/4/92

THE Harvey Cohen Centre for handicapped people in Eldorado Park, Johannesburg, made more than R53 000 in a win-a-car contest last week. (290

Mrs Dorothy Cornelius, the director of the centre which provides care and training for more than 200 handicapped people, said the contest went well, but they still had serious transport problems.

Yesterday the centre had to pay R180 to hire a bus to collect people because they had no transport.

Of their three buses, one was damaged in an accident, another would cost R14 000 to repair and another had mechanical problems and could not be used.

She appealed to the community to assist.

Hospital tariffs to be increased 12%

Political Staff

CAPE TOWN — Hospital tariffs will rise 12% from the beginning of next month.

Transvaal MEC Fanie Ferreira said yesterday the committee of all MECs for health in the four provinces had decided the increase would take place simultaneously. The rise would generate about R30m in the coming year, he said.

However, ambulance tariffs in the rural areas would drop by half on May 1. Ambulances currently charge R3 a kilometre from their point of departure in the major cities to the rural town to pick up the patient and back to the ambulance depot. Under the new system, a patient would be charged for the distance from the pick-up point to where he was dropped off.

GERALD REILLY reports Ferreira acknowledged that existing services, particularly medical and nursing services, were inadequate to deal with the growing number of patients at provincial hospitals.

Ferreira told the Transvaal extended committee on provincial affairs the opening of all outpatient and casualty departments and growing urbanisation had put hospitals under increased pressure.

Poor conditions had resulted in the loss of experienced hospital staff. About 35% of the most skilled nurses in the age group 26-35 left the service for the private sector.

● See Page 5

Mixed reaction to free Pill move

STAR 10/4/92

Pretoria Correspondent

The distribution of free oral contraceptives by pharmacists has met with mixed reaction.

The Pharmacy Council yesterday welcomed the decision by the Department of National Health and Population Development, and has praised the department for its "insight in involving pharmacists in primary health care".

"We wholeheartedly support the decision," said Pharmacy Council manager for education Michael Herbst.

He said the council was in favour of involving pharmacists in primary health care and family planning was a step in that direction.

The Medical Association of SA (Masa) has objected to the move, saying pharamacists do not possess the necessary medical training to safely prescribe these contraceptives — in spite of having completed the training course developed by the Department of National Health and Population Development in conjunction with the University of Potchefstroom.

"Although pharmacists may improve access to family planning, Masa is doubtful whether their involvement will have a positive impact on the level of care offered to the public in this regard," said director of professional services at Masa Dr Martin de Villiers.

Praising the move, Women's Bureau of South Africa director Margaret Lessing said: "As a member of the Brown Commission of Inquiry into Health Services, I welcome this."

Prolife spokesman Dr Claude Newbury said: "The Pill (produces) early abortions by preventing implantation of the 10-day old embryo into the lining of the womb.

"We therefore have difficulty accepting a move whereby birth control is given to children without parental knowledge and consent," he said.

"We also believe a drug as powerful and with as many acknowledged side-effects and complications as the Pill should not be made available to people without medical examination."

The reaction followed a decision by the Department of National Health and Population Development to allow more than 1 600 pharmacists who have completed a family planning course to supply the Pill under certain conditions.

These include taking a medical history from the client, monitoring blood pressure and referring the client to a medical doctor or clinic for an examination within a year of commencing oral contraception.

Although the contraceptives ordered by the pharmacists from provincial authorities are free, pharmacists can charge a professional fee of R3.

The service would only be available from June 1.

News set in braille for blind

299

STAR 13/4/92

Staff Reporter

Pupils at the Worcester Institute for the Blind, in the Western Cape, are now able to read newspapers for the first time, thanks to a joint effort by business and the media.

A computer link-up between Sanlam's Golden Acre network and Nasionale Pers' Foreshore headquarters now relays, via modem, the news and other educational material to the institute, where it is received on braille and voice printers.

This was announced recently by George Rudman, Sanlam's senior general manager, who donated R7 000 more to the institute, bringing the assurance company's total cash contribution to the institute to R22 000, in addition to equipment and technical assistance.

Mr Rudman described the development as "an historic breakthrough", because the pupils had previously been restricted to minimal reference sources and did not have access to newspapers.

Hospital tariffs rocket

HOSPITAL tariffs in SA will increase by 12 percent from May 1, Transvaal Provincial Administration MEC Fanie Ferreira said this week.

"Income from the tariff rise will generate R30-million in the coming year," he said.

TPA ambulance tariffs will drop by half on May 1 in certain rural areas.

Reports by CP Correspondents and Sapa.

New health plan mooted

Biocm 15/4/92 (299)

KATHRYN STRACHAN

AS THE state once again comes under attack from all sides for its increasingly expensive and deteriorating health services, the idea of a national health insurance scheme is gaining in popularity as the best solution.

Wits University Centre for Health Policy director Cedric de Beer believes that the state would best be able to raise funds for health care by combining an allocation from general tax revenue with funds raised through a statutory national health insurance scheme.

This system, which is used in many countries including Canada and Australia, involves replacing current medical aid contributions with compulsory health insurance for all those in employment.

ANC health department head Dr Ralph Mgijima says his organisation believes that drawing the private sector into a national health insurance scheme would be a logical step.

De Beer explains that there are only three possible options for central financing of health services. The money has to come out of general tax revenue, it must be raised from some form of statutory health insurance, or from some combination of the two.

The principle of a national health insurance scheme is that all those in formal employment pay a compulsory health insurance premium, which is usually matched by employers. As the scheme develops, self-employed groups can be brought into the scheme.

This revenue is then used to pay for a package of health services provided by either the public or the private sector. In many countries the funds are used only to pay for the health care of contributors. However, it is also possible for these funds to be pooled with government revenue set aside for health care, and used to pay for services for all. The state would pay the full costs of an agreed comprehensive package in any appropriate facility whether privately or publicly run.

Different countries have excluded specialist dental services, cosmetic surgery and the provision of glasses other than the most basic ones available. In Australia, the health insurance system will pay for medical services received in private hospitals, but those choosing to use private hospitals have to pay for the frills.

De Beer believes health insurance is merely a politically acceptable way of mobilising additional resources for health care from those groups which can afford to pay. It is easier to convince those better off to make additional payments earmarked specifically for health, than to pay the higher tax needed to pay for the subsidisation of health care from general revenue.

Linked to this argument is the notion that tax funding for health is relatively vulnerable. During periods of economic recession government can easily reduce the health budget. It is more difficult to do so with an earmarked allocation.

The development of a national health insurance scheme would not establish equity in health care overnight, warns De Beer. However, as the state gains control over extra funds, so it should become possible to direct funds for capital development to the areas at present under-serviced, and to create incentives for doctors and nurses to work in these areas.

Major opposition would be expected from a number of sources, most obviously the medical aid schemes and doctors and private hospitals that want to operate outside the state-financed health system.

The Medical Association of SA (Masa) is looking also at a national health insurance system, but remains concerned that it could undermine the role played by medical aid schemes. "If such a system were to be introduced it would be essential to find a way of synchronising it with the existing medical scheme system, so as to enhance rather than potentially to destroy the existing system," says Masa secretary-general Hendrik Hanekom.

De Beer believes medical aid schemes should be used only for services not included in the basic package provided by the national scheme. If they were allowed to operate in place of a national health insurance system for individuals who chose them, this would simply reproduce the existing exclusive private sector system which consumes 50% of resources while serving 20% of the population, and undermine the whole national health system.

There would also be the danger that medical aid would "skim off" better risk groups and offer them lower premiums, which would seriously undermine the national scheme.

He concedes that the expertise needed to operate such a system lies with medical aid administrators, and ways of incorporating them into the system could be discussed.

De Beer would also expect opposition from private sector doctors and hospitals in that a national health insurance system could reduce their earnings or profit margins.

This is because the state, being by far the largest buyer of health care, would be in a powerful bargaining position in negotiations with private hospitals and practitioners over rates of payment.

IF THERE is an identifiable financial

change rate mechanism parity -- to be

ANC joins call for new health policy

STAR 16/4/92

By Zingisa Mkhuma and Shirley Woodgate

The ANC has added its voice to the growing number of bodies concerned about the appalling state of the public health services, saying that it had warned a long time ago that there was a "health crisis" in the country.

South Africa is suffering a major breakdown of public health services and there have been calls for urgent action to alleviate the situation which is being aggravated by political violence and the horrific road accident rate.

The ANC yesterday reiterated its call for the Government to do away with the two tier health system which, it said, had made it possible for health workers to run away from public hospitals because of falling standards and low wages.

Democratic Party health spokesman Carole Charlewood said yesterday the situation was untenable when a country that called itself civilised had to decide which of its sick would live or die.

She called for an immediate round-table conference to fashion a new health policy.

PAC secretary for health Dr Selva Saman said the private sector consumed half of the national health budget, but served only 20 percent of the population. "The private cost of health is increasing at about twice the rate of inflation," he added.

The Department of National Health and Population Development this week said that the crisis was being aggravated by violence and the high number of accident victims being treated at provincial hospitals.

At the same time, about 35 percent of the most skilled nurses between the ages of 26 and 35 years have left the service for the private sector.

But the Transvaal Provincial Administration denies that any intensive care unit (ICU) beds in its five major hospitals have been closed.

However, chief director for advanced health-care services Dr Harm Pretorious acknowledged there was a shortage of resources which was felt in the ICU wards of some State and country hospitals. Patients in ICU wards were sometimes "pushed aside" by critically injured people, he said.

Dr Pretorius was responding to an earlier report from the Critical Care Society of Southern Africa, which stated that up to 20 percent of ICU beds in South Africa had been closed. The president of the society, Dr Dick Burrows, said that the crisis had reached a point where critically ill patients had had to be turned away.

The ANC said that, in its health policy document, it had proposed steps to attract nurses and doctors back to public hospitals.

A spokesman for the ANC's health department said it was a fallacy that the National Health budget had gone up by 22 percent this year.

"We think at the most it went up by about 16,6 percent, because the Government included the R440 million set aside for the Nutritional Development Programme in it," he said.

enthusiasm of some of the private entrepreneurs who wish to flourish. [Time expired.]

Mr M RAJAB: Mr Chairman, I stand corrected by the hon the Minister of Transport who said that we require R2,8 billion instead of R2,269 billion to keep our roads in a proper state of maintenance. Quite obviously I bow to the hon the Minister's expertise in this regard. After all, he is the Minister, not I.

I appreciate the admission made here by the hon the Minister this afternoon that we do require more money for the maintenance of our road system. It is interesting that just two weeks ago, in the debate on provincial affairs, his colleague, the hon MEC in charge of roads in Natal, was decrying the fact that not enough had been allocated to Natal per se for the maintenance of roads in that province. I was wondering whether, in the provincial allocation of the budget for the maintenance of roads, Natal was not in fact short-changed.

The CHAIRMAN OF THE HOUSE: Order! I regret that I have to short-change the hon member. His time has expired.

The MINISTER OF TRANSPORT: Mr Chairman, I agree that everyone is short of money. If that is valid for Natal, it is valid also for all the other provinces as well as the SA Roads Board.

I should like to say that there is an alternative. There is always an alternative. It is part and parcel of the practice of toll roads. I think the hon the Leader of the Official Opposition is correct in saying we must not push people onto new toll roads. We must have another look at the matter, however. We cannot keep two roads right next to each other in a superb condition. We shall have to address this again. It will be a political debate, however, and therefore I do not think it would be appropriate to discuss it now.

I should like to say that according to the Budget, the SA Roads Board will get about 52% from the Exchequer in 1992-93. The rest, 48%, will be financed by toll roads. Toll roads, therefore, are a major roleplayer in providing roads in South Africa. Unfortunately it will not be possible to build roads without toll roads.

I should also like to say that because of the shortage of money, we introduced a new policy on roads at the end of last year. I should like to summarise it, as the hon member for Bayview asked me to do. In terms of the new policy for roads, we shall maintain the existing road network. If there is money left in the kitty, we shall upgrade the roads. If there is money left after that, we shall build new roads. That is our policy. We should like to ask the four provinces as well as the independent and self-governing states to help us in implementing this policy.

Our national road assets are valued at about R90 billion. We have to keep those assets intact for future usage. That is why maintenance is our first priority. [Time expired.]

Debate concluded.

QUESTIONS

†Indicates translated version

For oral reply:

General Affairs:

Second-hand clothing: permits

*1. Mr M RAJAB asked the Minister of Trade and Industry:

(1) Whether his Department has issued any permits to churches and welfare bodies to import second-hand clothing duty-free; if so, (a) why and (b) how many such permits were issued;

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

D102E

The DEPUTY MINISTER OF JUSTICE (for the Minister of Trade and Industry):

(1) The provision in rebate item 405.04/63.09/01.00 in Annexure 4 to the Customs and Excise Act allows churches and welfare organizations to import second-hand clothing duty-free, provided the churches and organizations distribute the clothing free of charge. To qualify for the duty rebate, these organizations are required to submit a written statement to Customs and Excise in which they undertake to distribute the clothing free of charge. Under normal conditions, the import of second-hand clothing is subject to import control in terms of the Import and Export Control Act, 1963.

After it came to light that the provision concerned had allegedly been misused to a great extent, and that some of the clothing imported in terms of the provision had become available in ordinary business, the matter was investigated by the Board of Trade and Industry who will soon submit proposals to Government for the amendment of the provision in order to restrict the misuse thereof. The alleged misuses are specifically connected with a *concession* granted a few years ago which allowed the organizations concerned to sell a part of their second-hand clothing in order to cover import and distribution costs. It will, inter alia, be recommended that the abovementioned *concession* be cancelled.

(a) The goods in question are supplied free of charge by churches and welfare organizations abroad to similar organizations in South Africa which in turn, distribute them free of charge to needy people. Import permits are therefore issued for humanitarian reasons.

(b) During 1991, 121 "no-value" import permits with a value of R639 939 for Customs purposes were issued to churches and welfare organizations.

(2) No.

Mr M RAJAB: Mr Chairman, arising out of the hon the Deputy Minister's reply, I wish to state that I have a list of supplementary questions with which I will not burden the hon the Deputy Minister of Justice and of the National Intelligence Service. I have had a communication from his colleague the hon the Deputy Minister of Trade and Industry and I appreciate the fact that he is not here because he is in Johannesburg. I will ask these supplementary questions by means of direct communication with him.

Voluntary euthanasia

*2. Mr M RAJAB asked the Minister of Justice:

(1) Whether he has set up or intends to set up a body to investigate voluntary euthanasia; if not, why not; if so, what are the relevant details;

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

D103E

The DEPUTY MINISTER OF JUSTICE:

(1) and (2) The South African Law Commission, at its meeting held on 3 February 1992, recommended that the question of "Euthanasia and the artificial preservation of life" be included in an investigation in its programme. On 2 March 1992 I formally approved that the matter be included in the programme of the Law Commission under the title "Living Will". At present the project is receiving the Law Commission's attention and interested parties are welcome to submit proposals in this regard to the Secretariat of the Law Commission.

INTERPELLATION

The sign * indicates a translation. The sign †, used subsequently in the same interpellation, indicates the original language.

Own Affairs:

Springfield College of Education: facilities

1. Mr M RAJAB asked the Minister of Education and Culture:

(1) Whether it is the intention of his Department to restructure the facilities at the Springfield College of Education in view of its in-service programme; if not, why not; if so, what are the relevant details;

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

D116E.INT

The MINISTER OF EDUCATION AND CULTURE: The answer to the first part of the interpellation is no. The intention of the Department to restructure facilities at the college is not due to the implementation of the in-service education and training programme.

The facilities and infrastructure at the college are being refurbished by way of renovations and repairs to the tune of R2 169 796 for the pre-service programmes on offer at the college. The enrolment in these programmes has increased to approximately 577. The projections for the next two years are an intake of approximately 650 for 1993 and an intake of about 700 students in 1994. These renovations and repairs include offices for the rectorate, updating administration offices, updating the cafeteria, a new staff room, a new

cont-p

Emphasis must be on reality and the economy

PMA president Hugo Snyckers called for a lowering of taxation, inflation, interest rates and a reduction in the level of unrest and crime in order to create economic growth.

Speaking at the PMA's seminar on options for health last November, Dr Snyckers said it was useless to isolate a health-care delivery system from the country's economy.

He said businessmen needed reassurance that they would in future be operating in an economy based on private enterprise. This would increase local investment and attract investment from overseas.

"Unless there is economic growth, there will not be sufficient profits or income to tax for State-supplied health care or contribute to medical aid for health care provided within the private sector.

"And let me please remind everybody that out of profit, tax is paid on income and nothing could function unless there is profit," he said.

"It would indeed be wonderful if we could provide free or almost free and limitless, high quality health care to all, but this of course is totally unrealistic and even wealthy countries that have tried to move in that direction have failed."

Speaking about constitutional negotiations he said: "When negotiations begin, the emphasis should be on the requirements of sound economic and political systems for the future South Africa. We should take what is best from constitutional and economic models around the world and adapt those to our circumstances.

"However, one must recognise that expectations have escalated against the background of what remains a relatively poor economic performance.

"The immense challenge of the mobilisation of resources and the delicate matching of priorities and available inputs can only be achieved successfully in a predictable political framework.

"If we allow the constitutional negotiations to be bedeviled by redistribution issues, the risk of failure is likely to be very high. It is better to address the questions of socio-economic upliftment in their own right.

"What I am trying to say is that when we talk about a future cost-effective and obviously equitable and durable health care system, we should not be blinded by the immediate need to do something about current inequities.

"We should first agree on an economically sound system, which must fit into the overall economic scene, and then, separately from that, negotiate on how to overcome the worst inequities in the shorter term.

"If we opt for the alternative we can only be talking of a National Health Scheme, and if we do that we would seem to want to defy international experience stretching over more than 40 years and undergo what at best could be described as a bad experience."

Dr Snyckers said that in some countries, particularly the East Bloc countries, as well as in developing countries, including Africa, the nationalised health care delivery systems had lowered the standard of such services to an unacceptable, indeed an appalling standard.

Disabled Alex workers trapped

STAR 23/4/92

By Montshiwa Moroke

The violence in Alexandra has trapped disabled people in the township because they are afraid to go to work, a Self-Help Association of the Disabled (Shadax) spokesman said this week.

Shadax is based in London Road, Wynberg, and is near the area where the worst fighting takes place.

It employs about 60 disabled people from Alexandra, including paraplegics and blind and deaf people.

Shadax spokesman Sinah Gwebu said only between eight and 15 people had reported for work daily since the violence started in March and the company was suffering financial losses.

Mrs Gwebu said a doctor and several shopowners in the vicinity had already moved out of the area, fearing for their lives and properties.

She said the situation had become so serious that the company had decided it would be best to move to an area such as Marlboro, on the other side of the township.

"It is only us who still remain here but our colleagues are afraid to come to work because we are where some of the worst violence has taken place," she said.

"Two weeks ago we did not work for a week and this is negatively affecting our contracts.

She said her company would be speaking to owners of businesses to see whether they could assist them in any way. They would approach landlords to discuss the rental for alternative premises.

A committee from Shadax intended to meet Alexandra councillors to see if they can offer the organisation some land.

ea th-care costs come under worldwide scrutiny

No government, whether rich first world or poor third world, can accept sole responsibility for the health care delivery system in its country.

A World Bank report states: "The conclusions argue that present policies need to be substantially re-orientated in many countries. The conventional and still growing faith that health care should be totally paid for and administered by governments needs to be vigorously challenged."

The subject of an ever-increasing health care bill and how to fund such costs is receiving the highest priority internationally.

Eugene L Step, chairman of the board of the American Pharmaceutical Manufacturers Association (PMA), summed it up at the 14th IFPMA Assembly held in Washington in 1988:

"In the more than a century since Otto von Bismarck first established the German social security programme, we have seen not only a revolution in the science of health care, but a revolution in the politics of health care. The simple and primitive care that was once considered the privilege of the few has become the sophisticated, expensive care considered to be the right of all."

For decades governments have been making health care promises without realistically calculating the costs. Historically, rapidly growing economies have permitted governments to fund these promises.

With the slowing of economic growth, health care costs have come under increasing scrutiny.

"The confluence of a rising tide of health care expectations, expensive new technologies, longer life expectancies, and an ageing population have brought a world-wide focus on health care costs."

The position in South Africa is therefore no different to that in the rest of the world.

Strategy

This is the conclusion of the PMA (South Africa) who have written a strategy document entitled "A cost-effective, equitable and durable health care delivery system for South Africa", outlining its attitudes towards health care.

The PMA supports a health care scenario of economic growth coupled with a free enterprise economy within which privatisation and deregulation play a decisive role. This is essentially what the Government has committed itself to.

It does not support the idea of a national health system because this puts the onus of funding such a scheme on the fiscus with little or no responsibility on the individual.

The Government's own declared philosophy of a free enterprise economy and the long-term economic needs of South Africa would make such a national health scheme unaffordable.

The PMA acknowledges that currently the economic growth rate in South Africa is unacceptably low, thus limiting the creation of job opportunities and consequently there is an increase in the unemployed and underemployed.

This places additional and unnecessary burdens on the fiscus at a time when pressure is being exerted on the Government to reduce expenditure.

South Africa cannot afford for health care costs to increase in an uncontrollable manner and the PMA feels there is a need to adopt an equitable, cost-effective and durable health care delivery system.

The PMA outlines the following major problems facing South Africa's health care delivery system:

- Lower econonomic growth rates
- Population explosion (with minor exceptions) mainly in what is internationally termed the third world population
- Higher employment and underemployment
- A greater percentage of the total population moving into the category of the aged
- The overtaxation of the working population with such negative results as reducing personal private expenditure, eliminating entrepreneurial initiatives;
- Misuse and overuse of health care delivery services both in the public and private sectors
- Inhabitants who are loathe to accept greater responsibility for health care including preventative and curative health care services in that the perception has been cultivated since World War 2 that health care is a right and not a privilege
- Modern but more cost-effective techniques in treating patients
- More "expensive" but more cost-effective medicines.

The PMA warns that unless an orderly structure is designed to define the role and responsibility of the Government, the employer and the individual, a credibility gap will develop between Governments and the private sector health care delivery system, the Government and the patient, the private sector health care delivery team and the patient and even between members of the health care delivery team.

Furthermore, unless such structures are designed within the broad economic scenario defined, the demand on the fiscus will ultimately become unbearable because of other priorities.

One of the most important factors affecting the future of health care in South Africa is population growth.

This will effectively determine the quantity, quality and distribution of health care services.

A study by the University of South Africa's Bureau of Market Research found that the total population in South Africa would increase to more than 47 million by the end of this century and would double in the next 28 years.

Several factors should help to limit population growth.

These include education, promotive and preventive health education, improved housing and the securing of a stable job opportunity.

The PMA document quotes parts of the report by the Science Committee of the President's Council on Demographic Trends in South Africa of 1983.

On the subject of health care the report recommends that no elderly person should have to forego reasonable treatment because of an inability to pay but that in future every individual would have to become more responsible for the financing of his/her own medical and health care.

"This means the State will provide reasonable medical treatment for those who need it, while those who demand more, will have to be prepared to finance it themselves", the President's Council report concludes.

The report also recommends that the "greatest possible encouragement must be given to the private sector by means of public education programmes and tax incentives to ensure that adequate medical aid and/or insurance schemes are available and are utilised in South Africa".

The PMA points out that the growth of the population will lead to increased competition for scarce financial resources in the fields of economic investments such as job creation, the raising of per capita income (through training people), capital formation (in plant and infrastructure) and of demographic investments (education, health services, housing, energy, water supplies and social infrastructure) in addition to the requirements of the army and police.

According to the Earthscan Institute, 80 percent of the world's diseases are linked to inadequate water and sanitation in the form of waterborne diseases, water-based diseases and infections because of defective sanitation.

Globally, over 1 000 million people are affected.

Inadequate shelter and poor education all contribute to general morbidity. (There is a direct correlation between education and general wellness).

Other factors such as social and physical security and inadequate policing also contribute to South Africa's health problems.

The PMA feels that it is important that the Government expenditure is reduced (with consequential tax relief), as it has "been shown internationally that the greater the share of the Government in a national economy, the less chance there is to induce growth in that economy."

In conclusion the PMA argues that the principles of a cost-effective, equitable and durable health care system are:

- The individual is responsible for his/her own health
- Health care is a privilege and not a right, but the indigent and aged must be cared for
- There must be one health care system
- The individual should be funded rather than institutions. (There is widespread consensus that the direction for a solution for the indigent, the disabled, the chronically ill, the terminally ill and the social pensioner must be sought in the subsidisation of the needy individual. The underlying assumption is that this is more cost-effective than creating a subsidised delivery structure for these target populations.)
- The real costs of public sector facilities must be calculated so that the costs of public and private facilities can be compared realistically; the same rules regarding conditions, codes of practice, cost calculation, standards, controls etc will have to be applied to both public and private institutions.
- Principle of co-payment (the patient being charged in relation to his income)
- Promotion of self-medication
- Restructuring of medical aid/insurance schemes
- Using the free market concept to supply medicines and professional services

The PMA believes the adoption of these principles is essential for a health care delivery system, which will be cost effective, equitable and durable and which will offer sustained implementation in future.

Package

The philosophy expressed must be seen as a package.

Unless this principle is adopted, a situation can once again be reached that loopholes will be promoted to misuse and abuse both the private and public health care delivery systems.

The adoption of these principles, will be cardinal in developing a strategy for privatisation of the health care delivery system.

The PMA also recommends appropriate deregulation in order to facilitate privatisation.

'This is the way to provide best health system'

STAR 23/4/92

299

The subjects of health, and the system for the delivery of health care, are emotional and politically sensitive, all over the world.

At the same time it is impossible to look at such issues in isolation from South Africa's economy.

Unless there is economic growth there will not be sufficient profits or income to tax for state-supplied health care, or to contribute the medical aid for health care provided within the private sector.

The PMA believes in a free enterprise economic system and a dual system to provide health care.

The debate on this topic is complicated by a severe lack of accurate, comprehensive and unbiased health economic data and especially data relating to cost-effectiveness of health care.

South Africa has, however, a lot of information on cost which is used by everybody to "prove" the inefficiencies of the other side's system.

It would indeed be "magic" if South Africa could provide free or almost free and limitless high quality health care to all, but this of course is totally unrealistic and even wealthier countries that have tried to move in that direction have failed miserably.

Health care provision must also be seen in conjunction with other competing socio-economic needs that exist including housing, education, sanitation and water.

The PMA believes that all accept that socio-economic upliftment in South Africa is urgently necessary and must be given a high priority.

However, one cannot support the viewpoint that the immediate need for socio-economic development must be addressed separately from the fundamentals of a future economic and health care delivery strategy or system.

Scheme

It further seems that the World Health Organisation slogan, "Health for all by the year 2000", is being deliberately misinterpreted to mean that this should be the sole responsibility of a government. This is not so and to adopt this would be contrary to the conclusions reached in international studies.

It is, however, common knowledge that many see a possibility in financing a national health scheme similar to the one applicable in the United Kingdom. Recent changes to the scheme indicate that the original objective has not been successfully achieved.

It seems to be more correct for South Africa to continue with its dual system — but that a greater growth rate in economy is necessary to create more job opportunities in the private sector, particularly if cognisance is taken of the population explosion which is being experienced.

This conclusion should be associated with the address by Robert Dole, Republican leader in the US Senate in October 1988:

"My topic is about responsibility, and I believe that the Government's responsibility to control costs and avoid waste is no greater than its responsibility to encourage industry to continue to search for new and improved medicines.

"What I am suggesting is that the manner in which this health care is provided can have a significant impact on health care now — and most importantly — in the future."

The term "manner" naturally also includes not only the physical provision of health care but indeed the financing of health care.

The demand for health care for all population groups in South Africa currently exceeds the State's ability to meet this demand. It is likely that the extent of this inability will continue to increase.

The PMA believes it to be imperative for the State and private sector to co-operate to the fullest extent to bring about the most cost-effective use of scarce resources available to meet the demand for health care.

Call for nurses to handle primary health care

STAR 24/4/92

Staff Reporter

Capable nurses could easily handle 80 percent of the primary health care traffic now done by general practitioners, according to Ray Leigh, convener of the Lay Health Lobby which calls for the introduction of health maintenance organisations (HMOs) to alleviate the growing health crisis.

Mr Leigh believes registered nurses should be allowed to examine, diagnose, prescribe and treat patients up to the level of their expertise.

"Highly qualified doctors have no need to waste time on minor complaints.

"These doctors have more important work to do," said Mr Leigh.

He was speaking after the launch of a Lay Health Lobby booklet entitled "HMOs: Solution to the health-care crisis" which attacks legislation restricting the establishment of HMOs.

Vaalmed in Vanderbijlpark is a good example of an HMO, said Mr Leigh, which although restricted, managed to deliver health care services at no less than 40 percent below the costs of a medical aid society.

The Lay Health Lobby is now recruiting business support for converting medical aid schemes to HMOs.

"Until now, HMOs providing full hospital services could only be established in one-industry towns," said Mr Leigh.

"Apart from these, no single company can establish an HMO for its employees.

"A company's employees live in widely-dispersed suburbs and HMOs must be situated where employees and their families live," he said.

According to Mr Leigh the answer is clear: Companies can establish multi-company HMOs by pooling the numbers of their employees living in the same residential areas.

According to Mr Leigh HMOs could reduce the cost of health by more than 40 percent when restrictive legislation is removed.

Ill health a luxury, warns Venter

CAPE TOWN — South Africans can no longer afford to be ill, Minister of Health Dr Rina Venter said in Parliament yesterday.

Introducing debate on the health budget vote, she said payments by medical aid schemes to private hospitals had risen by 55 percent between 1989 and 1990.

South Africans were among the highest claimants for health services in the world.

"The increase in payments exceeds the inflation rate by far. South Africans can no longer afford to become ill."

There would have to be a revision of the "established interests and consumer patterns" if the survival of the private sector in the health dispensation was to be ensured.

Dr Venter said she planned to table draft legislation this session to amend the Medical Schemes Act by increasing the power of medical schemes to manage their own affairs, and help them to develop cost-saving measures and counter malpractice effectively.

The Bill would set out a maximum medical aid tariff in benefit structures and ensure regular actuarial investigations for the funding of schemes. — Sapa.

Caught between militant supporters and obstinate govt

B Day

PATRICK BULGER

24/6/92

THE paradox in the ANC's decision to call off talks and yet still want to inform President F W de Klerk personally of its demands reflects the tenuous position in which the organisation finds itself two years after its unbanning.

Having tried the full gamut of strategies to force the government from power, the ANC leadership finds itself trapped between the militancy of its followers and the obstinacy of government.

The paradox manifests itself at a number of levels. The armed struggle has been suspended, yet ANC officials are killed at will. Exiles are returning, only to face police harassment at home. To cap it, in the midst of the ANC's misery, De Klerk is fêted around the world.

The ANC thrashes about in this political no man's land — issuing ultimatums, making demands yet urging reasonableness. Its resources strained to the limit, its patience tested and its moderates embarrassed, the ANC casts a nervous eye at its constituency and fails to recognise it through the fog of political uncertainty.

A senior national executive committee (NEC) member relates how ANC leaders, facing township audiences, are confronted by new songs — which the leaders do not recognise — calling for guns. In the face of this grassroots militancy, the ANC has little option but to suspend negotiations. It does so, however, with the claim to being the custodian of negotiations, a graphic admission that a negotiated settlement is in the interests of its leadership.

Two visits to Boipatong at the weekend illustrated the challenges and the problems facing the negotiation process. De Klerk's face-to-face meeting with black anger — an encounter no other NP leader of government has yet experienced — taught government several lessons that will have an impact on negotiations.

Astute politician that he is, De Klerk underestimated black anger at the continuing carnage in the townships and at him as head of state. NP hopes of putting together a winning election alliance appeared in that fleeting visit to be ill-considered. The pressure on government to remove itself from power with the remaining grace it can summon is imperative as black anger rises by the day.

ANC president Nelson Mandela's visit the following day and the rapturous welcome he received illustrated just as graphically that the ANC and its leader is the only political force in the country with the capacity to control the townships. The alternative is ungovernability and unpopular security measures.

These are hard political facts for the NP to swallow. Yet, even harder to swallow, for the country as a whole, is an agreement with a political leadership divorced from its constituency. This is what government's campaign to undermine the ANC could come to, and it is a development that can only set SA on course for a disastrous confrontation between white diehards and township radicals with nothing to lose.

The ANC's demands contained in last night's NEC statement are "eminently reasonable", secretary-general Cyril Ramaphosa said. In essence they are similar to those linked to the ultimatum the ANC made last year, regarding security matters, and in some respects put SA back to the pre-Codesa era.

☐ RAMAPHOSA

Codesa had come to a virtual standstill since the May plenary session and it was generally accepted that progress in bilateral talks between the ANC and government was necessary before there would be progress at Codesa.

The political challenge facing SA now lies in the resumption of the negotiating process. The ANC will find it difficult to find solid reasons for restarting talks unless De Klerk acts on at least some of the demands presented to him. As with last year's impasse, the demands require that De Klerk puts a distance between himself and the security forces and that he show himself to be impartial in regard to security force conduct.

Whether he is willing or able to do so remains one of the big unanswered questions in SA political life. As with a year ago, Mandela maintains that either De Klerk is behind the violence or that he has no control over his security forces.

Codesa made some progress on the question of joint control of the security forces, but negotiations will remain bedevilled as long as there is a perception that the security forces are less than wholeheartedly committed to a negotiated solution.

It has become a truism to say that negotiations offer SA the only route to democracy. But negotiations can take place both before and after civil wars.

In the next few days government and the ANC will attempt to restart talks. In the meantime, SA's participation in world sport and its return to the international community will remain under threat. The economy will wither as political uncertainty drags on.

The ANC's long-term demand for a democratic constituent assembly is not going to be forgotten or dissipated in compromises that offer anything less than full-blown majoritarian democracy. Government will sooner or later have to test its strength among the electorate. De Klerk's Boipatong visit suggests he has no time to waste.

For the ANC, difficult months lie ahead. It will have to persuade its followers — against all the evidence to the contrary — that government is serious about a negotiated transition to democracy. It will have no chance of success should the township killings continue and should the security forces appear partial to political groupings.

Government will be hard pushed to persuade the international community of its sincerity. It faces a renewed loss of standing among world leaders who effectively granted government a last chance to negotiate itself out of power when De Klerk unbanned the ANC.

De Klerk cannot continue to live on international goodwill indefinitely. The mood of black South Africans is ugly — it will take more than smiles and kind words on his part.

Over the next few months, the militants in the ANC will take maximum advantage of the suspension of negotiations to prove the correctness of street-based confrontation. Should their methods of protest prove more effective in moving government, they will argue strongly against a resumption of negotiations.

In the chaos and economic debilitation that will accompany mass action, precious time will be ticking away. With the negotiators outwitted by circumstance and hidden agendas, it will be left to the warlords to pick up where they left off.

Specialised help for personal injury cases

BD Day 29/4/92 (299)

PERSONAL injury claims form a large part of the case load in SA courts.

Despite the fact that the claimant is an individual as opposed to a corporate body and very often a person of limited means, personal injury litigation is a specialised and highly responsible area of the law.

"It is imperative that the attorney concerned is experienced and has a full understanding of this type of work," says Peter van Niekerk, a partner at Routledge-MacCallums.

"The individual pays a heavy price if a matter is mishandled."

Van Niekerk says that although Routledge-MacCallums primarily acts for institutional and corporate clients, the firm decided some time ago to act only for individuals in respect of personal injury claims. The firm's personal injury department is headed by Van Niekerk and another partner, Miro Dvorak, with the support of an experienced team of assistants. Their case load includes MVA, public liability and malpractice claims.

"The department is committed to ensuring that their clients receive adequate compensation," Van Niekerk says. "In this regard, it is imperative to keep well abreast of all changes in the law and to set high standards."

Van Niekerk and his department have been involved in this area of the law for a considerable time and have been able to establish good contacts with top medical practitioners and other experts.

"We handle our clients professionally, informally and explain the implications of the matter.

"We appreciate that any accident is traumatic and we concentrate on alleviating the client's uncertainty regarding the legal aspects and on putting them at ease."

Clients are also offered a range of additional services after the resolution of their claim. These include commercial and tax advice, as well as advice on trusts and making a will.

Another Johannesburg attorney for whom personal injury claims form a large percentage of her case load is Monique Woods of Cuzen and Woods.

She says that although all attorneys are notionally qualified to handle personal injury claims, there are only a handful who have acquired the specialised knowledge in that field of the law.

This includes the ability to assess the negligence of the parties involved, the proper presentation of the claim to the third party insurer and, if the claim is not settled, the ability to proceed with the matter to trial in either a magistrate's or Supreme Court.

Medical knowledge is also a requisite for the proper assessment of the client's quantum of damage, says Woods.

Fees rise at hospitals

Sowetan 29/4/92

THE TPA's increased hospital tariffs which come into effect on May 1 could affect the poor - but a revised ambulance tariff system could bring relief to some patients.

MEC for Health Services Mr Fanie Ferreira said in Pretoria yesterday that the revised ambulance tariff system was not a general increase.

"In some cases the new system will result in an increase and others a decrease of tariffs," he said.

Ferreira said patients classified under hospital (H1) and who did not enjoy cover from medical schemes would pay less for ambulance transport over 50km (R10 instead of R15 a trip).

Patients classified as H2 and H3 would pay R3 and R5 more respectively for the same distance.

Sowetan Correspondent

(299)

Hospital tariffs had not been adjusted for outpatients in community hospitals, and minor adjustments had been made for academic and regional hospitals for H2 and H3 patients.

In community hospitals tariffs for patients from H1 to private were raised to between R19 an admission and R184 a day, and in academic and regional hospitals they were raised to between R24 an admission and R234 a day.

Fees for services such as theatre, intensive care, high care, maternity cases and community and primary health care for the various categories were increased by up to 50 percent.

Inquest into Webster's death

Sowetan 29/4/92

THE Attorney-General of the Witwatersrand Local Division will request that a Supreme Court judge be appointed to hold an inquest into Dr David Webster's death.

Webster was killed on May 1 1989 at his home in Troyeville, Johannesburg. His death was widely blamed by anti-apartheid forces on "hit squads".

In a statement yesterday, the office of the Attorney-General of the Witwatersrand said a legal task force was created a year ago to investigate the case.

The statement said: "Reg. ettably, during its year-long investigations, the legal task force was unable to uncover any further relevant and admissible facts.

"Thus, the position is that we clearly have an unlawful act but no accused, the various investigations having failed to obtain evidence identifying the perpertrator(s)." - *Sapa*

No study

BAROMETER

hotel development to the tune of about R4,6-billion.

Brown Nats
NATIONAL PARTY membership in the House of Representatives last week increased to 40 when the MP for Britstown, Louis Hollander, joined the party.

Medical Aid
National Health and Population Development Minister, Rina Venter, said in parliament this week that payments by medical aid schemes to private hospitals had increased by 55 percent from 1989 to 1990.

For this reason, she would table draft legislation to amend the Medical Schemes Act which would allow medical aid bodies to: manage their own affairs, create opportunities for cost-cutting and counter malpractice.

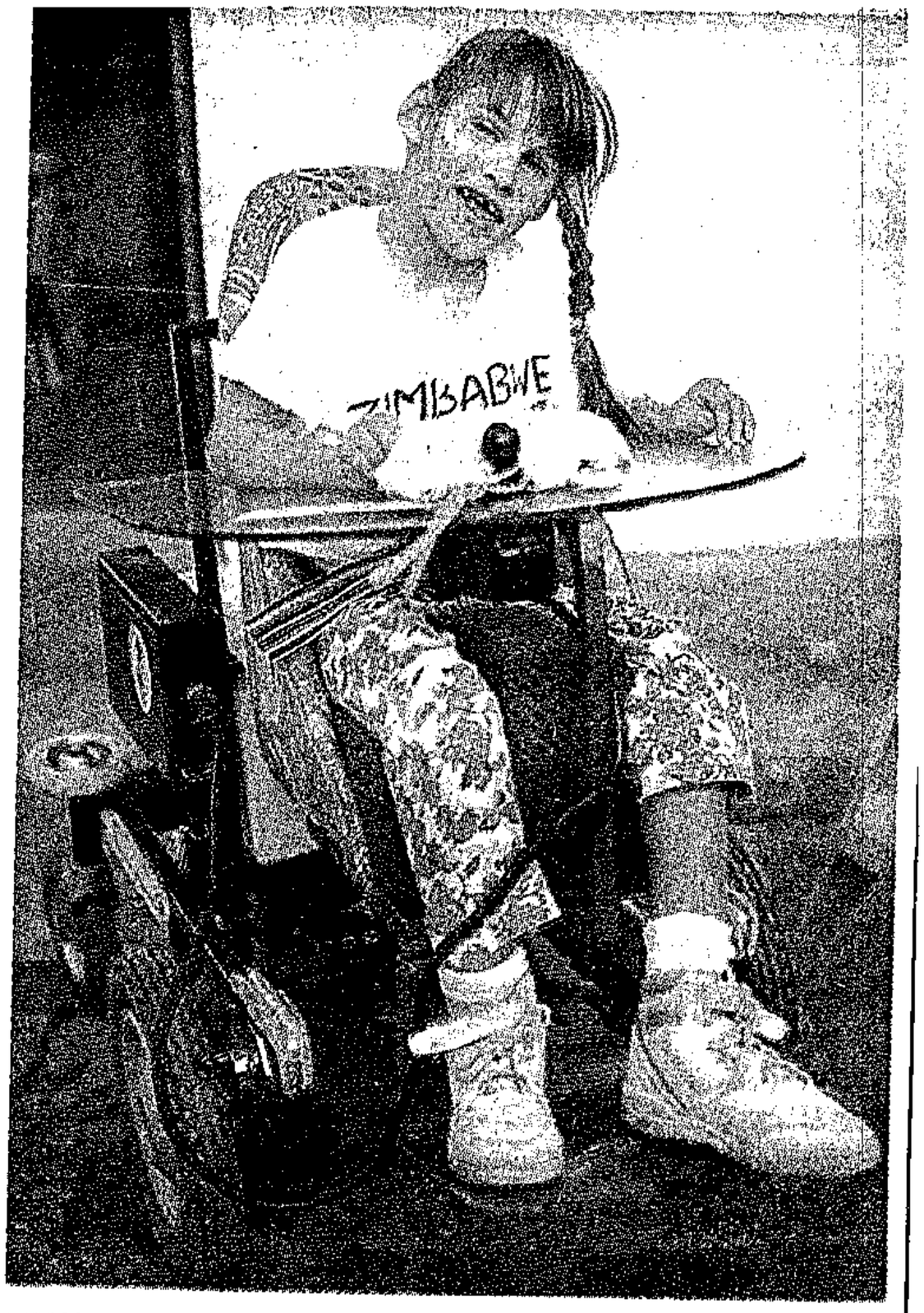
Tourism
IN 1995, one million tourists are expected to visit South Africa as the country's international relations thaw, says Minister of Administration and Tourism Org Marais.

The tourists would generate about R7,5-billion, create about 150 000 jobs, require new buses worth R150-million and need

Rebate anomaly is bad news for disabled

ST Times [Cape Metro] 3/5/92.

(299)



TAX WAR . . . Shelly McDonald, aged nine, is a victim of the law on excise duty which discriminates between different categories of disabled people **Picture: AMBROSE PETERS**

A NINE-YEAR-OLD Plumstead girl who is cerebal palsied and deaf, is the latest victim of an anomaly in the tax rebate system which discriminates against certain classes of physically disabled people.

In terms of the Tariff Rebate Listing issued by the Department of Customs and Excise full tax rebates are allowed for equipment for the deaf and the blind — but other disabled people are forced to pay full tax.

Little Shelly McDonald needs a page turner as she is learning to read but her mother Shona is baffled by the law.

"I don't see the logic," she said. Shelly needs the page turner because she is cerebral palsied and therefore would not qualify for the rebate. But because she is also deaf she should qualify even though her deafness is not the reason she needs this equipment.

In most cases the equipment is not made in South Africa and must be imported, but there appears to be no uniformity in the way the rules are applied.

Imported wheelchairs, for example, are exempt from tax . . . but parts imported to build chairs are taxed.

Mrs McDonald, who makes some equipment locally, has tried to bring in parts for wheelchairs to make a more affordable wheelchair here.

Impound

Although the rebate "discrimination" was first brought to the attention of various government departments nearly 18 months ago — and in spite of extensive correspondence — it has not yet been resolved.

When the principal of the Forest Town School in Johannesburg applied to the Board of Trade for an exemption on duty for an "Introtalker" for a six-year-old cerebral palsied boy, he was told his application had been rejected because the "Customs and Excise Act, 1964, does not provide for a rebate of duty on goods especially designed for the physically disabled, except for the deaf and the blind".

The equipment remained impounded by customs for two-and-a-half months before being sent back to the United States.

Dr David Boonzaier, director of Rehabilitation Technology at the Medical School of the University of Cape Town, said he had lent his department's own training equipment to Forest Town for the boy to use.

Dr Boonzaier said he had also battled for months to get an import duty exemption for highly specialised hearing-speaking devices made in the US for three pupils at the Eros School for the Cerebral Palsied and a polio patient in Durban. This was rejected.

An indication of differences between various government departments is that while the Department of Health and Population Development says it is looking at the issue with "great concern and commiseration", the director of the Board of Trade and Industry, Dr Willie Lubbe, said his department had no plans to make any changes.

The result of these different interpretations of the rebates is that vital equipment for disabled people has been held up in customs for months — and in some cases the equipment has been returned to the country of origin because the organisation concerned could not afford to pay the tax.

The failure of the authorities to deal with the problem has led to criticism from a wide range of organisations for the disabled.

Benefit

Although the National Council for the Physically Disabled in South Africa alerted various government departments, including the Board of Trade and Industry and the Office of Customs and Excise more than 18 months ago to possible confusion between sub clauses and headings in the tariff rebate lists, nothing has been done to rectify this.

The former director of the National Council for the Disabled, Mr Chris Nunan — who has since died — wrote in a letter in November 1990 to Mr PJ Eksteen, the chief executive of the Board of Trade and Industry in Pretoria, that the "error" "appears to be administrative" — and it was "obvious" the rebate was intended to benefit all disabled people.

A spokesman for the Board of Trade and Industry, which considers applications for exemptions in terms of the Customs and Excise Act, said it had investigated amending the rebate listing to include all handicapped people.

But, the spokesman said, the Office of Customs and Excise could not support this because of the "diversity of the kinds of disability and the wide variety of goods concerned".

The Office of Customs and Excise told the Sunday Times it has no knowledge of any rebates of customs duty previously granted on imports for disabled people and later withdrawn.

The Sunday Times, however, has documents which clearly show that this is not so. In 1989, the Board of Trade and Industry endorsed a request for an "Introtalker" that the National Council for the Phsyically Disabled requested for a cerebral palsy sufferer. Yet, in 1991, an identical request was turned down on the grounds that exemption only applied to "the deaf and the blind".

Mr Jacob Smit, director of Customs and Excise, said it appeared to be a question of someone "misreading" the provision prior to 1990.

Dr Boonzaier said: "Customs and Excise and Board of Trade and Industry seem to be run on the basis of arbitrary interpretation of the Act with regard to special "classes" of disabled people.

Ridiculous

"Because of this ridiculous situation, the shipment of specialised speech equipment for three non-speaking, multiple-handicapped children sat impounded in the bonded customs store for months."

Mrs Henna Opperman, Director of the National Society for the Deaf, said excise duty was only one example of how disabled issues are mismanaged by the public sector.

Secretary General of Disabled People of South African, Mr Mike Du Toit, said his organisation "condemns the bureaucratic inefficiency that has led to so many disabled people having to pay more for essential equipment when many disabled people can't even af-

By DIANA STREAK and MARILYN KEEGAN

Help Cluny Farm to beat the dry season

STAR 6/5/92

By Shirley Woodgate (299)

The ravages of the drought have been measured nationally in millions of rands.

At Cluny Farm near Kyalami, the losses are measured in bales of hay and the failed vegetable crop.

But the significance to the 40 ha farm tended almost entirely by about 40 intellectually handicapped adults, is as dramatic as the countrywide crisis.

Less than 20 km from the lush gardens of Sandton, the searing heat of the past few months, combined with a lack of summer rains since September, has slashed the annual hay crop at Cluny from 3 000 bales of hay to only 50.

Administrator John Cruickshank said instead of being able to produce enough cattle fodder for the winter, lack of water had forced him to buy bales of hay for the small Jersey herd which supplies milk for the residents, with enough over to produce the famed Cluny cream.

The farm, established 30 years ago as a welfare project deriving its income from the sale of surplus produce, contributions from residents' families and Government subsidies, is experiencing a sudden shortfall of funds.

This means little to Anthony, who has worked in the bakery making the popular Cluny bread for all of his adult life.

As one of the severely brain-damaged residents aged between 18 and 60 who spend their days working on the farm, his condition is incurable, his chances of mental improvement are nil.

But he has become a master baker specialising only in the 200 high-protein wholewheat loaves he produces with pride virtually every day of his life.

Like Anthony, the other residents specialise in their own fields: working in each of the four residential homes, preparing meals, caring for the fowls, tending the vegetable garden or cleaning the stables and working in the dairy.

The drought is an administrative nightmare to John Cruickshank, who has appealed to the people who live nearby, who have tasted Cluny bread or Cluny cream, to donate funds to the ailing farm.

Telephone him at (11) 702-1690 if you can help beat the drought which has crept right on to the doorstep of the city.

PresMed goes for day clinics

By ROBIN PEGLER

PRESIDENT Medical increased earnings a share by 39% to 30,9c and the dividend by 34% to 6,7c in the year to February 1992.

Development Capital Market graduate PresMed operates compact, affordable, no-frills hospitals and day clinics. ST 11 Mey (BUSS)

Managing director Carl Grillenberger says that of SA's hospital facilities, the State supplies 80% and the private sector 20%. The Government's tight budget is forcing more patients to use affordable private hospitals and day clinics. 10/5/92

PresMed is contracted to medical aid tariffs and can take advantage of this trend. Its policy of contracted-in tariffs ensures that higher occupancy rates maintain profitability.

PresMed is concentrating largely on developing day clinics. Technological advances in the past decade enable a patient to have an operation in the morning and go home the same day.

Mr Grillenberger thinks the main growth lies in day clinics. Patients can ill afford the high costs of hospitalisation. In the US, 50% of operations can be done in day clinics. The percentage of such operations is much lower in SA.

Expense

However, current medaid legislation favours hospitals at the expense of day clinics. Mr Grillenberger hopes the situation will be changed.

The affordability concept means that staff members have the attitude of keeping expenses low — to the advantage of patients and encouraging them to use PresMed's facilities.

Retrenchments have probably reduced the number of whites on medical aid, but medical insurance is growing. There is also growth from the higher-income segment of other races.

PresMed rents its premises instead of owning them. Long-term leases ensure predictability.

Development of hospitals and day clinics has necessitated fairly large outlays although care has been taken not to allow undue expansion at the expense of the shape of the balance sheet.

The high rate of return on assets allows higher debt than if the returns were lower. (299) (96)

PresMed has consistently reduced interest charges by issuing convertible securities with a conversion date some years ahead. The interest rate is much lower than borrowing at prime.

In January, R7,5-million was raised by issuing 3-million 12% compulsorily convertible debentures at 250c. Interest is 30c a debenture and they will presumably not be converted until the ordinary dividend reaches 30c.

Even at the current rate of growth, this is some years away.

Interest cover for the 1992 year was 9,3 times, which is more generous than for many leading companies at this stage of the recession. Substitution of the 12% interest rate for prime should result in an even better interest cover for the current year.

The development programme requires high dividend cover of 4,6. As long as expansion opportunities continue, which should be for the foreseeable future, high cover will be necessary.

PresMed shares are not easy to deal in, but an investor who can get them should be well rewarded.

WEEK IN

A SUMMARY of the week's corporate announcements.

MONDAY: Telemetrix members offered dividend of one share for 66 held plus nominal cash to give 1,52 new shares a 100.

Elsburg to distribute 65 Western areas shares for each 100 Elsburg in a voluntary winding up to cut costs. Investec Holdings' offer of prefs 94,2% subscribed.

Macmed is transferred to pharmaceutical and medical

Medical-aid funds get to grips with cost hazards

S/Times (BUSS) 10/5/92 299 E2

IF A mere 1% of medical-aid members contracted full-blown AIDS, contributions to schemes could rise by 31% if every claim was paid in full.

The result would be a loss of members and rebellion among healthy contributors to schemes, says Gary Taylor, human resources director of Medscheme.

Medscheme is the largest medical-aid administrator in SA, representing 39 schemes and 1,4-million beneficiaries.

Mr Taylor says: "There is pressure on medical-aid funds to stop the young and healthy from subsidising the old and infirm.

"Another way of looking at it is that, over time, you pay more when you are young and healthy to build up a reserve for possible serious illness or old age and higher claims."

Only 22% of the population is covered by medaid schemes — 80% of whites, 40% Indians, 36% coloureds and only 6% blacks.

"Medical-aid members are not fully representative of the total population at risk," says Mr Taylor

When a member contracts full-blown AIDS, it can cost the medaid between R48 000 and R68 000 for treatment until death.

Doctors have come under criticism for overtreating patients because of the perverse incentive scheme offered under medaid funds. The doctor's income is determined by the number of patient visits and not on the treatment of the case in its entirety.

"Doctors are not disclosing when a patient has AIDS, nor are they required to do so by law.

"They are fudging their diagnoses, stating pneumonia or tuberculosis when they know the patient has AIDS."

School

AMA, the second-largest medaid administrator in SA, is drawing up a "protocol for the treatment of HIV".

AMA marketing director Ray Welham says: "If approved and applied early enough, the protocol will greatly enhance the quality of life for the sufferer and contain costs at roughly the same level as an asthmatic sufferer who requires regular treatment.

"Education about HIV must start at primary school and be carried right through all socio-economic, ethnic and age groups."

Medaid schemes are required by law to provide a minimum of R600 a year for every family for any illness, including AIDS, although most funds pay more than this.

But no fund is able to meet the costs of treating large numbers of patients with AIDS. The cost of AZT treatment alone is often more than R500 a month.

"There is a belief in some medical aid schemes that AIDS, like alcohol and drug-induced illnesses, can be avoided," says Mr Taylor. "Although this strategy protects the interests of the medical-aid scheme, the employer could be faced with AIDS employees seeking loans to cover bills not refunded by medical aid."

Research in San Francisco shows that the use of home care and hospice facilities reduces the cost of treating AIDS without adversely affecting the quality of health care. The Guest House project in Johannesburg can accommodate patients for about R75 a day. The intensive care ward of a private hospital costs R855 a day, excluding drugs and other treatment.

Woman of the Week - Jermina Kgope

Where there is a will there is a way . . .

Sowetan 11/5/92

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MRS Jermina Kgope takes her work as a nurse beyond the boundaries of Mamelodi Clinic wards and her main concern is for the neglected and mentally handicapped people who are sometimes abused.

By PEARL MAJOLA

With a strong belief that where there is a will there is a way, the determined Kgope started Phuthanamagole (which means get together) Post Psychiatric Day Care Centre in 1986 and held a fulltime job at the same time.

The centre started with 20 "clients", as Kgope prefers to call them, and today houses 30.

Presently it is run from a church hall but a site has been bought and Kgope and her committee are now raising funds to build a proper centre.

Clients

The clients are at the centre from Monday to Friday between 8am and 4pm. On weekends they go home to their families.

"I saw a specific need in this area because I used to see them near my house begging and people would just abuse them," explained Kgope.

"They would send them everywhere and never give them anything in return. Then they would come to the clinic looking for help. So I decided to do something to improve their lives," she said.

"The aims of having this centre are to enrich the lives of the mentally handicapped people here and enable them to be self-sufficient by rendering special education programmes such as music, drama, recreation, hygiene and occupational therapy.

"Unfortunately we can only take people from nearby because we don't have transport for people from afar.

"When a big centre has been built, hopefully we will have a transport service."

A selfless community worker, Kgope taught for 11 years before quitting and joining the nursing profession, where she has been for the last 32 years.

"If I could do it all over again I would take up social work," she said. "I care for people and it breaks my heart to see people suffering."

She is a member of the National Council of African Women and twice stood as a candidate to be a councillor in Mamelodi.

"I could see the councillors were not doing their work and wanted to improve things for my community.

"For instance, we need three clinics in this township yet we have only one.

"We do not get any help from the council for the centre and yet we have identified 488 mentally handicapped people in this township," she said.

Retire

"I will retire in 1994 and hopefully I will have more time for the project.

"I try to divide my time so that I am able to do what I have to do at the centre and find time for my family as well.

"Where there is a will there is a way," she said confidently.

The caretaker is a volunteer but is given an allowance of R100 a month.

She is responsible for supervising the activities of the clients throughout the day.

These include exercises, handwork projects like sewing and knitting and preparing meals.

Other people also volunteer to help her with the work.

PROFILE

NAME: Jermina Kgope.
PROFESSION: Nurse, Mamelodi Clinic.
MARITAL STATUS: Married.
CHILDREN: Four.
GRANDCHILDREN: Five.

Kgope now automatically qualifies as a nominee for the Sowetan/Eskom Woman of the Year award.

11/5/92

Sowetan

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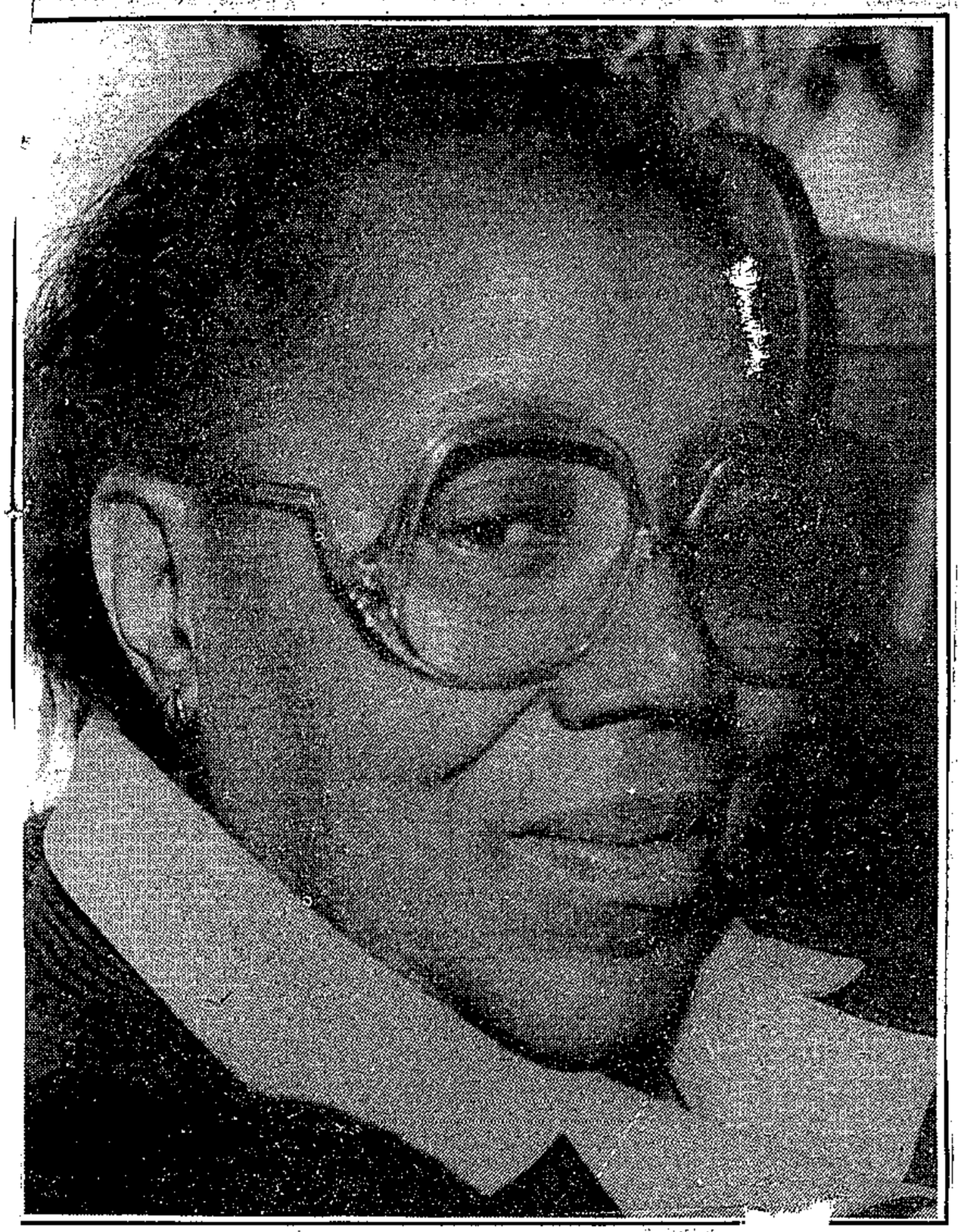

Jermina Kgope looks after the unde

R26 000 for a bypass — time for probe, says MP

(299) ARG 12/5/92

THE time had perhaps come for a thorough investigation into the tariff structures of some private hospitals, Dr Willie Snyman (CP Pietersburg) said.

"How can a bypass operation, for example, cost up to R26 000?

"Under these circumstances, the patient has to take out additional medical insurance because normal medical aid tariffs do not cover these exorbitant costs," he said during debate on the Own Affairs Health Budget Vote.

What was more disconcerting was it was causing the financial downfall of many medical aid societies.

"The biggest payments by medical aids used to be on medicines. Now nearly 33 percent goes to hospitalisation costs. There are also reports of patients being unnecessarily referred to private hospitals where the doctor was a director.

"If this is true then, on behalf of patients, I would like to call for a thorough investigation." — Sapa.

Assuredly, it was inevitable

STAR 14/5/92

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Spiralling medical costs have made it inevitable that life assurers would enter the health care market.

So says Yves D'Halluin, executive director, Individual Business at Liberty Life.

The company's entry into the market has paid off handsomely — in the four months following the launch of their "medical lifestyle" in August last year, Liberty Life sold 50 000 policies.

"Health care is no longer the preserve of the medical aids," says Mr Halluin.

"Medical expenses are soaring above inflation, the gap between medical expenses and the amounts paid out by medical aid schemes is widening all the time and the State lacks the funds to provide the required level of health care.

"Our market, the upper income group, have become dissatisfied with the value for money they have been receiving from medical aids and are turning to insurance-type products to provide the coverage they are looking for."

He believes the potential for the health insurance market is enormous and runs into billions of rands. This includes the expenditure by medical aids (R6 billion), the self-insured market (R3,6 billion) and the state (R8 billion).

Yves D'Halluin . . . health care is no longer the preserve of the medical aids.

Money

"We estimate the health insurance market to be four or five times bigger than the life assurance market and its growth rate in excess of 25 percent per annum.

"Health care products are certainly affordable because the money is already being spent. We believe that South Africa is following the same trends as the USA where health insurance forms a large proportion of the long-term insurance industry," says Mr Halluin.

Old Mutual's employee benefits manager Lindsay Walker says that a similar situation is developing in South Africa to that being experienced in the USA, with many smaller employers no longer offering health benefits, leaving individuals to pay for themselves.

He added: "The graph of the cost to the employer for the funding of retirement benefits has remained fairly constant as a percentage of overall salary for 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.

"Over the past two years membership of medical aid schemes has been stable. However, recently there has been a slight decline, indicating that people cannot afford to join," he said.

As the funding of comprehensive cover becomes more and more expensive, a growing number of employers will be providing only basic cover.

"In this event, a person wanting a high standard of medical care is going to have to meet the expense himself, or ensure he is adequately covered by an individual policy," says Mr Walker.

Individuals buying into medical aid schemes are finding rates high and increases sometimes as much as 70-80 percent. In some cases these people choose to opt out of the medical aid system altogether and move into medical insurance.

"The medical aid schemes pick up the majority of the members' medical expenses — sometimes 100 percent of the costs.

"Higher earners and those who use medical services less tend to subsidise lower earners and high use members.

"On the other hand, insurance does not cover the member for everyday medical expenses such as a visit to the doctor for a cold.

"Insurance comes into effect only when the medical costs rise above a certain level or when the member has suffered a catastrophe such as a heart attack or car accident," says Mr Walker.

Stoffel Burger, deputy general manager of Fedlife's Industrial Benefits division, says:

"If a client wants to be insured for hospitalisation, we would enter into a contract which would specify the basic daily benefit amount payable, eg R300. He would then be charged the cost of this benefit."

Expensive

The system of risk-rating — where clients pay according to their "health risk" — protects the company against massive claims.

"Hospitalisation, intensive care and surgery are the most expensive benefits and medical schemes generally do not cover them adequately," says Mr Burger.

However, medical aid schemes charge that the "playing fields are not level", saying they are obliged to accept all risks and that they end up with a majority of members who have health problems, namely the elderly or infirm.

Doctors, Govt clash over amendments

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STAR 14/5/92

Doctors and the Government disagree over certain aspects of proposed amendments to the Medical Schemes Act.

The idea of the Bill, which was published by the Minister last year, is to create incentive to control rising health care costs.

One of the proposals would permit medical aid schemes to contract only with doctors or medical services prepared to operate within affordable rates in so-called Health Maintenance Organisations.

Medical Association of South Africa (Masa) secretary general Dr Hendrik Hanekom says:

"While we agree that every effort should be made to render private health care more affordable, we don't think the Bill will achieve this.

"It is not in the interest of the poor and the elderly and it will limit the choice of doctors, dentists, pharmacists and other health professionals."

Masa objects to the Bill because it believes certain crucial issues have not been resolved.

Masa is concerned that the Bill will result in the removal of the protection provided to retired members who are currently entitled to continued membership of medical schemes.

The amendment may limit medical aid cover, which means contributing members run a greater risk of not being able to afford the necessary health care.

It could also lead to risk-rating of patients, and preference being given to young, healthy financially active contributors due to the removal of the medical aid scheme's obligation to provide certain minimum benefits.

"Masa will be able to support amendments to this legislation only if the responsibility of both medical schemes and of the state in assuring health care for patients who may suffer financial hardship as a result, has been spelt out," says Dr Hanekom.

Masa believes the ideal health system should be an affordable, non-racial comprehensive effective, unitary system to which all have the right of equal access.

Says Dr Hanekom: "It is unlikely that a restructured health care system for South Africa will involve only one method of funding and providing health-care services, therefore Masa is looking at all options including fee-for-service, managed health care and a National Health Insurance Fund.

"The review and restructuring of the health system must take place in accordance with the unique and divergent needs of SA's people and resources."

On the subject of Health Management Organisations, Masa says improved management of health care resources is of critical importance, but stresses that this should in no way compromise the patient's interests.

"Health care professionals should also neither directly or indirectly be not prevented from doing what is best for the patient.

"In order to involve the health care professions in the management of resources, Health Management Organisations may assume various forms.

"Professionals could be employed or contracted with, to provide services.

"Changes to the legislation are under way which will permit the formation of multi-speciality or multi-professional practices, where doctors, nurses, dentists and other health care professional can get together, share resources and compete with Health Management Organisations to provide a cost-efficient service," says Dr Hanekom.

He argues that if medical aids are allowed to create Health Management Organisations prior to the deregulation of the profession, it will create structural inefficiencies and irregularities in the health system.

Masa is reviewing a national health insurance system as an attempt to defuse the crisis in health care.

However, it is keen that it should not undermine the role played by medical aids — a system which they say is founded on basically sound principles.

'Market-driven' approach needed

STAR 14/5/92

The time has come to end bureaucratic-based funding of health care, according to one of South Africa's largest medical aid scheme administrators, AMA.

Chief executive officer Timothy Gelman says a market-driven approach is needed, providing a range of services that cater for tailor-made health care solutions with an awareness of the real cost of treatment.

"We have a private medical system which is excellent by world standards. Our solutions must retain this excellence while increasing the base and accessibility of it," says Mr Gelman.

He says part of the solution is the introduction of Heath Maintenance Organisations.

The concept involves a monthly prepaid subscription by members in return for a full range of benefits and services rendered by a group of medical and paramedical practitioners, often sharing facilities.

"We believe this could provide huge benefits to everyone in the health care chain.

"It would dramatically increase the cost efficiency of medical services and share responsibility for cost effective health care amongst practitioners, funders and members," says Mr Gelman.

AMA marketing director Ray Welman says the cost of medical scheme cover has increased across the board by as much as 172 percent over the past five years.

Difference

A cost study by AMA carried out last year showed that the difference between the doctors' tariffs and the RAMS rates was 60 percent on average.

However, the difference can go as high as 120 percent for minor services such as consultations.

He says there are a number of main reasons for the escalation of medical aid subscriptions. Not all of these are due to inflation.

He says many members unnecessarily over-utilise medical services and a minority of private medical practitioners are over-servicing patients.

"This includes over-subscription of medication, unnecessary consultations and treatment.

"There is also a high incidence of medical aid fraud by a small number of members and practitioners.

"This includes the illegal use of a member's card by non-dependents, not only for consultations, but also for expensive hospitalisations; illegal dual membership of more than one medical aid; selling medical aid membership cards; accounts falsified by both members and practitioners; and, pharmacy purchases against the value of a prescription without the medicine being issued," says Mr Welman.

AMA is addressing the problem of spiralling health costs in a number of ways, including offering tailor-made medical aid packages to suit specific groups of people and individuals as compared to straight funding.

"This means the member chooses his mix of funding and pays proportionately for it," says Mr Welman.

Timothy Gelman . . . our solutions must retain the element of excellence.

Ray Welman . . . member chooses mix of funding and pays proportionately.

GPs dislike generics – survey

STAR 14/5/92

A survey shows that 74 percent of general practitioners do not support the legalisation of generic substitutes.

Market research by Markinor shows that doctors are generally against pharmacists substituting their prescriptions and they say it should never occur without their permission.

Researchers interviewed a sample of general practitioners in active, full-time practice and pharmacists in large retail pharmacies. They found that respondents considered price to be the only real advantage of generic products.

Doctors believe that pharmacists are legally liable if they substitute a prescription without consulting the doctor.

But Graham Midlane, executive officer of the National Association of Pharmaceutical Manufacturers, said generic medicines had been used for the past 30 years in the public sector — which accounts for the greater part of medicine consumption in this country.

"Why not use them in the private sector as well? The arguments against generic substitution don't stand up to closer scrutiny," he says.

Unequal distribution of medical resources

(JKJ 299)

STAR 14/5/92

Nearly three quarters of all South Africans rely on the State to pay for their health care and the majority of them suffer diseases associated with poverty and instability.

Some 2,3 million South Africans have been classed as "nutritionally vulnerable", but the bulk of South Africa's health budget and services is not directed at them.

Instead the unequal distribution of health care means a bias towards urban rather than rural areas and to diseases associated with industrialisation.

Although South Africa has an aggregate gross national product six to seven times that of China and Sri Lanka, life expectancy is only four-fifths that of these much poorer states.

And the growing incidence of Aids may lead to a "potentially catastrophic" diversion of resources away from the problem, health care professionals have warned.

A major study, "Changing Health in South Africa: Towards New Perspectives in Research" was published in South Africa recently.

Comprising interviews with 354 leaders in the health care field, it was conducted by the Medical Research Council under the leadership of Dr Derek Yach on behalf of the California-based Henry J Kaiser Family Foundation.

The report argues that state efforts to liberalise the system have merely "resulted in superimposing flawed policy-making structures on a fundamentally flawed system of health services."

The study, which is aimed at facilitating the restructuring of the country's health services, sketches a bleak scenario. South Africa combines the worst health consequences of industrialisation and poverty.

There is a high incidence of heart diseases and cancers, mainly among whites but also rapidly increasing among urban blacks, and endemic patterns of preventable diseases, particularly among rural and peri-urban blacks.

The authors point out that the lack of basic public health conditions such as adequate housing, safe water and sanitation are the major causes of ill health.

The study says problems include health policy decisions being made on a political basis and an emphasis on curative urban health care.

Ending the fragmentation of health services — there are 14 departments of health in South Africa — and forming a unitary health service is the first important step.

Fragmentation of health services is inefficient and wasteful.

And the report recommends a move towards community-based primary health care.

Patient, why not heal thyself?

299 STAR 141592

VISITING the doctor is becoming an expensive business these days. Consulting a specialist can be as draining on the pocket as those plumbers' bills.

One way of reducing skyrocketing medical costs, says Minister of Health Rina Venter, is for people to take more responsibility for their health and not to go rushing off to the doctor for every little sniffle. They need to indulge in a little self-medication where minor ailments are concerned, she says.

But while this signals an important trend, and is a positive small step in the direction of affordable health care for all, self-medication must be informed, says Dr Nick Lee.

Dr Lee is editor of the Medical Association of South Africa's "Guide To Medicine and Drugs" (Reader's Digest, R94,58).

"We are not saying that people must treat themselves. They should try a simple remedy first for minor ailments. If symptoms persist, even on simple medications, they should seek professional help," Dr Lee says.

The 20th century has seen a revolution in medical treatment unlike anything in previous eras, says Dr Lee. Drug treatments are now available "which would have seemed magical to earlier generations", he says.

It still seems incredible that a few teaspoons of a sweet-tasting liquid can actually mean the difference between life and death, he says, in a foreward to the book.

But as with all good things in this world, there can be snags.

"Drugs are not only effective substances, they are powerful chemicals which may have harmful as well as beneficial effects," says Dr Lee.

But as people become more educated and aware, they are no longer content simply to take what is handed out to them on a prescription, he says. They need to know what they are doing and taking.

Part of the mystique surrounding the medical profession has been the myth that there's a pill for every medical problem, says Dr Lee.

And there is often an information gap between those who provide medication and those who take it. The doctor may be too busy to explain and the pharmacist may not see the need to dispense too much information along with the medication, he says.

"Nobody sits people down and tells them exactly what it is they are taking, or why they shouldn't take a drug under certain conditions."

The Medical Association's guide has been compiled to give information that the general public needs in a comprehensive, lucid and interesting form, he says.

The information has been compiled by experts and double-checked by doctors and pharmacists to ensure factual accuracy.

It is intended to supplement information given by doctors to patients, not replace it, Dr Lee stresses. The book is aimed at contributing towards effectiveness and safety of drugs which patients take.

And there's no danger of people knowing too much, says Dr Lee.

"You can't ever know too much about drugs," he says. That's another old-fashioned attitude among some doctors.

The first two sections of the book explain how drugs affect the body's systems and how the main classes of drugs work. The main section gives in-depth information about 199 widely used drugs, including what effects the drug has, potential problem areas and what to do if a drug is missed.

There is a comprehensive index of drugs and proprietary names, a colour identification guide to commonly prescribed tablets and capsules, and information about vitamins and drug abuse.

Most South Africans have no cover

STAR 14/5/92

(299)

The multi-billion-rand health care industry is ailing and, without a dramatic overhaul, medical care will soon be out of reach of most South Africans.

Almost half of the estimated R19 billion which will be spent this year on health care is in the private sector, which services only about 30 percent of the population.

South Africa spends 6 percent to 6,5 percent of its gross national product (GNP) on health care, which falls within the minimum recommendation of 5 percent by the World Health Organisation.

The Registrar of Medical Schemes says that in 1990, only 23,6 percent of the population enjoyed some form of health care cover.

This group represented about 70 percent of the white population and only 30 percent of blacks.

Explaining the crisis in private health care, Cedric de Beer, co-director of the Centre for the Study of Health Policy at the University of the Witwatersrand's medical school, says:

"There are three major interest groups in the private health care market — the suppliers, the patients and those who pay on behalf of the patient (the medical aid societies).

"Not one of these actors has the will, the ability and the incentive to keep control of costs."

Mr de Beer said medical aid costs have been increasing at more than 25 percent a year for the past decade.

"Increasingly, members of medical aid schemes will be asking whether they can afford the contributions. Potential new members will be scared off, and employers will resent this uncontrollable component of their wage bill.

"Private doctors and hospitals will soon be experiencing major consumer resistance, if this is not already occurring," says Mr de Beer.

Costs are rocketing because the conditions necessary for a free market to operate effectively do not exist in the health sector.

Says Mr de Beer: "A free market assumes informed consumers shopping around for goods they can afford in a market with an abundance of suppliers who compete with each other as far as both price and quality is concerned.

"The health care market differs from this in two respects: The first is the so-called information gap.

"Suppliers (doctors and hospitals) have virtual monopoly of knowledge and so exert substantial control over decisions concerning what services are necessary for their consumers (the patients).

"Often the only important decision a patient will make is to consult the doctor in first place."

The second market failure is the lack of true competition.

"Doctors and other professionals are prevented from competing by various ethical codes. Instead they tend to lobby together for increased fees."

Because advertising is prohibited, the consumer cannot "shop around".

Under these conditions prices are pushed up rather than controlled.

The fee-for-service payment method also contributes to spiralling costs. Patients pay separately for each service.

The income of suppliers therefore depends on the number of services provided — creating an incentive to deliver more services than are clinically necessary.

Mr de Beer says medical aid schemes merely compound these flaws.

"Providers do not need to consider costs and may feel entitled to use services in order to get value for money," he says.

Medical aid schemes have limited ability to control prices because suppliers can set their fees higher than the scale of benefits drawn up the Representative Association of Medical Schemes (RAMS).

"The crisis in health care stems from the unequal allocation of resources between white and black, rich and poor and the urban and rural populations.

"The whole system needs to be regulated to ensure cost-effective care without impinging on clinical independence," he says.

Nationalisation has been ruled out by the Wits Centre as impractical and politically untenable. It would result in doctors leaving the health sector and country "in droves".

A second alternative aims to reduce the size of the private sector by making it less attractive and more expensive.

Doing away with all state subsidies might release more funds for the public sector.

However, this option is regarded as less attractive by the Centre for Health Policy Studies.

It argues that drawing the private sector into a national system of health care provision is more viable.

Medical aid helps private health care to go to pot

Assuredly, it was inevitable

STAR 14/5/92

Spiralling medical costs have made it inevitable that life assurers would enter the health care market.

So says Yves D'Halluin, executive director, Individual Business at Liberty Life.

The company's entry into the market has paid off handsomely — in the four months following the launch of their "medical lifestyle" in August last year, Liberty Life sold 50 000 policies.

"Health care is no longer the preserve of the medical aids," says Mr Halluin.

"Medical expenses are soaring above inflation, the gap between medical expenses and the amounts paid out by medical aid schemes is widening all the time and the State lacks the funds to provide the required level of health care.

"Our market, the upper income group, have become dissatisfied with the value for money they have been receiving from medical aids and are turning to insurance-type products to provide the coverage they are looking for."

He believes the potential for the health insurance market is enormous and runs into billions of rands. This includes the expenditure by medical aids (R6 billion), the self-insured market (R3,6 billion) and the state (R8 billion).

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Money

"We estimate the health insurance market to be four or five times bigger than the life assurance market and its growth rate in excess of 25 percent per annum.

"Health care products are certainly affordable because the money is already being spent. We believe that South Africa is following the same trends as the USA where health insurance forms a large proportion of the long-term insurance industry," says Mr Halluin.

Old Mutual's employee benefits manager Lindsay Walker says that a similar situation is developing in South Africa to that being experienced in the USA, with many smaller employers no longer offering health benefits, leaving individuals to pay for themselves.

He added: "The graph of the cost to the employer for the funding of retirement benefits has remained fairly constant as a percentage of overall salary for 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.

"Over the past two years membership of medical aid schemes has been stable. However, recently there has been a slight decline, indicating that people cannot afford to join," he said.

As the funding of comprehensive cover becomes more and more expensive, a growing number of employers will be providing only basic cover.

"In this event, a person wanting a high standard of medical care is going to have to meet the expense himself, or ensure he is adequately covered by an individual policy," says Mr Walker.

Individuals buying into medical aid schemes are finding rates high and increases sometimes as much as 70-80 percent. In some cases these people choose to opt out of the medical aid system altogether and move into medical insurance.

"The medical aid schemes pick up the majority of the members' medical expenses — sometimes 100 percent of the costs.

"Higher earners and those who use medical services less tend to subsidise lower earners and high use members.

"On the other hand, insurance does not cover the member for everyday medical expenses such as a visit to the doctor for a cold.

"Insurance comes into effect only when the medical costs rise above a certain level or when the member has suffered a catastrophe such as a heart attack or car accident," says Mr Walker.

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"If a client wants to be insured for hospitalisation, we would enter into a contract which would specify the basic daily benefit amount payable, eg R300. He would then be charged the cost of this benefit."

Expensive

The system of risk-rating — where clients pay according to their "health risk" — protects the company against massive claims.

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However, medical aid schemes charge that the "playing fields are not level", saying they are obliged to accept all risks and that they end up with a majority of members who have health problems, namely the elderly or infirm.

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One of the proposals would permit medical aid schemes to contract only with doctors or medical services prepared to operate within affordable rates in so-called Health Maintenance Organisations.

Medical Association of South Africa (Masa) secretary general Dr Hendrik Hanekom says:

"While we agree that every effort should be made to render private health care more affordable, we don't think the Bill will achieve this.

"It is not in the interest of the poor and the elderly and it will limit the choice of doctors, dentists, pharmacists and other health professionals."

Masa objects to the Bill because it believes certain crucial issues have not been resolved.

Masa is concerned that the Bill will result in the removal of the protection provided to retired members who are currently entitled to continued membership of medical schemes.

The amendment may limit medical aid cover, which means contributing members run a greater risk of not being able to afford the necessary health care.

It could also lead to risk-rating of patients, and preference being given to young, healthy financially active contributors due to the removal of the medical aid scheme's obligation to provide certain minimum benefits.

"Masa will be able to support amendments to this legislation only if the responsibility of both medical schemes and of the state in assuring health care for patients who may suffer financial hardship as a result, has been spelt out," says Dr Hanekom.

Masa believes the ideal health system should be an affordable, non-racial comprehensive effective, unitary system to which all have the right of equal access.

Says Dr Hanekom: "It is unlikely that a restructured health care system for South Africa will involve only one method of funding and providing health-care services, therefore Masa is looking at all options including fee-for-service, managed health care and a National Health Insurance Fund.

"The review and restructuring of the health system must take place in accordance with the unique and divergent needs of SA's people and resources."

On the subject of Health Management Organisations, Masa says improved management of health care resources is of critical importance, but stresses that this should in no way compromise the patient's interests.

"Health care professionals should also neither directly or indirectly be not prevented from doing what is best for the patient.

"In order to involve the health care professions in the management of resources, Health Management Organisations may assume various forms.

"Professionals could be employed or contracted with, to provide services.

"Changes to the legislation are under way which will permit the formation of multi-speciality or multi-professional practices, where doctors, nurses, dentists and other health care professional can get together, share resources and compete with Health Management Organisations to provide a cost-efficient service," says Dr Hanekom.

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Masa is reviewing a national health insurance system as an attempt to defuse the crisis in health care.

However, it is keen that it should not undermine the role played by medical aids — a system which they say is founded on basically sound principles.

'Market-driven' approach needed

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The time has come to end bureaucratic-based funding of health care, according to one of South Africa's largest medical aid scheme administrators, AMA.

Chief executive officer Timothy Gelman says a market-driven approach is needed, providing a range of services that cater for tailor-made health care solutions with an awareness of the real cost of treatment.

"We have a private medical system which is excellent by world standards. Our solutions must retain this excellence while increasing the base and accessibility of it," says Mr Gelman.

He says part of the solution is the introduction of Heath Maintenance Organisations.

The concept involves a monthly prepaid subscription by members in return for a full range of benefits and services rendered by a group of medical and paramedical practitioners, often sharing facilities.

"We believe this could provide huge benefits to everyone in the health care chain.

"It would dramatically increase the cost efficiency of medical services and share responsibility for cost effective health care amongst practitioners, funders and members," says Mr Gelman.

AMA marketing director Ray Welman says the cost of medical scheme cover has increased across the board by as much as 172 percent over the past five years.

Difference

A cost study by AMA carried out last year showed that the difference between the doctors' tariffs and the RAMS rates was 60 percent on average.

However, the difference can go as high as 120 percent for minor services such as consultations.

He says there are a number of main reasons for the escalation of medical aid subscriptions. Not all of these are due to inflation.

He says many members unnecessarily over-utilise medical services and a minority of private medical practitioners are over-servicing patients.

"This includes over-subscription of medication, unnecessary consultations and treatment.

"There is also a high incidence of medical aid fraud by a small number of members and practitioners.

"This includes the illegal use of a member's card by non-dependents, not only for consultations, but also for expensive hospitalisations; illegal dual membership of more than one medical aid; selling medical aid membership cards; accounts falsified by both members and practitioners; and, pharmacy purchases against the value of a prescription without the medicine being issued," says Mr Welman.

AMA is addressing the problem of spiralling health costs in a number of ways, including offering tailor-made medical aid packages to suit specific groups of people and individuals as compared to straight funding.

"This means the member chooses his mix of funding and pays proportionately for it," says Mr Welman.

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Doctors believe that pharmacists are legally liable if they substitute a prescription without consulting the doctor.

But Graham Midlane, executive officer of the National Association of Pharmaceutical Manufacturers, said generic medicines had been used for the past 30 years in the public sector — which accounts for the greater part of medicine consumption in this country.

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"Why not use them in the private sector as well? The arguments against generic substitution don't stand up to closer scrutiny," he says.

Foundation pleads for disabled kids

299

Sowetan 14/5/92

THIS week, pause and spare a thought for children with learning difficulties.

The Remedial Teaching Foundation on Sunday launched its fifth annual Children with Learning Difficulties Week aimed at raising funds for teaching aids, educational facilities and bursaries.

It is estimated that 15 to 20 percent of school-going children experience learning problems.

"These children - often with average to above average intelligence - are physically and mentally normal, yet are unable to cope in a regular school," said Mrs Kate Dudley, director of the Remedial Teaching Foundation.

"It is unfortunate that these schools are sometimes seen as elitist because of astronomical fees, but parents do not voluntarily choose to send their children to remedial schools," she said.

The Remedial Teaching Foundation supports eight schools, including Ikemeleng in Soweto, Glenoaks and The Pretoria Preparatory School.

The week will be marked by the Junior Comrades Walkathon, street collections and raffles.

Flexible benefits may oust medical aids

NEW medical insurance policies that offer catastrophe cover, savings facilities for minor medical payments, and long-term endowment payouts could eventually replace traditional medical aids.

This is the view of Martin McAusland, financial planning manager of financial and business advisory firm, Price Waterhouse Meyernel.

"Medical benefit plans could well replace age-old medical aids that are very rigid and offer no cash savings opportunities to their members," he said.

"People are tired of traditional medical schemes that are plagued with tariff complications and restrictions which often work against members."

McAusland says three-tiered medical benefit products will provide attractive alternatives for many breadwinners and their families.

Visits

He envisages medical benefit plans working as follows:

A percentage of premiums will go into catastrophe cover to provide funds for major accidents and illnesses; a portion will go into a savings account that can be accessed for minor visits to doctors and dentists; and the remainder will go into a unit trust or endowment policy for long-term savings.

"Medical benefit plans could be financed on a straight salary forfeiture basis or jointly by employers and employees," he said.

"Instead of pouring money into a bottomless pit, members will be able to build up savings as well as provide for their health care needs."

To complement medical benefit plans, McAusland stressed that employees must ensure that their employers' group life schemes include adequate disablity and life cover.

WHO's Health for all thwarted by poverty

South 16/5-21/5/92

WORLD Health Organization (WHO) campaign to guarantee basic health care for everyone by the year 2000 is being thwarted by poverty, an African official said.

Botswana's health minister, Mr Bahiti K Temane, said the target "has become unattainable in many parts of the world — definitely in Africa" because Aids is spreading and the gap between rich and poor countries is widening.

In 1978 member states of WHO, a UN agency, set themselves the goal to promote "Health for All by the Year 2000". It includes ideas like providing safe water, immunization against childhood diseases and enough nutrition for mothers and children.

"There is no way the poverty in Africa can be eliminated in eight years," Temane told WHO's annual assembly recently. "Furthermore, Aids will reverse even the little achievements that had been attained to date."

Future efforts to widen health care "will founder ... as long as the rich nations are getting richer and the poor nations are getting poorer," Temane told a nearly empty meeting hall.

He asked rich countries to provide technology and help market reforms through investments.

WHO delegates are reviewing the global health programme, the framework for much of the agency's current work.

An example of how poverty overrides medical progress is cited in a WHO report to the meeting.

Treatments exist for diarrhoeal diseases like cholera — a major child killer — but little progress can be expected if people return to live in germ-infested conditions, it says.

While people are living longer everywhere, "improvements in life expectancy do not necessarily mean a healthier life," the report says.

Many scourges — cancer, cardiovascular disease, tropical sicknesses and the deadly immune system destroyer Aids - are spreading in the Third World, it says.

It admits "the expectations of health for all by the year 2000 will not be realized in most countries".

Since the end of the Cold War, developing countries have worried that western aid — already tight in an economic recession — will shift to rebuilding eastern Europe and the former Soviet Union.

Temane said "euphoria has now cleared" after the wave of democracy in eastern Europe and signs of economic hope for Africa that ended the 1980s.

Botswana, with close economic links to neighboring South Africa, is one of Africa's richer countries. — **Sapa-AP**

EDITED BY FRED ROFFEY

Group in effort to 'overcome harsh reality' of medical costs

ST Times (Cape metro) (299) 17/5/92.

MANAGED healthcare plans (MHPs) are coming to the Cape in an effort to overcome the "harsh reality" of the South African healthcare scene in which only 23 percent of the total population is covered by medical aid schemes, according to Quentin Robinson, a director of Medicaid, which is behind the development of MHPs.

He pointed out that the remaining 77 percent were using State facilities and heavily over-burdening the system.

The private sector, he believed, had an important role to play in helping the State and improving the economy by taking responsibility for supplying healthcare to the lower-paid worker.

This could be done by setting up a health maintenance organisation (HMO) as part of an MHP.

The aim of an HMO is to provide two healthcare services.

The first is preventive primary healthcare for employees and their dependants through its own consulting rooms, doctors and "preferred provider contracts" with specialists and hospitals.

The second is seen as falling into the occupational health category, providing employers with a management service for in-company healthcare facilities for their employees.

A good example of an HMO is Vaalmed, which is registered as a medical benefit scheme and has its own facilities in Vereeniging.

It provides managed care, operates its own pharmacy, uses generic medicines and keeps an eye on irregularities, so saving costs.

The first HMO management company in South Africa is Medimo, which was formed last year by Medi-Clinic, Afrox and Medicaid.

It is based on the American HMO model, with modifications.

"By doing this we have Africanised the HMO concept, and the company has already established HMO units close to work places in Pietermaritzburg and Pinetown, with further units opening this year in Natal, the Tansvaal and Cape Province," said Mr Robinson.

Based on experience with the Pietermaritzburg pilot programme, considerable savings have been achieved.

In this scheme, the average cost of MHP membership runs to about R140 a month compared with the average medical fund contribution of about R210 a month — a difference of some 30 percent.

"In order to have a group model HMO, the South African Medical and Dental Council will have to make changes in its ethical rules to allow group practices to be formed," said Mr Robinson.

"This will enable medical aid schemes to contract directly with doctors and specialists to provide health care to their members."

In preparation for the setting up of MHPs in the Cape, Dr John Cowlin, a director of Medicaid, has moved to Cape Town to take over the regional operation.

Week to highlight plight of terminally ill

STAR 18/5/92

The Hospice Association of the Witwatersrand yesterday received mayors, dignitaries and other guests at a special dedication and memorial service to launch annual Hospice Week and to commemmorate the local association's 13th year.

National Hospice Week is celebrated to increase awareness and understanding of the association which assists terminally ill people and their families. All services are provided an a basis of need, regardless of race, religion, creed or ability to pay.

The week also recognises the work of its staff and volunteers and helps raise funds to continue the association's services.

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During last night's service, 13 candles were lit, symbolising the support received during the 13 years of the Witwatersrand association.

The Orlando North Methodist Choir opened the proceedings. Rabbi Yossi Goldman conducted the service and the blessing was by Orlando East Methodist Church's Reverend Paul Verryn.

Law group plan offers new damages approach

SUSAN RUSSELL

A RECENT recommendation by the SA Law Commission could save millions of rands for victims of serious personal injury and other damages who often have to wait years for payment.

The commission has made a preliminary recommendation that interest on damages and debt be awarded from the date the damages originated to the date they are paid.

Currently, interest is payable only from the date the court makes an award — often four years or more after the date on which the injury or damage occurred.

This has made it worthwhile for defendants or their insurers to defend large claims, many of which exceed R1m.

Bell, Dewar & Hall attorney Andrew Mitchell said some insurance companies defended every large claim regardless of whether there was a valid defence, then settled at the doors of the court two to four years after the event.

In the case of serious personal injury it could take 18 months to two years to accurately assess the consequences to the individual and calculate the amount claimable in respect of medical expenses, general damages and future loss of earnings.

Once a claim was made, an insurance company could repudiate liability, and after receiving summons, immediately give notice that it intended to defend. It would take another 18 months to two years to get to court, by which time the value of the claim was eroded by inflation and the plaintiff would have had to pay medical expenses out of his own pocket.

Often the plaintiff, faced with this and the prospect of also having to fund the litigation personally in the meantime, was forced to abandon the claim, Mitchell said.

He had calculated that in claims exceeding R150 000 it made good business sense for the defendant's insurers to fight claims rather than settle because generally they did not have to pay interest on the amount until judgment. The interest saved more than covered the costs of litigation.

Mitchell said implementation of the Law Commission's recommendation would make the process more fair because there would be a stronger incentive for defendants or their insurers to settle claims at the start.

The delay and cost in getting judgment on damages claims meant that, typically, the plaintiff received about 50% of the amount he or she would have received had the matter been settled at the outset.

If defendants or insurance companies had to pay interst on damages they would often find it not worthwhile to defend claims, and the money would go to the person who needed it.

Seeff in Masterbond bid

CAPE TOWN — Seeff Trust is bidding for the management contract for the 11 property participation companies in the Masterbond group. A rival contender is the Johannesburg financing company, Citygate Corporate Finance.

Rumours that Realty Durr had also made a formal bid were denied yesterday by chairman Storm Durr, though he expressed interest in finding ways to assist investors who had only a few days left to send in their proxy votes before next Monday's meeting. B|Day 19/5/92

In a letter to about 1 200 investors in the companies owning properties valued at more than R60m, Seeff Trust MD Michael Flax said concerned investors had approached Seeff to take over the management of the companies.

Flax said if chosen as manager, Seeff Trust would manage the properties professionally and economically, maximise returns, and assist investors in trading their units on the secondary market. A property management fee of 5% and secretarial

LINDA ENSOR

fees of 2% of the buildings' monthly rentals would be charged. (69)

Flax said the properties had not been managed properly. The properties were burdened with a lot of bad debts and needed new tenants.

The letter recommended that investors vote onto the board of directors of the participation companies Flax, Seeff Organisation chairman Lawrence Seeff, Seeff Trust director Ryan Broomberg, Seeff Commercial Properties MD Theodore Yach, Seeff Trust national marketing manager Robert Knight and Seeff Residential Properties MD Samuel Seeff.

Citygate director Michael Addison said in terms of the Citygate offer J H Isaacs would be retained as property administrators and the possible amalgamation of the companies would be investigated with a view to a JSE listing to enhance the tradeability of the units.

Medicine price rises 'outstrip CPI'

MEDICINE prices had risen 10 times during the past 15 years compared with a rise in the consumer price index of eight times, Medical Association of SA (Masa) director Reg Magennis told the Pharmaceutical Society's national conference in Somerset West yesterday.

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KATHRYN STRACHAN

Magennis said medical aid schemes were facing a crisis precipitated by the increase in the cost of medicines.

The average annual increase in payouts for medicines since 1975 was 26%, while payouts for general benefits rose 25%.

The volume of medicine consumed per person rose 16% between 1975 and 1982, but had dropped back to below 1975 levels by 1991, which indicated a growing resistance to price increases, Magennis said.

Diet dangers 'preached by food Leninists'

Business Day 22/5/92

299 (15)

DAVID FLETCHER
in London

FASHIONABLE claims by health experts on the dangers of diet, alcohol, environmental hazards and passive smoking have been dismissed as unjustifiable panic-mongering in a report by the Social Affairs Unit, a UK research and educational trust.

It says Britain and other developed nations are now in the grip of a "health panic" unsustained by established facts and fuelled through the misuse of science by well-meaning but mistaken health activists.

"Just hint at danger in something — that it is a carcinogen or damaging to the heart — and the Western public will fall into a state of hypochondriacal terror and will look to the government for action."

Yet Westerners are now the healthiest people who have ever lived and the diseases from which they die are predominantly the diseases of old age.

The report says no less than 246 risk factors for heart disease have been found by epidemiologists including snoring, not eating mackerel, drinking too much or too little milk, alcoholism, total abstinence, no garlic and slow beard growth.

"But risk factors have nothing to do with causes. They are risk markers, neither sufficient nor necessary to explain the disease."

Health activists are accused of encouraging worries about tiny risks by stressing relative, rather than absolute, risks.

"It is often said that non-smoking wives of smoking men have a 30% increase in their risk of getting lung cancer.

"What is not so often said is that the annual death rate from lung cancer among non-smoking wives of non-smoking men is of the order of six per 100 000. Among the non-smoking wives of smoking men the corresponding figure is eight per 100 000."

Dr Digby Anderson, director of the Unit, says that health educationists stress that excess drinking ruins livers, livelihoods and families, that drinking when driving kills the innocent and that drunkenness is associated with crime.

But it is also true that 90% of men and 96% of women who drink do so within strict limits and small amounts of alcohol seem beneficial to health.

He says: "Health activists are set on making a mass problem out of a minority one. Their level of dangerous drinking was reduced from five to one or two large drinks a day without any mass of new evidence. At this rate it will soon be zero."

The report condemns scare-mongering over remote cancer risks. It cites the recent scare over the use of the chemical Alar to increase yields of apples after it was found to cause cancer in rats when given in huge quantities.

"For a human being to absorb as much Alar as the unfortunate rodents had been given to eat, something like 19 000 bottles of apple juice would need to be drunk at once."

The report concludes that health activists — whom it variously dismisses as "nannies", "food Leninists" and "consumer socialists" — are filling the gap left by religion by finding new ways of making the blood run cold in a gullible public.

"Accordingly they declaim against smoking and drinking and eating too heartily, passing on every fact and half-fact that comes their way." — Daily Telegraph.

REVIEW

Medical schemes overhaul?

299
CT 22/5/92

Own Correspondent

JOHANNESBURG. — The government yesterday proposed a major overhaul of the legislation covering medical schemes — with the major emphasis on deregulation.

Medical schemes will be able to determine their own fee structures — and minimum and maximum benefits if the Medical Schemes Amendment Bill becomes law.

Tabling the bill, National Health Minister Dr Rina Venter said the proposals had been discussed with the Central Council for Medical Schemes.

"In order to promote greater flexibility and in keeping with the policy of deregulation ... these matters ought to be left to the management of medical schemes," the memorandum to the bill states.

The bill takes issue with suppliers of services and scraps the guaranteeing of payment for services.

"Experience has taught that the system of guaranteed direct payments by medical schemes to suppliers of a service has in practice led to serious malpractices, by which the financial capacity of medical schemes is seriously jeopardised; consequently it is proposed that those sections be repealed," the memorandum states.

The bill also proposes that all medical schemes will have to belong to the Representative Association of Medical Schemes (Rams).

It is proposed that Rams prepare a scale of benefits, as a guideline to interested parties, indicating the benefits that schemes ought to consider affording their members.

It also provides that medical schemes be allowed to set up their own health care facilities and that they also be allowed to provide extra cover for their members by offering insurance, reinsurance or underwriting.

Another definition that has changed in the bill is that married women will be able to become members of medical schemes in their own right. Either spouse may now be a member of the medical scheme or a dependant, but children can only fall under one member's scheme.

All distinctions between medical aid schemes and medical benefit schemes had become so blurred that the definition of medical scheme was being extended.

Bill moots deregulation of SA's medical schemes

B/Day 22/9/92 (299)

BILLY PADDOCK

CAPE TOWN — Government yesterday proposed that medical schemes be deregulated and allowed to determine their own fee structures and minimum and maximum benefits.

Tabling the Medical Schemes Amendment Bill, National Health Minister Rina Venter said the proposals had been discussed with the Central Council for Medical Schemes.

A memorandum to the Bill states that should the proposals be accepted by Parliament the Minister would no longer regulate minimum and maximum benefits supplied by schemes nor the membership fees or the basis on which such fees were determined. These should be left to medical scheme managements to promote greater flexibility.

The Bill takes issue with service suppliers and scraps the guarantee of payment for services direct to suppliers, insisting that properly specified accounts are of cardinal importance to ensure accurate and quick assessment of claims and to facilitate timeous payment of benefits.

"In order to prevent disputes with regard to the rendering of accounts, other laws regulating accounts of the various health care professions are being amended accordingly. Experience has taught that the system of guaranteed direct payments by medical schemes to suppliers of a service has . . . led to serious malpractices, by which the financial capacity of medical schemes is seriously jeopardised; consequently it is proposed that those sections be repealed."

The Bill also proposes that all medical schemes belong to the Representative Association of Medical Schemes (Rams), which would act as a single mouthpiece for all schemes.

Sapa reports from Pretoria that the Medical Association of SA (Masa) expressed grave concern over the Bill tabled "at the 11th hour".

Masa federal council chairman Dr Bernard Mandell said it could have far-reaching implications for access to health care.

While Masa understood the need to review deregulation of the health system, it was "totally unreasonable" to expect the joint committee on health and Parliament to take the responsibility of considering proposed amendments to the Act in the one month remaining of the Parliamentary session. It would be folly to introduce steps which might alleviate problems in one sector only to exacerbate those in another.

The memorandum states that the Bill also makes provision for medical schemes to set up their own health care facilities and to provide extra cover for members by offering insurance, reinsurance or underwriting.

Schemes will be allowed to establish or operate clinics, hospitals, pharmacies, nursing homes and maternity homes. However, the Bill seeks to prevent schemes from encumbering an asset merely to manipulate the total value of its assets.

The Bill will enable married women to become members of medical schemes in their own right.

The new definition of a service includes all health care services for which schemes should provide cover. Accommodation not arising from any physical or mental defect, illness or deficiency, such as an old age home or similar institution, is excluded.

The Minister may appoint people from a wider range than previously to the council and it is suggested that people with knowledge of schemes, members of schemes and employers are considered. It is also proposed that Rams prepare a guideline scale of benefits which schemes ought to consider affording their members.

Bill seeks medical schemes revamp

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STAR 22/5/92.

CAPE TOWN — A Bill which proposes that medical aid schemes be allowed to set up their own health care facilities and provide additional cover for their members by offering insurance was published yesterday.

According to a memorandum attached to the Medical Schemes Amendment Bill, the measure will also allow married women to become members of a medical aid scheme in their own right.

Schemes will be allowed to "expand their scope of providing health care by means of their own facilities" and may establish or operate a "pharmacy, hospital, clinic, maternity home, nursing home, infirmary, home for aged persons or, with the approval of the Minister of Health, any similar institution.

"Furthermore, provision is made for schemes to provide additional cover for their members by means of insurance or reinsurance or underwriting," says the memorandum.

The Bill proposes that the statutory requirement for a scale of benefits to be published in the Government Gazette be repealed, and that the Representative Association of Medical Schemes prepare scales as an indication of the benefits that schemes ought to consider offering.

The definition of a member of a scheme is being amended to "exclude policyholders of insurance companies which market health care cover by means of insurance policies".

A spokesman for the Department of National Health said this would not mean that these policyholders would not be able to be members of medical aid schemes.

The intention was rather to draw a clear dividing line between the traditional activities of a medical aid scheme which came under the scrutiny of the department, and any insurance or reinsurance activities it might engage in, which would fall under the provisions of the Insurance Act. — Sapa.

Wife 'pockets' medical funds

wlmail 22/5 - 28/5/92 (299) (33)

By GAYE DAVIS

AN INVESTIGATION has been launched into one of the largest medical aid schemes in the country after it emerged that the wife of the chairman of the scheme's management committee was paid R16 000 "pocket money" out of trust funds.

The wife of Pro Sano medical aid scheme chairman Cyril Beukes received the money when she accompanied her husband and the vice-chairman of the management committee, Malcolm Domingo, to Hong Kong in 1990 — where they attended an international medical aid scheme conference before spending a four-week holiday.

Beukes is also the deputy director of administration in the House of Representatives, while Domingo is the registrar of the Athlone Technical College in Cape Town and also chairman of the Civil Servants' League of South Africa.

Mounting dissatisfaction among Pro Sano's 58 000 members — most of them formerly classified "coloured" and employed by the civil service as teachers, post and telecommunication workers and municipal employees — resulted in a special general meeting of the scheme being called in Parow recently.

Members' unhappiness was exacerbated when the scheme hiked its tariffs by 15,5 percent in May.

At the meeting, held at the request of the Union of Teachers' Associations in South Africa, whose 23 000 members are all registered with the scheme, a motion of no-confidence in the management committee was put.

It was decided that there should be a full investigation into the incident, that management committee members take no more foreign trips until the investigation was concluded and that because trust funds were involved, a supervisory committee would be appointed to monitor affairs.

Pro Sano is one of 39 medical aid schemes administered by Medscheme. A Medscheme director, Keith Hollis — speaking in the absence of Medscheme's chief executive officer, Piet van der Merwe, who is overseas — said it would not have been possible for members to bring about the removal of the management committee at the general meeting.

A supervisory committee, which included auditors and a legal representative, had been set up to investigate why the management committee took a decision to give Beukes' wife the money, as well as determine how the money was spent.

"There is a willingness on the part of everyone to get to the truth of the matter to the satisfaction of the members," Hollis said.

He said Medscheme administered Pro Sano, but did not run it as such. "We are subject to the management committee," he said.

He said results of the investigation would be made public.

Fighting fire is out, says welfare plan

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South 23/5-27/5/92

'The ANC recognises that many of the social goals it has set cannot be achieved "unless all people are empowered, for active involvement as citizens in the democratic process and as workers in the economy" '

THE policy guidelines of the ANC warn that if the well-being of the poorest 40 percent of South African society is not improved "after a reasonable time under a democratic government, this is likely to have serious political implications for the country".

The state would have to assume the major, but not sole, responsibility for the provision and financing of social services.

According to the guidelines, "the capacity of the state to provide such services will depend on economic growth. The welfare sector, therefore, has a direct interest in the evolution of realistic economic policies based on a multiple strategy of growth coupled with redistribution.

"We reject the hand-out, fire-fighting approach to social welfare provision and advocate a developmental approach aimed at empowering communities and individuals within a system that will increasingly project welfare spending as social investment."

Emphasis will be placed on assisting the family unit, including single-parent families.

"As far as the private sector is concerned, we believe that companies have a responsibility that goes beyond their immediate employees and includes the general improvement of the quality of life. In this regard, a cross-sectoral approach will have to be worked out with the education, health and other sectors."

The ANC's guidelines propose:

- Old-age and disability grants: these should be equalised for all races and both sexes and the present system where the elderly and weak have to queue for long hours or sleep overnight to receive their grants "must be overhauled".
- Child rights: a Child Welfare Policy will be developed along the lines of the UN Children's Rights provisions. Under this, the rights and interests of the child must take precedence when dealing with issues such as adoption and foster care.
- Disabled persons: their employment and other rights will be protected through practical measures such as quotas and monitoring of discriminatory practices. Legislation will be drawn up in close consultation with the disabled themselves.
- Health: essential health services must be provided free of charge.

The ANC recognises that many of the social goals it has set cannot be achieved "unless all people are empowered, through education and training, for active involvement as citizens in the democratic process and as workers in the economy".

In addition, "science and technology must be used for the benefit of the whole of society, and not just the minority. Our natural resources must be treated as the heritage of all, so that the pursuit of narrow interests does not rob the majority of access to natural resources or pollute the environment in which they live."

health of young children."

Vaal Triangle Air Pollution Health Study spokesman Dr

...ger in ...

The health standards for particulate matter as set by

two periods of ...g po...en counts during the year — late summer and early spring,

...tion's no-effect-exposure limit for particulate matter is 180

dustrial area) and Vereeniging during 1991.

Eviction biggest blow of all for disabled woman

By Michael Sparks (2599)

A 48-year-old Alberton resident managed to keep up her bond payments for 13 years — then tragedy struck and she could no longer work, or pay — now the bank is evicting her so that it can auction her house. STAR 28/5/92.

Even though Joan de Preez has gone through incredible hardship recently, this most recent blow is, she believes, greater than all the indignities of the past lumped together.

Four years ago the osteoporosis which caused her bones to become porous and brittle resulted in her spine collapsing. Her slight and fragile-looking frame has been racked by agonising pain ever since.

Attacked

Just a few days before Christmas she was attacked and savagely beaten by three men who broke into her home.

But then came what she considers to be the ultimate indignity. Since she has been unable to work, she is now reliant on her R338 disability pension.

But this is not enough to keep up the R700 monthly bond repayments on the house she bought in 1978, particularly after interest rates hit 20 percent.

Bondholders United Bank have instituted legal proceedings for her to be evicted from her home so that it can be sold at public auction. This would enable the bank to recoup the outstanding R45 000 on her house.

She was unable to make it to court yesterday, and the case has been postponed until Tuesday next week.

Indignity . . . Joan du Preez says that if people take away the things she has to live for, like her home, then all she is left with is pain. Picture: George Mashinini

She originally bought the house for R14 000 and increased the bond to R40 000 to fix it up.

She said she kept the bond paid up while she was working "except for the odd hiccup".

Jack Sherman, acting for United Bank, said outside the court: "It is a tragic story, but society at large is not duty bound to look after her. A debilitating disease is no grounds for defence."

Mrs du Preez said she put her house on the market even before she became ill, but there were no takers. "Now, since I have no money and I am unable to do anything, there is no one who would want to buy it," she said.

"I am in a Catch-22 situation because if I do manage to find work to pay the bond, then I have to declare it and welfare takes whatever I earn off my pension," she lamented.

United's assistant general manager of credit, Neil Dawson, said he was unable to speak about the particular case, but promised to look into it. He added: "The property sounds like it is worth more than the bond, and it is always better if the person sells the house themselves, rather than having it sold at auction."

Mr Dawson said he would look into the matter, but had no answer before going to press.

Court acquits 41 over tennis demo

STAR 28/5/92

The 41 people charged with disturbing the public peace during an international tennis tournament in Johannesburg on November 20 were yesterday acquitted in the Johannesburg Magistrate's Court.

They had all pleaded not guilty to the charge.

The case arose from demonstrations, at the World Doubles Tennis Championship at the Standard Bank Arena, called for by Azapo and the PAC.

Giving judgment, magistrate Z Moletsane said the State witnesses had contradicted themselves, and evidence led in court had not been sufficient to prove the accused guilty.

Although he said two of the accused came across as blatant liars, he found them not guilty on the grounds that the court accepted the fact that it was not for the accused to prove their innocence beyond reasonable doubt. — Staff Reporter.

Church blaze: case postponed

Pretoria Bureau

The case of a man alleged to have caused a fire at a Pretoria church in which eight street children died in March was postponed to next month in the Pretoria Regional Magistrate's Court yesterday.

No charges were put to unemployed boilermaker Stephanus Vorster (33), who appeared before D V Z van der

ANC region backs mass action call | HNP to contest

Flying hospital drives away

STAR 28/5/92 (299)

HEALTH MOVE
Primary health care is widely seen as a critical need and a human right, yet it is still not reaching millions of South Africans. Mobile medical units could be part of the answer. MARIKA SBOROS reports.

THE one-stop medical shop could be the answer to just one of the colossal problems facing southern Africa in the next decade: the provision of adequate health care to dispersed and economically distressed populations.

Primary health care is widely seen as a critical need and a human right, yet it is still not reaching millions of South Africans. Many rural clinics lack equipment, drugs and more importantly, staff. One solution is the concept of mobile clinics, which can take health care to those who are unable to reach existing medical facilities.

A new mobile medical unit (MMU) was launched in Johannesburg this week by its designer, Tel Aviv University medical professor Mordechai Ravid, who is also a World Health Organisation advisory committee member on health research.

The idea of mobile health care is not new, says Professor Ravid. "Nearly every army throughout histroy has had its fleet of field ambulances," he says. Australia's flying doctors have become world famous.

Professor Ravid has successfully used similar mobile concepts in remote areas of other developed countries, and developed the new unit to be sophisticated enough to provide the necessary level of service but simple to operate.

The unit is the most up-to-date development of the mobile concept, and one that most neatly fits our rural terrain, conditions and economic circumstances, he says.

MMUs provide the most immediate, visible and cost-effective way of providing health care to millions who don't have it, says Professor Ravid.

The answer . . . the mobile medical unit puts health care within the reach of rural and impoverished communities

Mounted on or towed by trucks, the MMU could care for a population of 30 to 50 000, spread over 50 to 100 km of remote, rugged terrain.

Apart from being robust, cost-effective, immediately available, and with a demonstrable ability to reach the most remote regions, the advantages of MMUs for health care delivery in developing countries, include:

- Simultaneous problem solving: normal clinical work of diagnosis and treatment can take place alongside massive screening for disease, immunisation and health education.
- Optimum operational flexibility: The MMU can be adapted entirely to the community's needs. Its contents, which normally include a radiology unit, automated laboratory, means for gynaecological examinations, minor surgery, basic dental equipment, medications, dressings and medical records — can be customised to fit differing medical needs. In times of rapid demographic change, the MMU can move with shifting communities, or move to epidemic-struck areas as part of "blitz squads" to contain infection, screen and immunise unaffected people.
- Incorporation into and maximising existing systems and facilities: where no permanent facility exists, the MMU clinic can function independently and assist in training community health workers. Where a hospital or permanent clinic exists, the MMU can act as its "long arm" into the community. This allows the hospital or clinic's influence to extend into the community, and take the load off existing facilities.
- Appropriate technology: the units are only moderately sophisticated, not too advanced for professional users. The equipment retains enough sophistication to meet treatment and preventative care needs of urban and rural communities.

Health care

Insurance is more and more attractive

THE insurance business believes the shift towards individual health cover will continue as medical costs continue to spin out of control.

Although health insurance has only been on the market for about 18 months, there is already a wide range of sophisticated products to meet the growing demand, says Old Mutual's Dave Hudson.

He says American research shows that appropriate health insurance is a top priority for employees when assessing benefit packages.

However, as Jonathan Broomberg from Witwatersrand University's Centre for Health Policy points out, spiralling costs in the health insurance industry in the US means that 37-million Americans are unable to afford health insurance.

A major reason for the growth of the medical insurance industry is the gap between medical costs and what medical aid schemes pay.

The Aegis Insurance Group's Adrian Hoffman says health insurance is necessary to cover the "big claims" over and above medical aid.

Aegis is one of the dominant insurers in the corporate market because of its low contribution scale.

According to Old Mutual, medical aid schemes are doing the best they can. "But gaps remain because medical aids are not allowed, in terms of the Medical Schemes Act, to pay more than the Representative Association of Medical Aid tariff on claims.

Higher

"Many medical practitioners are on the much higher Medical Association of SA tariff and this is generally where insurance schemes step in."

Hudson says Old Mutual's individual health insurance Flexicare accounted for 12% of the life assurer's new business in the first two months of launching.

A benefit fund, contributed to by the employer with pre-tax money on behalf of the employee, provides for all Flexicare benefits.

Hudson says it is a kind of self assurance which "allows the applicant to build up a personal fund for retirement, from which benefits can be paid".

Whatever the pros or cons of the myriad health insurance schemes, the danger is that medical aid schemes will be forced to compete with health insurance in order to survive, says Bloomberg.

He says this will open the way for an infinite range of medical scheme "packages" which will not hesitate to "risk rate" and "skim off" the good risks in pursuit of clients.

"This might suit the young, the healthy and the well-off, but it will be a disaster for everyone else."

Free-market co-operation 'needed to prevent disaster'

BD Day 29/5/92

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THE health care industry needs a critical change of direction and application, without which the country is doomed to spiralling costs and inadequate services, says AMA CE Timothy Gelman.

AMA, a Southern Life company, is SA's second largest medical scheme administrator.

"The days of bureaucratically based funding in the industry are over. The situation demands a market-driven approach, a range of services which caters for tailor-made solutions and an awareness of the costs of treatment at every point in the chain."

Gelman says the problems facing members, medical providers and suppliers include restrictive legislation and medical ethics, spiralling costs and a lack of understanding of their implications.

"We have a system in which abuse by a few — members and practitioners alike — can cause major problems in containing premiums," says Gelman.

"Abuse of medical aid ... has become second nature, with a complete disregard for consequences to the consumer."

AMA believes deregulation is essential and the private sector must be allowed to use free market principles if costs are to be contained. Services must be tailored to the customer's requirements, not the other way around.

"Unfortunately the Medical Schemes Act regulates the nature and price of our product and while recently proposed amendments reflect a move towards free market principles, much remains to be done."

Solutions require flexibility, education on preventative health care and the establishment of value chains which place the emphasis on health not on sickness. Managed health care, which includes health maintenance organisations, can also increase the cost-efficiency of medical services and share responsibility for cost effective health care.

"The system will work effectively at all levels when members stop seeing medical aid as an open cheque book, and providers start working according to sound business practice. If these issues are not addressed, the future scenario is one of health care which will be financially out of reach of all but the very wealthy," he says.

Companies under fire for high cost of medicine

WHEN it comes to laying blame for spiralling medical costs in SA — currently at about R19bn a year — pharmaceutical companies, medical practitioners, the private health sector and government all come under fire.

Pharmaceutical companies are seen as the main culprits because of the astronomical and rapidly increasing cost of drugs.

The two main pharmaceutical associations in SA — the Pharmaceutical Manufacturers Association (PMA) and the National Association of Pharmaceutical Manufacturers (NAPM) — differ markedly from each other on potential solutions.

The PMA, which represents mainly multinational drug companies, argues that drug spending must be concentrated on "efficient modern medicines" after proper first-time diagnosis.

Such an approach, according to the PMA, will mean a cost-effective health care policy because patients will be kept out of doctors rooms and hospitals. Modern drugs will enable patients to return to the economy as soon as possible.

The PMA supports the idea of self-medication and is opposed to generic substitution, especially without doctors being consulted. The NAPM believes that reducing the cost of medical care cannot be addressed without taking generic medicine into consideration.

SA Druggists MD Lou Morris says generic substitution means the pharmacist can supply a less expensive generic medicine to the original branded product prescribed by the the doctor.

The generic medicine is equal in terms of active chemical ingredients, strength and dosage form to the original prescribed product.

"The widespread use of generic medicine throughout the world attests to its success in achieving significant savings to the benefit of the patient. It is especially vital in the SA context where the less privileged cannot afford medicine," says Morris.

The higher price of branded medicines is a result of producers recovering the cost of initial research and development into the medicine.

The innovator of the medicine has 20 years to do this and once the patent has lapsed, the original product can be manufactured and sold at prices which are, in some cases, up to 70% less than the original.

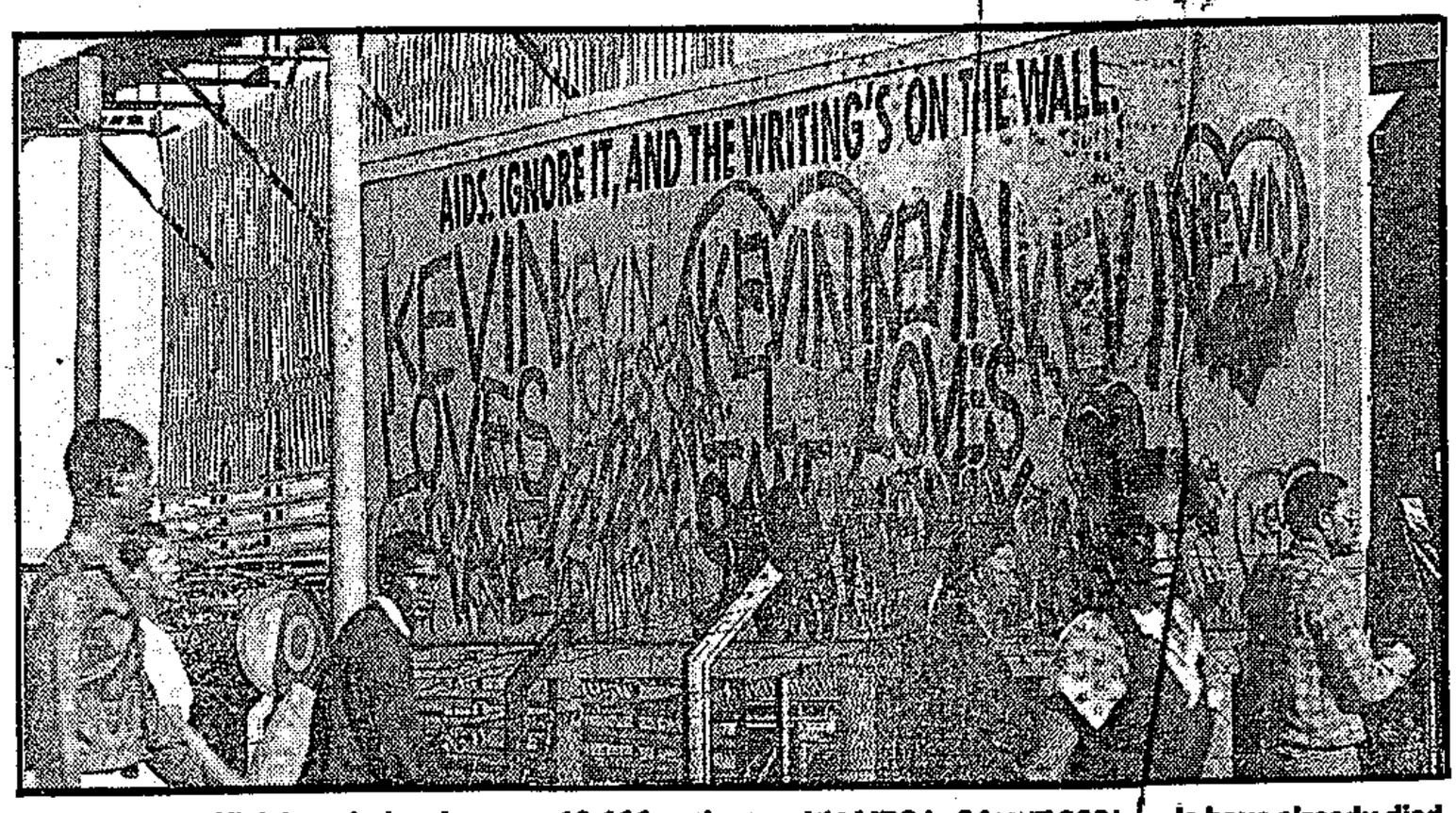
Approved

Morris says that before the product can be sold to the public it has to be approved by the Medicine Control Council (MCC).

The MCC sets down strict requirements to ensure the levels of the medicine comply with standards — as well as a number of controls designed to protect the health of the patient.

Morris says SA Druggists has over 90 generic products already registered and more in development.

He says medical aid companies are interested in generic medicine and many are introducing a maximum medical aid price to their members. This means the schemes will only recognise prices based on the generic medicine price.



According to official statistics there are 10 111 patients with AIDS in SA and 339 people have already died from the disease. The Medical Research Council estimates that by the year 2000 between 19% and 40% of SA's total health budget will be spent on treating AIDS patients at a cost of between R4bn and R8bn. The MRC says between 3,7-million and 4,1-million people will be HIV positive by the year 2000; 255 000 to 259 000 will be ill with AIDS and 197 000 to 203 000 will have died from the disease.

Workers' injuries pose problems

PERMANENT disability from workplace accidents and occupational diseases is a major problem for workers under the current Workmen's Compensation Act (WCA), says occupational health researcher Shelley Arkles.

She says every year thousands of claims are lodged with the Workmen's Compensation Commissioner, but the financial redress for workers with a permanent disability is extremely low.

If a worker is totally disabled (for example, paraplegia) a pension equal to 75% of his former monthly income is paid. If partial disability is greater than 30%, the worker is paid a pension that is proportionally reduced. If the injury is rated at less than or equal to 30%, a lump sum is paid.

Arkles says this approach — known as the "meat chart" approach — focuses on the physical impairment of the worker only. It takes no account of the worker's loss of earnings or loss of future earnings capacity.

She believes the WCA — which makes provision for financial compensation for workers injured in accidents at work or who suffer from scheduled occupational diseases — fails to meet the needs of disabled workers because:

☐ The wages on which compensation is calculated are low for unskilled and semi-skilled workers;

Erodes

☐ High inflation erodes the buying power of compensation pensions which, although periodically increased, are not linked to inflation or increased annually;

☐ The legislation does not distinguish between impairment and disability in calculating compensation and;

☐ Employment opportunities for disabled workers without appropiate skills are very limited.

She says a white collar worker who loses a leg and is assessed at 70% disabled (according to the meat chart) could still continue working. But a blue collar worker who loses four fingers and is assessed at 40% receives a much smaller pension and might never work again.

"Manual workers who rely on their physical capabilities for a living find their employment opportunities significantly reduced with any physical impairment.

"The WCA offers no protection against the dismissal of disabled workers who are often unemployable.

The level of benefits workers receive is extremely low because employers only pay an average of 1% of their wage bill on compensation, according to Arkles.

She says a restructured health system needs to consider permanent disability and workers' compensation in relation to:

☐ Social security generally;

☐ Health and safety prevention;

☐ Rehabilitation and;

☐ Appropriate structures for effective employer and employee negotiations on the issue.

Nationalisation debate still rages in health circles

WHILE protagonists for the nationalisation of the mines and major industries are increasingly less vocal in the ANC and the trade union movement, the same cannot be said for the health sector.

The Progessive Health Unity Forum, which includes the ANC, Cosatu and organisations of medical professionals, takes as its starting point the need for a strong national public health service in a future government.

The debate centres on what kind of public health service is needed and what — if any — the public and private sector mix should be.

The SA Communist Party is focussing its energy on a "triple H" campaign — health, housing and hunger. It believes people are entitled to free health care provided by the state.

The ANC believes the private sector should be involved in a national health insurance scheme paid for by tax revenue and compulsory health insurance for all those in employment.

Contributions to such a scheme would replace current medical aid contributions, and medical aids could only be used to pay for those services the national insurance scheme did not provide for — possibly, specialist dental services and cosmetic surgery.

Many supporters of the ANC-SACP-Cosatu alliance believe the health sector should be nationalised completely by taking over the private hospitals and compelling all doctors to work for the state.

Obstacle

According to the Health Policy Unit at Witwatersrand University, which argues that the private sector as currently constituted is the biggest obstacle to the creation of an equitable, efficient and appropriate health service, full scale nationalisation is not a practical solution and it is "unlikely" to be seriously considered.

"Health personnel, particularly doctors, would leave the sector and the country in droves and a black market in private care would soon emerge to undermine the public sector."

The unit also says that, even if all doctors stayed, it would more than double the state's already underfunded payroll.

Currently over half of all health expenditure is privately generated and this would disappear with wholesale nationalisation.

The unit favours the ANC's idea of a national health insurance system. "This would bring together into a single pool, controlled by the health authorities, both the public and private finances for health care. The money would then be used to pay for a package of health services for all citizens, provided by a combination of private and public sector providers."

Nehawu is a major player in the sector

BD aug 29/5/92.

WORKERS in the health sector are organising to fight "health for profit and the unilateral restructuring of services," says the assistant general secretary of the 50 000-strong National Education, Health and Allied Workers Union (Nehawu), Neal Thobejani.

Thobejani says the union is involved in a Progressive Health Unity Forum — that includes organisations like the ANC and the National Medical and Dental Association — where policy for a future health system in SA is being discussed.

He says the bottom-line is that the state must take responsibility for the health of people — especially the young, old and unemployed.

This month tariffs at public hospitals were increased by 12% and the union is "consulting with the community" about action against the increase. Nehawu sees the increase as part of the "commercialisation" of health services which is putting health out of reach of most people.

Dispute

Nehawu and three other unions are in dispute with the Commissioner of Administration over wages and working conditions.

Thonejani says industrial action — including sit-ins, demonstrations and strikes — is certain in the industry if the commissioner does not improve on the wages offer.

On private hospitals Thobejani says the conditions are slightly better. "But our main struggle is for centralised bargaining in the private hospitals."

The Nurses Forum has called on Codesa to decide the status of the SA Nurses Association (Sana), which, with about 150 000 members, has a majority of black members. Membership is compulsory.

Thobejane says many black nurses are also members of Nehawu and the referendum is a response to pressure on Sana to be a trade union. If Sana accepts union status the prospects for unity will be better.

Nehawu and Sana are at loggerheads on issues like the right of nurses to strike, whether health is an essential service or not and whether health workers should be covered by the Labour Relations Act.

Nehawu has been organising in hospitals for the past seven years, but it was only after the nationwide hospital strikes in 1990 that it was taken seriously by the health authorities and other unions in the sector.

Merging

Now Nehawu is on the brink of merging with four other unions in the sector — the Cape-based Health Workers Union, Northern Transvaal Public Sector Union, Venda Public Sector Union and the Kwa Ndebele Public Sector Union. This will increase its membership by a further 12 000.

In addition, Nehawu is discussing unity with Nactu's 30 000-strong Public Sector Union (PSU) under the auspices of the joint Cosatu-Nactu Workers Summit this weekend.

Outside the staff associations, Nehawu and the PSU are the main players in the health sector.

If they unite, the new union will be the major force among health workers.

HEALTH CARE INDUSTRY

Taking a scalpel to high prices

Health Minister Rina Venter finally appears to have realised that she will never be able to appease the vested interests in the health-care industry as she tries to halt spiralling medical costs for the public.

Certainly, introducing the Medical Schemes Amendment Bill in parliament last week, despite continued strong opposition from the Medical Association of SA, shows a resolve few of her critics could have anticipated. With only a month to go before parliament closes, Venter seems determined to deregulate the industry. Her proposed changes will give medical schemes more scope to keep costs in check and halt doctors' sole discretion in dispensing health care.

If passed, the Bill will put an end to guaranteed payments and scales of benefits. It will allow schemes to provide healthcare services, by running hospitals and clinics and employing doctors, nurses and pharmacists, a move that has lowered costs by as much as 40% elsewhere in the world.

In cutting medicine costs, the Minister's resolve to deregulate the pharmaceutical industry will have to be just as unflinching. SA drug prices are among the world's highest.

Last week's annual conference of the Pharmaceutical Society of SA showed little initiative in addressing the costs issue. The debate merely depicted an industry wracked with internal tensions and lacking direction. While retailers, wholesalers and manufacturers battled to define their roles in the industry's apparent identity crisis, little consensus was reached on containing spiralling medicine costs.

The industry is not short of suggestions. Several recommendations — based on the findings of the Browne Commission and believed to contain many of the recommendations of the uncompleted Wim de Villiers report — were canvassed earlier this year at a forum convened by the Minister.

Generic substitution, ending the ban on imports of medicines that could compete with locally made ones, pharmacist-initiated therapy, rescheduling some medicines so that you would not need prescriptions to get them, and allowing other retailers to compete with pharmacies are all proven cost-cutting mechanisms that have dropped medicine prices in other countries. But vested interests — mostly doctors and drug manufacturers — continue to prevent their being implemented in SA.

The heated debate on generic substitution is a case in point. Manufacturers and doctors are still debating the efficacy and safety of generic drugs in SA. Yet generic drugs have been used safely for 30 years in State hospitals, resulting in huge cost-savings. The anomaly is that, legally, the widespread use

of the drugs remains prohibited.

Still, there has been some progress on the issue of generics. In February, Venter's department tabled a list of 36 substances that could not be substituted by generics, implying that all other medicines could be. Considering the discord on the issue, she is expected to table legislation allowing the widespread use of generics long before consensus is reached.

Medical administrator David Boyce says: "While the pharmaceutical industry broadly favours generic substitution, the multinational drug companies do not." Boyce, a former retail pharmacist who heads TPS, a claims processing arm of Medicredit, says the multinationals are preoccupied with protecting the market share of their patented drugs and with recouping their research investments. International studies suggest manufacturers secure a return of more than 45% on capital investment.

The conference did resolve to investigate allowing the parallel import of cheaper medicines. In the UK, parallel imports accounted for £250m in medicine purchases last year. But local manufacturers have already begun to stress that these imports could pave the way for counterfeit medicines, lowered standards and lost jobs.

The call for volume-based prices from manufacturers remains a great source of controversy in the industry. Wholesalers and retail pharmacists have persistently criticised manufacturers for giving big discounts to dispensing doctors, who buy only small quantities of drugs compared with the far higher prices paid by retail and wholesale chemists for larger quantities.

"This encourages doctors to drive the product through the (prescription) pen," says Len Keating, CE of wholesalers ACA and PDC. "They get deals for buying a thousand rands worth of merchandise that a pharmaceutical wholesaler could not secure when buying even a million rands worth of the identical product." The matter is now before the Competition Board.

Rescheduling schedule two and three medicines to allow pharmacists more room to initiate therapy would lower prices and sometimes save on a doctor's consultation fee. Tom Carse, past president of the Pharmaceutical Society of SA, says a list has been compiled by Potchefstroom University detailing no less than 96 ailments that could be treated by a pharmacist without any need to consult a doctor.

Venter has indicated her support for such a move but the powerful Medicines Control Council appears to be the stumbling block to implementing this reform.

The council's director, Johan Schlebusch, asks why too little has been done to familiarise pharmacists with the clinical aspects of medicines in higher schedules "in anticipation of the day when these schedules become a reality." However, many argue that the council, a scientific body, must consider the economic needs of a Third-World population rather than apply unsuitable First-World standards.

Regrettably, nothing was said at the conference about dropping the ban on pharmacists working for nonpharmacists in retailing. Such a move would certainly pave the way for large retail chains such as Pick 'n Pay and Clicks to enter the market and challenge the manufacturers' drug-price stranglehold, described by a conference observer as "obscene and inappropriate to the needs of the country." ■

THE DROUGHT

Fuelling the price spiral

Government says food prices have soared by nearly 30% over the past year, while Pick 'n Pay's Raymond Ackerman and the Premier Group's Peter Wrighton put the figure at around 15%. But, whatever the increase, food prices are sure to rise faster in the months ahead as the effects of the drought kick in.

With much of the maize crop wiped out, downstream users of imported yellow maize will be hit hard, sending a ripple effect of higher prices through the food chain. In

Aid schemes have a role to play, says Masa

THE Medical Aid Association of SA (Masa) is concerned about the crisis in health care and believes all players in the system should join forces and address problems in a co-ordinated and responsible way, says Masa secretary-general Hendrik Hanekom.

Hanekom says Masa believes the health system should be an affordable, non-racial, comprehensive, effective, unitary system to which all have the right of equal access.

"It is unlikely that a restructured health care system for SA will involve only one method of funding and providing health care services," says Hanekom.

It is possible that the state may fund the provision of health care while the private sector actually provides the services.

Hanekom acknowledges the need for a review of the whole private care insurance system because of the spiralling cost of medical aid, but believes that every attempt should be made to ensure the existence of medical schemes.

In this regard, Masa has objected to several aspects of the proposed Medical Schemes Amendment Bill.

Masa believes the Bill could result in:

- ☐ The removal of the protection provided to retired members;
- ☐ The encouragement of a trend towards more limited medical aid cover;
- ☐ Risk-taking of beneficiaries so that high-risk people, including the chronically ill and old people, could be removed from medical schemes.

Hanekom says the proposed amendments will also allow medical aid schemes to run their own health maintenance organisations.

These are already functioning to a limited extent in SA under the auspices of medical benefit societies.

Cheaper

At Iscor in Vanderbijl Park, for example, an organisation employing 12 full-time doctors functions at a much cheaper rate than it would cost if Iscor employees were on a medical aid scheme.

Hanekom believes the organisations are likely to be designed to limit the patients' choice of doctors, dentists, pharmacists and medical facilities.

He is particularly concerned about the scope of partnership between the public and private health sectors. "Whereas the National Health minister has said that the use of private health services should be encouraged, the role of the state in ensuring access to health services to poorer patients needs to be defined."

A national health insurance plan — which is being mooted as a way out of the crisis — should provide a method for the state to fulfil its obligations to retired and poorer patients and to implement a minimum service for all patients.

A "poorly conceived national health plan" could undermine the role played by medical aids and he says it needs to be synchronised with the existing medical scheme system, "to enhance rather than potentially destroy the system".

Health care

Reasons aplenty for the failure of aid schemes

Bday 29/5/92 (299)

GETTING to grips with medical aid schemes is no easy task.

The bottom line for most medical aid beneficiaries is to feel secure about their health. But with medical aid costs increasing over the past 10 years by an annual average of 25%, even the security medical aids offer is waning.

Why? A big factor is the massive grow in medical aid beneficiaries in the past 10 years. Twenty years ago, when about 70% of whites belonged to medical aid schemes, virtually no black people were beneficiaries.

But by 1987 about 5% of blacks were on medical schemes, the number of beneficiaries had grown sixfold and the rate of increase for black contributors had escalated sharply.

Wits Health Policy Unit researchers Max Price and Jonathan Broomberg say the trend towards increasing membership of medical aid schemes has exacerbated the health crisis. Schemes increase cost pressures on the whole health sector and deepen the gulf between public and private health.

They argue that the structure and functioning of the medical aid system itself has compounded the problems.

AMA CE Timothy Gelman says the main problem with health care is that input costs are not being related to results — and this applies as much to the private market as the public Price and Bloomberg say the responses to increasing cost pressures — including making the schemes more flexible, risk-orientated and individually geared — have undermined the risk sharing and cross-subsidisation aspects of health insurance.

Higher income medical aid members contribute more to schemes then lower earners. This enables some cross-subsidisation, in which low income earners can use more than they contribute.

But with the flexible packages, each package corresponds to different income levels and cross-subsidation is being eroded. In addition, those who can afford it are topping up with health insurance schemes. Bloomberg and Price say the growth of medical aids and health insurance is aggravating and entrenching problems.

"It is exacerbating the maldistribution and misallocation of resources by increasing the financial barriers to equal access to health care and by undermining the public sector."

Bloomberg and Price say the solution is tointegrate public and private provision of health care by means of a public financing system like a national health insurance system.

Gelman disagrees: "It is naive to think a national health insurance system will provide anything better unless the issue is approached from a business perspective."

He says while the functioning and structure of the system is by no means ideal, replacing it with a national health insurance system will not solve the problems of improved and efficient resource allocation. While a form of national health insurance system might have merit as an integrating mechanism, the only workable solution is the careful management of health provision.

"Healthcare facilities in SA are excellent by world standards and we must beware of proposals for systems which could destroy the high standards we have achieved.

"With increased accessibility, we have to rework current provisional assets. This will take time and must be in place before volumes force the collapse of the present system.

Gelman says a growing private sector will lighten the burden placed on the state. Part of the solution will lie in redistributing the health care risk more equally between consumers, providers and funders. Under the current system medical aid bears all the risk.

KARIN SAKS

National health service mooted to cure the legacy of apartheid

299

South 30/5 – 3/6/92

'In line with the ANC commitment to a mixed economy, the provision of health care by the private sector will continue to be acknowledged and regulated'

HEALTH Minister Dr Rina Venter's startling assessment that South Africans can no longer afford to be ill starkly highlights the crisis in health care.

The crisis is a result of the government's emphasis on high-tech and private health care and fancy and expansive drugs, but it points to the need for a radical re-think on health care policies.

The ANC guidelines stress that for people to be healthy, they need to earn enough to live comfortable lives and work in safe conditions.

The guidelines emphasise the primary health care approach adopted by the World Health Organisation and the United Nations Children's Fund (Unicef).

The ANC proposes one comprehensive, integrated national health service (NHS).

There will be a single department of health for the whole country, which will co-ordinate all aspects of health care provision, and will be accountable to the people through democratic structures.

The homeland and own affairs departments of health will be integrated into the NHS, and there will be no segregation and racial discrimination in health services.

Health care

"In line with the ANC commitment to a mixed economy, the provision of health care by the private sector will continue to be acknowledged and regulated."

The responsibility for health care will be divided between national, regional and district authorities. Where possible, these will coincide with regional and local government boundaries.

The ANC stresses co-operation between the health service and government authorities responsible for sanitation, water supply, housing and other social services.

Also envisaged is a national drugs policy. This is needed because "there are many parts of the health service where there is not enough medicine in store, or where medicines run out from time to time. On the other hand, in the private sector, there is little doubt that too much money is spent on medicine."

It is also envisaged that strong affirmative action programmes will be needed to ensure that more black people, especially women, are trained as doctors.

'In line with the ANC commitment to a mixed economy, the provision of health care by the private sector will continue to be acknowledged and regulated'

But there is no doubt that better health care, even expanding primary health care facilities to all South Africans, will be expensive in a new South Africa.

It is difficult to determine how health care will be financed because there is a lack of statistics which show what the majority of South Africans need in terms of health care and how much government is spending on what at the moment.

This reflects the lack of systematic planning for health programmes.

The government has now set up a working committee to collect data on what is needed, and it is expected to report in October.

Several ideas have been put forward by the ANC and others about how the health cost will be met, but there is no consensus yet.

Some would like to see the defence budget channelled into a national health insurance scheme to provide good primary health care to the neediest South Africans.

The better-off could, if they wanted, still have access to private, high-tech treatment with the help of medical aid schemes.

But why should the better-off benefit from the national health insurance scheme? And should they not pay for everything themselves without the state reimbursing employers for their contribution to medical aid schemes?

On financing health care, the guidelines say it is "the responsibility of the government to mobilise sufficient funds to ensure a service of free and equal access to essential health care for all South Africans. No-one should be excluded from a public health facility because they cannot afford it. Only when this is achieved will it be possible to reduce the gap in access to health care between rich and poor; black and white; and urban and rural people.

"Since, however, government resources are limited, those who can afford to, will have to contribute to the cost of health care, either through general taxation, or by contributing to a national health or social insurance fund, or both. The costs of medical care should be kept down by careful accounting and the rational use of resources."

All this could be easier said than done. The World Bank warns that while most African countries have endorsed primary health care and "health for all", the influence of urban and upper-class elites have skewed the distribution of resources away from the rural poor and more preventative services.

The World Bank also warns the emphasis should not be on building more hospitals. It should be on running what there is more efficiently and on ensuring rural outreach programmes particularly to serve women who have no access to transport.

Plan to stop medical aid funds abuse

S/Times (Cape metro)
3/5/92
(299)

By DIANA STREAK

A MEDICAL aid company has established the first full-time cost containment programme to eliminate the "abuse" by doctors and private hospitals which has caused members' subscription rates to rocket in the past few years.

The Pro Sano Medical Aid Scheme, a state-assisted scheme for state employees, has appointed Mr Faldie Kamalie to investigate fraudulent claims after discovering that up to R25-million a year was lost in this way.

"Members' subscriptions already average 16 percent of their monthly salaries. This trend is totally unacceptable and is further aggravated by the abuse of benefits by members as well as suppliers of services."

"We have found doctors manipulating tariffs by performing a minor procedure and charging for a more elaborate and therefore more expensive procedure," Mr Kamalie said.

"For example, a doctor might give a patient an injection and charge for five on the account. We also investigate doctors who charge above-average rates.

"We have found that some private hospitals offer certain doctors kickbacks for doing certain procedures there.

"The use of ultrasonic scans instead of normal X-rays has nearly doubled. This sophisticated procedure is often used unnecessarily.

"I have medical advisers who pick up discrepencies in treatments and I meet them on a weekly basis.

He said patients also abused the scheme by buying medicines from pharmacies without subscriptions.

The advantage of the cost-containing programme was that subscriptions rates would be kept down. Presently 20 percent of the company's costs was taken up by abuse or manipulations.

"In the Western Cape it is happening quite a lot. Due to the economic circumstances people tend to do these things."

The programme will include improving methods of fraud detection and monitoring claims cost patterns of general practitioners, specialists, private hospitals and optometrists.

Computer programmes have been designed to identify and list practioners whose monthly claims cost per member exceed that of their peers.

Day care clinics set to boom for PresMed

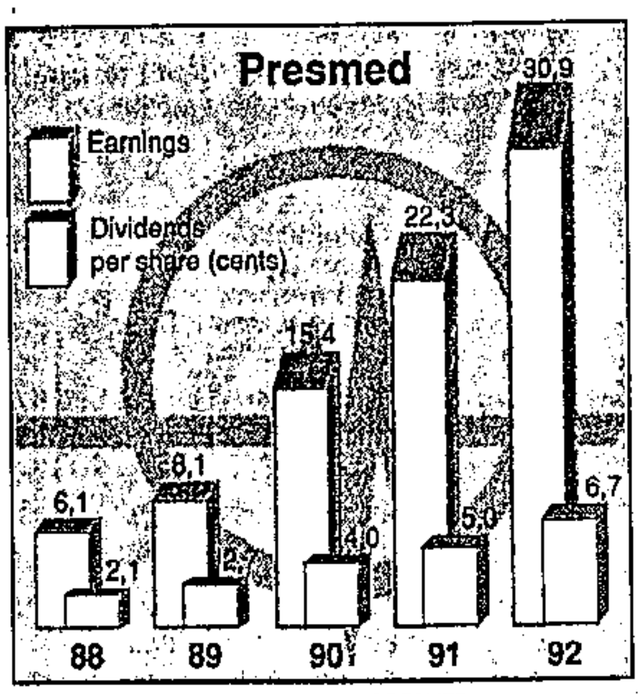
B1 Day 3/6/92

MICK ELLINGHAM

DAY care clinics in SA are set for "spectacular growth" as the medical aid industry begins to recognise the importance of cost-effective health care.

President Medical Investments (PresMed) MD Carl Grillenberger — speaking at a presentation in Johannesburg yesterday — said the trend towards day clinics had been prompted by three developments:

- New technology, which had opened the door to "same-day surgery" and shortened hospital stays;
- Concern about the cost and affordability of medical care; and
- Managed healthcare programmes, which had put pressure on patients and medical practitioners to cut costs.



Graphics: RUBY-GAY MARTIN Source: PRESMED

PresMed recently reported a 39% increase in earnings a share of 30,9c (22,3c) and a 34% rise in dividend payments of 6,7c (5,0c) for the year ended February 1992. Turnover rose 45% to. R74,3m from R51,3m. Grillenberger said the state supplied 80% of SA's hospital facilities, and the private sector 20%, with many patients forced into private hospitals by government's tight budget.

PresMed is taking advantage of this trend by providing compact, no-frills "contracted-in" hospitals and day clinics.

"Excellent" occupancy levels at the company's five hospitals were reported by PresMed chairman Naude Bremer, with the new Peglerae Hospital in Rustenburg expected to contribute to profits this year.

PresMed has acquired the Zandfontein Clinic in Sandton, and expects to open the Kempton Park Day Clinic in September.

Work on the Witbank Day Clinic is set to begin shortly, and an application has been made for a day clinic licence in Welkom.

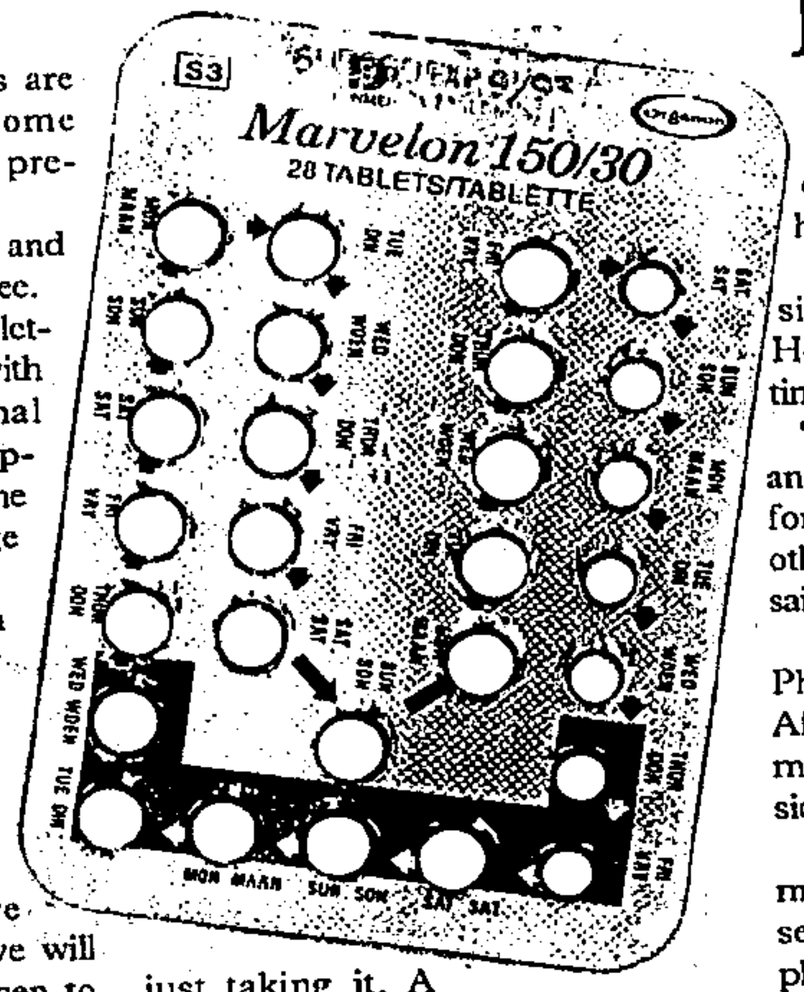
Government's health policy made strategic planning difficult, Bremer said.

Grillenberger said PresMed was looking at ways to increase the tradeability of the company's shares on the JSE, and were evaluating a proposal to consolidate and subdivide its ordinary shares to create a greater number of shares.

More to pill than swallowing it

SOUTH 6/6-10/6/92

By Karen Hurt



CONTRACEPTIVE pills are now available from some pharmacies without a prescription.

They will cost very little — and could in some cases be given free.

Pharmacists who have completed a family planning course with the Department of National Health and Population Development, will be able to order the contraceptives free of charge from the government.

They can then issue them free or charge R3,80 if they take a medical history from women who want to use the pill.

However, doctors are not completely satisfied that the new system will be effective despite the fact that the move will make it easier for many women to get the pill.

"There is more to the pill than just taking it. A woman who wants to go on to the pill should have a full medical history taken and tests done before choosing which pill will best suit her," said a general practitioner.

"Different pills have different side-effects for different women. How many pharmacists will have time to take a full medical history?

"Pharmacists are often busy — and is a chemist shop the best place for this to happen? There will be other customers around," the doctor said.

However, a spokesperson for the Pharmaceutical Society of South Africa said he was confident pharmacists would provide a "professional service".

The society was not yet sure how many pharmacists would offer the service but was aware that 1 625 pharmacists had passed the training offered by the Department of Health.

"Obviously pharmacists aren't able to do physical examinations when women come to get their contraception," the Pharmaceutical Society spokesperson said.

"Many have private areas in their chemists where they can take a medical history — this was one of the requirements for those wishing to provide the service.

"As far as having enough time to take a medical history, those who offer the service are committed to their clientele, there's no doubt about this."

A spokesperson for the Department of National Health said the pharmacists were trained to counsel, take a full history and decide on an oral contraceptive.

"The pharmacist is linked to a clinic to which women will be referred for yearly check-ups," the spokesperson said.

"We made the decision to introduce the new system to meet demands of women using contraception to make services more easily available, to include the pharmacist as a member of the primary health care team."

However, there are some questions which the Department of National Health did not answer.

Shouldn't the government provide more clinics where women can be given all the information and have the tests in privacy? Are women going to benefit in the long run or has the government just found a new and cheap way of handing out contraception?

Isn't this new system simply part of the old system — third-rate over-the-counter health care for women?

— Speak magazine

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AS politicians wrestle to control the freedom of the media, media owners struggle to find their role in a rapidly changing market. It is time, argues ROBERT FISK, for newspapers to reassert the value of investigative reporting and in-depth analysis.

1994

START 6/6/92

AT ABOUT 3.30 on the morning of January 17 last year, I was woken by the bedside telephone n my hotel in Dhahran, the ull, modern Saudi city conaining the United States's lartest Gulf air base.

It was The Independent in ondon calling to tell me that NN, the American Cable lews Network, had just reportd from Baghdad that bombs vere falling on the city, that he sky was lit up by anti-airraft fire, that the Gulf War ad begun.

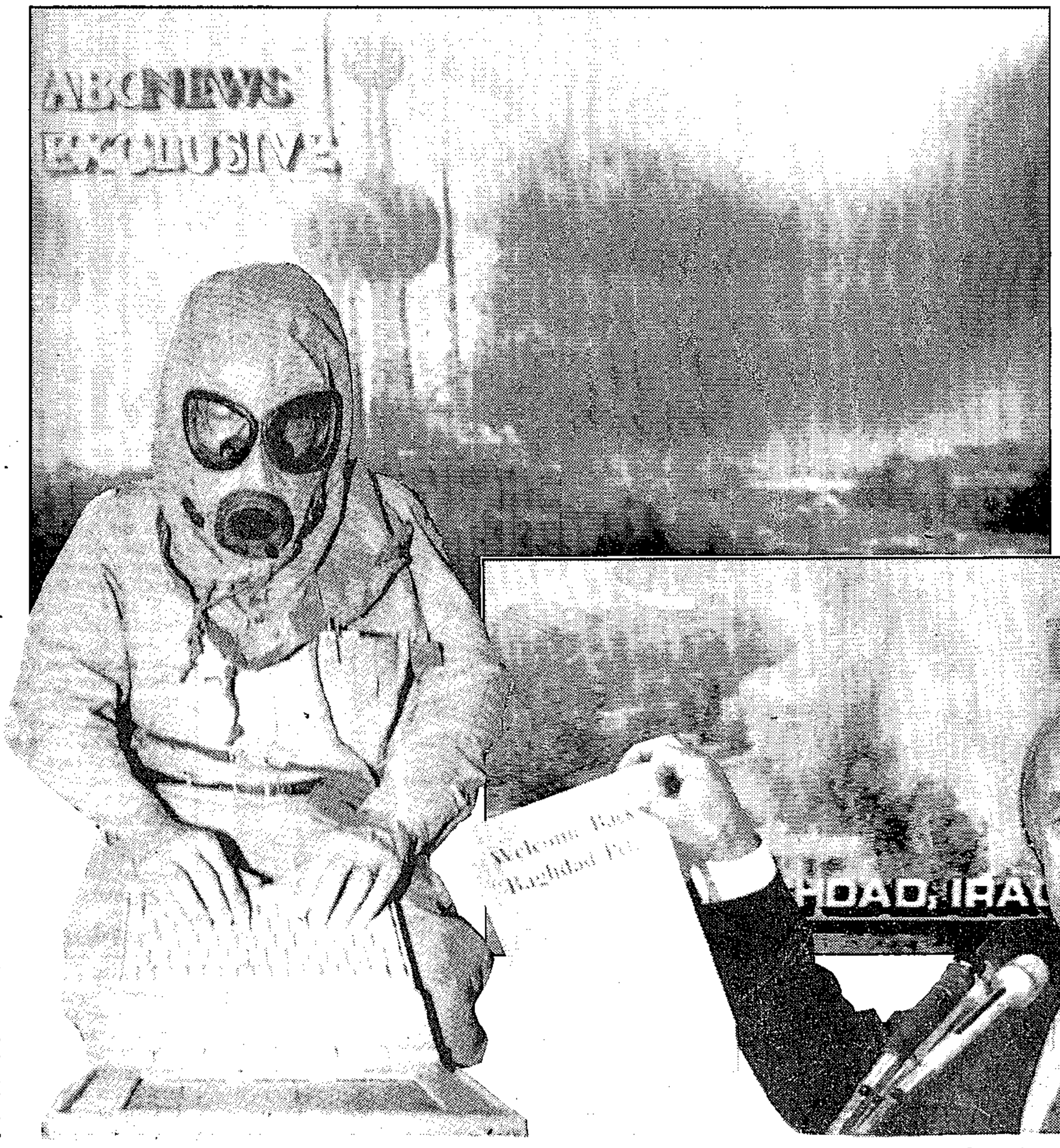
I had been forewarned. Ausralian radio had tipped me off he previous day that Cabinet nembers in Canberra had all sked for early calls which vould have them in their ofices by 3 am Saudi time.

A friend at the US air base ad told me to expect "somehing" early that day. But when he call came through from The ndependent, I was confronted vith a vacuum.

What could I report from Saudi Arabia in the first miutes of the war when the outbreak of hostilities was already being broadcast live from Baghdad on CNN? I recall experiencing an almost physical sense of shock as the realisation sank in that the old days of print journalism had vanished forever.

How many hours, weeks, months had I spent over the past decade and a half in the Middle East, perpetuating the 'hold-the-front-page" school of journalism?

In Beirut and Kabul, on the Iran-Iraq battlefronts, in Egypt and Syria, I had repaired telephones, cajoled operators and sometimes, I fear, physically attacked telex machines to connect myself to London, to pour forth from notebooks dramatic prose on riots, air raids and invasions. I was reporting news.



GULF CRISIS: While print journalists were racing to get their copy out (below left), live images of war were already on television screens around the world (top and centre). Peter Arnett (below right) was CNN's man who brought the war into our living rooms.

into humanitarian involvement in northern Iraq. It was BBC Television's shocking film of the Ethiopian famine that first awoke the world's conscience to the human disaster in east Africa in the mid-1980s.

One had to read the dispatches of print journalists — of The Independent's Harvey Morris, The Guardian's Martin Woollacott, or Jonathan Randal of The Washington Post — to appreciate the dimension of the tragedy and political betrayal.

But the satellite television pictures of babies and children actually dying on screen could not fail to be more powerful than the written word.

Nor is the written word so pure.

Just as newspaper reporters are always tempted to cluster round the news agency wire machines, so newspaper editors can spend too much time watching CNN and Ceefax.

A real sense of judgment is far more likely to come from journalistic investigation — something satellite television news can't do — and independent analysis.

It is not through coincidence that, with a few honourable exceptions, television prefers to follow up newspaper investigations rather than initiate its own. And that, one suspects, is one of print journalism's most important tasks in the future.

Television rarely holds politicians to the record. Despite all their archive material, for example, not a single television channel reminded its viewers last January that President Bush had promised the previous autumn that no offensive military action would be launched from Saudi territory.

Television reporters were interested in the present, not the past. *Writing* about a political crisis or a war means that the reporter has to take history books into battle.

Alas, no more. That telephone call last January symbolised for me what writing journalists have long understood but often refused to accept: the urgent need to redefine our role, to break free of the almost exclusive task we inherited from the newspapers of the 1920s and 1930s of recording news events, to embark on a new tradition of journalism.

For live television coverage has not only supplanted our old job: it has made news reporting ever more susceptible to ma nipulation. Governments can control cameras and television crews far more easily than they can newspaper reporters. They can therefore "manage" news events as they almost succeeded in doing in the Gulf War.

For a foreign correspondent, there is no way of escaping this conclusion. In Madrid, many reporters watched the Middle East peace conference last autumn in their hotel rooms or on a television screen at a press centre. I could have done the same in my home in Beirut.

Only when I obtained a seat in the Madrid conference chamber for the final day of the Arab-Israeli talks did I appreciate how cleverly the authorities had positioned the cameras — repeatedly showing the chamber in the *Palacio Real* dominated by a statue of justice, sword in hand.

I discovered that the statue had been brought into the hall just for the conference, that the faces of the Arab and Israeli delegates off-camera expressed just as much mutual animosity and suspicion as the rhetoric of their speeches. Television showed only the rhetoric.

Even when Terry Anderson, the longest held American hostage, was released in Damascus, the lessons were the same. The Syrians positioned CNN and other television networks nearest to Anderson and immediately in front of a portrait of President Hafez al-Assad — a picture which would, of course, appear in every shot of the freed hostage — while behind the cameras were lined the still photographers.

Behind them — in many cases too far away to see Anderson — were the newspaper reporters. Some of them only caught sight of the subject of their story by watching him on a tiny monitor. CNN viewers in London had a clearer vision of Anderson — and heard more of his words — than the reporters whose dispatches they would be reading hours later.

This does not mean that the day of the foreign correspondent is over, although governments might like to suggest this is the case. Quite the contrary.

Print journalism has probably never been so important to the functioning of democracy as it is in the age of satellite television. For however powerful and all-seeing a camera may appear to be, however "live" a press conference, it is effectively superintended by government authorities.

The import of satellite dishes, the operation of camera crews, the travel of television reporters, is invariably restricted, especially in times of crisis. The need for pictures means television will always submit to the demands of government.

Was it any wonder that CNN proved itself the most spineless of the television channels in accepting the notorious "pool" system of covering the conflict in the Gulf? With the shining exception of some Independent Television News teams and a few French crews, almost all the free and uncensored reporting of the Gulf was undertaken by print journalists.

Nor is it just submission to authority that flaws the new era of television news coverage. American television news demands immediacy, brevity, and, most pathetic of all, "sound-bites" — words that are both tasty and meaningless, a five-second substitute for human thought, the journalistic equivalent of junk food.

THE issue should not be simplified. In several cases, television crews in the Gulf offered invaluable personal help to their print colleagues. I owe two dangerous, uncensored, unofficial trips into the battlefront in Kuwait to Chris Morris of Sky TV. Both Sky and ITN allowed The Independent to use their satellite communications systems at cost price beyond the American lines in Iraq.

The problem not a personal one between print and television journalists. It is about the system of satellite TV news and what it represents.

Having broadcast a "clean" Gulf War to their viewers, television executives at last realised that they had been conned. Their speeches at the European Broadcasting Union's conference in Berlin last April were filled with lamentation at their lack of freedom to report the "reality" of the war, the pain as well as the victory. Only print journalists had described the horrors of the road to Basra.

In the hours after the ceasefire north of the Iraqi border, it was almost impossible to drive on the highway without running over parts of human bodies. I watched wild dogs feasting on Iraqi flesh and camera crews filmed all this. But scarcely a frame reached viewers.

Faced with the reality they supposedly craved, nearly all television editors decided that "good taste" would restrict their reports. Having therefore offered viewers war without responsibility, television ended the Gulf conflict by giving them war without death.

There are obvious exceptions. Videotape of the Kurdish catastrophe helped to shame George Bush and John Major into Investigation and analysis — and descriptive writing — have become the primary role of newspapers in the age of satellite television. Certainly this applies to foreign reporting.

If, on the other hand, newspapers choose to regard themselves as appendages of television, their readers are likely to respond accordingly. Is it any wonder that the American press — criticised so harshly by Seymour Hersh because of its reporters' obsession with television news — is in decline?

In the Middle East alone, there is ample evidence that satellite television news responds to events with the judgment of a robot. Governments like it that way.

American journalist John Hersey — the first reporter to write about the horrors of Hiroshima — commented:

"Tube" reporting of the Gulf War gave us a war of flags, yellow ribbons, parades and great pride in our power. I'm not sure, however, that we were ever given the deep look into the real texture and meaning of the storm in the desert."

Newspapers ignore such warnings at their peril. So do foreign correspondents. — The Independent, London.

How to deal with rising medical costs

STAR 6/6/92

(299)

INCREASING MEDICAL costs getting you down? Dick Otto, General Manager (Industrial Division) at Fedlife offers one remedy.

MEDICAL costs have been increasing at a rate substantially higher than inflation for many years, the State has largely withdrawn its subsidies of hospital services and VAT is now further increasing the average medical bill.

The reimbursement of medical expenses on a group cash-flow basis has therefore come under considerable pressure. In response, medical schemes have reduced overhead and increased contributions. Hospitalisation, intensive care and surgery are the most expensive benefits and medical schemes generally do not cover them adequately.

Since even a small number of high claims can further disrupt a medical scheme's cash-flow (or deplete its reserves), the obvious solution is to insure the risk of incurring high claims by means of stable group risk-premiums.

Intensive care

However, because insurers are not permitted to re-imburse actual medical expenses insured hospitalisation benefits are based on a fixed amount (for example a unit of R300) that is usually payable for each day spent in hospital, for intensive care and for every 15 minutes of surgery.

Members can choose how any excess of unit-based benefits over actual expenses is to be spent or allocated and if the insured benefits fall short of actual expenses, the difference could be made up by the medical scheme.

Schemes that have large reserves for the discretionary payment of high claims can apply those reserves towards insuring high claims by means of relativley low and stable insurance premiums.

Hospital

Being designed for the payment of unpredictable high claims, medical assurance normally only covers claims in excess of about R4 000 this threshold can, however, be reduced to R2 000 for members with lower salaries. It is also possible to insure group hospitalisation benefits from the first day of admission to hospital, but most insurers prefer medical schemes to continue handling the bulk of all claim administration, particularly the lower level of claims.

The insurance of medical schemes' benefits thus requires a basic correlation between the maximum amount payable by the medical scheme and the minimum amount insured.

The administrative cost of insuring medical schemes' higher benefits can be reduced significantly by linking up with exiting systems of the members' retirement, disability and group life assurance benefits.

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vide some light relief to the wife's reduced deduction for retirement annuity fund contributions.

Where contributions to

than R10 000 a year), then she may apply for a directive to include her income in her husband's return and be taxed at the

less of the additional cost involved, might do well to address the inequities in the current Income Tax Act.

Employee benefits like medical aid set to cost whole lot more

STAR 6/6/92

DEREK TOMMEY 299

SOUTH Africans must expect to pay more for their employee benefits. This is the message from Garth Griffin, general manager, employee benefits, at the Old Mutual.

He says that as employees grow older and need more medical attention they are likely to have to pay higher contributions for medical aid.

The increasing incidence of Aids will also force them to put their hands deeper in their pockets to pay substantially more for group life cover.

But on the other side of the coin, as fewer workers are expected to reach pensionable age owing to Aids, there should be no need for any major increase in pension contributions.

Griffin says that controlling costs these days is the top priority of company executives responsible for employee benefits.

The is partly the result of the dramatic increase in the cost of providing health benefits. In recent years these have escalated at a rate of about 25 percent a year — significantly more than the 15 percent inflation rate.

The average annual increase in the charge for a consultation at a general practitioner's rooms has been 27 percent. Recently, government hospitals have raised private patient charges by 30 percent.

And in the medical aid schemes administered by the Old Mutual Employee Benefits (OMEB), the claims frequency has increased by almost 50 percent in the past four years.

An examination of OMEB's claims showed that members under the age of 30 were actively subsidising those above this age, with the rate growing along with the age of the member. For members over 60 the subsidisation could be about 50 percent.

Griffin says this large cross-subsidy into the pensioner group will sooner rather than later raise issues of prudent pre-funding of this expense.

Most retirement funds provide for significant amounts of life cover, usually equal to between two to four times annual salary, he says.

"This part of the benefit is normally well understood. But what is seldom appreciated by either employee or employer is the scale of additional cover provided by the widow's or spouse's pension which is found in most arrangements."

Estimated conservatively, this could be worth about five times salary, but is probably worth more than double this if allowance is made for the pension increases normally granted.

Against this background, Aids is entering the local scene. "For those who may be hoping that South Africa is going to miss the full onslaught of this disease, let me reaffirm that regrettably, its progression is on course here in South Africa," Griffin warns.

draft operating budget of R1 060 million of the Corporation for the 1992/93 financial year. A further R28 million is required, for which approval must still be obtained.

(a) The additional amount of R28 million is required because of the fact that the Corporation's five year security plan has been shortened to three years, and on account of the Goldstone Commision's investigation into violence on trains. The five year security programme which would have ended on 31 March 1995 has been expedited and shall already be fully phased in on 31 March 1993. This entails that all stations will be secured for policing by erecting security fences, providing lighting, introducing access control and providing on-site accommodation for the SAP. Communication between the train driver, control room and the SAP is being improved to permit the speedier reporting of dangerous situations and incidents. Approximately R96 million of the draft capital budget of the Corporation of R288 million for the 1992/93 financial year, will be spent on security.

(b) The five year security plan has been shortened to three years with the aim to protect travel fare income by means of more efficient access control, and to appoint additional personnel to ensure better control at stations, to ensure better safety and to accomplish better crowd control.

A total amount of R250 million has been budgeted for the five year plan and will remain the same for the three year programme.

Tax deduction scheme: films

*9. Mr K M ANDREW asked the Minister of Finance:

(1) Whether, with reference to the film incentive tax deduction scheme, the Receiver of Revenue has reached a decision in respect of tax deductions for films for which deductions were claimed for the tax year ended 29 February 1988; if not, (a) why not and (b) (i) when is it expected that a decision will be reached and (ii) how long has the Receiver of Revenue been considering this decision; if so, what decision was taken;

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

B734E

The DEPUTY MINISTER OF FINANCE (Dr T G Alant):

(1) As the methods of finance as well as various other aspects of schemes of this nature differ from each other, it is necessary that every case is judged on its own merits and circumstances and each film scheme is decided upon separately. There is therefore no general decision which applies to all films.

In so far as the tax year ended 29 February 1988 is concerned, decisions have already been taken in respect of those films where sufficient information has been supplied by taxpayers. At present all film schemes are being dealt with by a special division which is situated in the office of the Receiver of Revenue, Johannesburg. Although it is a difficult and time-consuming task, the point has now been reached where assessments in respect of most of those schemes will be issued to the relevant taxpayers during the next few months.

(a) Not applicable.

(b) (i) Not applicable.

(ii) Not applicable.

(2) No.

Exemption of life-saving drugs from VAT

*10. Mr M J ELLIS asked the Minister of Finance:

(1) Whether he is considering or will consider exempting life-saving drugs from value-added tax (VAT); if not, why not;

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

B735E

†The DEPUTY MINISTER OF FINANCE (Dr T G Alant):

(1) No. The reasons are furnished in the following statement.

(2) During March 1992 the hon member posed a question in regard to medical services and as his question was fully answered at that stage, I do not consider it necessary to discuss VAT on medical services in general.

It is well known that sales tax at the rate of 13 per cent was payable on all medicines prior to the introduction of VAT. As the VAT rate is only 10 per cent and suppliers of medicines are now in a position to pass on to consumers the benefits of input credits in respect of capital and intermediate goods which are provided under the VAT system, the VAT system has created the climate to bring about a reduction in the cost of medicines.

As regards life-saving drugs, the question arises what are life-saving drugs. For one person a certain drug may be a life-saving drug but not for another. For practical reasons it is not possible to provide for the same item to be supplied to one person without VAT and to another with VAT.

Mr K M ANDREW: Mr Chairman, arising from the hon the Deputy Minister's reply, may I ask him, in the light of the fact that he has the answer to next week's question which has not as yet been asked, does he possibly have the results of the next by-election which has not as yet been held? [Interjections.]

(Question arising from wrong answer read by Deputy Minister of Finance (Dr T G Alant).)

Limited private practice: public service medical practitioners

*11. Mr M J ELLIS asked the Minister of National Health:

With reference to her reply to Question No 4 on 20 May 1992, what measures have been announced which enable registered (a) medical practitioners, (b) dentists and (c) (i) medical and (ii) dental specialists in the public service to participate in limited private practice?

B736E

The MINISTER OF NATIONAL HEALTH:

(Reply laid upon the Table with leave of House):

DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

S29/7/3
S29/7/4

1 April 1992

POLICY IN CONNECTION WITH LIMITED PRIVATE PRACTICE

1. *Introduction*
With regard to the national goal of an effective, efficient and affordable health service, the Cabinet approved the principle of limited private practice during a session on 2, 3 and 4 December 1991 and on 11 March 1992 which will enable medical and dental personnel to perform work outside employment in the Public Service and receive and retain the income which is generated from this, subject to certain conditions.

2. *Purpose of limited private practice*
To promote the recruitment and retention of medical and dental personnel.

3. *Scope of application*
All officers and employees employed in a full-time or part-time capacity who are registered with the SA Medical and Dental Council as medical practitioners, dentists and medical/dental specialists, qualify for participation in limited private practice.

4. *Operational measures*
4.1 Approval for participation in limited private practice by officers/employees still rests with the relevant Minister/Administrator or his delegate.
4.2 Limited private practice is performed outside and over and above the prescribed official duty times and duty hours, in other words such work must be performed outside the approved duty times and after the official minimum of 40 hours of service per working week or 56 hours of service per working week in the case of personnel who declare themselves willing to comply with a working week of at least 56 hours, or in the case of part-time personnel after the relevant number of hours of duty. (A working week is that period which extends from midnight between a Saturday and

cont—D

Doctors in protest march against Bill

Health Reporter (299) ARG 10/6/92

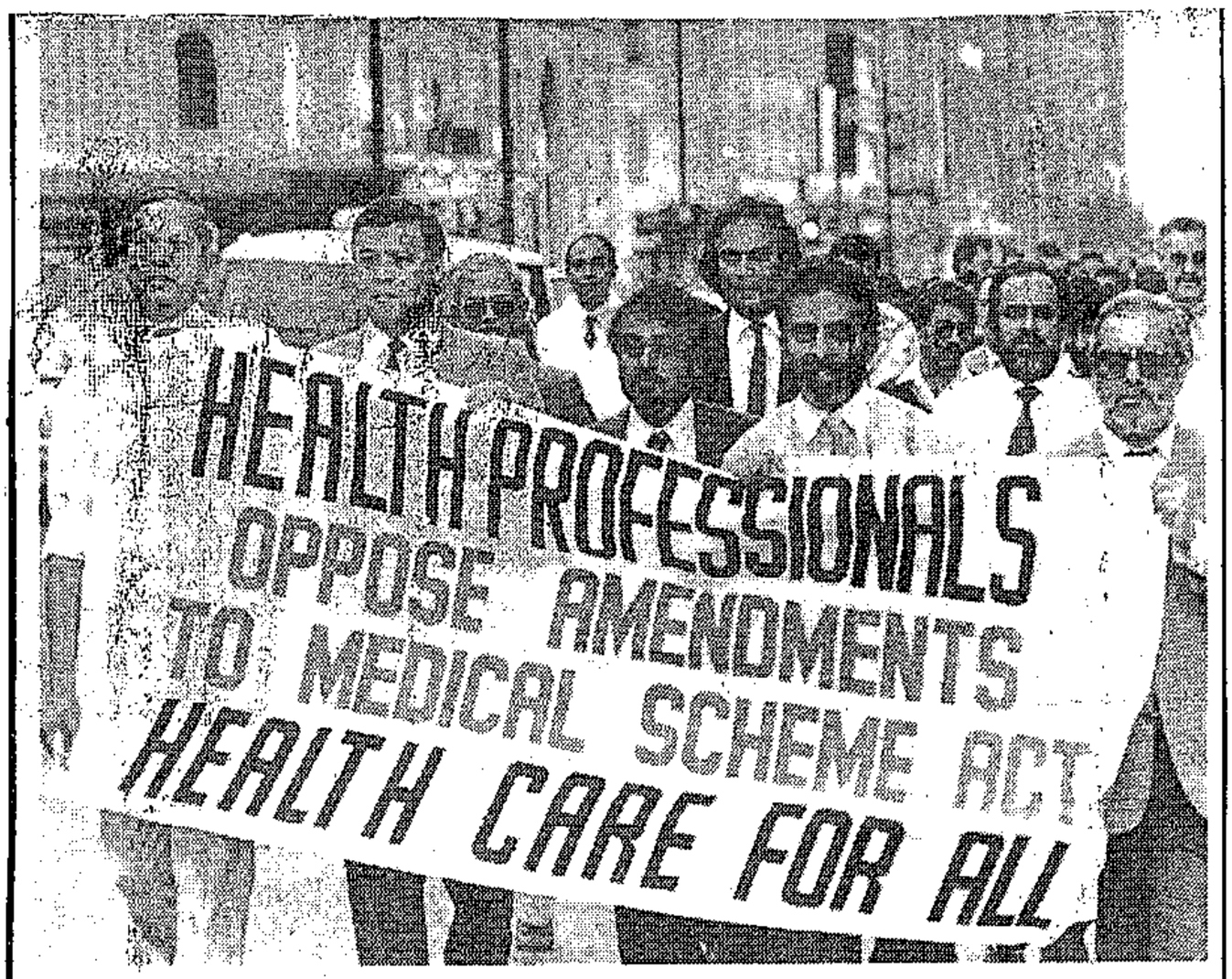
ABOUT 200 doctors, physiotherapists and dentists marched to parliament to protest against the Medical Schemes Amendment Bill.

The Bill proposes sweeping changes to medical aid schemes, including the abolition of guaranteed payment and a set scale of benefits.

In a memorandum addressed to Health Minister Dr Rina Venter, the health-care professionals said the Bill would allow businessmen to make profits out of the poor.

The Bill also failed to address the health-care needs of most indigent and unemployed people and pensioners.

They demanded that the Bill be stopped immediately and asked for an "urgent forum" made up of all those involved to discuss an equitable health policy for South Africa.



DOCTORS ON THE MARCH ... Doctors marched to Parliament yesterday to protest against the controversial Medical Schemes Amendment Bill. Picture: BENNY GOOL

299

Med-aid bill: Doctors march on Parliament

ET 10/6/92

By GLYNNIS UNDERHILL

MORE than 200 doctors made history yesterday when they marched on Parliament to protest the controversial Medical Schemes Amendment Bill which they claim will lead to the exploitation of underprivileged patients by businessmen.

Mr E Cronje, the administrative secretary to National Health Minister Dr Rina Venter, accepted from the group a memorandum opposing the bill.

The chairman of the Dispensing Family Practitioners' Association, Dr Rob Rapiti, said the marchers represented a broad cross-section of doctors, dentists, physiotherapists and others from private practice and government institutions.

"We object to the fact that the bill has laid open low socio-economic and under-served areas to be exploited by businessmen who are determined to open inappropriate medical services in these areas to make huge profits," he said.

According to the bill, which was tabled in Parliament on May 20, medical schemes will be able to determine their own fee structures and employ their own salaried practitioners.

Dr Venter denied yesterday the bill was being "steam-rolled" through Parliament.

Doctors stitch together plan to beat costs of medical aid

SOUTH 13/6-17/6/92

(299)

Justin Pearce looks at the pros and cons of a new deal for low-income patients:

MEMBERS OF a Claremont medical practice have come up with a novel way of beating rising medical aid costs. The new scheme side-steps medical aid companies by means of a straight contract between the patient and medical practitioner.

Promoted by an organisation called Accessible Health Systems (AHS), it was devised over the past two years by members of the Claremont practice. The scheme claims to make the services of private general practitioners available to low-income patients.

Insurance companies this year mooted the idea of health maintenance organisations (HMO's), comprising doctors and other health practitioners contracted into medical aid companies.

The HMO's attend to the medical needs of people contracted into the scheme.

The AHS is different in that no medical aid company is involved. The patient enters into a contract with the medical practitioner and pays a monthly subscription in return for the doctor's services.

Because of savings in operating costs, it is cheaper to subscribe to an AHS than to an HMO, and far cheaper than subscribing to a medical aid scheme.

In the case of an AHS, a single person pays only R40 a month or R400 a year, while a family of four pays R60 a month or R650 a year.

Pick 'n Pay is one of the first major employers to offer the AHS scheme to its staff.

Sister Gilly Podd, occupational health sister at Pick 'n Pay's Western Cape supermarket division, said the company was acting as a facilitator for employees to subscribe to the scheme, though subscription was voluntary.

She said the scheme was helpful for those who could not afford medical aid.

Podd commended the scheme for its provision towards preventive health care. The doctors in the scheme were well-placed to advise patients on issues such as nutrition, she said.

But the AHS has drawn criticism from people who believe low-cost basic health care is the state's responsibility.

Dr Robert Rapiti, chairperson of the Dispensing Family Practitioners Association, objected to the fact that the scheme provided only for the services of a general practitioner. People contracted into the scheme still had to pay for specialist care.

"It makes no sense to have a contract that only treats coughs and colds," Rapiti said.

He was also concerned that an employer could use the doctor to gain access to personal information about an employee. "This can happen in a contract situation," he said.

RAPITI believes the scheme would deny patients the right to a second opinion on medical matters, unless they pay for a private doctor.

Another problem is that patients must see a doctor who may not be conveniently located. For example, if a Claremont-based firm contracts with the AHS in Claremont, the service will not be easily accessible to employees living in Khayelitsha.

The ANC's policy on health is that the state must provide basic essential services. While not opposed to private health services, its policy is that state-funded clinics must be the point of first referral.

Thus under an ANC-dominated government there will be no room for a private service catering for basic medical needs at low cost.

Yet under a government which stubbornly resists increased public health spending, it is likely that schemes such as the AHS will proliferate with the support of people for whom the only alternative is an increasingly inadequate state health service.

health

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HOUSE OF ASSEMBLY

QUESTIONS

†Indicates translated version.

For written reply:

General Affairs:

Forums/conferences/discussions on health care

274. Mr M J Ellis asked the Minister of National Health:

(1) Whether, prior to holding a forum, conference or discussion on any matter relating to the health care rendering service, she consults with interested role players in regard to the holding of such a forum, conference or discussion; if not, why not; if so, how is this consultation effected;

(2) whether the items on the agenda for such a forum, conference or discussion form part of the consultation with interested role players; if not, why not;

(3) who makes the decision on who constitutes the relevant role players that should attend such a forum, conference or discussion;

(4) whether groups are consulted on this matter to ensure full representation of all interested role players, including extra-parliamentary groups; if not, why not;

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

B680E

The MINISTER OF NATIONAL HEALTH:

(1) Yes, depending on matters to be discussed at such a forum, important role players are consulted. It takes place either by inviting interested parties to pre-forum discussions to plan the agenda and approach and to decide on objectives for the forum, or through individual contact;

(2) yes — see point one;

(3) the Department of National Health and Population Development, subcommittees of the Health Matters Committee and those consulted re the forum;

(4) yes;

(5) no.

Aids and Lifestyle Education Programme kit

275. Mr M J ELLIS asked the Minister of National Health:

(1) (a) (i) How many and (ii) which education departments have requested that her Department's Aids and Lifestyle Education Programme kit be made available to them, (b) with effect from what date is this information available and (c) how many such kits have been distributed to each of these departments;

(2) whether her Department has received any feedback concerning the effectiveness of this education programme; if so, what is the nature of the feedback;

(3) whether there has been any international response to this programme; if so, what has been the response;

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

B681E

The MINISTER OF NATIONAL HEALTH:

(1) (a) (i) 13

(ii) the Department of Education and Training, the Department of Education and Culture, House of Representatives; the Department of Education and Culture, House of Delegates; the Department of Education and Culture, House of Assembly as well as the Departments of Education of Lebowa, KaNgwane, Ciskei, Transkei, KwaZulu, KwaNdebele, Qwa-Qwa, Venda and GaZankulu,

(b) 27 April 1922 and

(c) there have already been 2 000 requests for the school package;

(2) although formal research as to the efficacy of the programme will only com-

cont —D

Rates not racist, says medical scheme

BLOOMS 17/6/92 299

MICK ELLINGHAM

THE Representative Association of Medical Schemes (Rams) has denied any intended racial discrimination in setting rates along racial lines, resulting in whites' subscription rates being double that of blacks.

Executive director Rob Speedie said the subscription differences between race groups were not a form of inverse racial discrimination — they simply reflected the appropriate claims ratios. "Medical aid schemes set rates which mirror claims patterns, which at present divide up along racial lines."

However, the gaps between race groups are narrowing and may equalise completely in the future.

Medscheme deputy MD Les Hollis said for every R100 paid by whites and Asians in medical aid subscription fees, coloureds paid R75 and blacks R50-R55.

Hollis said different racial categories were necessary for the system to be fair.

"The cost of claims from coloured and black people is significantly lower than claims from whites and Asians," he said.

Hollis said subscription categories in future might be broken up according to categories such as age and claiming habits, rather than race. Blacks and coloureds did not have the same access to medical facilities, they tended to consult fewer specialists and they rarely used private hospitals.

(2) how much (a) had been spent on aid in terms of the above (i) scheme and (ii) programme as at the latest specified date for which information is available and (b) is it estimated will be spent on each in the current financial year?

B842E

The MINISTER OF NATIONAL HEALTH:

(1) (a) (i) and (ii) A minimum and maximum amount do not apply,

(aa) R40 per adult per month
R35 per child under 1 year per month
R40 per child over 10 years per month
R25 per child 2-9 years per month;

(bb) (i) R20 per person per month;

(ii) R30 per person per month;

(b) The financial circumstances of the farmer is evaluated to qualify for assistance of (aa) (bb) it is a supplementary scheme that provides for one third of a person's energy and protein need.

(2) (a) (i) 31 May 1992: R2,5 million and

(ii) 8 June 1992: R88 million awarded/spent;

(b) (i) R20 million and

(ii) R440 million.

Banquet facilities at home of Administrator of Natal

347. Mr M J ELLIS asked the Minister of Regional and Land Affairs:

Whether banquet facilities have been established at the home of the Administrator of Natal in Pietermaritzburg; if so, (a) at what cost, (b) who authorized it and (c) from which vote or votes was the cost of establishing these facilities drawn?

B845E

The MINISTER OF REGIONAL AND LAND AFFAIRS:

No. (a), (b) and (c) Fall away.

Forum on curtailment of cost of medicine

348. Mr M J ELLIS asked the Minister of National Health:

(1) Whether a forum on the curtailment of the cost of medicine was held on or about 28 February 1992; if so,

(2) whether a record was kept of the proceedings of this forum; if not, why not; if so,

(3) whether this record is available to the public; if not, why not;

(4) whether she has commissioned any investigations as proposed at this forum; if not, why not;

(5) whether she will make a statement on the recommendations made at the forum?

299 B846E

The MINISTER OF NATIONAL HEALTH:

(1) Yes,

(2) yes,

(3) no, because all organizations which showed an interest were accommodated at the forum. A copy of the record has been made available to them for submission of further comment;

(4) no, not at this stage, because all comments has not yet been received. The comments must be studied further and be considered before further decisions concerning investigations can be made;

(5) no.

SAP: issuing of bullet-proof vests

351. Mr E W TRENT asked the Minister of Law and Order:

With reference to his statement on 3 June 1992 on bullet-proof vests (a copy of which has been furnished to the South African Police for the purpose of the Minister's reply), (a) which branches and/or units of the Police are as a matter of policy issued with bullet-proof vests, (b) on what basis are priorities determined, (c) which of these units had been issued with such vests as at the latest specified date for which

information is available and (d) when is it anticipated that all units will have been issued with bullet-proof vests?

B849E

The MINISTER OF LAW AND ORDER:

(a) There is no fixed policy whereby specified branches and/or units are given preference when issuing bullet-proof vests. The issuing of bullet-proof vests is determined by priorities.

(b) The circumstances of each of the eleven (11) police regions are unique and priorities to establish to whom the vests will be allocated, are determined at a regional level.

Any branches and/or units of the Force may apply to be issued with bullet-proof vests. Reasons must be given in support of the application. Vests are then issued on a priority basis dependent on the available stock.

(c) As has been mentioned in paragraph (a) *supra*, preference is not given to any specified units in respect of the issue of vests. There is virtually no unit or branch that does not have bullet-proof vests at its disposal.

(d) As the suppliers cannot meet all demands, it is not possible to give a target date by which all units or branches will have been issued with bullet-proof vests.

Total amount spent on decentralization benefits

354. Mr W U NEL asked the Minister of Regional and Land Affairs:

(a) What total amount was spent on decentralization benefits in the 1991-92 financial year, (b) how much of this amount is related to new projects commenced during the said financial year and (c) how many new employment opportunities were created by way of such new projects (i) countrywide and (ii) in (aa) Phuthaditjhaba and (bb) Industriqwa in the 1991-92 financial year?

B852E

The MINISTER OF REGIONAL AND LAND AFFAIRS:

(a) 1982 RIDP—R629 928 789

(b) 1991 RIDP—R 1 242 608

(c) (i) 1982 RIDP—new projects which realized in the 1991-92 financial year—666 employment opportunities.
1991 RIDP—approvals from 1 August 1991 until 20 May 1992—17 035 employment opportunities.

(ii) (aa) 1982 RIDP—new projects which realized in the 1991-92 financial year at Phuthaditjhaba—None.
1991 RIDP—approvals from 1 August 1991 until 20 May 1992 at Phuthaditjhaba—None.

(bb) 1982 RIDP—new projects which realized in the 1991-92 financial year at Industriqwa—40 employment opportunities.
1991 RIDP—approvals from 1 August 1991 until 20 May 1992 at Industriqwa—258 employment opportunities.

Registered medical technologists: private practices

355. Mr W U NEL asked the Minister of National Health:

(1) Whether regulations permitting the establishment of private practice by registered medical technologists have been approved; if not, why not; if so, with effect from what date will such persons be permitted to enter into private practice;

(2) whether any qualifications and conditions have been set for such persons to be able to practise; if so, what (a) qualifications and (b) conditions?

B853E

The MINISTER OF NATIONAL HEALTH:

(1) Yes, regulations permitting private practice by medical technologists were pub-

Cont'd

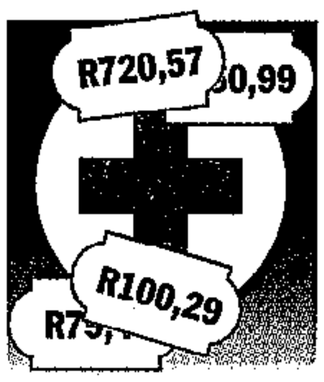
FM 19/6/92

HEALTH CARE

A prescription all can afford

299

Rina Venter's firm deregulation has antagonised a number of vested interests

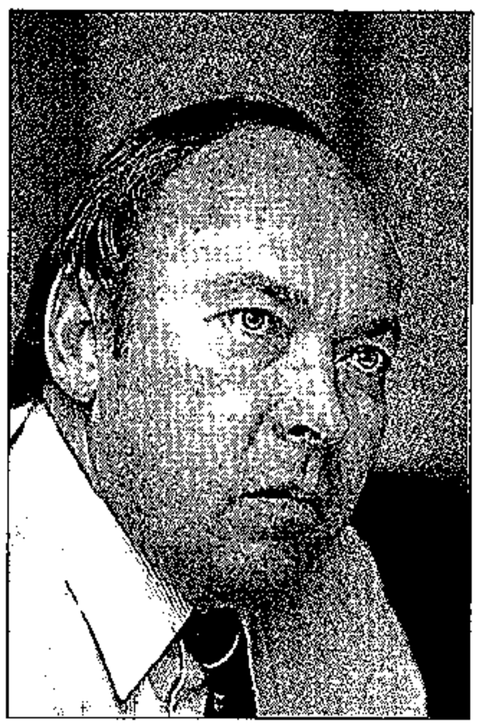


Finding solutions for the ailing health-care system hasn't made Health Minister Rina Venter very popular. Her first two years in office have seen her holding steady under fire from a huge array of vested interests which, of course, want protection from competition.

Her aim is to halt the upward spiral of medical costs — making health care affordable and accessible. That is why she has set about deregulating the entire sector. Since her proposals offer sound and well-tested mechanisms for cutting costs, introducing competition and improving standards, she has become a consumers' Minister. Yet these proposals challenge doctors, drug manufacturers, private hospitals and bureaucrats; so they resent her.

For its part, the ANC has dismissed her efforts as merely part of "government's unilateral restructuring programme." In other words, it wants to be consulted in decision-making. At present, too, Venter is in a wage conflict with striking hospital workers in the Transvaal. It comes as no surprise, then, that the anti-Venter lobby is strong.

The Minister will soon know whether she has won the first round — a measure which will take effect in the private sector. Parliament is due to vote on the controversial Medical Schemes Amendment Bill, which, if passed, will give medical schemes greater scope to check costs. In a nutshell, the Bill would end guaranteed payments and scales of benefits, ultimately curbing tendencies towards over-servicing by doctors and abuse by patients. It would also pave the way for schemes to run their own hospitals and clinics and employ doctors, nurses and pharmacists — a move that has lowered costs by up to 40% elsewhere.



Speedie

Venter's intention is to save the sector — which serves around 20% of the population — from collapse. The schemes are struggling to contain claim costs within the limits of subscription revenue; in 1990, almost half reported operating losses, with the red ink totalling R100m.

Doctors don't like it. Nearly a year after the proposed reforms were formally laid on the table for discussion, they are still attempting to stop the Bill as it stands. Last week, a group of about 30 doctors staged a demo outside parliament — and Johan Vilonel, chairman of the standing committee investigating the Bill, himself a physician, is said to be under particular pressure from his profession to delay a vote.

Off the street, the Medical Association of SA (Masa), which represents doctors, is in the forefront of anti-Venter agitation. The essence of the recalcitrance is that doctors believe the Bill is a threat to their professional discretion in dispensing medical services. They are concerned that the medical schemes could grow too powerful — acquiring virtually unchecked power to control the use and provision of services. A Masa spokesman puts it crisply: "Health professionals in the employ of medical schemes may be subjected to interference with their clinical judgment and might be pressured to compromise patient care because of cost considerations."

Venter

The Bill's supporters argue that the current fee-for-service system offers doctors and patients no incentive to be cost-effective. It is assumed that some faceless medical scheme will foot the bill; and the upshot is that some doctors push their patients further up the treatment scale than they need to go and some patients camp out in surgeries.

This is why Rob Speedie, executive director of the Representative Association of Medical Schemes (Rams), argues that health maintenance organisations run by medical schemes would actively discourage the oversupply of services. In addition, they would offer a number of options: "A medical scheme could provide its beneficiaries with total health care at a hospital staffed by specialists, nurses, paramedics, radiologists and pharmacists, etc — at ordinary contribution rates. If a member chooses to seek treatment outside this framework, he would probably have to pay some sort of penalty."

Speedie says that this model — successfully applied for some time in SA by Vaalmed — would cut costs for medical schemes because of economies of scale. Treating 80 people rather than eight gives the scheme greater buying power and enables a more cost-effective use of equipment and information resources.

The Bill could well usher in the US-style "preferred provider organisation." This means that a group of health-care professionals joins forces to provide for the needs of a community for a fixed time, usually a year. They contract out their services to a medical scheme but payment would be based on the number of clients rather than a fee-for-service arrangement.

Wits Commerce dean Duncan Reekie, a medical economist, says such schemes would make doctors wary of under-providing services — because patients would just keep coming back. "This would increase costs and lower profits and employers would take their business elsewhere. The incentive must, therefore, be not to overprovide or under-provide."

But even if the Bill passes parliament intact, Speedie says sophisticated health maintenance organisations will take some time to develop in SA: "The Bill merely seeks to achieve a larger measure of freedom to enable medical schemes and doctors to compete. Market mechanics don't adjust overnight to new trends."

Masa would like to see the scrapping of regulations prohibiting professionals from forming multi-speciality group practices. But it expresses concern that allowing medical schemes to control services could end the cross-subsidisation practised by many doctors who serve both the affluent and the poor. This would throw the poor into the grossly inadequate public sector. It also believes that the Bill would pave the way for less risk-rating — whereby health packages are designed to suit individual needs. Speedie says cross-subsidisation will continue, though "claims will be assessed with more care."

Masa has other demands:

- ☐ It wants the Minister to retain a system that guarantees minimum payments determined by the professional health-care associations;
- ☐ It wants medical schemes to be obliged to pay for what the doctors regard as certain essential services — such as basic consultations; and
- ☐ It believes that all payments by medical schemes should go directly to the provider of

cont'd

FM 19/6/92.

health care — the doctor — and not to the member. This would prevent the member from "using such benefits for his own purposes instead of paying the provider."

Masa apparently fears that the Bill would give medical schemes the opportunity to create a monopoly in the private health-care sector. "Patients' freedom of choice in respect of providers of services will be restricted," it argues. It also wants certain guarantees from government before it will support the Bill: "For example, to what extent would the State be prepared and capable of caring for patients who are not covered by health insurance, or who require services for which their schemes offer no benefits?" asks Masa's Bernard Mandell.

There is some validity in these points — but if costs are to be checked, there can be no hard-and-fast guarantees, particularly when it comes to minimum payments. This principle has been fully grasped by Venter.

The Minister's efforts to deregulate the pharmaceutical industry — that huge repository of vested interests — have further angered the doctors as well as manufacturers. When, earlier this year, Venter convened a forum to address the escalating costs of medicine, SA drug prices were pinpointed as among the world's highest. Yet there are simple ways to bring them down.

Venter would like to:

☐ Extend generic substitution;

☐ End the ban on medicines that would compete with locally made ones (so-called parallel imports);

☐ See the introduction of certain forms of pharmacist-initiated therapy; and

☐ Reschedule some medicines so they can be sold without a prescription.

Venter may well have to push ahead with her reforms long before any sector consensus is reached: "I simply can't accede to a massive anti-reform lobby, especially when the reforms are based on principles accepted around the world."

But discord runs deep. While the pharmaceutical industry broadly favours generic substitution, the multinational drug companies do not. Manufacturers — and some doctors — continue to question the efficacy and safety of these drugs whereas State hospitals have, in fact, been using them for the past 30 years with huge cost savings. Venter's department has listed 36 substances that could *not* safely be substituted by generics — which means that all other medicines could well be substituted. It could easily be done.

The multinationals' objections are understandable — they are not about to pave the way for cheaper medicines even though the bulk of the population can't afford patented brands. David Boyce, chairman of Medicredit's TPS, accuses these companies of being obsessed with protecting market share and recouping research investments, though international studies suggest that manufacturers secure a return of more than 45% on their capital investment.

Allowing the parallel import of cheaper medicines is another thorny issue. Local manufacturers have already begun to stress that such imports could pave the way for counterfeit medicines, lowered standards — and lost jobs. A familiar protectionist refrain. Yet in the UK, parallel imports accounted for £250m in medicine purchases last year.

Rescheduling certain prescription medicines to allow pharmacists greater freedom to initiate therapy could well lower prices by saving a consultation fee. A recent study by Potchefstroom University details 96 ailments that could be treated by a pharmacist without a doctor's intervention. And on this issue, Venter has some support: pharmacists are eager to extend their services to include limited clinical work, especially at the primary or preventive health care level.

But doctors and the all-powerful Medicines Control Council are dubious. Council director Johan Schlebusch has suggested that pharmacists could be required to undergo further clinical training before a rescheduling is allowed. Against that, many argue that the council — a scientific body — needs to apply standards more appropriate to a Third-World population than in the past.

Another simple cost-cutting exercise would be to drop the ban on pharmacists working for retailers such as Pick 'n Pay and Clicks, which could then enter the market and challenge the drug manufacturers' stranglehold on prices. Government is considering scrapping professional bars on freedom of association — and one result has been that SA embassies abroad have been inundated with visits from international drug companies threatening to pull out of SA if their operations are subjected to deregulation.

Venter comments: "I don't want to make things difficult for the multinational companies — but I do need to serve the interests of the public as a whole."

That is why, in addressing the gross imbalances and funding crisis in public health, Venter has opted to deregulate extensively. Her actions follow closely the SA Chamber of Business recommendations.

Formal racial barriers have been lifted and hospitals are required to treat all races. In practice, however, here as elsewhere, bureaucrats often frustrate reform. Added to this problem is the financial burden of maintaining 14 health departments while everyone awaits the final shape of the new political order.

Against such structural impediments Venter has made considerable progress. Her chief concern has been to reduce the gulf between preventive and curative services. She started by dedicating at least 5% of her budget to primary health care — and her intention is to increase this allocation to a sector which has been "particularly inaccessible to blacks."

Lack of adequate financial provision at this level is largely responsible for the overcrowding at provincial and academic hospitals. In the past two years, Venter has spent R80m on building 141 clinics and a further 60 have been sponsored by business. She has also set about reforming the top stratum of the public health system and is in the process of giving these hospitals complete autonomy in running their budgets and making their own decisions. Cape Town's Red Cross and Groote Schuur hospitals recently appointed accountants Ernst & Young to revamp their administrative and business practices.

Venter would also like to end licensing for private hospitals. She believes this would open the market to greater competition by giving developers greater responsibility for ensuring a viable project. And she believes the private sector should be more involved in optimising the use of facilities at State hospitals. At regional and local government levels, some hospitals will now fall under the local authorities and facilities are to be streamlined.

While finances are limited, Venter believes that good, lean, decentralised and autonomous administration will deliver the best health-care system in an imperfect world. She wants to "lay a good foundation for a future government to reach the needs of the population at an affordable level" — an ambition that indicates how far she has moved from the closed, overly protective and costly medical world of the past. ■

HEALTH BRIEFS

Cape Town tops the danger list

SOUTH 2016-24/6/92. (299)

Cape Town is the most dangerous city in the world.

A study of trauma here by the Medical Research Council (MRC) last year shows that one person in 10 requires medical treatment for a fresh injury annually.

This trauma rate is "considerably higher than anything recorded elsewhere in the world", according to the head of the MRC's National Trauma Research Institute, Dr Johan van der Spuy.

Producers defend board

GERALD REILLY

PRETORIA — Milk producers in the northern Transvaal have come to the defence of the Dairy Board in the row over levies paid by distributors.

Northern Milk Producers' Association chairman Willie Fourie said losses through milk dumping could have been far greater without the intervention of the Dairy Board.

In a weekend statement, he said it was untrue that millions of litres of milk had been thrown away. Milk had been dumped in isolated cases because of its perishability.

Milk had been dumped even before the Dairy Board was set up.

Deregulation in the industry also did not help to alleviate the problem. It was the orderly dispensation created by the board that had minimised losses.

Fourie said the industry was being damaged by the current dispute. Non-payment of levies could mean an interruption in the industry's services.

Lift for Otis Elevators

DUMA GQUBULE

OTIS Elevators has reported a 31% increase in earnings for the half year to end-May, the first set of results to include those of newly acquired lift company Melcorp.

At the weekend the company said earnings had increased to 24,4c (18,6c) on additional shares in issue. The interim dividend was increased by a third to 12c a share from 9c.

Turnover figures are not given, but operating profit was 61% up at R11m (R6,9m). After receiving interest in the previous year, Otis paid R476 000 in interest at the interim stage.

This resulted in a 50% rise in pre-tax income to R10,6m from R7m. Attributable income was 58% higher at R5m.

Melcorp, the local agent for Mitsubishi lifts, was bought from a UK subsidiary of Otis' US parent United Technologies for R16,3m. A R7m rights offer helped to finance the deal.

The company said it expected to maintain the performance to the year end, despite the difficult economic conditions.

Crisis for Truloc employees

DUMA GQUBULE

DOZENS of employees of Truloc SA, the SA associate of London Stock Exchange-listed freight company Lep group, have been left to foot huge medical bills incurred over the two months prior to the company's liquidation last month.

Former Truloc chairman Noel Marsh said the company's 250 employees, who were retrenched last month, were never told that payments to the company's non-contributory medical fund had been discontinued at the end of February. One former employee had reported the matter to the police, he said.

Marsh, who was suspended when Lep appointed a new management team to run its SA associate two months ago, said Truloc's problems had started when Lep ran out of money last year as a result of property speculation in the US.

Lep, the largest freight company in the UK, then said it could no longer advance additional cash facilities to Truloc.

After Lep unsuccessfully tried to find a buyer for the company, Truloc was liquidated.

TODAY'S WEATHER

PWV and eastern Highveld: mild.
Western, southwestern Transvaal: mild to warm.
Northwestern, northern and central Transvaal: warm to hot.
Eastern Escarpment, Lowveld and Venda: warm to hot.
Free State: mild.
Cape Province north of Orange River: cool to

Med aid costs 'reach unaffordable levels'

ST 25/6/92 (299)

PRETORIA. — The cost of medical aid schemes in SA has become unaffordable to both employer and employee, Chamber of Mines medical advisor Izak Fourie said yesterday.

Addressing a seminar on human resources development in the workplace, Fourie said contributions to medical aid schemes over the past year had increased on average by nearly 37%.

To keep costs down companies should concentrate on primary and preventative health care with [illegible] disciplinary approach including management, corporate [illegible] development programmes, employee aid and human

Remedy sought for schemes' soaring costs

STAR 27/6/92

By DICK OTTO, general manager (industrial benefits division) at Fedlife.

299

MEDICAL costs have been increasing at a rate substantially higher than inflation for many years, the State has largely withdrawn its subsidies of hospital services and VAT is now further increasing the average medical bill.

The reimbursement of medical expenses on a group cash-flow basis has therefore come under considerable pressure. In response, medical schemes have reduced rates and increased contributions. Hospitalisation, intensive care and surgery are the most expensive benefits and medical schemes generally do not cover them adequately.

Since even a small number of high claims can further disrupt a medical scheme's cash-flow (or deplete its reserves), the obvious solution is to insure the risk of incurring high claims by means of stable group risk-premiums.

However, because insurers are not permitted to reimburse actual medical expenses, insured hospitalisation benefits are based on a fixed amount (for example a unit of R300) that is usually payable for each day spent in hospital, for intensive care and for every 15 minutes of surgery.

Members can choose how any excess of unit-based benefits over actual expenses is to be spent or allocated, and if the insured benefits fall short of actual expenses, the difference can be made up by the medical scheme.

Schemes that have large reserves for the discretionary payment of high claims can apply those reserves towards insuring high claims by means of relatively low and stable insurance premiums.

Being designed for the payment of unpredictable high claims, medical assurance normally covers only claims in excess of about R4 000. This threshold can, however, be reduced to R2 000 for members with lower salaries. It is also possible to insure group hospitalisation benefits from the first day of admission to hospital, but most insurers prefer medical schemes to continue handling the bulk of all claim administration, particularly the lower level of claims.

The insurance of medical schemes' benefits thus requires a basic correlation between the maximum amount payable by the medical scheme and the minimum amount insured.

The administrative cost of insuring medical schemes' higher benefits can be reduced significantly by linking up with existing systems of the members' retirement, disability and group life assurance benefits.

TPA pays up cash denied to oldies

CIPRen 28/6/92

TEN readers received their pension payments from the TPA in person on Friday after complaining to City Press when their pensions were not reinstated in June.

Most of their pensions were cut off because of the controversial review procedure introduced by the TPA.

Christina Tsotetsi of Katlehong received R2 524 for the nine months the TPA cut off her pension.

The 70-year-old grandmother had her pension cut off in September 1991 because of a mistake with her date of birth in her new ID book, which made her 12 years younger than she is.

At her latest trip to the pensions office in June, she was told to make yet another new application.

City Press complained to the TPA, the pension was reinstated and the arrears paid to Mrs Tsotetsi.

Magdeline Lebojoa of Heidelberg has also had her pension reinstated and will get arrears of R3 250.

Her pension was cut off in 1989 and reinstated in January 1991, but she received none of the arrears for the year of payments she was owed.

After complaints by City Press, TPA paid out the full arrears.

Several other readers received one month's arrears, which was missing from the payments they received at the paypoints in June.

TPA promised to pay out full arrears in June, but several pensioners found they were paid out for two, instead of three months, in June.

Disabled pensioner Eunice Nzama of Soweto got arrears of R2 163 when her disability grant was reinstated. The grant was cut off in August and at the Zola payoint in June she was told to come back in July.

The TPA says the money was at the paypoint in June, but could not say why it had not been paid out.

Another disabled pensioner, Daniel Mosime of Stilfontein, has had his grant reinstated and received his arrears.

Like other disabled people, Mosime will not have to go through this review procedure every year.

The TPA has abandoned the policy it introduced in 1990 which was to make all disabled people, even those permanently disabled, undergo a thorough medical examination every year to prove they still qualified for a pension.

From now on, it will be sufficient for disabled people to convince pensions officers of their continued disability.

■ The TPA says no new applications for disability grants can be considered until the strikes at Baragwanath, Hillbrow, Johannesburg and Leratong Hospitals end.

There are usually 1 000 disability grant applications in the Johannesburg and Soweto areas a month.

TPA director of development activation, Willie van Niekerk, says the TPA will make "every effort to help those who are in danger of having their disability allowances suspended bacause they lack a medical certificate".

Van Niekerk says that in cases of permanent disability, district officers will be given discretion.

Readers' Hotline

Helping you with your problems

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☐ PO Box 548
Kengray 2100

CITY PRESS, June 28, 1992 PAGE 9

TPA suspends grants

THE strikes at the Baragwanath, Hillbrow, Johannesburg and Leratong hospitals made it impossible to process applications for disability allowances, the Transvaal Provincial Administration said on Thursday. CP News 28/6/92 299

"Altogether about 1 000 people in the Johannesburg and Soweto areas are affected by this every month," said TPA director Willie van Niekerk.

"Until the strikes come to an end and the position at the hospitals returns to normal, no new applications can be considered," he said.

■ See Page 10

Plan for health reform

ST Times 28/6/92. (299)

By PETER MALHERBE

A NATIONAL health scheme for all races, covering basic medical services and financed by taxpayers, has been drawn up by the Medical Association of SA.

The plan to reform the system was approved at a federal council meeting earlier this month.

It was proposed as a solution to the country's inefficient, unfair and expensive health care system, a doctor told the Sunday Times.

Higher

He said details would be released next month.

The present system resulted in an inequitable, two-tier state and private health system, with the state unable to pay for the higher level of service for all its patients.

The doctor, who wished to remain anonymous, sai[d] the health plan would [be] funded from income [tax].

Medical practiti[oners] saw it as the state's [respon]sibility to ensur[e] able core health [care] levels.

Additiona[l] insurance could be [provided] by private patients' insurance cover.

The national health plan would:

- Be run by a single ministry of health;
- Finance the purchase of core health services for the entire population;
- Be financed from general taxation;
- Provide the greatest assistance to people least able to provide for themselves.

Masa has long demanded a non-racial, single health service for all citizens. The insurance would cover all South Africans needing essential medical procedures. Private medical aid schemes would be used merely as a "topping up" facility.

People covered by private medical aid schemes would be free to seek treatment under the state fund or their own scheme.

People could buy extra, non-tax deductible insurance to provide cover for additional services which would allow them to choose their own doctors or hospitals.

Then, should they require any treatment under the state "core medical services" list, they could apply for a cost contribution from the state fund, subject to a means test and government guidelines.

Injury

Those unable to afford medical services would be covered by the government scheme. Medical services would be required to apply means tests to their patients.

Core medical services — to be defined by an advisory committee with community representation — would include pregnancy and maternal care, child care, emergency treatment, and medical and surgical treatment of injuries or illnesses.

Such a system would be funded to encourage co-operation between the private and public health care sectors, leading to the more efficient use of resources.

The state and private schemes would form part of a national health network to provide comprehensive data for planning budgets and designing facilities.

Fulfilling work in communications

Sowetan 30/6/92.

ARE you a teacher, a nurse, a social worker or a matriculant with a warm, compassionate nature and an urge to help members of your community who have communication problems?

The University of Witwatersrand has just the thing for you - a Diploma in Speech and Hearing Therapy.

It is a two-year diploma that is offered by the Department of Speech Pathology and Audiology.

The fact that about 12 percent of the total population suffer from hearing, speech and language disorders, makes it urgent to have professionally trained community workers in speech and hearing therapy.

Disorders

This community work is concerned with identifying and managing speech, hearing and language disorders in children and adults within a community-based framework.

These disorders lead to children having learning disabilities, adolescents maladjusted socially and adults losing their jobs.

They will deal with about three million South Africans who have a communications problem including stuttering, hearing loss, voice disorders, speech problems associated with cerebral palsy, cleft palate and articulation defects.

Community speech and hearing work involves:

Recognising and assessing speech and hearing disorders;

Treatment

Providing elementary treatment;

Providing basic information to the person concerned, his family, associates and teachers;

Consulting with speech and hearing therapists;

Educating the community in primary health care aspects of the work, emphasising the prevention of speech and hearing disorders,

Working in a team with doctors, therapists and teachers; and

Establishing services where there are none.

A worker should be warm, compassionate, sensitive to other people's problems and have good organisational skills.

Nurses

To apply for admission a matriculation pass with a university entrance is needed although applicants who have worked with people, such as nurses and teachers stand a better chance.

On qualifying you may work in community clinics, hospitals or in Departments of Education and Special Education.

Community Speech and Hearing Workers are required to register with the South African Medical and Dental Council and take the Hippocratic Oath as modified for them.

Application for admission close at the end of August.

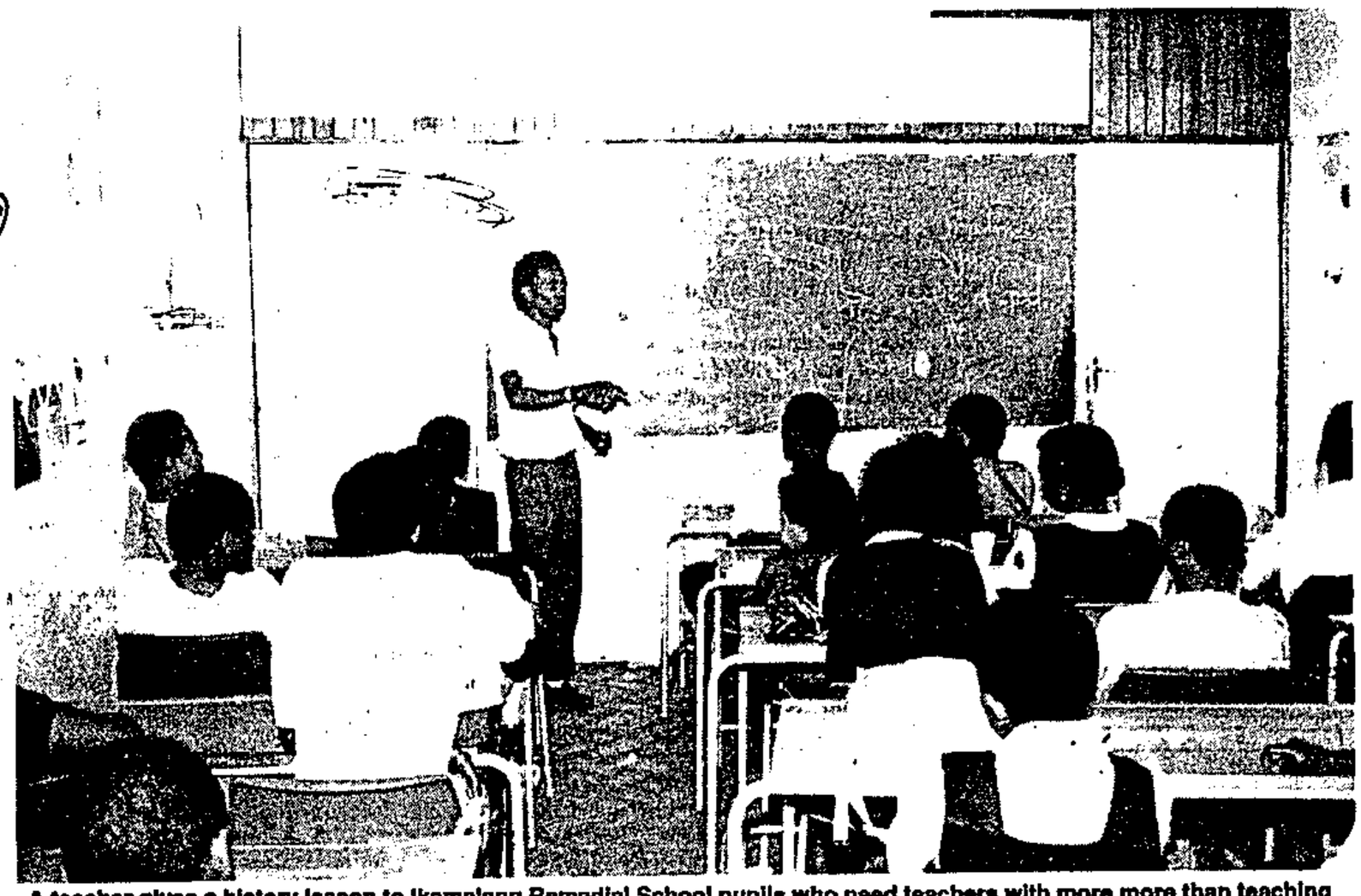
Wits Division of Specialised Education also offers a number of degree and diploma programmes to train people for different helping professions with education.

Two of them are:

Diploma in Specialised Education - Remedial Education for qualified teachers with a full matriculation exemption and two years experience.

Diploma in Remedial Education - a part-time two-year programme open to university graduates with at least three years experience in education.

For application forms contact the Central Admissions Office, PO Wits, 2050 or telephone (011) 716 3187.



A teacher gives a history lesson to Ikemeleng Remedial School pupils who need teachers with more more than teaching skills but understanding for their learning difficulties.

Watch out for sowetan schools material for Standards 8, 9 and 10 published every Thursday to supplement television lessons given daily between 3 and 5 pm.

Areas of concern as retirement looms

B/Day 2/7/92

PEOPLE with limited earnings years should take note of possible pitfalls before deciding where to invest their money.

Metboard investment marketing manager Greg Nowitz says there are five main areas to be wary of when earning power is about to be reduced:

☐ Credit risk. The investor must carefully choose an institution with a proven track record and good risk rating. "Better still, the older investor may prefer to spread his funds among several financial institutions, spreading the risk."

☐ Price risk. The price or value of one's investment funds may change. Nowitz again suggests diversifying to reduce the volatility of, say, equity investments.

☐ Purchasing power risk. This is mainly the risk of inflation. The over-50 should look at investment mechanisms that will grow faster than inflation, taking "cognisance of the future cost of living and mix the investment to yield sufficient income now and capital growth for later years".

☐ Changing legislation. The over-50 is usually paying maximum tax and might have significant property investments which could attract high tax rates under a new government. "Moving into retirement annuities (RAs) is one answer, but again there is always the threat of changing legislation which alters the tax shelter status of RAs."

☐ Flexibility. Here Nowitz suggests investors consider accepting lower returns to maintain liquidity as they must having quick and easy access to funds.

"This is especially important when one starts to consider medical costs and other emergencies. Obtaining an overdraft from a bank at age 60 is extremely difficult," he says.

MAKING PROVISION FOR MEDICAL EXPENSES SHOULD BE A PRIORITY

B/Day 2/7/92

A GOOD investment plan should not only include investing in tax-effective mediums such as assurance products and property, but also make provision for higher medical expenses later on.

Liberty Life legal and technical marketing manager Helita Mankowitz says given the inflationary rate of medical costs, one should invest in the health care products offered by life assurers.

"Comprehensive cover for the future is a must as it is usually in a person's later years that he or she needs such cover."

Mankowitz suggests over-50s ask:

☐ Has consideration be given to potential estate duty liabilities;

☐ Has the spouse been properly provided for in the event of the death of the other partner;

☐ How recently was your will reviewed;

☐ What will it cost to continue living in the style to which you are accustomed;

☐ Do you have any amount outstanding on your mortgage bond; and

☐ Are sufficient funds available to meet emergency needs?

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Vehicles

"There are many investment vehicles that meet these needs, but among those most commonly used are whole-life policies — for potential estate duty liabilities and which provide benefits for one's dependants.

"Other popular vehicles include (tax-free) maturing endowment policies, unit trusts for their capital growth and retirement annuities (RAs) with their reduced tax liability," she says.

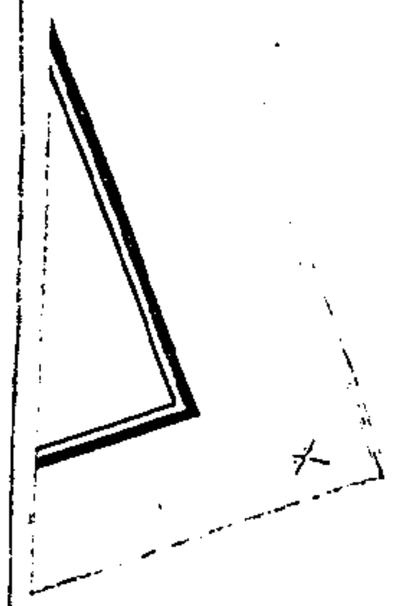
One's home should be virtually paid off.

Avoid speculative investments and look for low-risk retirement planning vehicles that offer some sort of guarantee.

"The minimum guaranteed returns offered by life assurance products are a unique feature among those investments with inflation-beating potential," she says.

"For instance, if you retire from an RA fund the one-third cash lump sum received should be wisely invested to provide capital appreciation or to generate high income."

She recommends opting for the one-third lump sum and not using the entire proceeds of an RA fund to purchase an annuity, since it is fully taxable. "About R120 000 of the one-third cash lump sum is tax free and can be more beneficially invested," she says.



Lifestyle sacrifices essential

Norwich launches first frail care policy

Bl Day 21/7/92

LINDA ENSOR

CAPE TOWN — Norwich Life has launched the first frail care insurance policy in SA as part of its improved package of medical insurance benefits.

Life division GM Robin Sharp said at the launch yesterday that the frail care policy guaranteed the holder cover for his entire life when, as a result of frailty, he was dependent on regular assistance to perform daily activities.

The frail care policy was available as an independent plan with a minimum entry age of 55 years (maximum 75 years). Sharp said the benefit would be a specified tax-free monthly amount which would be determined by the severity of the frailty, defined into three categories: where the person was mobile but required occasional daily nursing assistance; where day-care assistance was required; and where permanent assistance was needed.

At the time of death an additional month's payment would be made to the policyholder's beneficiary to help with funeral or other expenses," Sharp said.

In another new development Norwich Life's Medical Security Plan, which insures against listed diseases or surgical procedures, would now pay a tax-free lump sum up to an increased maximum of R75 000 to offset medical costs.

Sunninghill Medical Institute

New hospital to stick to medical aid rates

B1 Day 3/7/92

299 BK

MEDICAL inflation worldwide over the last decade, has been twice that of normal inflation. In SA, medical aid rates have risen by about 28% a year, making it the fastest growing component of corporate human resource costs.

Eskom Medical Aid Society manager Neville Ewing says employers have had enough. They are having to spend more but are not seeing the value added.

Employees too are finding medical aid help less and less affordable as many charges are higher than the tariff rate.

Statistics compiled by Eskom Medical Aid show that where tariffs for private hospitalisation (which comprises 32% of all claims) increased by 19,3% in 1990, the claims paid rose by 43%.

"It was because of this unsatisfactory situation that Eskom Medical Aid Society decided to get involved in the supply side and invested in Sunninghill Medical Institute," says Ewing.

The 230-bed hospital is situated just off the N1 Rivonia Road turnoff in Sandton. It went into operation on May 1 and was officially launched on June 27.

It is owned by the Eskom Pension Fund and leased from them by a consortium comprising Eskom Medical Aid, Sanmed, Hilpo and a syndicate of doctors practising from the hospital.

All services provided by the hospital, and by doctors linked to the hospital, are charged at medical aid rates and no deposits are required.

Sanmed GM Nick du Preez says his company wants to prove that a high-class hospital can be run at medical aid rates. "Sunninghill is a hospital which can compare with the best in the country and the medical care available compares to the best in the country but at a much lower cost."

The philosophy behind the project is to provide the "appropriate" service. Essentials in the hospital are the best, with an estimated R50m spent on equipment alone. But the non-essentials have been trimmed to the minimum.

Damaging

"The trauma of financial strain caused by unnecessarily expensive medical care can be as damaging to a patient as the illness for which he is being treated," says one of the doctors.

This does not detract from the pledge to provide the best patient care. There are secondary services provided in the hospital which are not necessarily profitable in themselves but are essential to the full treatment of the patient.

In conjunction with the above philosophy the owners do expect a return on their investment, albeit a moderate one. And with 60% of Sunninghill owned by two medical aid societies, profits will be filtering back into the medical aid industry.

Feasibility studies have indicated that the hospital will make a profit at 70% occupancy level. An added advantage of charging medical aid tariffs is that the likelihood of bad debts occurring is small. In other private hospitals the number of patients who are unable to fulfil their financial obligations for treatment received is becoming a major problem.

Specialties offered at Sunninghill are: ENT, cardio-thoracic, neuro-surgery, neurology, cardiology, maxillo-facial, vascular, medicine (chest and general), orthopaedics, rehabilitation and paediatrics. It also has a radiology department, offers physiotherapy for all the above specialities, has dieticians on call, and a 24 hour pathology laboratory.

Sunninghill Medical Institute

Sophisticated medicine has a place in SA

6/Day 3/7/92 299

BARBARA MOORE

THERE is definitely a place for high-tech, specialised medicine in SA, despite the need for general medical care for the country's burgeoning, poverty-stricken Third World element, says the developer of Sunninghill Medical Institute, who cannot be named for ethical reasons.

It is especially true when specialised medicine is provided at medical aid rates.

"At present, provincial hospitals are under pressure because of the number of medical aid patients using them. The patients are not going to the private hospitals because they cannot afford the deposits or the excess requested by most of them," she said.

For example, a heart bypass operation can cost up to R37 000 in a private clinic, while only R23 000 is covered by medical aid.

Eskom Medical Aid Society manager Neville Ewing says by providing a hospital that charges medical aid tariffs already makes medical care affordable to more. The fact that it is sophisticated medical care is a bonus.

He believes basic health care outlets in the rural areas is the state's responsiblity.

Nursing services manager Barbara Moore says: "The Health department is improving primary health care. Hospitals like Sunninghill play a supportive role."

She says the difficulty of a private company trying to provide primary health care is that rural health problems cannot be solved independently. Health care must be co-ordinated with agricultural practices, education and other spheres of a rural community's life.

The role of the private sector is to provide alternative medical assistance. By charging medical aid rates Sunninghill is a role model.

Privilege

Moore says: "Medical care is a privilege, not a right. People must make the effort to belong to a medical aid scheme. Many South Africans do not have their priorities right — they believe medical aid payments are too high but still pay monthly rentals for TV or go to restaurants regularly."

Ewing stresses that individuals should also make more effort to diet and exercise to maintain good health.

SA is also used by many African countries for specialised medical assistance. Lanseria airport outside Johannesburg is often used for emergency medical flights and Sunninghill is conveniently placed to provide medical assistance to such cases.

Sunninghill has linked up with an international rescue service, Medstar, that provides transport for critically ill and trauma patients who can be flown in from anywhere around the world.

Health care bodies unite

By BEATHUR BAKER

PROTRACTED attempts to unite health care organisations are set to bear fruit at the launch this weekend of the South African Health and Social Services Organisation.

Sahsso will bring together five major bodies, including the National Medical and Dental Association (Namda), the Organisation for Appropriate Social Services in South Africa (Oasssa) and the South African Health Workers' Congress.

A politically non-aligned organisation, its chief aims will be to provide primary health care to communities and to lobby for improved health services.

Unity talks, which began several years ago, are known to have been complicated by the differing character of the organisations. The constituent organisations have been duplicating services.

Melvyn Freeman, an Oasssa member from the Wits Community Health Centre, says the uniting of health care and social services under one umbrella allows the organisation to look not only at the provision of medical services for illness, but also at the social conditions in which disease occurs.

Sahsso membership will make it possible for health professionals such as doctors to join the same organisation as other workers in the health sector. Previously unorganised workers, such as those in mental health, can also be represented.

Call for state health scheme

By REG RUMNEY

THE conservative Medical Association of South Africa (Masa) has advocated a radical reshaping of the way health care is provided and paid for in South Africa.

This week it proposed that a state health plan under the control of a single ministry of health should assume responsibility for providing a basic set of medical services for all South Africans, "in the shortest possible time".

Its new approach stands in contrast to a policy that in past years concentrated mainly on defending doctors' incomes against what it regarded as insufficient payment by medical aid schemes.

As the medical schemes come under pressure and the political democratisation process gathers momentum, it has come to be accepted that the way health care is provided in South Africa has to change.

Against that background Masa this week released a wide-ranging working document to be used to develop health policy.

In advocating a form of national health scheme, it rejects the notion that the market alone can provide medical treatment for all South Africans.

"It's a recognition that Masa's always stated goal of providing good health care can only be achieved with extensive state intervention and state financing," notes a health policy researcher.

The key concept in the document is "core health" services, such as treatment for illnesses. Everyone should have reasonable, affordable access to these, and the state must help pay for those who can't provide for themselves. Masa proposes that such core services be defined by the government in consultation with informed community representatives.

How much the individual would pay, if anything, would depend on how much he or she earned. Masa suggests a "means test".

It would not depend on whether the individual had "top up" medical insurance or a medical aid scheme for services which are not "core". On the other hand, supplementary medical insurance would not be tax-deductible.

Masa proposes a "national health care financing system" funded from general tax revenue as opposed to funding from a special tax on employees, such as the special social insurance taxes common in European countries.

Masa acknowledges the current funding system, which it describes as a "voluntary system with a state-provided safety net", is insufficient.

Now the health system promotes multiple standards of service, where income, insurability and geographic location all determine the quality and range of access to health services, according to Masa.

The state health plan will have important consequences for the players who now dominate the health scene.

For instance, the document poses the question whether medical aid cover for core services will actually be necessary if the state does extend its health involvement. Masa also suggests the role of the state in financing non-core services should be reviewed.

Masa admits using general tax as a source of funds for this purpose has the weakness of not providing incentives for cost-effective use of medical services but it believes this is the best route.

There is no clear definition of the scope of the government's responsibility in providing health services. It proposes that state spending on core health services be budgeted for, and reported on, separately from other health services.

SOME BREAKS *for disabled,*

but severe limits otherwise

Doctors: taxman of little help

STAR 4/7/92.

299

If you're in good health generally and under 65, then you are responsible for most of your expenses yourself. You can only deduct them once they exceed 5 percent of taxable income or R1 000, writes LEIGH HASSALL.

TAX laws covering medical expenses are restrictive. But the physically disabled have recently been granted considerable concessions.

In an amendment to the Income Tax Act, "handicapped" people will be able to deduct medical and related disability expenses if these exceed R500 a year.

A "handicapped" person is defined as a person who is blind or deaf, requires a wheelchair, caliper or crutch, or has an artificial limb.

The concession includes the disabled child, step-child or spouse of a taxpayer.

To the healthy taxpayer under the age of 65, however, the deductibility of his medical expenses (including medical aid contributions) is severely limited.

Limit

He can only deduct medical expenses once they exceed 5 percent of his taxable income or R1 000, whichever is the greater. For example, a person earning R70 000 a year and incurring medical expenses of R5 000 will only be allowed to deduct R1 500, which is the amount exceeding his 5 percent limit of R3 500.

With the advent of separate taxation, both the husband and the wife are eligible for the medical expenses deduction. The claim will be allowed in the return of the spouse who pays the bill.

It is advisable, in order to maximise the portion of medical expenses deductible, that the spouse with the lower taxable income should incur all the medical payments so that the 5 percent minimum income limit will be reached at a lower level.

Many companies offer a non-contributory medical aid fund to staff, where the employee has no legal obligation to contribute to the fund. The company may, as part of the employee's structured package, pay the total contribution.

It should be remembered that in this case the employee may not include such contributions in his return.

In some companies, employees are obliged, by the rules of the fund, to pay a portion of the monthly medical aid contribution, with the employer paying the rest. Where, in these circumstances, the company pays the employees' contribution on a salary sacrifice basis, the amount will be regarded as a taxable fringe benefit.

The Income Tax Act allows a broad spectrum of medical expenses to be claimed, including payments to registered homeopaths, naturopaths, osteopaths, herbalists and chiropractors, among others.

Nurse

The expense of a nurse, mid-wife or nursing assistant hired in respect of an illness or confinement may also be claimed.

Many taxpayers are only subject to SITE and do not submit an annual tax return. In this case, Justin Cowley, tax partner at Ernst & Young, suggests, where the taxpayer's actual medical expenses exceed the 5 percent income limit, he may lodge a return to recover the excess tax paid, using a short-form return (IT 11) available at the Revenue office.

A person over 65 is allowed to claim the total amount of his medical expenses. Where the only tax paid by the taxpayer is SITE, it will greatly benefit him to submit an IT 11 and claim back his medical expenses. A person whose only income is a pension of less than R50 000 a year is subject to SITE only.

WHEELCHAIR BOUND: If you are disabled, the taxman will grant you relief on your medical bills.

A 'first' on frail care

STAR 4/7/92.

NORWICH Life has enhanced the benefits to policy-holders of its Medical Security Plan and Hospital Cash Benefit, as well as adding frail care insurance to the range — a South African first, it claims.

The Norwich Nu-Med range of insured benefits covering medical and disability products is said to offer complete protection against the financial consequences of sickness or an accident, and will protect the policyholder from the major medical costs, hospitalisation, frail care, personal income replacement, professional business expenses, dread diseases and disablement or loss of sight.

299

Presmed shares to be increased

Business Day Reporter

PRESIDENT Medical Investments (Presmed) would increase its number of ordinary shares from 11,5-million at 25c each to 18,4-million shares at 15,6c to improve tradeability and introduce a share option scheme, it said today.

The existing 11,5-million issued ordinary shares would be consolidated on a 1-for-5 basis.

The consolidated shares will then be subdivided to create an issued share capital of 18,4-million ordinary shares at 16,625c.

Authorised share capital would also be consolidated and subdivided on a similar basis, and increased to ensure that Presmed would have sufficient authorised but unissued shares in reserve.

Each shareholder's 100 shares would increase to 160. The effect of the proposal would reduce earnings a share from 30,9c to 19,3c, while dividends would move down from 6,7c to 4,2c. Net asset value a share would amount to 60,4c from 96,7c before the proposal. Although the earnings would be diluted by 37,5%, shareholders' earnings and net asset value would remain unaffected.

UAL files solid return

Business Day Reporter

UAL Unit Trust recorded excellent results for the first half of 1992, due mainly to substantial investments in Rustenburg Platinum, JCI, First National Bank, Liberty, Richemont and the Premier Group.

A return of 20,21% for the 12 months to 30 June 1992 was achieved.

A distribution of 27,41c a unit was declared for the second quarter of 1992.

In the past 12 months, the UAL Mining and Resources Unit Trust has outperformed the Mining Producers Index. A distribution of 3,91c a unit was declared.

The UAL Selected Opportunities Trust, a specialist fund, achieved a return of 16,11% for the past 12 months.

The UAL Gilt Unit Trust experienced a decline of interest rates during the second quarter of 1992.

The fund achieved a return of 21,4% over the past 12 months.

Sanlam's five trusts raise liquidity levels

LINDA ENSOR

CAPE TOWN — Sanlam's five unit trusts all raised liquidity levels significantly during the quarter to end-June to take advantage of buying opportunities expected to emerge in the stock market.

The level of cash in the Sanlam Index Trust increased to 11,7% (8,6%), Sanlam Trust to 12,4% (7,8%), Sanlam Dividend Trust to 21,2% (12,4%), Sanlam Industrial Trust to 13,7% (10,9%) and the Sanlam Mining Trust to 9,3% (8,6%).

The Industrial Trust has declared a distribution of 13,6c per unit, the Index Trust 21,2c and the Mining Trust 5,9c.

Senior portfolio manager Stafford Thomas said the market had been unstable in the last quarter, largely due to adjustments on most foreign markets and the uncertain local political situation.

In the short term, the local market would benefit from the underpinning of the US stock market by the presidential election campaign, which had decreased US interest rates. But industrial shares in SA were relatively expensive and significant growth could not be expected.

Thomas said higher growth in dividends and earnings was necessary before industrial shares could be expected to advance.

Commodity shares were the top performers in the last quarter. They benefited from the upturn in some world economies. Production shortages of some commodities were possible, which could positively influence SA's commodities and precious metals, Thomas said.

The biggest purchase by the Sanlam Trust over the quarter was the acquisition of 800 000 Midwits shares, and Tempora, Anglovaal Industries and Sappi shares.

The Dividend Trust bought Midwits (200 000), Datakor (471 600), AVI and Richemont and sold Q Data (538 200), Santam (242 700) and Carlcor. The Industrial Trust bought Tempora, AVI, Pepkor, Richemont and SA Breweries and sold Carlcor, Placor and Tiger Oats (322 500).

The Index Trust bought Absa shares (548 700), Palamin, Johnnies, CG Smith, Remgro, Richemont and Sappi and sold Libvest (200 000) and Tiger Oats (640 377).

Total returns over the last three years were — Industrial Trust 27,4%, Sanlam Trust 22,3%, Dividend Trust 20,5%, and the Index Trust 19,6%.

Sappi counting on overseas activities to reverse decline

MARCIA KLEIN

PULP and paper giant Sappi's aggressive foray into international markets could be the catalyst for reversing its declining profits trend of the past two years.

At end-February, the group's turnover had increased to R2,84bn from R2,67bn, but net income had dropped to R312,8m from R374,7m in the previous year and from R605m in financial 1990. Operating income and earnings a share had shown a similar decline, but international activities could change this trend.

Sappi supplies about 50% of SA's total paper requirements, and exports almost half of its production worldwide. About 50% of the income from its SA operations comes from international sales.

International links include Sappi Europe, which owns five fine paper mills in the UK, Sappi Trading, which markets the group's products internationally from SA, Zurich, the US and Hong Kong and the Usutu Pulp Company in Swaziland. In a massive overseas drive, Sappi recently announced the R825m acquisition of 90% of Germany's largest coated paper producer Hannover Papier.

The turnover of Sappi's non-SA operations increased by 7% to R1,8bn to end-February, and improved profitability is expected in the coming year.

Chairman Eugene Van As said in the annual report that exports to Europe, the US and the Far East were expected to improve "by well over the 10%" recorded last year.

At the group's AGM earlier this week, Van As said Sappi was trading better than a year ago and expected to show positive earnings growth in the current financial year.

Trading conditions had remained difficult in the first four months since the year-end, but there were "encouraging signs of further price increases in both the pulp and kraft liner board markets offshore".

The local market remained in a low growth phase with no signs of improvement on the levels obtained in the last trading period.

Despite significant improvements in productivity of its mills in Europe, trading conditions remained difficult. Van As said Sappi was well placed for a better economy in the UK.

The acquisition of Hannover Papier, and the international vendor placing of 19-million Sappi shares at R44 a share, had put the group in a stronger position.

Presmed shares to be increased

Business Day Reporter

PRESIDENT Medical Investments (Presmed) would increase its number of ordinary shares from 11,5-million at 25c each to 18,4-million shares at 15,6c to improve tradeability and introduce a share option scheme, it said today.

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HEALTH-CARE REFORM

Looking for a miracle cure

FM 10 7192 (299)

The Medical Association of SA's (Masa) prescription for the ailing health-care system can at best be described as well-intentioned and at worst wildly unrealistic. Masa wants the State to spend more money to provide health care for all but does not consider that the State coffers are depleted.

Masa's proposed reforms, announced last week, seek to ensure that everyone has access to basic health services, with a core to be agreed upon by the key players in the industry and the community at large. Masa says these core services will be funded by taxes and administered under a single Health Ministry.

Masa's recommendations would see that:

☐ A proposed State health plan would assume responsibility for ensuring cover for core health services as soon as possible. The State would also assume responsibility for training health personnel;

☐ Cover provided by the State health plan for core services would be paid according to a person's ability to afford services;

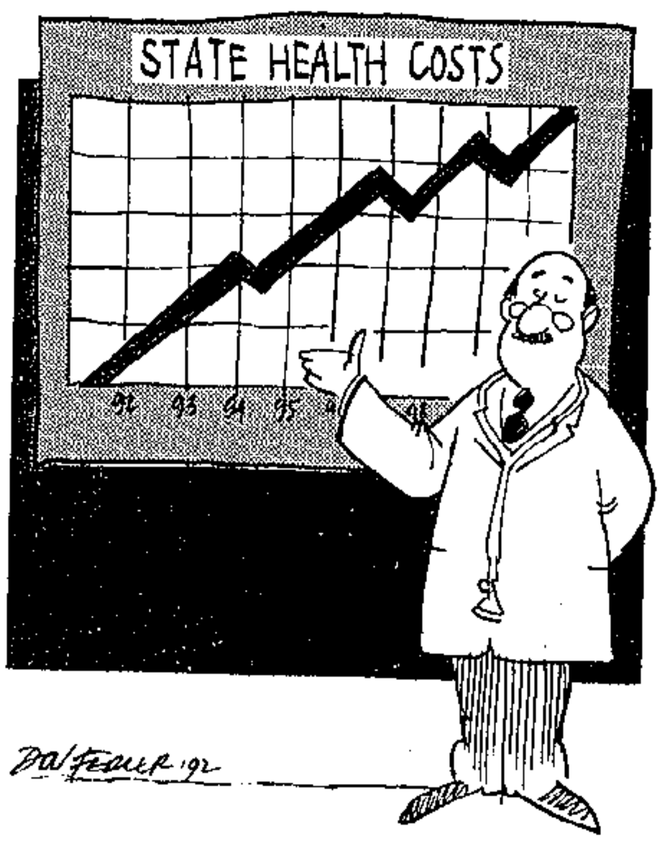
☐ Core health services would be defined by government in consultation with representatives from the community. For this purpose, a national advisory committee of experts would be established;

☐ Funds for core services would be allocated to regions based on a formula agreed upon;

☐ These services could be rendered by the private sector or public sector, depending on which would be cheaper;

☐ Individuals would be free to obtain supplementary insurance to provide cover for additional health services and/or allow them a larger choice of core services. Having supplementary insurance would not preclude access to government funding for core services. Alternative forms of insurance would be based on current options, for example private funds, insurance, medical schemes and managed health-care systems, such as health maintenance organisations; and

☐ Public and private sector providers would be free to render services to people covered by either the State or private health-care plans. Masa believes this would see doctors attract patients based on the terms they offered and quality of service they provided.



While many of Masa's proposals are sound, their viability and affordability remain in doubt without core health services being defined. Says National Health Director-General Coen Slabber: "As long as core services remain unquantified, it's impossible to say if we can afford such a scheme."

Slabber suggests that, unless core services amount to only a few basic services, the State will not be able to afford the proposed scheme. To its credit, Masa acknowledges that health-care resources and funds are extremely limited and talks of limiting core services. The association cites the Canadian system and some US examples that illustrate the potential for rationing health care in accordance with community norms and expectations. But industry observers ask whether the models could be transplanted to SA.

Masa's plan is also impractical to implement. Says Representative Association of Medical Schemes director Rob Speedie: "Masa is proposing that the State and the private sector provide and fund services. People will be able to switch between the two systems and obtain credits from both. How will that be administered?"

A major flaw in Masa's proposals is that there is no incentive to prevent abuse of the tax-financed system. The association acknowledges this and admits that a premium-based system would discourage overuse.

Speedie stresses that Masa's proposals can be of value only if they rely less on taxes than the present system does. "Masa talks of finding a definition of core health services that is equitable and affordable. The two concepts are almost irreconcilable in present-day SA. One must first determine what is affordable before considering defining core services. Having done so, one might find core services fall far short of expectations of equity, leading to pressure not for equity but equality at a poorer level of service." ■

HEALTH INSURANCE (299)

Frail care, too FM 10/7/92

The private sector spends more than R7bn a year on health and, with traditional medical aid societies and the State schemes under intense cost pressures, life offices are trying to fill the gaps. New products are flowing as they contend for a share of this market.

The latest addition is from Norwich Life, which was the first life office to offer guaranteed renewable health policies and which has now added frail care to the list of situations it will underwrite.

Norwich's Nu-Med range of benefits, announced this month, offers protection against major medical costs, hospitalisation, frail care, personal income replacement, professional business expense, dread disease, disablement and, in the case of disablement, waiver of other insurance premiums.

The assurer has also formed a benefit fund, with Inland Revenue approval, to enable employers to obtain medical and hospital cover for employees. Norwich Life GM Robin Sharp says employers will be entitled to a limited tax deduction on premiums.

Old Mutual and Liberty Life were among life assurers who came to the market with health insurance products at the end of last year, as did several nonlife offices. ■

Presmed directors release shares to improve tradeability

STAR 17/7/92, 299

By Stephen Cranston

A further 500 000 Presmed shares will be available in the market by the end of August, MD Carl Grillenberger said yesterday.

Presmed is the largest hospital group which is still contracted into medical aid and has enjoyed consistent profit growth since listing in 1987, outperforming Clinic Holdings and Rembrandt-controlled Medi-Clinic.

Mr Grillenberger said that the shares lacked tradeability and after discussion with three stockbroking firms it was agreed that shareholders — principally the company's directors — would put a portion of their shareholding on the market.

After a share split the number of shares in issue will increase from 11,520 million to 18,432 million. The net asset value per share will fall from 96,7c to 60,4c. The share is trading at 340c and the new shares will have a market value of 212c.

Shareholders will receive 160 shares for every 100 shares currently held.

Mr Grillenberger argues that Presmed has better prospects than its main competitors as it operates more cost-effective healthcare facilities and has high credibility among medical aid funds.

Southern Life's medical aid administration arm recently bought 50 percent of hospital group Medicor from Unidev.

Mr Grillenberger describes Medicor as "equally cost-effective".

While Presmed's directors have no intention of losing control of the business, Mr Grillenberger does not rule out some sort of tie up with medical aid schemes in the future.

"Our high credibility amongst medical aids will benefit us in the currently evolving healthcare environment. We have a power base from which to negotiate managed-care models to the advantage of our patients, suppliers and business partners," says Mr Grillenberger.

KENNISGEWING 625 VAN 1992

DEPARTEMENT VAN NASIONALE GESONDHEID EN BEVOLKINGS-ONTWIKKELING

VERTEENWOORDIGENDE VERENIGING VAN MEDIESE SKEMAS: VOORDELESKAAL TEN OPSIGTE VAN PRIVATE HOSPITALE EN LOSSTAANDE TEATEREENHEDE

Die volgende verbeterings moet aangebring word aan Algemene Kennisgewing 1132 van 1991, gepubliseer in *Staatskoerant* No. 13650 gedateer 29 November 1991, soos gewysig deur Kennisgewing 156 van 1992 wat in *Staatskoerant* No. 13775 van 21 Februarie 1992 gepubliseer was. Belanghebbende partye moet kennis neem dat die gelde soos gepubliseer in die bogenoemde *Staatskoerant* Belasting op Toegevoegde Waarde insluit.

S. J. ROODT,
Voorsitter: Verteenwoordigende Vereniging van Mediese Skemas.

NOTICE 625 OF 1992

DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

299

REPRESENTATIVE ASSOCIATION OF MEDICAL SCHEMES: SCALE OF BENEFITS IN RESPECT OF PRIVATE HOSPITALS AND UNATTACHED OPERATING THEATRE UNITS

The following corrections should be made to General Notice 1132 of 1991, published in *Government Gazette* No. 13650 dated 29 November 1991, as amended by Notice 156 of 1992 published in *Government Gazette* No. 13775 dated 21 February 1992. Interested parties should note that the fees as published in the aforementioned *Government Gazette* are inclusive of Value Added Tax.

S. J. ROODT,
Chairman: Representative Association of Medical Schemes.

Page / Bladsy 74

Remove items ..245, ..246, ..247 and ..248 from Section 3.1 and insert under Section 4 after item ..244 and add the following note after item ..248/Verwyder items ..245, ..246, ..247 en ..248 van Afdeling 3.1 en voeg dit byAfdeling 4 na item ..244 en voeg die volgende nota by na item ..248 :

Note : The fees in respect of items ..245 to ..248 are inclusive of equipment and consumables but exclusive of theatre fees/Let Wel : Die gelde met betrekking tot items ..245 tot ..248 sluit toerusting en verbruikbare items in, maar sluit teatergelde uit.

Page / Bladsy 77 : Item ..237

Amend the wording of this item as follows/Wysig die bewoording van die volgende item :

CUSA (plus lowest available manufacturer's price of CUSA pack plus 35%, which shall be inclusive of mark-up and Value Added Tax)/CUSA (plus laagste beskikbare vervaardigersprys vir CUSA-pak plus 35%, wat die hoër prys en BTW insluit).

Page / Bladsy 78 : Add a new item/Voeg 'n nuwe item by

Code/Kode 57/58/77	Description / Beskrywing	PRACTICE CODE NUMBER / PRAKTYKKODENOMMER 57 R	58 R	77 R
..269	Soluble bags for barrier nursing only, limited to 2 per patient per day/ Oplosbare sakke slegs vir sperverpleging, beperk tot 2 per pasiënt per dag	4,50	4,50	-

Page / Bladsy 79

299

Sections 5.1 and 5.2 : Amend the wording as follows/Afdelings 5.1 en 5.2 : Wysig die bewoording soos volg :

5.1 The amount charged shall not exceed the trade unit price, exclusive of VAT, as listed in the Ethical Price List prevailing from time to time, plus 48.5% (which shall be inclusive of mark-up and VAT), plus a dispensing fee of R2,20 which is inclusive of VAT/Die bedrag gehef mag nie die handelseenheidsprys, BTW uitgesluit, wat vervat is in die Etiese Pryslys van tyd tot tyd uitgereik, plus 48.5% (wat die hoër prys en BTW insluit), oorskry nie, plus 'n resepteringsfooi van R2,20 wat BTW insluit.

5.2 The amount charged shall not exceed the trade unit price, exclusive of VAT, as listed in the Ethical Price List prevailing from time to time, plus 48.5% (which shall be inclusive of mark-up and VAT), plus a dispensing fee of R2,20 which is inclusive of VAT/Die bedrag gehef mag nie die handelseenheidsprys, BTW uitgesluit, wat vervat is in die Etiese Pryslys van tyd tot tyd uitgereik, plus 48.5% (wat die hoër prys en BTW insluit), oorskry nie, plus 'n resepteringsfooi van R2,20 wat BTW insluit.

Page / Bladsy 80

5.5 **FRACTIONAL CHARGES/FRAKSIONELE GELDE**

Lowest available manufacturer's price inclusive of VAT, plus 35% (which shall be inclusive of mark-up and VAT), to be charged per case at the fractional rates indicated below/Laagste beskikbare vervaardigersprys, BTW ingesluit, plus 35% (wat die hoër prys en BTW insluit), om per geval gehef te word, op die fraksionele basis soos hieronder uiteengesit:

5.5.1 **Disposable drills, burrs, cutters, blades (e.g. Stryker or equivalent) and laryngeal masks/Wegdoenbare bore, ruimsysters, knippers, lemme (bv Stryker of gelykwaardige) en strottehoofmasker**

57/58/77 280	Neuro/Craniotomy / Neuro/Kraniotomy	33 1/3%
	Arthroscopy/Artroskopie	20%
	Orthopaedic/Ortopedies	33 1/3%
	Laryngeal masks/Strottehoofmasker	4%

5.5.2 **Surgical laser fibre optic leads, hand pieces and probes or scalpels/Chirurgiese laser optiese veselsnoere, handstukke en voelstafies of skalpels**

57/58/77 281	Vascular surgery/Vaskulêre chirurgie	100%
	General surgery/Algemene chirurgie	12½%

Hospitals/unattached operating theatre units shall show the name and reference number of each item together with the manufacturer's name, and schemes shall have the right to call for such invoices from the institution concerned/Hospitale/losstaande teater eenhede moet die naam en verwysingsnommer toon van elke item, met inbegrip van die leweransier se naam, en skemas sal die reg hê om sodanige fakture van die betrokke inrigting aan te vra.

(17 Julie 1992)/(17 July 1992)

KENNISGEWING 628 VAN 1992

ADMINISTRASIE: VOLKSRAAD

DEPARTEMENT VAN LANDBOU-ONTWIKKELING

KENNISGEWING VAN VERGADERING VAN SKULDEISERS KRAGTENS ARTIKEL 22 (1) VAN DIE WET OP LANDBOUKREDIET, 1966

Hierby word 'n vergadering van ondergenoemde applikant en sy skuldeisers op die plek en datum hieronder genoem, belê, met die doel om skuldeisers in staat te stel om hul vorderings teen die applikant te bewys en 'n skikkingsvoorstel van die Landboukredietraad te oorweeg.

J. H. SMIT,

Direkteur: Direktoraat Finansiële Bystand,
Departement van Landbou-ontwikkeling.

NOTICE 628 OF 1992

ADMINISTRATION: HOUSE OF ASSEMBLY

DEPARTMENT OF AGRICULTURAL DEVELOPMENT

NOTICE OF MEETING OF CREDITORS IN TERMS OF SECTION 22 (1) OF THE AGRICULTURAL CREDIT ACT, 1966

A meeting of the undermentioned applicant and his creditors is hereby convened at the place and date mentioned hereunder for the purpose of enabling creditors to prove their claims against the applicant and of considering a proposal for a compromise by the Agricultural Credit Board.

J. H. SMIT,

Director: Directorate Financial Assistance,
Department of Agricultural Development.

Medical aid vs health insurance: *Commercial sector must play by the same rules*

Beware 'unhealthy' schemes

STAR. 18/7/92.

MEDICAL aid schemes have slammed health policies offered by commercial insurance companies as using 'forcible foot-in-the-door marketing' to draw the attention of medical scheme members to their products. Representatives from both groups express their point of view. (299)

FINANCE STAFF

THE medical aid movement has hit out at the pseudo-medical- aid packages offered by insurance companies.

A pamphlet put out by the industry umbrella body, the Representative Association of Medical Schemes (Rams), says that glossy literature, expensive emotive print and electronic media advertising and "forcible foot-in-the-door direct marketing" have all combined to draw the attention of medical scheme members to insurance products such as dreaded disease and hospital policies.

"Perhaps the insurance sector does have some role to play," says Rams executive director Rob Speedie.

"But it must play by the same rules as medical schemes if it wants the same measure of respectability and acceptability."

Speedie says that for every rand that members pay to medical schemes in the form of subscriptions, on average 6c goes to administration and 94c to benefits in the form of claims paid and surpluses to reserves.

"But for every rand paid in premiums to commercial insurance companies for health insurance policies, up to 40c goes to broker or agent commission, administration cost and profit."

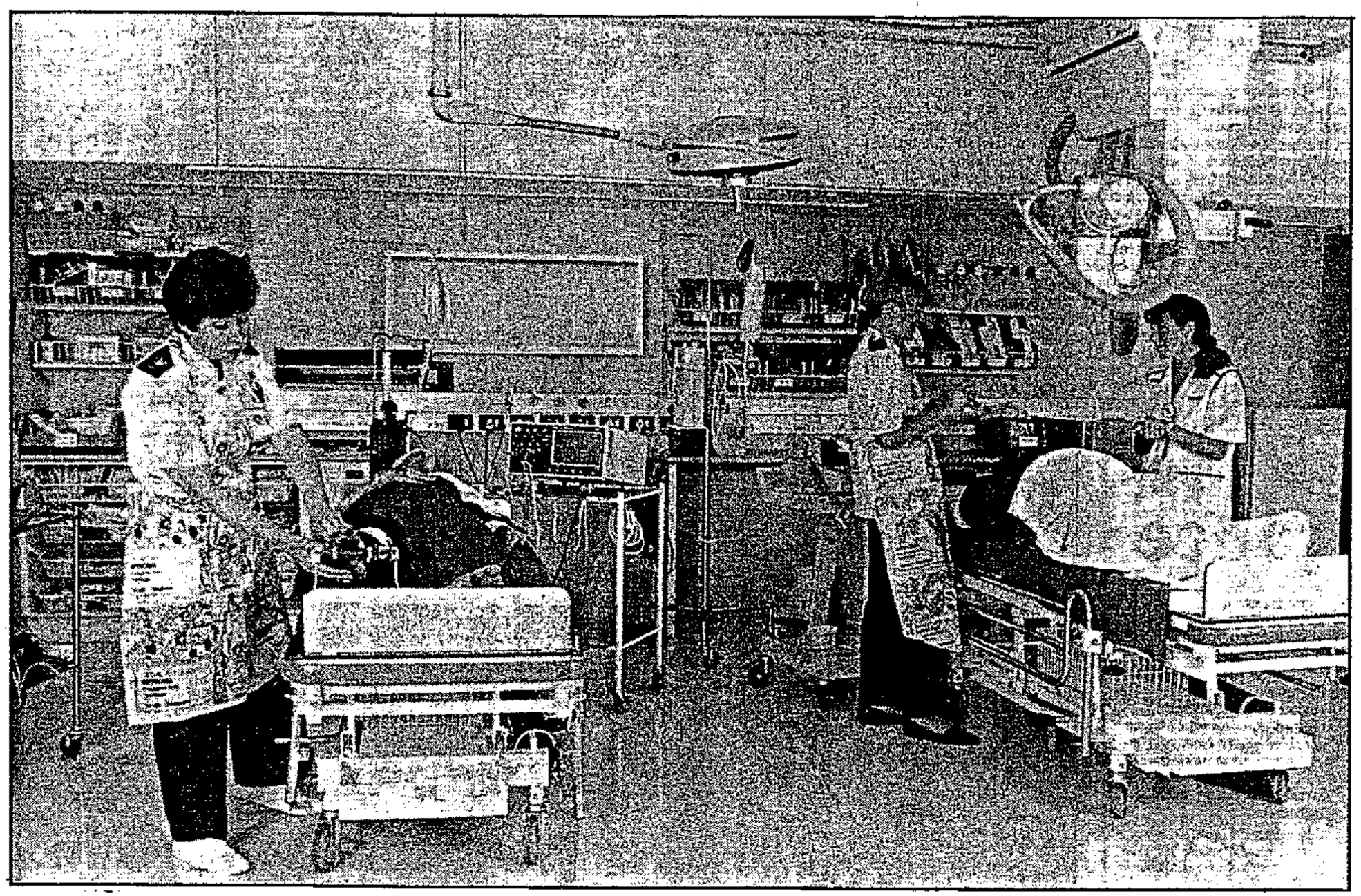
Medical schemes are still VAT exempt but VAT is payable on the administration of commercial insurance.

In terms of legislation, medical schemes must report regularly on their financial standing.

"Insurance companies, on the other hand, traditionally reveal a limited amount of information. They are under no obligation whatsoever to disclose publicly the financial state of any policy."

Medical scheme members have the right to vote in general meetings on the benefits they may choose to have — but that democratic right does not exist in the case of insurance policies.

Insurance premiums — particularly in the 40-plus age group — tend to be high and there is a general reluctance to cover the 60-plus age group "whereas medical schemes have an obligation in terms of the Medical Schemes Act to cover pensioners and widows as continuation members."



HEALTH INSURANCE: Such policies were created to supplement medical aids says marketing manager at Old Mutual, Danie Brink.

But Danie Brink, marketing manager at Old Mutual hit back saying: "Much has been said recently about health insurance policies being no substitute for traditional medical aid schemes.

"We have never claimed they were, but have pointed out such policies were created to supplement medical aids in the case of major medical expenses and to provide for those incidental costs not normally covered by medical aid benefits.

"Even at a low level of health care, the individual with medical aid may face shortfalls between benefits aid and actual costs. These shortfalls vary from medical aid to medical aid and can range from fairly limited to substantial amounts.

"In providing for this shortfall, the individual must always be aware of his medical aid's limitations."

Brink says in no way does FlexiCare compete with medical aids and the vital role played by such schemes must never be forgotten.

"The bottom line really is that a health insurance policy is testimony of solid planning for those wanting to avoid possible financial disaster when faced with serious and expensive illness," Brink says. "FlexiCare's performance over the past eight months clearly indicates many people are getting this message."

□ Well over 30 000 FlexiCare policies with more than R1 billion of health benefit cover have been issued by Old Mutual since the launch of the health care product in November last year.

This represents a substantial part of Old Mutual's new business over the eight-month period.

Insurers in medical aid row

299
ARG 18/7/97

The entry of insurance companies into the terrain of medical aid has sparked concern. But insurers say their role is not to supplant traditional medical aid schemes.

Business Staff

THE medical aid movement has hit out at the pseudo medical aid packages offered by insurance companies.

A pamphlet put out by the industry umbrella body, the Representative Association of Medical Schemes (Rams), said the attention of medical scheme members had been drawn to insurance products such as dread disease and hospital policies.

This had been done through a combination of glossy literature, print that was expensive and emotive, electronic media advertising and "forcible foot-in-the-door direct marketing".

Rams executive director Mr Rob Speedie said the insurance sector might have some role to play, "but it must play by the same rules as medical schemes if it wants the same measure of respectability and acceptability".

He said that for every rand paid by members to medical schemes in the form of subscriptions, on average 6c went to administration and 94c to benefits in the form of claims paid and surpluses to reserves.

"But for every rand paid in premiums to commercial insurance companies for health insurance policies, up to 40c goes to broker or agent commission, administration costs and profit."

Medical schemes are exempt from VAT but this tax is payable on the administration of commercial insurance.

In terms of legislation, medical schemes must report regularly on their financial standing.

Mr Speedie said: "Insurance companies, on the other hand, traditionally reveal a limited amount of information. They are under no obligation to disclose publicly the financial state of any policy."

Medical scheme members have the right to vote in general meetings on the benefits they may choose to have — but that democratic right does not exist in the case of insurance policies.

Insurance premiums — particularly in the 40-plus age group — tend to be high and there is a general reluctance to cover the 60-plus age group "whereas medical schemes have an obligation in terms of the Medical Schemes Act to cover pensioners and widows as continuation members".

The marketing manager at Old Mutual, Mr Danie Brink, hit back on the issue: "Much has been said recently about health insurance policies being no substitute for traditional medical aid schemes.

"We have never claimed they were, rather that such policies were created to supplement medical aids in the case of major medical expenses and to provide for those incidental costs not normally covered by medical aid benefits.

"Even at a low level of health care, the individual with medical aid may face shortfalls between benefits aid and actual costs. These shortfalls vary from medical aid to medical aid and can range from fairly limited to large amounts.

"In providing for this shortfall, the individual must always be aware of his medical aid's limitations."

Mr Brink said FlexiCare did not compete in any way with medical aids and that the vital role played by such schemes must never be forgotten.

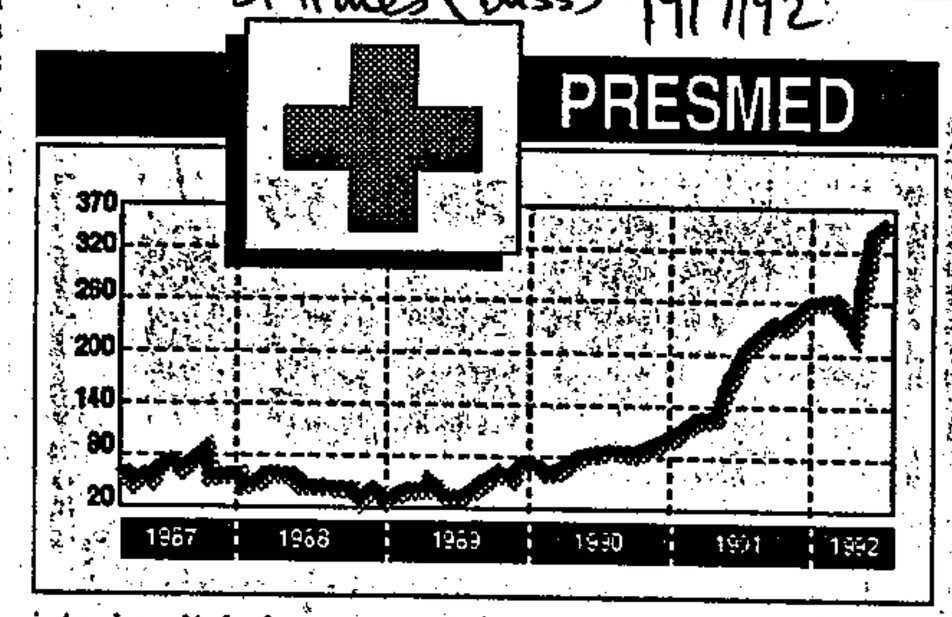
Presmed cuts the bills by offering few frills

ST Times (Buss) 19/7/92

PRESMED is to health care what City Lodge is to the hotel business — no frills and value for money.

President Medical Investments managing director Carl Grillenberger makes the analogy.

SA's medical profession by and large is untrained in keeping costs down. Perhaps this is because there has always been a wealthy sector of about 20% able to pay. But the recession and retrenchment have reduced medical-aid membership and reduced the number of people who can afford medical treatment. The trend will continue and the writing is on the wall — cut costs or the nation will suffer.



Mr Grillenberger says Presmed management was originally involved in Africa Invesco, a clone of an American company of similar designation. Its business was sectional title development in the early 1980s.

Hay can be made while the sun shines, but the cyclical nature of speculative property investment made the managers look for an alternative, counter-balancing business. Health care was chosen and Presmed has grown to five private hospitals and eight day clinics since 1983.

In America, medical-aid insurers meet the cost of treatment at the day-clinic rate. If a patient wants to go into hospital, he or she is obliged to foot the difference in cost.

In 1970, fewer than 6 000 operations were carried out at day clinics in America, but by 1990 the number topped 2,5-million.

In SA, a medical-aid scheme is compelled to pay the whole bill within the agreed tariffs irrespective of whether it could have been half the amount.

Mr Grillenberger estimates that 50% of the procedures undertaken at overnight hospitals can be done at day clinics at half the price.

One problem that had to be overcome was that of attracting doctors to perform the smaller operations at day clinics.

Mr Grillenberger says: "Our day clinics are geared to be more efficient in handling patients. In a hospital, a doctor might be able to get through five minor operations in an afternoon. At our day clinics the figure is more like 10. So the doctor earns more and the cost to the patient is lower.

"We are also siting our day clinics next to hospitals to make it easier for doctors to work at both."

Another inducement is joint ventures in which the medical professionals are co-owners and profit sharers.

Advances in medical technology have helped the day-clinic boom. Gone are the days of big cuts for small jobs, such as appendictomies and ligament repairs. Fibre optics has given rise to arthroscopy and laser treatments that obviate the need for the scalpel. Instead of several days' immobility after a ligament job, the patient can go home the same day because muscles are not hacked.

Anaesthetics is another example — 20 years ago it required two-day convalescence, now it is a matter of hours.

The health-care business is under review, but Mr Grillenberger says there is resistance to change not least from those with most to lose — private clinic operators. A well-run hospital needs 60%-plus occupancy rates to break even. But at current costs, SA's private hospital sector has too many beds.

Presmed is the only private operator to have gone for day clinics in a big way.

Its growth has been impressive in spite of the disincentives for many to use day clinics. Presmed's turnover in the year to February 1992 was R74-million, 45% up on 1991. Operating income was R11,6-million and interest only R1,2-million.

Compound earnings-a-share growth has been 50% a year for the past four years. It is one of the few success stories emerging from a 1986 Development Capital Market listing.

Low tradeability of the shares is being attended to. The number of shares in issue will increase by 60% after a consolidation and share split.

When the debentures are converted, the controlling stake in Presmed will be reduced to 50,1%.

The current share price is 340c, 11 times historic earnings. With improved tradeability and rosy prospects in a near recession-proof business, Presmed is the kind of company investors should be looking for.

CARL GRILLENBERGER: The City Lodge style Picture: ANDY KATZ

(299)

Most patients in the dark, STAR 20/7/92 survey finds

There is increasing outrage at the high cost of health but South Africans still know more about their cars than their health care, a recent survey has shown.

Feedback from the Affiliated Medical Administrators (AMA) showed that consumers — while they would query every aspect of a car's service — were generally not as informed when it came to their health.

For example, most medical aid members still did not know what a "generic-drug-option" was. Nor did they know that it was the patient's right to understand the type of treatment and medication prescribed.

"Patients must not remain ignorant; they must exercise their right to understand any stage of medical treatment," says AMA marketing director Ray Welham. — Medical Reporter.

Oasis of peace that lies in the heart of violence-hit Soweto ● Coping with Aids

Refuge for Soweto's handicapped

Sowetan 21/7/92

■ HELPING HAND Takalani Home for the Handicapped is where Soweto's disabled people can lead full lives: (299)

By Sonti Maseko

IN THE HEART of the violence and disorder of Soweto lies a home for mentally handicapped people, a place so serene, so peaceful, so orderly - it cannot be in the same township.

At 10am Takalani Home for the Mentally Handicapped is a hive of activity.

One group is busy with the gardening, another is working on the machines: knitting, sowing, making handbags and mats.

The dormitories are spotlessly clean and there is not a scrap of paper in the yard. A lovely aroma of soup coming from the kitchen hangs in the air.

On the wall of the office of workshop manager Mr Jerry Mkhize hangs a pencil sketch, a jersey, a leather purse and a toy poodle made with woollen pompoms on display.

Behind his desk is a poster that says: With your help, this is what they can do.

Takalani, which means be happy in Venda, is the only home for mentally retarded people in Soweto. A place where the disabled can live productive lives and have dignity.

It has indeed given joy to many of these marginalised people and their families.

Sadly, there are still many more mentally handicapped people in Soweto who are idling at home and neglected by relatives.

"Families with mentally retarded people believe they cannot perform any tasks and they leave them to sit and waste," Mr Mkhize says.

Takalani, which was officially opened on September 1991, has a workshop designed for 200 people. However, it is used by only 120 while other families still withhold their handicapped children through ignorance.

Mr Mkhize stresses that many of the mentally retarded people who are brought to the home have undergone some formal schooling when they were young until they dropped out after having reached their ceiling.

Therefore they can be trained to do various forms of work that their disabilities can allow.

As the man in charge of workshops for Takalani, he announces with pride that they have also added brick-making in the workshops. He is presently looking into computer training and has made some appeals to computer companies to explore possibilities for mentally retarded people.

TAKALANI ... A place of serenity in the midst of violence.

To continue functioning effectivelly, Takalani is heavily dependent on contract work.

"We are really in need of people who can supply us with work for a number of things that we can do," Mr Mkhize said.

Since September 1991, Takalani has extended its facilities and established wards for severely mentally handicapped patients, known as the Profound Unit, and also a school for young children.

Mentally retarded people have needs and personalities like many ordinary people. To be accepted, appreciated, to be loved and togetherness.

Therefore it takes specially trained, patient and loving staff at Takalani to supervise them, all under the directorship of Dr Mohale Semela, himself a speech and hearing therapist with vast experience.

STAR 23/7/92.

Helping hand for needy on farms

Organised agriculture is now dispersing an average R500 000 a month in emergency aid to the needy on farms in drought-stricken areas. More than two-thirds of the money is spent on helping black farmworkers and their families.

"We do not make relief contributions available for the purchase of food. There are other organisations, including The Star and the State, that provide such funds," said SA Agricultural Union (SAAU) director Piet Swart.

The SAAU emergency relief fund has now received about R3 million in contributions. — Agricultural Correspondent.

299

DRUG PRICES

Fingering the culprits

Everybody knows that medicine in SA costs too much but nobody is sure whom to blame. Pharmacies say drug manufacturers are the culprits. Manufacturers say their prices are in line with prices overseas and accuse pharmacies of excessive markups.

The truth lies somewhere in the middle. If blame must be assigned, the pharmacies appear to be more at fault even though all parties are culpable.

Over the years, a practice has developed that allows the wholesaler — who buys in bulk from the manufacturer and carries the storage costs — to charge pharmacies and other retailers a 21,3% markup.

Pharmacies mark up their medicine by a further 50% before adding — for prescriptions — a dispensing charge and a fee for breaking open a package. So the price of a drug can nearly double from the time it leaves the manufacturer to the purchase from the neighbourhood pharmacist.

The system fares poorly compared with other countries. Martin Jennings of US-based pharmaceutical manufacturer Glaxo says: "A prescription drug leaving the factory in the US arrives at the consumer level with a total delivery chain markup of only 20%."

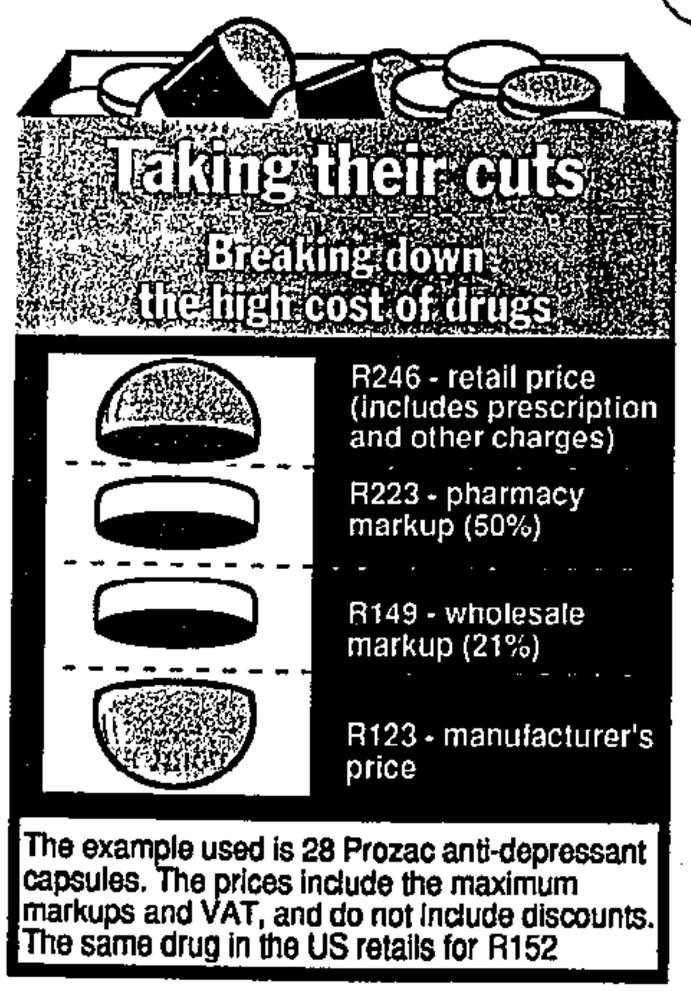
A comparison of the SA and US retail prices of three popular drugs — Prozac, Zantac and Nurofen — showed that SA prices were on average 120% higher (*Leading Articles* June 17).

But reforms are on the way. In recent months, the professional bodies and government have moved to cut back on the myriad rules that prop up prices, paving the way for more competition. Wolf Fürst, executive director of the National Association of Pharmaceutical Wholesalers, says wholesalers and retailers are now involved in a discount war that often cuts the markup in the distribution chain down to 45%.

Says Fürst: "Pressure from medical aid societies on dispensers to lower prices has resulted in retail discounts of no less than 15%. To enable retailers to afford this discount, wholesalers are discounting to their customers by at least 10%. The result is that prices to the patient are reduced by at least 20%."

He points out that even where pharmacies are franchised to a particular wholesaler, the pharmacies shop around for the best discount. "To get a net profit before tax of a mere 2%, wholesalers distribute around 6 000 products to more than 8 000 distribution outlets a day," he adds, defending the wholesalers.

He says the SA Pharmacy Council's decision last year to lift the ban on advertising prescription medicine prices has introduced more competition among pharmacies.



Dropping the ban on pharmacists working for large retailers such as Pick 'n Pay and Clicks — which, because of their size and buying power, would be better equipped to bargain with drug manufacturers — could mean steep discounts to the public.

The Competition Board this month recommended that government scrap the professional bars on pharmacists working for stores, medical schemes and doctors. Health Minister Rina Venter is keen to go along.

Wits Commerce dean Duncan Reekie, a medical economist, says: "A bulk buyer can obviously get prices cheaper. Professional codes have kept retail pharmacists small, operating on low turnovers and high profit margins." He suggests that, ideally, pharmacists should operate the same way as Boots, the giant UK manufacturer and retailer. Boots, with a 70% share, dominates the retail market there.

Many people in the pharmaceutical industry are questioning the continued role of the small independent pharmacist. Critics say that with the advent of large manufacturers, retail pharmacists have become little more than pill counters and poor businessmen. The pharmacists acknowledge the problem and recently proposed that government allow them a greater clinical role.

Retailers and wholesalers have their own axe to grind with the system. Not surprisingly, they apportion much of the blame to manufacturers and the State. They note that manufacturers remain opposed to legalising the generic equivalents of many drugs and imports of drugs made locally — though both steps would cut prices.

But their main criticism is that the entire drug supply system is distorted by the immense buying power of the State.

Pharmaceutical Society of SA chief Pieter van der Merwe says: "About 70% of all medicine is sold on tender to the State for, at most, a third of the price paid by the private sector for the same product." He suggests that manufacturers make up the difference by boosting the charges to the private sector.

Fürst says manufacturers have little choice but to take part in the State tender system. "Private-sector volumes alone are insufficient to justify manufacturing capacities, compelling manufacturers to participate in State tenders at almost any cost."

Reekie says the blame for high drug prices should not be shifted to the State tender system. He says manufacturers in the US, for example, face a similar problem; they must provide huge discounts to large State organisations, health maintenance organisations and medical schemes.

"The fact that the private-sector base price is higher than the State base price is not the major reason for high drug prices in SA. Added on to this admittedly high base price is a substantial distribution margin at the wholesale and retail levels. There can be very few fast-selling commodities that have almost a 100% markup." *Mirryéna Deeb*

AIRCRAFT MANUFACTURE

Flying start

A R500m order by the SA Air Force for 75 trainer aircraft is poised to make or break the embryonic aircraft industry. Tenders for the closely contested contract close on August 7 and it is expected to be awarded this year.

Local hopes are pinned on a consortium that includes Atlas Aircraft Corp; Denel, the four-month-old commercialised State company that took over Armscor's manufacturing activities; Aerotek, the CSIR's aeronautical engineering division; Aerodyne, a Somerset West composite materials manufacturer; Somchem, a Denel subsidiary; Midrand's Advanced Technologies & Engineering; and Fields Aviation.

Consortium members say winning the contract could mean the start of a lucrative aircraft industry. They add that previous efforts to build fighter aircraft were pie in the sky by comparison. The military trainer and a commercial derivative could put SA on the world map as a serious aircraft manufacturer.

Bidding is fierce. There are believed to be at least three formidable foreign contenders:

Disabled pupils allegedly abused

By ROSALEE TELELA

STAFF members and the governing body of a Soweto school for the disabled have been accused by the South African Democratic Teachers' Union (Sadtu) of abusing and harassing their charges.

The allegations include forcing pupils to eat faeces, assaulting them with electrical cord and bribing them.

Problems at JC Merkin, a state-subsidised school owned by the Association for the Physically Disabled (ADP), have been simmering since last year, when the school was temporarily closed following similar complaints.

JC Merkin teacher Dolly Tjale told *The Weekly Mail* this week that a colleague had allowed a pupil to relieve himself in class and then instructed him to eat the faeces. "She told him not to tell anybody, but other children who knew about it told their teachers," she said.

Tjale also claimed that pupils are fed only bread and milk during lunchtime, although the school receives state subsidy for a full lunch.

It is alleged that another teacher assaulted a pupil with an electrical cord and then bribed his classmates with money not to tell anybody about it.

Sadtu's Soweto deputy chairman Madoda Madi said the ADP had "threatened to close the school and withdraw funds, books and wheelchairs if Sadtu continues intervening".

The school's principal, JH Schoeman, and APD director Guy Houghton dismissed the claims, arguing that the faeces incident had been "dragged up from time to time. If there was some truth to it, it would have been properly dealt with". They denied any knowledge of the alleged assault.

The government food subsidies were inadequate, they asserted. Only R7 000 of the R40 000 spent on food last year was donated by the government, they said.

Sadtu and the Jabavu community plan to deliver a set of demands to the school on Monday, including a demand for the reinstatement of a teacher dismissed on charges of misconduct.

Industry leader backs med-aid plan

299 ARG 25/7/92

PORT ELIZABETH. — The Midland Chamber of Industries (MCI) has defended its proposed plan to deliver affordable medical aid to the public.

The Eastern Cape Health Association (ECHA) had called the proposed plan divisive and unpopular.

The proposed package, called the Independent Practitioner Agreement (IPA), aims at offering a lower rate of medical aid.

In a statement executive director of MCI Mr Brian Matthew said it was surprising that "a system like IPA, that has been proven in the United States, is rejected by members of ECHA".

The IPA package would allow doctors contracted to the MCI medical option to receive a monthly retainer for a fixed number of patients registered with them.

The doctor will also be paid a percentage of the normal fee once the patient goes for a consultation.

Mr Matthew was reacting to criticism by the chairman of ECHA, Dr Samuel Motumi who said the ECHA saw the development of the IPA package as blatant interference in the delivery of health-care services by doctors to their patients.

The IPA package offered "short-lived, divisive self-interest measures without addressing or exposing the health-care inequalities and discrimination in society", Dr Motumi said.

He added that the ECHA believed health-care and welfare were fundamental human rights which should be available and affordable to all people, irrespective of race, colour, creed and socio-economic status.

Dr Motumi also said the ECHA believed these rights should be sponsored in greater part by the state.

Meanwhile Mr Matthew has requested the ECHA to test the popularity of MCI's IPA proposal.

"They can test the IPA popularity in the most democratic way — give the employees the option and see how many people with take up the IPA.

"They (the ECHA) do not want to even try the system because they know the results will be the same as those achieved in USA — the IPA will be supported as an extremely cost-effective system.

"What the chairman of the ECHA should be explaining to the public is what they intend doing to bring down — or just contain — the costs that they impose on medical aids," said Mr Matthew.

"If they don't like the alternatives, why don't they put forward solutions that will enable the ordinary person to be able to afford medical aid." — Ecna.

SA blind may form link with Africa

SOUTH 2517-2917192.

(299)

BLIND people in South Africa could soon be forming links with the blind across the continent. The SA League of Friends of the Blind hopes to be admitted to the African Union of the Blind and is hosting a delegation from the African union that includes its president, Mr Ismail Konate of Mali.

Konate will attend the local league's annual general meeting, said director Mr Philip Bam.

There has been a large increase in the number of blind people referred to the SA league this year, according to Bam.

Its professional staff work to help people overcome the traumatic experience of loss of vision. They also help blind people to achieve independence and mobility.

Programmes include an English course for Xhosa-speaking blind and another course for visually impaired pre-school children.

● Interested people can attend the AGM on Thursday, July 23, at the league's Independence Development Centre, corner of Klip and First roads, Grassy Park, at 8pm.

health

Novel scheme takes health to the people

Distrust has been put aside as state funders and community groups work together on a new health project, writes **Justin Pearce:**

Pic Yunus Mohamed

HEALTH STARTS HERE: Trainer Ms Keli Xorile teaches new health workers the skills they will disseminate at home.

A NEW project that is pioneering the training of community health workers in the Western Cape hopes to see 120 trainees pass through its doors each year.

The scheme — a training centre for people chosen by their communities to serve as health workers — is the first systematic effort to develop the skills of community health workers. Once the project is running at full speed, the plan is to teach eight groups of 15 trainees each year.

Another novel aspect of the project, which started this month, is that it is providing a model of co-operation between community-based organisations and state funders.

The founders of the project were at first suspicious about embarking on a venture that involved state sponsorship — in this case the Western Cape Regional Services Council (RSC).

Said senior trainer Ms Keli Xorile: "When we drew up the contract with the RSC we were careful that it did not allow them to make the rules."

Now the founders believe they have been fortunate in dealing with individuals at the RSC who have acted in good faith.

But Dr Bob Mash, of the SA Christian Leadership Association's (Sacla) health project, warned that this goodwill had not yet been put to the test. The scheme has not reached the stage where communities have initiated their own health care projects and approached the RSC for funding. From the trainers' point of view this is the ideal situation, but it remains to be seen whether the RSC will comply.

The training centre is located at the Uluntu Community Centre in Guguletu — but only for now, since the project is still in the experimental stage.

"We didn't want to spend money on a fancy building and then find it was not what we needed. Once the project is under way we can look at future needs," said Xorile.

She describes a primary health care worker as "a jack of all trades who is on duty 24 hours a day".

Community health workers are the solid base which a health care system needs to survive. Working mostly with impoverished and under-educated people, they ensure that people know how to see to their own health needs and reduce the pressure on medical services by preventing illness and injury.

'A primary health worker is a jack of all trades who must be on duty 24 hours a day to attend to the community's needs'

The training scheme originated when the Progressive Primary Health Care Network (PPHC) was approached by the RSC, which had funding to train 20 community health workers to work in Site C Khayelitsha.

The PPHC felt that in the Western Cape, Sacla was best suited to run the training scheme as it had trained workers for its own health projects in the Cape Flats.

The first 10 workers for the RSC initiative were trained last year. The RSC then came forward with a proposal and funding for a further 60 trainees, who would work in the Macassar and Harare districts of Khayelitsha.

Ms Xorile said: "Sacla did not have the capacity to train so many people — and anyway it is not our job. We need to develop a culture where health workers are responsible to their communities and not to the government."

The PPHC then suggested a training centre for trainees chosen by their communities to serve as health workers. Sacla was asked to help start the scheme.

Several of the present trainees are nominated by Sacla, but the focus of the project is not to train new workers for this organisation.

"Sacla is big enough and we want to consolidate our operations rather than open up in new areas," said Mash.

Instead, other organisations and communities are asked to nominate trainees.

To be accepted on the training course candidates must be nominated by their communities with the backing of a health organisation operating in the area.

Communities must find sponsorship to pay for the course, the health worker's wages and to work out a support network and referral system for the community health project.

Sacla requires health care workers to live in the communities in which they work and to be based in their own homes. There they can expect to attend to people at any time of the day or night, occasionally making house calls if necessary.

The health workers are responsible for educating their community about how to stay healthy, advising on nutrition and preventative medicine.

They need to be able to carry out basic curative tasks such as dressing wounds and administering medicines, but refer patients to a doctor for more specialised care.

Eighty percent of people in the areas served by Sacla have used the services of a community health worker at some time, according to a survey conducted by Sacla last year.

Health workers may find themselves acting as facilitators for community development projects. If a community decides that it needs a creche or some other amenity, the health worker is usually the first person to be approached and may have to take the request to the relevant authorities.

Trainers are keeping an open mind about the project's future direction.

"We are serving the Western Cape and don't want to go national while we are still at the experimental stage," said Xorile.

"We don't want to raise people's hopes too much but we do want to make the project work. Primary health care is a matter of life and death."

Joy for the blind (299)

THERE was joy at the Rivoni Workshop and Training Centre for the Blind at Elim near Louis Trichardt at the weekend when South African Breweries presented it with a bakkie.

The centre trains more than 200 blind

Sowetan 27/7/92

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people from Lebowa, Venda and Gazankulu in handiwork and depends on donations from the private sector for its survival.

Anger over bid to change Medical Schemes Act

STAR 27/7/92 (299)

By Abel Mushi

Proposed amendments to the Medical Schemes Act will be met with harsh criticism from the Society of Dispensing Family Practitioners (SDFP) at its annual conference on August 22 and 23 in Sandton.

According to the SDFP, the proposed amendments have been drawn up by those with vested interests within the medical aid schemes fraternity and further entrench the position of the medical schemes.

The amendment Bill enabled the Representative Association of Medical Schemes to gain "monopolistic control" of the health care market, said a statement from the SDFP last week.

The statement said the proposed health maintenance organisations (HMO) — prepaid practices in which the service provider is paid a fixed monthly amount per person, based on the expected expenditure — had the potential to save costs compared to the fee-for-service system.

However, it was important to ensure protection of the medical profession from exploitation.

Among the SDFP's "non-negotiable" conditions for the implementation of HMOs are:

- The HMO must be subject to the same ethical rules as medical practitioners.
- The same rules regarding advertising and touting for patients should apply to HMOs and individual practitioners.
- HMOs should operate on a non-profit basis.
- No HMO should operate in an area if its existence threatened the survival of health care professionals currently rendering services.

COMPANIES

BIDAY 29/7/92

Insurers take on medical aid societies

ANDREW KRUMM

THE size of SA's R19bn health services sector had lured almost all insurers into direct competition with traditional medical aid societies, Liberty Life deputy GM Herschel Mayers said yesterday.

He said stakes were high in the conflict between health insurers and medical aid societies. Of the estimated R19bn spent on health services in SA in 1991, about R6bn represented medical aid subscriptions.

"Although it is this market for which we are competing, we also recognise that medical aid societies have a role to play. Consequently our product comes in two forms: one designed as a replacement for medical aid, the other planned as a supplement," said Mayers.

Since September 1991 all major players — with the exception of Momentum Life — had entered the new market, he said.

Old Mutual product research department head Trevor Pascoe said the five major players had generated about R500m in premium income from health insurance over the past year.

He estimated that the health insurance market made up between 10% and 20% of the new business in the industry.

Plea for blood

299

PEOPLE may die in Natal next week if additional blood donors do not give blood this week.

The shocking situation has arisen because the shortage of blood for the Natal Blood Bank has worsened since yesterday's appeal for people to come forward and help. Blood stocks are dwindling rapidly. Sowetan

This week it was reported that if supplies were not boosted urgently it could mean a life-threatening situation for people in need of transfusions. 30/7/92

Mrs Janis Chapman, public relations manager for the Natal Blood Transfusion Services, said: "If we do not get more donors this week, we could have deaths on our hands within the next few days."

- *Sowetan Correspondent*

Doubly disabled, they fight

299

W1 mail 3/17 - 6/8/92

By ROSALEE TELELA

THE man in a wheelchair waits impatiently outside a Johannesburg building. He asks people walking past to help him up the entrance stairs, but they ignore him. Finally someone reluctantly gives him a hand.

Most people do not understand disability, says Thulani Tshabalala, who has been paralysed since 1980. "You can see it in their eyes."

Disabled people face discrimination from all sides every day. "But I've now become immune to it," says Jerry Nkedi who has been disabled for 13 years.

"We are viewed as a problem. Our society is not geared for the kind of disabled people who want to face and challenge life, who would like to go out have a drink and fall in love," says Nkedi.

They have to work harder than able-bodied people simply to be accepted. "I had to prove myself before my colleagues would accept that I was competent," says social worker Thelma Dekile.

And it is even more difficult for women. "People think a disabled woman will not be productive physically or economically," says Dekile.

Michael Masutha, the director of the Lawyers for Human Rights' Disability Rights Unit, has only partial sight in one eye and has to overcome countless barriers in his daily life.

He arrives at work every morning, carrying a briefcase and a braille machine. On this, he records messages and types reports, later reading them back with his fingertips to a copy typist who enters them on a conventional word-processor.

Masutha spends his day slowly sifting through paperwork and scrutinising it at close range. He has access to a company car, but "since I cannot drive, I have to rely on either my assistant or somebody else to drive me". But colleagues cannot always accommodate him.

Masutha's job is to investigate cases of discrimination towards disabled people. He is playing a spearhead role in a growing campaign to protect the rights of disabled South Africans.

The Disability Rights Unit and Disabled People of South Africa (DPSA) are drawing up a charter for disabled people. To be finalised at the DPSA biennial conference in September, this is to be tabled for inclusion in a future constitution.

Central to the demands are discrimination in the workplace, inadequate social security provision and lack of facilities.

"The government must encourage us to live independently and not be dependent on charity," says Nkedi,

Existing legislation, says Nkedi, is archaic. That disabled people did not participate in drawing up the laws was "typical of apartheid legislation".

Discrimination permeates even the attitude of health and social workers - DPSA executive member Sinah Gwebu says that women have a particularly hard time. "When a disabled woman goes to a clinic for contraceptives she is often ridiculed. Nurses tell her she is silly to want to be sexually active or to bear children.

"We can't even adopt children," she adds. "The government does not allow us to because they think we are not capable of bringing children up properly."

Women are often given strong contraceptives or sterilised without their consent, she says.

DPSA's national training officer Shuaib Chalklen is concerned about the attitude of health and social workers towards disabled people. Therapists, who are often white, do not help disabled people adapt to their environment in the black townships or rural areas, he says.

"The reality is that if you need community assistance you have to negotiate for it," says Tshabalala, who is a development worker for the Southern Transvaal branch of the DPSA.

A major problem is lack of employment and income. According to Chalklen society looks at disabled people and thinks they are incapable or unproductive.

At present the state provides very little for disabled people: there are some sheltered workshops in the urban areas, a few special schools and disability grants.

"There is a lack of training opportunities for disabled women in this country," says Dekile. "The government has never been interested in empowering us."

Although the DPSA does have self-help groups which generate income through running co-operatives and taking in contract work, the projects are small and receive no state subsidy.

Says Nkedi: "The existing charity and welfare mentality prescribes how far we can go in life."

Integration with society, not a sheltered environment is the aim, Masutha stresses.

HEALTH-CARE COSTS FM 7/8/92

Biting the bullet 299

Sound business practices could do a lot to help SA's ailing and cash-strapped State-run hospitals. "Making costs visible, making doctors and patients accountable for costs at every level, and introducing effective management and cost controls would all help solve the problem," says Peter Hissnauer, a partner with Ernst & Young (Germany).

Hissnauer, who heads a 45-strong team that specialises in health-care management in Europe, visited SA recently to help Ernst & Young (Cape Town) revamp Groote Schuur Hospital's administrative and business practices. His advice would help all of the State's 13 academic hospitals, which in 1990 took 43% of the total health-care budget.

He stresses that inefficiency in controlling medical costs is a worldwide problem. "Hospital systems are costing more than government is willing to pay and the patient (buyer) feels he has the right to the product — so there is no link between the price of medical services and the cost."

Good, lean, decentralised and autonomous administration — principles that Health Minister Rina Venter appears determined to introduce at State hospitals — can go a long way towards treating the problem.

Hissnauer believes that the hospitals themselves are not sufficiently aware of their costs due to a general lack of accountability and effective management information systems. He stresses that costs need to be broken down, made visible and controlled at every department level or cost centre. This system also monitors the quality of care being delivered more effectively. He says that within one year, up to 30% savings can generally be made without sacrificing the quality of medical care.

Hissnauer pinpoints theft and wastage as major budget drains. While theft is difficult to quantify, wastage can often be avoided. International research, for example, shows that hospitals need to provide meals for only 95% of their patients — the rest are usually too ill, are artificially fed or simply unable to eat. Maintaining medical equipment can also push up bills unnecessarily. The purchase price of this equipment is usually reasonable but maintenance contracts are costly. He suggests a properly managed in-house maintenance department is often a cheaper and more effective alternative.

Because 70% of hospital expenditure goes to personnel, shedding superfluous employees generally cuts costs dramatically. Says Hissnauer: "It's cheaper running a good, lean organisation — pay a few good people more rather than a lot of people less." He accepts that getting rid of the extra staff will be difficult and politically dangerous. Still, he suggests that nonproductive staff can be retrained with the savings.

FM 7/8/92 299

The greatest challenge lies in cutting costs that are entrenched by historical medical practices. He says there is a tendency for hospitals to supply more services than are necessary and for patients to demand more care than they need. "The real problem is that health care must be limited to the services that can be afforded by the patient and the State. Equitably sharing this cost burden is the major problem to be resolved, not only in SA but all over the world."

Hissnauer says built-in incentives are needed to encourage hospital personnel to provide adequate treatment while keeping to a budget. He says a major problem is that university students are trained at sophisticated academic hospitals — the costliest level of health care — and, therefore, tend to overprovide the best care. He says there is no sound reason why students should not also be trained in primary, preventive health care.

He would also like to see the academic curriculum reflect cost-awareness. He believes that medical students need to be taught more about drugs in general and also about the cost-effectiveness and safety of generic medicines. He stresses the need for a pharmacologist — a clinically trained pharmacist — in every hospital to consult with the physicians and monitor the general drug list.

He also believes that patients should not be allowed to bypass primary service levels and go straight to the tertiary level — the most costly. Ernst & Young's SA health-care consulting director Malcolm Brown agrees. "SA's sophisticated academic hospital complexes should be used predominantly to train doctors and nurses for the SA demand and as medical centres to diagnose rare diseases and injuries. They should not spend a disproportionate part of their budgets on primary care services."

But he adds that the abuse of these expensive facilities is likely to continue until SA has an adequate and accessible primary health-care structure — a goal that Venter has been working towards with contributions from the private sector. ■

Medical aid over-use and fraud wastes a fortune

(299) STAR 10/8/92

By Paula Fray
Medical Reporter

About R1 billion of medical aid payouts each year — nearly 25 percent of all subscriptions — is wasted by continued fraud and over-utilisation of medical aid facilities, according to a leading medical aid scheme administrator.

Affiliated Medical Administrators (AMA) marketing director Ray Welham said the organisation believed that if the system were free of abuse, members' subscriptions would cost at least 25 percent less.

"At least one-quarter — and in some cases up to 33 percent — of the members' contributions goes towards paying for fraud and over-utilisation," he said.

These statistics come in the light of "horrendous" examples of misuse and fraud uncovered by the AMA's cost containment unit, which was set up two years ago to investigate fraudulent medical aid claims.

Thus far the results are horrifying, said AMA chief executive officer Timothy Gelman.

Already 98 cases have been finalised and a further 110 are being investigated with the help of the police and Fraud Squad.

According to Mr Gelman, the cost crisis in the health sector is being exacerbated by medical aid fraud and misuse.

About 25 percent of medical aid payouts are attributable to misdemeanours and non-essential services — about R1 billion of an estimated R4 billion annual national medical payout.

Examples include:

- One person who was jailed for changing details on old accounts before submitting the claim to the medical aid. He was paid out nearly R39 000 over a two-year period.
- Illegal use of a card by non-dependants including a member who gave his card to his father to use in hospital. The membership was subsequently cancelled when the father died.
- Selling or renting of medical aid cards — discovered when the same card was used at several doctors for wide-ranging illnesses.
- Trusting patients who signed doctors' accounts before they are filled out.
- Pharmacists who let members buy items such as cosmetics on prescription.

The examples of repeated and often unnecessary visits to doctors includes a request for payment for 158 house calls for a headache in a month.

Another example of over-utilisation was a general practitioner who, under peer review, was found to be earning up to R1,5 million a year. It cost on average between R600 and R700 for each visit by a member as various hi-tech and sophisticated tests were undertaken.

Basic tests, such as a chest x-ray which would have cost about R24, were omitted. But sophisticated lung tests, which brought about the same result, were done by the doctor at a cost of about R300.

Ignorance often played a major role as patients were unaware of the medical costing system while most members did not know what the generic drug option was, said Mr Welham. Nor did patients know it was their right to understand the type of treatment and medication provided.

Mr Welham encouraged people to start communicating with their doctors and pharamacists.

"Many medical practitioners do offer a cash-discount service but cannot advertise it. Just as in any other business, a client has the right to inquire about a cash discount."

New health bill causes an uproar

PRETORIA. — The Patients' Rights Organisation of South Africa (Prosa) has strongly opposed certain sections of the Medical Schemes Bill.

Prosa said yesterday the bill, which was heard by the Parliamentary Committee on Health here last week, contained sections which could allow medical schemes to run their own Health Maintenance Organisations (HMOs) with their own hospitals and pharmacies, where they would employ their own medical practitioners.

CT 10/8/92

In evidence to the committee last week, Prosa said it felt HMOs would stifle competition and infringe the rights of patients who belonged to medical schemes. — Sapa

299

Medical aid fraud

(299) ARG 10/8/92

R1-bn of payouts are a result of abuse and over-utilisation

The Argus Correspondent

JOHANNESBURG. — About R1 billion of medical aid payouts each year — nearly 25 percent of all subscriptions — is wasted by continued fraud and over-utilisation of medical aid facilities, according to a leading medical aid scheme administrator.

Affiliated Medical Administrators (AMA) marketing director Mr Ray Welham said the organisation believed that if the system was free of abuse members' subscriptions would cost at least 25 percent less.

"At least one quarter — and in some cases up to 33 percent — of the members' contributions goes towards paying for fraud and over-utilisation," he said.

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Already 98 cases have been finalised and a further 110 are being investigated with the help of the police and fraud squad.

According to Mr Gelman, the cost crisis in the health sector is being exacerbated by medical aid fraud and misuse.

About 25 percent of medical aid payouts are attributable to misdemeanours and non-essential services — about R1 billion of an estimated R4 billion annual national medical payout.

Examples include:

- One person was imprisoned for changing details on old accounts before submitting the claim to the medical aid. He was paid out nearly R39 000 over a two-year period.
- Illegal use of a card by non-dependants, including a member who gave his card to his father to use in hospital.
- Selling or renting of medical aid cards — discovered when the same card was used at several doctors for wide-ranging illnesses.
- Trusting patients who signed doctors accounts before they were filled out.
- Pharmacists who let members buy items such as cosmetics against the value of a prescription.

Among the examples of repeated, and often unnecessary, visits to doctors was a request for payment for 158 house-calls for a headache in a month.

Another example of over-utilisation was a general practitioner who, under peer review, was found to earn up to R1,5 million a year. It cost on average between R600 and R700 for each visit by a member as various hi-tech and sophisticated tests were undertaken.

Ignorance often played a major role as patients were unaware of the medical costing system while most members did not know what the generic drug option was, said Mr Gelham.

'Drive to curb medical costs hampered'

Medical Reporter (299) STAR 11/8/92

Alleged abuse and over-use of medical scheme benefits had a direct impact on efforts to make private health services more accessible and affordable, Medical Association of South Africa (Masa) secretary-general Dr Hendrik Hanekom said yesterday.

In view of the fact that some 80 percent of South Africans were still not being catered for by means of health care assurance, these reports were of "great concern" to the association.

Dr Hanekom was reacting to recent statistics released by the Affiliated Medical Administrators (AMA) cost containment unit, which was set up two years ago to investigate fraudulent medical aid claims. At least a quarter — nearly R1 billion — of claims could be wasted by continued fraud and over-utilisation of medical aid facilities, the investigation revealed.

However, he said, the association was satisfied that the majority of doctors were cost conscious. "Over-servicing and abuse of medical scheme benefits, through indiscriminate use of services, is the exception rather than the rule."

Masa said more should be done to encourage the cost-conscious use of medical scheme benefits by, among other things, the education of members of the public.

DISABILITY FM 14/8/92

Capping claims (299)

Lump sum disability insurance policies are producing large losses for all major life assurers, according to Don Brown of Southern Life's employee benefits division. Disability claims are now running at about twice the level of three years ago.

A reason advanced by Brown is that employers are endorsing disability claims of employees who are being retrenched. A reaction from the life assurers is to tighten up disability conditions in their group policies.

Brown says originally the only benefit insurers offered was the lump sum benefit, contingent on the employee being totally and permanently disabled. There were drawbacks — for example, there was no payment where recovery was expected, yet some illnesses or injuries involve a year or more of recovery time. So policies were adapted, to introduce disability income payments.

Experience has shown, he says, that the employee's attitude will often affect the outcome of a disability. A positive attitude may result in rehabilitation, while passive acceptance will result in deterioration.

The worsening claims experience of the past three years is attributed by Brown, in

part, to the state of the economy and to retrenchments. "Retrenchment usually involves some cost to the company at that time as well as the unpleasantness of telling an employee he no longer has a job. It has become apparent that some employers are attempting to avoid this by submitting disability claims for employees who, while they undeniably have some degree of disability, have, nonetheless, been able to work satisfactorily up until then."

In restructures of organisations, employees may find their previous responsibilities no longer exist. "Again, if any degree of disability can be found, a disability claim will often be submitted."

He says insurers have already taken action to stem the flow of claims and firmer action can be expected. Measures include reducing to 60 the maximum age for which disability cover is provided; reduction of the benefit level over the last 10 years of employment; and allowing the insurer a longer period to assess certain conditions, such as depression. Another measure could be to limit benefits, possibly to twice the annual salary. ■

Appeal for funds

299

THE Silent Ad-Hoc Committee for deaf blacks has appealed for public funding to help serve its members "who are even more discriminated against than deaf whites". SDwrfan 18/8/92.

SAHC chairman Mr Tumane Mokoena said problems encountered by the organisation's members were that they were often unfairly dismissed and did not receive salaries equal to their hearing colleagues. Mokoena can be contacted at (011) 838 6734/5. - *Sapa*

Children stranded as JC Merkin closes

Soweten 20/8/92

299

By Mzimasi Ngudle

■ WAR OF WORDS *Sadtu and administration in standoff over dismissal:*

LITTLE Mampho Motlakeng (10) does not know why she is not at school. Her father Mr Isaac Motlakeng also does not know.

Mampho is one of 190 physically disabled pupils at JC Merkin School in White City Jabavu, Soweto, who may not write this year's examinations as the school has been closed indefinitely.

The problem: The South African Democratic Teachers' Union is at war with school authorities over the dismissal of a teacher, Miss Rebecca Sebudi.

Hostel closed

The school is owned by the Association for the Physically Disabled and accommodates 50 pupils in its hostel which has also been closed.

Last month more than 5 000 Sadtu members met at Regina Mundi Church in Soweto and resolved to stage a demonstration to demand the resignation of the principal and the reinstatement of Sebudi.

Forty-three teachers were arrested during the demonstration in which more than 500 teachers took part.

The actual cause of the conflict is submerged in a plethora of allegations and counter-allegations where everybody tells the truth and nobody tells a lie. When a *Sowetan* team visited the school this week, Motlakeng, who lives a few metres from the school, did not have the faintest idea what was going on.

He only knows that there is trouble at the school. He looked stunned and expressed shock when he saw the burnt bus. "Have they burnt the bus? I only heard someone telling me but did not believe it was true."

Unfortunately he was not at the parents' meeting last week which allegedly resolved to close the school indefinitely and sanctioned the dismissal of Sebudi. The parents were fetched by a minibus as the bus that was supposed to transport them to the meeting in town was burnt in the early hours of the morning.

APD director Mr Guy Houghton said at the meeting 60 percent of the parents showed they "unanimously condemned Sadtu and agreed that the teacher be dismissed".

"The parents also resolved that the school be closed indefinitely," he said. He said they had asked to no avail for guarantees from Sadtu that classes would not be disrupted again.

Sadtu knew nothing about the meeting. Houghton said he had deliberately refrained from notifying Sadtu because "we feared disruptions as they frequently allege that we co-opt the parents".

Houghton said the school was closed because of intimidation and harassment by Sadtu members. Sadtu has, however, denied the allegations. Houghton said the teacher was dismissed for desertion and disobedience.

Meanwhile, Sadtu has submitted a list of demands to the Department of Education threatening a strike if they are not met. One of the demands is the reinstatement of Sebudi and the reopening of JC Merkin School.

Denied allegations

Sadtu chairman of the Soweto branch Mr Matakanye Matakanye denied allegations of intimidation and said the union knew nothing about the bus incident.

He said Sebudi was instructed by the principal to take down the minutes of a meeting "which she did but later lost the scrap paper she wrote on".

She was subsequently dismissed for insurbodination when she failed to produce the minutes of the meeting.

Matakanye also blamed the deadlock in negotiations for the reinstatement of the teacher on Houghton's "arrogance and intransigence".

However, Houghton flatly denied these allegations and said Sebudi did not raise the loss of the minutes but "simply ignored requests for the minutes".

With each party placing the ball in the other's court there seems to be no remedy for the plight of the kids.

Activist with a life mission

299

■ Fighting for the rights of disabled people:

Soweta

By Lulama Luti 21/8/92

SEATED behind her desk at the Johannesburg Hospital, where she works as a receptionist, one is hardly aware of Phindile Mavuso's impairment.

During the interview, she comes across as articulate and so full of energy and determination that it is not until she strolls to the next desk that one noticesa limp.

"Disabled does not mean unable," she says as she speaks of her involvement in the Disability Rights Movement.

Mavuso was a victim of the 1976 students' uprisings in Soweto. Doctors battled to save her right leg but it eventually had to be amputated.

Not only has she learnt to live with walking with an artificial limb but she has managed not to let her disability deprive her way of leading a normal life.

And this 31-year-old mother of two is definitely living her life to the full.

Apart from her involvement in the DRM, Mavuso is vice-president of the Azanian Youth Organisation - right-hand person to unionist and well known Soweto youth activist Thami Mcerwa.

Mavuso is fighting for communities to rid themselves of stereotypes about the disabled.

Big business looks at links with sangomas

B10A4 24/8/92 (299)

KATHRYN STRACHAN

TRADITIONAL healers and businessmen met near Johannesburg last week to discuss ways of incorporating sangomas into company medical schemes.

Representatives of Anglo American, SA Breweries, AECI, Toyota and other companies listened intently as they were told sangomas often were more effective conduits of information about AIDS and family planning than Western doctors.

At the Indaba Hotel meeting, the corporate world asked questions about the nature of a "tokolosh" and raised concerns about paying for rituals and herbal potions.

The medical world has long recognised the vital role healers play in primary health care. Research indicates they are consulted by about 80% of black people.

The healers proposed that their sick-leave certificates be formally accepted, and that companies provide premises for them to conduct their businesses.

But spokesman for the Traditional Healers' Council, ex-SADF officer Pip Erasmus, said healers could never be accountable to a company MD as they were answerable only to their ancestors.

A new healers' co-ordinating body has agreed to monitor members' activities and enforce a strict code of conduct, which forbids dabbling in witchcraft.

Conference organiser John Durran said the talks had opened up communication and it was now up to individual companies to contact the co-ordinating body.

The Representative Association of Medical Aid Schemes (Rams) has said one scheme has begun accepting claims for traditional treatment, and others will implement a similar policy soon.

Big business may turn to sangomas

(299) CT 24/8/92

Own Correspondent

JOHANNESBURG. — Traditional healers and business representatives have got together to discuss ways of incorporating the sangoma into company medical schemes.

At the meeting at the Indaba Hotel last week, representatives of the corporate world — including Anglo American, SA Breweries, AECI and Toyota — listened intently as they were told that sangomas were often more effective conduits of information about health issues such as Aids and family planning than Western-style doctors.

The businessmen asked questions about the nature of a "tokolosh" and the effectiveness of traditional remedies, and raised their concerns about paying out benefits for rituals and herbal potions.

The healers have elected a co-ordinating body with trade union and business representation to facilitate communication.

They have proposed that their sick-leave certificates be formally accepted, and that companies provide premises for them to conduct their businesses.

But the spokesman for the Traditional Healer Council, Mr Pip Erasmus, said healers could never be accountable to a company as they were answerable only to their ancestors.

To get around this problem, the healer body — as a channel of communication for the ancestors — has agreed to assume responsibility for appointing healers to companies and to monitor their services.

Convention organiser Mr John Durran said it was now up to individual companies to contact the co-ordinating body.

Senior police to probe 'execution'

B|DAY 25|8|92.

Own Correspondent

DURBAN — Police are carrying out a top-level investigation into the execution by uniformed and masked gunmen of an induna, his wife and four children at a kraal near Richmond at the weekend.

And the Inkatha Freedom Party says the Goldstone commission should investigate the incident "as a matter of the gravest urgency".

SAP regional commissioner Gen Colin Steyn accompanied senior policemen yesterday to the scene in a remote area of Nkobeni.

The bodies of the six victims — one a four-year-old boy — were found on Sunday. They were airlifted from the kraal yesterday morning to the Richmond mortuary.

According to the police eight members of the Nzimande family were lined up outside the main building of the kraal on Sunday afternoon and gunned down. Six were killed and two others wounded.

A police spokesman at Richmond said five or six men wearing brown overalls, resembling those worn by the SADF, and balaclavas arrived at the kraal just after noon and requested Nzimande to produce his firearms, two KwaZulu government-issue G3 rifles. After the weapons were handed over, the family members were lined up and "shot repeatedly".

Police found 14 spent AK-47 cartridges and 37 R4 shells at the scene.

The gunmen then fled with Nzimande's weapons.

Study points way to welfare reform

299

B|DAY 25|8|92

GERALD REILLY

PRETORIA — Government departments overwhelmingly recognise the need for a major overhaul of welfare services, a Human Sciences Research Council survey shows.

The survey, conducted by Natal University's F J Lund, found nearly 4-million people received welfare payments amounting to R4,5bn from government organisations last year.

She stressed the urgent need for a unitary nonracial welfare system to eliminate fragmentation, waste and inefficiency.

Welfare — for the aged, the disabled, families, and for relief — was provided by three houses of Parliament, four provincial administrations, six self governing and four independent homelands.

Lund said there had been brave attempts to introduce innovations but on the whole, new schemes became swamped by the need for statutory work.

Also, some government officials called for privatisation and independent initiative but other bureaucrats discouraged new initiatives.

In the year to end-March last year, R1bn went to white welfare services, about R800m to coloured services, R200m to Indian services and the remaining R2,4bn to black welfare services, Lund said.

Calculated on a per capita basis, coloured people received R246, whites and Indians about R200 and blacks about R100.

Of the 3,9-million people who benefited directly, 2,6-million received pensions and 830 000 disability grants.

Social workers emphasised that the major challenge lay in overcoming the backlog in coloured, Indian and black welfare services.

The purpose of the Lund study was to determine the size, scope and cost of government welfare bureaucracies and to formulate a database.

Social workers acknowledged social work had to be redefined. Statutory work predominated although some departments were trying new approaches with a greater emphasis on community development.

Lund said unless attitudes changed social workers would find themselves without a role which had "appropriateness and integrity".

Recent political shifts had made social workers more positive about working for government, although there were areas where government employment obstructed grassroots social work.

Epileptics lose cash

299

Sowetan 25/8/92

■ Grants for "controllable diseases" cut back:

AT least 60 people in Port Elizabeth who suffer from epileptic seizures have lost their Government disability grants this year.

Black Sash researcher Ms Lynne Teixeira said in a statement yesterday this was because the Government had decided to cut back on all grants for "controllable diseases".

While in the past epileptics could qualify for disability grants quite easily, they were now considered fit for the labour market "because regular medication should reduce the number of seizures per month to not more than 3 or 4.

"This means that many epileptics are now losing their grants," said Teixeira.

She said the action was "not justifiable".

"There should be some financial assistance, especially in the beginning of the disease because it may take a while before the right medical prescription for each individual is found.

"Some people get one epileptic fit a day until the right medication is found."

Teixeira also appealed to employers not to dismiss workers who were epileptic "but rather to consider the fact that such a worker receives no financial assistance from the Government".

PEOPLE'S LIVES *Phindile Mavuso says disabled does not mean unable and she wants no pity*

Champion of disabled

Soweten 27/8/92

By Lulama Luti

■ LOST GENERATION Mavuso believes there is hope for the youth: (299)

IT IS 16 YEARS SINCE that fateful day in 1976 when Phindile Mavuso was shot during the students' uprising in Soweto.

In the incident Mavuso lost the use of her right leg. But she is not bitter. Instead, her handicap has proved an incentive in her bid to fight for the rights of the disabled in the country - especially women.

And she pulls no punches about it: "Disabled does not mean unable," she says as she speaks of the reasons why she is involved in the Disability Rights Movement.

A former pupil at Meadowlands High School in Soweto, Mavuso is employed as a receptionist in the Wits Medicine Department's Photographic Unit at the Johannesburg Hospital.

Seated behind her desk at the Johannesburg Hospital, one is hardly aware of her impairment.

During the interview, she comes across as articulate and so full of energy and determination that it is not until she strolls to the next desk that one notices that she walks with a limp.

A victim of the white man's wrath, doctors battled to save her right leg. The pain was unbearable and amputation was the only available option.

Today she has learnt to live and walk with an artificial limb.

Possessing a desire to be remembered as a fighter, she stresses the need for communities to rid themselves of stereotypes about the disabled.

And she says the last thing disabled people need is to be pitied.

"I don't need pity and handicaps (obstacles) - I need accessibility. We all need to be given a chance to prove our worth," she said.

Because of her strong convictions that the disabled should not be discriminated against, she is always on the road addressing seminars and conferences in a bid to help spread this message.

"The movement is about the rights of disabled people. Not only are we shunned by the public but we also suffer double oppression because we are regarded as half-women.

"I don't think this is the right attitude. Most of us are intelligent and have got healthy minds, why should we be treated as lepers?"

And this 31-year-old mother of two lives what she preaches.

Apart from her involvement in the DRM, Mavuso is vice-president of the Azanian Youth Organisation - right hand to unionist and well known Soweto youth activist, Thami Mcerwa.

Phindile Mavuso.

Error in report on HSRC

OUR report on Tuesday on Francie Lund's HSRC-sponsored research of SA's government welfare bureaucracies erroneously stated: "Of the 3,9-million people who benefited directly, 2,6-million received pensions and 830 000 disability grants." This should have read: "Of the R3,9bn spent directly on pensions and grants, R2,6bn went to pensions for the elderly and R830m on disability grants." Business Day regrets the error.

REPORTS: Sapa, Own Correspondent, Business Day Reporter, AP-DJ.

(b) 6. KLOUSULE 16: LIKWIDASIE

In subklousule (v) vervang die uitdrukking "klousule 10 (7)" met die uitdrukking "klousule 10 (8)" waar dit in die voorlaaste reël van die paragraaf voorkom.

2. In die Engelse teks van die Bylae:

(a) 5. CLAUSE 15: DISSOLUTION

In subklousule (iii) vervang die uitdrukking "clause 10 (7)" met die uitdrukking "clause 10 (8)" waar dit in die laaste reël van die paragraaf voorkom.

(b) 6. CLAUSE 16: LIQUIDATION

In subklousule (v) vervang die uitdrukking "clause 10 (7)" met die uitdrukking "clause 10 (8)" waar dit in die laaste reël van die paragraaf voorkom.

No. R. 2444 **28 Augustus 1992**

WET OP ARBEIDSVERHOUDINGE, 1956

ELEKTROTEGNIESE NYWERHEID (NATAL): WYSIGING VAN DIE MEDIESE HULPFONDSOOREENKOMS

Ek, Glen Morris Edwin Carelse, Adjunkminister van Mannekrag, verklaar hierby, kragtens artikel 48 (1) (a) van die Wet op Arbeidsverhoudinge, 1956, dat die bepalings van die Ooreenkoms (hierna die Wysigingsooreenkoms genoem) wat in die Bylae hiervan verskyn en betrekking het op die Onderneming, Nywerheid, Bedryf of Beroep in die opskrif by hierdie kennisgewing vermeld, met ingang van die tweede Maandag na die datum van publikasie van hierdie kennisgewing en vir die tydperk wat op 30 Junie 1993 eindig, bindend is vir die werkgewersorganisasie en die vakverenigings wat die Wysigingsooreenkoms aangegaan het en vir die werkgewers en werknemers wat lede van genoemde organisasie of vereniging is.

G. M. E. CARELSE,
Adjunkminister van Mannekrag.

BYLAE

NYWERHEIDSRAAD VIR DIE ELEKTROTEGNIESE NYWERHEID (NATAL)

MEDIESE HULPFONDSOOREENKOMS

ooreenkomstig die Wet op Arbeidsverhoudinge, 1956, gesluit deur en aangegaan tussen die

Electrical Contractors' Association (South Africa)

(hierna die "werkgewers" of die "werkgewersorganisasie" genoem), aan die een kant, en die

South African Electrican Workers' Association

en die

Metal and Electrical Workers' Union of South Africa

(hierna die "werknemers" of die "vakverenigings" genoem), aan die ander kant

wat die partye is by die Nywerheidsraad vir die Elektrotegniese Nywerheid (Natal),

(b) 6. KLOUSULE 16: LIKWIDASIE

In subclause (v) substitute the expression "klousule 10 (8)" for the expression "klousule 10 (7)" where it appears in the penultimate line of the paragraph.

2. In the English text to the Schedule:

(a) 5. CLAUSE 15: DISSOLUTION

In subclause (iii) substitute the expression "clause 10 (8)" for the expression "clause 10 (7)" where it appears in the last line of the paragraph.

(b) 6. CLAUSE 16: LIQUIDATION

In subclause (v) substitute the expression "clause 10 (8)" for the expression "clause 10 (7)" where it appears in the last line of the paragraph.

No. R. 2444 **28 August 1992**

LABOUR RELATIONS ACT, 1956

ELECTRICAL INDUSTRY (NATAL): AMENDMENT OF MEDICAL AID FUND AGREEMENT

I, Glen Morris Edwin Carelse, Deputy Minister of Manpower, hereby, in terms of section 48 (1) (a) of the Labour Relations Act, 1956, declare that the provisions of the Agreement (hereinafter referred to as the Amending Agreement) which appears in the Schedule hereto and which relates to the Undertaking, Industry, Trade or Occupation referred to in the heading to this notice, shall be binding, with effect from the second Monday after the date of publication of this notice and for the period ending 30 June 1993, upon the employers' organisation and the trade unions which entered into the Amending Agreement and upon the employers and employees who are members of the said organisation or unions.

299

G. M. E. CARELSE,
Deputy Minister of Manpower.

SCHEDULE

INDUSTRIAL COUNCIL FOR THE ELECTRICAL INDUSTRY (NATAL)

MEDICAL AID FUND AGREEMENT

in accordance with the provisions of the Labour Relations Act, 1956, made and entered into by and between the

Electrical Contractor's Association (South Africa)

(hereinafter referred to as the "employers" or the "employers' organisation"), of the one part, and the

South African Electrical Workers' Association

and the

Metal and Electrical Workers' Union of South Africa

(hereinafter referred to as the "employees" or the "trade unions"), of the other part,

being the parties to the Industrial Council for the Electrical Industry (Natal),

om die Ooreenkoms gepubliseer by Goewermentskennisgewing, No. R. 1659 van 19 Augustus 1988 (hierna die Herbekragtigingsooreenkoms genoem), soos gewysig en verleng by Goewermentskennisgewings Nos. R. 1214 van 9 Junie 1989, R. 396 van 23 Februarie 1990, R. 1493 van 29 Junie 1990, R. 1872 van 10 Augustus 1990, R. 1232 van 30 Mei 1991 and R. 2048 van 23 Augustus 1991, te wysig.

1. TOEPASSINGSBESTEK VAN OOREENKOMS

(1) Behoudens andersluidende bepalings in hierdie klousule, is hierdie Ooreenkoms van toepassing op en moet dit nagekom word in die Elektrotegniese Nywerheid (Natal) deur alle werkgewers en werknemers wat lede van onderskeidelik die werkgewersorganisasie en die vakverenigings is en wat betrokke is by of in diens is in die Nywerheid in die provinsie Natal, uitgesonderd enige gedeeltes van daardie gebied wat binne die selfregerende gebied KwaZulu val.

(2) Hierdie Ooreenkoms is nie van toepassing nie op werkgewers en hul werknemers wat saam met die werkgewers deelnemers is aan 'n skema wat mediese voordele verskaf en wat op 3 Januarie 1966 bestaan het en waartoe die betrokke werkgewer minstens 45 sent per week bydra ten opsigte van elke werknemer wat lid van die skema is en andersins deur hierdie Ooreenkoms gedek word, terwyl die skema in werking bly en genoemde werkgewers en werknemers voortgaan om deelnemers aan die skema te wees en die werkgewers voortgaan om 'n bydrae van minstens 45 sent per week ten opsigte van elke sodanige werknemer te betaal.

(3) Ondanks subklousule (2), is hierdie Ooreenkoms van toepassing op werkgewers en werknemers ten opsigte van 'n werknemer wat nie deur 'n fonds of skema bedoel in daardie subklousule gedek word nie, of wat ophou om daardeur gedek te word.

2. ALGEMENE BEPALINGS

Klousules 3 tot en met 19 van die Ooreenkoms gepubliseer by Goewermentskennisgewing No. R. 2604 van 2 Desember 1983, soos gewysig en herbekragtig by Goewermentskennisgewings Nos. R. 1429 van 13 Julie 1984, R. 994 van 23 Mei 1986, R. 2068 van 26 September 1986 en R. 1659 van 19 Augustus 1988 (soos van tyd tot tyd gewysig, herbekragtig en verleng), is van toepassing op werkgewers en werknemers.

3. KLOUSULE 3: WOORDOMSKRYWING

Voeg die volgende nuwe omskrywing in na die omskrywing van "Elektrotegniese Nywerheid":

" 'boekjaar' die periode van 1 Januarie tot 31 Desember van elke jaar.".

4. KLOUSULE 9: BYDRAES

In subklousule (1) vervang die uitdrukking "R20,00" deur die uitdrukking "R24,00".

5. KLOUSULE 10: BYSTAND

In subklousule (1), vervang paragrawe (a) tot (f) deur die volgende:

"(a) Betaling van koste, uitgesonderd koste vir tandheelkundig dienste, oogkundige dienste en voorskrifte, van altesaam hoogstens R9 000 (met inbegrip van koste vir bevallings) in elke boekjaar vir die lid en sy afhanklikes;

(b) betaling van koste aangegaan vir gewone tandheelkundige dienste, insluitende tandestelle van plastiek, van altesaam hoogstens R1 125 in elke boekjaar vir die lid en sy afhanklikes;

(c) betaling van koste vir oogkundige dienste, insluitende die toets van oë en brille, van altesaam hoogstens R450 in elke boekjaar vir die lid en sy afhanklikes;

to amend the Agreement published under Government Notice, No. R. 1659 of 19 August 1988 (hereinafter referred to as the Re-enacting Agreement), as amended and extended by Government Notices Nos. R. 1214 of 9 June 1989, R. 396 of 23 February 1990, R. 1493 of 29 June 1990, R. 1872 of 10 August 1990, R. 1232 of 30 May 1991 and R. 2048 of 23 August 1991.

(355) (299)

1. SCOPE OF APPLICATION OF AGREEMENT

(1) Except as otherwise provided in this clause, the terms of this Agreement shall apply to and be observed in the Electrical Industry (Natal) by all employers and employees who are members of the employers' organisation and the trade unions, respectively and who are engaged or employed in the Industry in the Province of Natal, excluding any portions of that area falling within the Self-governing Territory of KwaZulu.

(2) The terms of this Agreement shall not apply to employers and their employees who are participants with the employers in any scheme providing medical benefits, in existence on 3 January 1966, to which the employer concerned contributes not less than 45 cents per week for each employee who is a member of the scheme continues to operate and the said employers and employees continue as participants in the scheme and the employers continues to pay a contribution of not less than 45 cents per week for each such employee.

(3) Notwithstanding the provisions of subclause (2), the terms of this Agreement shall apply to employers and employees in respect of any employee who is not covered by, or ceases to be covered by, a fund or scheme referred to in that subclause.

2. GENERAL PROVISIONS

The provisions contained in clauses 3 to 19, inclusive, of the Agreement published under Government Notice No. R. 2604 of 2 December 1983, as amended and re-enacted by Government Notices Nos, R. 1429 of 13 July 1984, R. 994 of 23 May 1986, R. 2068 of 26 September 1986 and R. 1659 of 19 August 1988 (as amended, re-enacted and extended from time to time) shall apply to employers and employees.

3. CLAUSE 3: DEFINITIONS

Insert the following new definition after the definition of "Electrical Industry":

" 'financial year' means the period from 1 January to 31 December of each year.".

4. CLAUSE 9: CONTRIBUTIONS

In subclause (1) substitute the expression "R24,00" for the expression "R20,00".

5. CLAUSE 10: BENEFITS

In subclause (1), substitute the following for paragraphs (a) to (f):

"(a) Payment of expenses, other than expenses for dental services, optical services and prescriptions, not exceeding the amount of R9 000 (including payment of expenses for confinements) in the aggregate per financial year for the member and his dependants;

(b) payment of expenses for ordinary dental services, including plastic dentures, not exceeding the amount of R1 125 in the aggregate per financial year for the member and his dependants;

(c) payment of expenses for optical services, including eye-testing and spectacles, not exceeding an amount of R450 in the aggregate per financial year for the member and his dependants;

(d) betaling van koste vir voorskrifte van altesaam hoogstens R2 250 in elke boekjaar vir die lid en sy afhanklikes; die Fonds is nie verantwoordelik vir die eerste R10 met betrekking tot elke voorskrif van 'n mediese praktisyn of spesialis vir medisyne, verdowingsdmiddels, verbande, salwe of velmiddels nie;

(e) betaling van koste aangegaan vir spesiale tandheelkundige dienste, d.w.s. kroon- en brugwerk, goud-inlegwerk, ortodontiek, periodontiek, prostodontiek en tandestelle met 'n metaalbasis, van altesaam hoogstens R550 in elke boekjaar vir die lid en sy afhanklikes;

(f) betaling van koste vir mekdiese en chirurgiese hulpmiddels van altesaam hoogstens R275 in elke boekjaar vir die lid en sy afhanklikes.''.

Namens en soos gemagtig deur die partye op hede die 3de dag van Maart 1992 te Durban onderteken.

B. CARR,
Voorsitter van die Raad.

T. EVANS,
Ondervoorsitter van die Raad.

L. A. DICKASON,
Sekretaris van die Raad.

No. R. 2445 **28 Augustus 1992**

WET OP MANNEKRAGOPLEIDING, 1981

VERLENGING VAN DIE OPLEIDINGSKEMA VIR DIE BOUNYWERHEID

Ek, Glen Morris Edwin Carelse, Adjunkminister van Mannekrag, handelende kragtens artikel 39 (3) van die Wet op Mannekragopleiding, 1981—

(a) verleng hierby die tydperk vasgestel by Goewermentskennisgewing No. R. 2398 van 4 Oktober 1991 met 'n tydperk van ses maande wat op 28 Februarie 1993 eindig; en

(b) wysig hierby, met ingang van 1 September 1992, die Skema gepubliseer by Goewermentskennisgewing No. R. 1948 van 11 September 1987 deur die onderstaande klousule na klousule 13 in te voeg:

"14. VRYSTELLINGS

Enige aansoek om vrystelling van enige bepaling van hierdie Skema, wat kragtens artikel 47 van die Wet deur die Minister verleen kan word, moet by die Opleidingskema vir die Bounywerheid, Posbus 1619, Halfweghuis, 1685, ingedien word, wat sodanige aansoek tesame met enige aanbeveling deur die Raad moet deurstuur na die Direkteur-generaal: Mannekrag.''.

G. M. E. CARELSE,
Adjunkminister van Mannekrag.

No. R. 2455 **28 Augustus 1992**

WET OP ARBEIDSVERHOUDINGE, 1956

MOTORNYWERHEID: HERNUWING VAN HOOFOOREENKOMS

Ek, Izak Jacobus van Zyl, Hoofdirekteur: Arbeidsverhoudinge, behoorlik daartoe gemagtig deur die Minister van Mannekrag, verklaar hierby, kragtens artikel 48 (4) (a) (ii) van die Wet op Arbeidsverhoudinge, 1956,

(d) payment of expenses for prescriptions not exceeding an amount of R2 250 in the aggregate per financial year for the member and his dependants; the Fund shall not be liable for the first R10 in respect of each prescription of a medical practitioner or specialist for medicines, drugs, dressings, ointments or lotions;

(e) payment of expenses for special dental services, i.e. crowns and bridgework, gold inlays, orthodontics, periodontics, prosthodontics and metal base dentures, not exceeding the amount of R550 in the aggregate per financial year for the member and his dependants;

(f) payment of expenses for medical and surgical accessories not exceeding R275 in the aggregate per financial year for the member and his dependants.''.

Signed at Durban as authorised, for and on behalf of the parties, this 3rd day of March 1992.

B. CARR,
Chairman of Council.

T. EVANS,
Vice-Chairman of Council.

L. A. DICKASON,
Secretary of Council.

No. R. 2445 **28 August 1992**

MANPOWER TRAINING ACT, 1981

EXTENSION OF TRAINING SCHEME FOR THE BUILDING INDUSTRY

I, Glen Morris Edwin Carelse, Deputy Minister of Manpower, acting in terms of section 39 (3) of the Manpower Training Act, 1981, hereby—

(a) extend the period fixed in Government Notice No. R. 2398 of 4 October 1991, by a further period of six months ending on 28 February 1993; and

(b) amend, with effect from 1 September 1992, the Scheme published by Government Notice No. R. 1948 of 11 September 1987 by the insertion of the undermentioned clause after clause 13:

"14. EXEMPTION

Any application for exemption from any provision of this Scheme, which may be granted by the Minister in terms of section 47 of the Act, shall be submitted to the Training Scheme for the Building Industry, P.O. Box 1619, Halfway House, 1685, which shall forward such application together with any recommendation by the Board to the Director-General: Manpower.''.

G. M. E. CARELSE,
Deputy Minister of Manpower.

No. R. 2455 **28 August 1992**

LABOUR RELATIONS ACT, 1956

MOTOR INDUSTRY: RENEWAL OF MAIN AGREEMENT

I, Izak Jacobus van Zyl, Chief Director: Labour Relations, duly authorised thereto by the Minister of Manpower, hereby, in terms of section 48 (4) (a) (ii) of the Labour Relations Act, 1956, declare the provisions of

PEOPLE'S LIVES *Motse was devastated by her mother's death last year after she died of cancer*

Ms Emily Motse.

Symbol of hope

woman of the **Week**

Sowetan 31/8/92

By Pearl Majola

SELFLESS HELPER Emily carries out a weekly pilgrimage to the clinic to help nurses treat the terminally ill.

EMILY Motse has become a symbol of hope to the blind and to cancer victims who attend a weekly clinic at the Thabong hospital in Welkom.

Her involvement with cancer patients began in 1990, after her mother was struck by the disease. Emily volunteered as a health-care worker at the local hospital.

Although she was devastated by her mother's death last year, she continues her weekly pilgrimage to the clinic to help nurses treat the terminally ill.

"I understand the pain and the fear cancer patients go through because my mother was a victim," says Motse. "The least I can do is be there," she adds passionately.

"My past experience as an assistant nurse for private doctors helps."

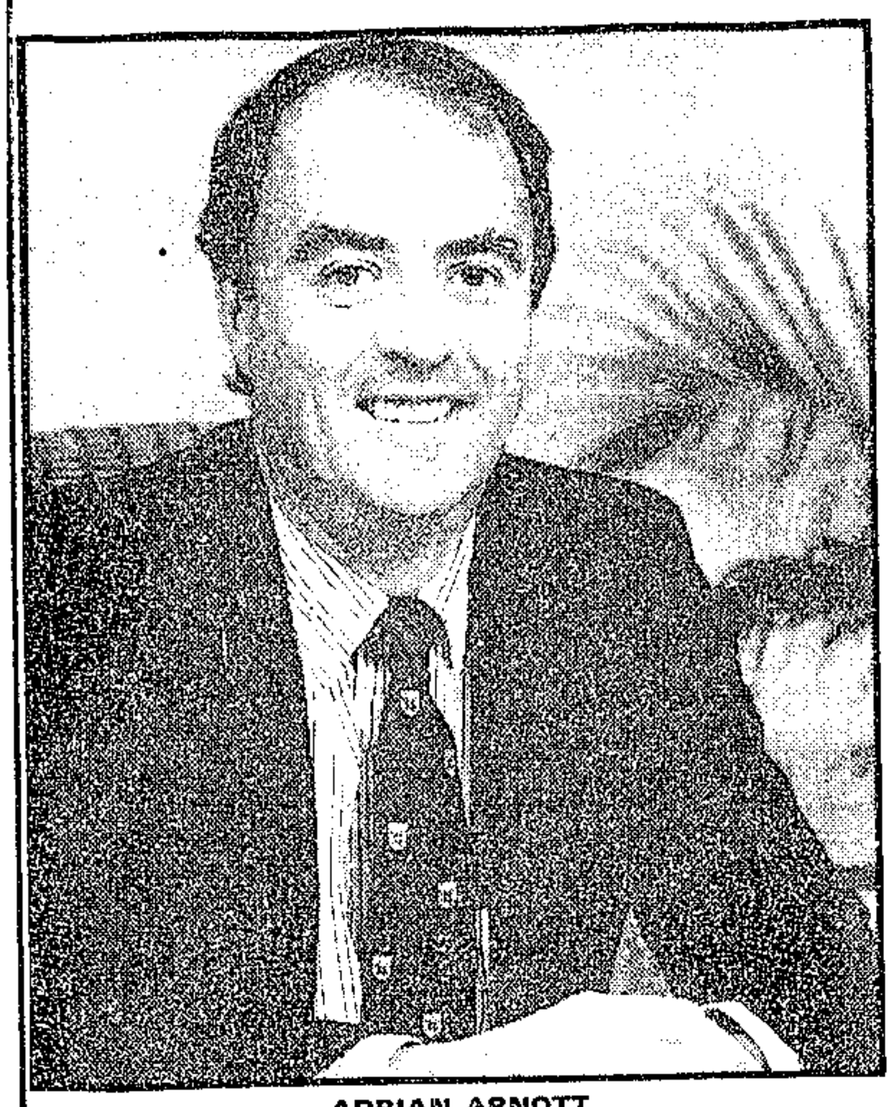
But Motse just cannot rest until she has seen to it that a person in need receives help. That is why the cancer patients are not the only people she concerns herself with.

A devoted Manyano woman, Motse has also started a sewing project for the aged women in her church. In 1987, she started a feeding and survival skills project for the blind in Welkom.

Skills developer

Name Emily Motse
Age 43
Single
Children Five (three of her own and two foster children)
Projects Skills developer for Gold Fields Society for the Blind; soup kitchen and skills projects for the physically disabled and the destitute in Thabong, Odendaalsrus, Bultfontein, Parys and Theunissen.

AMA (299)



ADRIAN ARNOTT

Smooth transition to corporate entity

BIDAY 19/8/92 (299)

IN THE space of just three years, AMA's top leadership has changed from having a founder-owner at the helm to being a fully-fledged corporate entity.

Southern Life acquired 100% of AMA in December 1989 from founder Tony Leveton, who stayed on temporarily as a director to ensure a smooth transition to the management team which is now in place.

As AMA chairman Adrian Arnott explains, Southern's expertise lies in the field of life insurance. When it branches out into a new field, it is an established policy to do so in partnership with an established expert, in this case Leveton.

The current management team has been in place for about 18 months and Arnott says he is happy to maintain a low profile, leaving the affairs of AMA "in the capable hands of Tim Gelman and his executive team".

Arnott, who is also Southern's executive director of employee benefits, says Southern considered medical aid to be a natural extension of its existing base.

The idea, he says, is to position AMA as the healthcare expert within Southern's stable and as a complement to its other services.

Reluctant

Arnott is reluctant to discuss what Southern paid for AMA, but says it was considerably less than the R100m involved in its recent acquisition and refinancing of debt of a 50% stake in the MediCor group. MediCor operates 10 MediCity hospitals in SA and Namibia.

With the envisaged changes to legislation governing medical aids, Southern's hospital and medical aid interests mean it is well positioned to move strongly in the direction of managed health care.

'Healthy funds le to a healthy soci

BIDAY 19/8/9

A staggering R250m in accumulated funds underlines AMA's standing as the country's second largest medical aid administrator.

In the past 12 months, the equity portions of the AMA societies' investments have delivered impressive returns of between 30% and 32%, while prescribed investments have realised an average of 18,2%.

One of the most important services with which AMA provides its societies is detailed and expert budgetary advice. This involves analysing increases in providers' fees and changing utilisation patterns.

AMA financial director Alan Naude emphasises that a society's health is determined by the health of its funds — and given AMA's proven solidity, members can look forward to long-term financial security.

ALAN NAUDE

Expertise

"There can be no doubt that AMA societies' funds are indeed very healthy. This is something we have built up over a long period of time and the expertise we offer means that the funds are invested with a view to the future," says Naude.

Members of a medical aid (which works on the principle of short-term insurance) are, in effect, shareholders. AMA acts as a trustee of members' funds.

Statistical and socio-economic formulae are used for setting contribution levels, based on past performance, increases in medical costs and fees and claims trends. Other information such as age, sex, family size, location and employment are all considered. High levels of actuarial expertise are essential, along with top management skills and technology.

Naude says there nevertheless exists an incorrect perception that medical aids simply hike up contributions to cover ever-increasing costs. For several years, medical inflation has been running at between 25% and 30% — and the blanket imposition of VAT has not helped.

Like most industries, medical aids are subject to unforeseen circumstances over which they have little or no control.

Naude explains: "One gets good years and bad years. We have had lean times which have lasted for several years. In those times it is possible to push up subscriptions to meet expenses, but one can't do so indefinitely.

"Quite simply, our business is to keep people in medical aid, not to force them out."

Another uncertain factor, he says, is AIDS.

"Nobody knows when there will be a miracle cure. Nobody knows just how bad the situation will become.

"There are estimates by experts that AIDS will affect 10% of the SA population. Others say 40%. If it's 10%, the financial position of our societies will be fine; if it's 40%, every single medical aid in the country has a very serious problem."

Importance

Perhaps better than any other single example, AIDS illustrates the importance of medical aids retaining healthy accumulated funds. The registrar has laid down an unenforced guideline that 25% of annual contributions should go towards accumulated funding.

Naude explains that this view is largely dictated by the rule of thumb that, should a medical aid be

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benefits for a period
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adds that AMA has a
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nding.

35 000 claims are processed daily.

Strategic business units pay dividends

B1DA7 19/8/92

EARLIER this year, AMA introduced strategic business units. As the country's second-largest administrator with 250 000 members and close on 1-million beneficiaries, the greater efficiency and improved customer service yielded by this restructure made the move a logical one.

Each of the 11 schemes administered by AMA now operates as an independent business unit. However, AMA continually appraises the performance of each unit and ensures each scheme, while independent, slots into AMA's holistic design.

Each scheme has its own dedicated telephone line with the company's framework. This means telephonic inquiries are answered by the appropriate staffer at the relevant scheme.

Operations director Theo von Solms says the implementation of the strategic business units will undoubtedly continue to increase the efficient processing of the 35 000 daily claims that AMA administers. (294)

"Each unit takes total responsibility for that product or sector, providing a one stop, A to Z service. The team will process the claim through assessment, dealing with queries, all the way to issuing the cheque," says Von Solms.

Southern move a for the

SOUTHERN Life's acqu
tion of AMA last y
marked a turning point
health care history in S

AMA changed direct
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industry.

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It is also acutely av
of health care issues

ross-subsidisation is entral to medical aid

B1DA7 19/8/92. (294)

an underlying principle
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MA stresses the impor-
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has strategies — like
70/100 scheme — that
es schemes attractive
he young — while main-
g the integrity of the
ding mechanisms and
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nprehensive cover in
ir later years.

Marketing director Ray
lham says it is impor-
t to remember most
dical costs are incurred
old age and this is when
nprehensive cover be-
nes important.

'This is when medical
l really kicks in If you subscribe to a medical insurance scheme rather than a medical aid, you should remeber that most insurance policies have a cut-off age, and attempt to offer gap or top-up cover rather than comprehensive cover.

"Medical insurance should not be considered a replacement for medical aid. Medical aids work along the lines of short-term insurance, which means groups of people contribute an affordable amount of money into a fund, which is then used to pay medical expenses on a pro-rata basis. Medical aids also split the costs, responsibility and financial burden between employer and employee.

hern Life's e a watershed he industry

BIDAY 19/8/92 299

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has reacted swiftly to alleviate the financial burden on its members, with a range of products.

The fact that many medical aid members are out of pocket after a major operation has seen AMA introduce a form of medical insurance or "gap" cover, for one of its largest funds.

This move was a response to a recent relaxation in legislation which ensures that members of this scheme do not need any extra medical insurance. These members are covered up to 50% above the scale of benefits for major expenses such as hospitalisation and surgery.

As medical aids have reasonably large membership bases, they can offer the same gap cover as insurance companies at very competitive rates, mostly because they operate on margins of between 6% and 8%, while the insurance companies' cost for underwriting is about 40%.

Another innovation, which encourages frugal use of medical aid, is a "no-claim-bonus".

Linking

The 70/100 plan — first developed locally by AMA — sees the member paying 30% of all the costs incurred in a particular year — up to a certain threshold.

This scheme has been

Detailed in-house programme focuses on AIDS awareness

BIDAY 19/8/92 299

THROUGH a combined approach, AMA is addressing HIV/AIDS and its impact on healthcare provision. Its approach includes an internal policy and regular briefing and training, as well as the development of a medical protocol, dental protocol and a care centre.

AMA corporate communications manager Gillian Gresak is the driving force behind the company's AIDS awareness programme.

The policy provides that an employee infected with HIV/AIDS will not be ostracised by the company.

"An HIV/AIDS infected employee of AMA has his/her dignity as a proud human being and is respected in the same way as any other employee in the company," it states.

It does not recommend pre-employment screening because the virus may be in the window period and not be detectable.

Also, the employee may contract AIDS after employment and because not all HIV positive people will develop full-blown aids, this could be considered discriminatory.

Where employees choose to disclose their HIV positive status, the policy lays down strict guidelines on how this information will be treated.

Misconduct

"It is considered to be gross misconduct for an employee or manager to give out this kind of information without the individual's informed written permission and they will be subject to summary dismissal pending a disciplinary hearing."

The policy also provides for company-assisted counselling and requires that all infected workers be treated "with respect, dignity and compassion — as would any other employee".

Although considered extremely unlikely, the policy makes specific provisions to counter the spread of AIDS in the workplace.

For instance, bleach will be available and accessible at all times for sterilising tools and clothing and guidelines are laid down for people involved in first aid.

Despite some staff's misgivings about the programme, Gresak is determined that the company and its staff should be prepared to meet the challenges which are already starting to manifest themselves from the AIDS time bomb.

A committee comprising staff members is responsible for planning AMA's in-house AIDS programme and regular information and discussion meetings involving all staff, including the top echelons, are held.

The idea is that once staff members are properly informed and equipped to deal with AIDS situations they should take the message into the broader community and involve themselves with counselling and other AIDS action groups.

Meaningful

In consultation with society committees and other administrators, AMA's intention is to agree on meaningful, practical and cost-effective management of this illness.

"Because information-based education programmes have largely proved to be ineffective, we have assumed that people will contract the virus and that we need to maintain their condition as HIV-well as against HIV-ill."

GILLIAN GRESAK

"The obstacle is still whether or not people will sufficiently trust the society/administrator to identify themsleves with confidence.

"But, we believe that the policy, philosophy and medical protocol will encourage people to come forward so that we can assist them to achieve quality of life and, at the same tme identify and contain real costs — as against perceived costs."

margins of between 6% and 8%, while the insurance companies' cost for underwriting is about 40%.

Another innovation, which encourages frugal use of medical aid, is a "no-claim-bonus".

Linking

The 70/100 plan — first developed locally by AMA — sees the member paying 30% of all the costs incurred in a particular year — up to a certain threshold.

This scheme has been further developed by linking it to a savings option.

If, for example, a member pays R500 a month, R150 of this can be put into a fund to co-finance co-payments. At the end of the year, the member builds up a "no-claim" bonus which can then be used to cover future medical costs.

This system offers particularly younger members more cost-effective medical cover with very direct benefits for low claims, while building up a material nest egg.

AMA marketing director Ray Welham believes that an important spin-off from the direction in which

RAY WELHAM

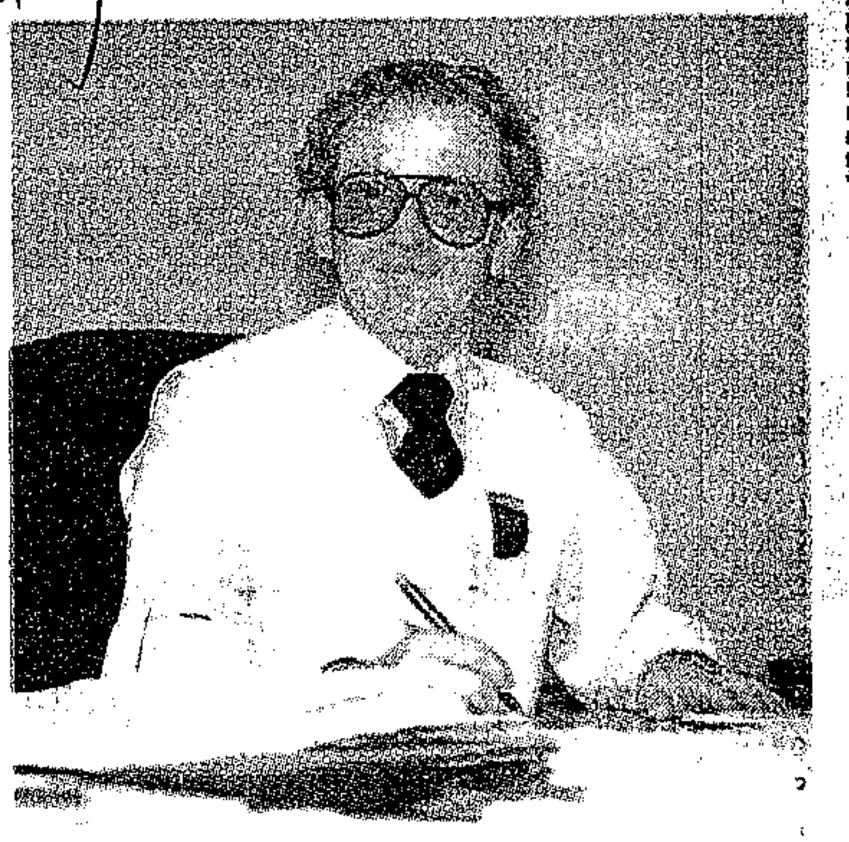
AMA's product development has moved will be to get people involvement in the whole cost containment exercise.

"We have acted to ease the burden on our members' pockets, as much as legislation allows. However, it is crucial that members contain costs from their side. Frugal and informed use of medical aid will see a healthy and adequate system for all."

AMA
299

19/8/82 B/day

Healthcare sector now poised for sweeping change



TIMOTHY GELMAN

SA's healthcare sector is poised to undergo changes as sweeping as those unfolding in the political sphere.

A leading player in the medical aid sector, Affiliated Medical Administrators (AMA) is gearing up to meet the demands flowing from change and is also positioning the company to play a decisive role in the healthcare industry.

AMA CEO Timothy Gelman says the company has a "unique opportunity" to play a pioneering role in a field which is of tremendous infrastructural relevance to the future of the country.

Countries which have experienced significant economic growth, he says, have all had one thing in common: a well-developed healthcare infrastructure.

Together with housing, education and welfare, he says, health forms one of the four pillars of our society which need to be addressed by both the public and the private sectors if the country is to fulfil its economic and development potential.

Vital

"Medical aid funders and schemes are a vital component of the overall health delivery system, but sweeping changes are needed — both within their structures and in terms of the current legislation — if they are to be effective in delivering appropriate solutions to the healthcare crisis."

Every medical aid in the country is facing a mounting crisis over spiralling costs, red tape and inadequate facilities, Gelman says. Proposed changes to the Medical Schemes Act will go a long way towards promoting the delivery of effective healthcare services for all the people of SA.

But while the industry involves itself in heated debate over the issues at stake, Gelman says AMA has been preparing the foundations for implementing innovations such as managed healthcare processes and market-driven healthcare products. These, he says, will keep it at the forefront of the industry and able to cope with the challenges of the future.

AMA has restructured in terms of direction and application to become a service orientated provider of tailor-made healthcare solutions.

There is virtual unanimity within the medical aid movement that managed healthcare is the foundation of the future, he says.

Gelman describes managed healthcare as a process, proven in other parts of the world, which incorporates multispeciality practices remunerated on the basis which allows risk to be managed where appropriate.

The emphasis is on keeping patients healthy and not simply to treat sickness.

Such systems function according to the criteria of price, appropriateness of medical treatment and quality of outcome.

With the sharing of responsibility, the whole focus changes from fee-for-service treatment for the sick to prevention and health maintenance, with tremendous cost savings for everyone involved in the healthcare chain.

AMA recently acquired a 50% stake in MediCor's MediCity hospital group, the fourth-largest private hospital group in the country all contracted into medical aid tariffs.

The combination of the specialist facilities and strategic skills with AMA's more than 30 years of medical aid administrative expertise and substantial resources, places it in a position to implement the managed healthcare process.

Employees encouraged to use their skills and expertise

AMA's personnel policies are highly innovative and underline the company's determination to be the acknowledged leader in the provision of healthcare solutions.

Human resources director Imogen Lawrence says the emphasis is on the concept of empowerment — getting employees not just to think for themselves, but to use their own expertise and skills to provide the customer with a better service.

Lawrence describes it as an exciting environment in which to work, characterised by a high energy level, among staff.

AMA has a high profile and visible management team: staff get to see the bosses. Lawrence says AMA staff also believes the company has visionary leadership and direction.

She attributes the environment at AMA to the company's leadership and says CEO Timothy Gelman sets the tone for efficiency and flexibility.

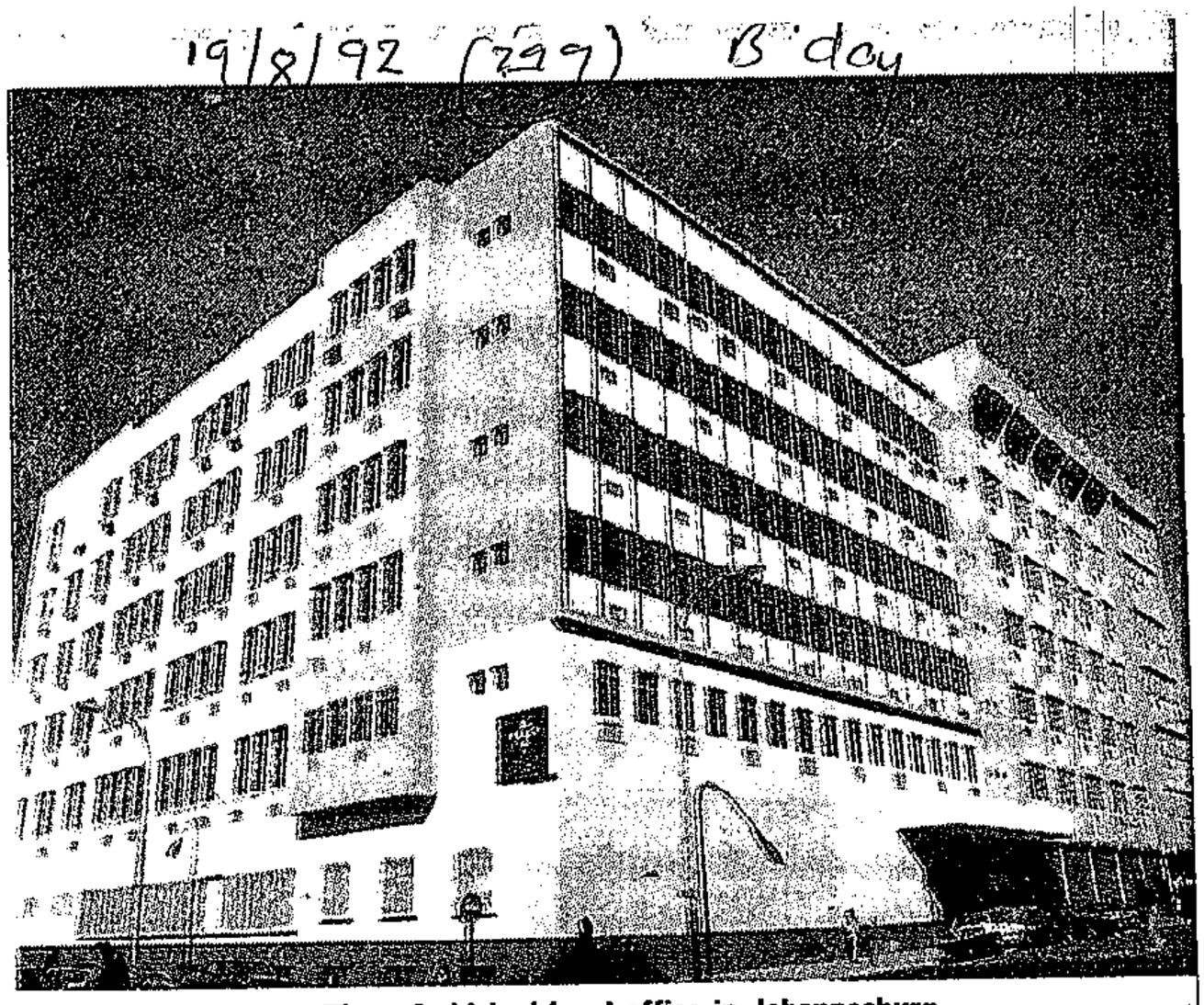
"The philosophy here is less management and more leadership. By empowering people, we are ensuring that the company as a whole improves its ability to learn, which gives us a marketplace."

Part of the overall strategy is to promote cross-cultural understanding and AMA recently launched a programme of sending groups of personnel — from all races, levels and both sexes — away for three-day "country breaks". This encourages candid discussion of problems and has yielded constructive results, Lawrence says.

She adds that there is no ivory tower mentality at AMA. The policy is one of open doors to management and total involvement at all levels in decisions affecting the company's strategic

Business Day SURVEY

Medical aid schemes are a vital component of the health delivery system, but sweeping changes are needed if they are to deliver appropriate solutions to the healthcare crisis. Affiliated Medical Administrators (AMA) is gearing up to meet the demands of change and play a decisive role in the healthcare industry. ***PETER DELMAR*** *reports.*



The refurbished head office in Johannesburg.

R15m building refurbishment to cope with rapid growth

IMAGINE a medical aid administrator's offices responsible for nearly a million principal members and dependents, processing in excess of 35 000 claims a day — and the mind might conjure up an image of cluttered desks piled high with thousands of forms.

In the case of AMA, nothing could be further from the truth.

State-of-the art systems and technology allows AMA to cope efficiently and cost-effectively with the massive administrative volumes. The building is laid out to assist the work flow, while the work environment is open and bright.

Computer cabling and other enabling technologies have been designed into the building itself, ensuring the environment will retain its flexibility to adapt and to work efficiently for years to come.

The R15m refurbishment of AMA's 30-year old head office in Commissioner Street was undertaken with the specific purpose of modernising and expanding facilities to cope with the rapid growth of AMA, and to pave the way for future needs.

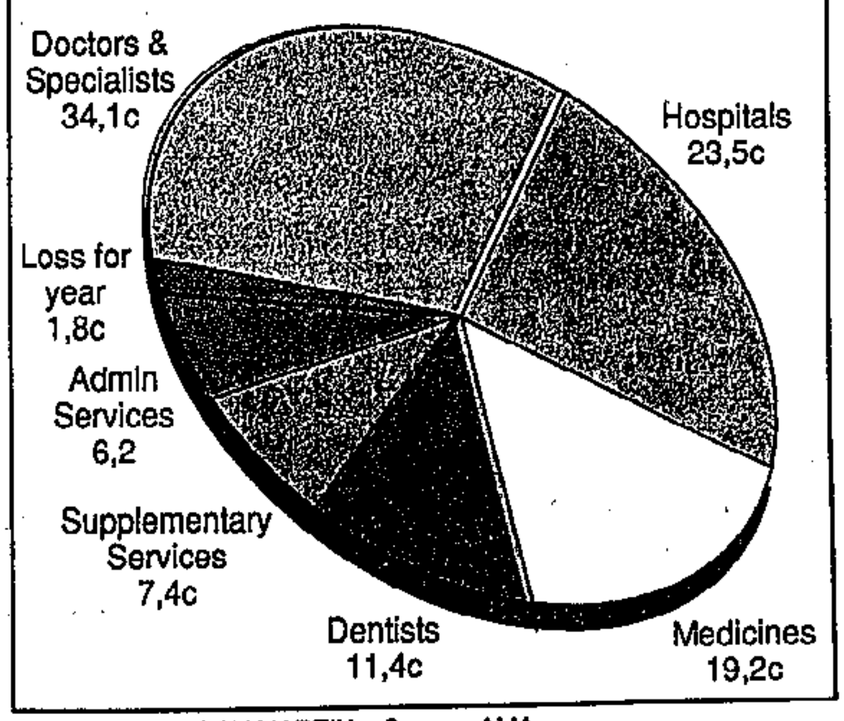
The joint decision by AMA and owners Southern Life was taken in line with Southern's policy of ur[b]an renewal and building [to] market demand rat[her] than for its own sake.

The convenience of the site in the well-establish[ed] eastern node of the Johan[nes]burg CBD and its pro[x]imity to public transpo[rt] systems were also majo[r] advantages.

Work on the refurbishment, which involved re[-]ducing the structures [to] two interlinked buildings [on] a shell, began in Januar[y] 1991 and was completed [in] December — a mamm[oth] task in view of the fact [that] AMA continued with busi[-]ness as usual. The interio[rs] were completely re[-]and the buildings are no[w] linked at each level. The exteriors were also totally refurbished.

The most notable single achievement was probably the relocation in four days of AMA's computer system which is networked to AMA facilities in several parts of the country and features a national PC-based linkup. The system now takes up a whole floor of one building.

How each rand of income is spent; MEDS, 1991



Graphic: RUBY-GAY MARTIN Source: AMA

'Utopian' relationship pleases Durbanites

DOWN at the National Medical Plan (NMP) offices in Durban, they cannot keep the smiles off their faces since they joined AMA in April last year.

So says NMP CE Rob Basson in response to a question about the society's relationship with AMA. He goes further, describing it as "utopian".

Largest

NMP is the largest of the 11 societies administered by AMA, with a membership of some 60 000.

Says Basson: "In a nutshell, being with AMA offers our members more efficient service at a more cost-effective price.

"The Southern Life culture and that of AMA is very similar to that of NMP. It has been a very painless birth."

AMA CE Timothy Gelman is also delighted with the relationship, apart from the obvious benefits of increased business and improved economies of scale. NMP has a particularly good reputation with the public and the move gives AMA a major presence in Natal, he says.

While NMP is AMA's newest society, AECI Medical Aid Society is one of the oldest, with a relationship going back some 20 years.

Society chairman Declan Brennan lists the advantages of being with AMA as its solid service, very competitive rates and expert advice on health funding.

With the challenges facing medical aid, there are obvious benefits to being in the same camp as a big company like AMA, he says.

Peter Eustace, chairman of the Anglo American Corporation's 36 000-member society, says AMA's approach to technology has always set it apart.

"They have always been at the very forefront of technological developments in the industry as far as processing is concerned.

Professionals

"It is particularly important to have professionals on your side in the current environment in which costs are running away with themselves," Eustace says.

Another competitive advantage not always appreciated is AMA's links with the medical aid movements of other countries.

THE proposed amendments to the Medical Schemes Act have almost brought the fractious relationship between doctors and medical aids to breaking point.

Dr Colin Plotkin, chief medical consultant to AMA, has set himself the task of convincing his medical peers that the amendments offer the prospect a win-win situation for both sides.

"Since the introduction of the Act in 1967 antagonism has existed between doctors and medical aids," Plotkin says.

"The time has come for the professions and the industry to accept that the relationship is both symbiotic and inseparable and their efforts should be aimed towards working together rather than against each other."

The amendments provide a golden opportunity to help suppliers disentangle themselves from over-regulation.

Removing the system of minimum and maximum amounts — as recommended — will free medical aids to pay more than the 100% of scales of benefits, he says.

Schemes realise that general practitioners cannot survive on the current tariff of R31,10 (VAT included).

By motivating for the removal of payment restrictions, medical aids are aiming to pay GP's fees of, for example, R50 or R60.

This, is subject to the proviso that suppliers don't oversevice or over-prescribe.

New medical aid regulations can mean a win-win situation for all

BIDAY 19/8/92.

Opportunity (299)

"What this means in reality to the majority of doctors who are acting responsibly is that they now have the opportunity of entering into a deal with a scheme to better their income.

"At the same time, they can be equal partners in helping to continue responsible medicine for a healthy delivery which, if not rectified, is destined to doom."

The abolition of guaranteed payments, Plotkin says, does not mean that medical aids may not continue with direct payments to suppliers in favour of paying the member direct.

It will be much more cost-effective for an administrator to deal with 10 000 suppliers as opposed to 250 000 members. The amendments would make it possible for suppliers to not only negotiate higher fees, but also continued guaranteed payment.

The other major changes proposed concern health maintenance organisations (HMOs) and preferred provider organisations (PPOs), both proposals which have been the subject of often acrimonious debate between doctors and medical aids.

An HMO will provide a full range of medical and paramedical benefits and services, in essence giving members a one-stop treatment centre.

Plotkin envisages numerous advantages of doctors participating in HMOs. These include above average remuneration, relieving the doctor of administrative and financial problems, continuing medical education and benefits such as regular holidays and pensions.

A major complaint from doctors is that HMOs will remove a patient's freedom of choice. But Plotkin queries this as patients will have up to 25 doctors at a single HMO to choose from.

Autonomy

The other major fear is that doctors will lose their autonomy to bureaucrats obsessed with budgets.

It is an accepted phenomenon, he says, that "doctors must manage doctors".

In the HMO system this is exactly what occurs. An accepted norm for each situation is laid down by unanimous consensus of the doctors employed by the HMO.

Doctors decide on a list of drugs over which the administrators have no say.

AMA CE Timothy Gelman says that one vital aspect of HMOs is that they should be rooted in the community.

On fears that doctors will no longer be able to subsidise poorer patients by charging wealthier ones more, Plotkin responds: "If anything, HMOs are intended either through individual membership, or through employers, to bring health care within the reach of these very people who have in the past required this level of subsidisation."

However, HMOs will not suddenly spring up on each street corner and PPOs should be considered the "building stones" of HMOs.

Gelman says providing an HMO "on every street corner" would be beyond the means of the whole country, let alone a single section of the health care sector. As a rule, it is envisaged that members will not have to travel more than 20 minutes.

PPOs will give medical aids the chance to direct their members to providers who they know deliver high-quality but cost-effective health care.

SOCIAL SECURITY — MEDICARE

1992

SEPTEMBER — DECEMBER.

NEWS Two friends a source of joy for sufferers

Bringing comfort to Soweto epileptics

Sowetan 1/9/92

LIFE'S WORK It all started with her husband but now many others also benefit: 299

Name: Sarah Sibanyoni
Age: 55
Family: epileptic husband, no children.
Occupation: Unemployed domestic worker
Motivation: "When I saw my husband get up from his sick-bed to make kennels and support the family, I knew it could be done."

By Sowetan Reporter

WHAT started as wifely duty towards an epileptic husband for Mrs Sarah Sibanyoni, is today a source of joy and income for over 80 epileptic people in Soweto.

When her husband became an epileptic in 1985, she did not know that seven years later she would devote her life to helping other epileptic people.

In 1987 Sibanyoni and her friend of 20 years, Mrs Dorothy Zikalala, pioneered the Soweto Epileptic Self-Help Organisation (Sesho) by starting a club for the epileptics in their neighourhood.

At the same time they launched the Tsakane Luncheon Club for the aged of Diepkloof.

The club, which is now partly sponsored by the Soweto Care of the Aged, provides meals. Zikalala and Sibanyoni organise outings and other social events for the grannies who have found solace at the club every Wednesday.

Zikalala and Sibanyoni also find time for the epileptics belonging to Sesho who meet daily.

These epileptic men, women and teenagers gather at clinics and churches in Zola, Tladi and Chiawelo for moral support and also to earn a living through the loving attention of Sibanyoni and Zikalala. The two will also be opening a new branch in Phomolong.

Women crochet educational toys and doilies, make patchwork bags, quilts and table mats. Men make wooden lamps and children's furniture for local creches.

Members have literacy classes and they debate current events.

"Members use whatever they make from their handwork for themselves."said Sibanyoni.

"They do not pay anything to the club but its eight-member volunteer committee contribute R10 a month for daily needs. The committee also gets most of the material for patchwork from dressmakers' waste bins. They have cake and jumble sales to buy the material they can't get as donations."

But getting to where they are has not been easy for the two dedicated friends.

Sesho is the result of Sibanyoni following up an appeal by doctors.

"I attended a meeting at which doctors asked families to support epileptics in any way they could,"she said.

"I knew I had to do something. I spoke to Dorothy (Zikalala) and we decided to get more information before starting anything."

Zikalala said: "We went to clinics, attended welfare and community meetings and approached other self-help organisations. Nobody wanted to listen to us."

Later on they were helped by social workers from the South African National Epileptic League who kicked some doors down and gave "our efforts the status they deserved".

Mrs Sarah Sibanyoni

Community builder

Mrs Sarah Sibanyoni and Mrs Dorothy Zikalala are finalists in the *Sowetan*/CCV Community Builder of the Year Award. They can be seen again on two CCV programmes tonight - on New Times at 6.30pm and on Ntome Tsebe at 8.30pm.

Name: Dorothy Zikalala
Age: 65
Family: Widow, mother of four
Occupation: Pensioner
Motivation: "People think epilepsy is infectious or it is witchcraft or the victims are mad. Sesho has to change that view."

Testing for diabetes . . . Johannesburg branch chairman Verle Smit tests a volunteer's blood.
Picture: Gary Bernard

Bid to boost diabetes association

299 STAR 21/9/92

By Paula Fray
Medical Reporter

Greater Johannesburg diabetics have injected new life into the local branch of the South African Diabetes Association (Sada) in a renewed bid for the body to gain a higher profile in society.

Sada national executive Josina Barnes said yesterday that it had to create public awareness and educate diabetics.

She said there were between 500 000 and a million diagnosed diabetics in South Africa.

Johannesburg Sada chairman Verle Smit said the branch had been quiet for nine months with little interest and participation. But an offer of assistance by a drug company could strengthen the group.

There are about 12 Sada branches in South Africa — some of them run by volunteers, said Mrs Barnes.

Among the suggestions the regional branch will look at is a call to negotiate lower costs for insulin for members.

Other suggestions include a discount card for members and a supportive social club. Members will also be informed of facilities available, including a counselling toll-free line. The number is 0800-121-555.

Local diabetics who are interested can call Mrs Smit for more information at (011) 462-3223.

What Prosa stands for

299

STAR 31/9/92

The Patients' Rights Organisation of South Africa (Prosa) is a lobbying group with three major demands:

- For patients to be given duplicates of their records at the times they are recorded; this will help should the doctor be taken to the South African Medical and Dental Council or to the courts for any complaint. "At the moment, patients have no leg to stand on when they make a complaint to the SAMDC," says Mary Fanner.
- For it to be mandatory for doctors to tell patients of treatment risks.
- For the scrapping of the ethical referral system from statute books so that patients can see a doctor of their choice.

Prosa does not act for individuals, or give medical advice. It does not act as an agent for suppliers of services, and does not refer members to individual lawyers.

- For more information, send a self-addressed envelope to Prosa, Box 3699, Pretoria 0001.

Health
TRENDS

MAMA'S SNEEZE:

The gene responsible for asthma, hay fever and other allergy-type illnesses is active only when inherited from the mother, UK researchers say. — The Independent.

BRIGHTER NIGHT:

Therapy can help different types of nightmare: Those that threaten one's survival or security and those that attack self-esteem, such as failing an examination. — The Independent.

Patients are pulling their weight

STAR 3/9/92 (299)

LIKE TOPSY IT GROWED
Mary Fanner (above) had no idea what she was letting herself in for when she called for an organisation to represent the rights of patients, reports **PAULA FRAY.**

MARY Fanner's telephone started ringing non-stop within hours of her dream of a patients' rights organisation being announced. Today, her telephone has been delisted to give her time to get on with the job.

What started out as an isolated call a year ago was soon joined by the voices of hundreds of South Africans who wanted to be heard. More than 400 people have put their complaints on paper or called her.

These include:

- A man who had an eye operation — and whose vision subsequently deteriotated so that he could no longer work. He has been to 25 doctors to get expert testimony to prove his case. All refused. So far, he has spent R50 000 on costs.
- A 52-year-old woman who died after her colon was perforated during an examination of her intestines. The family could not get medical reports.
- A man whose father had cancer and who saw six doctors who said he had six weeks to go. One doctor suggested an operation to remove the liver at a cost of R25 000.
- A man who had neck operation and ended up with paralysed arms and legs. A subsequent specialist report said the operation was "still in the process of refinement".

The groundswell of support for a body which promoted patients' rights has changed Mrs Fanner's one-woman crusade into a fully fledged organisation which has already made representations to the Parliamentary Committee on Health.

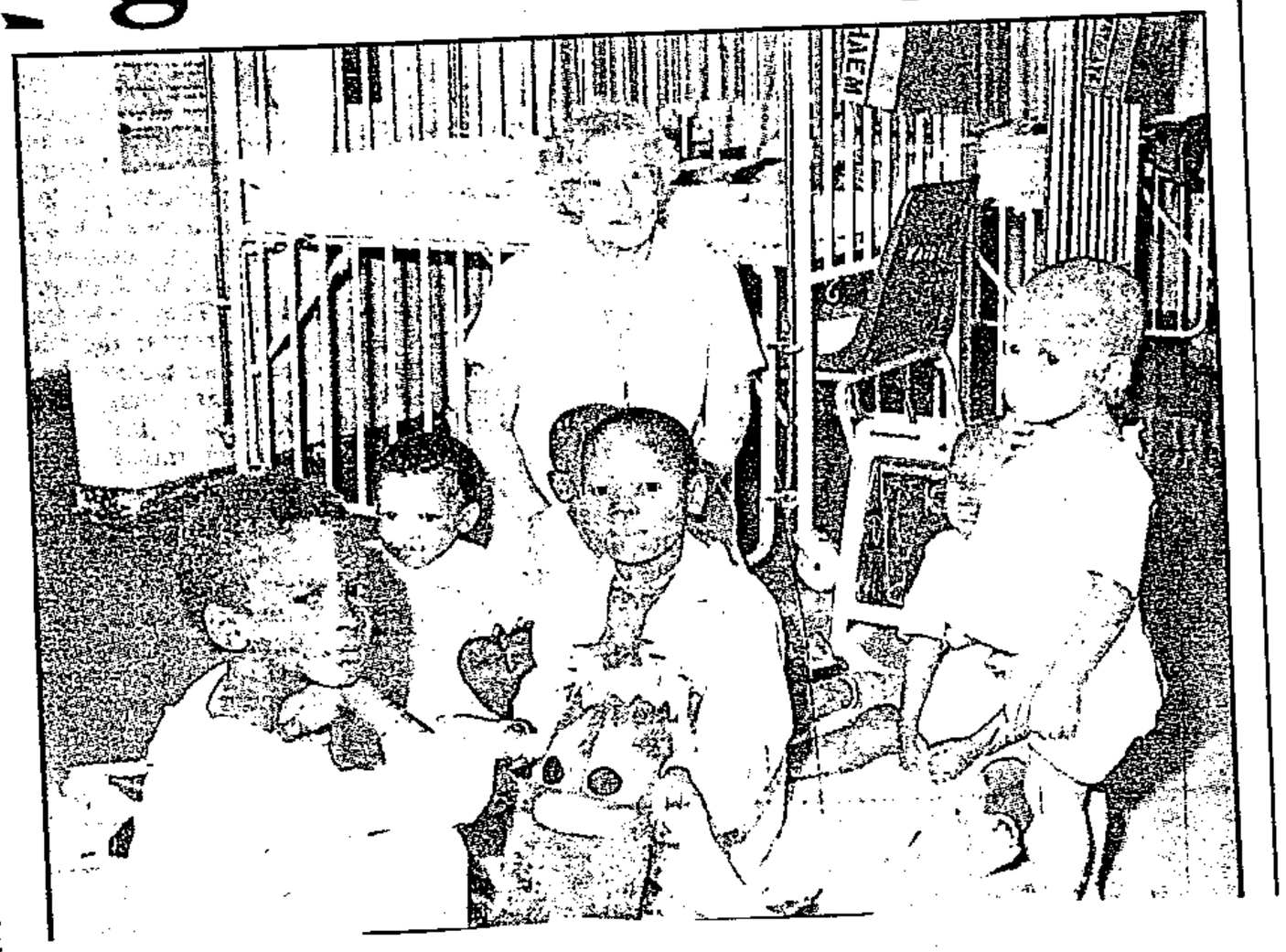
Today, the Patients Rights Organisation of South Africa is spearheaded by an eight-person committee and is finalising its declaration of rights; despite deliberately delaying its membership drive until there was suitable infrastructure, the organisation already has members signed up.

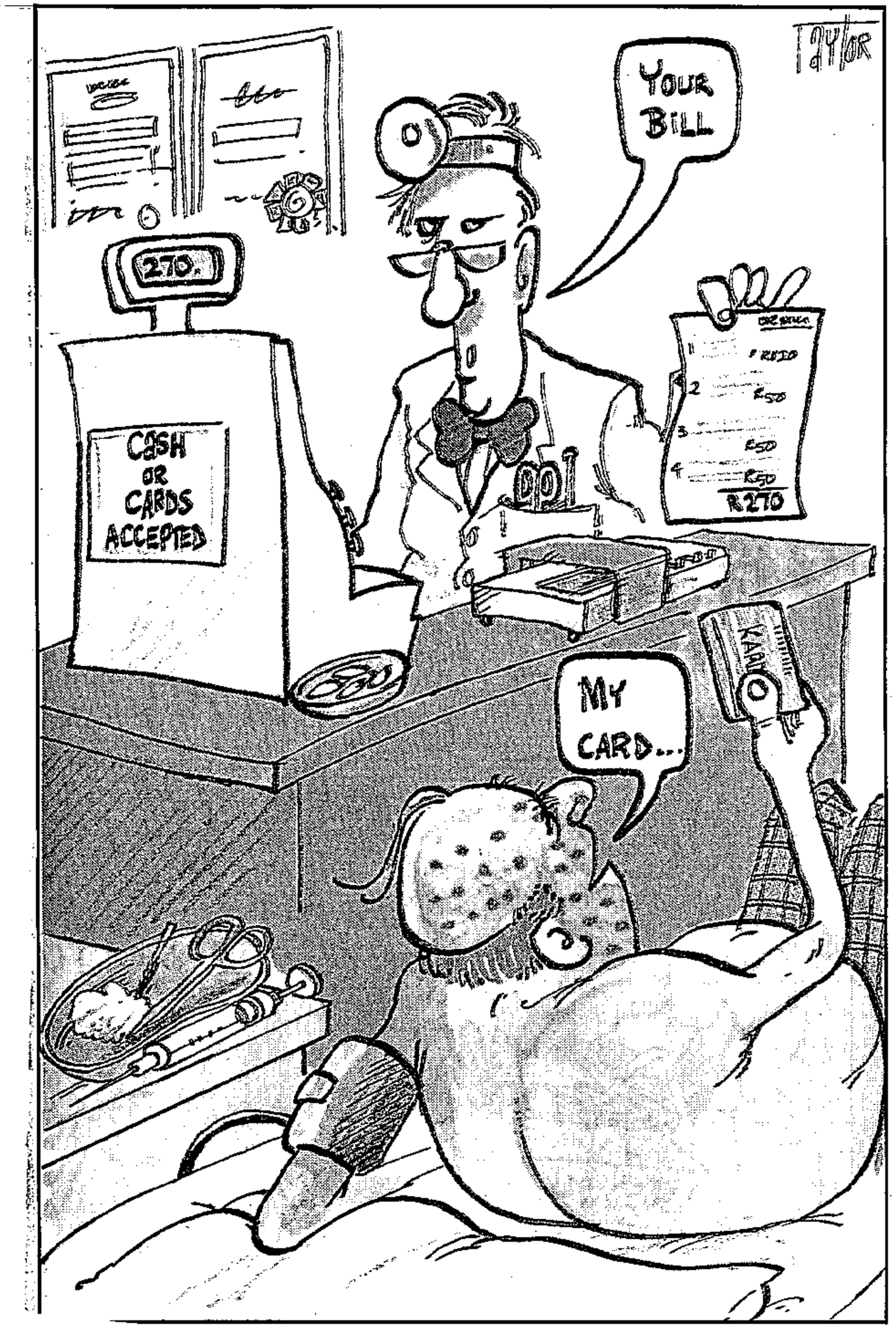
Mrs Fanner heads the organisation as chairman; its executive committee boasts a lawyer, an accountant, business people and housewives.

Redress

The group is investigating the best ways of redress for patients and says that for damages claims, patients must not go to the South African Medical and Dental Council or to any of the professional associations "which exist solely to protect their own members".

If Prosa can achieve its demands (see box), then perhaps "the playing fields will be a bit more level", says Mrs Fanner.





Benefits abound in new medicare plan

STAR 5/9/92. (299)

A GROUP of enterprising doctors, with the backing of an insurance consortium, has created a health care option, writes LEIGH HASSALL.

IF YOUR family is in good health and submits few medical claims, or if you are disenchanted with the current medical aid scenario, you may be a candidate for the new strain of medical care schemes on the market.

A group of enterprising doctors, with the backing of a consortium of insurance groups, has created the Botshelo Health Care System (BHC).

The scheme has two major thrusts: firstly, a savings account from which the member is responsible for his day-to-day medical bills and, secondly, a comprehensive insurance plan.

The member's savings account is financed by monthly contributions which are split between himself and his employer. Tax-free interest is earned on the daily balance of the account, currently about 15 percent.

In a properly structured salary package the member's contributions can be tax-free and the company's contribution can be tax-deductible.

An aspect of the scheme which will suit the medical fraternity is the quick and guaranteed payment to the service provider.

Each member is given a smart-card which holds the latest balance in his savings account. At the doctor's rooms the member swipes his card through the reader, immediately transferring payment into the doctor's account.

BHC says the benefit to members is that they can make use of the cash discounts offered by most doctors.

A notable aspect of the scheme is that members can reduce their monthly contributions to the savings account once the balance has reached an adequate level.

The second major thrust of the BHC system is an insurance plan which allows members to choose the type and extent of cover they require. The minimum cover includes major medical expenses and a daily hospital allowance.

BHC aims at cost containment through a predetermined lump-sum payout for each type of hospital admission. The payouts are based on Masa rates and on private hospital fees.

The excesses on hospital visits are competitive, with an illness excess at R2 500 and an accident excess at R500.

An often-quoted statistic is that 78 percent of all hospital admissions are for three days or less. For minor hospital admissions the illness excess of R2 500 may be a high proportion of the total bill.

BHC is currently negotiating with the underwriters for a separate additional insurance option to cover short hospital stays.

The insurance cover ceases at age 70, so members are advised to provide for this in a long-term savings plan offered through BHC.

For those who are prepared to bear the risk of financing their day-to-day medical bills, the new strain of medical care may prove a more favourable alternative.

ART OF HOPE . . . this large canvas was painted by Abri Day Centre members supervisor Nophumzile Zihlangu, Mike Walliss, Trevor Castleman, John Koukoullis, Hennie Muller, Carel Kruger and Bobby Diderick
Pictures: JACK LESTRADE

Centre brings hope to the mentally ill

S/Time [Cape Metro] 6/9/92 (299)

By DIANA STREAK

A PAINT-splashed room has become the focus of a recreation centre for people with chronic mental illness which opened in Observatory yesterday, providing much-needed companionship and support.

The Abri art, craft and recreation centre is part of a move to accommodate and give meaningful occupation to people suffering from mental illness, like schizophrenia and bipolar dysfunction, who might otherwise be on the streets.

Mrs Kim Elias of Abri Foundation, which provides accommodation for 12 people in two houses, said the centre was open to anybody with a mental illness. "People who come here have nowhere else to go."

So far the day centre has about 30 members and provides classes in art, pottery, stained glass and music. Badminton, table tennis and snooker are available.

Mrs Elias said she was positive and excited about the centre, where the activities provided therapy for members. "In the study of psychiatry no art or music therapy is included. I would love our centre to be the place where they could come to learn."

She said the medical profession had shown a keen interest in progress at Abri, which means shelter in French, but funding was needed for materials.

Art teacher Mimmie Pienaar said classes increased the members' confidence, particularly in their creative ability. "They have very few things with which to build their confidence so it's very important."

Hennie, 44, who has been in and out of Stikland Hospital 16 times, has lived at the Abri house for five years and said it was the happiest place he has ever lived in. He had been on the streets for several years, jobless and rejected by his family who did not understand his illness.

Callie, 59, said he had been a president's patient for 20 years, always in an institution without a home to go to.

Love

In 1987 he met Mrs Elias and joined Abri. "I get the feeling my family don't want to see me and I don't want to go where I'm not welcome."

Callie said he felt part of a family at Abri. "I'm so happy here. Ive even got a girlfriend."

Abri is looking for a drama teacher to take classes once a week.

Minah, 34, would also love to do drama and while she is waiting for a disability grant she works as a domestic.

Ros, 52, a qualified librarian, lives alone in a flat in Rondebosch. "Abri has meant such a lot to me. It's the highlight of my week."

● The Abri Day Centre is at the Methodist Church Hall, corner Wesley and Milton Roads, Observatory.

Home facility closing

STAR 8/9/92

By Abdul Milazi

The Avril Elizabeth Home for the Mentally Handicapped in Fishers Hill, Germiston, will temporarily close its day-care facility this month due to a drop in public donations, Avril Elizabeth Home executive director John Rees has disclosed.

"Public donations have decreased because of the serious economic circumstances. At present the families for whom we have been catering are unable to sustain a significant increase in the amount charged. The only option we have is to close the day-care centre," he said.

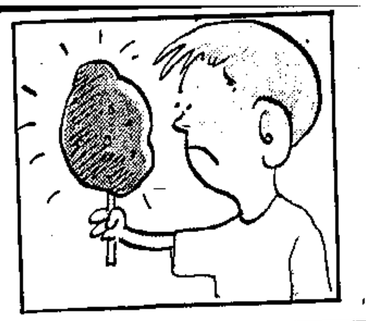
However the home will continue to care for the 120 persons in residential facilities.

The day-care centre, which is currently caring for 14 people, will be closed until funding is available.

Mr Rees said the Government contributed a quarter of the administrative budget which made the home depend on public donations.

Consumer
TRENDS

FIZZY FRAUD:
Consumer watchdogs in Britain have uncovered a racket deceiving many pub and club owners. Bar managers are selling cheap colas from taps marked Pepsi and Coca-Cola. — The Independent.



POTATO SWEETS:
Low-cal lollipops made i
on the way. German sci
"sweet potatoes" by ai
the plant so that it cont
of starch. — The Indep

YOU can help your medical aid keep a clean health bill

STAR 8/9/92 (299)

UNHEALTHY PRACTICE
Treating your medical aid like a blank cheque might seem like a good idea, but in the end you sign the cheques as healthcare costs go up, and up, and up . . . reports **PAULA FRAY.**

IF you subscribe to a medical aid, you probably feel like a punch-bag from inflation's regular knock-out blows. Subscribers often believe that costs have been inflated way beyond their control, but they have not.

Medical aid members, like doctors, specialists, hospital administrators and medical aids, can help reverse the spiralling health-care cost trend.

Healthcare costs have risen faster than inflation in most countries, and South Africa is no exception. While medical aid administrators debate the true extent of over-use and fraud in the industry, experts agree the two activities raise costs, and if curbed can benefit the subscriber in the long run.

The over-use of medical aid schemes was highlighted recently when the Affiliated Medical Administrators' (AMA) cost-containment unit released "horrifying" results. During the past two years, police and fraud squad have helped fi nalise 98 cases; another 110 are being investigated.

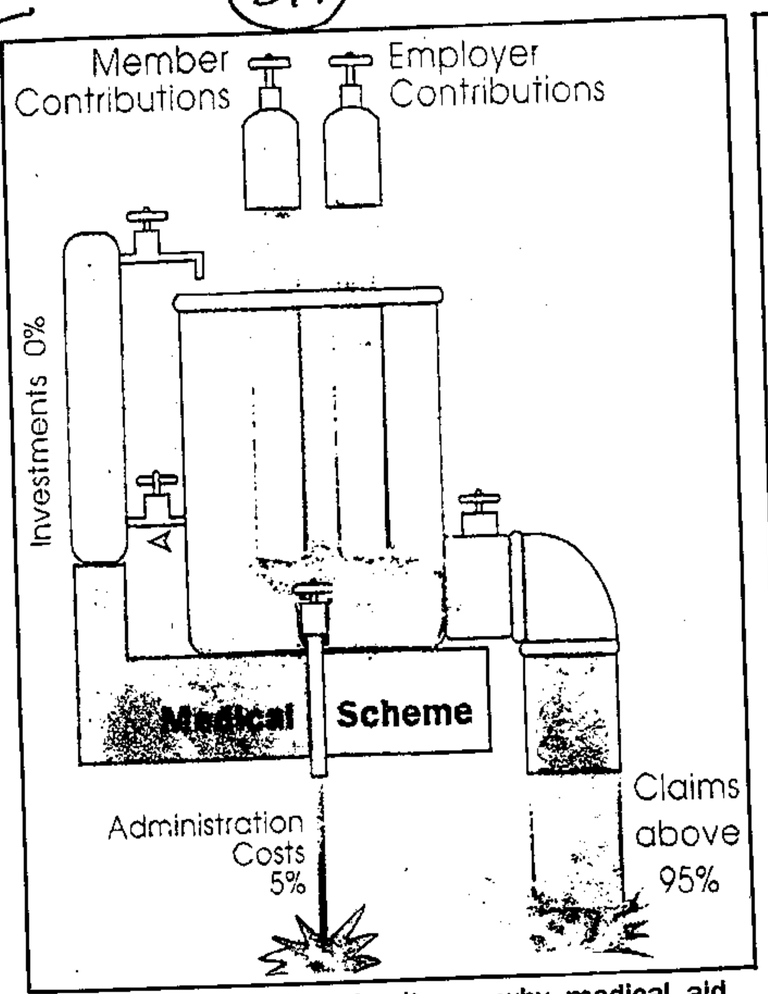
AMA CEO Timothy Gelman says about 25 percent of medical aid payouts can be attributed to fraud, abuse and over-use — about R1 billion of an estimated R4 billion annual national medical payout.

Medicaid MD Jeff Slome disagrees: "Any figure is a guestimate; I would put it at between seven and 10 percent.

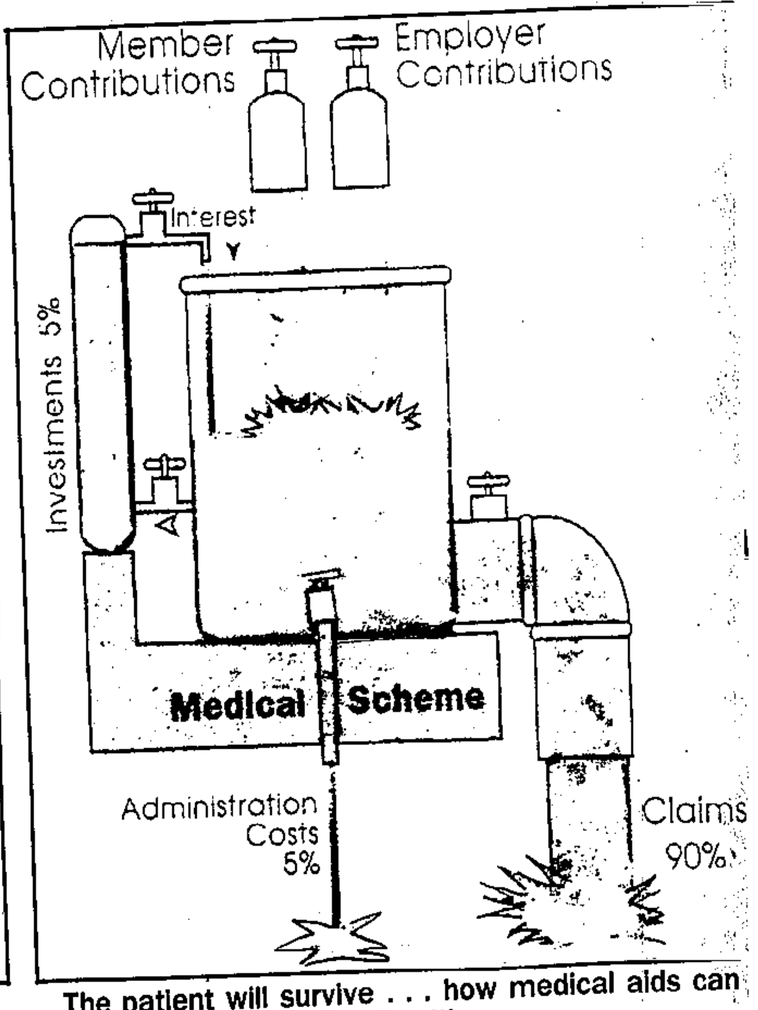
"People must understand that there is no free lunch. Members are the medical aid. Increased payments come back to members and their employers."

Subscribers are now being educated on how to cut down on overuse. Medical aids are also restructuring benefits to discourage the willy-nilly use of services, says Mr Slome.

Alleged abuse and overuse of medical scheme benefits impact directly on efforts to make private services more accessible and affordable, says Dr Hendrik Hanekom, secretary general of the Medical Association of South Africa (Masa). These reports are of "great concern" to Masa, he says, as about 80 percent of South Africans are still not catered for by means of health care assurance.



The patient won't make it . . . why medical aid taps run dry.



The patient will survive . . . how medical aids can stay healthy.

AMA marketing director Ray Welham says fraud and overuse is often not premeditated, and can be due to lack of understanding.

People feel that medical aids should be used to justify monthly contributions.

But schemes operate according to short-term insurance principles. The money in the fund is accumulated from contributions made by the members and paid out, in accordance with legislated tariffs and rules.

Formulae for setting contribution levels are based on past performance, cost and fee increases and claims trends data coupled with future utilisation. Schemes aim to keep a set amount of money — usually 25 percent of annual contributions — in an "accumulated fund" used as a buffer, should claims exceed monies available.

If this happens, contribution levels must be reset to cope with the shortfall and balance the books. If a scheme experiences repeated losses which it cannot recoup, bankruptcy results.

"The more claims paid out by a medical scheme, the more likely the contribution levels are to increase," says Mr Welham.

Healthcare services are ordered the practitioner and not usually the tient, says NCB Medical Aid MD chard Rowe.

Also, the pursuit of diagnostic tainty beyond clinical usefulness cascading effect, leading to more sive and expensive tests. It has said that the general practitioner sho assume the role of the gatekeeper.

Culture too, says Mr Rowe, plays part in demands made on the healthc industry as the public is constant being exhorted to seek medical adv for every minor ailment.

How costs are pushed up . . .

STAR 8/9/92 (299)

How are medical aid costs pushed up? Medscheme names some of the factors contributing to the abnormal medical inflation rate as follows:

- Increases in medical services fees.
- Increase in number of providers of health care.
- Increase in specialists and decrease in general practitioners.
- Little competition on price among health providers.
- Demand for ever-increasing quality of health care.
- Increase in medicine prices.
- Increase in sophistication and cost of medical technology.
- The cost of earlier diagnosis and diseases.
- New diseases such as Aids and "yuppie flu".
- Increased incidence rate in existing diseases such as mental disorders.
- Unhealthy lifestyles such as smoking, stress, lack of excercise and alcohol and drug abuse.
- Environmental pollution.
- Ageing population.
- Little or bad health planning.
- Fraud and abuse.

When these factors are combined with continuous over-use, says Medscheme, medical aid funds are drained.

. . . how to help bring them down

STAR 8/9/92 (299)

So, how can members help cut costs?

- Cut down on over-use; check whether a visit to the doctor is necessary; be aware that your initial consultation sometimes leads to unnecessary referrals and exploratory procedures.
- Communicate with your doctor as you would with anyone else doing a service for which you are paying; exercise your right to know.
- Ask your doctor, in advance, about fees and cash discounts for prompt payment.
- Use the "generic option" for medication. Generics are available for many expensive drugs and medicines; it is acceptable to ask for a generic replacement.
- Manage your medical aid as you would your insurance. Check details on accounts before submitting them.
- Become aware of what constitutes fraud. "Lending" your medical aid card to someone is effectively theft from your fund.
- If you can, shop around for medical aid products and packages that suit your requirements.
- Check and sign all accounts received from suppliers of services, as administrative errors can easily lead to overcharging.
- Accept more responsibility for your health — and the way prices are rocketing — and stop regarding medical aid as an open cheque book.

Medikon collapse: Members must pay

(299) ARG 9/9/92

VENNESSA SCHOLTZ and ANDREA WEISS
Staff Reporters

SEVERAL hundred Cape Town people will have to pay their own medical bills following the provisional liquidation of the Medikon Medical Scheme.

Provisional liquidator Mr Charl Stander, of Bloemfontein, said the scheme had about 3 500 members countrywide, many of them in Cape Town.

Plumstead jeweller Mr Fred Gilissen said he was liable for R6 000 in bills following the collapse of the scheme.

He said there had been no indication or warning that Medikon was in financial difficulties.

"My wife had a major operation in March and I became suspicious when the bills had not been paid by the end of April. I called the scheme and they told me their new computers were causing hassles. When I called in the middle of August, I was told the company had cash-flow problems, but it would come right soon," said Mr Gilissen.

He said he had no option but to pay the bills himself.

His biggest problem was to join another medical aid scheme because he was turning 50 in four months.

Mr Stander said scale of benefit bills submitted directly by doctors and hospitals would probably be settled.

But members were classed as deferred creditors, who would have their bills evaluated only when all other creditors had been paid.

Reimbursement for bills outside of the scale of benefits would have to be claimed by members, but it seemed unlikely they could be settled given the available funds.

Mr Stander said it looked as if some of Medikon's clients would be sequestrated because of large bills they could not afford to pay.

Medical schemes woes 'temporary'

299 CT 10/9/92

Staff Reporter

A NUMBER of South Africa's medical aid and benefit schemes are suffering trading losses but there is no need to fear a rush of insolvencies, the Registrar of Medical Schemes, Mr Danie Kolver, announced yesterday.

He said it would be "unjust" to name the schemes because he believed their difficulties were only temporary.

The announcement follows the provisional liquidation of the Medikon Medical Scheme which has left about 3 500 members in the lurch.

Mr Fred Gilissen of Plumstead has had to raise R6 000 to pay for his wife's recent operation.

Medikor registered a trading loss at the end of its first year in operation and Mr Kolver felt he had "no choice" but to apply for liquidation.

It is the first time since 1967 that a medical scheme has had to be liquidated involuntarily.

umbrella, professional conduct would be judged strictly on an individual basis.

Practitioners were expected to benefit

council believed any abuse of the system would be reported to the council, and that medical aid schemes would be alert to the potential for unnecessary use of funds.

Call for shift to primary health care

BIDAY 14/9/92 (299)

KATHRYN STRACHAN

SA COULD not afford the existing health care structure, and only a shift towards primary care channelled through local authorities could provide an affordable system.

Speaking at a seminar in Johannesburg last week, National Health director-general Dr Coen Slabber reiterated the critical state of health services.

He said SA, like many developing countries, was faced with a population which had an "unacceptable health status" and limited access to health services.

This was compounded by the deepening recession, unemployment, poverty and political unrest.

The emphasis should therefore shift from the purely curative in hospitals to primary health care through local authorities, Slabber said.

The transfer of functions and responsibilities to local authorities would simultaneously lead to a devolution of resources such as manpower and facilities — but would not mean that government would scale down its financial responsibility.

Slabber said local authorities would have to find alternative sources of income and initiate cost effective practices.

This could include selling or letting redundant facilities, or entering into contracts with major employers to render primary health services to their workforce.

More than R15bn was spent annually on health services in SA. Approximately 55% of this amount was spent by the public sector and 45% by the private sector, Slabber said.

This annual expenditure was about 6,4% of the GNP — which meant that SA had already exceeded the target of the World Health Organisation of 5% for the year 2000.

SA spent 11% of its total budget in the public sector on health. The payment by medical schemes to beneficiaries increased by an average of 27,2% a year while the number of beneficiaries increased by only 3,3% a year.

Added to this was the low economic growth rate combined with a population growth rate of 2,3%.

"It takes no economic genius to realise that the health allocation will not increase dramatically in the foreseeable future. In terms of economic constraints, we have to look at efficiency and affordability," said Slabber.

Agencies cutback development loans

CT 14/9/92

Own Correspondent

JOHANNESBURG. — SA's leading development agencies have all cut back on loans recently.

The Small Business Development Corporation (SBDC) has already reduced loans to small and medium-sized entrepreneurs by 20% and predicts that a further 20% cut could be in the pipeline if the organisation does not find new funding.

The Development Bank of Southern Africa's recent annual report shows that only R759m of a budgeted R932m was disbursed in the last financial year.

And an Industrial Development Corporation (IDC) spokesman confirmed that in the past three months industrial funding allocations had dropped for the first time in several years.

The cutbacks are the result of the current recession and various other factors. But the agencies said they are well placed to help lead an upswing if political and other conditions are met.

The SBDC's cutbacks relate to a reduction in State capital funding to the SBDC from R100m to less than R8m.

SBDC accounting GM Tertia van der Merwe said negotiations are being held with various parties but as yet no major new funding have become available.

Meanwhile, applications for loans are expected to grow by 30% this year.

The DBSA's Nic Christodoulou said the reduction in disbursements was the result of a complex set of factors, including poor economic conditions, lack of clear community support for projects and low institutional capacity.

Although there had been a lower flow of funds in the past financial year, the outlook was positive with "a lot of people coming to agreement" on projects.

There had also been a positive shift in priorities as well as a move towards sounder planning.

"There is a growing consensus that in a new SA we will have to live within our means and highlight the need to spend in productive areas with more prudent spending in the consumption areas," he said.

It was hoped the DBSA would disburse at least R850m this year.

IDC GM Malcolm MacDonald said up until May this year the IDC had granted industrial financing worth about R1,2bn — slightly up on previous years. Since June, however, the moving average had been lower.

In July the IDC dropped its interest rates to stimulate capital investment, but the effects of this move could not yet be determined.

One positive development was the IDC's recently launched funding for ecotourism. Applications for funding of about R170m were being investigated, while R30m had already been approved.

Major projects collectively worth several billions were in the final stages of being approved and would have a stimulatory effect when they came on stream.

14/9/92 (299) Arg.

Pensioners' medical ai

Woman's life savings gone

ANDREA WEISS
Health Reporter

PENSIONERS have been warned to take the utmost care before submitting to medical treatment in private hospitals which could see them having to pay out their life's savings for one operation.

This warning comes from the Association for Retired Persons and Pensioners (ARP & P) after a complaint by a railways pensioner that his 85-year-old father was liable for R3 227 in medical bills.

Mr Charles Roberts of Rondebosch said his father, on a pension of about R800 a month, was liable for 25 percent of bills after his 80-year-old mother had to have a hernia operation at Vincent Palotti Hospital.

He said Transmed, the medical aid, stipulated that railway patients should use this hospital — and, since the operation, she has been sent 62 bills from one doctor alone.

His mother now has had to have a second operation while the family is still struggling to pay off what they owe on the original bills.

Transmed confirmed that members, including pensioners, were liable for 25 percent on certain medical services.

"The primary reason for introducing this policy is to make all members more cost aware."

Transmed also said pensioners and widows had been made aware of "existing channels which they use should they require financial assistance".

Mrs Kay Altman of ARP & P warned pensioners to exercise utmost caution before agreeing to treatment:

● She said pensioners should ensure they were fully familiar with what their medical aid was prepared to pay for treatment;

● They should resist being sent to private hospitals, especially if the medical aid was not prepared to pay the full costs of surgery. Pensioners should find out what the costs would be and decide if they could afford the procedure. State hospitals did accept a certain number of private patients, she pointed out;

● Pensioners should negotiate for waivers to fees or discounts from doctors and hospitals if they were financially hard-pressed;

● In cases where pensioners had exhausted their medicine allowances, they could get medicine from state institutions if they had a letter of proof from their own medical aids;

● Before agreeing to major surgery, pensioners should get second opinions;

● They should also find out what their medical aid would refund on ambulance services and avoid using "very, expensive" private ambulance services. If it was at all possible, they should make sure they were taken to hospital only by provincial ambulances. One example of private ambulance fees was of a person being charged R400 from Wynberg to Constantiaberg Hospital, said Mrs Altman;

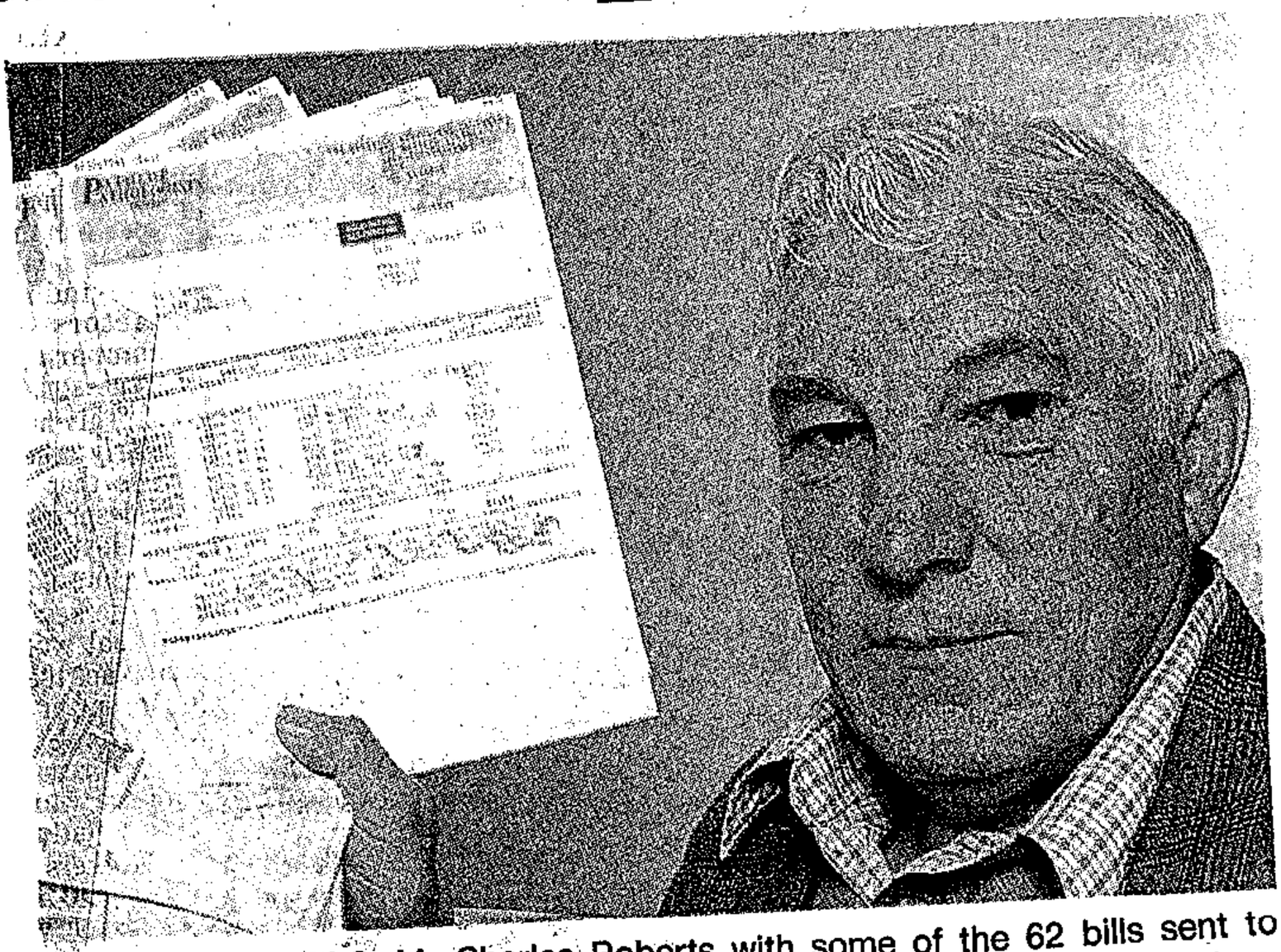
● Pensioners also should scrutinise accounts carefully to make sure they were not being over-charged. One of the association's members was charged for 31 days' hospitalisation in February. The woman, who was not on medical aid, had to pay out R25 000 before she was discharged. She drew everything she had in her building society and her daughter had to make up the shortfall;

● Mrs Altman advised pensioners not to be pushed around by their doctors. If a surgeon indicated he or she would only operate at a particular hospital, the patient should opt for another doctor. She said it was common knowledge that many doctors had vested interests in these concerns; and

● She also said pensioners should be aware that if they abused their medical aids, they pushed up the ultimate costs. They should resist seeing their doctors too often and also stop their doctors from over-prescribing drugs. Wherever possible, they should ask doctors to prescribe cheaper, generic

warned of ls and pitfalls

(299)
ARG 14/9/92



SHOWER OF BILLS: Mr Charles Roberts with some of the 62 bills sent to his mother after an operation.

Picture: ANDREW INGRAM, The Argus.

Bisho's mourners plan huge stayaway

BIDMy 18/9/92

HUNDREDS of thousands of workers are expected to stay away from work in the eastern Cape and Border regions today as preparations for the funeral of 28 ANC supporters killed in Bisho last week got under way.

And in a security clampdown, government yesterday declared five more unrest areas in the eastern Cape, bringing to 10 the number of unrest areas declared in the regior in the past month.

Scores of SA Police and soldiers took up positions on both sides of the Ciskei border yesterday as the ANC began its two days of mourning. Fifteen of the 29 victims — 28 ANC supporters and one Ciskei soldier — are scheduled to be buried in the King William's Town cemetery at 10am today.

The funeral will be attended by World Council of Churches secretary-general Emilio Castro, UN monitors and Border-Ciskei regional dispute resolution committee members.

UN special representative Virenda Dayal, who will also attend the funeral, met Foreign Minister Pik Botha in Pretoria yesterday. After the talks, Botha said Dayal would act as catalyst in the process to eradicate violence.

Sapa reports that the five districts declared unrest areas in a special Government Gazette published yesterday are Cradock, Fort Beaufort, Grahamstown, Port Elizabeth and Uitenhage, all of which are on the western side of Ciskei.

On September 5, just prior to the Bisho massacre, King William's Town, Cathcart, Queenstown, Stutterheim and East London, all on the eastern side of Ciskei, were proclaimed unrest areas.

The ANC yesterday slammed the latest move, saying it was insensitive.

"Law and Order Minister Hernus Kriel has taken these steps despite the fact that, in the days following the tragic massacre in Bisho, tens of thousands of people participated in peaceful and disciplined marches, rallies and vigils without incident," the organisation said in a statement.

Business Day Reporters

LINDA ENSOR reports that Cape Town Chamber of Commerce yesterday appealed to its members to consider sympathetically requests by workers for time off to attend commemoration meetings.

Meanwhile, Sapa reports from Sebokeng in the southern Transvaal that Bavumile Vilakazi, deputy secretary general of the ANC's PWV region and a former Delmas treason trialist, was seriously wounded when gunmen armed with AK-47s shot him outside a hardware shop in the township.

Vilakazi was in the Sebokeng Hospital and police were investigating, police spokesman Capt van Burger Rooyen said.

□ At least five people, one of the them a policeman, died violently in unrest-related incidents on Wednesday.

A police report issued yesterday said the bodies of four men were found by police at the Mandela Park squatter camp in Katlehong. They had been shot.

At Tembisa, Kempton Park, a number of shots were fired by unidentified gunmen at a police vehicle, killing a policeman and seriously wounding another.

The names of those killed have not yet been released.

□ SA Institute of Race Releations executive director John Kane-Berman told the Pietersburg Chamber of Commerce yesterday that one of the main reasons for violence in SA was the ANC's strategy to make the country ungovernable, Sapa reports.

Kane-Berman was reported by SABC radio news as saying '80s ANC strategy for a people's war focused on government but it was also a declaration of war against sections of the black community and that this had provoked a backlash.

ANC may raise excise duties

(299)

CAPE TOWN — The ANC health department was researching the possibility of increasing the excise duties on tobacco and alcohol products as a way of funding its strategy to provide health for all, ANC health department economist Di McIntyre said at a forum on the organisation's health policy yesterday.

LINDA ENSOR

McIntyre is the co-ordinator of the subcommission on the future of health financing policy. BIDMy 18/9/92.

She said that the use and abuse of tobacco and alcohol placed a big burden on the health system yet SA's excise of 30% was very low compared, for example, with the UK's 75%. A higher excise would enable government to inject funds into building up the primary health care system.

The heavy demands placed on a future government made it unlikely that more than the present 11% of GNP would be allocated for health services. This meant other sources of income would have to be found.

Another form of financing being debated was a national health insurance system which would require employed workers in the formal sector to contribute to a health fund for basic health services. McIntyre said research was necessary to determine what funds would be required to provide a national health system and how much could be raised by an insurance scheme.

Also, McIntyre said, the more efficient use of existing resources and the elimination of waste, fragmentation and duplication would be an additional source of funds.

The predominance of the private health sector, especially its ability to draw the best health personnel into its ranks, would have to be addressed by creating the conditions and career structures to encourage people to return to the public sector.

ANC health department head Cheryl Carolus told the forum 58% of SA's doctors were in private practice and the private sector was allocated a disproportionate share of the health budget.

The privatisation of health care, she said had led to an emphasis on the private sector and thus to an overemphasis on curative medicine. There was a need to strengthen the public health sector and to refocus it towards primary health care and preventive medicine.

2 metro

Paraplegic in pension limbo

(299) Star 28/9/92

By Montshiwa Moroke

The Transvaal Provincial Administration has not paid a paraplegic man from Alexandra his disability grant for almost a year and has offered him no explanation.

Instead, he has had to repeatedly undergo medical examinations to renew his grant.

Joseph Makapan (55), a breadwinner and father of a teenage daughter, started receiving his disability pension in 1961 after he had become paralysed from the waist down from a knife attack.

His problems started in October last year when he went to the Alexandra Resource Centre to collect his monthly dues. He was told he could not receive the money unless he renewed his application.

"To do so I went to a doctor for medical examination. He referred me to a district surgeon who, after examining me, said I was entitled to receive the money.

"I submitted the completed forms from the doctors to TPA officials who said they would forward them to Pretoria. I was told to return in December but when I went there, the money was still not available," Mr Makapan said.

When in January the grant was still not forthcoming, he again went through the same motions of seeing the doctors and submitting the forms to the TPA.

Mr Makapan said he was advised to come back in April. He went back in April and again in June, to no avail. In July, officials in Alexandra said they would handle the matter themselves and told him to return this month.

Hard times . . . paraplegic Joseph Makapan earns a meagre living teaching basket weaving to the disabled and blind. His disability grant was suspended in October last year after he had been receiving it since 1961.

"I went on September 1 and it was the same old story again. I have to maintain my family. My wife is asthmatic and unemployed, and my daughter is at school. We are pulling hard to make ends meet," Mr Makapan said.

Meanwhile, he keeps the home fires burning through meagre earnings he gets by teaching basket weaving to the disabled and blind at the Alexandra Co-operative Workshop for the Disabled.

A spokesman for the TPA in Pretoria confirmed Mr Makapan's grant had been cut off since October 1991. He said: "When Mr Makapan originally applied for a grant in 1970 he was unable to present the clerk with documentary proof of his age. The clerk who handled his application estimated his date of birth as November 11 1905."

He said few births of black people were registered early in the century and officials often had to estimate the age of applicants.

"As a result of his Mr Makapan's new ID number, the allowance was cut off."

The spokesman said that in October last year a number of beneficiaries were informed that their grants had been suspended because their age disqualified them. These pensioners had been informed in writing that their identity numbers and birthdates differed.

"These grants will be reinstated as soon as documentary proof of age has been presented to the branch Community Development," the spokesman said.

Bloom 25/9/92

Migraines 'cost SA millions'

KATHRYN STRACHAN

MIGRAINES cost the SA economy more than R800m a year through lost productivity, yet the problem was largely ignored by researchers and doctors, a Glaxo Pharmaceuticals spokesman said recently.

Nick Wells, a British pharmaceutical expert who advises Glaxo on health economics, said on his visit to SA last week there was a tendency to focus only on the costs of illness to the health care system and to overlook the other costs involved. Bloom 25/9/92

"We need to look across the spectrum and understand the broader economic and personal costs involved. But people in health care have their budgetary contraints to consider rather than taking a comprehensive view," he said.

This included getting away from focusing only on the cost of treatment, to investigating its cost-effectiveness instead.

Although there was great emphasis on reducing the costs of medicines, Wells said it was not necessarily the best approach. Investing more in medicines, thereby increasing the price, could prove to be more cost-effective than other forms of treatment such as hospitalisation.

Migraines were a classic example of this bias, he said. Although it caused tremendous pain to sufferers and amounted to millions of rands in lost productivity, very little research had been done into the problem because its cost to the health care system was minimal.

Unlike migraines, illnesses such as flu could cause further complications if not treated, and could eventually result in expensive hospitalisation.

Glaxo MD Martin Jennings estimated that more than 10% of the population suffered from migraines.

In the land of the blind . . . no blacks allowed

South 26/9-30/9/92.

By Edwina Booysen (299)

A seven-year-old blind boy has been refused admission to a school for blind children — allegedly because he is black.

His specialist, Dr Ebrahim Bhettay, claims Pioneer School for the Blind in Worcester had been prepared to accept Vuyisani Nguza until they learnt he was black.

Bhettay, who has been treating Vuyisani for over a year, says the principal of Pioneer had been eager to admit Vuyisani and had referred him to the school social worker, Ms Lynne de Swart.

"She was just as eager, until she found out his race. She then said that Vuyisani could only be accepted if the parents of children currently at the school agreed to it," the physician said.

Pioneer's principal, Dr Johan van der Poel, refused to comment. He referred queries to De Swart, who denied Vuyisani had been refused admission because of his colour.

She said he could not be accepted because of his physical disability. Vuyisani has arthritis in his legs and began walking only a year ago.

"The bedrooms in the hostels all have to be reached by stairs and if the child cannot dimb stairs he cannot be accommodated," De Swart said.

She said many other children have had to be turned away for the same reason.

De Swart confirmed that parents would have to decide whether a black child could be accepted, but would not comment on whether there were any black pupils at the school.

In response, Vuyisani's physician said Pioneer had no idea at the time that Vuyisani had a walking disability.

"They did not see him, having dealt with me over the telephone and nothing was said about his inability to climb stairs," he said.

He said the boy has had to return to his home in Ciskei.

According to a Groote Schuur occupational therapist, the Khanyisa School in Port Elizabeth and the Efata School in Umtata had both been found to be unsuitable. Khanyisa had stairs which Vuyisani would have had to negotiate while Efata had no occupational therapist.

He had also been refused admission by the Athlone School for the Blind in Bellville South, according to Dr Bhettay.

But Athlone School principal Mr Benny Pizer said Vuyisani had not been accepted because he "did not meet the requirements set by the school's assessment team".

"We are not equipped to deal with a multi-handicapped person such as Vuyisani," he said.

According to the physician, however, Vuyisani was assessed again and this time passed the requirements. Athlone School then said there was no place at the school as he had not been placed on a waiting list.

Vuyisani has been travelling to Groote Schuur Hospital in Cape Town since he was six months old to receive treatment for his ailments, which include visual loss and arthritis.

He has had several operations on his eyes and after numerous corneal grafts he was declared practically blind.

The Groote Schuur occupational therapist, who assessed Vuyisani at the request of orthopaedists last year, said that due to frequent hospitalisation he had suffered developmental delay.

"He was very dependent and was often tearful and frightened," she said.

The Efata School has now agreed to assess Vuyisani for possible admission.

Probe slams medical aid schemes

BIDAY 28/9/92 (299)

KATHRYN STRACHAN

AN investigation commissioned by the Medical Association of SA (Masa) into health care expenditure between 1975 and 1991 has found that rocketing medical aid scheme fees were not justified by the increase in medical costs.

The report shows that, contrary to popular theories, South Africans are no greater pill swallowers now than they were 16 years ago. No evidence of over-prescribing of medicines by doctors was borne out by the study and inflation in medical services was below the national average, as expressed by the CPI, for most of the period.

The most worrying aspect identified by the report was what it called the "clear inability of medical schemes to keep their annual subscriptions to members in line with inflation in the health sector".

"Escalating membership fees, together with the recent imposition of VAT on medical services, are contributing to an intolerable health cost burden to the man on the street," the report said.

"There is a real danger that medical schemes are pricing themselves out of their existing markets and that consequently the health cost burden will shift to the state and the taxpayer."

A comparison of the growth of medical aid membership fees with the growth in

☐ To Page 2

Medical aid

BIDAY 28/9/92. (299)

☐ From Page 1

the cost of medicines and services showed membership fees should have been lower than those imposed on the public.

The result was that by 1991 membership fees were 95,6% higher than the CPI, while the cost of medicine was 31,8% higher and the cost of services was 13,4% higher.

The analysis suggested that neither health cost inflation nor increased usage or over-prescribing contributed to the rocketing membership fees. The proposed changes to the Medical Schemes Act would be inadequate to deal with underlying structural problems, it said.

During the 16-year period the state had progressively withdrawn its free and subsidised services, leaving the consumer to pay more. Private consumption expenditure on medicines and services increased to 5,15c in 1991 from 3,78c in 1975.

But the volume of pharmaceutical products consumed by the private sector, as a percentage of other real consumption expenditure, had remained virtually unchanged, killing the myth that SA had increasingly become a pill-popping nation.

The imposition of GST was not the only reason for medicine prices outpacing the CPI. A second factor was the depreciation of the rand and the high import content of medicines. A further cause was the state tender system for medicines. The study claimed the state purchased medicines from the suppliers at less than half the price the private sector paid.

Report hits at med schemes

CT 28/9/92 (299)

Own Correspondent

JOHANNESBURG. — An investigation commissioned by the Medical Association of SA (Masa) into health care expenditure between 1975 and 1991 has found that rocketing medical aid scheme fees were not justified by the increase in medical costs.

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The volume of pharmaceutical products consumed by the private sector had remained virtually unchanged, killing the myth that South Africa had increasingly become a pill-popping nation.

As well as the imposition of tax on medicines, the depreciation of the rand and the high import content of medicines, costs had been affected by the state tender system for medicines. The study claims the state paid less than half the price the private sector paid for medicines.

New name for body

THE National Cancer Association of South Africa will in future be known as the Cancer Association of South Africa. 299 65

The association will also have a new logo and corporate colour.

Making the announcement on Wednesday, Dr Tommie Liebenberg, executive director of the association, said the word "national" had been deleted from the association's name as it had become superfluous. Sowetan 1/10/92

"The term 'South Africa' already indicates the association serves the total population of South Africa and underpins its mission to fight cancer with the help of the South African community," he said. - *Sapa.*

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Note: The interim and full year results for 1991 have not been adjusted by the results of operations discontinued after the end of the year

Masa rejects study 'leaked' to media

BD DAY 2/10/92

KATHRYN GERACHAN

THE Medical Association of SA (Masa) has dissociated itself from a study it commissioned which claimed that medical aid scheme fees were not justified by actual health costs.

Masa health policy director Reg Magennis said yesterday the study, covered in a report in Business Day on Monday, was one of several commissioned to assist Masa in its representations to government to make health services VAT-free.

But the study was discarded because it was found to be incomplete and to contain "inconsistencies, unsubstantiated conclusions and conjecture".

The economist who compiled the report had died.

Magennis said official Masa figures did not support the view that medical scheme membership fees were not justified by the increase in health costs.

He said the study had apparently been made available to Business Day by third parties without the knowledge or consent of Masa. Masa would not have granted permission for its publication.

Business Day was sent the report by a company that owns private clinics.

R50-m boost to health care

Star 9/10/92

By Philip Zoio

The Department of National Health and Population Development yesterday unveiled a R50 million-a-year plan to improve primary health care (PHC) in South Africa.

The department's director-general, Dr Coen Slabber, told a press conference in Johannesburg that 151 clinics were being built around the country in a "concerted effort to expand our PHC services".

Although South Africa's hospital services were good, its health services were only average and significantly poorer than those of developed countries.

He said there was a marked difference in life expectancies and infant mortality rates between South Africa's population groups.

In the PHC programme, the department is to address the eight "critical" elements of PHC identified by the World Health Organisation.

These elements deal with nutrition, sanitation, disease control and family planning, and provision of information, medication and medical treatment.

NEWS SA lifestyle not conducive to longevity ● Organisations unite to ensure commuter safety

Beating chronic diseases

Sowetan 12/10/92

■ **New study shows South Africans are extremely vulnerable to deadly illnesses:**

By Mokgadi Pela

NEARLY a quarter of all deaths in 1988 were from chronic diseases like stroke, heart disease and cancer, according to the results of a newly released study.

Researchers at the Medical Research Council say the deaths resulted from tobacco smoking, an unhealthy diet and lack of exercise.

These habits can cause the development of conditions such as tobacco addiction, hypertension, heart disease, high blood cholesterol, obesity and diabetes.

299 84

Nearly half

The researchers found that nearly half the South African population must improve their lifestyles in order to reduce risk factors for chronic diseases.

The researchers tested five communittees totalling 10 000 people.

They found that 4,88 million South Africans, mostly black males, are smokers. Nearly five million South Africans have high cholesterol levels and carry the associated risk of heart disease while 5,5 million have high blood pressure.

news in brief

6 die in unrest

SIX people died and at least 10 were wounded in unrest-related incidents on Monday and early yesterday, police reported.

At Tokoza in Alberton gunmen firing from a vehicle killed four people and wounded seven.

In Alexandra on the Witwatersrand police found the bodies of a man and a woman. Both had been shot.

Gunmen opened fire on a man at Wembezi, Estcourt, seriously wounding him.

Explosives were detonated at homes in Ratanda, Heidelberg, and at Khuma, Stilfontein. There were no injuries in the Ratanda explosion but the blast at Khuma early yesterday injured two people.

2 Durban suicides

A POLICE constable shot and killed himself in his flat in Overport, Durban, on Monday night. Police said Constable TM Shangase (30) was found with a bullet wound to his head in a flat in South Road. Foul play is not suspected.

In another incident, Mr J Govender of Chatsworth was found hanging from a tree.

Cop shot four times

AN off-duty municipal policeman, Sergeant Robert Khatshelo (39), was shot and wounded on Monday night.

Soweto police liaison officer Lieutenant Eugene Henning said Khatshelo went to investigate a noise at a neighbour's house in Generator Street, Power Park, at about 7.40pm when he was confronted by three men, one with a firearm.

During an ensuing argument four shots were fired, wounding the policeman twice in the right arm and twice in the left leg.

The suspects fled on foot.

Khatshelo was admitted to the Garden City Clinic. His condition is stable.

Mental health care

THE South African Federation for Mental Health launched its public awareness campaign for October at a two-day conference in Johannesburg last week (Oct 6 and 7).

The conference, which focused on mentally handicapped children, resolved to reduce the incidence of mental handicap in children.

Driver dies in hijack

A TRUCK driver has been shot dead near Dundee in what police believe to be an attempted robbery and hijacking, SABC radio news reported yesterday.

Church discriminates against blacks, claim

■ **BLACKS EXPELLED**: 300 members bring accusations against church:

By Mandla Zibi

A GROUP of 300 people who were allegedly expelled from the Old Apostolic Church of Africa's Transvaal region have accused the church of discriminating against black members.

This was said at a Press briefing in Carletonville at which representatives of the fired members expressed their dissatisfaction about the church administration headed by Apostle JJ Boshoff.

The group's spokesman, Mr Theophilus Mahlatshana, said the church had promised to build creches, old people's homes, schools and other projects but only white members's needs had been met so far.

Mahlatshana claimed about 300 members had been expelled.

"For example, we have long been asking for an old people's home but only white church members have one in Johannesburg, and yet everyone of us contributes 10 percent of their monthly salary to the church," Mahlatshana said.

Another major grievance was that blacks were denied top positions in the church.

Measles attacks older kids

■ **Outbreak in Johannesburg also emphasises need for immunisation:**

By Mokgadi Pela

THE Department of Health has reiterated the importance of early immunisation against measles in the wake of recent outbreaks of the disease in Greater Johannesburg.

Dr Coen Slabber, director general of the department, said 40 cases were reported to the Johannesburg City Health Department in one week. This indicated a sharp increase in the incidence of the disease compared to the same period last year.

The Johannesburg outbreak came largely from high school pupils who were not immunised as children. According to Slabber, such outbreaks can only be prevented by the early immunisation of children and by maintaining vaccination levels.

Most children in South Africa received the measles vaccine but a small proportion did not develop immunity.

Sowetan 14/10/92

Mental health care

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The conference, which focused on mentally handicapped children, resolved to reduce the incidence of mental handicap in children.

This is how they should be treated

Human rights charter for hospitalised mental patients

Sowetan 15/10/92

299

The bill of rights provides that within five days of admission every patient shall receive written notice of the rights to which the patient is entitled.
If a patient has a crisis the period shall be extended to fifteen days. A signed copy of the receipt of this notice of patient's human rights is to be placed in the patient's medical record folder.
A mental patient has the right:

- **To a safe,** sanitary and humane living environment; three meals every day; water for a regular bath; a mattress and blanket; appropriate medication and professional attention; suitable clothing.
- **To be free** of unnecessary or excessive medication.
- **To be free** of physical repression.
- **To be free** from isolation, except if necessary - in that case it will be limited to 24 hours.
- **To receive** prompt and adequate treatment for any physical ailment.
- **To have** the opportunity to meet with physicians and other members of the treatment team.
- **To sue** for physical, moral or psychological abuse against the person who commits it.
- **To wear** own clothes.
- **To go** outdoors at regular and frequent intervals with authorisation.
- **To have** suitable opportunities for interaction with members of the opposite sex.
- **To practice** the religion of own choice.
- **To mail** and receive unopened correspondence. To have ready access to letter writing materials, including postage.
- **To have** access to a telephone, to make and receive confidential calls (long distance calls will be made at the patient's expense).
- **To education** if minor or illiterate.
- **To participate** in a rehabilitation programme.
- **To ask for** a review and /or revision of treatment plan if you don't agree with it.

Major changes in private care loom

(299) ARG 29/10/92

Health Reporter

THE Medical Schemes Amendment Bill will change the face of private health care should it be enacted in parliament.

Its main thrust is to deregulate a business which in the past has been strictly legislated.

Theoretically this will help medical aid schemes cut costs.

Costs should also be cut because schemes will be able to tailor themselves to suit their members' needs, although this could mean that some may get left by the wayside.

Free-marketeers have welcomed the Bill.

Detractors, such as the Medical Association of South Africa (Masa), are opposed to it in principle, saying restructuring should not take place before the entire health-care delivery system is sorted out.

Because the Bill gives medical schemes a free hand, it could drive some people towards State health care, Masa argues. This would be disastrous given that the system is overburdened.

Critics envisage the Bill giving the schemes monopolistic power which would allow them to refuse to pay for certain items.

Another aspect which would allow medical schemes to set up their own group practices, hospitals and pharmacies could restrict patients and remove freedom of choice.

The following are a few of the major changes the Bill proposes:

● The scale of benefits will no longer be published in the Government Gazette but the Representative Association of Medical Schemes (RAMS) will prepare a scale as a guide to interested parties.

● Guaranteed payment for certain services will be scrapped.

The rationale behind this is that in the past guaranteed payment has led to "serious malpractices by which the financial capacity of medical schemes is seriously jeopardised".

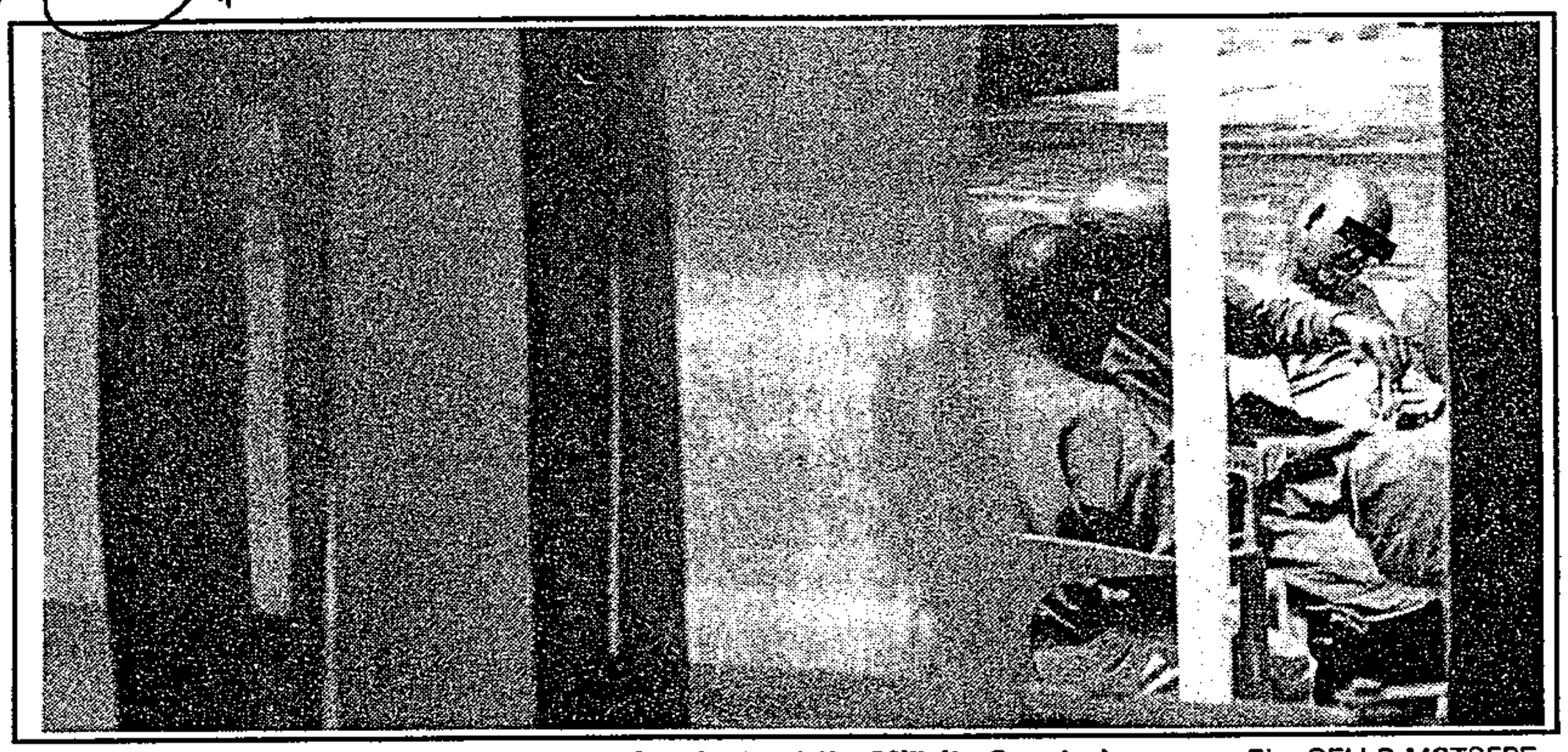
● Schemes will be allowed to provide for additional cover for their members through insurance. They will also be allowed to start their own pharmacies, hospitals, clinics, maternity homes, nursing homes, infirmaries, homes for the aged and similar institutions approved by the minister.

One flew over the cuckoo's nest

Sowetan 15/10/92. 299

■ SHOCK TREATMENT *The appalling conditions under which mental patients live:*

Exclusive by Investigations Reporter RUTH BHENGU



Room with a view ... a sneak picture taken of patients at the Millsite Sanatorium. Pic: SELLO MOTSEPE

WE ARE SITTING ON a bench in the grounds of Millsite Sanatorium: my sister, a family friend and I.

A tall, gaunt, barefooted man in a dirty brown uniform shuffles towards us.

Next to him walks a shorter man in a snow-white uniform.

The man in white uniform walks with confidence. He smiles as we exchange greetings. He is a nurse.

The man in the brown uniform - who barely looks up as we inquire after his health - is a patient.

> **"We struggle to hold back the tears as we watch him wolf down the food"**

The patient does not smile. His feet are calloused and he looks as if he has not had a bath for months. His hair is unkempt.

The dried-up grime on his legs and arms falls off in flakes as he walks.

We struggle to hold back the tears as we watch him wolf down the food we have brought for him. This is our younger brother, Vusi Elijah Bhengu. He is 35 years old.

He has been in and out of mental institutions since 1976. The doctors describe him as a chronic schizophrenic.

We notice there is something wrong with his right hand. It looks as if it has been scalded with water. The skin has bunched up into a grotesque pattern. The fingers are bandaged with plaster and two of them are welded together.

My composure is beginning to desert me. My sister has this perturbed look on her face. I ask my brother what happened. Without lifting his eyes from the ground he says it happened long ago and that he cannot remember the details.

I ask the nurse. He says he does not know what happened. He refers me to the sister in charge of Vusi's ward.

A week later I am back at the hospital, this time accompanied by colleagues. I request to see the sister in charge.

The sister in charge, who refuses to tell me her name, is defensive. She cannot understand why I am asking questions.

The fact that I also want to see the psychiatrist who attends to my brother unsettles her.

The matron who mans the front office assures me my request is reasonable. She says I can also see the physician if I am not satisfied with the sister's report.

Eventually the sister in charge promises to set up an appointment with the psychiatrist. She says she does not know what happened to my brother's hand because she was transferred to Ward Six only two days ago. She can check the medical records and see what happened. She asks me to phone her the next day.

When I phone the following day we are back to square one.

I have to explain who I am and what I want. Reluctantly she tells me the psychiatrist, Dr Hammer, will see me between 10.30 and 11am the next day.

> **"The patient does not smile. His feet are calloused and he looks as if he has not had a bath for months. His hair is unkempt"**

She tells me that maybe my brother was injured during a fight among patients. The physician who attended to him is Dr Gilles. He is on leave.

The following day I am there to see Hammer at the appointed time. This time I am accompanied by a photographer.

Hammer asks us to wait for him at section six of Ward Six.

We walk through the hospital grounds to the ward. Along the way we sneak pictures.

The sister in charge to whom I spoke the previous day is off. There is another sister in charge. She says my brother suffered a fracture while fighting with another patient. The skin on his hand looked as if it had been scalded because it had been bandaged.

I decide to shut my mouth and concentrate on the psychiatrist. After a chat with Hammer - who tells me he has only been at the sanatorium for two months - we leave.

A week later I meet the physician, Gilles. He shows me X-ray plates that show my brother's fingers were fractured. Gilles also does not know how it happened.

I still have no idea how my brother's hand was injured.

UP NEXT

TOMORROW we will take a look at conditions inside Millsite Sanatorium

MEDICAL INSURANCE

Fees plus VAT are intolerable

A Business Times SURVEY

THE findings of the Medical Association of SA (Masa) investigation into health-care and expenditure patterns for the period 1975 to 1991 make interesting reading.

Clearly refuted is the myth that South Africans are pill-poppers — we are not greater pill-swallowers now than we were in 1975.

There was no evidence of over-servicing in the macro-statistics and inflation in medical services was below the national average as expressed by the consumer price index for most of the period.

DANGER

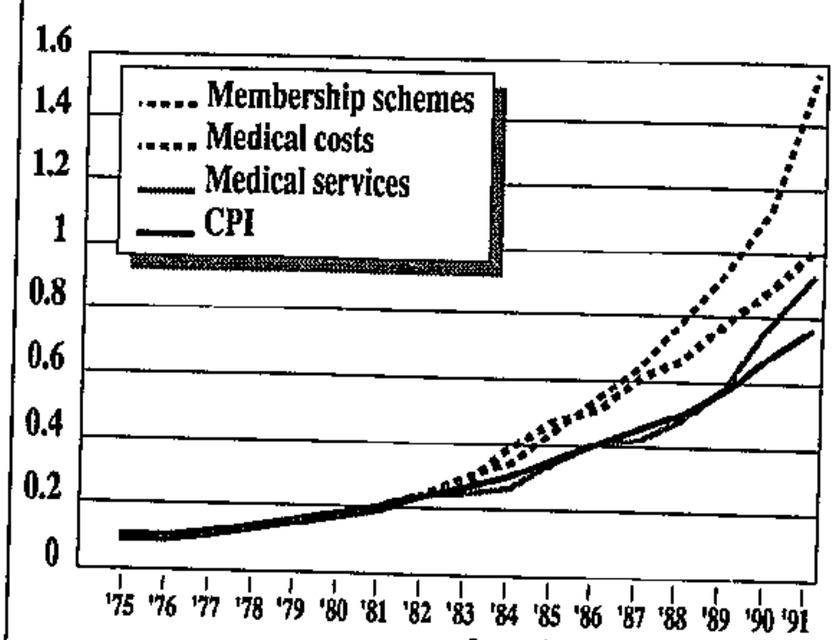
The most worrying aspect of the report is the clear inability of medical aid schemes to keep their annual subscriptions to members in line with inflation in the health sector.

Escalating membership fees, together with the imposition of VAT on medical services, are contributing to an intolerable health-cost burden on the man in the street.

"There is a real danger that medical schemes are pricing themselves out of their existing markets and that, consequently, the health-cost burden will shift to the state and hence the taxpayer," according to Masa's investigation.

PRICE INDICES

MEDICINES; SERVICES; CPI; MEDICAL AID CONTRBUTIONS



Source: Medical Association of SA

"The analysis suggests that the proposed changes to the Medical Schemes Acts will be inadequate to deal with underlying and basic structural problems which the authorities still need to identify."

The investigation found that the high cost of medicines is due largely to the decline in value of the rand against hard currencies. This rapid rise inhibited the flow of medicines to the population at large. The rise in the price of private medicines was accelerated by GST and now VAT imposts.

Over the 16-year period under review, the cost of medical services exceeded the CPI by only 13,1% and that of medicines was 32% greater than inflation, whereas the cost of membership to a medical aid scheme grew at a rate 96% higher than inflation.

DEMAND

The investigation queries the wisdom of imposing VAT on medical expenditure.

Higher prices create resistance, private sector demand falls off, only to create pent-up demand for the same goods and services on a subsidised (free) basis, from the public sector — eventually paid for by the taxpayer.

It concludes that the structural problems underlying SA's private health care industry — existing medical aids — need to be analysed comprehensively, including such factors as the quality of management expertise in the health-care delivery system.

'Violations' of court's authority criticised

Binny 15/10/92

GERALD REILLY

GOVERNMENT has been called on to remove the "checkmate situation" which has arisen regarding the death penalty, in terms of existing legislation and the fact that since November 1989 it has not been carried out.

In an editorial in the SA Bar journal, Consultus, it is stressed that a basic principle of a civilised legal system is that sentences pronounced by the courts should be carried out.

This principle has been violated by the government decision to suspend the death sentence for a further period until the constitutionality of the punishment has been firmly established, the editorial says.

This presumably means the suspension will apply until a new constitution with a bill of rights has been enacted. The suspension of the execution of the death sentence amounts to approved encroachment on the functions of the courts — just as the premature release of thousands of non-political prisoners did last year.

"Either the death penalty should be carried out, or abolished and all prisoners on death row reprieved, or death sentences which are not commuted should be carried out within a reasonable time," says the journal's editorial.

The courts, it says, should no longer be inhibited in carrying out their task in an orderly manner.

To expect trial judges to spend days hearing evidence and reasoning to determine that a death sentence should be imposed when it is, from the outset, certain that, whatever the courts may decide, no death penalty will be executed "is really not acceptable", it says.

Untenable

The suspenion of the execution of the death sentence for an indefinite period in fact was probably unlawful. In times such as the present the judiciary should be strong and free to perform its function unimpeded and without let or hinderance of whatever nature.

The uncertainty on the death penalty could not be allowed to continue. Apart from the untenable situation that has developed in regard to the courts, it is in the public interest that clarity be obtained without further delay. It is also inhuman to keep prisoners on death row for unreasonably long periods with agonising uncertainty, the journal says.

Medical aid schemes start campaign against fraud

Sloany 15/10/92 (299)

ANDREW KRUMM

CERTAIN medical aid societies had started a campaign to clamp down on fraud and abuse of medical schemes, an industry source said yesterday.

The source said the campaign included swopping accounting records among certain societies to track down doctors who were blatantly over-servicing patients and having experienced investigators talk to them.

It was hoped these investigators would eradicate the abuse in the interests of the profession as a whole.

"Medical Fund Administrators has a good idea of who the abusers are, but unfortunately finds it difficult to press charges formally."

Steps would be taken against medical aid members who abused their schemes to create awareness that the over-use of benefits prejudiced medical care for others.

SA Association of Medical Schemes (Saams) chairman Keith Hollis said: "The medical schemes movement is in crisis as claims escalate at a rate considerably faster than inflation through over-use and over-servicing."

Hollis said Saams was not involved in any investigation, as investigations were the responsibility of individual administrators.

"Saams has launched an educational video to change perceptions and improve members' understanding of how their medical scheme works."

The video would be distributed among 82 medical aid societies and among employers for viewing by nearly 2-million members.

It was likely that a letter campaign would also be launched soon.

Jo'burg 'worse than Koeberg'

Sloany 15/10/92

Business Day Reporter

PEOPLE living in Johannesburg were exposed to higher radiation levels than those working at the Koeberg nuclear power station, Koeberg communications manager Donne Murray said yesterday.

He was reacting to a report released this week which said 640 of the station's 1 400 radiation workers received detectable radiation doses during 1991.

Murray said exposure to radiation was normal. People living in Johannesburg were exposed to 1 850 microsieverts as opposed to 1 500 microsieverts in Cape Town.

Exposure at Koeberg was below the World Association of Nuclear Operators' norm.

The company's health physics department ensured that exposure to radiation was minimised at all times, he said.

UNDERCOVER *The second article in a three-part probe into condi*

Life in Stalag Millsite

Sowetan 16/10/92. (299)

Exclusive by Investigations Reporter Ruth Bhengu

DOUBLE IDENTITY *Some say Millsite is caring, some say that it is grossly negligent:*

HEALTH WORKERS AT the Millsite Sanatorium describe it as a concentration camp.

Management talks about it as a caring and efficient private institution.

It is tempting to believe management, especially after a guided tour of the hospital. The authorities sound rational.

The problem is there are things that simply do not add up.

For instance, it is not only the professional nurses, the nursing assistants and social workers who claim that patients are subjected to gross negligence and abuse at Millsite.

The World Health Organisation (WHO) and the American Psychiatric Association (APA), after visiting the hospitals, published reports claiming that black patients at psychiatric facilities were abused.

> **"Making millions out of madness"**
>
> **Comment in an 1975 newspaper expose of the Life Care Group**

The surveys were aimed specifically at hospitals owned by Smith Mitchell and Company, which has since been changed to the Life Care Group.

Life Care is the largest private health care group in South Africa and is the only one that caters for black psychiatric patients.

In 1975 several newspapers exposed conditions at Life Care hospitals alleging that they were "making millions out of madness". The reports included allegations that patients worked for over 11 hours a day and slept on grass mats on the floor in converted mine compounds.

Staff at Millsite claim that the hospital is chronically understaffed with sometimes as few as six nurses looking after 300 patients.

The authorities say the nurse-patient ratio is 1 to 8. But during the tour we counted six nurses to about three hundred patients in most wards.

In April last year a male patient at Millsite was burnt beyond recognition while lying in his bed in the hospital ward. The staff only noticed the fire when it was too late. If the number of nurses had been evenly spread, would it have been possible for a patient to be burnt beyond recognition before someone noticed?

Another patient fractured his hand and none of the staff could tell how it had happened.

Staff also make the following claims:

- A high death rate during winter months because patients are exposed to cold. According to the staff most windows are broken and the heating system is poor.
- Inadequate clothing, with only a few patients supplied with jerseys, pyjamas and shoes. None of the patients have underwear.
- Poor food which led to malnutrition and diarrhoea. Patients ate from rubbish bins because there was not enough food.

"Patients at Millsite always suffer from diarrhoea. The toilets are few and overcrowded and diarrhoea and any other infectious disease spread quickly.

"So if one patient has diarrhoea soon every patient has it," said a staff member. This was confirmed by several other health workers we spoke to.

- There was often no hot water and patients had to share bath water.
- Most wards had broken windows and it was easy for patients to escape. Some patients were found dead after they had escaped from the hospital.
- The patients' beds were very close to one another and this promoted sodomy.
- Shortage of staff included a shortage of security and this led to patients escaping easily. Also psychiatric patients had easy access to the retarded children's ward and sometimes raped them.
- There was not enough protection for female nurses working in male psychiatric wards. In some wards there were no male nurses. One nurse said she had been attacked by a violent patient.
- Management of Millsite was quick to bury patients as paupers and they did not bother to trace relatives.
- As a result of Millsite being able to admit patients directly from communities from 1990, staff have been increasingly subjected to violence.
- The hospital often ran out of medical supplies and patients were affected.
- Staff worked for up to 15 hours a day.
- There was only one social worker in a hospital with at least 3 000 patients.

> **"Patients at Millsite always suffer from diarrhoea. The toilets are overcrowded and diarrhoea and other diseases spread quickly"**

UP NEXT

at Millsite Sanatorium

All-in peace of mind

ST Times Buss 18/10/92. 299

CLINIC Holdings, one of the country's largest private health care groups, has introduced a no-deposit, no account, no shortfall hospital plan called Clini+Sure.

It aims to combine the best features of medical aid and of medical insurance, allows full interchangeability between medical aid societies and furnishes peace-of-mind, in that there will be no hidden costs or shortfalls to be met if one is treated at any Clinic Holdings hospital.

The contribution for a member plus three dependants is R322 a month, no matter what population group, age or income. An optional recovery benefit can be bought for a further R25 a month.

For this sum the following are covered:

- The full cost of hospitalisation and all related costs for surgery, doctors, specialists, medicines, X-rays, dental surgery, etc, at any of Clinic's 16 hospitals or any of its associated hospitals located in centres not served by Clinics;
- Emergency medical transportation;
- Treatment at any one of Clinic's casualty departments for minor accidents not requiring admittance;
- Additional benefits for the GP, dentist, specialist and pharmacist if you are not hospitalised;
- No deposit is required. The member merely signs an account on discharge, leaving no outstanding liabilities;
- Accommodation is provided in a general ward and members can elect private or semi-private accommodation by paying for the difference;
- If you are admitted to a hospital other than a Clinics or associated one, benefits will be paid according to scale of benefits only. Wherever possible, Clinics will arrange your transfer to one of its own hospitals at no charge;
- If you use a Clinics 24-hour casualty centre, the cost for treatment, X-rays, minor surgery, dressings, bandages and so on, is covered, but normal diagnostic examinations and treatments for minor illnesses are excluded.

LIMITS

To help you in self-insuring against costs for doctors, dentists and pharmacists, Clini+Sure membership offers additional benefits for non-hospitalisation.

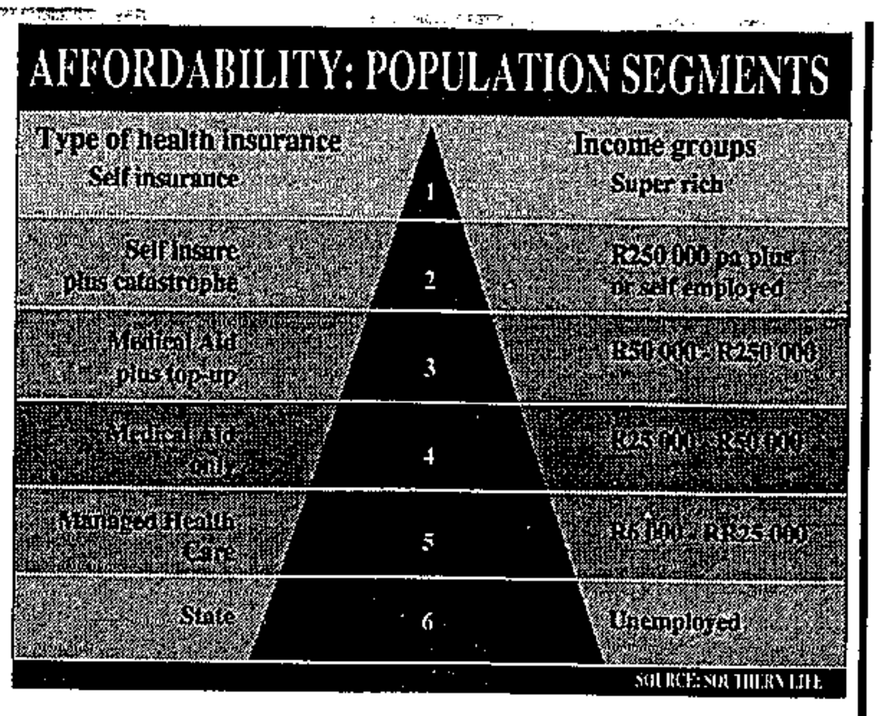
Visits to general practitioners and homeopaths are paid to 100% of the scale of benefits, subject to an annual limit of R125 a family a year. The same applies to specialists. The limit for prescribed medicines and materials for injections, infusions and vaccinations is R350 a family a year.

Dental services are subjected to R1 000 a year maximum and medication for a chronic disease is R5 000.

The serious illness recovery benefit for a member or spouse is R4 000 a month for a period of 12 consecutive months, and for children R2 000.

Clini+Sure offers value-for-money cover against the kind of incident most of us fear.

There is a list of exclusions and limitations which itemises the kind of exceptions you would expect to see — slimming pills, cosmetic surgery, infertility and on disorders such as AIDS, alcoholism, drug addiction, spectacles and nose jobs.



FLEXIBLE BENEFITS FROM FLEXIBLE FUNDING

299

S/Times (Buss) 18/10/92.

SINCE launching Med-Help in February, Southern Life reports that this medical insurance scheme now accounts for almost 10% of its new-business recurring premium income.

Southern's Patrick Sheehy, co-ordinator of Med-Help, describes SA's existing health insurance position as a bottom-heavy triangle (see graph).

The super-rich income group at the tiny apex of the triangle is totally self-sufficient.

The next layer down — R250 000 or more earners or the self-employed — usually opt for self insurance plus catastrophe cover.

The third income bracket — from R50 000 to R250 000 a year — is covered by medical aid and a top-up scheme.

Only levels two and three can afford extra medical cover.

Level four — R25 000 to R50 000 — is covered by medical aid only. Apart from very minor medical procedures, group four should be adequately covered because many medical aids offer gap cover.

Because of its income level, this group is content to rely on the medical treatment provided by provincial hospitals and doctors contracted in with medical aid societies, whereas those in the upper brackets will seek treatment in private clinics where even the additional cover provided by medical aids nowhere near funds the total bill.

Those at the bottom of the triangle have no option but to rely on state health care.

CHOICE

State funding is being shifted away from subsidies of private care to community-based preventative health care.

The government is earmarking more and more resources for Third World medicine and is finding it increasingly difficult to cater for the public sector's needs.

Mr Sheehy says Med-Help allows clients to choose what medical procedures they want to insure. This enables a plan to be tailored to their exact requirements.

"For example," he says, "clients in group two do not want cover for minor medical treatment, but they do want cover for catastrophe. This includes major operations, such as organ transplants, cancer therapy, etc. Med-Help provides cover for these at a low cost."

It offers seven optional flexible benefits — one of the widest choices available on the market: major medical procedures; hospital benefit; incapacity benefit; medical aid benefit; the unit trust benefit; the life products benefit; and the Southern Benefit Fund.

Within major medical procedures are three elements and cover can be selected from R10 000 to R75 000. The non-surgical element provides for cancer and kidney failure — once a patient is diagnosed as having one of these conditions a payment is made, regardless of whether the person is hospitalised or receiving treatment.

Hospital benefit ranges from R100 to R400 a day. A waiting period can be three, seven or 14 days — the longer, the cheaper the benefit. But if the waiting period is selected at three days, this will be waived for hospitalisation in an intensive-care unit or as the result of an accident.

Incapacity benefit provides "dreaded diseases" cover.

With Southern's association with AMA, the country's second-largest medical aid administrator, Med-Help offers clients the choice of membership from nine medical aid societies.

SAVE

The unit trust benefit is designed to save clients money on their regular monthly medical expenditure.

These savings can be invested in one of Southern's high-yielding unit trust funds to help fund the cost of frail care, minor medical costs or to supplement retirement income.

Any of the group's life assurance benefits may be incorporated with Med-Help.

Finally, the Southern Benefit Fund has the approval of the Commissioner for Inland Revenue and provides employer and employee with tax savings on conventional medical aid contributions.

The diagnosis is not good for medical aids

S/Times (BUSS) 18/10/92 (299)

SOUTH AFRICA's medical business is in a pickle. Few medical practitioners are happy with the way medical aid schemes deal with their accounts.

There can be few employers unconcerned with the rate of increase in medical aid contributions they make on behalf of their employees. Members themselves are more and more concerned about facing a large bill if they require treatment not fully covered by their medical aid schemes. This trio's favourite scapegoat is the medical aid scheme itself.

The doctors sing: "No wonder their admin costs are so high; I have to submit every invoice six times before they will pay me, and I object to providing medical aid schemes with free finance." Employers say: "We have tried to help our staff by paying the entire cost ourselves, because medical aid contributions are tax deductible in our hands, whereas the employee pays out of taxed earnings. But the cost has become so high that we are having to consider alternatives".

The members are more concerned about bridging the growing gap between the minimum amount a medical aid scheme is legally obliged to pay and the amount charged by practitioners for their services.

The medical aids say: "There is so much abuse by members. They sell their cards for R20 when they are not sick, and buy them back when they're ill. Instead of paying for one family, we have to pay for several."

No doubt critics of the schemes will query their ability to administer and manage large amounts of somebody else's money effectively.

One thing seems certain: the status quo will not pertain.

Jannie de Beer, senior marketing underwriter of Guardian National Management Services, explains:

BURDEN

"Existing legislation was originally intended to impose basic ground rules for uniformity within medical aid schemes, whose fraternity is urging the government to improve the medical schemes' flexibility by proposing new legislation. The proposal has already been tabled in Parliament as a draft Bill.

"Should it be proclamated, its major impact will be the abolition of guaranteed payment.

"For most scheme members this would have significant implications. Health care will require self-funding to an even greater extent."

According to Central Statistical Services, medical costs have become the fifth largest expense in the consumer price index for the average person. It is estimated that the burden of health care contributions as a percentage of payroll will double in fewer than 10 years.

Almost every insurance company in the country has identified the opportunity to offer supplementary health care insurance packages.

Originally, policies were intended to augment shortfalls in the event of catastrophe.

However, now the move is towards replacing existing medical aid schemes with a total, more cost-effective package.

A Business Times SURVEY

Ever-escalating contributions to medical aid schemes are a cause for concern for employee and employer alike as the costs of providing adequate health care extends beyond the means of many South Africans. At its peak, only 20% of the country's population was covered by a medical aid scheme. Now, as thousands lose their jobs because of the recession, they and their dependants cease to be covered under a corporate scheme. Business Times reporter JULIE WALKER takes a look at the medical insurance market

Not home from home

Sowetan 19/10/92. (299)

Exclusive by Investigations Reporter Ruth Bhengu

IN DEFENCE *Management of Millsite*

Sanatorium responds to Sowetan allegations:

MILLSITE SANATORIUM, the black mental health centre, is no home from home.

Besides the appalling lack of facilities listed in our Friday story, the hospital has also been found to have no hot water. Many sections lack heating.

The hospital provides no underwear and many patients have no shoes, jerseys or pyjamas.

There are not enough blankets. Patients do not have their own regular beds and lockers. A patient can change beds every night.

We put all the allegations and our observations to the hospital authorities and this is how Manager Mr Abie Masiela responded to the charges:

"There are three large boilers constantly heating water. Additional electric geysers are also operating in certain ablution areas.

All windows on exterior walls are burglar-proofed. All broken windows are replaced on an ongoing basis. Only one patient was found dead after escaping last year.

Millsite supplies five blankets a patient during winter. In winter all wards have heating systems. The minimum temperature in a ward, recorded last winter, was 15 degrees Celsius. The temperature varies between 15 and 21 degrees Celsius.

A large percentage of the patients (especially children) at Millsite are highly prone to respiratory ailments because they are immobilised by severe physical handicaps.

Many come to Millsite with a history of respiratory problems. The number of deaths occuring, however is well within the US rate for chronic mental retards.

Patients have three jerseys and three T-shirts at any given time. The supply of shoes is done via the ward sisters. The records show an issue of 2 278 pairs of shoes for the period October 4 1991 to September 30 1992.

Because of their mental condition, patients have varied attitudes to clothes. Some take off as much as possible, others will wear a dozen layers. Many throw their shoes away. The grading and grouping system helps to keep patients in groups but they are not forced to participate in group activities. Loitering patients sometimes scavenge but this is stopped when noticed.

"An average of one patient a month escapes. Five patients a month die"

Special diets and dietary requirements (also required quantities) are worked out and monitored by a qualified dietician.

Patient labour has long been done away with. However, work-related activities (washing dishes, cleaning) are included in the rehabilitation programme of the A and B group, as part of their preparation for leaving Millsite.

The closeness of beds cannot in any way contribute to homosexuality.

Nurses work the 40 hours a week prescribed by SANC. No case of assault has been reported in the past year. If an assault has taken place, it is the nurse's responsibility to report the matter. (This would be regarded as an injury on duty case, and handled by Workman's Compensation.)

Thorough screening is done before any patient is admitted. Millsite accommodates only chronic, long-term patients. Violent patients would be referred back to Sterkfontein.

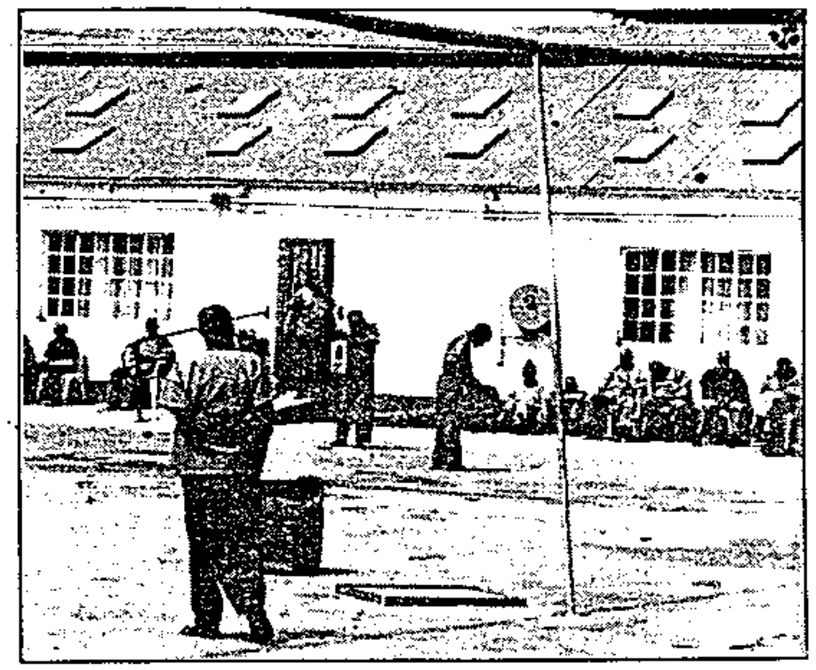
Only one case of rape between patients has been reported in a five-year period. On investigation it was found to have been an attempted rape. If nurses are aware of such occurrences, and do not report them, they would be guilty of negligence and could be reported to the Nursing Council.

All attempts are made to locate the family of a deceased. Relatives pay for such burials. Pauper burials are arranged after a minimum of 14 days (sometimes as long as 21 days) if the family cannot be traced. Millsite pays for burials and certainly does not benefit financially.

Diarrhoea has many causes, not only unsuitable food. Special committees dealing with infection control and hygiene assess and correct situations if and when they occur. An average of one patient per month escapes. Three patients are known to have died while being an escapee. An average of five patients a month die.

All our doctors belong to the SA Medical and Dental Council. Allegations of abuse are serious and should be reported. If these are untrue it would be construed as libel."

"Because of their mental condition, patients have varied attitudes to clothes. Some take off as much as possible, others will wear a dozen layers"



Battle field ... Millsite, scene of the controversy.

UP NEXT

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PEOPLE'S LIVES *Nomasonto could be easily mistaken for a white woman*

Low esteem of the albinos

Sowetan 19/10/92 (299)

By Pearl Majola

■ SELF-HELP Albino support group has been launched to build their self-esteem:

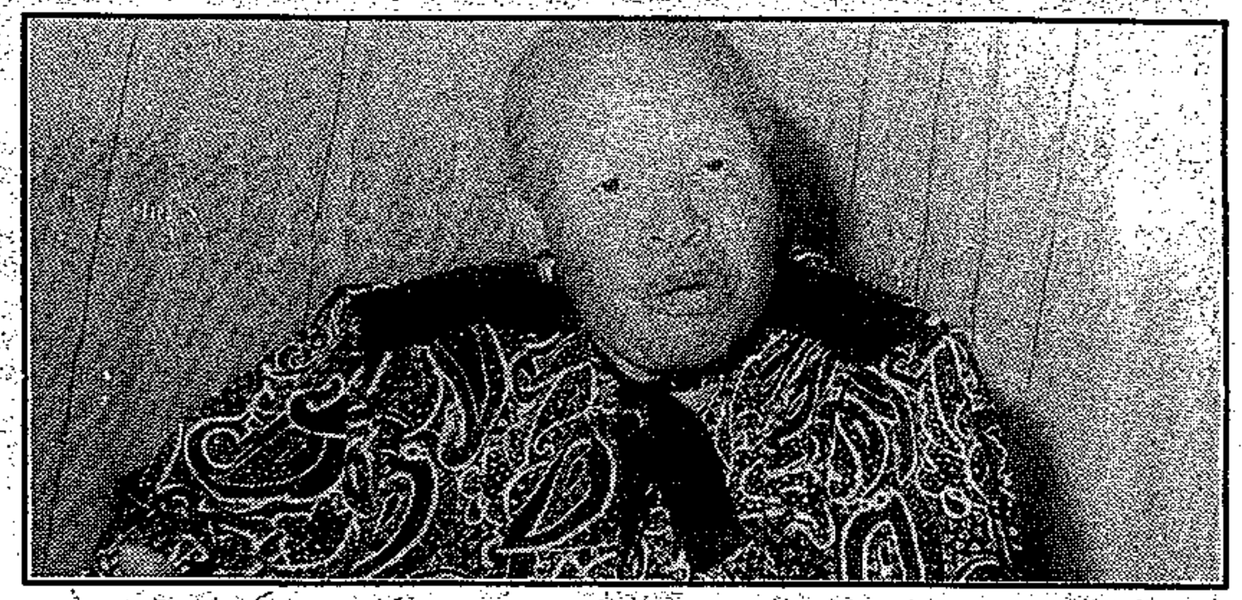
BUT FOR HER curly hair, Mrs Nomasonto Mazibuko could easily be mistaken for a white woman living in Soweto.

She is as white as one of the madams in the surburbs and also needs a sun screen lotion. She is an albino.

Mazibuko says she is not bitter about the fact that people sometimes insult her and other albinos. She does not even feel bad about her condition or ask God why she had to be this way.

In fact, the 42-year-old mother of four and primary school teacher is confident, full of energy and has no hangups about life.

But something is bugging her - the low self-esteem of other albinos caused by the community's attitude towards them and by the fact that they are different.



Nomasonto Mazibuko ... raising the self-esteem of albinos.

Beginnings

This has motivated her to start the Soweto Albinism Society, the first organisation for albinos in South Africa, which was launched at a conference at the Careers Centre in Diepkloof last Saturday.

"The conference is the beginning of a massive campaign I intend running until albinos feel part of society and the myths are dispelled about us," Mazibuko says determinedly.

"We are here and it is time we stopped feeling sorry for ourselves and got on with our lives. We can do this if we are united and with a little help from our communities," she says.

Mazibuko, one of five albinos in a family of 10 children, dismisses as sheer myth such beliefs as that albinos do not die but disappear.

She says she and her siblings have never allowed the condition to affect their lifestyle negatively. But this is not true for many other albinos in the townships.

"We are human beings. It is just our skin pigmentation that makes us different. I believe people create these myths because they don't know about us. The SAS will try to solve this problem."

UNDERCOVER *The final article in our probe into conditions at the Millsite Sanatorium*

What the eye doesn't see ...

Sowetan 20/10/92.

299

NO CHANGE *A 14-year-old report by American psychiatrists underlines the message:*

Exclusive by Investigations Reporter Ruth Bhengu

THE ABUSE OF BLACK patients in private psychiatric hospitals in South Africa can only be described as a gangrenous sore.

Instead of the authorities improving conditions in these institutions, they improve their methods of hiding things from the public.

Over the years different groups and individuals have exposed the unbearable conditions that mental patients have to endure but very little has changed according to those who work in some of these institutions.

In fact, health workers who spoke to *Sowetan* are beginning to despair.

Said one health professional who would not be named for fear of reprisals: "Even as I tell you about the horror we witness daily, I have a feeling that nothing is going to change.

"The hospital authorities do not want to get rid of the rot, they just dress it up nicely and spray it with perfume.

"When the public comes to investigate they are taken on a guided tour. There are certain wards which are meant for showing to the public.

"Many patients at Millsite, in our view, could benefit from more lively psychiatric care"

"When the Press exposed these institutions a year ago, all that happened was that security was tightened."

Fourteen years ago a team of American psychiatrists visited South Africa's mental health institutions after reports by the World Health Organisation (WHO) of gross abuse of black patients.

The State was also accused of placing blacks in such facilities for political reasons.

These members of the American Psychiatric Association (APA), led by their president, Dr Jack Weinberg, were invited by the South African Government to do an independent survey and prove WHO wrong.

South African officials denied the WHO allegations.

Ironically the APA found that most charges made by WHO were factual. The criticism was directed mainly at the Government-funded private psychiatric facility of Smith, Mitchell and Company, which has since been renamed Life Care.

Life Care, among other hospitals, runs Millsite which is notorious for its alleged abuse of patients.

Smith, Mitchell and Company, under contract to the South African Government, provided racially segregated daily care for chronic psychiatric patients transferred from State institutions.

"Our investigation convinced us that there is good reason for international concern about black psychiatric patients in South Africa. We found unacceptable medical practices that resulted in needless deaths of black South Africans.

"Medical and psychiatric care for blacks were grossly inferior to that of whites.

"We believe that these findings substantiate the allegations of social and political abuse of psychiatry in South Africa.

"Some of the charges of abuse were misleading. We found no evidence that black dissidents were confined in Smith, Mitchell and Company facilities. However, what we did find is sufficiently disturbing to warrant criticism and continued scrutiny by objective international observers.

"We were heartened to discover concern about and criticism of these abusive apartheid practices among psychiatrists, physicians, medical students and nurses in South Africa," wrote the APA in their report.

The charges involving Smith, Mitchell and Company facilities for blacks were:

- High death rate - the committee found evidence of needless deaths among black patients.
- Sub-standard care - the committee found substantial grounds for this charge at most Smith Mitchell facilities.
- Abusive practices - the committee found this was true is some cases.
- Grossly inadequate professional staff - the committee found the evidence was unequivocal.
- Inappropriate use of drugs and electro-shock treatment - the committee concluded that there was no substance to this charge in the facilities it was allowed to investigate.
- Exploitation of patient labour - there was no evidence that Smith and Mitchell had made significant profits from patient labour but there were unresolved questions about the use of patient labour.

The APA also found the following:

- Black patients were provided neither toilet paper nor wash basins. The Department of Health suggested that "when toilet paper is provided the patients misuse it, causing sewerage blockages and inconvenience to fellow-patients".
- Many black patients by policy were not provided with sheets although a significant number are incontinent.
- In many instances the beds were crowded together without adequate ventilation.
- Most black patients had no lockers, no bedsteads and no personal possessions.
- Black patients had unnecessarily crowded dining rooms.
- Black patients were bathed in group showers.
- Smith Mitchell provided two-piece pyjama-like clothing for black male patients and sack type dresses. Many were without shoes.
- The food met minimum standards but there was a drastic discrepancy between what whites and blacks had.

Following the visit of the APA delegation that investigated Life Care (formerly Smith, Mitchell and Company) and State psychiatric hospitals and residential facilities for the chronically ill and mentally retarded, Life Care conducted its own investigation of facilities and has made many changes, according to a report by the American Psychiatric Association.

This report was made after two psychiatrists from the APA had visited South Africa in 1989. They were part of a delegation of the American Association for the Advancement of Science.

An American psychiatrist has also visited and reviewed the Life Care facilities regularly since 1981 at their request, the report shows.

"In our own estimation and according to several knowledgeable South African psychiatrists, the Life Care facilities have improved over the past 10 years and they are probably better run than the Government-sponsored mental health centres.

"Certainly there is less red tape. Yet the severe shortage of psychiatrists in the country creates a burden on those working for both private and Government facilities, and allows many gaps in the supervision and quality of care," a spokesman for the APA said.

Unlike the 1987 APA visit this one lasted about two hours and did not include a review of patient records, or more than brief talks with staff and patients.

The report shows there are 4 000 beds at Millsite. Patients usually stay five years or longer. Some of the patients arrive without names and are given names by the Millsite staff.

"We asked for, but were not given, the amount of money spent by Life Care on each patient a day for black compared to white patients. We were told that the black-white gap has narrowed over ten years, but it is not clear by how much."

The psychiatrists visited the children's unit and several adult wards.

"Many patients at Millsite, in our view, could benefit from more lively psychiatric care," the APA said.

"We believe that these findings substantiate the allegations of social and political abuse of psychiatry in South Africa"

(1) Whether the Government is responsible for paying the costs of representatives of the (a) United Nations and (b) Organization for African Unity who recently visited or are currently visiting the Republic as observers; if so, (i) to what extent, and (ii)(aa) what are these costs to date and (bb) in respect of what period is this information furnished; if not,

(2) whether he will make a statement on the financing of the above-mentioned visits?

B859E

The MINISTER OF FOREIGN AFFAIRS:

(1) (a) As far as the UN and other observers are concerned the Department of Foreign Affairs did not pay any expenditure to date.

(b) (i) and (ii)

Only certain transport costs in accordance with international practice. From 14 September 1992 to 4 October 1992 and amount of R9 550 has been paid.

(2) The general worldwide practice in the case of such missions is that the host country where a team is being deployed, provides financial assistance with regard to office accommodation and related expenditure. It could thus be expected that certain costs will indeed be paid. The amount cannot be provided at this point in time because there still have to be discussions about the extent of the services.

Special representative of Secretary-General of UN: costs of visit

362. Mr F J LE ROUX asked the Minister of Foreign Affairs:†

(1) Whether the Government is responsible for paying the costs involved in the visit to the Republic in August this year of Mr Cyrus Vance, Special Representative of the Secretary-General of the United Nations; if so, (a) to what extent and (b) what were the costs involved; if not,

(2) whether he will make a statement on the financing of this visit?

B860E

The MINISTER OF FOREIGN AFFAIRS:

(1) No.

(a) and (b) Fall away.

(2) Not applicable given the answer under (1).

Imizamo Yethu settlement at Hout Bay: site

364. Mr C W EGLIN asked the Minister of Local Government and National Housing:

(1) Whether the Imizamo Yethu settlement at Hout Bay is situated on a site of approximately 18 hectares agreed to in the second phase of the development in this regard; if not, what are the relevant details; if so,

(2) whether his Department has any plans for extending the above settlement; if so, what are these plans;

(3) whether these plans have been discussed with the liaison committee representing the Hout Bay communities; if so, when; if not, why not?

B862E

The MINISTER OF LOCAL GOVERNMENT AND NATIONAL HOUSING:

(1) Yes.

(2) No; the activities of the Western Cape Regional Services Council on the relevant site of approximately 34 ha have been influenced to such an extent that they have to acquire an alternative site. Consequently the Cape Provincial Administration is obliged to purchase the whole area of approximately 34 ha.

(3) Although no formal plans for the development of the additional approximately 16 ha have been discussed, the Hout Bay Liaison Committee has agreed that the residential component will be confined to approximately 18 ha. The future utilisation of the additional approximately 16 ha is thus still to be decided upon in consultation with the local communities. This land could possibly be utilised for community facilities.

Pine forest area in Hout Bay: cutting down of trees

365. Mr C W EGLIN asked the Minister of Local Government and National Housing:

(1) Whether his Department has any plans to cut down any trees in the existing pine forest area near the Imizamo Yuethu settlement at Hout Bay; if so, (a) what trees and (b) why;

(2) whether an independent environmental impact study has been made regarding the possible effect of the cutting down of these trees; if not, why not; if so, (a) when and (b) by whom;

(3) whether he will make public the findings resulting from such a study?

B863E

The MINISTER OF LOCAL GOVERNMENT AND NATIONAL HOUSING:

(1) Yes;

(a) only those trees that have been identified during a scientific investigation to be dead, or are in the process of dying, as well as a limited number of trees which will hamper the alignment of roads or services in the development;

(b) the retention of the dead trees is a risk to the lives of people and property. It would also not be cost effective to re-align roads and trunk services for purposes of retaining a small number of trees.

(2) Yes;

(a) in June 1992;

(b) by Ms E L van and Honert, M.Sc. (Botany) employed by Messrs Hill, Kaplan and Scott, consulting engineers;

(3) Yes.

Single care grants: children of each race group

367. Mr K M ANDREW asked the Minister of National Health:

How many children of each race group were receiving single care grants in terms of the Mental Health Act, No 18 of 1973, in respect of each province as at 30 September 1992 or the latest specified date for which information is available?

B865E

The MINISTER OF NATIONAL HEALTH:

Province	White	Coloured	Indian	Black
Orange Free State	7	0	0	18
Cape	98	0	0	580
Natal	44	0	101	307
Transvaal	141	0	19	459
Total	290	580*	120	1 364

*Figures are not kept per province.

SA citizenship: independent Black states

368. Mr P G SOAL asked the Minister of Home Affairs:

Whether any Blacks in the independent Black states have applied to regain their South African citizenship in terms of the provisions of the National States Citizenship Act, No 26 of 1970, as amended by the National States Citizenship Amendment Act, No 13 of 1978; if so, in respect of each such state, (a) how many applied, (b) how many applications were approved and (c) for what specified period is this information furnished?

B866E

The MINISTER OF HOME AFFAIRS:

Owing to the provisions of the Restoration of South African Citizenship Act, 1986 (Act 73 of 1986), which came into effect on 1 July 1986, no Black of any of the independent states applied in terms of section 3 of the National States Citizenship Act, 1970 (Act 26 of 1970), as amended by the National States Citizenship Amendment Act, 1978 (Act 13 of 1978), for South African citizenship since that date.

Particulars of applications prior to the commencement of the above-mentioned Restoration of South African Citizenship Act are not readily available.

Telephone installations: North Rand

369. Mr P G SOAL asked the Minister of Posts and Telecommunications:

Whether any applications for telephone installations for (a) residential, (b) facsimile and (c) business purposes were outstanding at the North Rand office of Telkom as at 1 October 1992; if so, (i) how many in each case and (ii) when is it anticipated that these backlogs will be eliminated?

B867E

Professor Hennie Snyman, principal of the Port Elizabeth Technikon.

METROPOLITAN DIGEST (Johannesburg)

(a) Vol 9 no 3 1991.

(b) Food Gardens Unlimited.

(c) People are encouraged to plant their own food.

(a) February and April 1992.

(b) South African Fashion Designers' Association.

(c) The organisation and its founder president: Ms Esther Mohlabi.

VISION (Durban)

(a) February 1992.

(b) ASSIST (Association Supporting Survivors of Incest and Sexual Trauma).

(c) The work that this organisation does.

(a) March 1992.

(b) Advice Desk for Abused Women.

(c) Where abused women can obtain advice.

KARET (Cape Town)

(a) 14 February.

(b) Women's Bureau.

(c) Report on seminar: 'Taking charge of your life'.

(a) 13 March.

(b) Kontak.

(c) Women must build on peaceful future.

(a) 13 March.

(b) Women for South Africa
Women's Bureau
National Council of African women
Orange Free State Women's Association.

(c) Group photograph.

(a) 1 September.

(b) Women for South Africa.

(c) Organisations co-operate to establish a training centre for women in Stellenbosch.

(a) 1 October.

(b) Women for South Africa.

(c) National president, Ms Jenny Malan, talks about human rights.

(a) 1 November.

(b) Kontak.

(c) Ms Pauline Mkalipe, chairperson, speaks about the aims and objectives of the organisation.

LIGHT/KHANYA (Pretoria)

(a) January 1992.

(b) Pretoria Friendship Forum.

(c) Function held by this organisation.

(a) April 1992.

(b) Tholuwazi Women's League.

(c) Activities of the group.

(a) May 1992.

(b) Tekset.

(c) Negotiation seminar held by this group.

(a) September 1992.

(b) Itsoseng Women's Club.

(c) Club receives financial aid from private sector.

LUX FEMINA, women's magazine, Pretoria Regional Office:

(a) December 1991.

(b) Atteridgeville Ladies' Club.

(c) Founding of the organisation.

(a) December 1991.

(b) SA Vroue Federasie.

(c) Interview with the president.

(a) March 1992.

(b) Kontak.

(c) Kontak emphasises nation-building.

(a) June 1992.

(b) Women's prayer day.

(c) A function in Mamelodi.

(a) June 1992.

(b) Tekset.

(c) Negotiation seminar for members of the organisation.

(a) September 1992.

(b) Sidingulwazi Women's League.

(c) The activities of the group.

PUISANO (Bloemfontein)

(a) October 1991.

(b) Women for South Africa.

(c) Profile of Dr Elsie de Beer.

(a) October 1992.

(b) Women for South Africa.

(c) Women in various communities must learn to understand one another.

4.4 RSA POLICY REVIEW/ RSA-BELEIDSOORSIG published the following:

(a) September 1991 p 56.

(b) The South African Nursing Association.

(c) Nursing Centenary: An interview with the president of the Association, Dr Anna-Marie Bruwer.

(a) September 1991 p 67.

(b) The sections: Vocational Matters and Community Health Care of the Department of National Health and Population Development, and the South African Nursing Council.

(c) Nursing geared for challenges: An article based on interviews with Ms Odelia Muller, Deputy Director: Vocational Matters, and Ms Iris Röscher, Director: Community Health Care of the department, and representatives of the South African Nursing Council.

(a) October 1992, p 94.

(b) Natal women's congress of the National Party.

(c) An announcement by the State President in Amanzimtoti (Natal) stating that the Government will sign international conventions relating to women and women's rights.

Forum on curtailment of cost of medicine

403. Mr M J ELLIS asked the Minister of National Health: 299

(1) Whether, with reference to her reply to Question No 348 on 19 June 1992, all interested parties have commented on the record of the proceedings of the forum held on 28 Feburary 1992; if not, when is it anticipated that this will be the case; if so, what parties;

(2) whether she is in a position to commission any investigations as recomended at this forum; if not, why not; if so, what are the relevant details;

(3) whether any such investigations have been commissioned to date; if not, why not; if so, (a) by whom and (b) on which recommendations;

(4) whether she will make a statement on the matter? B906E

The MINISTER OF NATIONAL HEALTH:

(1) Only 8 (eight) interested groups submitted comments on the report of the forum. The groups are:

The South African Pharmacy Council
The Medical Association of South Africa
The Pharmaceutical Manufacturers' Association of South Africa
National Association of Pharmaceutical Wholesalers
The South African Nursing Association
Noristan Group
Patients Rights Organisation of South Africa
Pfizer South Africa;

(2) yes, no investigation excepting those by the working groups have until now been commissioned;

(3) no, a working group has been appointed to investigate the recommendations of the forum and to report back;

(4) no.

Importation of parallel medicines

404. Mr M J ELLIS asked the Minister of National Health:

(1) Whether the Medicines Control Council has considered, is considering or intends considering regulations to allow the im-

cont-d.

portation of parallel medicines; if not, why not; if so, when;

(2) whether the proposed regulations have been or are to be (a) made known to and/or (b) discussed with interested parties; if not, why not; if so, what are the relevant particulars;

(3) whether she will make a statement on the matter? B907E

The MINISTER OF NATIONAL HEALTH:

(1) Yes, the Medicines Control Council is at present investigating the desirability of requesting the amendment of certain regulations made in terms of the Medicines and Related Substances Control Act, 1965 (Act 101 of 1965);

(2) yes, any proposed amendment of regulations must be published for comment unless the Minister is of the opinion that the public interest requires the regulation to be made without delay;

(3) no.

Discussions on health services

405. Mr M J ELLIS asked the Minister of National Health:

(1) Whether, subsequent to discussions held on 28 September 1992, a paper entitled "Announcement of a strategy to manage health services in the present economic climate" was published; if so, what are the names of the main participants and professional groups involved in these discussions;

(2) whether one of the aims discussed was to stimulate discussions on how health services could be made more affordable; if so, what items were discussed in this connection;

(3) whether the points debated at the forum held on 28 February1992 have been reviewed; if not, why not; if so, which points;

(4) whether any decisions have been taken on any of these points; if so, what decisions;

(5) whether she will make a statement on the matter? B908E

The MINISTER OF NATIONAL HEALTH:

(1) Following the discussion held on the 28 September 1992 with certain roleplayers on financial questions in the field of health I released a press statement entitled "Announcement of a strategy to manage health services in the present economic climate".

The main participants and professional groups involved in these discussions were:

Dr E H Venter MP
Minister of National Health and of Health Services: House of Assembly

Rev A A Julies MP
Minister of Health Services and Welfare: House of Representatives

Dr A S Jacobs
Department of Finance

Mr J W H Meiring
Administrator of the Cape of Good Hope

Mr D E T le Roux
Member of the Executive Committee: Cape

Mr J H A Beukes
Director-General: Provincial Administration of the Cape of Good Hope

Dr G S Watermeyer
CPA Branch: Hospital and Health Services

Mr C J van R Botha
Administrator of Natal

Mr P M Miller
Member of the Executive Committee: Natal

Dr N E Howes
Director-General: Provincial Administration of Natal

Dr L van der Watt
Administrator of the Orange Free State

Dr P J C Nel
Member of the Executive Committee: Orange Free State

Dr J H Kotzé
PAO Branch: Health Services

Mr S E S Ferreira
Member of the Executive Committee: Transvaal

Mr A Cornelissen
Director-General: Provincial Administration of the Transvaal

Dr H van Wyk
TPA Branch: Health Services

Mr P D McEnery
Director-General: Administration: House of Representatives

Dr L J Nel
Ministerial Representative

Mr R Dercksen
Ministerial Representative

Dr M H Veldman
Ministerial Representative

Mr H J Smith
Ministerial Representative

Mr R E Redinger
Ministerial Representative

Dr J H Kruger
Supervisory Board, Bloemfontein

Mr B B Humphris
Supervisory Board, Witwatersrand

Prof G Everingham
Supervisory Board, Cape Town

Prof J V Leatt
University of Natal

Prof J R van Dellen
University of Natal

Prof G J de Korte
Medunsa

Prof J Terblanche
University of Cape Town

Prof C W I Pistorius
University of Pretoria

Prof J V van der Merwe
University of Pretoria

Prof H P Wasserman
University of Stellenbosch

Prof C J C Nel
University of Orange Free State

Prof A D Rothberg
University of the Witwatersrand

Dr P S Maharaj
Administration: House of Delegates

Dr J E Pieterse
Administration: House of Assembly

Dr C F Slabber
Director-General: National Health and Population Development

Professional Groups:

Dr D A Green
Medical Association of South Africa

Mrs S J du Preez
Nursing Council of South Africa

Dr A M Bruwer
Nursing Council of South Africa

Prof M E Muller
Nursing Council of South Africa

P R de Kock
Environmental Health Officers Association of South Africa

R D Kennedy
Medunsa

Mrs L Munro
Society of Radiographers

Ms M Horak
Society of Radiographers

Ms A Hugo
Society of Radiographers

Dr M Adam
Society of Dispensing Family Practitioners

Cmdt H C Grobler
SA Association of Biochinetics

Mr M Tepper
Society of Medical Laboratory Technologists of South Africa

Prof B van Os
Dental Association of South Africa

Mr W Kriel
Pharmaceutical Society of South Africa

G N Lyne
Pharmaceutical Society of South Africa

E D Smith
South African Society of Physiotherapy

M W Cheyne
Orthotic and Prosthetic Association of South Africa

C M Smith

Orthotic and Prosthetic Association of South Africa

Dr G Kinmont Hicks

Psychological Society of South Africa

(2) yes, the aim was a discussion to make health services *within the public sector* more affordable and to have all within the public sector to participate in the establishing of priorities and possible identifying of saving precautions. No other items were discussed.

(3) no;

(4) no;

(5) no.

Own Affairs:

Model C schools: payment of school fees

74. Mr R M BURROWS asked the Minister of Education and Culture:

(1) Whether his Department has laid down any guidelines concerning the measures that may be introduced by the governing body of a Model C school to recover compulsory school fees and other moneys owed by the parents; if not, what procedure is followed in this regard; if so, what measures may be introduced for this purpose;

(2) whether any steps will be taken in respect of any pupil whose parents do not pay compulsory school fees; if so, what steps;

(3) whether the governing body of a Model C school may refuse admission to any applicant pupil on the grounds that his parents have a history of non-payment of school fees? B895E

The MINISTER OF EDUCATION AND CULTURE:

(1) No, governing bodies determine their own measures regarding the recovery of compulsory fees and other moneys owed by the parents;

(2) no, legal action may be taken against the parent under specific circumstances but no steps will be taken against a pupil;

(3) no.

Educational properties: municipal rates

75. Mr D H M GIBSON asked the Minister of Education and Culture:

(1) Whether the Government will remain responsible for the payment of municipal rates levied by local authorities on Government-owned properties used for educational purposes; if not, (a) why not and (b) what is envisaged in this regard;

(2) whether the buildings housing Model C schools will remain Government-owned properties; if not, why not;

(3) whether it is the intention of the Government to pay rates levied on educational properties belonging to independent schools once such properties become rateable; if not, (a) why not and (b) what procedure will be followed in this regard? B905E

The MINISTER OF EDUCATION AND CULTURE:

(1) With reference to public schools for either public ordinary education or specialised education, which are state property, yes; with reference to state institutions as defined by the Rating of State Property Act, relating to universities and technikons, yes; with reference to state-aided schools for specialised education and technical colleges, yes; and with reference to state-aided schools for ordinary education yes, until such time as another arrangement, for example possible exemption, may be made by means of further negotiations,

(2) no, because the immovable property concerned is transferred to state aided schools in accordance with the provisions of article 31A(a) of Act 70 of 1988;

(3) no,

(a) in terms of a recent Cabinet decision private schools will not be expected to pay municipal rates until such time as another arrangement has been determined through negotiation.

(b) see answer 3(a).

School governing bodies: title deeds

76. Mr R M BURROWS asked the Minister of Education and Culture:

(1) Whether it is the intention of the Government to make over title deeds to school governing bodies; if not, why not; if so, when;

(2) whether he will make a statement on the matter? B900E

The MINISTER OF EDUCATION AND CULTURE:

(1) No, because as from the date on which a public school is declared to be a state-aided school, the ownership of immovable property vested in the State, shall devolve upon the *state-aided school*. In order to record the transfer certain endorsements must be made on the title deed, and entries in the register of the Registrar of Deeds. The original title deeds remain in possession of the Registrar of Deeds, but after the endorsements and entries referred to, have been made, the state-aided school receives a copy of the title deed. The transfer is, however, subject to a reversionary clause endorsed on the title deed.

(2) no.

School fees: financial assistance

77. Mr R M BURROWS asked the Minister of Education and Culture:

(1) Whether any applications for financial assistance regarding the payment of school fees have been received from parents of children attending Model C schools; if so, how many such applications were (a) received and (b) approved;

(2) whether any funds have been allocated in respect of such assistance; if not, why not; if so, what total amount as at the latest specified date for which information is available? B901E

The MINISTER OF EDUCATION AND CULTURE:

(1) Yes,

(a) 53 304,

(b) 48 944;

(2) yes,

R38,89 million on 26 October 1992.

Private health plans slated

B1DAY 21/10/92

PLANS by the private health care community to introduce managed health care organisations have been condemned by the SA Dispensing Practitioners' Association.

Addressing the association's conference at the weekend, committee member Dr Rashid Saloojee said medical aid schemes, in collusion with clinic groups, planned to entrench "their dominance over all aspects of the private health care market".

Saloojee said while medical scheme administrators claimed managed health care organisations would do away with the abuse of medical aid schemes by patients and doctors, they would serve only vested interests and not the needs of the people. B1DAY

The concept originated in the US and could not simply be transplanted into SA. 21/10/92

Account of Webster murder claim denied

B1DAY 21/10/92

SUSAN RUSSELL

A FORMER member of 32 Battalion, called to testify at the inquest into the murder of academic David Webster yesterday, denied former CCB freelance operative Ferdi Barnard had told him "we did Webster".

Kevin Treisman, who was subpoenaed to testify by lawyers acting for the Webster family, said he had never discussed the Webster murder with Barnard whom he described as an acquaintance.

When Treisman took the witness stand, counsel for the Webster family, E Bertelsmann SC, asked him if it was correct he had told instructing attorney Greg Nott earlier yesterday that he had been pressured and was not prepared to testify.

"I didn't say I was scared," Treisman said. "I said I had nothing to say."

He denied telling Nott yesterday that certain people and the police were all involved and/or a colonel from Bramley had said he should keep his mouth shut.

"Did you say you were prepared to spend 90 days in Diepkloof rather than answer questions," Bertelsmann asked him. "No sir," he replied.

He agreed that an explosive device thrown into his garden some months ago could be regarded as a threat.

"I would take it as a threat, but it could be for many things," Treisman said.

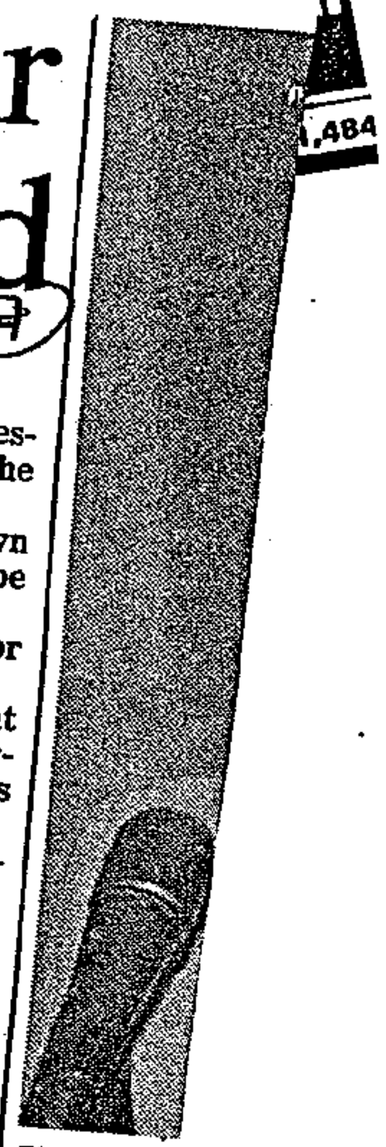
Questioned by Bertelsmann, he agreed that Nott and Weekly Mail journalists, Drew Forrest and Eddie Koch, had visited him at his Corlett drive home in May this year.

Treisman said he had not discussed his relationship with Ferdi Barnard with them.

He also denied telling them that he had discussed the Webster murder with Barnard or that Barnard had said "we did Webster".

He said when Nott called at his home in September he told him he had nothing to say.

Bertelsmann told Treisman that he would ask his instructing attorneys to arrange "that circumstances be created in which you may reconsider the evidence which you have given".



Finance dir
conference
of 13% to

Retirement and disability security

299

Gerard Ehmke, a deputy general manager of Fedlife Assurance, gives advice on employee benefits packages:

Sowetan 22/10/92.

Just imagine. One of your valued workers dies suddenly, leaving behind a sickly wife and three children. Who will care for them?

More and more, workers are turning to their employers in times of crisis, looking for financial help. Although it's not a law, employers do have an obligation to look after their workers and their worker's families.

A retirement benefit, for instance, should not be seen as a gift but rather as wages which have been put aside for past service with a company. It makes sense to spread the future cost of a worker's retirement by making monthly payments to a pension or provident fund.

The difference between these two is that a pension is paid out at retirement with a maximum of one third of the pension taken as a cash lump sum. This worker would still receive the rest of his monthly pension until he dies.

In the case of a provident fund benefit, the worker receives all the money invested in the fund on his behalf in cash.

Pension or provident fund

A pension or provident fund takes care of a worker and his family when he is too old to work, but if he dies before retirement a cash lump sum can be paid to his family. Once this payment is made by the retirement fund, employers can be satisfied that they gave the family financial assistance.

Then there's the problem of the funeral. A funeral insurance benefit which is part of the worker's retirement fund makes sure that should a worker or a member of his family die, a cash sum is given to assist with funeral costs.

If a worker is injured or is too sick to work, many retirement funds today take care of disabled workers. Further benefits are possible if serious illness like blindness or stroke occur.

When a worker changes jobs he is paid back his own contributions to the fund plus interest. It is becoming very common today for a refund of the employer's contributions made on behalf of the worker to be included in this withdrawal benefit.

Provision of all the benefits described (retirement, death, disability, funeral and serious illnesses) are usually trade union requirements. The provision of these also helps to attract and maintain good staff. Most people would far rather work for a business which offers financial security.

Fedlife offers all these employee benefit products. If you'd like more information please contact Vincent Sepuru at 332-6376.

Drawing the veil on blindness

Sowth 24/10-28/10/92 (299)

By Quentin Wilson

EVER wondered how blind people cope with daily tasks such as making telephone calls, preparing a sandwich and pouring water into a cup?

Last Saturday, the League of the Friends of the Blind (LOFOB) gave sighted people a glimpse of what it was like being blind by organising a "make a friend" day in Grassy Park.

Attended by about 80 people, the 40 people who could see were blindfolded and challenged to do a variety of everyday activities at the annual event.

They were also coached to lead their blind partners on a walk and getting to know one another was an all-important aspect of the day.

LOFOB, supported financially by corporate business, state subsidies and its own fundraising initiatives, is a 60-year-old organisation committed to integrating blind people into society while nurturing their independence.

According to LOFOB director, Mr Philip Barn, the aim of Saturday was to heighten awareness around blind people.

Says Barn: "Blind people are sometimes a mystery for those who can see. Sometimes they have an overwhelming feeling of pity, sometimes they have a feeling of thankfulness that they have the gift of sight and take better care of their eyes.

"But in the case of our staff, blindness creates empathy rather than sympathy. They take care to understand and help people integrate and be accepted in society.

"Often well-meaning people do ill-meaning things. While sighted people can never fully understand the soul of a blind person, they can learn to understand that blind people are normal people."

Mr Isaac Court, 60, who lost his sight when he was five, agrees there is a problem with the attitudes of sighted people.

"A lot of them seem to pity you," Court says, "I suppose it is the duty for blind people as well to show their independence as much as possible.

"I don't ever remember seeing — this is my world, I know no other — its pointless being negative and depressed. I have to make the best of what I have got."

Court preaches from the bible, plays both the guitar and the piano and lives with his wife in Manenberg. For money, he repairs chairs at a workshop in Salt River.

Maybe Mr Jeffrey van de Westhuizen, who preaches with Court, summed it up when he said: "Most people say they can see, but they really can't."

26/10/92

Sowetan

March for handicapped (299)

MARCHES to highlight the plight of the mentally handicapped will take place nationally today. A spokesman for the SA Federation for Mental Health, Mrs Thelma Mahlobo, said the marchers would press for a charter of rights for the mentally handicapped.

Mahlobo said petition forms would be made available at major shopping centres today and on October 31.

Demand for rights

■ Plight of mentally handicapped:

CAMPAIGNS to press for a charter of rights for the mentally handicapped take place on Saturday with petitions being signed at major shopping centres in the country.

South African Federation for Mental Health spokeswoman Mrs Thelma Mahlobo, announcing this, said that the campaigns would reinforce previous activities aimed at highlighting the plight of the mentally-handicapped.

Earlier this week, relatives of the handicapped and mental health workers staged a march as part of the campaign.Mahlobo said Health Minister Dr Rina Venter would talk about her position on the subject on Saturday.

Mysteries of medical scheme maze explained

(299) ARGUS 29/10/92

Health Reporter

A CRITICISM frequently levelled at users of medical aid is that they don't understand the way the system works.

They are blamed for "over-using and abusing" their medical aids by going to see their doctors too often, or even defrauding their schemes through false claims.

But, for confused consumers there is often little explanation of why, for instance, they still have to pay when subscription rates are high.

Or why they should make every effort to cut back on claims to ensure their subscription rates are kept down.

The following should answer some of these queries.

● **How does a medical aid work?**

A medical aid is rather like a large kitty (or stokvel in South African parlance). Members club together to provide for their medical expenses. The underpinning mechanism is that certain members will "cross subsidise" others with their subscriptions.

Thus, money obtained from healthy members will go towards those who need it. The healthy members are in turn covered when they are in need. If all the members claimed back maximum benefits at the same time, they could push their medical schemes to the brink. This is why "abuse" of the system is of concern to medical aid administrators.

● **What is scale of benefits and how does it affect me?**

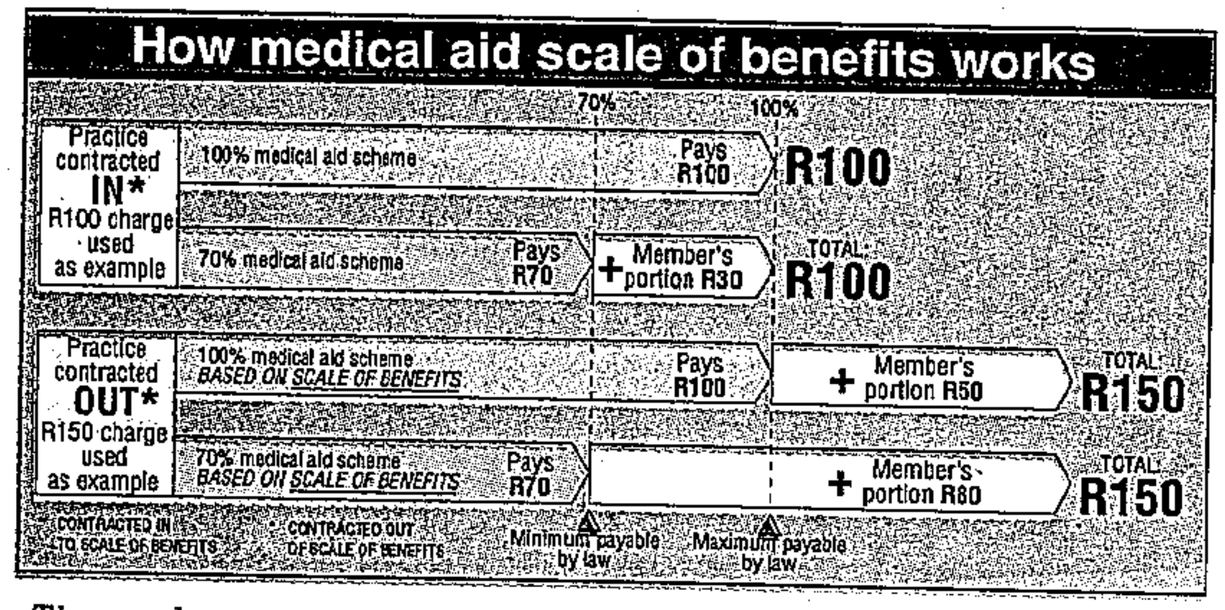
The scale of benefits is a list of tariffs compiled by the Representative Association of Medical Schemes (RAMS) and published in the Government Gazette according to which schemes are obliged to pay certain amounts. By law, they may not pay less than 70 percent of scale of benefits for certain medical, surgical, dental procedures as well as physiotherapy, hospitalisation and medicines.

Scale of benefits tariffs are not necessarily what particular services are worth in the market place, but rather what medical schemes believe they can afford to pay without going under.

The new Medical Schemes Amendment Bill does away with an obligatory scale of benefits by which medical aids must pay members.

● **What does it mean when a doctor charges private rates?**

The Medical Association of South Africa (Masa) and Dental Association of South Africa (Dasa) recommend to their members (doctors and dentists) what they should charge for various procedures.



These charges are sometimes much higher than the gazetted scale of benefits and, in some cases, can be twice as much.

Dentists, in particular, argue that the scale of benefits is way below what they can charge customers if they are to keep in practice. Because of this difference, customers sometimes have to pay up to 50 percent out of their own pockets.

● **When is a doctor contracted in?**

Doctors and other medical practitioners who charge according to the RAMS scale of benefits are said to be contracted in. This means that by law, the medical scheme must pay them directly.

But if a practitioner charges more than the scale of benefits (often the case) they are said to be "contracted out" and there is no obligation on schemes to pay directly.

Medical schemes can therefore ask their members to pay these doctors and reclaim the portion they are owed by thire schemes.

● **What is RAMS?**

It's the Representative Association of Medical Schemes representing about 200 schemes with about 2,5 million members. All medical schemes registered with the Registrar of Medical Schemes have to belong to RAMS. There are a few large schemes, such as Transmed, that do not fall under the registrar's jurisdiction but under the Labour Relations Act. RAMS draws up the scale of benefits.

● **Why, when my scheme says it pays 100 percent, am I still left with a sizeable portion of the bill to pay myself?**

Some schemes may advertise to members that they pay 100 percent of benefit. This does not necessarily mean members will get all their money back. If a doctor, for instance, charges a private rate of R50 for a procedure when the scale of benefit sets it at R40, the 100 percent scheme will only out R40.

Even though the scheme is 100 percent, members have to pay R10 out of their own pockets. By the same process, a 70 percent scheme (which is the lowest a scheme can go legally) will only pay R28, leaving the member to pay R22.

● **What is the subscription?**

This is the money paid into the scheme by the member. The majority of members will probably pay only half the and their employers the rest.

A "middle-of-the-road" scheme today charges around R600 a month for a family of four. Thus the member will pay R300 a month and the employer R300. For members who are relatively healthy, this can seem a sizeable whack, especially if they are still having to pay to make up the difference between scale of benefits and doctors' charges.

For those plagued by ill-health, the payments are well worth it and in a sense they are relying on their healthier colleagues.

Cracks in medical aid

(299) ARG 29/10/92

ANDREA WEISS
Health Reporter

RISING medical costs and rocketing medical aid subscription rates. This is the scenario facing South African consumers who are having increasingly to cough up out of their own pockets for reasonable health care.

In recent months, the cracks in the medical aid scenario have begun to show. This year a registered medical scheme — Medikon — was involuntarily liquidated, leaving about 3 500 members without cover.

According to the annual report of the Registrar of Medical Schemes, Mr Danie Kolver, last year three schemes opted for voluntary liquidation and several schemes had trading losses.

Dr Hendrik Hanekom, secretary general of the Medical Association of South Africa, maintains that schemes are "under tremendous pressure as a result of overuse of benefits and resistance by patients to continuing hikes in subscriptions".

In a statement, he added: "The past few months have seen the collapse of several medical schemes and the closure of others appears imminent."

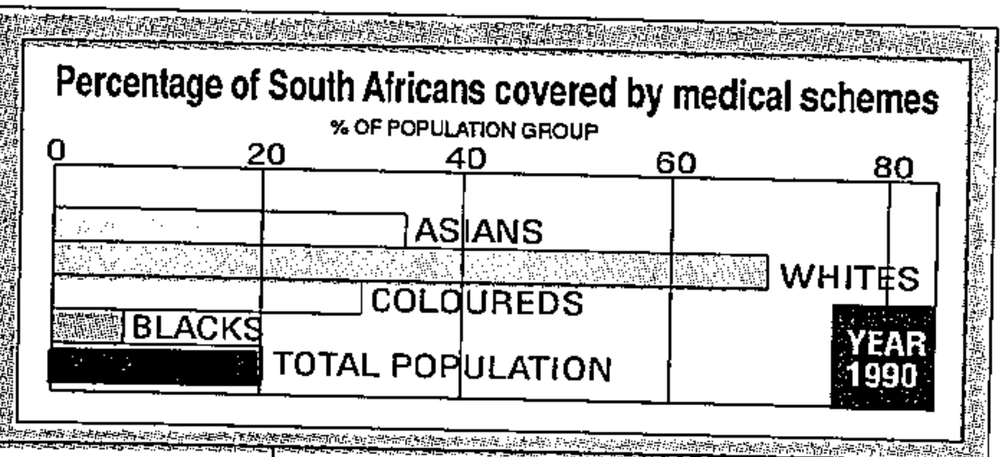
This latter point has been hotly contested by Mr Kolver and by Mr Rob Speedie, executive director of the Representative Association of Medical Schemes (RAMS).

But Mr Kolver does point out in his annual report that there "seems to be a growing reluctance among the young and healthy to subsidise the sick and elderly".

This, coupled with the estimate that pensioners are claiming more than four times as much as ordinary members, spells trouble for the ability of schemes to "spread the risk".

Membership statistics: All schemes 31 December 1990

Midyear estimated figures as at June 1990 furnished by Central Statistical Services



Population group	Beneficiaries	Population	Cover
Asians	328 643	956 000	34,4
Whites	3 453 193	5 018 000	68,8
Coloureds	964 213	3 214 000	30,0
Blacks	1 441 925	21 609 000	6,7
TOTAL	6 187 974	30 797 000	20,1

Graphics: BOB GRIERSON, The Argus

THE BIG DIVIDE: Only about 20 to 25 percent of South Africans are covered by medical aid.

Medical inflation has also escalated at a faster rate than ordinary inflation, making it increasingly difficult for medical schemes to provide affordable cover for everybody.

In the view of the Medical Association of South Africa, medical schemes may be pricing themselves out of the market — leaving a gap which is being eagerly occupied by insurance companies.

But Mr Kolver disputes allegations that medical schemes are on the brink of collapse.

He says new schemes now have to have at least 2 500 members, R1 million in starting capital and a further R1 million cover underwritten by a reputable insurance company.

RAMS concedes that the business of providing medical aid has been under pressure for a variety of reasons. While there has not been an absolute decline in membership, there is a definite slowing off in the rate of growth over the past decade.

Mr Speedie says "times are tough and we're feeling the strain" but he does not believe the industry is under threat.

In his view, the biggest problem confronting medical schemes is costs, both the payment of benefits and the impact this has on subscriptions.

In his view, containing those costs is being hampered by the existing Act.

Mr Kolver concurs: "In my view medical schemes will be unable to devise remedial measures without the greater flexibility proposed in the draft legislation."

The new Medical Schemes Amendment Bill, which is before a parliamentary standing committee, would give schemes a free hand in pegging costs by doing away with many of the obligations they now have to fulfil.

But where does the blame lie when it comes to rising medical costs outstripping ordinary inflation?

The following have all been blamed:

- The economic recession — possibly the longest this century — and the fact that the rand has lost value against hard currencies. This has chased up the price of medical services as has the introduction of VAT.
- An oversupply of expensive equipment and beds in the private health-care sector, pushing up the cost of medical care.
- Abuse of schemes through fraud. Allegations are that some members defraud their schemes by selling their cards or allowing friends to use them and by falsifying accounts, sometimes in cahoots with their doctors.
- Over-utilisation and over-supply. It is claimed that many members consult doctors far too often for petty complaints which could be dealt with adequately at home. Some doctors, in turn, are accused of seeing their patients too often.

"The medical scheme movement is in a crisis through overuse, overservicing and fraud," says Mr Keith Hollis, chairman of the SA Association of Medical Schemes, representing 82 medical schemes.

Dr Hanekom of Masa said: "(Overuse) creates a vicious circle whereby the more benefits that are paid out, the higher the subscriptions become — forcing more and more people out of the privately funded health-care sector and into the already over-burdened state sector or into the shaky status of the uninsured."

Masa also believes there should be a restructuring of the health-care system to reduce the inequalities between those who cannot afford medical aid (about 80 percent of the population) and those who can.

Therefore, the problems of the system as it stands need to be reviewed within the whole picture and not in isolation — as the Medical Schemes Amendment Bill does.

Without medical schemes, most private practitioners and private hospitals would go out of business. Thus it is in everybody's interest to work out a better system.

Major scheme increases rates

(299)
CT 31/10/92

Massive hike in medical aid expected

Staff Reporter

A MAJOR medical aid group said yesterday its subscription rates would be increased by about 17% next year from January 1.

Managing director of Medischeme and chairman of the Southern African Medical Schemes, Mr Keith Hollis, said increased medicine costs, greater use of services and a 10% increase in the scale of benefits by the Representative Association of Medical Schemes (Rams) had caused the increase.

This follows a recent statement by Dr Hendrik Hanekom, secretary-general of the Medical Association of South Africa, that medical schemes were "under tremendous pressure as a result of overuse of benefits and resistance by patients to continue hikes in subscriptions".

Mr Hollis said medicine costs were expected to increase by 35% next year because of the weak rand against the dollar.

He said today a family of one contributed about R500 a month, which included the employer's contribution.

The increase would mean that for a family of one, medical coverage would increase by about R1 000 a year, including the contribution by the employer.

Mr Hollis said medical aid subscriptions could be reduced by a reduction of services, but the law prevented this option.

Rams spokesman Mr Rob Speedie declined to predict "what the 200-odd medical schemes" would do about increases next year.

He said there was a "great emphasis on affordability in 1993".

Mr Speedie said the impending Medical Schemes Amendment Bill due to be passed through Parliament next year would allow for "managed health care".

In theory the amendments would help medical aid schemes cut costs.

Mr Speedie said the Joint Parliamentary Commission had finished deliberations and "recommended minor adjustments".

He acknowledged that "times are tough" but said the medical schemes could not price themselves out of the market.

Mr Speedie said there was "disappointment, but also understanding for problems we all face (the recession)".

'Give us houses, equal pay ... and wheelchairs'

South 31/10 – 4/11/92

(299)

By Shawn Benton

Parents of the disabled are fed up with the lack of state care for their children. And the Parents of Disabled Children Action Group (PDCAG) made these frustrations clear when they took to Cape Town's centre on Monday.

There were children in wheelchairs or on crutches, children walking or carried by their mothers.

They marched from the Grand Parade to the Cape Provincial Administration offices in Wale Street to present their demands to the director general of the CPA.

A group of 150 people gathered outside the CPA offices as a representative from the action group read out their demands, which included a call for government disability grants to be equal for all races.

The demands were presented to Dr Norman Kahlberg, director of Community Health, at the CPA Offices in Wale Street. He was accompanied by Dr Waldemar Terblanche, who said that all those parents owed back-pay for outstanding grants would be paid during the first 15 days of November.

Many parents have not received grants since April this year.

Dr Kahlberg told SOUTH: "We really do feel sympathy for these people and we are planning to meet with all interested organisations to work out a plan for improved care for the handicapped."

Parents of profoundly mentally disabled black children get a grant of up to R150 a month.

Those of severely physically disabled children receive nothing until the child turns 16.

Parents of disabled black children receive a grant of R278 a month, while whites get R348. Coloured children get R308 a month.

The CPA said it endorsed the principle of equal grants irrespective of race, but that equality could only be decided on a national level.

It said that "encouraging indications were given that equality in single care grants and pensions will be provided for in next year's budget".

Another demand from parents was that grants be received as soon as the child was diagnosed as being disabled. At present, grants are only handed over once the child turns three. This reduces the child's hopes of recovery.

Parents also demanded that all back pay on single care grants be paid out with immediate effect; that parents with more than one child qualifying for a grant be granted the full amount for each child; that community-based health care centres be made available in their communities, with their participation.

Mrs Thembisa Mgudlwa, from Khayelitsha, said: "The government doesn't treat us correctly. We need special schools. Our grants must be equal. We need houses for our children — with electricity."

"We need wheelchairs because it's hard to carry the children all the time. And we need physiotherapists in our locations."

Her son Khaya, 7, suffers from Down's Syndrome.

The parents' march was supported by organisations such as the non-racial Disabled People of South Africa (DPSA), the SA National Civic Organisation, the Black Sash and Cape Mental Health.

A few officials of the Pan Africanist Congress were present, including national publicity secretary Mr Barney Desai.

"We are here to show support. We believe in equal grants and in caring for our disabled. Their situation is disgraceful — these are forgotten people."

● Parents needing help with disability grants can contact the DPSA on (021) 696 0386.

PROTEST: Monday's march by disabled people

SA 'sliding towards third-rate medicine'

S/Times [Cape Metro] 1/11/92.

IF academic medicine was not salvaged urgently "from its terminal illness", South Africa could face a future of not just Third World but also third-rate medicine.

This was said by Professor John Terblanche, president of the South African College of Medicine, at the college's admission ceremony in Cape Town on Friday night.

Prof Terblanche said that in the private sector about 50 percent of the medical manpower provided care for about 20 percent of the population.

There were serious problems in this sector.

Inadequate

"Medical aid societies and insurance companies are spending more on medical services than they can afford or than can be construed as reasonable.

"There are more than 200 medical insurance companies. Clearly this has to change."

Prof Terblanche predicted that these would be reduced "to a very small number", which would promote the rational use of resources.

Private hospitals had an excess of beds and facilities, but many of these were being over-used "to the detriment of good patient care".

"Unless the medical profession controls these excesses, this or a future government will be forced to do so. I urge the medical profession and the medical association to take on this role as a matter of urgency."

In the public sector, 50 percent of available medical manpower provided care for 80 percent of the population "with inadequate resources and facilities", especially in the rural areas.

"Despite promises from the state, we remain with many of the serious legacies of the apartheid system, including 14 ministeries of health. Clearly this is ridiculous and needs to be rectified with great urgency."

Prof Terblanche believed the government had the political will to rectify this problem, but it "must ensure that the groundwork for a unitary health-care system is laid soundly at this time and that this is achieved on the basis of extensive consultation with all medical and political groups".

State plans included the provision of primary health care at the local level, secondary health care in nine proposed regions that would replace the provinces and tertiary care in the teaching hospitals, which would become autonomous academic complexes in April 1993.

"All this would sound fine and should be easy to implement were it not for South Africa's being in serious financial difficulties," Prof Terblanche said.

"Superimposed on these problems are an increasing demand for health-care services, a frightening increase in trauma load and the potential of Aids' aggravating the situation.

"Expenditure on health care is rising dramatically while the financial allocation for health is being cut back continually. In addition there is a gross maldistribution of human resources."

A "cure" required greater acknowledgement of the crisis by the state and alternative political groups.

"There has to be the political will to institute changes."

"Additional funds, which must be dedicated to health care, can be obtained by an immediate and significant raise in the tax on alcohol and tobacco."

However, this alone would not provide enough money.

"The only other method that can be instituted with minimal problems and which can generate major funds is a lottery."

By EVE VOSLOO

New medaid plan cares for over-70s

S/Times (Buss) 8/11/92. (299)

HALF of all an individual's medical costs are incurred in the last six months of life — a time often not covered by conventional medical-aid and top-up insurance schemes.

SA's first specialist long-term health insurance company, Momentum Health, has been designed to replace medical aid and insurance. Momentum Life, a medical-aid administrator, and its management will also be shareholders in Momentum Health.

Managing director Adrian Gore says that the problem with most health-care top-up schemes offered by insurance companies is that they are the wrong type. They often discontinue cover for the over-70s when it is most needed.

Minor

Everyone accepts that the State can no longer afford to provide First-World health care and will focus on primary issues.

Medical-aid schemes are becoming too expensive for ordinary people and their employers on several counts, including inflation and abuse. They do not return anything to the contributor if there is no claim. They cover cheap things, but fall short on big-ticket items such as hospital bills.

At the other end of the scale, top-up

By JULIE WALKER

schemes offer no cover for minor expenses and are seldom fully comprehensive.

Momentum Health's first product, Discovery, will be targeted at the corporate market, especially companies with upwards of 50 employees.

Discovery provides 100% hospital cover for life to the insured, minors and spouse, with no gaps and no shortfalls.

But its most striking feature involves the out-of-hospital benefits where there is a built-in disincentive to abuse. A family of four bears an annual excess of R4 500, and a single member R2 700. Costs above this are met in full at scale-of-benefits rates.

There is some cover below this level — medical savings allowance, which pays for the first slice of costs, R1 750 for the family and R1 050 for an individual.

The gap between the medical savings allowance and the annual excesses has to be met by the member. But if the initial allowance is not used, it can be carried over to the next year like a savings account that grows in healthy times and gets called on when a member is sick.

If the insured leaves the scheme, or dies, the money in the medical savings allowance is paid out.

Emergency transport, foreign catastrophe cover of up to R500 000 and advice are all dealt with on a hot-line.

Discovery's premiums should prove attractive to employers battling to pay perhaps R900 a month an employee for inferior benefits that would require another R100 or more top-up insurance.

To provide the highest level of cover, Discovery comes in at about 70% — with the advantage that the savings are for the benefit of the member and not the medaid scheme. A cheaper option is available.

Dormant

The biggest advantage to Discovery is the asset account, held separately for each employee. Mr Gore, an actuary, likens it to a pension fund. But instead of retirement benefits, it provides for major health-care expenses in old age. It is unaffected by claims and is never depleted. If a member resigns or dies, he gets back part or all of the contributions paid in.

Mr Gore, who was behind Liberty Life's entry into health assurance, says that Rand Merchant Bank — now part of Momentum — had a dormant insurance licence. He approached the group. Its managing director, Laurie Dippenaar, shared the view that a dedicated health life assurer was a good idea. Mr Dippenaar is now chairman of both Momentum Life and Momentum Health.

PEOPLE'S LIVES *Early intervention shapes development*

Help for disabled kids

Sowetan 9/11/92. (299)

By Tsale Makam

SHEER DEDICATION *Success of Sunshine Centre can be credited to staff:*

WATCHING pretty, 4-year-old Elelwani Ramashau play on the slide at her pre-school, the Sunshine Centre Association, no one could guess that she is a developmentally delayed child with a slight physical defect.

She has a learning disability. Her developmental milestones lag behind those of her peers. She drags her left leg slightly and moves with her chest pushed uncomfortably forward.

Her doting mother, Mrs Keketso Ramashau, credits Elelwani's normal appearance to the Sunshine Centre Association.

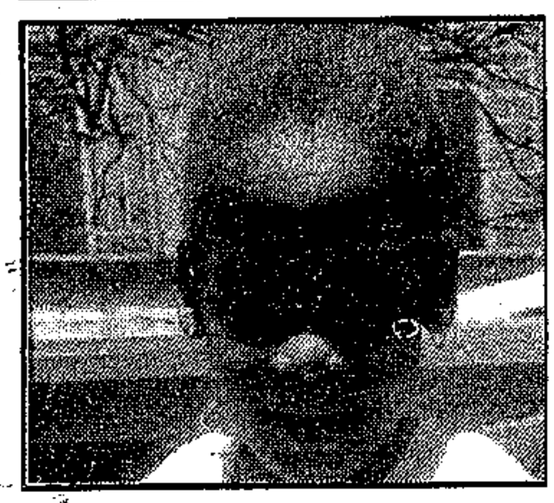
In 1976 parents of young, mentally disabled and developmentally delayed children found that there were no appropriate facil: es for such children. This was when the Sunshine Association pre-school was born.

Today, a few privileged children like Elelwani have the advantage of receiving specialised care at the association's two pre-schools. One in Craighall, Johannesburg, and the other in Elsburg near Germiston.

The pre-school helps bring together parents and provides support groups for them to share the problems and joys of their "special" children.

But its main aim is to offer early intervention, stimulate the children and nip their problems in the bud.

Disabilities range from severe mental disorders to minor developmental ones.



Ray of sunshine ... Elelwani Ramashau.

Elelwani's mother says her daughter's movement has improved considerably thanks to regular physiotherapy.

A speech, occupational and physiotherapist are among the professionals that work with the children.

Rowena Cornelius says when her child, Evan, first went to the centre, he was three years old and could not talk. Today, at age 6, he can hold a fairly comprehensible conversation.

Elelwani and Evan's mothers are divorcees. They will stop at nothing to give their children the best. Unfortunately the state does not provide much funding for early intervention.

At R400 a month from 8am to 1pm and a further R110 for the care service for working mothers many parents cannot afford the fees.

"We are aware that it is costly for most parents, but to do anything less would be to drop the standards and offer less service. The specialised care is really expensive."

Outreach programmes to Soweto, KwaThema, Springs and Eldorado Park are the centre's attempt to make a difference in the lives of children whose families cannot afford to take them to special schools.

Another form of mental and physical stimulation is a toy library.

Toy libraries are open once a week in Eldorado Park, Soweto and KwaThema where the "Start Striving Towards Achieving Results Together" outreach programme offers counselling to parents and children.

Therapists visit centres in these communities to offer professional assistance and guide the parents on how to stimulate a particular child. Sibling support groups are also encouraged.

Some parents find it hard to accept that they have such children and may even reject them at first.

"Most of it is caused by ignorance about the condition and societal stereotypes. Mental retardation and physical disability are not diseases. Parents should learn to accept their children and not feel ashamed of them."

Cure for ailing medical aid

W|Mail 13|11-19|11|92

Medical schemes aren't working because doctors and patients rip it off. Now another system offers to cap the rising cost of health care.

By **FERIAL HAFFAJEE**

A NEW type of health insurance could be just the remedy the medical aid industry needs to get out of the doldrums.

Called "managed health care", the new system promises to cut the cost of medical insurance and maintain quality health care.

Members of the new system pay a fixed monthly amount to the company. The company engages doctors who are paid a fixed amount per month replacing the fee-for-service system.

The first of these new medical insurance companies — Medimo — was recently established by Rembrandt's Medi-Clinic, the Health Care Division of Afrox and Medicaid Administrators, a member of the Price Forbes Group.

Medimo representatives say the new system is cheaper, offers a choice of medical care (basic or comprehensive) provides free medicine and ensures quality by subjecting participating doctors to tests by peers.

The basic package offers general practitioner care, medicines, diagnostic radiology and pathology and costs about R35.

The other option is comprehensive care which also offers specialist treatment, hospitalisation, dental care, and paramedical services like physiotherapy, blood transfusions, ambulance services, spectacles, surgical and medical appliances. The price of comprehensive treatment can vary, depending on the services you require.

The new system also cuts costs by reducing the bureaucracy of medical aids because there are no claims to be processed and paper work is kept to a minimum.

"The GP acts as the gatekeeper," says a Medscheme representative, and is pivotal to the new system. All other health care, like specialist treatment, paramedical services and hospital treatment, is available only if the patient is referred by a GP.

But this scheme is restrictive because patients have no, or limited access, to GPs and specialists not contracted into the Medimo network.

The organisation says that doctors undergo a strict selection process, continuous review by Medimo appointed doctors and patient committees who meet regularly to evaluate all aspects of the service.

If patients still chose to go to non-Medimo doctors, they pay for their own treatment.

In September, another company, Medshield, was launched by Johannesburg doctor, Mohamed Adam. Doctors are more closely involved in the provision of the service than with Medico.

Medshield is a hybrid between the United States model of Health Maintenance Organisations and a medical aid and "removes the disadvantages of both", says Adam, by offering doctors and patients a stake in the system.

Although medical aid costs have soared, doctors had no incentive to cut costs with conventional medical aids and there is also widespread member abuse of medical aids.

Medshield operates on a fee for service basis, but doctors control the system through an elected committee in every geographical area where Medshield operates.

A computer generated letter lets a doctor know when they are exceeding the costs of their colleagues in the same area. If the doctor has legitimate reasons, these are fed into the computer which "never again writes to the doctor", says Adam. If costs are not cut after a second letter, the doctor has to explain to the committee.

Clients are also used to "milking the system" and want to get every cent they pay out of the medical aid, says Adam.

To end both doctor and patient abuse of the system, Medshield has a number of built-in bonuses.

Doctors get tax free bonuses and patients get lower premiums if there are any contributions left in the fund at the end of the year.

"It is a free market system," says Adam, explaining that patients can shop around for the lowest premiums and doctors can contain costs to attract more members and earn higher bonuses.

Ombudsman reports

LINDA ENSOR

CAPE TOWN — Disputed disability claims featured prominently among the complaints handled by the life assurance ombudsman last year.

Of the 141 complaints handled (345 in 1990), 49 were disability claims, 43 were claims repudiated by life assurers on the grounds of alleged non-disclosure and 39 related to lapsed policies.

A total of 31 cases of misleading, unethical or negligent conduct by intermediaries was reported, leading the ombudsman — former Appeal Court Judge G P C Kotze — to praise the role of broking and intermediary disciplinary bodies for their efficient supervision of members.

Of the complaints against intermediaries, 14 were resolved in favour of complainants.

Of the 332 cases finalised, partial or complete relief was recommended in 58% (190) of cases.

FM 20/11/92 (299)

HEALTH INSURANCE FM 20/11/92

Gaining Momentum

(299)

Compared to the health-care approach introduced recently by Momentum Health, most of the other life assurance-based offerings featured in the past two years seem a little tentative.

By declaring itself a separate company, dedicated to selling only health-care policies, the newcomer will have to report publicly on its experience in a market where there are few marketing, actuarial or management records.

The other major players in the health market, such as Old Mutual and Liberty Life, can put their products in intensive care if they get their sums wrong at the outset, or even bury them among the life company profits. That option is not open to Momentum Health, a new member of the RMB-Momentum Life Group.

Also, while most other assurers have positioned their products as top-up services, to make good the shortfall between what medical aid societies can afford and what the public wants, Momentum Health MD Adrian Gore says bluntly that medical aid societies in their current form are on the way out. The State will provide primary care — all it can now afford — and the health policies will have to meet the needs of people who can afford sophisticated procedures.

Momentum's introduction of its health-care company is high-key in presentation but modest in its initial ambitions. The company, which will deal only through employee benefit brokers and will not handle individual business, is targeting medium-sized employers with upwards of 50 staff. Gore says he wants 50 000 on the book within three years which, at an average of R500 a month per member, produces a modest premium flow (by life industry standards) of R25m. Liberty attracted 300 000 members and dependants within a year of launching its health range. But Momentum's premiums seem attractive, for comprehensive health care, if they can be maintained.

If the sums do prove incorrect, health premiums — unlike life policy premiums — can be adjusted. A member company could re-evaluate its contributions and swap, if necessary, to another system of employee protection. "That is a constraint against sudden and inappropriate premium revisions," Gore agrees.

But the insurance health-care sector, viewed against a total SA spend of R17bn annually on health, is determined to take a slice even if it means going on a learning curve.

At a recent forum arranged by Hollandia Reinsurers, a US authority on medical expense insurance, Hobson Carroll, cited several leading American insurers that had entered the market, then retreated. Being successful in one line of insurance, he said, did not guarantee success in any other branch of the business. Life assurers were accustomed to predicating two factors, the likely date of death and the cost of maintaining a policy until that date. "With medical expense insurance, an initial event may lead to a stream of benefit events of variable number and severity."

Carroll raised another issue that is plaguing the nascent industry: the extent to which a member's doctor should be free to prescribe treatment. The gulf between compassion and hard business sense has led some US insurers to introduce review procedures for expensive operations.

Gore agrees there is a problem, which may have contributed to the shortcomings of the medical aid movement. "Certainly there have been abuses — one wonders how many hysterectomies have been recommended when not really needed."

But he is adamant that Momentum will not directly interfere in the patient-doctor relationship. The company will, however, require that when non-emergency surgery is proposed, the member should receive a second opinion. If it is not sought the benefit reduces.

There are other safeguards against abuse. There is a small element of self-insurance and there are incentives for members not to over-use service providers. If their pool of benefits is under-utilised, the surplus carries over into their personal account so someone who has lived a fit and healthy life will earn a cash payout at the end of the policy. In addition there is a long-term fund build-up that is actuarially managed to meet members' needs in old age. When a member leaves the scheme this saving is treated for tax purposes as deferred compensation. ■

Southern launches group medical scheme

(299)
CT 20/11/92

SOUTHERN Life has developed a group health insurance product, Group Med-Help, with a unique long-term feature enabling current employees to fund for their future medical costs in retirement.

The Capital Health Builder plan is an industry first and allows fund members to accumulate capital through monthly contributions. Withdrawals may be made to pay for major medical catastrophes but the facility is not a replacement for medical aid as regular withdrawals are not permitted.

General manager employee benefits, Roy Lennox, said with the excessive medical inflation rate, conservatively estimated to be running at more than 25% per annum, it was likely that health care costs would continue to soar.

Barnard said he killed Webster — CCB officer

Blorn 20/11/92.

FORMER CCB agent Ferdi Barnard told his handler Lafras Luitingh he had killed David Webster to prove to the bureau's MD Col Joe Verster that he was of use, the Rand Supreme Court heard this week.

This was said by former CCB information officer Derrick Louw, an alias, at the judicial inquest into Webster's assassination.

On Monday Louw testified that Luitingh had told him shortly after the May 1 1989 attack that Barnard had confessed to the killing, in an attempt to show Verster that he was acceptable and of use to the bureau and should not be dismissed.

Louw's evidence was heard in camera on Monday but the transcript was made public yesterday afternoon.

He said following Barnard's dismissal from the CCB in 1989, Luitingh, a personal friend and former co-ordinator of Barnard, had approached him to use his contacts to try and get Barnard a job with special forces.

He had approached someone in special forces who required more background on Barnard — who had a criminal record and was a convicted murderer.

He had allowed the matter to rest there as he had not considered the matter a priority.

Luitingh had approached him a few days after Webster's death to tell him to inform special forces to rather "stay away" from Barnard.

He had told Louw he feared Verster would dismiss him too if he found out he was trying to get Barnard re-employed.

He admitted then that Barnard had confessed to him that he had killed Webster.

Louw said he found it strange that Barnard had chosen Webster as a target as he was unknown to the information branch of the CCB.

At no stage had the CCB targeted Webster as this would usually involve an intensive investigation of the person's activities, his routine, photographs of his house and aerial photographs.

"To my knowledge there was no indication of any sort that Webster was a priority of the CCB."

He had told former Military Intelligence chief Gen Witkop Badenhorst during his internal investigation into the Webster incident about the conversation with Luitingh. He was under the impression from later interviews with Verster that the information had been conveyed to him too.

Louw acknowledged during cross-examination by State Advocate Jannie van Vuuren that information had been gathered on activist Gavin Evans, but denied that it was the sort of information that would suggest that Evans had been targeted for assassination.

Van Vuuren put it to him that CCB chairman Gen Eddie Webb had told the inquest Verster had admitted in his presence that Evans had been targeted for murder.

He said he had no knowledge of this order nor did he have any knowledge about the collection of information regarding lawyer and activist Dullah Omar, who Webb also said was targeted.

Luitingh was called to give evidence yesterday as a consequence of Louw's evidence. His evidence was heard in camera.

Verster is expected to give evidence today. — Sapa.

KATHRYN STRACHAN

Contraceptive put under the spotlight

299

Blorn 20/11/92

THE controversial contraceptive injection Depo Provera came under the spotlight yesterday as leaders in the medical, political and labour spheres debated its use and abuse at a heated international symposium in Johannesburg.

Jan Peterse, CE of Upjohn Pharmaceuticals — which produces the drug — said his company had planned the symposium to provide a forum to review recent scientific evidence on the product.

Wits Centre for Health Policy researcher Barbara Klugman said the problem had not been with the product itself, but the way it was used.

Family planning in SA had historically been aimed at controlling and limiting the black population, she said, and it was in this context that Depo Provera had been prescribed.

Makhosazana Xaba, also at the centre, said it was now accepted internationally that Depo Provera was a medically safe and reliable drug, but the concern was that it was open to abuse.

It could be administered without women knowing what it was and uneducated black women were not always informed of its side effects and contra-indications. They were also not advised of alternative methods.

White women, on the other hand, were discouraged from using the drug.

The symposium focused on the need for more training, education and counselling to ensure that abuses of the drug came to an end.

Peterse said the recent approval of Depo Provera by the US Food and Drug Administration further proved the safety and effectiveness of the contraceptive injection.

Speakers at the symposium included a World Health Organisation advisory committee member, a World Bank representative and medical experts from Washington, Sweden and Australia.

PEOPLE'S LIVES *Joy of helping patients to die with dignity is tinged with pain for Bibi Nkosi*

Extramile

Sowetan 26/11/92

By Pearl Majola

LOVE HURTS *Watching lives slip through the fingers is very painful:*

ALMOST EVERY DAY Sister Bibi Nkosi (56) watches the life of a loved one slip through her hands. Yet she still hurts every time another one of her patients dies.

A mother of two and a grandmother of three, stress and age have not affected Nkosi's energy or her enthusiasm.

She is a strong woman committed to her demanding work as a nurse.

Through the newly established Hospice-in-Soweto, she has gone that extra mile to remain true to her nursing pledge and to help those in need of more than just medical care.

Hospice, a welfare association existing on donations, provides care with the aim of improving the quality of life for patients with life threatening illnesses.

The only nursing sister employed by the association in the area, Nkosi is on call 24 hours a day.

She sees up to five patients a day, spending at least one hour with each, and has a total of 30 patients at any time in her care.

Sad part about my job

She goes around Soweto seeing to her clients, comforting and counselling them and their families and helping them come to terms with their fate. The patients are referred to the association by different health services, friends and the community.

"The only sad part about my job is that I develop relationships with these patients but know they will be short-lived," says Nkosi.

"But I love it because it has given me a sense of value for life. I have learnt to cope with the loss with help from our own support group as Hospice workers as well as from our clinical psychologist.

"One of the worst losses I have suffered was a 35-year-old mother of five," she recalls tearfully.

Shared a three-roomed house

"Maria had lost her husband a few years before and had later developed lung cancer, which forced her to give up her job. She and her children shared a three-roomed home with the rest of her family of brothers and sisters who also had their own children. There were 17 people in that house.

"Despite her illness she slept on the floor, which only made it worse."

Keep improving

Although Maria died in March this year, Nkosi has kept contact with her family and recently managed to get two dresses for Maria's daughters.

Nkosi's involvement with Hospice began out of curiosity about the organisation and the urge to keep improving her nursing skills (she has specialised in such fields as nursing administration and psychiatry).

"Naturally I am curious and always want to be the first to do things.

"When I saw the Hospice post advertised I decided to go for it and here I am," she explains.

"I have learnt a lot about life and I am fulfilled by helping the victims (of terminal disease) and their families come to terms with the situation.

"It makes me feel I have done something to ease the pain," she says.

Though the concept of Hospice is new to the people of Soweto, Nkosi says she has had a very good response from the people she has worked with.

"My family have given me a lot of support through all this, especially my husband."

Sister Bibi Nkosi

All about Hospice-In-Soweto

- Hospice-in-Soweto started in March last year.
- Apart from Nkosi seeing patients in their homes, there is also a weekly out-patient clinic and day-care centre service run from the Hospice Witwatersrand in-patient unit in Rosettenville.
- There is also a social worker who helps with counselling and establishing support groups among her duties.

The Witwatersrand Hospice

- Hospice is a welfare organisation concerned with improving the quality of life for patients with terminal diseases.
- The Hospice multi-disciplinary team help with pain control, physical mobility, problem solving and pastoral support.
- The association provides care on the basis of need only, not on the ability to pay.
- Hospice (Witwatersrand) can be contacted at PO Box 87600, Houghton, 2041 or phone 483 1068.
- The programme has reached over 2 000 patients and families, counselled over 3 000 and visited about 3 000.
- The association has a staff of 62 including doctors, nurses, social workers and other health, administrative and development workers. There are about 350 volunteer workers.

'Maria had lost her husband a few years before and had later developed lung cancer, which forced her to give up her job. She and her children shared a three-roomed house. There were 17 people in that house'

Healing the country's diseased heart

STAR 26/11/92

IF THE family is any barometer of a society's health, South Africa needs a doctor badly.

Fortunately there's a kindred spirit, a "traditional healer" already at work treating the "patient's" worst symptoms ... in the bosom of the family.

For two years now, The Family Institute has focused on healing society's chronic, febrile wounds which show up clearly in the family.

Decades of apartheid rule have contributed to the family's vulnerability. The rapid pace of political change over the past two years has exacerbated the condition, says institute director Dr Saths Cooper.

Destroy

The institute's work is based on a simple medical premise: strengthen the immune system (the family) and you strengthen the whole body (the nation). And it begins with children.

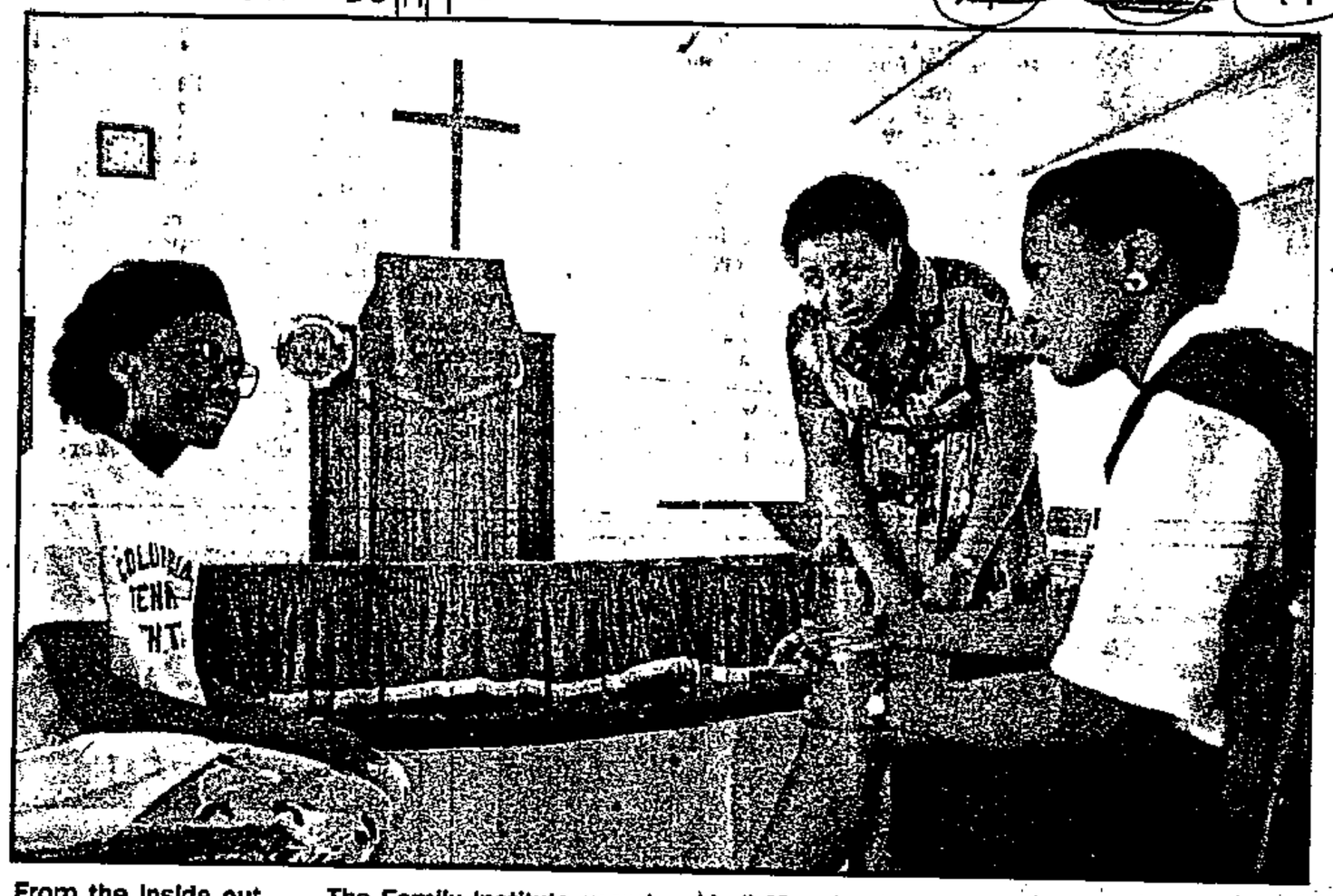
Ironically, while the Government has always upheld rightist notions of family values, it has done the most to destroy family life, Cooper says. Black families have taken the impact head on, but others have felt the ripple effect.

"We would not be suffering the degree of physical destabilising and anguish if the family could do what it is supposed to do: protect the children, give them a sense of self-worth, safety and sanity," says Cooper.

In just over 24 months the institute has expanded its areas of operation, and its projects have flourished.

It's special brand of "medical students" is the youth, especially black youth in their late teens to early 20s, who have trained as community counsellors and form the backbone of the institute's volunteer work.

The success of this operation destroys the myth of disaffected, marginalised youth being uneducated and uneducable, says Cooper. The "lost generation" has been found.



From the inside out ... The Family Institute member Lindi Maseko (centre) works with volunteers in Duduza as part of a programme to encourage the youth to help the youth. Picture: Joao Silva

Change is difficult to mediate at the best of times, he says. The type of change expected to occur now within individuals, families, organisations and communities is so far-reaching that it aggravates basic insecurities and inadequacies.

Families are affected by stresses such as public violence, unemployment, homelessness and an environment characterised by general instability.

Many people, particularly men, are taking out their rage, frustration and unrealised expectations on those closest to them, in the family. Sexual abuse of children, once unheard of in the black community, is increasing, as is general domestic violence including wife-bashing and famicide.

Children are alienated from parents and siblings and there are few if any stable communities. Cooper has counselled many young black activists who have never had a relationship with either parent.

Divisions run so deep these days that to declare that you are a Zulu in an urban setting is to invite an attack.

We have reached a "crescendo" of self-destructive behaviour, in which violence is an accepted way of resolving conflict, says Cooper.

The effects of structural violence in all its manifestations on individuals, families, organisations and communities represent formidable obstacles to current reconstruction and development initiatives aimed at the "historically disadvantaged" majority in South Africa.

The Family Institute finds its genesis and role in these contexts.

Cooper ascribes the institute's success to an open approach to collaboration with other institutions. "This avoids the risk of territoriality that feeds the intolerance underlying many endeavours in this country."

The institute offers a unique, holistic, interdisciplinary approach to relieving deep-seated trauma in this country's heart and to routing the causes.

Creative

No sector, discipline or interest in the institute is paramount; specialised expertise complements existing diversity. The institute intervenes where needs are expressed, and does not impose external "expertise". Independence from sectarian or individual interests allows it to operate without hidden agenda.

Its creative ways of training and intervention to empower families and communities reduce dependence and increase skills and knowledge in communities that need them most.

The institute's work, says Cooper, will have direct policy implications. These will be invaluable to a democratic government and the non-governmental sector, especially in cost-efficiency and measurable programme penetration to larger numbers of people who have traditionally been excluded from service delivery systems, resources, decision making and developmental initiatives.

Working together

THE Family Institute focuses attention on the family and on communities — at their invitation.

It is interdisciplinary in nature. Intervention activities involve doctors, nurses, social workers, psychologists, teachers and educationists, a few business people (even accountants), community workers, lawyers, academics and artists.

It is committed to creating the necessary understanding and linkages essential to nation-building, so does not confine itself to one area of expertise.

The notion of outside experts entering communities with esoteric knowledge and skills which lay people are incapable of understanding is contrary to the institute's ethos.

Its work includes:

- Children first: enrichment and prevention programmes, for example education for peace, maximising creativity.
- Family centres: to treat family related problems and offer training programmes to enhance family, organisation and community efficiency.
- Violence intervention: direct services to victims of violence and training for those keen on intervening at all levels, including prevention. Services are in the victim's language of choice.
- Community mediation and conflict resolution: training and intervention in collaboration with other professional agencies.
- Community support and enhancement.
- Youth leadership development: training youth to help the youth.
- Research to improve quality of life for all.
- Support in the work environment.
- Coping with change — managing transition and beyond.

For more information, telephone The Family Institute at (011) 838-4541.

When death becomes a living hell

How can a doctor tell if an unconscious patient wishes to be kept alive artificially when there is no hope of recovery? JUSTIN PEARCE looks at the concept of a 'Living Will':

IS IT worth living when you're unconscious, being fed by a tube and are on an artificial breathing apparatus?

The South African Voluntary Euthanasia Society (Saves) was established to campaign for the patient's right to a peaceful and dignified death.

According to Saves president Dr Margaret Barlow, every patient has the legal and moral right to refuse medical treatment.

But what is a doctor to do with an unconscious patient who has no chance of recovery and is being kept alive artificially? How can one tell whether the patient would wish to be kept alive in this way?

To help answer these questions, Saves has instituted the "Living Will". This document, like any other will, is signed while you are in a conscious state. By signing the document you declare that if you are ever unconscious with no chance of recovery, you do not wish to have your life prolonged artificially.

The Living Will originally covered the area of medical treatment. A more recent addendum, which a signatory has the option of signing, also refuses consent to artificial feeding.

This is to cover instances in which a patient has been rendered unconscious by brain damage. In such a case the patient may be capable of remaining alive without continuous medical treatment.

A patient who has signed a Living Will saves the doctor from the dilemma over whether to continue treatment when the patient has no chance of recovering consciousness.

"We have had remarkably little opposition from the medical profession," said Barlow. "We have also found that the more experienced doctors have been the most sympathetic."

The presence of a Living Will can be a relief to the families of unconscious patients. Barlow said that when the patient's intentions were not known, bitter arguments often took place between family members over whether to keep the patient alive by artificial means, or to allow a peaceful and dignified death.

"I do not recall a family ever disputing a Living Will," Barlow said. "In fact it is often a relief to know that their relative has made this decision."

She emphasised that every patient, under South African common law, has the right to refuse treatment. In fact, a doctor who administers treatment against the patient's wishes is guilty of a common law assault.

If a patient is unconscious, dependent on life support apparatus and has not signed a Living Will, the case must be referred to a court of law for arbitration before life support can be withdrawn.

The legal dispute may take years, during which time the patient is kept alive at great expense, and the patient's family is under emotional stress. Saves has approached the Law Society of South Africa with recommendations that this procedure be simplified.

Barlow suggested that cases be referred to special committees rather than the courts.

She drew a distinction between "passive euthanasia" (the withdrawal of artificial life support) and active euthanasia (actively ending a patient's life). Saves is concerned only with passive euthanasia.

Active euthanasia involves more complicated ethical issues and is illegal. A doctor who actively assists in the termination of a patient's life is liable to prosecution, even if the patient has given consent.

"We would never take up the cause of active euthanasia," Barlow said.

Saves has collected statements by religious leaders from a number of Christian and Jewish denominations supporting the right of the patient to refuse the artificial prolongation of life.

● You can contact Saves at PO Box 1460, Wandsbeck 3631.

Medical aid rates likely to increase

B1D 1
30/11/92 (299)

GERALD REILLY

MEDICAL aid subscriptions are likely to go up between 15% and 25% in the new year because of increases in the statutory scale of benefits, as well as expected steep rises in medicine costs and hospital fees, says Representive Association of Medical Schemes (Rams) chairman Fanie Roodt.

To be gazetted soon are scale of benefits increases of 10% on GP, specialist, dentist and physiotherapy fees, and 11% on private hospital fees from January.

Industry sources said medicine costs were likely to increase by at least 20%, state and provincial hospital fees by 15% and paramedical and optical fees by 10%.

Also to be taken into account, Roodt said, was the expected hike in VAT, from which medical costs were not exempt.

The Registrar of Medical Schemes's Danie Kolver said all 200 registered funds had been under increasing pressure for the past few years.

National Health Minister Rina Venter was concerned at the extent of continuing overservicing by doctors and other health services providers, and unnecessary consultations by fund members, he said.

Kolver said latest figures — for 1991 — showed the income of the funds had increased by 28,5% to R7,104bn compared with the previous year. Benefits payouts had increased by 29,5% to R6,890bn.

National health system not possible — Adcock Ingram

299

ANDREW KRUMM

SA COULD not afford a unitary national health system or national health insurance scheme, Adcock Ingram chairman Robbie Williams said in his annual statement for the year to September.

Williams said: "SA's tax and resource base is totally inadequate to meet current demands let alone any new health care requirements."

He said deregulation and an increase in self-regulation among health care professionals could enhance the cost-effectiveness of health care without lowering standards.

"Proposed legislation to deregulate medical aid schemes will enable them to offer a range of cover ... (and) will encourage the prescriber and the consumer to become more cost-conscious."

However, changes to the proposed Medical Schemes Amendment Bill (to be presented to Parliament in February 1993) should take account of the patient's right to choose medical personnel and doctors' rights to choose therapy. BIDAY 1/12/92.

"Responsible self-medication should be encouraged through an educational programme in self-medication, and by allowing the pharmacist to dispense Schedule 3 and 4 medicines without a prescription under certain conditions."

The establishment of managed Health Maintenance Organisations by medical aid administrators would cater for the cost-effective treatment of the lower to middle income groups, he said.

Cabinet shuffle strengthens talks team

BIDDY 1/12/92.

THE Cabinet takes on a slightly new face today with the addition of former Deputy Constitutional Minister Tertius Delport, but the thrust towards a streamlined negotiations team is much stronger.

President F W de Klerk has taken the opportunity of State Affairs Minister Gerrit Viljoen's resignation to realign his limited manpower with the focus on intensified negotiations by lightening the load on key negotiators.

Delport's promotion to the Cabinet as Local Government Minister can be seen a shrewd move by De Klerk, who wants him to concentrate on developing and negotiating one of the NP's fundamental constitutional proposals — regional government.

BILLY PADDOCK

Delport has been the key NP politician drafting the regional proposals.

One of Delport's problems at Codesa II — when he stepped into Viljoen's shoes as the main negotiator on the last critical days — was that he did not have the authority to clinch deals with the parties and had to return constantly to Cabinet for the go-ahead.

This allowed the ANC to escape from the plan that government had manoeuvred it into and resulted in Codesa II failing and government losing the initiative.

Lightening the load on Manpower Minister Leon Wessels, a known liberal in the NP, was also a strong indication that he would be playing an increasingly important role in negotiations. His attitude and track record over the past year have demonstrated that he consults widely on controversial issues, but at the same time is a tough negotiator.

By loading an extra portfolio, that of National Housing, onto Education and Training Minister Sam de Beer, government has acknowledged that although the black education portfolio is a tough job, government is not going to do anything more than administer the portfolio until the new dispensation scraps it in favour of a single education department. De Beer will be assisted by Glen Carelse who has been appointed to devote his attention to National Housing, dropping his former functions of Local Government and Manpower.

Constitutional Development Minister Roelf Meyer has also shed the communication portfolio, allowing him to involve himself solely in negotiations. His work in this field has already been a huge burden with a series of bilateral negotiations with different parties each week.

Delport's replacement as Meyer's deputy has gone to former National Health Deputy Minister Fanus Schoeman, a loyal De Klerk follower but unschooled in constitutional matters. It is expected he will be responsible merely for the communications function.

De Klerk has also rewarded another stalwart supporter by appointing Boy Geldenhuys to take over Schoeman's functions of Health and Welfare.

In the near future, probably during the first half of next year, there may be further changes as more older NP MPs resign under the new law that does not require by-elections — making way for younger and more liberal appointees.

DP constitutional expert Colin Eglin states blandly that De Klerk had such limited scope within which to move, because of the lack of talent among NP MPs, that he could not free his negotiators entirely from their responsibilities as Cabinet Ministers.

Scheme pays not to claim

BIDDY 1/12/92 299

A MEDICAL aid scheme which allows members to regulate their own contributions and exercise full control over their benefit funds has been launched.

The Managed Health Care System, launched by Pro Regno Financial and Economic Services together with Botshelo Health Care Systems, gives members an incentive to reduce medical consultations.

The package includes a savings account into which two-thirds of monthly contributions are paid.

Each member receives a card to pay immediately for routine medical services. The other third covers insurance against hospitalisation.

Botshelo Health Care Systems MD Douglas Kalkwarf estimated that 25% of all medical aid payouts were fraudulent, amounting to about R1,3bn.

KATHRYN STRACHAN

"The managed health care system places the control of medical expenses in the hands of the member and provides an incentive for him to handle it in a responsible manner to his own benefit."

Kalkwarf expects fewer claims will mean that contributions will not rise as rapidly as in past.

Dr Lawrence McCrystal, CE of Pro Regno and member of the President's economic advisory council, claims that members' medical aid costs are rising faster than medical expenses. Yet medical aid schemes are increasingly running at a deficit.

Costly deadline for CFCs

THE Copenhagen agreement signed last week, which brought forward the deadline for the phasing out of CFCs worldwide, will have enormous financial consequences for local industries, Castrol marketing director Chris le Marquand says.

KATHRYN STRACHAN

The agreement set January 1 1996 as the date for the removal of all ozone-depleting gases — a drastic acceleration on the earlier Montreal agreement which set the deadline at 1999.

"The financial consequences of this accelerated process to SA are enormous as it is estimated that to phase out in 1999 could cost millions of rands, but to push this to January 1 1996 would cost billions instead," said Le Marquand.

"Fifty percent of the CFCs generated by SA come from the refrigerant industry and, while SA comprises only 1% of the world's production of CFCs, our role is as critical as any other country," he said.

Castrol and AECI play a leading role in the conversion of CFC 12s to the environmentally friendly gas R134a.

Le Marquand said the industries which would be most affected by the increased costs would be those that depended heavily on refrigerants, such as mining, transport and food wholesalers.

Serviceable CFC refrigeration equipment would have to be converted to the more environmentally friendly alternatives with the minimum expense and disruption, he said.

"Fortunately the ingenuity of various manufacturers has ensured more efficient methods of conversion from existing CFC 12 to HFC 134a within the refrigeration industry."

But the major problem was the incompatibility of the new HFC refrigerants and conventional compressor oils, he said.

Castrol industrial marketing manager Kevin le Roux said that although the new deadline would increase the cost of conversion for manufacturers, the industry was concerned about the hazardous environmental effects of the gases and had not lobbied government to delay the deadline.

Proposed overhaul of aid schemes welcomed

By Stephen Cranston

Proposed legislation to deregulate medical aid schemes, which would allow them to offer a range of options from all-inclusive to basic cover is to be welcomed, says Adcock Ingram chairman Robbie Williams.

He says in the annual report for the year to September that patient care and the right of access to consultative services, dentistry and medicines should not be compromised in any structure in which the medical aid scheme becomes both a funder and provider.

The establishment of managed health maintenance organisations by medical aid administrators and other organisations will eliminate fees for service and cater for the cost-effective treatment of the lower-to-middle-income groups.

Independence

But some degree of choice needs to be provided and a degree of independence given to health care professionals employed by such organisations.

He says the introduction of a limited list of medicines by medical aids is to the detriment of the consumer and may also subvert the doctor's right to choose the appropriate treatment.

Williams says it would be better for the consumer to have a choice of funding alternatives within any medical aid scheme, with the major health insurers competing freely.

He says responsible self-medication should be encouraged by an educational programme and by allowing the community pharmacist to dispense schedule III and IV medicines without prescription.

During the year all six business units took the Adcock Ingram name so that, for example, Sabax was renamed Adcock Ingram Critical Care, and Saphar-Med renamed Adcock Ingram Self-Medication.

The generics business enjoyed the strongest growth in the year, increasing turnover by 47,1 percent to R17,7 million.

The slowest growth was experienced by self-medication, which increased turnover by just five percent to R108,1 million.

Sowetan 2/12/92

Mourning for 7 000

AN act of mourning for the more than 7 000 people who have died in political violence in Natal since 1987 will precede a mass peace prayer rally in Durban later this month.

The service at Westridge Park tennis stadium on December 13 will be conducted in English, Zulu and Afrikaans by church leaders of several denominations. Political leaders, various consular corps and international monitors have been invited to attend.

Taverners gauge impact

TAVERNERS are meeting today to assess progress in their four-day boycott of South African Breweries beer. A joint meeting of the National Taverners Association and the SA Taverners Association will be held at the NTA offices in Soweto to gauge the impact of their confrontation with the liquor giant.

The two organisations would also prepare for tomorrow's meeting with SAB in an attempt to resolve the dispute. They staged pickets in front of SAB's plant near Baragwanath Hospital during the past two days. Sowetan 2/12/92

Epileptics unemployed

THE vast majority of people with epilepsy in townships and squatter camps on the West Rand, including Soweto, are unemployed, according to a study by the South African National Epilepsy League (Sanel). Sowetan 2/12/92.

There are about 50 000 people with epilepsy in Greater Soweto, Kagiso, Munsieville, Bekkersdal, Evaton, Lekoa, Mohlakeng, Sebokeng, Sharpeville, Boipatong, Orange Farm, Weiler's Farm and Alexandra, Sanel said yesterday. "The majority of the 50 000 people are unemployed - indications are that the number of unemployed people with epilepsy in this area can be as high as 39 000."

Medical aid groups to fund HIV care centre

Star 3/12/92.

Medical Reporter

Top medical aid companies have agreed to fund and implement an Aids/HIV management plan — which includes the setting up of an HIV care centre — after an historic industry meeting in Johannesburg this week.

Speaking at the "Living Healthy with HIV" meeting, Affiliated Medical Administrators chief executive officer Timothy Gelman said South Africa was facing an Aids problem of potential crisis proportions and appealed for united industry action in the face of general lethargy and denial of the problem.

He emphasised that the many conferences and seminars on the subject had so far yielded little more than rhetoric and academic arguments without concomitant action.

A working group has now been formed to fund and set up an HIV care centre as the first step in the Aids/HIV management plan. The aim of the plan is to keep HIV-positive members of various medical aid and insurance schemes "HIV well" as opposed to "HIV ill", in order for them to remain physically and economically active as long as possible.

This would be done within a structured system to provide optimal care most effectively.

The critical factors in achieving this are:

- Early detection of the HIV virus.
- The establishment of a community-based infrastructure.
- The development of the process of managing access to and cost-effectiveness of care.

The care centre will provide co-ordination of community and home services; the technologies and materials necessary for effective management and treatment of infection; the co-ordination of a network of pharmaceutical groups, primary care providers and infectious-disease experts to deliver care at appropriate levels as well as hospice services for Aids cases.

● More reports — Page 21

Health care groups to discuss policy issues

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STAR 3/12/92

Medical Reporter

Prompted by expectations that the health sector is facing a "fundamental transformation" within the next few years, primary health care groups will gather outside Johannesburg next week to discuss policy issues within the industry.

A joint South African Health and Social Services Organisation (Sahsso) and National Progressive Primary Health Care Network (NPPHCN) conference was announced at a press conference in Johannesburg yesterday.

Joint policy committee chairman Dr Max Price said the theme, "Transforming the Health Services", had been precipitated by the "realisation that within the next two to three years we expect to see a fundamental transformation of health services".

Price said pressure on the Government to reduce inequities in health care would be so great that it would have to respond immediately.

He added that transforming the present health bureaucracy — such as the attitudes and practices of health service managers who would probably continue to work in the future health services — would receive special attention at the two organisations' joint national policy conference next week.

Price said transformation would require the reallocation of financial resources and the establishment of facilities which were more accessible to previously oppressed communities. It would also require transforming the ideology, attitudes and practices of the current personnel in the health sector.

Cut medical aid costs by giving incentives — expert

(299)

Medical Reporter STAR 3/12/92

Predicted medical aid fund subscription increases of up to 25 percent next year can be avoided or reduced if schemes implement positive cost-containment measures, according to a leading medical aid administrator.

Representative Association of Medical Schemes chairman Fanie Roodt has said medical aid subscriptions were likely to rise between 15 and 25 percent in the new year because of increases in the statutory scale of benefits and expected steep rises in medical costs and hospital fees.

But Medicaid Administrators director Dr John Cowlin said: "Increasing contributions is not the only solution. The time has come for medical schemes to really push cost containment."

Cowlin said schemes needed to provide members with incentives, not disincentives, to control medical costs through co-payment alternatives to conventional 100 percent benefit schemes.

"Co-payment encourages members to be cost conscious and to refrain from going to the doctor at the drop of a hat. In this way, contributions can be reduced without cutting back on benefits."

Cowlin recalled one of the many examples of members directly abusing 100 percent benefit schemes: a member had 96 consultations with doctors between January and September this year — more than two visits a week. "One of the major reasons for this is that the scheme offers no incentive to contain costs."

Contributions could be lowered only if benefits were reduced in conventional approaches. However, a 70 to 100 percent scheme was able to maintain the level of benefits when members most needed them.

"It does this by requiring a 30 percent co-payment from members for all medical services up to a set threshold value, after which it reverts to paying 100 percent of the scale of benefits."

A place of hope in Guguletu helps the disabled

S Times (Cape Metro) 299

WHAT started as a work-party meeting for a group of concerned Guguletu citizens 11 years ago, has grown into a venture which is fittingly called "Place of Hope". 6/12/92.

By JESSICA BEZUIDENHOUT

Pictures: JACK LESTRADE

Kwa-Nothemba, which means Place of Hope in Xhosa, is a multi-diagnostic protective workshop for the disabled in Guguletu.

It provides non-residential employment to black disabled adults in the area.

The benefits of remunerative and meaningful employment for severely disabled people have been amply demonstrated at Kwa-Nothemba, the Project's co-ordinator, Ms Cherrel Herbert, said this week.

After a short while, workers gain "immeasureably in self-esteem and dignity", she said.

Despite the severe disability of all 68 people employed at Kwa-Nothemba, she said, it runs successfully as a small business.

"Our workers' productivity cannot be compared to that of normal people in the open labour market," she said.

With a workforce of just under 70 people, Kwa-Nothemba had a turnover of more than R330 000 during the 1990/1991 financial year.

Kwa-Nothemba provides employment for people who are either physically disabled, mentally disabled, those with hearing disabilities and epilepsy sufferers.

A group of workers are employed in the contract section, which does contract work like quality control and bulk-packing of products for major manufacturing companies.

A full-time carpenter has been employed in the woodwork room where top-quality furniture and educational toys are produced.

In the sewing room, curtains, bedspreads and cushions are made by women.

Independent

Kwa-Nothemba, which pays its workers the maximum wage which still allows them to qualify for state grants, aims to be totally independent of government grants in future, Ms Herbert said.

With this they hope to relieve the burden of support on the government and pay a maximum living wage.

As a direct result of Kwa-Nothemba's success, a second facility is to open in Khayelitsha early next year at a total cost of R1,1 million, providing work for a further 150 disabled people.

Kwa-Nothemba's aim to "equip disabled people with marketable skills" has proved successful as more than 20 people have left the workshop to start their own businesses in the

WILLING WORKER . . . Mr Peter Manwill is productive despite his disability

news from around the showbiz scene

Where being different just doesn't matter

Sowetan 7/12/92

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■ Victor Metsoamere takes a look at one of the four beneficiaries of the Heal Yourself concerts at the Standard Bank Arena in Johannesburg on December 11 and 12:

Imagine a young girl, pretty and vigorous, but not envied by her peers at school just because she cannot keep pace with them.

Perhaps they make snide remarks behind her back because she is "different".

The parents despair because they think the situation is hopeless and there is nowhere to take their beloved child for help.

But then someone tells them about the Ikemeleng Remedial Education Centre (IREC) in Orlando, Soweto, where girls and boys with learning disabilities are given a chance through special and easily understood methods not used in the conventional educational system.

Without this community-based remedial education programme, the only one in Soweto, these children would be isolated from society.

Ikemeleng, supported mainly by the community, was adopted by the *Sowetan* as part of its Nation Building campaign, while additional funding was provided by the Kellogs Foundation from last year.

IREC presently has a waiting list of about 100 names from concerned parents from as far as the East Rand, Port Elizabeth and the West Rand.

IREC desperately needs sponsorship to accommodate children whose needs are severely neglected in South Africa.

Helping the children

Name of Institution: Ikemeleng Remedial Education Centre.
Purpose: To help children with learning disabilities.
Year formed: 1984.
Reason for starting IREC: Prompted by the backlog of referral for children with learning disabilities at Baragwanath Hospital.
A parent group initiated the formation of the school in Soweto.
First staff: One teacher with 15 children. 40 children in 1988. 130 children in 1990.
Current teaching staff: 12 teachers - nine full-time and three part-time, a psychologist, an education officer, a health officer, a secretary, a bookkeeper and a field worker. The first teacher at IREC is the school's director.
Home: Dube Village
New home: Orlando, Soweto.

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WATCH OUT FOR OUR SPECIAL ON THE HEAL YOURSELF CONCERTS IN TOMORROW'S SOWETAN.

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GENERIC DRUGS

Siding with consumers

Consumers hit by the high cost of drugs got a break from the courts recently. The Appellate Division ruled against a pharmaceutical manufacturer trying to block software that makes it easier for pharmacists to sell generic — and usually cheaper — equivalents of prescribed drugs.

The saga began when the UK-based Beecham pharmaceutical group discovered that Superscripts, a software program that helps pharmacists in dispensing medicines, showed that the seven Beecham drugs listed were in most cases more expensive than their generic equivalents. Beecham tried to stop Superscripts' sales effort by claiming that the software firm was infringing its trademarks by listing its branded drugs for the purpose of price comparisons.

The court's rejection of the application was unanimous. Chief Justice Michael Corbett described Beecham's argument as leading to results that would border on the absurd. In the landmark decision for trademark law, the judge suggested that to include the information about Beecham's products in an index of this sort was not the same thing at all as trading in those products and did not infringe the trademarks.

Says David Boyce, chairman of Medikredit and Superscripts, which are both wholly owned subsidiaries of the Pharmaceutical Society of SA or its branches: "The decision is a resounding victory for consumers. Had Beecham succeeded with its application, pharmacists, doctors or in fact anyone, cont-2

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would have been prohibited by law from informing consumers about the availability of any alternative product or providing price comparisons to the public."

Superscripts was designed 10 years ago but didn't take off until 1985 with the advent of Medikredit's Maximum Medical Aid Pricing system. The system, to which medical schemes belong voluntarily, sets a maximum price that schemes will pay for an active ingredient — whether this is contained in a branded drug or a generic equivalent. Beneficiaries can accordingly request their practitioner or pharmacist to prescribe or dispense the cheaper equivalent. Today, Superscripts operates nationally with about 500 pharmacists using the program.

Subscribers to the system have also boomed. Says Boyce: "In 1990, 250 000 members belonged. Membership (including people in medical aid schemes) has now reached 1m."

Propelling the software and the pricing system has been the growth of generics as more generic equivalents become available and the public becomes more aware of them. Boyce points out that in 1988 generic sales accounted for 2,6% of all private-sector drug sales. This figure now stands at around 12%.

Clearly, this doesn't go down well with the major drug manufacturers. Says Johan Moorcroft, a legal adviser to the Pharmaceutical Manufacturers' Association, who attended the proceedings: "I believe Superscripts is objectionable because it portrays two different products as being equivalent — something that has never been scientifically validated. What wasn't discussed in the case was that the non-active ingredients in drugs are often absorbed by the body differently and, accordingly, react differently, irrespective of the active ingredient common to both the patented drug and the generic."

But, with a 30-year unblemished record in SA's public sector, generics are clearly here to stay and the manufacturers will have to learn to live with them. ■

Overcome the social stigma

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Star 11/12/92

Hearing impairment is a debilitating handicap and often the thought of wearing a hearing aid causes as much anxiety as actually coping with the social and communication problems associated with the hearing loss itself.

However, there are a number of professionals and professional bodies available to assist the person suffering from hearing loss. These include audiologists in private practice, hospital clinics and hearing aid consultancies; ear, nose and throat surgeons and acousticians.

Professionalism is a very important issue in the fitting of hearing aids and the rehabilitation of the hearing impaired person. It is a person's right to be informed of the professional's qualifications, and to ensure that he is registered with the South African Medical and Dental Council.

Often medical aid societies require medical clearance of the hearing loss as well as diagnostic testing by qualified audiologists.

Says an audiologist from Rosebank Hearing Aids (who's may not be named for professional reasons): "In our practice, patients are given a full diagnostic audiological test battery. If indicated a suitable hearing aid is selected from a wide range of makes and models.

"The fitting process is very individual, with each patient reacting differently to amplification and presenting different requirements. Adjustment to amplification is rarely immediate and good interaction between patient and professional is vital for the successful use of a hearing aid.

The audiologist suggests people who are interested in more information should contact one of the practice's qualified staff on (011) 880 4584/5.

National health policy proposed

BIDM 14/12/92

KATHRYN STRACHAN

AFTER a week-long conference, major health organisations on Friday released their national health policy which is expected to hold far-reaching implications for future health provision in SA.

The policy document — which was formulated by the SA Health and Social Services Organisation and the National Progressive Primary Health Care Network — has first to be ratified at a regional level before it is formally adopted.

The document focused on the fragmentation of the present health service which has resulted in wasted resources and inequitable care to different sectors of the population.

The issue of labour relations in the public health sector was given prominence in the document. Poor labour relations had damaged and disrupted health care in SA and, by undermining the morale of workers, it had affected the quality of their care, it said.

The exclusion of civil servants from the Labour Relations Amendment Act of 1991 was the root cause of the strife. The conference called for the Act to be extended immediately to include all public servants and to guarantee their right to strike.

In order to avoid strike action workers, especially nurses, had to be guaranteed freedom of professional association, and acceptable dispute resolution mechanisms had to be adopted.

Many of the health sector's problems arose from the concentration of health personnel in urban white areas and in the private sector. To redress the imbalance, the document resolved to implement incentives such as higher pay or greater professional recognition for work to attract personnel to underserved rural areas or to the public sector.

The document also proposed a stronger emphasis on mental health. Several investigations in recent years had found that up to four in 10 people were suffering from some form of mental ill-health, which was often brought about by the violence in communities as well as within families and by alcohol and drug abuse.

Speaking at the conference Gerald Bloom, a developmental studies lecturer at Sussex University, said there was no simple solution to the problem of financing essential health services in a society as segmented as in SA, where there were many sophisticated hospitals for the rich and an under-developed primary health care service for the poor.

"It may be unrealistic to attempt to provide the entire population with the kinds of services which have been developed to serve the elite, or even those services which formal sector employees have come to regard as their right. The establishment of new institutions is costly and takes time to establish," said Bloom.

Johannesburg city health executive director Dr Nicky Padayachee proposed an option for health sector restructuring which could be rapidly implemented once an interim government was in place.

"There is obvious support for a unitary health system with decentralised implementation and the removal of fragmentation, duplication and racism. There is also wide support for equity and for a primary health care approach, including community accountability and participation."

Miss World 1992 Julia Kurotc
the Lost City. She is flanked
Gago, 19, who was named t

ANC slates TPA over hostels

RAY HARTLEY

THE ANC has called on the Transvaal Provincial Administration (TPA) to hand over the R326m set aside for upgrading of hostels to the National Housing Forum in order to improve community participation in the process. BIDM 14/12/92

ANC PWV spokesman Ronnie Mamoepa said the TPA was acting unilaterally and making false claims about having formally consulted hostel dwellers about the upgrading process.

"There have been instances where the TPA has talked to individuals. In reality the TPA has not consulted and, where there have been consultations, they have been undemocratic," he said.

The Hostel Residents' Association had informed the ANC that it had never been officially consulted by the TPA, he said.

The TPA said at the weekend it had reached consensus during consultations with the residents of 35 of the 92 hostels it administered.

"Negotiations among representative negotiation groups are in progress in respect of 42 other hostels," the TPA said, adding that it would proceed with the upgrading process despite recent ANC criticism.

A TPA statement said allegations that it was not following guidelines for upgrading agreed on in November by the National Discussion Forum on Hostels, were untrue.

"The TPA wishes to appeal to all role-players in this important aspect of housing to co-operate so that the whole issue may be addressed as speedily as possible.

"It must be stressed that the TPA regards proper and representative consultation of the utmost importance in achieving consensus regarding the upgrading or conversion of hostels in the Transvaal.

"This allegation is noted with concern as it appears that in some cases, ANC members at the grassroots level are not being informed on negotiations and progress regarding the upgrading and conversion of hostels by their organisation's representatives," the TPA said.

But Mamoepa said the ANC was "seriously concerned about the way the TPA goes about this kind of thing".

Tokoza hostel dwellers who had vacated their rooms when the TPA had begun renovations could not afford the higher fees charged after upgrading, he said.

The TPA said expectations of better living conditions had been created during the consultation process and the TPA wished to meet these by continuing upgrading.

SAP torture probe is on

BIDM 14/12/92

STEPHANE BOTHMA

CLAIMS of widescale torture of suspects by Brixton murder and robbery unit detectives would be probed by Witwatersrand Regional Police Commissioner Maj-Gen Chris Serfontein, the SAP said at the weekend.

The announcement followed media reports alleging that policemen routinely extracted information from detainees by torturing them in a "truth room" at Brixton murder and robbery headquarters.

The Weekly Mail reported that electric shocks, hanging prisoners by their wrists and beatings appeared to be an everyday occurrence at Brixton.

The newspaper reportedly possessed a statement from a police source, backed by interviews with other policemen, former policemen, lawyers and former Brixton detainees to support the claims.

Witwatersrand police liaison officer Capt Eugene Opperman said the SAP had never tolerated misconduct by its members and called on those who alleged the torture to prove the claims so that the police force could be rid of "any unsavoury character".

An independent police board would soon investigate serious complaints, Opperman said.

SA is not so 'dear'

Ever rising health care costs have resulted in fingers of accusation being pointed in all directions, and members of the various medical professions have come under fire with suggestions of over-inflated fees.

However, Moscon Optics International, which supplies spectacle frames to optometrists, says people buying glasses in South Africa are getting the best deals in the world.

Managing director Colin Lewis says: "I think it is very important for the public to know that while the cost of spectacles from their optometrist may appear to be high, there is nowhere in the world that people are getting a fairer deal than in South Africa.

"I know what the prices of lenses and frames are in the rest of the world and they are much higher. In many cases the South African cost is half that of Britain or the USA.

"There are places such as Hong Kong which offer very cheap optics, but people must understand they are buying very inferior product. Most optometrists in South Africa offer quality products and services at incredibly reasonable prices."

He also says people buying spectacles through non-professional outlets are short-changing themselves on quality of service.

Says Mr Lewis: "It is important to realise that while the consumer can buy a frame through a totally non-professional outlet, he will never be able to get the kind of service and direct health care relationship which he will obtain from the professional optometrist.

"In the same way as when a person is sick he goes to a doctor, when his eyes need attention there is no-one more qualified in the country to take care of his needs than an optometrist."

His strong belief in the need for people to use the services of an optometrist has resulted in Moscon adopting the policy of supply frames only to professional practices.

Call to review health care plan

■ Lack of skilled personnel to implement system:

By Mokgadi Pela

THE GROSS maldistribution of personnel in the country should be reversed to suit the health care needs of the population, delegates resolved at the end of a five-day meeting on Friday.

The resolution emerged from a conference organised by the National Progressive Primary Health Care Network and the South African Health and Social Services Organisation in Broederstroom.

The delegates felt the problems with the present health care system include:

The concentration of health personnel in urban areas and the corresponding under-provision in the rural settings;

Concentration of health personnel in sophisticated, curative settings in the private sector with corresponding under-staffing of public health sector facilities; and

Complete lack of personnel with training and skills to implement specific programmes of a reformed system based on Primary Health Care (PHC).

The delegates further resolved to call on the Government to train new categories of health personnel in:

● Environmental health to tackle the need for small water supplies and household sanitation in poor communities; and

● Health promotion and advocacy to equip communities with skills to campaign for proper public policies.

The conference urged the Government to put a moratorium on the building of new training facilities in already well-served areas.

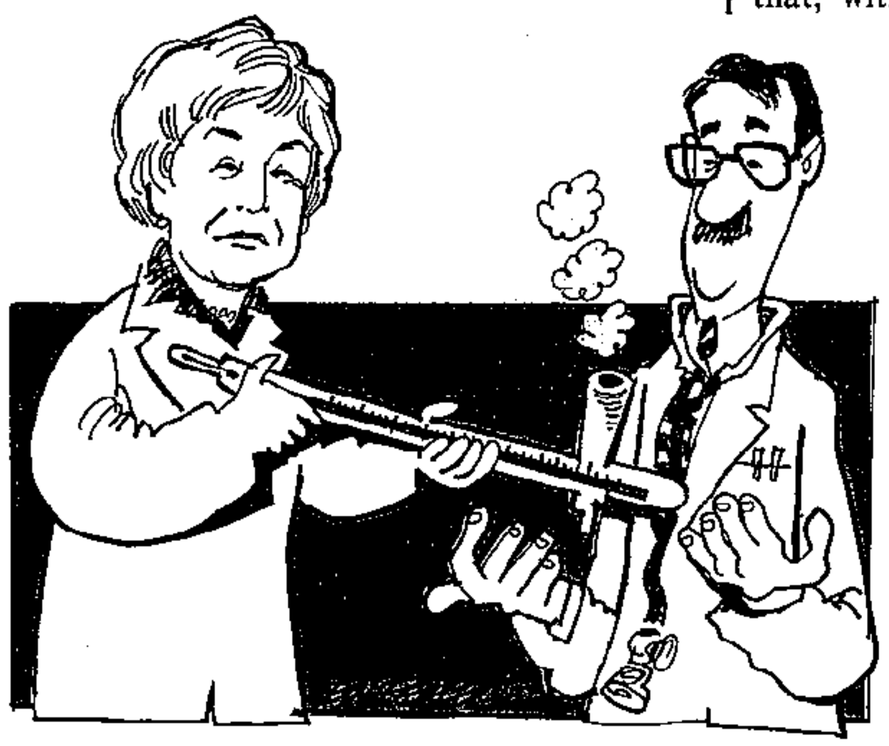
FM 18/12/92.

Putting reform back on track

(299)

Last year the doctors' lobby called for Health Minister Rina Venter's resignation, so upset was it over her proposed Medical Schemes Amendment Bill. Now Venter and the doctors are back on speaking terms. They've reached a compromise that clears the way for parliament to pass this major health care reform early in the next session.

Under the Bill, the automatic payments that medical schemes must now make when they receive a claim would no longer be guaranteed. Instead, schemes will have much more discretion in approving or rejecting claims. In addition, the minimum rates set by law that schemes must pay for each type of medical procedure would be abolished, giving schemes the power to negotiate benefits with each member it signs up.



In another far-reaching provision, the Bill would allow medical schemes to employ doctors and run their own hospitals. This practice, called managed health care, has cut costs by as much as 40% in other countries.

But it will also challenge the absolute discretion of doctors in dispensing health care, so they've fought it tooth and nail for the past two years.

A recent concession, however, has ended the stand-off. Venter agrees to write the Representative Association of Medical Schemes (Rams) out of the Bill, ending the organisation's statutory powers. This means Rams will become an independent body, representing medical schemes voluntarily. It also means that the Bill will go through parliament with the doctors' approval.

The compromise was hard-won. Venter initially wrote Rams into the new legislation, arguing that a body dealing with so much public money needs statutory powers to mediate between medical schemes and doctors. The doctors, represented by the Medical Association of SA (Masa), however, felt that medical schemes shouldn't enjoy statutory protection if they are allowed to compete with doctors in providing services. Masa also was not happy that Rams' status as the representative of medical schemes would be gained through compulsory membership.

For now, Masa appears happy. Says Masa health policy director Reg Magennis: "Masa has broken away from a conflict approach to a consultative approach. We're looking for total solutions. In particular, Masa realises that, without an effective medical-scheme system, doctors and patients will be affected detrimentally. We also realise that it's crucial for the private sector to improve its capacity to manage the use of scarce resources. For this reason, Masa accepts the concept of managed health care."

But, despite the progress, some doctors still have serious reservations about the reforms, and these could well hinder the implementation of managed health care.

A fundamental concern is that their professionalism and clinical judgment could be compromised under managed health care because of pressure to keep down costs. They also fear that medical schemes could put many private practitioners out of business by restricting the patient's freedom of choice.

Rams executive director Rob Speedie disagrees. He says the reforms will merely increase the scope for negotiation as players become increasingly competitive and patients become more aware of the costs. "Doctors will be able to negotiate payments they receive and the services they provide, together with the criteria for determining the level of health care. We will need each other. No player will be able to dictate to another."

Masa is also concerned that the Bill could pave the way for increased risk-rating — where health packages are increasingly based on the individual's condition, age and other factors — eliminating the benefits of cross-subsidisation for the aged, chronically ill and poor. This practice, it argues, would throw the neediest into the grossly inadequate public sector.

Speedie, however, is adamant that cross-subsidisation will continue with the new dispensation, though it probably will be reduced. He adds that the industry has practised risk-rating for at least three years but with circumspection. "Cross-subsidisation remains a fundamental concept of health insurance. One can't ignore the fact that young members resent subsidising the old and ill."

The Medical Schemes Act requires schemes to pay the money they receive into a trust fund for the benefit of all members.

One worry that doctors have is that, without guaranteed payments under the new system, there's a danger that they might sometimes not get paid.

But Venter points out legal fees, like health care costs, are also expensive, yet no system of guaranteed payments is available to exclude risk.

For Masa, a complete levelling of the playing field would mean scrapping all regulations that prohibit medical professionals from forming group practices — several specialists working for the same firm — that can compete with the managed health care organisations run by medical schemes. Says Magennis: "The SA Medical and Dental Council decided in October to change the Medical and Dental Act to allow for group practices, but Venter still needs to promulgate these changes."

A major gripe is that pharmacists and nurses are not included in this new dispensation.

The stumbling blocks are the professional councils — pharmaceutical and nursing — that need to approve multiprofession profit- and loss-sharing relationships, Magennis says. "Until this happens and the appropriate legislation and regulations are changed, the advent of managed health care cannot be facilitated." ■

the work of the earlier committee established by the Goldstone com-

violence."

Police needed to respond to calls

tempts to launch a local dispute resolution committee had failed.

Fixed medicine prices would hit poor hardest, warns Masa

PETER DELMAR

THE Medical Association of SA (Masa) has warned that enforcing uniform selling prices for prescription medicines could have a detrimental effect on poorer communities.

Responding to recommendations by the Competition Board that drug manufacturers not be allowed to discriminate in selling medicines to doctors, wholesalers and pharmacists, the association said it acccepted that price discrimination had a negative effect on the distribution chain.

Masa's health policy director Reg Magennis said the association was concerned that the proposed single exit price policy would have a negative impact on the valuable role played by dispensing doctors serving poorer communities.

"These doctors have been able to provide medication to poor patients at reduced prices.

"The Competition Board has indicated that exceptions could be made under justifiable circumstances. Masa regards any service to an indigent patient as a circumstance which warrants a concession."

Although Masa supported free market competition and was against price fixing, it recognised that price discrimination had a negative impact on the efficiency within the distribution chain, and that a single exit price policy could result in structural improvements to the existing system.

Magennis said Masa supported dispensing by doctors if this was "in keeping with the norms associated with high quality clinical practice, in the interests of patients".

The Competition Board's investigation followed complaints that doctors were receiving discounts relative to wholesalers and other buyers of prescription medicines, despite buying smaller quantities.

The board's recommendation is currently with Public Enterprises Minister Dawie de Villiers, who is expected to decide whether to accept the recommendation early next year.

Security radio link for farmers

STEPHANE BOTHMA

AN EXTENSIVE private radio communications system is being installed in the southern Free State, enabling farmers to be in constant contact with each other and local security forces.

The Agri-Alert two-way radio system, with facilities similar to those made available to farmers during the Rhodesian bush war, was one of the biggest installed in SA, a spokesman for suppliers Afritech, Mike Myers, said yesterday.

The system operated on the basis whereby farmers in a specific area were linked by radio between their homes and vehicles and also between themselves with hand-held radios, Myers said.

"The system is also directly linked to and and monitored by police and military establishments, who will provide quick response capability to farm homesteads in times of attack," he said.

Although nationwide government-owned alert systems have some merit, it was far better for groups of farmers to organise themselves on a co-operative basis, Myers said.

Disabled hit by break-in

299

Sowt 19/12/92 — 13/1/93

By Diane Coetzer

THE future of an information service employing physically disabled people is in the balance after a break-in at the weekend.

More than R1 000 taken from the sale of Community Chest scratch cards, numerous scratch cards and a hi-fi system were taken from the Infoquick offices on Saturday night.

Workers at the firm are despondent as this may mean the end of their employment at a time when physically disabled people are last in the job queue.

Infoquick manager, Mr Manie van den Heever, said the robbery was a severe setback for the project, which started recently.

"We are apparently responsible for replacing the door that was broken in the robbery and this will cost a fortune.

"We also lost a large amount of Community Chest tickets which we have already paid for up front so that is a big sum. Then there is also the cash that was taken."

A worker, Mr Solomon Magujulwa, 31, said he felt "very low-spirited" after the incident.

"This is the first job I have had for a long time and I would hate it if we could not continue to operate."

Mr Edward Esau, 30, was shocked when the news reached him.

"I cannot help but think someone who saw us bringing community chest tickets into the office was responsible for this.

"It has been very hard for me to find a job and what happened makes me feel very low."

According to van den Heever, who is currently doing a doctorate on the employment of disabled people, 98 percent of physically handicapped people are unemployed.

For the seven handicapped people working at Infoquick, then, this is the only employment they are likely to get.

"Even here in this building the facilities are very bad. The toilets are far away from the office and when anyone wants to use these facilities they have to be carried to them."

Infoquick was set up three months ago and offers the public easy access to information supplied by businesses. Tel 24-9676

FINE FOCUS ... Little John Makoela looks out on to a new world while Lions Club members Staal Reeves, left, and Rochlic Metha enjoy his delight. ■ **Pic: THULANI SITHOLE**

Lions Club has a vision for the needy

By DESMOND BLOW

THE Lions Club of SA has launched one of its most ambitious projects yet – Operation Brightsight – to help thousands of people who are walking around half-blind but cannot afford spectacles.

Last weekend a clinic for Operation Brightsight was opened at 6 Regent Street, Yeoville, Johannesburg, by Lions Club International president Rohit Mehta of India, who was in South Africa on a three-day visit.

Spectacles normally cost hundreds of rands, far beyond what most underprivileged people can afford, so the Lions operation collects second-hand lenses and frames, which their original owners discarded when they obtained new glasses.

The lenses are graded according to strength and prisms and after the patient has his eyes tested by a qualified optometrist the spectacles are made up for him, either with a second-hand frame or with an inexpensive new frame.

The scheme is non-profit making but generally patients will be charged a nominal fee to cover costs.

It is not generally realised that poor sight leads to many problems for students in the classroom and for people in the workplace.

Literacy projects have revealed that in many cases the poor results of some students in examinations are due to poor eyesight. Poor eyesight can also have a detrimental effect on health.

The clinic, which is on the main bus route, will begin operating in January and appointments can be made by telephoning Operation Brightsight at Johannesburg (011) 487-1944.

Spectacles will also be dispensed all over the country by post, if a valid prescription is sent to the clinic.

Generic medicine cuts costs, say medical administrators

STAR 21/12/92

299

Medical Reporter

Patients who actively request generic medicine substitutes could save up to 50 percent on many commonly prescribed drugs, according to Affiliated Medical Administrators.

AMA said the cost of prescriptions formed a large portion of medical aid scheme payouts each year, and that more generic substitutions could make a dramatic difference to the schemes' viability.

AMA marketing director Ray Welham said research among medical aid members had revealed alarming levels of ignorance about generics.

Many saw generics as cheaper and hence less effective, and were reluctant to ask doctors for them.

Generics, a "copy-cat" product of the original, are manufactured once the patent of the original expires.

Medical aid fees increased

299

SANMED yesterday announced increases in membership fees of the six public medical aid schemes it manages for groups, as well as improvements to benefits. General manager Nick du Preez said membership fees would be increased by not more than 14 percent in any of the six funds. - *Sapa.*

Sowetan 22/12/92

Medaid fees up by 'no more than 14%'

STAR 23/12/92

Medical Reporter (299)

Cape-based Sanmed has announced medical aid membership fee increases "not higher than 14 percent" for six of the public-sector medical aid schemes it manages.

The announcement, the first of several expected within the next few weeks, was lower than earlier predictions of membership fee increases of up to 25 percent for 1993.

Representative Association of Medical Schemes chairman Fanie Roodt has said medical aid subscriptions were likely to go up between 15 and 25 percent next year because of increases in the statutory scale of benefits and expected steep rises in medical costs and hospital fees.

Sanmed general manager Nick du Preez said the average increases in membership fees "will not be higher than 14 percent in any of the six funds".

Sanmed's five group schemes are Helpmed, with an average increase of 14 percent; and Bonmed, Belmed, Swamed and Topmed, with an average increase of 12 percent. The sixth scheme is aimed at individual private members.

The six schemes have a total membership of about 90 000 and represent about 250 000 people, including dependants of members.

"Higher fees were necessitated by the rising costs Sanmed and other medical aid schemes have to face. They include hospital fees, higher medical and dental tariffs and more expensive prescribed medicine. Medical aid schemes have little control over the latter," said Du Preez.

"At the same time, some benefits will be improved. This, with the fact that increases could be limited to 14 percent on average, we regard as an achievement."

Du Preez attributed the lower-than-expected increases to a "fantastic response" from members to cost-cutting moves. "We managed to do it by means of a number of restrictive measures introduced over the past year, and also thanks to the co-operation of most of our members."

Du Preez said that if all members used their medical aid schemes in the right spirit, it would be possible to manage such schemes cost-effectively.

He said misuse, fraud and over-utilisation still occurred.

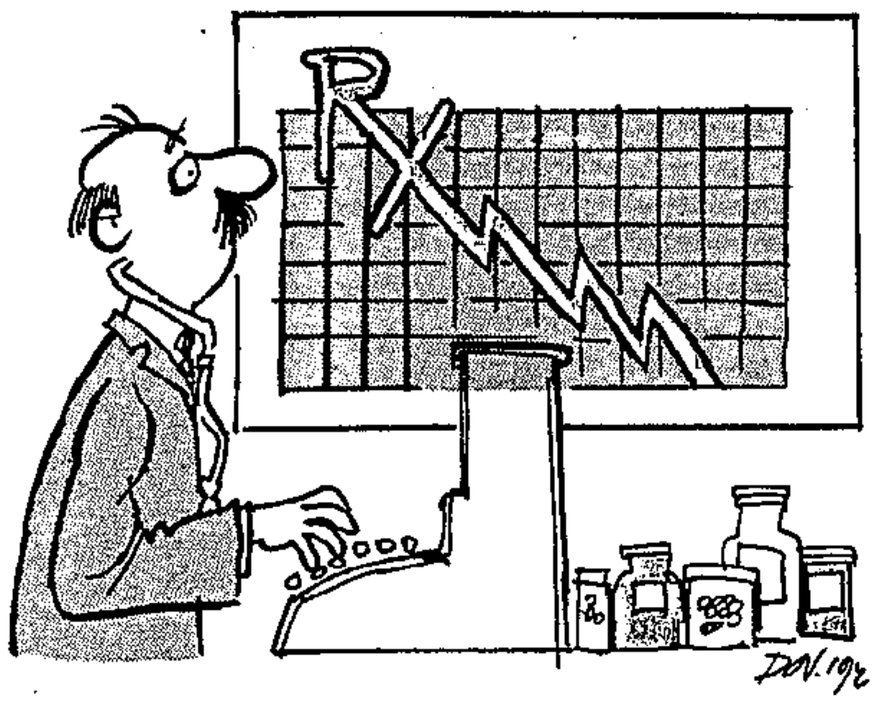
Referring to a possible VAT increase next year, Du Preez warned that if this higher rate were applied to medical services, costs would be negatively affected.

DRUG SALES

Ending doctors' profit bonanza

Back in 1984, in an effort to contain escalating drug prices, pharmacists were allowed for the first time to substitute patented drugs with cheaper generic equivalents.

Drug manufacturers, incensed by the reform, began encouraging doctors to buy drugs from them and then sell directly to the public. For many, the offer, sweetened by huge price cuts, was irresistible — doctors could obtain discounts that undercut wholesalers by as much as 50%. For the manufacturer, the doctor often became a valuable marketing tool, pushing drug lines via the prescription pen.



The party, however, could soon be over. Last week the Competition Board released proposals that if accepted by Public Enterprises Minister Dawie de Villiers, would force manufacturers to charge the same price to all buyers of prescription medicine.

The board's recommendations are far-reaching. Describing the special pricing relationship between manufacturers and doctors as uncompetitive, the board proposes that manufacturers should be prohibited from selling or disposing of medicine in any way that discriminates between buyers or recipients of the medicine.

The proposals are certain to become controversial as copies of the report circulate among the industry's players. So far, the organisations whose members would have the most to lose, representing the pharmaceutical manufacturers and doctors, have been muted in their response. Also sure to raise objections are critics of more government intervention in the economy. They'll argue that telling companies how to charge for products is none of government's business; that if manufacturers want to give enormous discounts to doctors, that's their right.

Says Wouter Meyer, of the board's investigations directorate: "The principle underlying the board's thinking is that there should be no discrimination for an equivalent transaction. Put differently, if a buyer purchases 1 000 pills, he should pay less per unit than the person who buys only 100 pills."

He explains that wholesalers have been particularly aggrieved that doctors, who buy relatively small quantities of medicine from manufacturers, obtain larger discounts than wholesalers, who buy the same medicine in bulk. They argue that little or none of these discounts is passed on to the consumer.

Of course, the nub of the issue is an ethical one. Can a doctor who dispenses for profit be objective?

Medical schemes report having processed claims by doctors who have dispensed more than R800 000 in medicines in a single year. Comparative statistics are also telling. Five years ago, only 10% of all private-sector prescriptions were dispensed by doctors. Today, this figure stands at around 30%.

A major bone of contention is that many doctors have become little more than traders, using their discounts to bypass the formal wholesale and retail distribution chain.

They can sell drugs to wholesalers and retailers at less than the manufacturers' prices.

Welcoming the board's recommendations, Wolf Furst, of the National Association of Pharmaceutical Wholesalers, explains that this practice merely inflates the price of medicine to the consumer. "If these sales to dispensing doctors continue — lower volumes at lower prices — the consumer price will have to increase."

Meyer says the board noted that the Medical Act prohibits doctors from trading. The board, however, suggests that the Medical & Dental Council should enforce its own laws in this instance.

Responding to the recommendations, Medical Association of SA health policy director Reg Magennis says dispensing doctors have been somewhat of a mixed blessing. While they have introduced competition to the traditional distribution chain, there are dangers to fragmenting this rigid chain.

He suggests that a less formal distribution chain could threaten quality and standards. He adds: "The association fully supports the values associated with free-market competition, and will therefore continue to support dispensing by doctors, provided it complies with the norms associated with high-quality clinical practice."

Coupled to this thinking is the board's insistence that pharmacies be allowed to advertise fully. Now, they can advertise only prices of specific drugs. While this enables consumers to shop around for repeat prescriptions, it does little to inform them about general discounts available on all medicines.

Meyer doesn't foresee that the dispensing doctor will cease to operate, should the Minister accept the board's recommendations. He says that most doctors — particularly those practising in remote areas and townships — buy from wholesalers and will continue to offer a valuable service to patients. "The doctor who dispenses and trades as a mini-wholesaler, however, could find that his side-dealings become less lucrative."

Of course, the difficulty of policing a single exit price could render the board's recommendations useless. But Meyer disagrees. "We can't expect to catch everyone, but we could make an example of a few people. Wholesalers are especially likely to monitor deals and could report them to the police." A conviction under the Maintenance & Promotion of Competition Act could result in a five-year prison term or a fine of up to R100 000, or both.

On this score the Pharmaceutical Manufacturers' Association makes a valuable point.

It suggests that a deregulated market, in which group practices and medical aid-run health maintenance organisations operate their own cost-effective dispensaries, could well eliminate the need for the board's recommendations and the problem of trying to police it.

Mirryèna Deeb

TELECOMMUNICATIONS

Hello, America

Telkom's monopoly on international calls will take a beating in the new year when several private companies switch on. WorldPhone, the local subsidiary of US telecommunications company Viatel, has been operating for about four months.

WorldPhone CE Jerome Swersky won't say how many subscribers he's signed up but he plans to boost the size of his staff early next year. "Our volumes are picking up nicely and more corporates are coming in."

Other long-distance services due to start in the new year include US telephone giant MCI and New York-based International Discount Telecommunications (IDT). AT&T says it won't come in until the ANC calls for an end to sanctions.

WorldPhone and IDT offer cut-rate international services by giving subscribers access to the US telephone network. Subscribers to either company dial assigned numbers at switchboards in the US and then hang up.

CABANAS CRISIS

Racing against time

Shareholders in the liquidated Winkelspruit Cabanas del Mar and Cabanas del Sol developments met liquidators on December 11. They also had a few possibly constructive words with the Timeshare Institute of SA (Tisa) and Resort Condominiums International (RCI) aimed at structuring their own rescue plan.

The resorts were put into final liquidation on November 24 with the result that shareholders now have to race against time to counter offers from outsiders.

Their bid is unlikely to involve the developers of the schemes — Cabanas Marketing directors Renier van Loggerenberg, Harold Hees and Willem Erasmus, who have also proposed a rescue plan (*Property* December 11). Shareholders Action Committee head Carl Mischke, a member of the Cabanas del Sol shareblock, says the outcome of all these talks is that a meeting of 4 000 shareholders has been scheduled for January 20 at the Old Edwardian Health and Sports Club, Johannesburg. Shareholders have been requested not to respond to outside proposals or form other working committees.

Mischke says shareholders are being sent several proposals by prospective buyers — in addition to the rescue proposal by the developers. RCI, in co-operation with Tisa, is acting as facilitator for the rescue process on behalf of shareholders.

The action committee also met Metboard and RCI on December 14 to discuss time scales and "to put the facts straight concerning the developers' accusations (*Property* December 4) that they received a negative response from shareholders in the first half of the year when they attempted their first rescue bid as agreed by Metboard."

According to Mischke: "Shareholders were never contacted, nor were we requested to pay a special levy, even though Hees reported to Metboard in a letter dated June 17 that they had had a very negative response from shareholders."

Referring to the previous and current rescue bids of the developers, lawyers comment that it is illegal to raise a levy to pay off a bond: "It therefore draws into question the claim by the developers that the resorts ran into trouble because of the failure of timeshare owners to pay their levies. As the major creditor is the bondholder it would seem that the problem lies with the developers not paying off the bond. It should also be noted that the developers are obliged to pay off the loan allocation on the bond with each sale."

As a result of the meeting between the shareholders and Metboard, it was agreed that the closing date for tenders from prospective buyers would be set between late February to early March — as opposed to the original end-January deadline — to accommodate their rescue bid. The dates, however, are still subject to the approval of the Master of the Supreme Court.

The liquidators' advertisement offering the properties for sale by tender should appear in the press early next month. They have told shareholders that if they do not receive satisfactory offers then they will auction the properties in March.

Because of the large amounts of money involved, the rising interest bill and the daily operating costs incurred in running the resorts, Metboard is keen to press ahead. It has already lost time allowing the developers to come up with their first rescue bid. But, if the properties are sold at auction, Mischke says shareholders could lose everything.

The shareholders' action committee's rescue plan basically involves the payment of an additional capital amount. Details should be in a letter to shareholders. Should the committee succeed in raising money to pay off Metboard's bonds on the two properties — with a combined value of R5,5m — and pay off concurrent creditors, the properties will be bond-free and belong to the members of the shareblock companies. Shares of unsold stock, which for all intents and purposes belong to the developers, will "also belong to the shareholders unless the developers make their respective contributions."

The action committee comprises three people: Mischke, a physicist, business broker and management consultant; advocate Dries Loots, corporate secretary for Eskom; and Nick Pretorius, town engineer for Rustenburg. It is being assisted by RCI accounts manager Brett Archibald and Tisa executive director Peter Erasmus. ■

COASTAL HOMES

Price spiral

Five years ago, when Board of Executors launched the 67 ha Belvidere Estate on the Knysna lagoon, waterfront plots started at R130 000. They sold out in nine weeks. Today they are valued at around R700 000 apiece — a fivefold increase. And houses in this Victorian-style village range from R550 000 to R1,6m on the waterfront.

According to an Allied Bank spokesman in George, these escalations have outstripped any other resort in the southern Cape. From Allied records, though, the pace now seems to be slowing.

Land values in other prime Knysna areas such as Leisure Island and the Heads, have soared almost as dramatically over this period, probably by as much as three- to fourfold, according to Fisch Property Group partner and Belvidere House owner Gray Rutherford.

Comparisons between Knysna waterfront land values and those in Plettenberg Bay are inappropriate; no scientific data is available. However, it may be true to say that those in Knysna have now caught up. According to estate agency Pick of Plett owner Tim Hutchinson, there are only 80 beachfront erven in Plett for which demand is extraordinarily high. Prices have reached R1,3m for a vacant 1 000 m² site and there are only three to four of these on the market.

Says Hutchinson: "This is unusual, but obviously indicative of the state of the economy."

Rutherford notes that over a year ago a 1 000 m² site at the Knysna Heads went for R1m.

The phenomenal rise in Knysna property prices may account for the R1,1m price of a Cape Cod-style home in the new Island Cove housing estate on Leisure Island. It could also explain the R7,5m tag on Belvidere House, the historic homestead at the centre of Belvidere Estate, which Rutherford recently put on the market. It'll be interesting to see whether these prices are achieved.

Belvidere House, situated on a 3,7 ha property, includes a beautifully restored colonial Georgian and Victorian manor house-cum-country hotel. According to Rutherford, occupancies range from almost 100% in the long season between October and April, to a 60% average during the rest of the year. The cottage rate is R330 per person, including bed and breakfast.

The manor house dates back to 1834, when George Rex's son-in-law, Thomas Henry Duthie, bought it from Rex and established the estate. Rex, a former British naval officer of dubious royal links, is a legend in Knysna — having owned most of the area in the early 1800s. "Belvidere House is one of the most important pieces of real estate in the southern Cape in terms of its historical and architectural value," Rutherford says.

The manor house has been restored by its present owner — a task which took four years. It provides the hotel's elegant, yellowwood-floored dining and reception rooms. Guests are accommodated in eight luxury Victorian-style cottages (some sleep two, others four), all of which front the lagoon. There are also a number of outbuildings, which include the quaint 1820 George Rex Cottage and Yellowwood Barn.

A low-density masterplan for the further development of the property provides for 25 additional cottages, each set in a parkland environment.

Cost-cutting sets an unhealthy precedent for 1993

STAR 31/12/92. (299)

While the world's eyes were focused on the Aids pandemic during 1992, further cracks began showing in SA's public health system, reports PAULA FRAY.

SOUTH Africa's cash-strapped public health system did not go untouched during the ongoing violence and political change in 1992 as Government embarked on a cost-cutting venture amid calls for more money to be poured into health.

As the Transvaal Provincial Administration (TPA) proceeds with cost-cutting plans in the public sector — in line with a Government call to cut staff by 5 percent — overworked doctors are concerned essential services will be first in the firing line.

Already, doctors at State hospitals are being offered substantial incentives if they leave the employment of the TPA.

Doctors are particularly concerned about what this will mean for rural health care where it is already difficult to retain good medical staff.

And Wits University Medical School is still discussing cost-cutting moves — to come into effect early next year — at TPA academic hospitals.

The lack of cash and even the shortage of medical staff was highlighted when concerned doctors at J G Strijdom Hospital warned that patients would die unless something was done urgently.

Although the TPA denied that any posts had been frozen, doctors there maintained that posts at consultancy and registrar level had not been filled.

The J G Strijdom crisis also highlighted the severe shortage of interns nationwide as high education costs and low pay in state hospitals discourage students from entering the medical field.

Many interns worked far longer than the maximum 80 hours a week laid down by the SA Medical and Dental Council. An investigation by the Department of National Health and Population Development found that all interns "work far too long hours as a result of the shortage of interns throughout the country".

Indicative of a health care system riddled with contradictions, it was also revealed that about R1 billion of medical payouts in the private sector each year — nearly 25 percent of all subscriptions — was wasted by continued fraud and over-utilisation of medical aid facilities.

It was a year in which South African medical expertise was used to separate Mauritian Siamese twins Ashlay and Ashil Fokeer. The weaker twin Ashil died in the operating theatre while Ashlay is preparing for the journey back home.

It was the year in which alcohol consumption by South Africans reached an all-time high. It is now conservatively estimated that there are at least 1 025 198 alcoholics in South Africa, nearly 30 percent of them women.

It was the year which saw the first fully representative medical congress. The National Aids Convention of South Africa (Nacosa) was labelled the "Medical Codesa" as it brought together a wide range of organisations dealing with the Aids dilemma.

In Amsterdam, the world's Aids authorities heard that one new person was infected with the Aids virus every 15 seconds, while between 10 million and 12 million adults — and one million children — already had HIV, according to the World Health Organisation (WHO). More than two million people have developed Aids.

The figures, released at the eighth International Conference on Aids, gave a chilling picture of the spread of the pandemic which is outrunning the modest progress of scientific efforts to combat it.

"One person is infected every 15-20 seconds," said Michael Merson, head of the WHO's global Aids programme.

In South Africa, the figures are as startling. At a multi-disciplinary conference in November, Dr James McIntyre of the Department of Gynaecology and Obstetrics at Baragwanath Hospital revealed that:

- At least two HIV-positive women give birth daily at Baragwanath.
- About 200 women had been identified as HIV-positive in the first eight months of this year.
- Figures indicated that about 20 000 Soweto women might be HIV-positive.

But it was also the year in which South Africa released a Charter of Rights on Aids and HIV which set out 12 basic non-discriminatory principles dealing with the fair and just treatment of those affected by the virus.

Activists believe the charter — signed by a wide range of political, medical, business and social groups — will play an important role in the fight against Aids.

However, it is at primary health level where medical experts believe South Africa should begin the fight for equal and adequate facilities for all.

Primary health care organisations believe the basic solution to ongoing problems in the public health sector is a reorganised and restructured public health service oriented towards primary health care, and not in privatisation or procurement by the State.

Achievement . . . Mauritian Siamese twins Ashlay and Ashil were separated in Cape Town, but the weaker twin Ashil died in the theatre.
Picture: Eric Miller

This month, health workers and members of the community, met to debate recommendations for the transformation of South Africa's primary health care system at a national conference outside Johannesburg.

Malnutrition was identified as a serious threat to the health of the nation, expecially children, at the joint health policy conference of the National Progressive Primary Health Care Network and the South African Health and Social Services Organisation. It recognised undernutrition as being caused by the economic inequalities reinforced by the apartheid system. □